Neutral Citation Number: [2022] EWHC 847 (QB)

Case No: E90BS740

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
BIRMINGHAM DISTRICT REGISTRY

Birmingham Civil and Family Justice
The Priory Courts
33 Bull Street
Birmingham B4 6DS

Date: 12th April 2022

Before:

HER HONOUR JUDGE EMMA KELLY

- -

Between :

Miss Victoria Richins

Claimant

- and –

Birmingham Women's and Children's NHS Foundation Trust

Defendant

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- -

James Marwick (instructed by Enable Law) for the **Claimant**
John Coughlan QC (instructed by Bevan Brittan LLP) for the **Defendant**

Hearing dates: 7th, 8th, 9th, 10th March 2022

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Approved Judgment

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Her Honour Judge Emma Kelly:

1. This is the judgment upon the issue of liability only in this clinical negligence claim.

2. By her claim issued on 4th July 2018, the Claimant seeks damages for losses arising out of the stillbirth of her son, Kyron, on 7th July 2008 whilst she was an inpatient at the Defendant's Birmingham Women's Hospital ("the Hospital.") The Claimant's case is that she would not have suffered nervous shock and consequential Post Traumatic Stress Disorder and Obsessive Compulsive Disorder had Kyron been born alive. The parties have agreed quantum, subject to liability, in the sum of £145,000 gross of CRU but net of a previous settlement of a dispute as to limitation, which was compromised on a 50/50 basis.

Background

3. The following chronology is not in dispute.

4. In January 2008 the Claimant (date of birth 5th May 1988 and then aged 19) attended the early pregnancy assessment unit and a single viable intrauterine pregnancy was identified. It was the Claimant's first pregnancy.

5. The Claimant was booked to give birth at the Hospital with an estimated date of delivery of 16th September 2008.

6. Initially the pregnancy was unremarkable. Scans took place on 7th March 2008 and 1st April 2008 with no concerns arising. Midwifery reviews at 16+3 and 25+5 weeks raised no material issues.

7. On 16th June 2008 the Claimant self-referred with a history of no fetal movement for 48 hours. Maternal observations were unremarkable. Cardiotocography ("CTG") was undertaken, which identified a deemed baseline with accelerations present and no decelerations, and fetal movements were felt.

8. On 24th June 2008 the Claimant attended a further routine appointment. She had a scan on the Hospital's Day Assessment Unit ("DAU"). The baby's abdominal circumference was noted to be below the 10th percentile. This prompted obstetric review resulting in a transfer to consultant led care and a recommendation for two-weekly scans.

9. On 27th June 2008 the Claimant self-referred with concerns over diminished fetal movement. A CTG was reassuring and the Claimant was booked in for a follow-up appointment in the DAU on 1st July 2008. The CTG on 1st July was again satisfactory and another appointment booked for Friday 4th July 2008 to include a further CTG.

10. On 4th July 2008 the Claimant attended her appointment on the DAU. By this stage she was 29+4 weeks' gestation. Examination revealed pregnancy induced hypertension ("PIHT") with raised urea levels, together with an absent end diastolic flow on a Doppler scan. There continued to be intrauterine growth

restriction ("IUGR"). A decision was made to admit the Claimant to the Hospital as an inpatient. The plan was for steroids to be administered for fetal lung maturation, anti-hypertensives to be given and there be regular observations including daily CTG monitoring.

11. On Saturday 5th July 2008 a midwife recorded that the Claimant would be seen by a paediatrician who would discuss the possibility of an early delivery. The Claimant was seen by a paediatrician around 1440 hrs and the consequences of an early delivery were discussed including warnings as to what treatment the baby may need.

12. On Sunday 6th July 2008, at approximately 1035 hrs, a registrar review occurred. The Defendant contends an earlier midwife review also occurred at approximately 0900 hrs when the Claimant's urine was tested and noted to be negative and a satisfactory CTG performed.

13. The Claimant makes no complaint as to the standard of care received up to this point.

Summary of the Claimant's case

14. In summary, the Claimant's pleaded case is that:

    i) At about 1700 hrs on Sunday 6th July 2008 she began to feel unwell. She told midwife Rosie Mackintosh (then known as Rosie Hemming) ("Midwife Hemming") who took her blood pressure, undertook CTG monitoring and said there were no problems. At 1800 hrs Midwife Hemming noted epigastric pain and administered paracetamol. The Claimant's urine was not tested.

    ii) At approximately 2100 hrs the Claimant started to experience more symptoms: she did not feel right, her stomach felt tender, she had pain under her ribs on the right side, had lower back pain, breathlessness, kept going hot and cold with clammy hands, could not get comfortable and had heartburn. The Claimant reported these symptoms to midwife Valerie Morton ("Midwife Morton") who said it was just the baby pushing her ribs out and heartburn. Midwife Morton gave the Claimant some Gaviscon.

    iii) The Claimant informed Midwife Morton of her symptoms again. Midwife Morton did not review the Claimant again at this stage. A lady in the next bed shouted out "can somebody help her, she's clearly not well."

    iv) At approximately 2300 hrs the Claimant's symptoms were continuing and she felt much worse. Midwife Morton checked her blood pressure, listened to the fetal heart rate and gave her another dose of paracetamol. Midwife Morton reiterated that it was just heartburn and the baby pushing the Claimant's ribs out.

v) Overnight the Claimant remained unwell with significant pain to her abdomen and back. She felt very unwell but unable to seek help as her mind was fuzzy, she was drowsy, tired and too unwell to move.

vi) At approximately 0645 hrs on 7th July 2008 the Claimant had searing pain in her stomach and suffered a massive placental abruption. At 0710 hrs intrauterine death was recorded.

15. The Claimant asserts that the midwifery care and treatment from 1800 hrs onwards on 6th July 2008 fell below the required standard. I shall return to the allegations of breach in due course.

16. The Claimant's case is that but for the breach of duty, she would have been referred for obstetric review leading to probable transfer to the delivery suite on the evening of 6th July 2008 with a subsequent diagnosis of pre-eclampsia. The Claimant contends that Kyron would have been born alive and she would not have suffered the psychiatric injury.

Summary of the Defendant's Case

17. The Defendant takes issue with the Claimant's factual account of events from 1700 hrs on 6th July 2008 and, in particular, her case as to her developing symptomatology. The Defendant's pleaded case is as follows:

i) It is not admitted that the Claimant complained of feeling unwell at 1700 hrs.

ii) At approximately 1800 hrs it is admitted that the Claimant complained of epigastric pain to Midwife Hemming. The Claimant's blood pressure and a CTG were normal. No paracetamol was administered at that time.

iii) At approximately 2300 hrs Midwife Morton reviewed the Claimant when undertaking a drug round. She administered paracetamol. The Claimant complained of rib pain which Midwife Morton explained may be rib flare. The Claimant's blood pressure was normal, fetal heart rate was normal and Midwife Morton recorded that the Claimant was asymptomatic. It is not admitted that the Claimant told Midwife Morton she felt much worse.

iv) The Defendant makes no admission as to whether the Claimant remained in significant pain overnight and felt very unwell. There is no record of the Claimant complaining of symptoms overnight.

v) It is admitted that a massive placental abruption probably occurred at approximately 0645 hrs on 7th July 2008.

18. Following the oral evidence, the Defendant concedes that the Claimant had been given paracetamol by Midwife Hemming at the 1800 hrs intervention. Further, the Defendant now accepts that the Claimant received Gaviscon later in the evening although from Midwife Hemming not from Midwife Morton.

19. The Defendant denies there is any breach of duty on its own factual case. The Defendant does however admit that, if the Court accepts the Claimant's factual case, breach of duty is established.

20. The Defendant denies causation, regardless of whether the Court finds in favour of the Claimant or Defendant's factual case. The Defendant contends tha,t even if the Claimant's case on breach of duty is established, sadly the death of Kyron would not have been avoided.

Issues

21. The issues for determination can be summarised as follows:

    i) How are the conflicts of fact to be resolved as to how events unfolded from approximately 1700 hrs on 6th July 2008 to abruption at around 0645 hrs on 7th July 2008?

    ii) Subject to the findings of fact, can the Claimant prove breach of duty in the way that the midwives administered care and treatment from approximately 1700 hrs on 6th July 2008?

    iii) If the Claimant can prove breach of duty, what would have occurred but for that breach of duty? In particular, can the Claimant establish medical causation to the effect that Kyron's death would have been avoided?

The lay witness evidence

22. The court heard oral evidence from the Claimant, Ms Debbie Richins (the Claimant's mother), Ms Jemma Fulford (the Claimant's friend) and Ms Simone Hilton (a patient in the bed in the Hospital next to the Claimant on the 6th/7th July 2008.) On behalf of the Defendant, the court heard oral evidence from Midwife Hemming and Midwife Morton.

Lay witness evidence for the Claimant

The Claimant

23. The Claimant confirmed the content of her witness statement dated 24th October 2020. In her statement she described starting to feel unwell at about 1700 hrs on the 6th July 2008 and telling the midwife who said she would fetch her some paracetamol. She accepted a CTG was performed, her blood pressure checked and being told there were no problems.

24. The Claimant stated that by approximately 2100 hrs, when the paracetamol was wearing off, she started to experience more symptoms. She described these in her witness statement as follows:

    - *"I just didn't feel right (my actual words to the midwife)*

    - *Stomach felt tender to touch and was painful under my ribs on the right side*

- *Lower back pain*
- *Breathlessness – it was uncomfortable and a struggle to inhale*
- *Kept going hot and cold with clammy hands*
- *Couldn't get comfortable*
- *Heartburn discomfort."*

25. The Claimant stated she reported the symptoms to a new midwife who advised it was the baby pushing her ribs out and heartburn. She described receiving Gaviscon. She accepted in cross-examination she may have been wrong about the attendance being at 2100 hrs and that it may have been closer to 2130 hrs. She maintained that this event was however a separate occasion to Midwife Morton's attendance around 2300 hrs. She told the court she had not yet spoken to the midwife about her deteriorating symptoms when she received a text message from her friend, Jemma, at 9.16pm. The Claimant told the court she did not have copies of any other text messages from that time as the memory on her phone had been full and she had been deleting messages to make room for more incoming messages. Although not in her witness statement, the Claimant told the court she also spoke to Jemma and her mother by the telephone during the course of the evening of 6th July. The Claimant's explanation for not including reference to the telephone calls in her statement was that, unlike the text message, she had no documentary evidence in support.

26. The Claimant told the court that when the Gaviscon didn't work, she again informed the midwife of her problems. The Claimant's evidence was that the midwife was ignoring her and fobbing her off as the staff were dealing with an incident on the ward involving a patient who had about six children crying at her bedside, requiring the involvement of social services. The Claimant stated she was in considerable pain such that the lady in the bed next to her, Simone Hilton, shouted to the midwife on her behalf for assistance.

27. The Claimant's evidence was that it was almost 2300 hrs by the time the midwife came to see her again. The Claimant maintained she continued to suffer the same type of symptoms although overall she was feeling much worse. In her witness statement she stated that the only two things the midwife did were to check her blood pressure and listen with a pinard horn for one minute. In cross-examination the Claimant accepted that a pinard horn had not been used and indeed that she did not know what one looked like. She agreed that the midwife had used a handheld scanner to check the fetal heartrate. The Claimant also accepted that the midwife had asked her about headaches and flashing lights but maintained the midwife had not asked further questions about the pain. She described the midwife telling her everything was ok, reiterating it was just heartburn and the baby pushing her ribs out, and giving her another dose of paracetamol.

28. The Claimant stated she thereafter gave up trying to tell the midwife as she was clearly not going to do anything else to help her. In cross-examination she accepted that she had access to the call bell but did not use it. She also accepted

that after the 2300 hrs interaction with the midwife, she did not otherwise inform the midwives of her worsening position until the next morning. She believed she eventually got to sleep or at least thought it was sleep. She described feeling *"as if I was unconscious or something because I could feel pain all through my abdomen and back but it was as though the pain was numbed out and my mind was fuzzy."* By the time she came round, she stated she had searing pain in her stomach and hobbled in agony to the midwife desk. The midwife could not find a heartbeat on the CTG and her baby was confirmed dead shortly thereafter.

29. In cross-examination the Claimant accepted that she had relived and retold her account hundreds or thousands of times over the years including to multiple professionals as she tried to pursue complaints and an earlier legal case. The Claimant had sent a letter of complaint to the Hospital, date stamped received on 2nd December 2008. She accepted that the account she gave in that letter differed from the account she gave today including in that it only referred to two relevant attendances with the midwifes on the evening of 6th July 2008. A first when Gaviscon was administered and a second around 2300 hrs. She stated the solicitor to whom she had given the account in 2008 had got it wrong when drafting the letter.

Debbie Richins

30. Ms Richins, the Claimant's mother, confirmed the content of her statement dated 27th October 2020.

31. Ms Richins stated she visited the Claimant around lunchtime on 6th July 2008, leaving mid-afternoon, and that the Claimant had seemed ok when she saw her. She described receiving a telephone call later that evening from the Claimant. She stated the Claimant told her she was not feeling well with bad bellyache, pain around her ribs and shortness of breath and that she had been given some Gaviscon by a nurse. Ms Richins stated she told the Claimant to ring the bell again or tell someone if she was in pain. She did not hear from the Claimant again before she went to bed.

32. In cross-examination Ms Richins accepted that her first statement, dated 7th March 2020, made no reference to the telephone conversation with the Claimant. Ms Richins clarified in re-examination that this was because the first statement was prepared for the planned preliminary issue trial on limitation and did not deal with any matters before the death of Kyron. Ms Richins maintained that there had been a telephone conversation, but she could not now say what time it had taken place. She stated that nothing the Claimant had told her during the call had led her to the conclusion that the Claimant was on the cusp of disaster.

Jemma Fulford

33. Ms Fulford, the Claimant's childhood friend, confirmed the content of her statement dated 26th March 2020.

34. Ms Fulford stated that she was pregnant at the same time as the Claimant and the two spoke on the phone and texted a lot when the Claimant was in the

Hospital. She described receiving a text message from the Claimant during the evening of 6th July 2008 in which the Claimant reported feeling breathless and having pains in her stomach. Ms Fulford agreed that the photograph of a text message timed at 9.16pm was her message in response to the Claimant in which Ms Fulford had suggested the baby was moving up towards her lungs.

35. Ms Fulford described a call from the Claimant on the evening of 6th July in which the Claimant expressed concern about pains in her stomach to which Ms Fulford had suggested asking for some Gaviscon. In cross examination she stated she thought the call was some time after the text message at 9.16pm and that the Claimant had told her she had already been given some Gaviscon. She said she remembered the Claimant saying she was breathless and had pains in her stomach.

36. In her statement Ms Fulford stated that the Claimant also sent other text messages to her saying she was disappointed with the midwives as she was telling them about her pain but they were helping another family in the ward and not paying attention to her. In cross-examination she initially said she had received more text messages from the Claimant during the evening, then said she "must have" received other messages before conceding she was not sure.

37. In cross-examination Ms Fulford was questioned over the accuracy of her memory given the passage of time and the extent to which she had discussed her evidence the Claimant. She stated the first time she was asked to recall the circumstances of the text message was when she made her witness statement in 2020. She no longer had the telephone which she was using at that time. She denied discussing her statement with the Claimant.

Simone Hilton

38. Ms Hilton, the patient in the bed next to the Claimant, confirmed the content of her statement dated 28th February 2020.

39. Ms Hilton described talking to the Claimant during the daytime of 6th July at which point the Claimant seemed okay and was laughing and joking, She stated the Claimant's condition changed in the late afternoon when she started to have pain in her stomach and went pale. Ms Hilton stated she alerted the midwife who gave the Claimant some Gaviscon. In cross-examination she said she thought the Gaviscon was given late afternoon, between 3 – 5pm, but she couldn't be precise.

40. Ms Hilton described an Asian lady in the bed opposite who had about four children crying and screaming around her bed. She stated the midwives were with that lady and somebody official came in to see the lady.

41. Ms Hilton described the Claimant as starting to complain of more pain during the evening and she recalled the Claimant telling the midwife on numerous occasions that she was in pain but the midwife was too busy dealing with the Asian lady. She described the Claimant as crying with pain and Ms Hilton advising her to ring the emergency bell. Ms Hilton stated she shouted out to the midwife on behalf of the Claimant.

42. Ms Hilton's evidence was that when the midwife did attend, she stated that she was the only midwife on duty, that they were understaffed and that the Claimant had received all her pain relief and should go to sleep. Ms Hilton said she called the midwife a number of times overnight but on each occasion, the midwife simply came to the door of the room, put the lights on and said she would be with them shortly or that they should go to sleep.

43. In cross-examination, Ms Hilton told the court she had not seen anyone taking the Claimant's blood pressure, undertaking a CTG trace or giving the Claimant any paracetamol. She denied being angry in the way she gave her evidence stating she had seen the Claimant in a lot of pain and distress but not getting the help she needed.

44. Ms Hilton was taken to an unnamed and redacted statement provided in the course of the Nursing and Midwifery Council ("NMC") investigation into Midwife Morton in around 2017/18. Ms Hilton agreed that she had been contacted by the NMC and that the document appeared to be her account of events although she had never seen the document before being taken to it in cross examination. She recalled that she had been telephoned by the NMC whilst she was at work in a school and given an account over the telephone but was never provided with a copy of the statement or asked to sign it. She conceded that there were a number of inaccuracies in the document: she did not recall the Claimant saying she did not want to call the midwife, she did not recall the midwife saying there was nothing wrong with the Claimant, the midwife was not a small black woman and the lady involved in the social services incident was not in labour.

45. Ms Hilton explained that she saw the Claimant's grandad as she was leaving the Hospital and he told her the baby had died. She gave her telephone number to the Claimant's granddad for him to pass to the Claimant. She stated she had last seen the Claimant in 2009 when the Claimant purchased some baby clothes from her, after which she had lost contact with the Claimant for several years before the Claimant tracked her down for the purpose of the court case.

Lay witness evidence for the Defendant

Rosemary Mackintosh (nee Hemming)

46. Midwife Hemming confirmed her statement of 16th November 2020. She was the ward sister on duty on 6th July 2008 working the late shift from 1330 hrs to 2130 hrs.

47. The midwife stated she saw the Claimant at around 1800 hrs on 6th July whereupon she made the following note in the Claimant's records:

"c/o epigastric pain – BP 130/80

~~*No proteinuria*~~ *for CTG*

CTG commenced for IUGR (Intrauterine growth restriction)

Baseline 132

Accelerations Yes

Decelerations No

Variability 5 – 10 bpm (beats per minute)"

48. She considered the most common cause of epigastric pain was heartburn, but that it could be a sign of pre-eclampsia which is why she had checked for signs. She was also concerned because the Claimant had a history of high blood pressure and IUGR. She was satisfied the Claimant's blood pressure was similar to previous readings and checked there were no headaches or visual disturbances, which there were not.

49. The midwife could not remember why she had crossed through the wording "no proteinuria." She thought she may have written it in the wrong person's notes in error and crossed it out when she realised.

50. She stated her usual practice would be to check urine if she had concerns about pre-eclampsia but could not now remember whether it was checked. In cross-examination she stated she was 99% sure she asked for a urine sample and had a memory of giving the Claimant a urine bottle and the Claimant telling her she had just been to the toilet. She believed she would have told the Claimant to give her the sample later but was then preoccupied with transferring another lady to the delivery suite which had taken her off the ward for up to an hour from 1900 hrs. The midwife explained she had wanted to write up the Claimant's notes but had not had time due to the trip to the delivery suite, the arrival of another lady in early labour and the social services incident. She agreed that busyness of the ward was a reason why the urine sample may not have been chased. She agreed a urine sample should have been taken, checked and recorded in the notes.

51. The midwife accepted in cross-examination that she had given the Claimant paracetamol when she saw her at 1800 hrs but did not record that in the notes as she should have done. The midwife also accepted she probably did give the Claimant some Gaviscon, probably at some point after the paracetamol at 1800 hrs.

52. In her witness statement Midwife Hemming had stated that she could not recall if there had been a specific incident with social services that evening. In evidence in chief, she explained that, having read and heard the Claimant's witness evidence, she had been reminded of an incident on the ward involving social services and now accepted it had occurred that day. In cross examination, she agreed that the incident had been a drain on resources and had taken up quite a lot of her time. She recalled the social worker not arriving until just after 2100 hrs but that the social worker had gone before she finished her shift. In cross-examination, the midwife told the court it was likely another midwife would have completed the hand over to the incoming night shift while she dealt with

the social worker. She stated that if she did not do a verbal handover to the next shift, the incoming staff were reliant on the notes.

53. When asked about her recollection of events, the midwife accepted that an account she gave in 2009 was largely a reiteration of the medical notes and she had not thereafter had to think about the events of that evening before being asked to make a statement for this claim in 2020.

Valerie Morton

54. Midwife Morton confirmed the content of her witness statement dated 26th October 2020. She was a midwife on duty working the night shift from 2115 hrs on 6th July 2008 to 0745 hrs on 7th July 2008. At that time she had been a midwife for 19 years.

55. Midwife Morton told the court that the night shift was staffed by two midwives and an auxiliary and that evening there were 25 patients on the antenatal ward. The midwife explained the usual handover practice as involving a meeting in which the incoming staff were given a brief rundown of each patient's history and it being common practice for the midwives to make notes about the patients on pieces of paper which were not kept. In cross examination, the midwife accepted there had been a social services incident that evening but that it had been resolved by the time she came onto the ward after handover at about 2230 hrs. She stated she could not remember if there were any other incidents that evening but that most night shifts were "really bad" with only two midwives to care for 22 ladies.

56. She described that on the evening of 6th July she had been responsible for doing the drugs trolley round whilst the other midwife carried out fetal and maternal observations. She stated that because the Claimant had told her she was in pain, she had examined her rather than leave her to wait for the midwife who was carrying out the observations. Midwife Morton's witness statement stated that although it was now over 12 years later, she knew that she would have examined the Claimant in accordance with her usual practice. That would have involved palpating the Claimant, starting at the top of the stomach and palpating from right to left to feel if the abdomen was tense like a balloon. She stated she would start at the top of her fundus and work her way over the abdomen. She would also have asked if there was any pain and looked at the Claimant during the examination.

57. Midwife Morton described listening to the fetal heart rate for one minute, which would also have required palpation to the abdomen. In cross examination she maintained she would have needed to palpate to find the baby's back to check the fetal heartrate with the sonicaid. She stated she also took the Claimant's blood pressure. She noted the blood pressure as 120/80 although thinks she made an error when recording it on the observation chart as 130/80. Either way, she considered the reading normal.

58. Midwife Morton maintained her conclusion that the complaint of rib pain was as a result of rib flare and that, in coming to that diagnosis, she had ruled out other possible diagnoses such as pre-eclampsia. In cross examination she stated

she had come to the conclusion it was rib flare as she could not find anything else wrong with her. She explained she had encountered a number of ladies with rib flare at different times of pregnancy and denied closing her mind to something more sinister.

59. The midwife could not explain why her entry in the Claimant's medical records was not timed but said that the examination would have been around 2250-2300 hrs. She made the following entry in the medical records:

"6.7.08
Written after event
Listened to fetal heart rate 140 BPM. Blood pressure 120/80, asymptomatic. Complained of pain under ribs sounds like rib flare. Given two paracetamol and slept well."

60. The midwife explained that her use of the word "asymptomatic" meant she had asked the Claimant whether she had any headaches, flashing lights or epigastric pain to rule out pre-eclampsia and the Claimant must have denied suffering with these symptoms. In cross examination she maintained that the Claimant made no reference to feeling breathless and, had she done so, she definitely would have escalated matters. Midwife Morton accepted she was unaware that the Claimant had received two paracetamol earlier in the evening given that the dose was not on the drug chart. She said she would not have seen the Claimant's medical records so would not have read that the Claimant had reported epigastric pain at 1800 hrs. She didn't know if Midwife Mackintosh had referred to epigastric pain or paracetamol on handover. Later in cross examination she accepted that when she saw the Claimant around 2300 hrs she did not know that the Claimant had been suffering from epigastric pain earlier that evening. She asserted that the Claimant could not have mentioned the epigastric pain because, if the Claimant had, she would have given her Gaviscon. She accepted that had been aware of the previous epigastric pain and the dose of Gaviscon, she would have tried more Gaviscon but, if that had not worked, she would have called a doctor.

61. Midwife Morton stated that she completed the entry in the medical records during the latter part of her shift. In cross examination she timed this at probably 0300 or 0400 hrs but definitely not after 0645 hrs. This, she explained, was standard practice as midwives were not allowed to leave the drugs trolley unattended and wrote up the notes later in the shift.

62. She stated she had no recollection of the Claimant complaining of any further pain until 0645 hrs. She thought she went back to the Claimant's room at one point but the lights were off and curtains closed. Once the Claimant went to sleep, the usual practice at the time was not to wake a patient to take their blood pressure overnight unless the previous readings were high, there was concern about the patient or it had been ordered by a doctor.

63. Midwife Morton explained that, in addition to the call button, the patients have an emergency button but the Claimant used neither.

64. The midwife described the Claimant walking to the desk at 0645 hrs complaining of pain in her left side down by her groin. She made an entry in the Claimant's medical records as follows:

"Came to the desk complaining of left iliac fossa pain. Went down to listen to the fetal heart, uterus tender to touch. Felt tense, tried for a little while to pick up foetal heart but could not pick it up, not happy as tense and worried no FH (fetal heart rate) Rang delivery prompt transfer to delivery into triage for scan."

65. The midwife agreed that her second entry in the medical records recorded her physical examination of the Claimant and her earlier entry had not. She maintained she would nonetheless have performed a palpation of the abdomen at around 2300 hrs.

66. Midwife Morton stated she went to visit the Claimant on the High Dependency Unit on 9th July to see if she was ok and to express her sadness about what had happened.

The expert evidence

67. Each party relies on midwifery and obstetric expert evidence. The midwifery evidence is provided by Dr Brenda Ashcroft for the Claimant and Ms Jennifer Fraser for the Defendant. The obstetric evidence is provided by Dr Jo Gillham for the Claimant and Professor Derek Tuffnell for the Defendant. Each discipline of experts provided a joint statement and all attended court to give oral evidence.

68. The experts were asked to provide their opinions based the two separate factual accounts. What is referred to as "The First Scenario" reflects the Claimant's pleaded case, with "The Second Scenario" reflecting the Defendant's case.

The midwifery experts

69. If the facts of The First Scenario are accepted, the joint statement revealed a significant level of agreement between the midwifery experts. Both experts agreed that the pregnancy was high risk in light of the PIHT, IUGR, absent end diastolic flow and epigastric pain.

70. As to events at 1800 hrs, the midwives agreed the situation required blood pressure testing, CTG monitoring and that the Claimant's urine should have been tested for protein. They agreed the matter should have be referred for obstetric review if the Claimant was unwell. They further agreed the record keeping at 1800 hrs was inadequate and that Midwife Hemming should have checked on the Claimant again before going off duty later that evening.

71. As to events at 2200 to 2300 hrs, they agreed that the facts of The First Scenario required obstetric review and that the record keeping was inadequate. They disagreed as to whether rib flare was a reasonable conclusion at this stage. They also agreed that if the Claimant's signs and symptoms continued throughout the night, obstetric referral was appropriate.

72. Assuming The Second Scenario facts to be correct, the midwives agreed that should have been a urine test at around 1800 hours. Dr Ashcroft contended that the Claimant should have been asked further questions and that, if the urine had been positive for protein, there should have been a referral to the registrar. Ms Fraser contended that no referral was required at that stage because the Claimant was stable. The experts disagreed as to whether Midwife Hemming should have checked on the Claimant before going off duty.

73. As to events at 2300 hrs but based on The Second Scenario, Ms Fraser contended that Midwife Morton's actions at this time were appropriate. Dr Ashcroft took the view that Midwife Morton should have been asking about nausea or vomiting and should have tested the urine. Ms Fraser disagreed as to urine testing on the basis that the Claimant was presenting as asymptomatic to pre-eclampsia. The experts disagreed as to whether rib flare was a reasonable conclusion and whether obstetric review as required on these assumed facts.

74. Having heard the lay evidence, Dr Ashcroft expressed the view that the recording keeping was inadequate in light of the failure to document the paracetamol and Gaviscon, and that Midwife Morton had insufficient information when she took over the night shift. The Defendant criticised Dr Ashcroft in cross-examination on the basis that some of her opinions strayed outside her area of expertise and into that of the obstetric experts. She accepted she should defer to the obstetricians on some of the issues. She accepted that she had not held a clinical post for many years but noted that she had been teaching midwifes for the last 30 years which meant she had the requisite expertise to give her opinion. Dr Ashcroft took the view that all the symptoms from 1700 hrs were a continuing part of the same process. Dr Ashcroft maintained her criticism of the recording keeping and was critical of Midwife Morton's use of the term "asymptomatic" without further explanation.

75. Ms Fraser confirmed that, having heard the evidence, she stood by the joint statement. She agreed that the record keeping at 1800 hrs was deficient in that it failed to record the paracetamol and that the urine should have been dipped and recorded. She stated that epigastric pain is a symptom of pre-eclampsia and would require further questioning such as asking about headaches and visual disturbances. She did not accept an obstetric review was mandated unless the Claimant was also displaying other symptoms. However, if on midwifery assessment the Claimant was unwell, she agreed that she would have expected an obstetrician to be involved. In re-examination she clarified that such obstetric review could have been by telephone or in-person. She did not accept Midwife Morton was lacking information when she saw the Claimant around 2300 hrs as she would have received the relevant information at the handover, even if the medical notes omitted reference to the paracetamol. She explained that Midwife Morton must have palpated the Claimant in order to be able to check the fetal heart rate. She stated that normal practice does not require a palpation to be documented unless there was a complaint of tender abdomen that led to the palpation.

The obstetric experts

76. Both obstetric experts are very experienced consultant obstetricians. They agreed that if the court prefers the facts contended for by the Defendant in The Second Scenario, then the Claimant would not have been transferred to the delivery suite and Kyron would not have survived. The experts disagree as to the likely consequences of earlier obstetric involvement arising in The First Scenario.

77. Both experts agree that pre-eclampsia can present as asymptomatic or with a variety of different symptoms. There is however a level of agreement that headaches, visual disturbances and epigastric pain are common symptoms and raised blood pressure and proteinuria are common signs.

1800 hrs on 6th July 2008

78. In the joint statement Dr Gillham contended that a urine sample at 1800 hrs on 6th July 2008 probably would have shown proteinuria notwithstanding the normal blood pressure reading at that time, and the absence of protein in the urine earlier in the day. Professor Tuffnell disagreed given the normal blood pressure reading. He explained that the common sequence in the development of pre-eclampsia is for hypertension to arise first, followed by proteinuria.

79. Dr Gillham concluded that transfer to the delivery suite at that time was possible depending on the extent of symptoms and clinical concern, with the alternative being that the Claimant remain on the ward with her risk status elevated. She accepted in cross examination that if the delivery suite had been busy, keeping the Claimant on the ward at 1800 hrs was within a reasonable range of responses but that if the Claimant had remained on the ward, she would have been reviewed by a registrar. Professor Tuffnell did not accept the Claimant would have been transferred to the delivery suite at that time.

2200-2300 hrs on 6th July 2008

80. Professor Tuffnell accepted that an obstetric review would have been appropriate at 2200 hrs on The First Scenario facts. However, with a normal CTG and normal blood pressure, he thought that transfer to the delivery unit was unlikely. In cross examination Professor Tuffnell stated that if there were concerns about developing symptomology, the doctor would have attended and performed various tests including a blood test. Dr Gillham considered that transfer to the delivery suite would have been the probable outcome by late evening.

81. Dr Gillham maintained the rib flare was not the most likely diagnosis when faced with a very growth restricted baby of 29 weeks gestation.

82. In the joint statement Professor Tuffnell concluded that proteinuria was possible but not probable at 2200 hrs but was more likely in the early hours, namely approximately 0300 hrs. In cross examination, he maintained that proteinuria was possible at 2300 hrs and more likely as time when on but still not probable at 0300 hrs. He took the view that proteinuria was only probable around

abruption. Dr Gillham concluded proteinuria would have been probable at both 2200/2300 hrs and in the early hours of the morning.

Early hours of 7 July 2008

83. Dr Gillham considered that an obstetrician would not have wished the Claimant to remain on the ward by 2200-2300 hrs in light of the high risk clinical situation, worsening symptoms and the lower level of attention and monitoring that would be available on an ante-natal ward. She contended that by the early hours of the morning a transfer to the delivery suite would already have occurred allowing for increased maternal observations and blood pressure measurements. In the joint statement she opined: *"at some point after transfer secondary to the ongoing/deteriorating symptomology CTG monitoring would have been continuous. This was a vulnerable baby with a vulnerable placenta and it is probable that overnight delivery would have been achieved secondary to increasing clinical concern, concerns about the development of severe pre-eclampsia and/or CTG concerns, before the onset of placental abruption. If a high risk woman is on a delivery suite with a diagnosis of pre-eclampsia, any deterioration is not usually so rapid so as to preclude a live birth."*

84. Dr Gillham concluded that the Claimant's symptoms could be consistent with the development of pre-eclampsia. Her view is that it was probable that blood pressure was elevated and there was protein in the urine prior to the abruption.

85. In cross-examination, Dr Gillham emphasised the importance of looking at the bigger picture rather than making decisions in isolation. Dr Gillham accepted that pre-eclampsia often first presents as raised blood pressure, then with proteinuria and then symptoms but that the disease is one with a large spectrum such that presentation can differ. She agreed that the Claimant's blood pressure readings were normal at 1800 hrs and 2300 hrs but noted there was an absence of any readings during an 8-hour period overnight. She took the view that, given what was known about the Claimant's background, it was over-simplifying the position to suggest that because the blood pressure was normal, the Claimant was not presenting with pre-eclampsia. Dr Gillham stated there was no set pattern to the way in which a CTG trace develops with pre-eclampsia and one can see gradual changes or a sudden deterioration.

86. Dr Gillham was asked about the blood test results taken on 4th July and following the abruption on 7th July. She agreed that the AST and ALT levels were indicative of normal liver function and that, although raised, they were within normal limits after abruption. She stated that even if the liver was inflamed and causing epigastric pain, it would not necessarily be seen in the blood tests. Dr Gillham agreed one would not expect to see blood pressure come down as quickly as the Claimant's had after abruption but noted that the Claimant's blood pressure had not presented in a typical way either in respect of the hypertension.

87. In cross examination, Dr Gillham accepted that, if faced with the Claimant's description of symptoms at 2100 hrs, if there was no protein in urine, normal blood pressure and a normal trace, subject to the level of clinical concern, there was the potential that she would have remained on the ward. If there had been

raised protein in the urine, that would have heighted concern and may have prompted transfer to the delivery suite but it would have been equally reasonable to stay on the ante-natal ward and review later. Dr Gillham expected that the abdomen would still have been soft and non-tender at 2300 hrs but a deteriorating position would have prompted a decision to transfer to the delivery suite.

88. Dr Gillham accepted that a decision to deliver a baby is always a balanced decision. There was a general desire to prolong pregnancy but in the Claimant's case it was known there was placental dysfunction and steroids had already been given to strengthen Kyron's lungs. In cross-examination, Dr Gillham took the view that monitoring on the delivery suite would have been at least hourly. She explained that the time frame for saving Kyron depending on monitoring and that building the hypothetical was very difficult in the absence of 8 hours of information. She opined that if the Claimant had been increasingly unwell, needed hypertensives, had CTG abnormalities, a decision may have been taken before abruption. [Emphasis added.] She stated it was unclear if there had been a more marginal abruption before the catastrophic event.

89. Professor Tuffnell did not accept that there would have been a planned obstetric review in the early hours of the morning given the blood pressure was normal at 2300 hrs. He said it would not be routine to wake a patient in the night to recheck her blood pressure.

90. Professor Tuffnell stated that if, contrary to his view, the Claimant would have been transferred to the delivery suite, her blood pressure would have been rechecked and blood tests taken. If the blood pressure was normal then further checks would have been undertaken every couple of hours. A CTG would have been performed on transfer but discontinued unless there was a marked change in maternal condition. In the joint statement he concluded: *"if there had been a medical review at around 0300 hrs it is difficult to envisage a scenario that would justify caesarean section at 30 weeks at that time, with normal blood tests if there had been a rise in blood pressure and even if there was proteinuria. I consider it probable that the abruption developed acutely and that was the cause of a rise in blood pressure, probably fairly close to the time she presented to the midwife at 0645 hours. I think the outcome is due to a very acute event and birth before that event is unlikely."*

91. Professor Tuffnell concluded that the only symptom the Claimant described that was associated with pre-eclampsia was epigastric pain but that alone would not have led to a diagnosis of pre-eclampsia prior to the abruption. If she had been suffering from pre-eclampsia, he would have expected the blood pressure to be elevated for several hours. Professor Tuffnell did not accept that epigastric pain would occur without the blood tests revealing liver dysfunction, which they did not. He explained that epigastric pain arises when the liver capsule is extended and that due to liver cells being fragile, extension of the liver results in changes to the blood. He strongly disagreed with Dr Gillham's conclusion that epigastric pain related to pre-eclampsia can occur without being evident in a blood test. He concluded that the absence of severe headaches or visual disturbances and the normal blood tests immediately after abruption indicated that any epigastric pain was not related to the liver.

92. In cross examination, Professor Tuffnell was criticised for commenting on questions of breach of duty as to which the midwifery experts were reporting. He explained that it was difficult to comment on how the case unfolded without some comment on the level of care. Professor Tuffnell maintained that he did not accept that the Claimant had symptoms of pre-eclampsia before the abruption.

93. Professor Tuffnell denied that his non-acceptance of The First Scenario facts had coloured his views on causation. When asked questions about what would have happened if the Claimant had been on the delivery suite, Professor Tuffnel explained it still would have been extraordinarily unlikely that the baby would have been born alive. Whilst he acknowledged that a quicker response can be achieved on the delivery suite, he took the view that the situation arose so quickly, that he did not believe the baby could have been born alive. He noted that Dr Gillham's oral evidence as to a possible partial abruption in advance of 0645 hrs was a theory that she had postulated for the first time in oral evidence. He said there was no reason to be planning to deliver a very small 30-week baby in the middle of the night and that, at the very most, the clinicians would have planned for a daylight hours delivery with senior staff available.

The applicable law

Assessing witness reliability

94. The lay witnesses in this case are faced with the Herculean task of recalling events that took place in July 2008 and being cross-examined about those events nearly 14 years later. Both parties have referred the Court to the observations of Cotter J in *HTR v Nottingham University Hospitals NHS Trust [2021] EWHC 3228 (QB)* in which the accuracy of witness recollection and the correct approach to medical records are considered from paragraph 74 onwards:

> "74. As noted by Stewart J in *Kimathi v Foreign and Commonwealth Office* [2018] EWHC 2066 (QB) and by Warby J (as he then was) in *Dutta v General Medical Council* [2020] EWHC 1974 (Admin) , there has been a considerable body of authority in recent years setting out the key principles in relation to the judicial determination of facts and the approach to witness evidence. These cases include *Gestmin SGPS SA v Credit Suisse (UK) Limited* [2013] EWHC 3560 (Comm) (Leggatt J, as he then was) ; *Lachaux v Lachaux* [2017] EWHC 385 (Fam), [2017] 4 WLR 57 (Mostyn J) ; and *Carmarthenshire County Council v Y* [2017] EWFC 36, [2017] 4 WLR 136 (Mostyn J) .
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> 75. In *Gestmin SGPS SA v Credit Suisse (UK) Limited* [2013] EWHC 3560 (Comm) , Leggatt J made the following observations:
>
> > "16. While everybody knows that memory is fallible, I do not believe that the legal system sufficiently absorbs the lessons of a century of psychological research into the nature of memory and the unreliability of eye witness testimony. One of the most

> important lessons of such research is that in everyday life we are not aware of the extent to which our own and other peoples' memories are unreliable and believe our memories to be more faithful then they are. Two common (and related) errors are supposed: (1) that the stronger and more vivid is our feeling or experience of recollection, the more likely the recollection is to be accurate; and (2) that the more confident another person is in their recollection, the more likely their recollection is to be accurate.
>
> 17. Underlying both these errors is a faulty model of memory as a mental record which is fixed at the time of experience of an event and then fades over (more or less slowly) over time. In fact, psychological research has demonstrated that memories are fluid and malleable, being constantly rewritten whenever they are retrieved. This is true even of so-called 'flash bulb' memories, that is memories of experiencing or learning of a particularly shocking or traumatic event. (The very description 'flash bulb' memory is in fact misleading, reflecting as it does the misconception that memory operates like a camera or other device that makes a fixed record of an experience). External information can intrude into a witness's memory, as can his or her own thoughts and beliefs, and both can cause dramatic changes in recollection. Events can come to be recalled as memories which have not happened, which did not happen at all or which happened to someone else (referred to in the literature as a failure of source memory).
>
> 18. Memory is especially unreliable when it comes to recalling past beliefs. Our memories of past beliefs are revised to make them more consistent with our present beliefs. Studies have also shown that memory is particularly vulnerable to interference and alteration when a person is presented with new information or suggestion about an event in circumstances where his or her memory of it is already weak due to the passage of time".

76. At [19] – [22], Leggatt J went on consider the relationship between these characteristics of memory and the civil litigation process—including the "considerable interference with memory" introduced by the procedure of preparing for trial, and the potential biases and influences exerted through the process of preparing witness statements and giving evidence. In those circumstances, he suggested at [22] that:

> "… the best approach for a judge to adopt in the trial of a commercial case is, in my view, to place little if any reliance at all on witnesses' recollections of what was said in meetings and conversations, and <u>to base factual findings on inferences drawn from the documentary evidence and known or probable facts ."</u> [Emphasis added.]

77. While Gestmin was a commercial case (and notwithstanding that Leggatt J's observations explicitly referred to that context), the ' Gestmin approach' (as it has become known) has broader utility. In *Carmarthenshire County Council v Y* [2017] EWFC 36 , Mostyn J noted at [17] in reference to paragraph 22 of Gestmin that:

> "In my opinion this approach applies equally to all fact-finding exercises , especially where the facts in issue are in the distant past. This approach does not dilute the importance that the law places on cross-examination as a vital component of due process, but it does place it in its correct context."

78. Mostyn J observed that while "the general rule is that oral evidence given under cross- examination is the gold standard" (at [7]), noting (as summarised by Stewart J in Kimathi , above, at [96]) that it reflects the long-established common law consensus that the best way of assessing the reliability of evidence is by confronting the witness, "[i]t should not be thought however that oral evidence under cross-examination is the be all and end all of forensic proof" (at [17]).

79. Turning to medical records in *Synclair v East Lancashire Hospitals NHS Trust* [2015] EWCA Civ 1283, Tomlinson LJ made the following observation:

> "[12] … [I]t is too obvious to need stating that simply because a document is apparently contemporary does not absolve the court of deciding whether it is a reliable record and what weight can be given to it. Some documents are by their nature likely to be reliable, and medical records ordinarily fall into that category. Other documents may be less obviously reliable, as when written by a person with imperfect understanding of the issues under discussion, or with an axe to grind."

80. In those circumstances, Tomlinson LJ "commend[ed] the approach of His Honour Judge Collender QC, sitting as a judge of the High Court, in *E W v Johnson* [2015] EWHC 276 (QB) where he said, at paragraph 71 of his judgment":

> "I turn to the evidence of Dr Johnson. He did not purport to have a clear recollection of the consultation but depended heavily upon his clinical note of the consultation, and his standard practice. As a contemporaneous record that Dr Johnson was duty bound to make, that record is obviously worthy of careful consideration. However, that record must be judged alongside the other evidence in the action. The circumstances in which it was created do not of themselves prevent it being established by other evidence that that record is in fact inaccurate."

81. Tomlinson LJ noted at [15] that while there was general force in the submissions made by Counsel that clinical notes are inherently likely to be reliable,

> "here [those submissions] are less persuasive because there is so much uncertainty concerning the circumstances in which the critical note was made".

82. Similarly, in *HXC v Hind & Craze* [2020] EWHC (QB) (5th October 2020), faced with a dispute about the accuracy of medical records, I stated at [137] that:

> "In my judgment a court can and often will taking a starting point, but no more than a starting point , that a contemporaneous entry made by a medical professional is likely to be a correct and accurate record of what was said and done at a consultation/examination." [Emphasis added]

83. As for the approach to evaluation of the evidence of a witness I set out my view in *Pomphrey v Secretary of State for Health & North Bristol NHS Trust* [2019] EWHC QBD [2019] Med LR Plus 25:

> [31] I start with some very general and basic propositions. When evaluating the evidence of a witness whose testimony has been challenged it should be broken down into its component parts. If one element is incorrect it may, but does not necessarily mean, that the rest of the evidence is unreliable. There are a number of reasons why an incorrect element has crept in. Apart from the obvious loss of recollection due to the passage of time, there may be a process of conscious or subconscious reconstruction or exposure to the recollection of another which has corrupted or created the recollection of an event or part of an event.
>
> [32] The court must also have regard to the fact that there can be bias, conscious or subconscious within the recollection process. When asked to recall an event that took place some time ago within the context of criticism people often take an initial stance that they cannot have been at fault; all the more so if the act in question was in terms of their ordinary lives; unmemorable. There is a tendency to fall back on usual practice with the tell-tale statement being "I would have" rather than "I remember that I did".
>
> [33] To approach the exercise of fact finding in a complex case (when faced with stark conflicts in witness evidence) as necessarily requiring all the pieces of the jigsaw to be fitted together is often both flawed and an exercise in the impossible. This is because individual pieces of the jigsaw may be wrong, distorted to a greater or lesser degree or absent. Indeed, it is not possible to make findings if the state of the evidence or other matters mean that it is not proper to do so (see generally *Rhesa Shipping Co SA v Edmunds (The Popi (M)* [1985] 1 W.L.R. 948). However, often a sufficient number of pieces may be fitted together to allow the full picture to be seen."

95. The aforementioned observations are apposite in this case given the heavy reliance on the witnesses' memories of events that took place many years ago. I bear in mind that the reliability of the witnesses' evidence may also be affected by the conscious or sub-conscious reconstruction of events. Whilst there are contemporaneous medical records which can be taken as a starting point, the Defendant's own evidence reveals some shortcomings in the preparation of the same. By way of example, Midwife Hemmings accepted she failed to record the giving of paracetamol or Gaviscon and she could not recall why "no proteinuria" had been crossed through. Midwife Morton accepted she did not write up her observations at around 2300 hrs until around 0300-0400 hrs on what was a busy night shift and accepted she had incorrectly recorded the Claimant's blood pressure.

Keefe benevolence

96. The Claimant urges the Court to apply a benevolent approach to the evidence the Claimant relies on ("Claimant Benevolence"). The Claimant submits that, where it can be demonstrated that there has been a breach of duty, this approach should extend to both factual findings relevant to breach of duty and to the reconstruction of the hypothetical for causation purposes. The Claimant invites the court to adopt a benevolent approach to determination of the timing of any positive proteinuria results, the timing of any transfer to the delivery suite and the timing and outcome of any deterioration on the delivery suite. The rationale for the Claimant's submission is that it is the Defendant's breach of duty that has deprived the Claimant of evidence she would otherwise have had to prove her factual case and causation.

97. In *Keefe v Isle of Man Steam Packet Co* [2010] EWCA Civ 683 the defendant failed to measure noise levels but asserted that the noise levels would not have been at an excessive level. At paragraph 19 Longmore LJ held:

> "If it is a defendant's duty to measure noise levels in places where his employees work and he does not do so, it hardly lies in his mouth to assert that the noise levels were not, in fact, excessive. In such circumstances the court should judge a claimant's evidence benevolently and the defendant's evidence critically… Similarly a defendant who has, in breach of duty, made it difficult or impossible for a claimant to adduce relevant evidence must run the risk of adverse factual findings. To my mind this is just such a case."

98. The applicability of the benevolent approach adopted in *Keefe* to causation and clinical negligence claims was considered in *JAH v Dr Matthew Burne & others* [2018] EWHC 3461 (QB) by Martin Spencer J at paragraph 64:

> "In my judgment, in resolving issues of detail such as how long it would have taken for investigations to be carried out and when a competent vascular surgeon would have appreciated that anticoagulation was the appropriate treatment, the court should err in

> favour of the claimant where it is the defendant's negligence which deprives the court of the best evidence and causes the need to delve into this hypothetical world."

99. In *Younas v Dr. Okeahialam* [2019] EWHC 2502 (QB) Deputy High Court Judge Collins-Rice, as she then was, was asked to apply benevolence when reconstructing the diagnostic process. At paragraph 35:

> "It is clear, and Mr Bradley very fairly accepted, that this does not amount to a reversal of the burden of proof. It is also clear that Keefe was a case in which the breach of duty specifically related to a failure to make measurements (of noise levels). The claimant was directly, and wrongly, deprived of the very records which would have been the best, or only, evidence of the precise levels to which he had been exposed. The Court of Appeal in these circumstances took a 'benevolent' approach to such positive, if second-best, evidence as there was that it had been excessive, and found the claimant's burden of proof discharged on that evidence."

100. In *Mackenzie v Aloca Manufacturing (GB) Ltd* [2020] PIQR 6 the Court of Appeal reversed the decision of the High Court and reinstated the decision of the Circuit Judge who had declined to draw an inference adverse to the defendant in a hearing loss case. After a review of the authorities, Dingemans LJ at paragraph 52 concluded:

> "It seems therefore that it is possible to state the following propositions. First whether it is appropriate to draw an inference, and if it is appropriate to draw an inference the nature and extent of the inference, will depend on the facts of the particular case, see *Shawe-Lincoln* at [81]–[82]. Secondly silence or a failure to adduce relevant documents may convert evidence on the other side into proof, but that may depend on the explanation given for the absence of the witness or document, see *Herrington* at 970G; *Keefe* at [19] and *Petrodel* at [44]."

101. He continued at paragraph 55:

> "A principal reason why HHJ Vosper QC did not draw the inference against Alcoa was because he accepted Mr Worthington's evidence that it could not be shown that Mr Mackenzie had been "regularly exposed to noise levels in excess of 90dB(A)". HHJ Vosper QC found in [56] of his judgment that Mr Worthington had regard to the nature of the work done, the circumstances in which it was done, his own engineering experience, and the results from a comparable factory carrying out comparable processes. This was much more than a dismissal of the case because on the balance of probabilities it was not possible to say what was the exposure to noise. In my judgment HHJ Vosper QC was entitled to accept this engineering evidence and avoid resort to inferences, even if they might otherwise have been drawn. The approach taken by Garnham J to the adverse inference

> risked elevating the decision in Keefe to a rule of law, rather than an example of the proper approach to finding facts in a particular case where the evidence showed that the defendant had failed in its duty to carry out noise surveys, and the claimant had been deprived of the opportunity to prove his case."

102. The Defendant submits that there is no role for Claimant Benevolence on the facts of this case in circumstances where there is no gap in the evidence or hiding of documents. Whilst the Defendant accepts there is no urine sample at 1800 hrs, it is submitted that the lack of sample does not prejudice the Claimant because she does not need to prove such a sample would have been positive for her case to succeed. Furthermore, the Defendant submits, the Court has the expert obstetric evidence to rely upon without resorting to the need to rely on inferences. By way of example, the Defendant relies on *ZZZ v Yeovil District Hospital NHS Foundation Trust* [2019] EWHC 1642 in which Garnham J rejected the need to rely on Keefe in a clinical negligence claim where there was expert evidence to explain the issue.

103. I recognise that Claimant Benevolence does not reverse the standard of proof and that, by definition, most clinical negligence claims involve some construction of the hypothetical as far as causation is concerned. I will revert to whether it is appropriate for the principles in *Keefe* to be deployed when I consider my factual findings and thereafter causation.

The approach to breach of duty

104. The parties agree as to the correct approach to breach of duty. In *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 McNair J held:

> "…The test is the standard of the ordinary skilled man exercising the professing to have that special skill. A man need not possess the highest expert skill; it is well established law that it is sufficient if he exercises the ordinary skill or an ordinary competent man exercising that particular art… [p586]
>
> … [A doctor] is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in this particular art … Putting it the other way around, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that would take a contrary view." [p587]

105. As noted by the authors of Clerk and Lindsell on Torts at 9-77: "judges are now more willing to scrutinise the medical opinion in accordance with which the defendant acted." This comment is based on the conclusions reached by the House of Lords in *Bolitho v City and Hackney Health Authority* [1998] AC 232. In that case a breach of duty arose when a doctor failed to attend to a patient. A second issue arose as to whether, if the doctor had attended, she would have intubated the patient. Without intubation the patient would not have survived. The extent of the application of *Bolam* to questions of causation was considered by Lord Browne-Wilkinson at p239F – 240G:

> "Where, as in the present case, a breach of a duty of care is proved or admitted, the burden still lies on the plaintiff to prove that such breach caused the injury suffered: *Bonnington Castings Ltd. v. Wardlaw* [1956] A.C. 613; *Wilsher v. Essex Area Health Authority* [1988] A.C. 1074. In all cases the primary question is one of fact: did the wrongful act cause the G injury? But in cases where the breach of duty consists of an omission to do an act which ought to be done (e.g. the failure by a doctor to attend) that factual inquiry is, by definition, in the realms of hypothesis. The question is what would have happened if an event which by definition did not occur had occurred. In a case of non-attendance by a doctor, there may be cases in which there is a doubt as to which doctor would have attended if the duty had been fulfilled. …
>
> …At the trial the defendants accepted that if the professional standard of care required any doctor who attended to intubate Patrick, Patrick's claim must succeed. Dr. Horn could not escape liability by proving that she would have failed to take the course which any competent doctor would have adopted. A defendant cannot escape liability by saying that the damage would have occurred in any event because he would have committed some other breach of duty thereafter. I have no doubt that this concession was rightly made by the defendants…
>
> … There were, therefore, two questions for the judge to decide on causation. (1) What would Dr. Horn have done, or authorised to be done, if she had attended Patrick? And (2) if she would not have intubated, would that have been negligent? The Bolam test has no relevance to the first of those questions but is central to the second."

106. Lord Browne-Wilkinson went on to consider the circumstances in which a defendant may be held liable notwithstanding support continued at p243A-D:

> "… in cases of diagnosis and treatment there are cases where, despite a body of professional opinion sanctioning the defendant's conduct, the defendant can properly be held liable for negligence (I am not here considering questions of disclosure of risk). In my judgment that is because, in some cases, it cannot be demonstrated to the judge's satisfaction that the body of opinion relied upon is reasonable or responsible. In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of that opinion. In particular, where there are questions of assessment of the relative risks and benefits of adopting a particular medical practice, a reasonable view necessarily presupposes that the relative risks and benefits have been weighed by the experts in forming their opinions. But if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible.
>
> I emphasise that in my view it will very seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical

> expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment which a judge would not normally be able to make without expert evidence. As the quotation from Lord Scarman makes clear, it would be wrong to allow such assessment to deteriorate into seeking to persuade the judge to prefer one of two views both of which are capable of being logically supported. It is only where a judge can be satisfied that the body of expert opinion cannot be logically supported at all that such opinion will not provide the benchmark by reference to which the defendant's conduct falls to be assessed."

Findings of Fact

107. In my judgment the passage of time in this case has affected the ability of all the lay witnesses to now recollect the detailed chronology of events of 6th and 7th July 2008 with accuracy. I take the view that all the lay witnesses are nonetheless trying to assist the court and are genuine in their belief that their account is accurate. It will however be apparent from my observations that follow that there are examples of inconsistencies throughout the evidence of all the lay witnesses.

108. I bear in mind the guidance in *Gestmin* that the court must avoid the error of assuming that stronger and more vivid feelings and/or confidence of recollection make it more likely a recollection is accurate. *Gestmin* suggested that factual findings be based "on inferences drawn from the documentary evidence and known or probable facts." The Court is assisted in this case by contemporaneous documents (ie the medical records) and has expert evidence, particularly from the obstetricians, to assist with the determination of probable facts. I adopt the approach suggested in *HXC* that Court take the medical records as a starting point and that such entries are likely to be a correct and accurate record. However, I must bear in mind any other evidence that establishes that the medical records are inaccurate. For the reasons I have already touched upon, the medical records in this case are not without difficulty given the known inaccuracies in respect of the entry made by Midwife Hemming following the 1800 hrs observation and the entry made by Midwife Morton after the event in the early hours of 7th July. I therefore approach the reliability of the two key entries in the medical entries with caution.

109. As the Defendant rightly acknowledges, notwithstanding the highly emotive subject matter, the Claimant was composed and dignified throughout her evidence and made for an impressive witness. I bear in mind that the Claimant has relived the events multiple times since 2008 both in her own mind when dealing with the agony of the outcome, but also when discussing with friends and family and when pursuing her complaints with the Defendant, NMC and in her interactions with her various solicitors. That gives rise to the risk that her recollection has been corrupted as it has been repeated over time. The most contemporaneous documentary record of the Claimant's account appears in a letter of complaint she sent to the Defendant, date stamped received on 2nd December 2008 ("the 2008 account.") In that account the Claimant stated:

> "During the evening of Sunday 6th July 2008 I started to feel bloated and breathless. My tummy was very swollen and I had pain in my chest and around my ribs.
>
> I told the midwife about this. She gave me Gaviscon. I told the midwife that I couldn't breathe very well. The midwife did not carry out any checks on the baby.
>
> By about 11.00pm I told a second midwife about these problems. The second midwife suggested that the pain in my chest was due to the baby pushing on the ribs. This midwife put the Doppler test on me but did not carry out any trace or any other checks. I think that everyone in the ward was pre-occupied with a problem with another patient in the bed opposite.
>
> This was a problem concerning the involvement of social services rather than anything medical.
>
> I remember being in pain all night and at about 5.00am I told another midwife about the pain. She came to the bed and quickly realised that she could not get a heartbeat…"

110. The Claimant's evidence as to the chronology differs from her 2008 account in that she now asserts there were three relevant midwife interventions – the first with Midwife Hemming around 1700-1800 hrs, the second around 2100 hrs with Midwife Morton by which time she was experiencing more symptoms, and the third around 2300 hrs following a lengthy wait during which time the midwife had been dealing with the social services incident. The Claimant attributes any error in the 2008 account to the solicitor who drafted the letter. It is however telling that the letter in 2008 was signed by the Claimant in person rather than being sent by the solicitor. In my judgment it is dangerous to assess the Claimant's current account of events in isolation of the other witness and documentary evidence. However, standing back the consistent tenor of the Claimant's account was that she had felt increasingly unwell over the course of the evening of 6th July, the ward was really busy and that the midwives were preoccupied with other duties and were generally dismissive of her complaints.

111. The evidence of Jemma Fulford adds weight to the Claimant's evidence that she was feeling more and more unwell as the evening progressed. Ms Fulford's text message response at 9.16pm states: *"… maybe hes movein up towards ur lungs wen I was bout 7 an half months I cud neva breath properly…"* Although the Court does not have the message from the Claimant that prompted Ms Fulford's reply, the reference to the baby impacting on lungs and not being able to breathe properly is consistent with the Claimant complaining to her friend of pain around her lungs and/or breathlessness. Other than the text message, the court can place very little reliance of the remaining evidence of Ms Fulford. It was apparent she struggled, understandably given the passage of time, to recall the fine details of her interactions with the Claimant over the evening of 6th July 2008.

112. Whilst recognising that Debbie Richins is not an independent witness, her evidence as to receiving a telephone call from the Claimant during the evening of 6th July also adds weight to the Claimant's case that her symptoms were getting worse. Her reference to the Claimant saying she had already received Gaviscon is consistent with the concession made by Midwife Hemming at trial that Gaviscon had indeed been given before she went off shift. Ms Richins was credible and did not seek to overplay the evidence she could give; she readily agreed that as a result of the conversation she did not believe the Claimant was on the brink of catastrophe.

113. The evidence of Simon Hilton was demonstrably inaccurate in a number of respects. Her account that the midwives had failed to give the Claimant paracetamol, check her blood pressure or undertake any CTG trace is at odds with the agreed position. I tend to agree with the Defendant's assertion in cross-examination that Ms Hilton came across as an angry witness. However, one explanation for that anger is that it is borne out of her belief that the Claimant suffered unnecessarily and was not given the care she was entitled to. Ms Hilton is wholly independent of the parties and has nothing to gain from the outcome of this litigation. Given the material inaccuracies as to Ms Hilton's recollection of events, I cannot rely on her as to the details of care. However, her overall impression that the Claimant was deteriorating over the course of the evening, and that the midwives were not giving her the time of day she deserved, is a powerful image and consistent with the Claimant's case.

114. The oral evidence of Midwife Hemming was illuminating. She made concessions in oral evidence that were not evident in her witness statement. Despite saying in her statement that she could not remember an incident with social services that evening, she accepted in chief that there had been. She went on to describe the incident as "particularly complex" and that it had taken up a lot of her time. She also described for the first time in oral evidence another incident involving a lady in labour who needed transferring to the delivery suite such that it took her off the ward for about an hour. Midwife Hemming's description as the shift being "one of the busiest" in her career is consistent with the Claimant's impression that the midwives had no time for her. Contrary to that written in the notes, Midwife Hemming accepted she had given the Claimant paracetamol but forgotten to include it in her notes. The fact that the Claimant needed pain relief is consistent with the Claimant having deteriorated from the position earlier that day. In her witness statement Midwife Hemming stated that, after removing the CTG, she had seen the Claimant walking around the ward and could not recall her complaining of further symptoms. In oral evidence Midwife Hemming agreed that she thought she had given the Claimant a dose of Gaviscon at some time after the dose of paracetamol at 1800 hrs. Midwife Hemming also agreed that, if she had been able to find time to go back to monitor the Claimant, she would have done. Her oral evidence was inconsistent with the image portrayed in her witness statement that the Claimant was walking around the ward with no cause for concern. The Defendant's evidence thus moved far closer to the Claimant's account that she had needed and received paracetamol at 1800 hrs, had continued to have symptoms such that a midwife provided Gaviscon around 2100 hrs and that the midwives were frantically busy with other patients. On the timing of the shift patterns, it is

probable that the midwife administering the Gaviscon was Midwife Hemming and not, as the Claimant now recalls, Midwife Morton. That is also consistent with the Claimant's 2008 account that the midwife providing the Gaviscon was different to the midwife she saw at 2300 hrs.

115. Midwife Morton's witness statement is a carefully drafted document. It provides a detailed description as to her involvement with the Claimant but the use of language demonstrates that much of the account is based on the midwife's usual working practices as opposed to her actual recollection. For example, *"I would have looked at the drugs chart….I would have examined the Claimant in accordance with my usual practice…I would have examined her by starting at the top of her stomach…In order for me to reach this diagnosis the Claimant must have told me…"*.

116. Midwife Morton's oral evidence was rather less considered than her witness statement. She was asked a number of questions about her intervention around 2300 hrs leading to her conclusion that the Claimant was suffering from rib flare. Whilst her statement described a careful physical examination, cognisant of the Claimant's pre-existing conditions, her oral evidence suggested a rather more relaxed approach. She stated she did not know about the Claimant's earlier epigastric pain and *"would not have asked her about earlier."* She was unaware the Claimant had already received paracetamol and Gaviscon. The combination of that evidence is of concern. Midwife Morton was thus approaching her assessment of the Claimant without knowledge of recent symptoms, including epigastric pain, and that the giving of paracetamol and Gaviscon had not resolved the issue. She said she came to the conclusion it was rib flare as she *"could not find anything else wrong with her."* Her description that she thought she would have asked the Claimant if the baby was kicking or had his head under her ribs was at odds with her earlier written evidence that her careful palpation had been instrumental in her diagnosis. The combination of her lack of understanding of the Claimant's recent history and midwifery interventions, coupled with the fact that she had been called away from her drugs round on a very busy ward, makes it more probable that the Claimant's case that this was a cursory and somewhat dismissive assessment is correct. Midwife Morton's untimed entry in the medical records is unsatisfactory in that it makes no reference to the palpation nor does it satisfactorily explain why she records the Claimant as asymptomatic when the Claimant must have reported pain in order for her to conclude it was rib flare. Against that background, and taking into account what the midwifery and obstetric experts say about rib flare, it is difficult to conclude that Midwife Morton's assessment of rib flare was a considered assessment of the position as a whole.

117. Bearing in mind that the burden of proof rests on the Claimant, and the caution with which I must approach recollections tempered by the passage of many years, I make the following findings of fact:

i) Around 1700 hrs on 6th July 2008 the Claimant started to feel unwell with pain in her upper abdomen and felt generally unwell.

ii) Midwife Hemming attended around 1800 hrs. She noted epigastric pain, checked the Claimant's blood pressure (which was normal) and

undertook a CTG trace (which was normal). She gave the Claimant two paracetamol but failed to record that in the drug chart or in the Claimant's notes. Midwife Hemming forgot to take a urine sample.

iii) The ante-natal ward was extremely busy. Midwife Hemming was engaged in dealing with a complex incident involving social services and also left the ward for around an hour to take another lady to the delivery suite.

iv) After being seen at 1800 hrs, the Claimant's symptoms deteriorated. By around 2100 hrs, in addition to the continued pain in her upper abdomen under her ribs on the right side, she also had a general feeling of not feeling right, breathlessness, was unable to get comfortable and had heartburn.

v) The Claimant, with the assistance of Ms Hilton, tried to attract the attention of a midwife.

vi) Midwife Hemming was aware that the Claimant was unwell but had no time to revert to her other than to give her a dose of Gaviscon towards the end of her shift which finished at 2130 hrs. This interaction did not involve a full examination. The Claimant is incorrect in her recollection that it was Midwife Morton who gave her the Gaviscon.

vii) Midwife Morton came on duty around 2100 hrs but was initially engaged in the handover meeting and thereafter started on the ward with the drugs trolley.

viii) By around 2250 hrs the Claimant was sufficiently unwell that Midwife Morton interrupted the drugs round to see her. The Claimant reported to Midwife Morton that she didn't feel right, had pain under her ribs on the right side, was breathless, could not get comfortable and had heartburn. (The lack of reference to lower back pain, feeling hot and cold and tenderness to the stomach in the contemporaneous documentary evidence (including the 2008 account) means I am not satisfied the Claimant can prove these additional symptoms were present at this hour. Dr Gillham also accepted in cross examination that she thought the uterus would still have been soft and non-tender at 2300 hrs.)

ix) Midwife Morton was unaware of the earlier recording of epigastric pain or that the Claimant had already been given paracetamol and Gaviscon. Midwife Morton did not ask the Claimant about her earlier symptoms. Midwife Morton took the Claimant's blood pressure (which was normal) and listened to the fetal heart rate with a Doppler (which was normal.) Midwife Morton asked the Claimant whether she had headaches or flashing lights and the Claimant told her she did not. Midwife Morton gave the Claimant two paracetamol and concluded the Claimant was suffering from "rib flare".

x) The symptoms the Claimant had reported at 2250 hrs continued through the night and she felt worse. The Claimant did not call for a midwife during the night nor did the midwives check on her.

xi) Shortly before 0645 hrs the Claimant felt severe pain in her stomach and hobbled over to the midwives' desk.

Breach of duty

118. The findings of fact are close to, but not a complete reflection of, the Claimant's factual case put to the experts as The First Scenario. The main difference being the absence of complaints as to stomach tenderness, lower back pain and a feeling of going hot and cold with clammy hands during the three material midwifery interventions.

1800 hrs

119. The Claimant had a known history of PIHT and IUGR and absent end diastolic flow. The findings of fact mean that the Claimant was complaining of pain in her upper abdomen and of feeling generally unwell when she saw Midwife Hemming at 1800 hrs. The findings of fact accord with The First Scenario as described to the experts in relation to 1800 hrs.

120. Dr Ashcroft and Ms Fraser agreed that the Claimant's pregnancy was high risk and her urine should have been tested at 1800 hrs. The midwifery experts also agree that the note taking was inadequate in that it failed to record the giving of paracetamol.

121. In the joint statement Dr Ashcroft concluded that an obstetric review should have been requested by Midwife Hemming. Ms Fraser opined *"an obstetrician may have been required if, on further assessment, the claimant was found to be unwell."* In cross examination, she agreed that if the Claimant was unwell on midwifery assessment, she would have expected an obstetrician to be involved.

122. In circumstances where the Claimant was presenting as generally unwell with epigastric pain, breach of duty is established in failing to refer for obstetric review. There are also further breaches of duty arising from the failure to test the Claimant's urine and to record the dose of paracetamol.

2130 – 2300 hrs

Midwife Hemming

123. There was a second interaction with Midwife Hemming when she administered Gaviscon towards the end of her shift which finished at 2130 hrs but did not conduct an examination.

124. On The First Scenario facts, Dr Ashcroft and Ms Fraser agreed that Midwife Hemming should have checked on the Claimant before she went off shift. Based on my findings of fact, the Claimant was presenting as more unwell by around 2100 hrs and, accordingly, I find there was a further breach of duty by Midwife Hemming in not conducting an assessment before she went off shift and in failing to record that she had given the Claimant a dose of Gaviscon.

Midwife Morton

125. The Claimant was presenting with a variety of symptoms when seen by Midwife Morton: she felt didn't feel right, had pain under her ribs on the right side, was breathless, could not get comfortable and had heartburn. Her presentation differs from The First Scenario upon which the experts commented in that she was not complaining of: lower back pain, feeling hot and cold and tenderness to the stomach. I therefore approach the expert evidence with caution as Dr Ashcroft and Ms Fraser did not have the opportunity to comment on the specific combination of symptoms.

126. The midwifery experts were asked to comment in the joint report on whether adequate attention had been given to the Claimant if presenting with a feeling of unwellness, a stomach tender to touch, pain under the ribs on her right side, breathlessness and feeling hot and cold with clammy hands. Both agreed that such signs and symptoms were deviations from the norm. Dr Ashcroft opined: *"The above signs and symptoms are deviations from the normal and therefore I would have expected the midwife to inform the registrar, according to the Midwives' Rules (2004, rule 6): "In an emergency, or where a deviation from the norm which is outside her current sphere of practice becomes apparent in a woman or baby during antenatal, intranatal or postnatal periods, a practising midwife shall call such qualified health professional as may reasonably be expected to have the necessary skills and expertise to assist her in the provision of care."* Ms Fraser opined: *"If the claimant was feeling unwell with these symptoms then a detailed examination was required +/- obstetric review."* She went on to say that whilst the symptoms as described by the Claimant were non-specific and not signs of developing pre-eclampsia, any such symptoms would require attention to see if obstetric review was required. Ms Fraser accepted in the joint report that *"if such signs were present and the claimant felt unwell than an obstetric review should have been requested, but not on an urgent basis."*

127. The findings of fact mean that the Claimant was not presenting at 2300 hrs with the full correlation of symptoms upon which the midwives were asked to comment. However, the Claimant was presenting with deviations from the norm, namely she didn't feel right, had pain under her ribs on the right side, was breathless, could not get comfortable and had heartburn. The essence of the expert midwifery evidence was that deviations from the norm are something that should ring alarm bells. Set against a background of known high risk factors with the Claimant, failed attempts at controlling the position with paracetamol and Gaviscon and a worsening clinical position over the course of the evening, I am satisfied that there was a breach of duty at 2300 hrs in not referring the Claimant was obstetric review.

128. The midwives agreed that the recording keeping was not adequate if the Claimant had been expressing concern. The Claimant was expressing concern and therefore I accept there was a further breach of duty insofar as the records did not give an accurate picture of the factual position.

129. The experts disagreed as to whether a urine sample should have been taken at 2300 hrs. Dr Ashcroft stated it should have been tested in any women with PIHT who had complained of epigastric pain. Ms Fraser did not accept a urine test was required unless she was displaying signs of pre-eclampsia and the records suggest she was not doing so. Ms Fraser's logic is difficult to accept. On the one hand she accepted that the urine should have been tested for protein at 1800 hrs based The First Scenario Facts. On the other hand, she stated there was no duty to test when faced with a lady with more significant symptoms and deviations from the norm later that evening. In my judgment, when answering the question, Ms Fraser fell into the trap of allowing the Defendant's factual case that the Claimant was asymptomatic at 2300 hrs to colour her view. Whilst the Claimant did not have all the typical symptoms or signs of pre-eclampsia, she was referring to pain under her ribs, epigastric pain had been recorded at 1800hrs, she was known to have PIHT and she had deteriorated generally over the evening. I thus therefore prefer the evidence of Dr Ashcroft that the midwife failing to take a urine sample at 2300 hrs amounted to a breach of duty.

After 2300 hrs and during the course of the night of 6th – 7th July

130. The midwives agreed in their joint statement that on The First Scenario facts inadequate attention was given to the Claimant overnight and that there should have been midwife reviews leading to obstetric review if the Claimant had not improved.

131. Whilst the number of symptoms presenting at 2300 hrs have not been found to be as extensive as The First Scenario, the Claimant was nonetheless presenting with a variety of symptoms and signs that deviated from the norm and had deteriorated. The expert midwives' comments as to the overnight position based on The First Scenario can thus be applied to the facts as found. A further breach of duty is established in failing to conduct midwife reviews overnight.

Causation

132. The parties agree, guided by their respective obstetric experts, that the Claimant needs to prove, on the balance of probabilities, that she would have been transferred from the ante-natal ward to the delivery suite. Thereafter, she needs to prove that in order for Kyron to have been born alive a decision would have been made to deliver Kyron before the abruption at 0645hrs on 7th July 2008. It follows that there are questions of both factual and medical causation that require determination.

133. The parties rightly acknowledge that both obstetric experts are well qualified to opine on the issues. Each expert was impressive, clearly had substantial experience in their discipline and gave evidence in an authoritative manner. There was however significant disagreement between the experts as to the probable turn of events on the Claimant's factual case. As with the midwifery experts, I bear in mind that the findings of fact depart in some respects from The First Scenario upon which the experts were asked to comment.

Urine testing

134. There is a dispute between Dr Gillham and Professor Tuffnell as whether there would have been protein in the Claimant's urine had it been tested at various intervals from 1800 hrs. The issue is relevant because the result may have informed a registrar when making a decision on whether to transfer the Claimant to the delivery suite.

135. Dr Gillham's evidence was that proteinuria probably would have been present at 1800 hrs given that the Claimant had a high risk of pre-eclampsia and had developed symptomatology in the pre-eclampsia spectrum. Dr Gillham concluded that proteinuria would also have been present if it had been tested at 2200 hrs and in the early hours of 7th July. She took the view that taking into account the Claimant's known high-risk factors and the known end-point abruption, the Claimant's symptoms reflected the deteriorating disease process.

136. Professor Tuffnell concluded that protein would probably not have been present at 1800 hrs given the negative test earlier in the day and normal blood pressure. He stated that proteinuria was possible but not probable at 2200 hrs and more likely in the early hours of the morning at approximately 0300 hrs. In cross-examination, he emphasised that more likely in the early hours does not mean probable. He considered it probable that proteinuria would only have been present around abruption and still possible it would not even have shown at abruption.

137. In my judgment the concept of Claimant Benevolence following *Keefe* and the subsequent authorities does have a role to play when determining whether proteinuria would have been present. The Claimant has been deprived of first-hand evidence as to the protein levels as a direct result of the Defendant's breach of duty in failing to take samples at 1800 hrs and 2300 hrs. Such benevolence does not however reverse the burden of proof and I take into account the obstetric expert evidence. Professor Tuffnell concedes an increasing likelihood of proteinuria as time progresses. To that extent there is more of but not a complete convergence between the experts as to the likelihood of proteinuria by early hours of the morning.

138. I am not persuaded that the Claimant can establish that it was probable that proteinuria would have been present at 1800 hrs. Claimant Benevolence on its own is not enough and I prefer the evidence and analysis of Professor Tuffnell on this point. The Claimant has only started to feel unwell an hour before, her urine sample had been normal earlier that day, her blood pressure was normal and both experts agreed that raised blood pressure typically precedes proteinuria. It may be thought the likelihood of the Claimant presenting with

raised blood pressure prior to proteinuria was enhanced by her pre-existing pregnancy induced hypertension. Thus, whilst it is possible that proteinuria may have been present at 1800 hrs, I am not persuaded that it was probable.

139. Turning to the position at 2300 hrs, the Claimant was presenting as generally more unwell than at 1800 hrs although, other than rib pain, her symptoms were not classic of pre-eclampsia. Again, I am not persuaded that Claimant can establish it was probable that proteinuria would have been present at this time. Professor Tuffnell's evidence reflects the more probable position, taking into account the Claimant's normal blood pressure and the typical presentation of high blood pressure before proteinuria. The notion of Claimant Benevolence does not undermine the reasoned explanation provided by the expert evidence of Professor Tuffnell on this issue.

140. Moving into the early hours of the morning, there is a complete lack of any data. In breach of duty there was no obstetric referral and no midwife reviews during the night. This has resulted in an absence of any blood pressure readings after 2300 hrs until after the abruption. There was also a lack of urine testing and fetal heart monitoring. By the early hours of the morning, it is no longer possible to say that the data demonstrates that the Claimant's blood pressure was normal. Coupled with that is agreed expert evidence that the likelihood of proteinuria increased as time went on. Professor Tuffnell conceded an increasing likelihood of proteinuria by 0300 hrs, albeit his view is that it would not have been probable until around abruption. In my judgment, Claimant Benevolence does have a role to play when determining whether it is probable that proteinuria would have been present at in the early hours of the morning. The Claimant is deprived of data as to both blood pressure and proteinuria. Dr Gillham's evidence was supportive of proteinuria at this time; Professor Tuffnell accepting of an increasing likelihood. Taking the expert evidence together with benevolence in favour of the Claimant, I am persuaded that the Claimant has established that it is probable that proteinuria would have been present by the early hours of the morning (approximately 0300 hrs.)

Transfer to the delivery suite

1800 hrs on 6th July 2008

141. The Claimant has established the following breaches of duty at 1800 hrs: failure to (1) test the Claimant's urine, (2) record the dose of paracetamol and (3) refer for obstetric review.

142. For the reasons given above, if the urine had been tested at 1800 hrs, it is probable it would not have been positive for urine. The failure to record the paracetamol had no causative effect at 1800 hrs but may be relevant later in the evening. The key issue at 1800 hrs is what would have been the probable outcome of obstetric review.

143. Professor Tuffnell maintained the Claimant would have remained on the ante-natal ward. In the joint statement, Dr Gillham stated it was possible the Claimant would have been transferred depending on the symptomology and clinical concern. She agreed in cross-examination that a decision to remain on the ante-

natal ward was within a reasonable range of opinion. Taken with my finding that there would not have been proteinuria at 1800 hrs, the Claimant cannot establish it was probable rather than merely possible that she would have been transferred to the delivery suite at that time. The probability is that she would have remained on the ante-natal ward with an acknowledgement that this already high-risk patient was complaining of a symptom indicative of pre-eclampsia.

2200- 2300 hrs on 6th July 2008

144. The Claimant has established breaches of duty at 2300 hrs in respect of failures to (1) refer for obstetric review, (2) test the urine and (3) keep proper records. I have found that it is probable that any urine test at this time would not have shown proteinuria. The lack of proper record keeping at 1800 hrs and around 2130 hrs meant that the treating clinician was unaware that the Claimant had already been given paracetamol and Gaviscon.

145. As to the probability of transfer to the delivery suite at 2200-2300 hrs, Professor Tuffnell concluded that was unlikely given the normal blood pressure check and normal CTG. Dr Gillham's opinion was that *"with a high risk clinical situation and a woman who was becoming more unwell and symptomatic an obstetrician would not have wished her to remain on the antenatal ward at a review around 22/2300…if symptomatology of the claimant is accepted transfer to the delivery suite would already have occurred in the early hours of the morning."* Dr Gillham pointed out that an earlier plan had been for the Claimant to deliver the previous day so the notion of an early delivery was one that the clinicians were alive to. In cross examination, Dr Gillham maintained that the Claimant would not have been left on the ward given her deteriorating position

146. I bear in mind that the findings I have made as to signs and symptoms at 2300 hrs do not include the full gamut of the Claimant's pleaded case. At 2300 hrs the Claimant's blood pressure, urine sample and CTG trace would all have been normal, and she had no headaches or visual disturbances. She was however presenting as increasingly unwell against a backdrop of known high risk factors. I am not satisfied the Claimant can establish that it is probable she would have been moved to the delivery suite at 2300 hrs. It is not appropriate to rely on Claimant Benevolence when the Court has before it reasoned expert evidence addressing this aspect of causation. Given the lack of typical symptoms of pre-eclampsia at 2300 hrs, I prefer the conclusion of Professor Tuffnell that it is probable she would have remained on the ante-natal ward. However, she would have been kept under review and not left unattended all night.

Early hours of 7th July 2008

147. The effect of the findings on breach of duty are that the Claimant should have been subjected to further midwife observations leading to obstetric review in the early hours of the morning. It is apparent from the joint statement that Professor Tuffnell's opinion as to probable events in the early hours of the morning, based on The First Scenario facts, had been influenced by his view that there would have been no clinical intervention after 2300 hrs before abruption at 0645 hrs. For example he opined, *"Unless she called the midwife*

back I do not see further checks would be performed" and *"obstetric review at that time (2300 hrs) would not have led to further checks without the woman presenting to the midwives so I do not see it could have been diagnosed before 0645 hrs."* In cross examination, he accepted that he did not think that the Claimant was desperately unwell with pre-eclampsia in the early hours of the morning and agreed he did not accept the Claimant's factual case that she was unwell. In my judgment, Professor Tuffnell's non-acceptance of the Claimant's factual case has coloured his opinion as to what action would have been taken in the early hours.

148. At 0300 hrs the Claimant would have been presenting with proteinuria together with ongoing symptoms of not feeling right, pain under her ribs on the right side, breathlessness, feeling uncomfortable and with heartburn. It would have been known that these symptoms were occurring against a backdrop of IUGR, PIHT and absent end diastolic flow. Her general clinical picture had deteriorated, particularly in light of the finding of proteinuria. Set against her known high risk factors, I prefer the evidence of Dr Gillham that by this time is was probable that a decision would have been made to transfer her to the delivery suite. Whilst I recognise the merit in Professor Tuffnell's opinion that when deciding to move a patient to a high dependency environment of a delivery suite one has to balance the needs to the health service as a whole, this was an already high risk patient presenting with a deteriorating clinical position. I therefore find that it is probable that the Claimant would have been transferred to the delivery suite shortly after 0300 hrs. I come to this decision based on the expert evidence and without the need to rely on any notion of Claimant Benevolence.

Delivery of Kyron

149. The Claimant would have arrived on the delivery suite shortly after 0300 hrs. The obstetric experts agreed that once on the delivery suite, the Claimant's blood pressure would have been checked, blood tests undertaken and a CTG trace performed. The experts further agreed that the delivery suite was better placed to provide a quicker response to an emergency than the ante-natal ward.

150. I first consider whether a decision would have been made to proceed with a planned (as opposed to emergency) delivery once the tests on arrival in the delivery suite had been undertaken. The Claimant would by this time have been presenting with proteinuria but, given the blood tests at 0900 hrs on 7th July showed no liver function abnormality, it is probable that the blood tests would have been within normal bounds when tested on arrival on the delivery suite. Both experts recognised that a decision to deliver is always a balanced one. Dr Gillham accepted that there was a general desire to prolong pregnancy but that had to be weighed against known problems about placental function. Professor Tuffnell's view was that it was unlikely the clinicians would have concluded that a planned delivery in the early hours of 7th July was appropriate. His position was that, at the very most, the clinicians would have been planning for a delivery the next day during daylight hours when senior staff were on hand. The Defendant's "Guidelines for the Management of Severe Hypertension, including Eclampsia", dated August 2007, at paragraph 6 reads: *"Prolonging the pregnancy at the very early gestations may improve the outcome for the*

premature infant but can only be considered if the mother remains stable." The Royal College of Obstetricians and Gynaecologist guidance, dated March 2006 on "the management of severe pre-eclampsia/eclampsia" states at paragraph 5.5: *"The decision is deliver should be made once the woman is stable and with appropriate senior personnel present…The delivery should be well planned, done on the best day, performed in the best place, by the best route and with the best support team."*

151. The Claimant would not have arrived on the delivery suite until shortly after 0300 hrs whereupon the various tests would then have been performed prior to the clinicians being able to make an informed decision as to the merits of a planned delivery. The notion of an early planned delivery had been in the minds of the treating clinicians on 5th July with steroid injunctions being given on 4th and 5th July to strengthen the baby's lungs. That plan was then rejected in favour of continued monitoring. The clinicians would have been aware that any delivery would have been high risk: the baby was only 30 weeks' gestation and known to be below the 10th centile on the growth chart. The focus of Dr Gillham's evidence was on monitoring on the delivery suite leading to a decision to deliver when something changed, such as blood pressure or CTG abnormalities, rather than a planned delivery made after the tests on arrival had taken place. In my judgment, the opinion of Professor Tuffnell on this issue is the probable and more logical outcome. Whilst a planned delivery would have been considered, it was probable it would not have been scheduled for the middle of the night without senior staff on hand in circumstances where the baby was known to be so premature and small for his gestational age.

152. The second issue is whether there would nonetheless have been an emergency delivery leading to Kyron's safe arrival at some point prior to the abruption at 0645 hrs. On paper Dr Gillham and Professor Tuffnell took opposing positions as to whether a safe delivery was the probable outcome. However, in cross-examination, Dr Gillham softened her position. She spoke of the triggers that would have been required to deliver Kyron before 0645 hrs and commented on the difficulty in reconstructing the hypothetical in the absence of information over an 8-hour period. However, she stated that if the Claimant had been increasingly unwell with pain, if she had needed hypertensives and they weren't working, if there were CTG abnormalities then a decision to deliver <u>may</u> have been made prior to abruption. [Emphasis added.] The Claimant has to establish that it would have been probable not possible that delivery would have occurred prior to 0645 hrs. Dr Gillham and Professor Tuffnell, as experienced expert witnesses, made careful use throughout their opinion evidence as to whether outcomes were possible or probable. Dr Gillham's use of the word "may" is therefore very significant.

153. The Claimant asks the court to apply Claimant Benevolence to the reconstruction of the hypothetical. However, I am not persuaded such a concept can provide a bridge to causation in the face of the Claimant's own expert evidence and that of Professor Tuffnell. Even if one accepted that the evidence should be interpreted in a way benevolent to the Claimant so as to reach the conclusion that the Claimant would have been presenting as being increasingly unwell, hypertensives would have been administered but not have worked,

proteinuria would have been present along with CTG abnormalities, the difficulty the Claimant faces is that her own oral expert evidence is that this leads to a conclusion that there may have been a decision to deliver. The hard, medical evidence does not demonstrate that it was probable as opposed to possible that Kyron would have been safely delivered before the fatal abruption at 0645 hrs. It is one thing to apply a benevolent approach to the existence of signs and symptoms but another to use it to construct the planks of causation when not supported by the expert evidence.

Conclusion

154. Nothing can detract from the fact that this is a tragic case with devastating consequences for the Claimant, Kyron, her family and all involved. I anticipate that no one involved in this case has anything other than the utmost sympathy and respect for the Claimant. She has pursued her case with dignity and, as evidenced by the findings of fact, was a credible and truthful witness. She is right to be aggrieved at the negligent standard of care afforded to her by the Defendant over the evening of the 6th and into the 7th July 2008. However, the sad reality is that, even if the standard of care had not been negligent, the probability is that Kyron would not have been safely delivered before the abruption. The need to establish causation on the balance of probabilities can be a cruel concept in cases of medical negligence. Loss of a chance of something that was not the probable outcome will not suffice. I appreciate that this leaves the Claimant with the knowledge that there was a chance, even if not a probability, that Kyron would have been safely delivered. I do not underestimate the difficulty of being left with that unknown. I hope that the Claimant can take some solace in the formal recognition that the care she received at that time was not that which it should have been.

155. The outcome of litigation can be brutal and, despite having crossed many of the hurdles, the claims fails on the issue of causation. For the reasons aforementioned in this judgment, the claim is dismissed.