Neutral Citation Number: [2019] EWHC 840 (QB)

Case No: HQ16C02898

**IN THE HIGH COURT OF JUSTICE**
**QUEEN'S BENCH DIVISION**

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 05/04/2019

**Before**:

**HIS HONOUR JUDGE MARTIN McKENNA**
**(Sitting as a Judge of the High Court)**

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**Between:**

| | |
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| **PXW**<br>**(a Minor, suing by his Father and Litigation Friend, MXW)** | **Claimant** |
| **- and -** | |
| **KINGSTON HOSPITAL NHS FOUNDATION TRUST** | **Defendant** |

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**Christopher Gibson QC and Harry Trusted** (instructed by **Ashtons Legal**) for the **Claimant**
**Clodagh Bradley QC** (instructed by **Capsticks LLP**) for the **Defendant**

Hearing dates: 19-22, 25, 27 March 2019

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# Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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HHJ MARTIN McKENNA

## HHJ Martin McKenna:

Introduction

1. This is a clinical negligence claim arising from the birth of the Claimant, PXW, at Kingston Hospital in Southwest London ("the Hospital") on 15 March 2011. PXW's parents are MXW, who is also PXW's Litigation Friend, RXF. PXW is their third child with James having been born in 2004 and Sarah in 2007, both without any complications.

2. Kingston Hospital NHS Foundation Trust, the Defendant, is the statutory body charged with the provision of healthcare for Kingston and it owns and manages the Hospital.

3. PXW has cerebral palsy and on his behalf it is alleged that he sustained hypoxic-ischaemic brain injury as a result of midwifery negligence when his mother attended at the Hospital's Maternity Assessment Unit at 39 weeks and three days gestation at 17:55 on 15 March 2011 ("the first admission") and/or (at least until after the conclusion of the evidence) when she returned to the Hospital at about 20:45 the same evening ("the second admission").

4. PXW was in fact born at 20:57 on 15 March 2011, very shortly after the second admission.

5. This court is concerned with a preliminary issue as to whether or not the Defendant is liable to PXW by reason of the matters alleged in the (now) Re-Amended Particulars of Claim, and if so, whether or not any of the injuries were so caused and, if any such injuries were so caused, the extent of the same, pursuant to the order of Master Yoxall dated 13 July 2017.

Chronology

6. I set out below a chronology of relevant events with the timings being taken from contemporaneous records:

| | |
|---|---|
| 17:55 | PXW's parents arrive at the Hospital and are triaged by Midwife Truu in the Maternity Assessment Unit, who recorded the following presenting history in a note timed 18:05:<br><br>"*Contracting 2-3 in 10mins since 17:50 today – no analgesia required abdo and back pain (bad period pain)*"<br><br>The contractions were said to be mild in strength and irregular.<br><br>The results of observations and palpations were recorded as was the fetal heartrate (127-133) which was said to be normal.<br><br>A vaginal examination was undertaken and the results noted in a note timed at 18:10.<br><br>The plan was recorded as "*Go home to await for events. Call back when contractions stronger*".<br><br>That note is not timed. |

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|---|---|
| | RXF/MXW' notes of contractions are as follows:<br>"*4.29 – 65 secs*<br>*4.39*<br>*4.45*<br>*4.48*<br>*4.56 – 50 secs*<br>*5:06 – 1 min*<br>*6:10 – 1 min 30 mins (sic)*<br>*5:15 – 1 min*<br>*5:18 – 45 secs*<br>*5:22 – 50 secs*<br>*5:25*<br>*5:28 – 1:55 secs*<br>*5:31 – 1 min*<br>*5:35 – 1 min*<br>*5:38 – 50 secs*<br>*5:40 – 50 secs*<br>*5:47 – 1:50*<br>*5:52 – 1 min*<br>*5:55 – 1 min 10 secs*<br>*6:24, 6:26, 6:29, 6:33, 6:37, 6:40, 6:41, 6:45, 6:46, 6:60, 6:53, 6:55, 6:58, 7:00*" |
| 18:20 | PXW's parents left the Maternity Assessment Unit. |
| 19:30 | Time at which it is agreed that RXF went into established labour. |
| 19:40 | PXW's parents arrive back at RXF's father's flat. |
| 20:20 | MXW telephones the Maternity Unit to say that he and RXF are returning to the Unit. |
| 20:41 | PXW's parents arrive at the Maternity Unit's reception. |
| 20:45 | RXF arrives at the Malden Suite at which point she is asked to give a urine sample. |
| 20:48 | Midwife Clarke notes that she has been called to the bathroom to find that there had been a spontaneous rupture of membranes ("SRM") which she noted as clear.<br>On return to the room, Midwife Clarke attempted to auscultate the fetal heart |

| | |
|---|---|
| | without success. |
| 20:50 | The vertex was noted as visible and advancing but RXF was unable to get onto the bed. |
| 20:52 | Midwife Clarke notes being unable to hear the fetal heart and "*Vertex advancing quickly*". |
| 20:55 | PXW's head is delivered. |
| 20:57 | PXW is born. |

## The issues

### The first admission

7. What is said on behalf of PXW is that it was inappropriate and negligent of Midwife Truu to send RXF home and that, had she not done so, then PXW would, on the balance of probabilities, have been delivered without permanent injury on the basis that had PXW's mother been admitted or invited to stay on the Unit to await developments, the likelihood is that she would have been observed to be in established labour at 19:30, would then have been appropriately observed and auscultation of the fetal heart would have commenced at fifteen minute intervals which in turn would have led to abnormalities being detected, the application of a CTG monitor and the detection of non-damaging hypoxia secondary to intermittent compression of the cord which would have led to a decision being taken to deliver PXW earlier with no injury.

8. The essence of the Defendant's case on the first admission is that following an appropriate assessment, RXF was assessed to be in the latent first stage of labour and not established first stage labour; that both the national and the local recommendations are and were to encourage such women to remain at or return home and that the advice to return home was reasonable. As to causation, what is said is that had RXF remained in the Hospital, auscultation would indeed have commenced at 19:30 but no abnormalities would have been detected so no CTG would have been commenced and PXW would have been born at the same time as he in fact was.

### The second admission

9. What is, or was, said on behalf of PXW, is that Midwife Clarke was negligent in failing to auscultate the fetal heart immediately on RXF's arrival in the Malden Suite and in failing to perform an episiotomy and in failing to call for obstetric and paediatric assistance and thereby expediting PXW's birth by 20:53, again thereby avoiding permanent injury.

10. The case on behalf of the Defendant is that on admission at 20:45 RXF gave a history of more intense contractions since 19:30, good fetal movement, no vaginal loss and no rectal pressure, suggesting that she was still in the active first stage of labour and without any complications such that it was reasonable to request a urine sample prior

to any assessment. The labour progressed very quickly; there was no indication for an episiotomy, nor would one have been possible in the circumstances and earlier attendance by paediatricians would have made no difference. PXW's injuries were in effect inevitable and unavoidable.

11. Following the conclusion of evidence and before submissions the court was informed that the Claimant no longer advanced any claim in negligence in respect of the second admission.

12. To my mind that was clearly a sensible decision but left the Claimant pursuing claims in negligence in respect of the first admission relying on the same experts who had supported the Claimant's case in respect of the second admission but where a decision had been taken that that claim was not sustainable on the evidence. Needless to say, the Defendant makes much of this difficulty in its submission on the first admission.

The agreed issues

13. A number of issues have been agreed by the parties and/or their respective experts. They include the following:

    i) RXF was in established labour at 19:30 (joint obstetric statement);

    ii) Had RXF remained at the Hospital after 18:20, intermittent auscultation would have commenced at 19:30 and continued every fifteen minutes (joint obstetric statement);

    iii) There was an acute near total cord occlusion in the minutes before PXW's birth due to head descent associated with the onset of the second stage of labour and at around the time of membrane rupture and this caused the hypoxic damage (joint neonatology statement);

    iv) There was a fetal bradycardia as a result of severe cord compression. The term "terminal bradycardia" in this case is a fetal bradycardia which does not recover without delivery and resuscitation. It does not imply that the bradycardia was at the end of a chronic partial insult (joint neonatology statement);

    v) PXW responded rapidly to resuscitation with a heartrate greater than 100 beats per minute at one minute following birth (APGAR score 2) and by five minutes he had some respiratory effort and improved perfusion (APGAR score 4) (joint neonatology statement);

    vi) Earlier attendance of the paediatricians would have made no difference as they would have initiated the same process as the midwives and the heartrate responded within one minute with the same outcome (joint neonatology statement);

    vii) The MRI scan abnormalities are likely to be due to an acute near total hypoxic-ischemic insult, with the causative event having probably been towards the shorter end of the 10 to 25 minute window of potential damaging insult but the

neuro-radiologists could not specify an accurate duration (joint neuroradiology statement);

viii) The MRI scans show no evidence of a superimposed chronic partial asphyxia insult;

ix) The neonatologists agree that there is no clinical or radiological evidence that PXW suffered any chronic partial hypoxic-ischemic insult prior to the acute profound hypoxic-ischemic insult (joint neonatology statement);

x) If PXW had been delivered by 20:43, it is likely that he would have been undamaged (joint neonatology statement);

xi) If delivery had been by 20:55 hours it is likely that PXW would have sustained neurological injury in any event (joint neonatology statement).

Witness evidence

14. The court has heard evidence from PXW's mother and father and in addition has read short statements from PXW's maternal grandmother and maternal grandfather.

15. The court has also heard evidence on behalf of the Defendant from Midwives Cort and Freedman (neé Clarke,) the former via video link from Bosnia, in respect of the second admission and has read a witness statement from Midwife Karin Truu who, although she had cooperated with the Defendant's solicitors during the course of case preparation, notified the Defendant's solicitors in January 2019 that she no longer felt able to give evidence at trial, citing the bereavement of her partner as a result of a tragic accident leaving her as a single parent to a new-born baby, as the reason. She now lives back in her home country of Estonia.

16. On 1 March 2019 there was a contested hearing relating to the admissibility of Midwife Truu's witness statement before Mrs Justice Cutts and after full argument, she ordered that the evidence was admissible pursuant to the Civil Evidence Act, with the issue of weight being a matter for the trial judge.

17. In addition to the factual witness evidence, there were expert witnesses in four disciplines, midwifery, obstetrics, neonatology and neuroradiology. I heard oral evidence from the midwifery, obstetric and neonatology experts. There was, however, no significant disagreement between the neuro-radiologists and their evidence was read.

18. The midwifery experts were Sandra Reading for the Claimant, whose report is dated 10 January 2018, and Tracey Reeves, whose report is dated November 2017, for the Defendant.

19. The obstetric experts were Peter Brunskill, whose report is dated January 2018 for the Claimant, and Derek Tuffnell, whose main report is dated November 2017 and who provided a supplementary report in June 2018 following the service of the Re-Amended Particulars of Claim.

20. The neonatology experts were Prof Simon Mitchell on behalf of the Claimant and Dr Anthony Emmerson on behalf of the Defendant.

21. The neuroradiology experts were Dr W St Clair Forbes instructed by the Claimant and Dr Neil Stoodley instructed by the Defendant.

The law

22. The classic test for breach of duty is that identified by McNair J in *Bolam v Freirn Hospital Management Committee* [1957] 1 WLR 583 at page 586:

> "*The test is the standard of the ordinary skilled man exercising and 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 of an ordinary competent man exercising that particular art.*"

23. Later at page 587, McNair J put it this way:

> "*…he 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 that particular art. I do not think there is much difference in sense. It is just a different way of expressing the same thought. Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view.*"

24. The practice relied on in defending an allegation of clinical negligence has to be "responsible, reasonable and respectable" and has to have "a logical basis" and where it involves weighing comparative risks it has to be shown that those advocating it had directed their minds to the relevant matters and reached a defensible conclusion. Lord Browne-Wilkinson explained and refined the *Bolam* test in this way in *Bolitho v City and Hackney Health Authority* [1998] AC 232 at page 243:

> "*These decisions demonstrate that 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 bench mark by reference to which the defendant's conduct falls to be assessed.*"

25. In *C v North Cumbria University Hospitals NHS Trust* [2014] EWHC 61 Green J, as he then was, gave a helpful analysis of the case law on breach of duty at paragraph 25 as follows:

> "*25. In the present case I have received evidence from 4 experts, 2 on each side. It seems to me that in the light of the case law the following principles and considerations apply to the assessment of such expert evidence in a case such as the present:*
>
> *i) Where a body of appropriate expert opinion considers that an act or omission alleged to be negligent is reasonable a Court will attach substantial weight to that opinion.*
>
> *ii) This is so even if there is another body of appropriate opinion which condemns the same act or omission as negligent.*
>
> *iii) The Court in making this assessment must not however delegate the task of deciding the issue to the expert. It is ultimately an issue that the Court, taking account of that expert evidence, must decide for itself.*
>
> *iv) In making an assessment of whether to accept an expert's opinion the Court should take account of a variety of factors including (but not limited to): whether the evidence is tendered in good faith; whether the expert is 'responsible', 'competent' and/or 'respectable'; and whether the opinion is reasonable and logical.*
>
> *v) Good faith: A sine qua non for treating an expert's opinion as valid and relevant is that it is tendered in good faith. However, the mere fact that one or more expert opinions are tendered in good faith is not per se sufficient for a conclusion that a defendant's conduct, endorsed by expert opinion tendered in good faith, necessarily accords with sound medical practice.*

*vi) Responsible/competent/respectable: In* Bolitho *Lord Brown Wilkinson cited each of these three adjectives as relevant to the exercise of assessment of an expert opinion. The judge appeared to treat these as relevant to whether the opinion was 'logical'. It seems to me that whilst they may be relevant to whether an opinion is 'logical' they may not be determinative of that issue. A highly responsible and competent expert of the highest degree of respectability may, nonetheless, proffer a conclusion that a Court does not accept, ultimately, as 'logical' . Nonetheless these are material considerations. In the course of my discussions with Counsel, both of whom are hugely experienced in matters of clinical negligence, I queried the sorts of matters that might fall within these headings. The following are illustrations which arose from that discussion. 'Competence' is a matter which flows from qualifications and experience. In the context of allegations of clinical negligence in an NHS setting particular weight may be accorded to an expert with a lengthy experience in the NHS. Such a person expressing an opinion about normal clinical conditions will be doing so with first hand knowledge of the environment that medical professionals work under within the NHS and with a broad range of experience of the issue in dispute. This does not mean to say that an expert with a lesser level of NHS experience necessarily lacks the same degree of competence; but I do accept that lengthy experience within the NHS is a matter of significance. By the same token an expert who retired 10 years ago and whose retirement is spent expressing expert opinions may turn out to be far removed from the fray and much more likely to form an opinion divorced from current practical reality. 'Respectability' is also a matter to be taken into account. Its absence might be a rare occurrence, but many judges and litigators have come across so called experts who can 'talk the talk' but who veer towards the eccentric or unacceptable end of the spectrum. Regrettably there are, in many fields of law, individuals who profess expertise but who, on true analysis, must be categorised as 'fringe'. A 'responsible' expert is one who does not adapt an extreme position, who will make the necessary concessions and who adheres to the spirit as well as the words of his professional declaration (see CPR35 and the PD and Protocol).*

*vii) Logic/reasonableness: By far and away the most important consideration is the logic of the expert opinion tendered. A Judge should not simply accept an expert opinion; it should be tested both against the other evidence tendered during the course of a trial, and, against its internal consistency. For example, a judge will consider whether the expert opinion accords with the inferences*

> *properly to be drawn from the Clinical Notes or the CTG. A judge will ask whether the expert has addressed all the relevant considerations which applied at the time of the alleged negligent act or omission. If there are manufacturer's or clinical guidelines, a Court will consider whether the expert has addressed these and placed the defendant's conduct in their context. There are 2 other points which arise in this case which I would mention. First, a matter of some importance is whether the expert opinion reflects the evidence that has emerged in the course of the trial. Far too often in cases of all sorts experts prepare their evidence in advance of trial making a variety of evidential assumptions and then fail or omit to address themselves to the question of whether these assumptions, and the inferences and opinions drawn therefrom, remain current at the time they come to tender their evidence in the trial. An expert's report will lack logic if, at the point in which it is tendered, it is out of date and not reflective of the evidence in the case as it has unfolded. Secondly, a further issue arising in the present case emerges from the trenchant criticisms that Mr Spencer QC, for the Claimant, made of the Defendant's two experts due to the incomplete and sometimes inaccurate nature of the summaries of the relevant facts (and in particular the Clinical Notes) that were contained within their reports. It seems to me that it is good practice for experts to ensure that when they are reciting critical matters, such as Clinical Notes, they do so with precision. These notes represent short documents (in the present case two sides only) but form the basis for an important part of the analytical task of the Court. If an expert is giving a précis then that should be expressly stated in the body of the opinion and, ideally, the Notes should be annexed and accurately cross-referred to by the expert. If, however, the account from within the body of the expert opinion is intended to constitute the bedrock for the subsequent opinion then accuracy is a virtue. Having said this, the task of the Court is to see beyond stylistic blemishes and to concentrate upon the pith and substance of the expert opinion and to then evaluate its content against the evidence as a whole and thereby to assess its logic. If on analysis of the report as a whole the opinion conveyed is from a person of real experience, exhibiting competence and respectability, and it is consistent with the surrounding evidence, and of course internally logical, this is an opinion which a judge should attach considerable weight to*."

26. A professional person is not to be judged by the wisdom of hindsight so the breach of duty should only be judged prospectively based upon what was known or ought to have been known.

NICE Guidelines

27. The National Institute for Health and Care Excellence ("NICE") in a document entitled "Intrapartum care: Care of healthy women and their babies during childbirth" issued in September 2007 includes the following:

> "*1.6. Normal labour: first stage*
>
> *1.6.1. Clinical intervention should not be offered or advised where labour is progressing normally and the woman and baby are well.*
>
> *…*
>
> *Definition of the first stage*
>
> *1.6.3. For the purposes of this guideline, the following definitions of labour are recommended:*
>
> - *Latent first stage of labour – a period of time, not necessarily continuous, when:*
>
>  – *There are painful contractions, and*
>
>  – *There is some cervical change, including cervical effacement and dilatation up to 4cm.*
>
> - *Establish first stage of labour – when:*
>
>  – *There are regular painful contractions, and*
>
>  – *There is progressive cervical dilatation from 4cm.*
>
> *…*
>
> *Observations on presentation in suspected labour*
>
> *1.6.6. The initial assessment of a women by midwife should include,*
>
> - *Listening to her story, considering her emotional and psychological needs and reviewing her clinical records.*
>
> - *Physical observation – temperature, pulse, blood pressure, urinalysis.*
>
> - *Length, strength and frequency of contractions.*
>
> - *Abdominal palpation – fundal height, lie, presentation, position and station.*
>
> - *Vaginal loss – show, liquor, blood.*

- *Assessment of the woman's pain including her wishes for coping with labour along with the range of options for pain relief.*

*…*

*1.6.8. Some women have pain without cervical change. Although these women are described as not being in labour, they may well consider themselves 'in labour' by their own definition. Women who seek advice or attend hospital with painful contractions but who are not in established labour should be offered individualised support and occasionally analgesia, and encouraged to remain at or return home.*

*1.6.9. The use of admission cardiotocography (CTG) in low risk pregnancy is not recommended in any birth setting.*"

The Defendant's midwife assessment triage

28. Under the heading "Telephone triage and risk assessment" the following appears:

"*All women who call the MAT should be given sufficient time on each telephone call for the midwife to make an assessment of her needs. Using the telephone triage proforma (see Appendix 1) the MAT midwife must elicit and document the following information in order to carry out a thorough risk assessment:*

- *Reason for the call*
- *Parity and gestation*
- *Previous obstetric history (including type of previous birth; any major complications)*
- *Recent obstetric history (including singleton/multiple pregnancy; current complications)*
- *Relevant medical history*
- *Presence/reduction/absence of fetal movements*
- *Presence, length, strength and frequency of contractions*
- *Any PV loss (SROM; PV bleeding, including description of loss*
- *Assessment of coping strategies.*

*On the basis of this telephone conversation the midwife will use her clinical judgment to recommend whether the woman:*

- *Remains at home*
- *Gets referred to community services (GP, community midwife)*
- *Attends for a face-to-face assessment.*

*When making this representation the midwife should bear in mind the NICE recommendation that women in early labour should be advised to remain at home as long as possible. To enable women to remain at home for as long as possible, it is helpful to provide them with reassurance as to what they are experiencing and make suggestions of coping strategies that will help (see the Labour Triage Handbook for further guidance).*"

29. The document includes at Appendix 2 a flow diagram of admissions into maternity department which includes the following steps: Assess woman in MAT area, if the woman is not in established labour is the woman willing to go home to await events. If yes, allow home with instructions of when/how to call back. If no, triage woman to Thameside Anti-Natal Area to await events. Agree on management plan if situation remains the same.

Root Cause Analysis Investigation Report

30. The Defendant conducted an investigation entitled "Root Cause Analysis Investigation Report" into the care given to PXW and his mother. Under the heading "Terms of Reference" the purpose of the investigation was said to be to identify the root causes and key learning from the incident and to use the information to significantly reduce the likelihood of future harm to patients. Objectives included to establish the facts, that is to say, the root causes and to establish whether failings occurred in care or treatment. The methodology included gathering information in the form of statements, interviews and hand-held notes.

31. Under the heading "Care and service delivery problems" the following appears:

- "*A full history of assessment of a multiparous woman was not undertaken by the midwife in triage prior to sending the woman home.*
- *The woman's transport arrangements were not considered.*
- *The emergency bell was not pulled in the delivery room.*
- *The resuscitator is placed in a corridor outside the delivery room requiring the baby to be taken from the room for resuscitation.*"

32. Under the heading "Contributory factors" the following appear:

- "*The assessment which took place in Maternity Triage might have indicated the need for admission;*

- *The communication skills and the advice of the midwife in triage may have influenced the decision of the couple to delay returning to the Maternity Unit;*

- *The woman was a para 2, therefore she was more likely to progress quickly once in established labour.*"

33. Under the heading "Lessons learned" the following appears:

> "*Multiparous women in early labour should be given the option to mobilise for an hour in the Maternity Unit and be clinically reassessed prior to discharge home.*
>
> *When midwives are taking a clinical history they should also consider any social factors such as transport which may have an impact on their ability to access the service.*
>
> *If a baby is delivered in poor condition with no respiratory effort, the emergency bell should be pulled at the time of delivery.*"

34. Under "Conclusions" the following appears:

> "*Recommendations*
>
> - *Reflection by the midwife in triage with the manager of the midwifery led area to improve her communication skills.*
>
> - *A full Supervisor of Midwives investigation to be undertaken to review and highlight midwifery practice issues.*
>
> - *All midwives must pull the emergency bell as soon as a baby is delivered in poor condition in order to summon immediate assistance and enable to midwife to remain with the mother in the room.*
>
> - *To consider the installation of Cosi Cabinets on the midwifery led unit to ensure that babies are not unnecessarily separated from their mother when resuscitation is required.*"

Adequacy of the Assessment in Triage Unit

35. The factual witnesses in respect of the assessment in the Triage Unit are RXF and MXW and Midwife Truu.

36. The substance of RXF's evidence and indeed that of MXW was that on the morning of 15 March she phoned the unit to say that things seemed to be getting started and she was told to wait until she needed to come in and that, based on a pattern of contractions, intensity and previous experience, she decided to do this in late afternoon, phoning on route. She and her partner arrived at the unit at 17:40 having been driven by her father and, at her request, dropped at the Kingston Gate, her intention being to walk the remaining distance (of about a half to three-quarters of a mile) to the Hospital to help manage the pain of her contractions. On arrival she let the midwife know that she was finding the contractions intense and it was getting hard to cope. She also mentioned having been admitted on two previous labours and having had her waters artificially ruptured to regularise the contractions. She did not recall any exchange about analgesia and nor did MXW but neither sought to dispute the accuracy of the record.

37. After a clinical assessment the midwife was, she said, firm in her advice that she should go home and not return until contractions were occurring at regular intervals of two minutes or less.

38. As with her previous two pregnancies, she had begun to keep a record of her contractions and that record was continued by MXW who drew the midwife's attention to the fact that, according to that record, some of the contractions were at intervals of two minutes or fewer and some were strong but the midwife did not ask to see the notes.

39. During the course of cross-examination RXF agreed that the midwife's note of contracting two to three in ten minutes since 17:15 was in fact accurate and that the contractions were milder than those which she subsequently experienced at her father's apartment and irregular. Neither RXF nor MXW suggested that they actively asked that RXF be admitted, nor did they raise any concerns about transport, as MXW put it in re-examination, they accepted what they were told because from the demeanour of the midwife and the way she presented it, she had a very firm and fixed plan about what they should do. They deferred to her.

40. When they left the Hospital they did not quite know what to do so decided to walk to Norbiton station, which is about half a mile away from the Hospital. On the way, they had to stop several times because of continuing contractions, many of which were intense. On reaching Norbiton station, they decided it would be unwise to take the train so MXW phoned RXF's father and asked that he collect them, which he did.

41. In her witness statement Karin Truu explained that she had no independent recollection of the events and that her statement was based entirely on her review of the medical records and her standard practice at the time. She said that on reviewing RXF she followed the Hospital and NICE guidelines taking a verbal history, she carried out maternal observation and noted that RXF described the contractions as being period like, lower abdominal and back pain, with intervals of about two to three in ten minutes. She also performed a vaginal examination, having obtained RXF's consent, the findings of which were consistent with the latent stage of labour. Her usual explanation about the latent phase was often the pain started off in the back and you could feel period type aches and pains which increase in strength and turn into contractions. These contractions could stop and start varying in frequency, strength and length and the aim was to get established labour which was when the cervix was

dilated to at least four centimetres with strong and regular contractions. She noted that she had asked RXF if she required any analgesia but she had declined. She followed her usual practice of advising RXF to call or return if labour was established or if there was an increase in strength and length of contractions, spontaneous rupture of membranes or any reduced fetal movement, vaginal bleeding or other concerns. She also indicated that if RXF had expressed any concerns she would have documented them in the notes. She also noted that her assessment appeared to have taken about 25 minutes and that such assessments usually took her between 25 and 35 minutes.

42. It was the view of Mrs Reading that the time taken by Midwife Truu to assess RXF, whether that be 15 minutes or 25 minutes, was inadequate properly to assess and enable an effective decision to be made. In her view, RXF should have been advised to remain for observation to take place. She was also critical of the midwife's failure to ascertain whether or not RXF had access to transport.

43. Ms Reeves for the Defendant agreed that 15 minutes would not be a sufficient amount of time to assess the progress of RXF's labour but not if, as Midwife Truu stated, the assessment took around 25 minutes. She also did not agree with Mrs Reading about the issue of transport, since she took the view that it was reasonable to expect the woman to flag up transport if that was an issue. Moreover, following what appeared to be a thorough assessment including palpation and vaginal examination, the midwife concluded that RXF was in the latent phase of labour and, as such, it was in her view reasonable to allow her to go home so long as she was advised on when to return. As she put it in cross-examination:

> "*So based on the clinical findings, so you don't – you do listen to what the woman's preference is, but it would be impractical to keep every woman that might like to stay in a Maternity Unit, when the clinical findings don't support that decision, and it is – you know – it is that total picture, so it's not just the regularity of the contractions, it's the palpation, it's the engagement of the head and the vaginal examination, and it's the whole combination.*
>
> *So what's really important is that there is a dialogue but that the woman understands that the midwife has made a clinical assessment that she is in the latent phase and, therefore, there is no requirement, and in fact, it's advised that she return home to mobilise. That is completely reasonable clinical advice.*
>
> *So based on the total clinical picture, combining all of the factors that the midwife assessed, so the palpation, the fetal wellbeing, the cervical situation which was unchanged, it is important to listen to the woman, but the clinical findings indicated that she was not in established labour.*
>
> *Now, if the woman had said 'I absolutely do not want to go home and I want to mobilise, I want to stay here for a while', the woman – you know, of course, you would listen to that view, but you would also say, 'actually, it's really important that you*

> *mobilise and actually, you might be more comfortable to do that' and if she did stay in the vicinity of the hospital mobilised that would be completely reasonable and that might have been a compromise. But you certainly wouldn't be considering admission.*"

44. I should add that Mr Brunskill, although accepting that this was primarily a matter for midwifery experts, nevertheless expressed his view that the decision to discharge RXF was premature. As he put it:

> "*At the very least, given her transport problems, she should have been offered the opportunity to stay for a short period to see if labour became established. Preferably however she should have been advised to remain in Hospital. Discharging [RXF], without giving her any opportunity to remain in hospital, in my opinion constituted care below an acceptable standard.*"

45. Mr Tuffnell, obstetrician instructed by the Defendant, deferred to the midwifery experts.

46. What is said on behalf of the Claimant is that the clear inference from the midwifery notes is that, after an assessment of 15 minutes, Midwife Truu had formed a plan to send RXF home and that was, on the agreed evidence of both midwives, an inadequate period of time to assess RXF. Moreover, and in any event, regardless of its length, the assessment was also inadequate because Midwife Truu failed to listen to what she was being told by RXF and MXW and did not pay sufficient attention to what they had to say in particular about the contractions and did not explore with them whether or not they were happy to go home and await events.

47. Reliance was placed on the conclusions of the Root Cause Analysis Investigation Report, namely that a full history and assessment of a multiparous woman was not undertaken by the midwife in triage at the time and RXF was sent home and the short time she stayed in triage (25 minutes) was not long enough to assess and determine her needs and on the contents of the Hospital's own flow chart, in particular, the step which it is said should be taken if the woman is not willing to go home and await events, namely triage the woman to Thameside Ante-Natal area to await events and agree on management plan if situation remains the same.

48. In all the circumstances therefore it was submitted on behalf of the Claimant that the assessment was inadequate and failed to take into account the history of contractions and what RXF felt about the progress of her labour as well as her circumstances and wishes.

49. The first issue to determine is the length of time of the assessment. Midwife Truu in her witness statement puts it at 25 minutes and that is the period identified in the Root Cause Analysis Investigation Report. The actual note is not timed. RXF and MXW accepted that following the completion of the vaginal examination (the note for which is timed at 18:10) there was a period of discussion with Midwife Truu prior to their leaving the unit at 18:20. Moreover, on analysis there is very little between RXF and MXW on the one hand and Midwife Truu on the other, save for Midwife Truu's noted

description of the contractions as mild and, as counsel for the Defendant submitted, whether contractions are mild or moderate or strong is something that a lay person may not have the same perspective on as an experienced clinician such as Midwife Truu, who is accustomed to assessing the strength of contractions on palpation at every stage of labour with very many different women and thereby can be taken to have a more objective overview than the woman who is herself experiencing the pain or indeed her partner. In the circumstances, as it seems to me, therefore, I can safely rely on the statement of Midwife Truu as an accurate account given that it is consistent with the contemporaneous notes written at the time and there is very little of what she says with which the parents take issue and that PXW's parents accept that there was a period of discussion with the midwife after the completion of the clinical examination and before they left the Unit. On the balance of probabilities therefore, I conclude that the length of the assessment was 25 minutes.

50. The real issue between the parties is as to the adequacy, not the duration of the assessment. RXF had had two previous uneventful pregnancies and normal births. Her pregnancy with PXW in the ante-natal period was straightforward. On any view, she was a low risk at the time of her presentation in the Maternity Assessment Unit. She was plainly in the latent phase of labour. RXF was able to give a clear history. She had been able to walk the half to three-quarters of a mile to the Hospital from the Kingston Gate. Neither RXF nor MXW suggest that they actively asked that RXF be kept in, nor that they raised any concerns about transport. Clearly they had expectations that RXF would be admitted but that does not render the advice given unreasonable.

51. Importantly, Midwife Truu's clinical judgment was that RXF was in the latent phase of labour and therefore the advice which she gave was in line with national and local guidance.

52. Both Ms Reeves and Mr Tuffnell in their reports and their oral evidence expressed the view that there was no clinical indication to keep RXF in hospital and in those circumstances it was submitted on behalf of the Defendant that it would be contrary to public policy for this court to find that it was negligent not to admit a woman to hospital who did not require hospital admission merely because that was her unstated desire and because the midwife had not elicited this from the mother despite the fact that neither the mother nor her partner had articulated her desire to remain in hospital, nor had they raised any concerns about transport.

53. For my part I can see force in that submission and in the submission that to impose a positive duty of care to make enquiries as to transportation concerns, at least in the context of an urban hospital, would be to impose too high a duty, would not be fair, just or reasonable. After all, RXF and MXW had arrived at the Hospital independently which suggested the absence of any transport difficulties and the midwife would have no reason to anticipate such difficulties prospectively.

54. But what of the view expressed by Mrs Reading that even an assessment of 25 minutes was inadequate? I have to say that I found Ms Reading's evidence to be unsatisfactory in a number of regards:

    i) Her criticisms of Midwife Truu were predicated on the basis that RXF's different account was fact rather than one of two disputed accounts;

ii) She repeatedly applied hindsight to justify her criticisms;

iii) She was partisan rather than impartial, she offered opinions which strayed beyond her expertise and was at best evasive when challenged about her opinions as to the appropriateness or otherwise of requesting a urine sample before undertaking a fetal examination. Her opinions also seemed to shift when, for example, in her oral evidence she suggested that auscultation should occur when the contraction was wearing off, rather than after contraction, which had been her expressed view in her report and is the position in the NICE guidelines. To my mind this very late change of view damaged her credibility generally.

55. Moreover, I accept the submission made on behalf of the Defendant that she appeared to elevate what she thought was possibly achievable to the status of what was required of midwives who were caring for RXF, for example on the issue of whether or not Midwife Truu should have investigated RXF's transportation options, as well as on the issue of whether or not it was mandatory to auscultate within two minutes of arrival (the second admission) notwithstanding the absence of any evidence to support such a contention.

56. To my mind, in the particular circumstances of this case, Mrs Reading's persistence in supporting the allegations of breach of duty as against Midwife Clarke and Midwife Cort fundamentally undermine her credibility as a reliable expert witness when it comes to considering the Claimant's case in respect of Midwife Truu's management of RXF.

57. By contrast, I found the evidence of Ms Reeves to be compelling. She was measured and thoughtful and was someone whose opinions I could safely accept.

58. I have no hesitation in preferring the evidence of Ms Reeves to that of Mrs Reading and indeed Mr Brunskill on this issue and I am satisfied on the balance of probabilities that all the necessary checks of maternal and fetal wellbeing were completed within the period of the assessment that Midwife Truu carried out and those assessments were sufficient to confirm that RXF was in the latent phase of labour and there was no clinical indication to advise staying in hospital. That advice was in accordance with the Defendant's and the NICE guidance and prospectively RXF's pregnancy was, as I have indicated, low-risk and uncomplicated.

59. The Claimant's reliance on the conclusion of the Root Cause Analysis Investigation Report is to my mind misguided. As was submitted on behalf of the Defendant, it was prepared without any account from Midwife Truu. No interviews were carried out and no hearing and the purposes of the report were very different, namely to identify any shortcomings in practice and to improve standards of best practice. It does not apply the legal test for negligence and of course does not consider either the local or national guidance. Equally, reliance on the flow chart is misplaced in circumstances where RXF did not in fact articulate a desire not to be sent home but rather accepted Midwife Truu's clinical judgement.

60. It follows, in my judgment, that the Claimant has failed to establish any actionable breach of duty and the claim therefore fails.

Causation

61. I turn now to consider the issue of causation, albeit relatively shortly, having regard to my findings on the issue of breach of duty.

62. The opinion of Mr Brunskill, on behalf of PXW, expressed at paragraphs 4.1.23 to 4.1.30 of his report can be summarised in this way. Given the likelihood, on the balance of probabilities, that the acute episode of cord occlusion was preceded by a period of non-damaging cord compression caused by the cord being compressed between the presenting part, i.e. the head and the maternal pelvis, this would have been detected on auscultation by means of decelerations in the fetal heartrate following contractions, which would have resulted in the immediate commencement of external fetal monitoring with any significant abnormalities in the CTG trace resulting in an obstetric referral and appropriate action.

63. Thus, after initial auscultation at 19:30, and, assuming the CTG was commenced at 19:45, abnormal findings would have resulted in a call for an obstetrician by 20:00, obstetric review by 20:10 and the characterisation of the CTG as pathological. This in turn would have led to fetal blood sampling if full dilatation was not confirmed involving an artificial rupturing of the membranes which itself would have expedited labour and delivery. Assisted or instrumental delivery would, on his analysis, have been accomplished by 20:43, thereby avoiding any brain damage.

64. Mr Brunskill accepted that this analysis was necessarily a reconstruction of what he considered should have happened.

65. Mr Brunskill summarised his position in the course of his oral evidence in this way:

> "*It's been my view right from the beginning in this case, and I expressed it in these terms, that where there is a labour that progresses in this manner and where the woman is being properly monitored in accordance with the guidelines, it will be inevitably the case that abnormalities will be detected in time to allow for timely intervention. Now that remains my view as an obstetrician…*"

66. In the joint statement, Mr Brunskill expressed the view that there would have been prolonged decelerations persisting beyond the end of the contractions prior to the rupture of membranes provided, as he said should happen, listening was commenced as the contractions were waning rather than after they had ceased. This was a material change in his position which he maintained in his oral evidence to the court and is not in accordance with the relevant NICE guideline, or indeed the Defendant's own guidance which provides for intermittent auscultation after the contraction. It was submitted on behalf of the Defendant that Mr Brunskill's only motive for this shift was his realisation, following discussions with Mr Tuffnell, that Mr Tuffnell was correct in his opinion that short variable decelerations with contractions were not detectable by intermittent auscultation. To my mind there is some force in that submission.

67. Mr Tuffnell, in his report, expressed the view that it was relatively uncommon for the cord to become occluded whilst the membranes were intact and most commonly

occurred once the membranes had ruptured with the consequent release of the liquor. If that were the mechanism then on the balance of probabilities any fetal heartrate readings between 19:30 and 20:45 would have been normal and hence there would have been no cause for intervention. However he went on to accept that intermittent cord compression is commonly seen in labour and results in variable decelerations identifiable on a CTG trace. Such decelerations can be tolerated without hypoxic damage. He accepted the probability that initially cord compression was intermittent and non-damaging but expressed a clear view that they would not have been identified by intermittent auscultation because any decelerations would not have persisted after a contraction prior to the rupture of membranes. Prolonged variable decelerations were unlikely and even if possible it was very unlikely that they would be atypical variable decelerations.

68. Mr Tuffnell addressed these issues further in his supplementary report where he again made the point that cord compression tends to cause decelerations that begin with a contraction and more often than not the deceleration ends by the end of the contraction. Such decelerations would not be detected by intermittent auscultation. For detection they would have to be prolonged and would lead to the trace being classified as pathological if present with more than 50 per cent of contractions for more than 30 minutes.

69. In the joint statement, Mr Tuffnell he expressed the view that it would be unlikely that auscultation would have identified any abnormality in effect prior to head descent just before the rupture of the membranes. In his view, therefore, it was unlikely that abnormalities would have been identified as early as 20:00 but even if they were, they would have to be present for 30 minutes for the trace to be considered pathological.

70. Mr Tuffnell also expressed the view that it was extremely unlikely that RXF was fully dilated as early as 20:10 or 20:20 as was canvassed by Mr Brunskill. If that be right then even if there were abnormalities detected at 20:10 and the obstetrician was called and fetal blood sampling took place this would involve the rupture of the membranes and with rapid progress of labour and rapid descent of the presenting part, the onset of the fetal bradycardia of a similar duration to that which occurred, if not longer. As he put it in his report:

> "*In order to alter the outcome he would have to reduce the duration of the bradycardia and simply bringing forward the time of birth does not do that unless you reduce the time period from the onset of bradycardia to birth. Due to the mechanism of injury, changing the approach by early rupture of the membranes or in response to the onset of bradycardia could not reduce the duration of bradycardia as it seems that the duration of bradycardia is only just over ten minutes including a post-natal element.*"

71. During the course of cross-examination Mr Brunskill accepted that intermittent cord compression would not commonly occur before rupture of the membranes and that CTGs are rarely commenced in the absence of membrane rupture but notwithstanding that fact he would not accept that the risk of such intermittent cord compression occurring repeatedly for more than 50 per cent of the time was much lower before rupture. It is difficult to see the logic of Mr Brunskill's position on this point.

72. In closing submissions, counsel for the Defendant made a number of criticisms of Mr Brunskill's evidence. They include:

i) That gynaecological oncology was his special interest, that he retired from full-time practice in 2009 which itself came after two periods of extended leave lasting four and seven months respectively when he was doing no clinical work and that he had never in his entire career held a substantive obstetric post where he was in charge of a labour ward;

ii) The units where Mr Brunskill worked had much lower birth rates than the Hospital's 5,800 per annum or 6,000 plus per annum at the hospital where Mr Tuffnell works;

iii) Mr Brunskill had published no papers, given no lectures and had not been involved in the drafting of any of the national guidelines all of which could be contrasted starkly with the position of Mr Tuffnell whose career had been focused on the labour ward and who had been involved in the drafting of the relevant NICE guidelines and their update;

iv) He strayed beyond his expertise in judging the midwifery notes and in offering opinions on breach of duty relating to Midwives Clarke and Cort so far as their contemporaneous notes were concerned;

v) He was partial in raising pure credibility points about the records showing a surprising degree of chronological detail;

vi) He applied hindsight repeatedly in volunteering his opinion about what Midwife Truu should have done;

vii) He plainly regarded the definition in the NICE guidance of the established first stage of labour as commencing at four centimetres of dilatation as a millstone and did not appear to appreciate or respect the need to differentiate between women in the latent phase of labour and the established phase of labour in order to deliver safe care to those who needed it most;

viii) He strayed beyond his expertise and sought to decide questions of pure fact which were contrary to the evidence.

There is significant force in those submissions.

73. But what of counsel for PXW's criticism of Mr Tuffnell based on his adherence to the view that it was the rupture of membranes which led to the change in the fetal position and hence to the cord compression and the bradycardia in circumstances where it was submitted that the occlusion must have started before the rupture of membranes? The difficulty with this argument is that it is not known exactly when the membranes did rupture. The note on which reliance is placed for the timing of 20:48 actually records what was seen when Midwife Clarke was called to the bathroom at that recorded time. Logically the rupture must have preceded that time. Moreover, in the joint statement Mr Tuffnell did discuss the possibility of the bradycardia commencing with head descent and prior to membrane rupture.

74. It is also to be borne in mind that there is no causation evidence to demonstrate that there were in fact any fetal heartrate abnormalities which preceded the acute profound hypoxic event near the end of labour as might have been the case if there was any clinical or neuroradiological evidence of chronic partial damage.

75. To my mind, accepting as I do the force of the Defendant's submissions on this issue, the case put forward on PXW's behalf lacks any coherence, is unrealistic and in many respects contrary to the evidence and results, as it seems to me, from a failure to understand what a CTG would, and would not, show and whether or not any trace would have been non-reassuring or rather suspicious or pathological and indeed when a CTG would be utilised.

76. PXW's case is pleaded, no doubt on the basis of the opinions of Mr Brunskill, on the basis that the trace would have become pathological by 20:10 but was also non-reassuring/pathological despite the fact that those are different classifications requiring different responses. There is also a reference to a concept of increasingly pathological and there is also plainly confusion between atypical variable and late decelerations which are in fact materially different with late decelerations having no bearing on this case as they are, as Mr Tuffnell pointed out, indicative of a placental problem and not of a cord occlusion. These evident confusions cast significant doubt on Mr Brunskill's competence in this area.

77. Moreover, in the joint meeting Mr Brunskill also accepted that had a CTG been in place it would not have become pathological by 20:10. Rather it would have been, in his view, suspicious mandating further observation, which again demonstrates muddled thinking.

78. It also became clear from the cross-examination of Mr Brunskill that he accepted that variable decelerations would be typical at the beginning; that variable decelerations which are short with a quick recovery would not be heard on auscultation and that atypical variable decelerations are in fact non-reassuring and not pathological and that they do not go from normal to non-reassuring or rather suspicious and then to pathological.

79. I have no hesitation in preferring the evidence of Mr Tuffnell on these various aspects. His evidence was authoritative, objective and highly persuasive reflecting, in my judgment, his much greater relevant experience and learning.

80. It is to be noted that, although by no means determinative, the amniotic fluid released following the spontaneous rupture of membranes was clear, suggestive as Midwife Clarke explained in her evidence, that there was no meconium present which might have been present if there had been fetal distress. The absence is a reassuring sign and, at best, is inconsistent with Mr Brunskill's theory of a significant period of intermittent cord compression preceding a period of total acute cord compression.

81. It is also to be noted that Prof Mitchell for the Claimant did not support Mr Brunskill's theory since in his view this was and always had been an isolated acute profound insult at the end of labour preceded by intermittent cord compression in the moments leading up to the total acute hypoxia and not in the preceding hour and a half.

82. I find myself equally unable to accept Mr Brunskill's opinion that RXF had in fact reached full dilatation much earlier than the time when it was first noted by Midwife Clarke at 20:50 when she could see that the vertex was visible and advancing. That evidence was not challenged, moreover as I have recorded, Mr Tuffnell disagreed with Mr Brunskill on this aspect pointing out the inherent unlikelihood of the timing of the first and second stages of labour of such proportions. For my part, I accept the suggestion that it would be unlikely that RXF had an active first stage of labour of only 50 minutes (from about 19:30 to 20:20) and then a second stage of 37 minutes particularly having regard to the contents of the Abalos paper and on the balance of probabilities I conclude that RXF probably reached full dilatation shortly after arrival at the Hospital and in any event by 20:50 hours.

83. That as counsel for the Defendant submitted is entirely consistent with Mr Tuffnell's oral evidence and with logical analysis since the mechanism of the injury, namely descent of the presenting part causing an occlusion of the cord against the maternal pelvis, would in all probability have happened at about the time of full dilatation and membrane rupture which on the balance of probabilities, having regard to the totality of the evidence, must have been after 20:45 and before 20:48 and therefore at 20:46 or 20:47.

84. The reality of the situation is that had RXF been admitted to the Hospital's Maternity Unit at or about 18:20 the eventual outcome would have been the same. Intermittent auscultation would not have identified any abnormalities as early as 20:00 and there would therefore have been no cause to commence a CTG.

85. A fundamental flaw that flows through the Claimant's case, as counsel for the Defendant submitted, is that it is predicated on the assumption that the injury to PXW resulted from precisely ten minutes of non-damaging hypoxia followed by five minutes, according to Prof Mitchell, of damaging hypoxia yet plainly these durations are proximations at best.

86. In the light of my findings on this aspect there is no need to go on to consider the neonatologist's evidence. Had I had to do so, I would have preferred the evidence of Dr Emmerson where it differed from that of Prof Mitchell since it was logical, well-reasoned and accorded with the evidence, including the absence of any evidence of any partial chronic hypoxia preceding the cord occlusion.

Disposal

87. For all of these reasons, therefore, I would dismiss this claim.

88. I trust that the parties will be able to agree the terms of an order that reflects the substance of this judgment including the issue of costs.

89. Finally, I would like to take this opportunity to thank all counsel for their enormous assistance with this case.