Roj:	STS 7026/2010
Id Cendoj:	28079130042010100681
Organ:	Supreme Court. Litigation Chamber
Headquarters:	Madrid
Section:	4
Appeal No.:	1633/2008
Resolution No.:	
Proceedings:	CASSATION APPEAL
Speaker:	ENRIQUE LECUMBERRI MARTI
Resolution type:	Ruling

RULING

In the Villa of Madrid, December 14 2010.

FACTUAL BACKGROUND

First.- Section 8 of the Administrative Litigation Chamber of Madrid's Supreme Court of Justice, in the decisions number 21/2005, on February 20 2008 passed a sentence, whose ruling states: *"WE MUST DISMISS AND WE DISMISS the complaint of the administrative litigation appeal No. 21/2005, lodged by the Procurator Mrs. María del Carmen Gímenez Cardona, in the name and on behalf of Mrs. Lidia, due to implicit dismissal of the Administration on request for its patrimonial responsibility, on 1 April 2005. Without costs"*.

Second.- The procedural representation of Mrs. Lidia and her daughter Melisa filed a cassation appeal by writing on March 25 2008.

Third.- By a decision issued by Section 3 of this Chamber, on June 18 2009, the cassation appeal is uphold and the case is forwarded to this Section 4 in accordance with the distribution rules; where they were received on September 7 2009, conferring the notification to the appellant parties to file the opposition.

Fourth.- The Lawyer of Madrid Region lodged a statement of opposition on October 21 2009. The procedural representation of the Company *Zurich España Co.* of insurance and reinsurance on October 29 2009.

Fifth.- After concluding the proceedings, a date was set for the voting and judgment of this appeal: May 25 2010, when it took place after observing the procedures established by law.

Sixth.- This Chamber and Section passed a sentence on June 9 2010. Its ruling reads as follows: *"1st.-There is ground for the cassation appeal lodged by the procedural representation of Mrs. Lidia and her daughter Melisa, against the ruling issued by Section 8 of the Administrative Litigation Chamber of the Supreme Court of Justice of Madrid, on February 20 2009, relapsed in the decisions number 21/2005, against the implied decision, for implicit dismissal of the claim filed for its patrimonial responsibility before the Department of Health of the Madrid Region, as a result of the healthcare received in the Hospital Santa Cristina of Madrid during the birth of her child.*

2nd.- We uphold in part the administrative litigation appeal inferred from the aforementioned procedural representation before Section 8 of the Administrative Litigation

Chamber of the Supreme Court of Justice of Madrid, against the implied decision, for implicit dismissal of the claim filed before the Department of Health of the Madrid Region, which we annul for being unlawful and we claim the right of the appellant and her underage daughter, to receive the payment from the Department of Health of the Madrid Region, respectively, of the compensation. The sum of four thousand euro (EUR 40000) that the Administration will pay in the name of the appellant's daughter will be administered following the civil regulations on the administration of assets of the minors or disabled.

We do not make an express condemnation in the costs of this cassation appeal nor in the cost incurred in this ruling".

Seventh.- The procedural representation of Zurich España Co. of Insurance and Reinsurance, by writing on September 22 2010, declared the annulment of the proceedings under article 241 of the Organic Law of the Judiciary; a document that was admitted by order issued on September 29 2010, conferring the notification to the other parties in litigation so that within five days they made allegations, a procedure that was evacuated by the procedural representation of Mrs. Lidia and her daughter, Melisa, by a letter dated October 8 2010, and by the Lawyer of the Region of Madrid by letter dated October 20 2010.

Eighth.- By a decision issued on November 18 2010, it is resolved to give rise to the incident of annulment of the proceedings promoted by the procedural representation of Zurich Co of Insurance and Reinsurance, Inc. against the ruling that was passed on June 9 2010 – cassation appeal **1633/2008**- that becomes void, setting a date for the voting and judgment: November 30 2010, at 10:30 AM., when it took place after observing the procedures established by law.

With His Excellency Mr. Enrique Lecumberri Marti as judge rapporteur.

LEGAL RATIONALE

First.- In this cassation appeal it is contested by the procedural representation of Mrs. Lydia and her daughter Melisa, the ruling issued by Section 8 of the Administrative Litigation Chamber of the Supreme Court of Justice of Madrid, on February 20 2008, which dismissed the administrative litigation appeal lodged against the against the implied decision, for implicit dismissal of the claim filed for its patrimonial responsibility before the Department of Health of the Madrid Region, as a result of the healthcare received in the Hospital Santa Cristina of Madrid during the birth of her child.

Second.- After the trial court noted, in these terms, the background that results of the evidence:

<< 1) Mrs. Lidia with a history of addiction to intravenous drugs (not during the gestation at hand), hepatitis B and C, insulin-dependent diabetes, with no known allergies; with an obstetric history of two abortions and two previous eutocic deliveries, one of a weight of 3000 gr. and the other one of 3540 gr.; was being controlled in the Pathology of Pregnancy Consultation from week 9. Her last period was on 18 April 2001.

2) She underwent the following medical examinations:

On June 25 2001 it was confirmed that she was 9.5 weeks pregnant. The existence of a single embryo with positive heartbeat and of a 42 mm CRL (corresponding to 11 weeks) was confirmed. From this moment, the gestational age was corrected to two weeks beyond the date that had been estimated according to the last period.

On August 22 2001, with a corrected gestational age of 20 weeks, it was informed as a breech presentation with normal biometrics and a normal placenta and amniotic fluid.

On November 5 2005: corrected gestational age of 31 weeks; single fetus; positive heartbeat with biometrics like amenorrhea except abdominal circumference which corresponds to 34 weeks; an estimated weight of 1900 gr.: posterior placenta and slightly increased amniotic fluid (AFI 25). Normal uterine artery Doppler and mild fetal hydronephrosis on the right kidney.

On November 26 2001, the corrected gestational age was 34 weeks; cephalic presentation, positive heartbeat with biometrics like amenorrhea except abdominal circumference which corresponds to 2 more weeks; estimated weight of 3100 gr.; posterior placenta and hydramnios (AFI 33); Normal uterine artery Doppler.

3) Outstanding data of the gestation evolution: Mrs. Lidia was admitted being 33 weeks pregnant because of the threat of a preterm labor and several adjustments of insulin by Endocrinology to normalize the blood glucose level. There were also emergency visits, on November 15 2001, because of the expulsion of two blood clots and pain at renal fossa. No pathology was found. And on December 3 2001, when she went to the ER because she was having contractions.

4) On December 26 2001 she had a routine revision where her admission was ordered for a diabetes control and a fetal well-being assessment; a hypertension protocol was also requested due to significant edemas in the lower extremities; after adjusting the insulin and checking the medical tests, the patient was discharged.

5) On December 3 2001 with a gestational age of 35 weeks, she went to the Emergency Services because she was having contractions. Her diagnosis established that she was in threatened preterm labor, so she was admitted in the high risk floor.

The ultrasound presented a single gestation, cephalic; posterior placenta, polyhydramnios (AFI 42) and normal uterine artery Doppler. Biparietal diameter of 91 cm, abdominal circumference of 364 and femur longitude of 60. Induction by polihydramnios was noted, with the corespondent informed consent signed by the patient.

6) The induction took place on December 4 of the same year, applying prostaglandin gel and starting at 13:10 AM. At 2:45 PM. it presented a 2 cm. dilatation and 80 % effacement; the presentation was not felt. At 7:05 PM there was a dilatation of 6cm., and an ultrasound was done that informed of a breech presentation of with a biparietal diameter of 89 mm, proceeding to the intentional breaking of the waters, with the drainage of clear fluid and verifying the breech presentation at 1 level. At 7:50 PM the dilation was complete and she was taken to the delivery room. In the second stage of labor, the Bracht maneuver was employed first. Then, the Mauriceau maneuver, and since it was problematic, it was decided to apply a forceps in last head for the fetal extraction. The dilation took 4 hours and 30 minutes, and the expulsion took 15 minutes, being a spontaneous delivery with intact membranes. The cardiotocographic register remained normal during dilation and delivery.

7) The birth took place at 8:05 PM., and the baby was a girl with a weight of 2690 gr., Apgar score of 6 at the first minute and 10 at 5 minutes, and umbilical artery pH of 7.28, needing type III resuscitation.

8) The newborn baby was admitted in Neonatology since she was a preterm baby and her mother had diabetes. On the next day, she had a head ultrasound done that reported a minor hyperechogenicity at the occipital region to be controlled.

9) Two more ultrasound controls were done: one on December 10, which informed that the hyperechogenicity at the occipital region with a right echogenic caudate nucleus persisted; grade 1 hemorrhage; and one on 17 December, which detected a minor periventricular hyperecogenity and a subependymal cyst of 12 mm. The cardiology, ophthalmology examinations and the abdominal ultrasound were normal.

10) On December 18 she was discharged with the diagnosis: preterm child with a diabetic mother, grade 1 periventricular hemorrhage and multifactorial jaundice. She was referred to Neurology in the Hospital "Niño Jesús" of Madrid.11 on January 13 2004; a technical optional opinion was delivered, certifying a disability level of 75 %. She presented: learning disability caused by encephalopathy; fetal/perinatal distress; and partial encephalopathy crisis caused by fetal/perinatal distress. >>

Analyses closely the various expert medical reports and concludes that "the professional doctors who have intervened in the examined case, acted in compliance with the lex artis ad hoc principle and there are no signs of malpractice".

Third.- There are two grounds of appeal set out under sections A and B of the application, against the abovementioned ruling:

. first, under Article 99.1 d) of the Jurisdiction Act, for infringement of *Articles 106 of the Spanish Constitution, 139 and the following of the Law 30/1992 of 26 November 1992, on Rules governing general government institutions* and Common Administrative Procedure, as well as the case-law doctrine that it mentions at great length, since the trial court did not value correctly the objective liability of the Administration and the evidence presented before the court.

. second, on the basis of Article 88 (1.) (c) and (d), since the contested judgment did not contain the facts that were proved during the trial, and the Court made no reference to the lack of information about the option of performing a cesarean for the breech delivery instead of performing a vaginal delivery, that were alleged in the complaints and solutions.

The appellant disagrees with the legal reasoning supported by the Court "a quo" when affirming that:

<<According to the applicants there is a causal relationship between the medical choice of performing a vaginal delivery and the severe damage of the newborn baby.

In light to this, the gynecology specialists, Drs. Jose Francisco and Carlos Miguel, say in page 20 of their report that "the professionals involved acted in compliance with the lex artis ad hoc principle and there are no signs of malpractice."

According to the expert report of SEGO (Spanish Society of Gynecology and Obstetrics), when answering the first question (page 6) it was said "I believe that the end of the gestation in week 34 is in line with the current protocols of SEGO in view of a delicate

fetal and maternal status and of the contraindication of using betamimetics for the premature labor". In the pages 9 and 10 of the expert report that has been provided as document number 1 of the claim of the defense it is read:

"In this case, the patient was 30 weeks pregnant, she had an ultrasound done and was diagnosed with polyhydramnios (excess of amniotic fluid). Furthermore, when she was admitted at week 34 in threatened preterm labor, the polyhydramnios was more important and the reported abdominal measurement of the fetus were indicative of macrosomia. Therefore, there were two signs, polyhydramnios and a possible macrosomia, which are directly related to gestational diabetes that deal with irregularly controlled glucose (we must also remember that the patient required various insulin adjustments for adapting glucose controls),in other words, macrosomia and polyhydramnios are two clear signs of decompensated diabetes. This justifies completely the termination of pregnancy. Today we know that a bad maternal metabolic control raises the incidence of fetal complications, although small deviations from normality are sufficient to cause adverse effects on the fetus.

The protocol on assistance at delivery with diabetic mothers of the Spanish Society of Gynecology and Obstetrics states that pregnancy can be terminated electively at term or earlier if a poor metabolic control or the suspicion of fetal damage recommend it this way. It also notes that the optimal delivery is vaginal, since diabetes by itself, is not sufficient indication to perform a cesarean.

Finally, in the conclusions of the aforementioned expert report (page 21) it is said:

"Mrs. Lidia presented a complicated gestation with insulin-dependent diabetes.

The instruction for termination of pregnancy at 34 weeks due to the appearance of two signs related with a poor perinatal prognosis (polyhydramnios and fetal macrosomia) is correct and in line with the current assistance protocols".

The assistance during the second stage of labor was correct, with relevant maneuvers performed for the extraction of the fetal head. This it is stated in the expert report of the SEGO, when answering the third question (page 6):

"The maneuvers that Dr. Celso refers to in his letter are correct in a breech delivery, namely: Bracht maneuver, followed by the extraction with the Mauriceau maneuver and forceps in last head if the previous maneuvers are not enough to detach the fetal head".

With the same sense of accuracy of the medical intervention practiced, it is exposed on page12 of the report of Drs. Jose Francisco and Carlos Miguel:

"3- Evaluation of assistance at delivery; the longest fetal diameter is the head, which means that in a cephalic delivery, once the head comes out, the rest of the body will be easily expelled, with some exceptions. It is not this way in a breech delivery, so it is customary to employ a series of maneuvers to facilitate the emergence of the baby's head.

In this case, the assistance during the active phase of labor was correct because it was monitored permanently, and there were no alterations of the fetal heart rate reported on the partogram. The dilation was quick; it took four and a half hours. The expulsion was taking place normally until the emergence of the head. A first Bracht maneuver was performed to

help in the extraction; this consists of taking the fetus to the maternal abdomen. When this maneuver failed a Mauriceau maneuver was performed, consisting of introducing the right forearm, holding the fetus' mouth while traction is made to bring the chin close to the sternum. With the help of another person, the abdomen is compressed to make traction. Since the fetal head could not be expelled with these maneuvers, it was decided to use a forceps in last head.

This sequence of operations was entirely correct and we should also remember that the second stage of labor only took 10 minutes.

The operations that have been described, which are done to assist the emergence of the fetal head in a breech delivery, must be performed in a simple way, without forcing them. It is preferable to change to another one. Therefore, we can say that a forceps in last head does not imply an inadequate obstetric care and since it is preferable to use it having failed in the previous maneuvers, much credit goes to the Specialist".

In its conclusions (page 19) it is added:

"The maneuvers to help in the emergence of the fetal head were the appropriate, including the use of the forceps; in line with the current protocols (forceps in last head).

According to the revised reports and the partogram, the use of the forcepswas correct, since there was no technical problem."

Afterwards, in the act of ratification of his expert report, Mr. Jose Francisco, answering the codefendant said that "the sequence of maneuvers was the right one because when one fails it is necessary to do the next one and so on. The forceps is the last one."

In the medical examination report (pages 147 and seq. of the administrative record) it is stated:

"1. There was not negligence in the obstetric performance followed in this case. There were various circumstances (prematurity, diabetes and breech presentation) interrelated and unrelated to the assistance, that led to certain complications."

Together with all the above points, we consider that there were no prenatal nor postnatal data that suggested the existence of intrapartum hypoxia. The expert report of the SEGO (Spanish Society of Gynecology and Obstetrics) says in answer to the fourth question (page 7): "the analyzed documents only mention an initial Apgar socre of 6, which is moderately low (rated out of 10) and an excess base of -5(acidosis), offset by the normal pH. Therefore, we believe that there is no data indicating a significant intrapartum hypoxia.

The report of Drs. Jose Francisco and Carlos Miguel (page 15 and 16) reaffirms the aforementioned:

"From our point of view, there was not a hypoxia of the sufficient level as to cause permanent neurological damage. We make this statement on the basis of the following points:

-No alteration patterns of fetal heart rate in the cardiotopographic register indicating hypoxia.

The second stage of labor lasted only 10 minutes. Assuming that during these 10 minutes there was a high level of hypoxia, the short period of time is perfectly tolerated by the fetus.

The data collected after the delivery do not present the necessary criteria to considere an intrapartum hypoxic event as the casue of the neurologic injury. In this regard, the Neonatal Encephalopathy and Cerebral Palsy Committee Of the American College of Obstetrics and Gynecology and the American Academy of Pediatrics determine the criteria to define an acute intrapartum hypoxic event as the potential cause of a permanent neurological injury:

1. *Existence of a "signal" of hypoxia that occurs inmediately before or during the delivery.*
2. *A sudden and persistent bradycardia or absense of variability in the fetal cardiotocographic register together with late decelerations, variable or persistent, when the previous pattern had been normal.*
3. *Apgar score of 0-3 at 5 minutes.*
4. *Start of a multisystemic affectation within 72 hours after birth.*
5. *Imaging studies that show a clear evidence of unfocussed acute brain injury.*

In this case the cardiotocographic register is absolutely normal, with no parameter indicating fetal hypoxia; Apgar score at 5 minutes was superior to 3 (out of 10). There is no evidence of multisystemic affectation and ultrasound studies did show focused injury (right periventricular hemorrhage).

Furthermore, in the act of ratification of his expert report, Mr. Jose Francisco, in response to the question from the codefendant (4th clarification), said that "the fetus was monitored permanetly during the partogram and there were no signs of hypoxia observed".

In the "report review", in relation to the prenatal –not intrapartum- signs of hypoxia, which the legal expert, Mr. Leandro, highlighted in the act of ratification of his report, Mr. Jose Francisco added: "This data can indicate that during the intrapartum there could have been more frequent signs of hypoxia than during other deliveries of expectant mothers that do not have these pathologies, but the fact of suffering from this illnesses is not neccesarily related to an intrapartum hypoxia." This has to be related with the answer of SEGO to the fourth question in the expert report (page 7): "The analyzed documents only mention an initial Apgar score of 6, which is moderately low (out of 10) and an excess base of -5 (acidosis) offset by the normal pH. Therefore, I believe that there is no evidence that indicates a significant intrapartum hypoxia."

It is true that the newborn baby presented ventricular hemorrhage, but this has to be related to the prematurity. Thus, in the expert report of SEGO, the answer to the fifth question (page 8) is: "the primary cause of cerebral hemorrhage in fetuses is prematurity, followed by

hypertension, hypoxia and trauma (...) I believe that hypothetically the intraventricular hemorrhage in the fetus could have been caused by endothelial and vascular fragility due to prematurity and perhaps to a sharp decompensation of the fetal head. A previous metabolic injury (diabetes) or infection (hepatitis) cannot be ruled out."

In the same way, the expert report provided as document number 1 of the claim of the defense states:

"We should remember that the newborn baby was diagnosed with grade I periventricular hemorrhage; this is the denomination for the periventricular bleeding of the subependymal germinal matrix (Grade I) that can progress inside the ventricular system with no hydrocephalus (Grade II) or with hydrocephalus (Grade III) until extending into the parenchyma (Grade IV). There are multiple causes for these hemorrhages. Any factor that can cause a disruption in the self-regulation of the blood flow (fluctuation, increase, decrease) can lead to an intraventricular hemorrhage.

- prolonged labor, intrapartum hemorrhage, low Apgar score, arterial low blood pressure, hypocapnia and coagulopathies.

- hypoxia, ischemia, rapid changes in liquids, high mechanical ventilation parameters, inappropriate maneuvers in the care for the newborn.

Among these causes, the most important one is prematurity, with no doubt.

In this case we must not forget that this is a preterm newborn (gestation of 34 weeks); all newborn between weeks 22 and 37 is considered preterm. This is still today the main cause of perinatal morbidity and mortality. A higher incidence of intraventricular hemorrhage can be found among the complications related to prematurity. This occurs mainly in preterm neonates and its incidence increases with the level of prematurity, being rare in full-term babies. The importance of this injury is not only related to its high incidence but also to the severity of such complications and the severe long-term neurological after effects.

According to literature, there are both maternal factors and factors of the newborn that increase the apparition of these hemorrhages.

There are associated pathologies like pregnancy-induced hypertension, diabetes, acute hemorrhages during delivery and chorioamnionitis. Other important factors to consider are the birth canal and its processes.

Therefore, prematurity in itself, is a very important factor when talking abour intraventricular hemorrhage."

As for the eventual birth trauma caused by the application of forceps for the extraction of the fetal head or the eventual concurrence of other important factors, Drs. Jose Francisco and Carlos Miguel say (page 18):

"Trying to answer the question of whether the forceps could have caused the neurological damage, we note that the type of hemorrhage that was resented is not related to

birth trauma secondary to its application. Moreover, there was no external injury in the fetal head, secondary to its use.

Finally, we must note another important fact: in the examined case, there was a grade I periventricular hemorrhage; according to literature, this does not imply a risk of neurological after effects. Grade II hemorrhages have a 10 % risk of after effects, grade III, with the development of hydrocephalus, have a 50 % risk and at grade IV, with bleeding of the surrounding of the brain parenchyma, the risk rises to 90 %.

In the light of the above, from our point of view, the periventricular hemorrhage is related primarily to the prematurity, ruling out hypoxia and not being able to assess the degree of involvement of other aforementioned .factors."

The Inspection report makes the same point (pages 147 et seq of the administrative file:"a causal link cannot be established categorically, between the type of delivery chosen and the complications presented by the patient".

Drs. Jose Francisco and Carlos Miguel (pages 19 and 20 of their expert report) state:

"There are no pre and postnatal data indicating the existence of intrapartum hypoxia.

The newborn baby was diagnosed with intraventricular hemorrhage, a pathology that is associated with prematurity.

The obstetric trauma caused by the application of the forceps results mainly in the apparition of cephalohematomas and subdural hematomas, which are not present in this case.

The periventricular hemorrhage must be related primarily to prematurity, rulling out hypoxia and making the degree of involvement of other factors difficult to assess (rapid changes in liquids, hypercapnia, etc.).

According to literature, grade I periventricular hemorrhage does not have long-term neurological effects. The experts acted in compliance with the lex artis ad hoc principle and there were no signs of malpractice."

The expert report of SEGO, in answer to the sixth question (page 8) states:

"I think that the documents point out an obstetric performance in compliance with the lex artis, the same way it is pointed out in the following conclusion:

In any case, the doctors faced two difficult decisions: terminate pregnancy prematurely and performing a vaginal breech delivery. These decisions could not prevent one of the most feared complications in these situations: fetal periventricular fetal hemorrhage.

In page 9 of the same report it is added that:

"Ultimately, we believe that it is very possible that the maternal diabetes was the primary cause for the fetal macrosomia and polyhydramnios, causing the premature delivery, in week 30 and in week 32 + 5, and leaded to the delivery on 12.4.01.

This premature delivery and the polyhydramnios caused the breech presentation.

Finally, it is possible that the combination of the breech delivery and the prematurity was the cause of the alleged fetal brain hemorrhage.

In this sequence of events, doctors have been making choices of action that seem to be in line with the practice protocol, showing no malpractice nor negligence since we cannot ensure that if it had been done otherwise, the risk would have decreased, but nevertheless they did not manage to prevent the fetal damage.>>, since, for her, the protocol of SEGO protocol on assistance to breech delivery is not as conclusive as the trial court says it is, because according to the Spanish Society of Gynecology and Obstetrics: *"results indicate that elective cesarean section is a better choice than a vaginal delivery for assisting a breech delivery at term. Both the perinatal and the neonatal mortality were less frequent in the group of cesarean delivery than in the group of vaginal delivery."*

Fourth.- The precedents set by previous decisions of this well-known Court, establish that the cassation appeal has the objective of ensuring the correct and consistent interpretation of the rules by the Court of First Instance, therefore, there is no point in discussing the outcome of the evidence assessment conducted by the Court "a quo", unless it can be described as unreasonable, arbitrary or completely irrational. Nevertheless, it is permitted under Article 88.3 of the Regulatory Law of this jurisdiction, that this Court may integrate into the facts proven by the Court of First Instance those facts that the Court has omitted and that are sufficiently justified by the actions and if it is necessary to take them into consideration to appreciate the alleged infringement of the rules of the legal order or case law. In the same way, we must consider that in terms of financial liability of the Administration, this Court declares that the exclusion, with the aforementioned exceptions, of the assessment of the evidence carried out by the Court of First Instance of its discussion on the court of cassation does not prevent that the latter raises the matter of the correctness of the assessment that the judgment under appeal has established about the causal link between the facts it has valued and the harmful legal consequences that they are charged with, since this legal matter could be reviewed before this Court.

With these assumptions we can face the first ground of appeal raised by the appellant, under Article 88.1.d) of the Regulatory Law of this jurisdiction, which reports that the first instance judgment has infringed Article 106 of the Spanish Constitution and Articles 139 and seq of the Law 30/1992 of 26 November 1992, on Rules governing general government institutions and Common Administrative Procedure.

After observing the various medical reports, the Court concludes that they cannot consider this cassation appeal, since they respond to a review that cannot be described as illogical or irrational. Once the vaginal delivery started, a series of maneuvers were performed successively and failed (Bracht and Mauriceau maneuvers and finally, the use of the forceps in last head.) They have to be considered adequate treatments and in compliance with the "lex artis ad hoc."

Nevertheless, there is several data to take into consideration, which has not been analyzed by the Court and leads to a different result. The first piece of information is that,

although according to the protocols of the SEGO it cannot be said that whenever there is a breech presentation it is mandatory to perform a cesarean delivery, this is the case of the preterm labor of a diabetic mother with an obstetric history of two abortions and two eutocic deliveries. Certainly, all cesarean deliveries carry risks for the mother, but in this case, it would have prevented the serious damage that the daughter of the appellant has suffered. The second element to consider is that although the vaginal delivery was performed in accordance with the orders of those doctors attending the appellant, in compliance with the lex artis, the technical optional opinion issued by the Area of Neurology of the Hospital Niño Jesús de Madrid, on January 13 2004, after certifying a disability level of 75 % and a learning disability caused by encephalopathy, concludes that the etiology is fetal/perinatal distress.

Finally, although this will be discussed further on in another ground of appeal, it was decided to perform a vaginal delivery without warning the appellant of the risks that this procedure involves and without informing her (as they should have done) of the possibility of preventing these risks by performing a cesarean section, although this would also present some inconveniences.

Fifth.- The second appeal based on the infringement of Article 67 of the Jurisdiction Act and Article 24 of the Spanish constitution, and the case-law doctrine of the judgments of June 22 and November 9, must be estimated, since the appellant is right when stating that the contested judgment should have been about the doctor's obligation of informing the patient about the possibility of preforming a cesarean delivery instead of a vaginal delivery.

This issue was raised in the statements of claim and the conclusions of the appellant, since she thought that there was a chance of performing a cesarean section that she was not informed of, and the doctors decided to perform a vaginal delivery. Since this was not raised by the Court, inconsistency by omission was committed. Therefore, in accordance with Article 95.1 d) of the Jurisdiction Act we must abrogate the judgment under appeal and resolve the corresponding matters of this significant question. For the of the procedural representation of the insurance company it is legally irrelevant to the resolution of the litigation, since it considers that the termination of labor has to be decided by the doctors and not by the patient. Otherwise, the decision would always be the medically inacceptable "cesarean section on demand", which cannot be performed in an adequate medical assistance and it would contravene the protocols of the SEGO. Moreover, the doctors did not consider the cesarean delivery appropriate at any time, so they could not be obliged to inform of this situation.

We do not believe that it is a "cesarean section on demand"-agreed with the doctor without there being any indication for it- since, according to the Spanish Society of Gynecology and Obstetrics, performing cesarean section in a breech labor carries a much higher risk for the fetus. Since the pregnancy of this case presented a high risk due to the associated pathology, the prematurity, the poorly controlled diabetes –macrosomia or suspected large size of fetus, polihydramnios or increase of the amniotic fluid- when the doctors realized it was a breech presentation they should have informed the mother of the

potential risks, which derive from a breech delivery, and offered her the possibility of performing a cesarean delivery, if she had not taken the risks of a vaginal delivery. If she had been informed, she would have had to sign a consent authorizing a vaginal breech delivery; and as we have already noted, it was a high risk pregnancy because of the associated pathology, the prematurity, the breech presentation and therefore, there was a higher morbidity, and since the patient wanted a tubal ligation, a cesarean section seems more appropriate.

This was a breach of the "lex artis", because as they did not give the mother the possibility of assuming this risk, damage was caused, which she would not have suffered if she had had the possibility to choose a cesarean delivery. As our Court admits, among others, in the judgments of October 22 2009 –cassation appeal 710/2008 – and of March 24 2010 – cassation appeal 3944/2008-, this infringement (the privation of the ability to decide) produces a moral damage that can be repaired economically.

Sixth- The appellant on behalf of herself and her daughter, without specifying the concepts to which she is referring to, claims compensation of one million five hundred thousand euro (EUR 1,500,000). We must consider the amounts that we have recognized in similar cases. Therefore, in this case, we establish a compensation of fifty thousand euro (EUR 50,000) for the moral damage suffered by Mrs. Lidia, current as of the date of this ruling. For the material damage suffered by her daughter Melisa, that according to the technical optional opinion of the Hospital "Niño Jesús" of January 2004, she has a disability level of 75 %.: << learning disability caused by encephalopathy; fetal/perinatal distress; and partial encephalopathy crisis caused by fetal/perinatal distress. >>, we establish a compensation of four hundred thousand euros (EUR 400,000), also current as of the date of this ruling. This amount will be paid by the Administration in the name of the appellant's daughter and will be administered following the civil regulations of the administration of assets of the minors and disabled.

Seventh.- Since we uphold this ground of appeal, under Article 139 of the Jurisdiction Act, there is no need of making a damning pronouncement on the costs of this appeal.

For these reasons, on behalf of His Majesty the King of Spain, and in the exercise of the power of judging that emanates from the people and is conferred by the Spanish Constitution.

WE DECIDE

1st .- There is ground for the cassation appeal lodged by the procedural representation of Mrs. Lidia and her daughter Melisa, against the ruling issued by Section 8 of the Administrative Litigation Chamber of the Supreme Court of Justice of Madrid, on February 20 2009, recaída in the decisions number 21/2005, against the implied decision, for implicit dismissal of the claim filed for its patrimonial responsibility before the Department of Health of the Madrid Region, as a result of the healthcare received in the Hospital Santa Cristina of Madrid during the birth of her child.

2nd .- We uphold in part the administrative litigation appeal inferred from the aforementioned procedural representation before Section 8 of the Administrative Litigation Chamber of the Supreme Court of Justice of Madrid, against the implied decision, for implicit dismissal of the claim filed before the Department of Health of the Madrid Region, which we annul for being unlawful and we claim the right of the appellant and her underage daughter, to receive the payment from the Department of Health of the Madrid Region, respectively, of the compensation. The sum of four thousand euro (EUR 40000) that the Administration will pay in the name of the appellant's daughter will be administered following the civil regulations on the administration of assets of the minors or disabled.

We do not make an express condemnation in the costs of this cassation appeal nor in the cost incurred in this ruling.

Thus, by this our ruling, we pronounce, command and sign it PUBLICATION.- In the same day that was read and published the herein decision, in public audience, I his Excellency Mr. Enrique Lecumberri Marti as judge rapporteur, herein certify.