Case No: HQ14C05097

Neutral Citation Number: [2016] EWHC 1101 (QB)
IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 12/05/2016

Before :

MR JUSTICE NICOL

- -

Between :

Claire Manzi	**Claimant**
- and -	
King's College Hospital NHS Foundation Trust	**Defendant**

- -
- -

Leanne Woods (instructed by **Leigh Day**) for the **Claimant**
Luka Krsljanin (instructed by **Kennedys**) for the **Defendant**

Hearing dates: 25th, 26th, 28th & 29th April 2016

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Judgment

Mr Justice Nicol:

1. This was the trial of a claim for clinical negligence against the Princess Royal Hospital ('the Hospital' – now the responsibility of the Defendant) where, on 6th April 2011, the Claimant gave birth to her second child, Harry. In brief, the Claimant alleges that the registrar who attended her, Dr Ali, negligently failed to see on an ultrasound scan ('USS') after the birth that she had failed to deliver a substantial part of the placenta. As a result, it is said, she suffered pain and, on 21st April 2011, had to have the piece of the placenta removed under a general anaesthetic following which she also suffered a distressing haemorrhage. As a result, she says, she suffered two periods of Adjustment Disorder. The first was for about 1 year after Harry's birth. The second was when she was pregnant with her third child, Elsie, and lasted for about 8 months until that child was born. There are claims for pain and suffering, lost income, care and other incidental expenses.

2. The Defendant accepts that a small piece of placenta may have been retained after Harry's birth, but says that it was not substantial. What was removed on 21st April was this small piece together with blood which had clotted and accreted around it. Consequently, the Defendant says, there was no negligence by Dr Ali. Alternatively, if that was wrong, and Dr Ali should have identified that a substantial piece of placenta remained in the Claimant's uterus, it is not accepted that the Claimant would have agreed to undergo another operation to have it removed so soon after she had given birth when there was the possibility that even a substantial piece of retained placenta would have passed out of her without medical intervention. The length of time that the Claimant suffered from an Adjustment Disorder is disputed as is the quantification of the other items of loss. The trial was of both liability and quantum.

3. The parties were agreed that a critical issue of fact was whether on 6th April the piece of placenta which was retained was no more than small or whether the piece of placenta was substantial. For these purposes, the parties agreed that I should treat 'small' as around 2 cm long and 'substantial' as about 7 cm.

The factual evidence regarding the size of the piece of retained placenta

4. The Claimant's pregnancy with Harry proceeded normally and uneventfully, although the GP noted in September 2010 that the Claimant was suffering from low mood and she had a depressive episode. She saw a psychiatrist in early October 2010 who diagnosed an Adjustment Disorder and she had a follow-up psychiatric assessment in early November 2010.

5. She was under the Defendant's care during her pregnancy. On 22nd March 2011 her haemoglobin level was measured at 13.2 g/dL.

6. She was admitted to the Hospital at 0010 on 6th April 2011 and reported that at that stage she had been experiencing contractions for about 2 hours. She gave birth to Harry at 0630. The midwife noted that the baby was delivered in poor condition with little colour or tone.

7. At 0647 the midwife noted that the third stage of birth (i.e. the delivery of the placenta and membranes) was achieved by controlled cord traction ('CCT') i.e. by pulling on the umbilical cord. The notes are contradictory as to whether the placenta was or was

not complete. The printed Summary of Labour form gives the two alternatives and 'incomplete' (rather than 'complete') has been circled. However next to that, the midwife has written 'complete – USS by SpR [ultra sound scan by Specialist Registrar]'. In the narrative notes, Midwife Harrison wrote

> 'Placenta and membranes delivered by CCT. Placenta delivered in pieces ? complete, membranes ragged. Uterus w/c [presumably 'well contracted'], lochia normal.'

8. In a retrospective note (but still within the midwife's notes) Midwife Janett Barrow wrote, 'Taken over care at 0720. History noted re placenta Dr Ali bleeped and asked to scan re ? placenta incomplete.'

9. It would seem that Dr Ali saw the Claimant at 0730. His notes recorded that she was comfortable, her uterus was contracted and there was no bleeding through the vagina. He noted that the placenta seemed to him to be complete and the membranes appeared ragged. He prescribed antibiotics for 7 days and told the Claimant that she should have a follow-up appointment in two weeks' time and if there were any problems she should call the midwife.

10. Dr Ali's contemporary medical notes make no mention of a USS being performed at this stage, but the Claimant says that this did occur. The Summary of Labour form also says that there was a 'USS by SPR [Specialist Registrar]'.

11. The Mother's Discharge Summary said of the placenta that,

> 'Condition: Other – friable broke in pieces at delivery, completeness: Incomplete – scan identified a 2 cm area of possible placenta left in situ.'
>
> 'membranes – Complete'

12. The Claimant says that she was told by the doctor that there was a piece of placenta retained, that it was about 2 cm, but that it would pass from her naturally and that she should keep an eye out for it as it would pass when she was going to the toilet.

13. Dr Ali qualified as a doctor in Syria. He practiced in Obstetrics and Gynaecology in that country and in Saudi Arabia for 11 years before coming to the UK in 2009. He was authorised to practice medicine here, but he was still undergoing basic training in the use of a USS. The curriculum vitae which he attached to his witness statement gave the dates when he attained all of his qualifications with the exception of the Ultrasound Intermediate Modules. That omission was just a mistake. He had obtained this qualification in 2012.

14. In his witness statement he said that he had been asked to examine the Claimant by the midwives because of their concern as to the completeness of the placenta and membranes after Harry's birth. He said that he visually examined the placenta and it seemed to be complete. The Claimant's uterus was well contracted which was also consistent with complete delivery of the placenta. He said that he was aware that immediately after the birth a USS was of limited help because blood clots could not be distinguished from retained products. Nonetheless, he did do a USS because he considered that this would be useful for him for his training. His usual practice would

be to explain to the patient the purpose of the scan and its limitations and to obtain her verbal consent. The scanner had a measuring device. The operator placed markers at two points and the machine automatically measured the distance between them.

15. In his oral evidence, Dr Ali agreed that he ought to have recorded the clinical reasons for performing a scan, the result of the scan and, if he was doing the scan for training rather than clinical purposes, a record of his explanation to the patient that this was so and her consent. He agreed that he had done none of these things.

16. Dr Ali said that he had very little recollection of his dealings with the Claimant. He was entirely reliant on the records which had been made.

17. Dr Ali said he had started the Claimant on antibiotics as a prophylactic because the membranes had been ragged and because it was good to put a safety net in place.

18. The Claimant had also suffered a tear to her perineum in the course of giving birth. This was painful and it had to be stitched up between 0930 and 1000 on the morning of 6th April 2011. Ms Barrow, the Midwife, recorded that the delay had been because the Delivery Suite had been very busy and she was looking after other women.

19. By 1030 the Claimant was expressing a wish to go home, but the midwife noted that she 'need to be observed for some hours re ? incomplete placenta and perineum.'

20. In the event, the Claimant was kept in overnight. At 0920 on 7th April 2011 the midwife recorded that the Claimant's uterus was well contracted. She had passed one blood clot the previous day but none on 7th April. The Claimant was discharged on 7th April 2011 at 1157. In her witness statement, the Claimant said that the day after the birth she continued to bleed very heavily, so much so that at one point the bleeding soaked through both the maternity pad she was wearing and the pad she was sitting on. The blood soiled the sheets on the bed.

21. The Community Midwife visited the Claimant on 8th April 2011. She noted that the Claimant's perineum was tender and she gave advice regarding its care. She also noted 'Placenta 2 cm in area retained'. It is not suggested that the midwife undertook any investigation of her own to reach this conclusion. The likelihood is that the information was taken from the Mother's Discharge Summary. The midwife did comment that the uterus was well contracted and was not tender on palpation.

22. In her witness statement the Claimant said that after the midwife left that day the pain got worse and worse. She experienced a terrible cramping pain on her left side. The pain felt crippling and she had to lie on the floor for relief. She continued to be in pain over the weekend. The Claimant said that she was able to distinguish the pain in her abdomen from the pain as a result of the tear to her perineum.

23. The Community Midwife visited the Claimant again on Monday 11th April 2011. She recorded that the Claimant was 'complaining of intermittent pain on her left side, concerned re retained products, passed 2 clots last night, jelly like. Still taking [antibiotics]. Not tender to touch, to contact [the Hospital] for review, ? due to retained products. Perineum tender.'

24. The Claimant said that she understood the midwife had referred her back to the Hospital, but when she called the Hospital, they said she had been discharged and the Claimant should speak to her GP. The Claimant did so. The GP's notes record for 11th April 2011, 'Discussion, retained products, on [antibiotics], loss easing. But increasing pain left iliac fossa, and tender uterus ++ [midwife] tried to get her seen at [the Hospital], but told to see Dr first. [discussion with] gynaecological registrar, will see her at A and E.'

25. The Claimant went to the Accident and Emergency Department of the Hospital. As the attending doctor recorded, she reported left lower abdominal pain and she referred to 'retained small part of placenta'. It was noted that she was on painkillers.

26. The Claimant was then seen on the same day by an ST2 Senior House Officer who recorded that she was suffering from perineal pain, but had no abdominal pain. The uterus was well contracted and non-tender. The SHO's impression was that the perineal wound had broken down and there was 'RPOC' [Retained Products of Conception]. She proposed that the Claimant should continue with the antibiotics and be scanned in 2 weeks' time.

27. On about 13th or 14th April 2011 the Claimant found that she was no longer producing breast milk.

28. The Claimant was visited by a midwife at home on 18th April 2011. She observed that the Claimant's uterus was 'tender + +'. The midwife added, 'If Claire misses analgesia she is in pain + +'. The Claimant spoke to her GP as well on 18th April and told him of her pain. The Claimant says in her witness statement that over the next few days she continued to be in a great deal of pain and for that reason could not leave the house.

29. The Claimant went back to the Hospital on 20th April 2011. She was seen in the Accident and Emergency Department by an ST2 doctor who recorded that she was taking painkillers. 'No discharge but spotting and occasionally more bleeding for 5/7 [5 days]. Also increased left sided abdominal pain since Saturday. Moved around to lower abdomen. Constant dull ache but gets worse if not taking analgesia.'

30. On 20th April 2011 another USS was performed. On this occasion it was done by Claire Robinson who, at the time, was a senior radiographer. She was told that the clinical indications were '?RPOC [Retained Products of Conception]'. She performed a transabdominal scan, meaning that the probe was moved externally over the patient's abdomen as opposed to inserting the probe into the patient's vagina.

31. In her report Ms Robinson wrote,

> 'The anteverted uterus appears normal in size and shape for post partum patient.
>
> There is an echogenic area of ? retained placenta seen within the endometrial cavity measuring 7.0 x 2.2 x 4.4 cm. This area is surrounded by ? fluid/blood.
>
> Neither ovary seen. No adnexal cysts or masses demonstrated. No free fluid within the pelvis.'

32. In her witness statement Ms Robinson said that on occasions it can be difficult to differentiate between blood clot and changing or decaying placental tissue.

33. In her oral evidence, Ms Robinson explained that an echogenic mass is a solid mass. It shows up as a white area on the USS. That is noticeably different from liquid. The 'products of conception' consist of the foetus (or baby), the placenta, the amniotic fluid, and the lochia (watery blood left behind in the uterus after labour and which includes the breakdown from the lining of the womb). In this case, the echogenic mass had been a solid and so it was not liquid blood or lochia. It had some reasonably clear definition so that she was able to measure it. She had no present recollection of the examination at this distance in time, but she would have written '? Placenta' because she thought it was likely that the echogenic mass had been a piece of placenta of these dimensions although she could not be 100% sure. Her best estimate was that it was a piece of the placenta. She did draw a distinction between that mass and the fluid or blood which surrounded it.

34. At 1400 on 20th April one of the doctors in the Hospital noted that the Claimant had continued to have bleeding from her vagina and lower abdominal pain. On examination her lower abdomen was mildly tender. There was a discussion with the Claimant about 'ERPC' [evacuation of retained products of conception]. The Claimant signed a consent form for the evacuation of retained products of conception. Arrangements were made for her to be added to the theatre list for the following day. At some point on 20th April, the Haemoglobin level in the Claimant's blood was tested and was found to be 13.6 g/dL.

35. The Claimant went home but returned to the Hospital on 21st April 2011.

36. On that day she was seen at about 0830 by Dr R. Hooper (an ST1) who confirmed that the Claimant had no further questions and wished the procedure to go ahead. The Claimant agreed that Dr Hooper was quite a young doctor and explained to her that she would not herself be the surgeon.

37. The operation took place under a general anaesthetic. The consultant for the operation was Dr (or Mr) Hill and the Registrar was Dr (or Mr) Krueger. Dr Krueger's notes of the operation say,

> 'Operation performed: Evacuation of retained products of conception post partum
>
> Infected site of 2nd degree perineal tear, opened during procedure.
>
> 14/40 A/V bulky mobile uterus
>
> Cx [Cervix] open admits 1 finger
>
> Asepsis (drapes), bladder emptied, swab taken, digital separation of RPOC [Retained Products of Conception] from uterus
>
> Removal by sponge holding forceps,
>
> Suction curettage 12 to evacuate remains
>
> POC – H

Cavity empty

Haemostasis lowered (illegible)

Minimal spotting from cx antlip (vascular insert)

P [patient] home later if well, continue [antibiotic], chase swab re [illegible]…'

38. At 1230 on 21st April 2011 the Claimant was seen by the ST1 Dr Hooper whose note of the interview reads,

> 'Explained removed products with forceps approximately 8 cm. Suction curette to remove any further products. Slight degeneration of perineal tear. Swab taken. No complications.'

Dr Hooper also explained that the plan was for the Claimant to go home later that day, to continue with the antibiotics for 5 days and to be seen for a follow-up appointment in 6 weeks' time. Dr Hooper recorded that the Claimant was happy with that plan.

39. The Defendant did not serve a witness statement from Dr Hooper who could not therefore be called to give evidence.

40. In her witness statement the Claimant said she was spoken to by one of the doctors after the operation. The doctor told her that the placenta was a lot larger than expected and gave the measurements for it. The Claimant said she was shocked by this. In her oral evidence she said that the doctor had said the piece of placenta that was removed measured 8 cm. She agreed that she has heard the phrase 'Retained Products of Conception' or RPOC many times, but she denied that she had mistakenly thought such a phrase was used on this occasion. Prior to the operation she had begun to wonder whether the pain and the problems were a figment of her imagination. She was relieved by what the doctor said because it confirmed that there had been a real problem. Her partner, Lewis, had also been present, although he had not provided a witness statement or given evidence.

41. The discharge summary recorded that the diagnosis had been 'retained products', the operative procedure had been 'ERPC [Evacuation of Retained Products of Conception]', there had been no complications and she was to be reviewed in 4 – 6 weeks' time.

42. In her statement, the Claimant describes how she was driven away from the Hospital by her partner and they stopped in a car park. Her partner went to get some food. While he was away she started to bleed. She said that her clothes were soaked in blood. They returned to the Hospital. The Claimant says that the experience was very frightening and she thought she was going to die.

43. She was re-admitted at about 1500. Her estimated blood loss was about 1,000ml. Her uterus was observed not to be well contracted. The bleeding was managed by a propess pessary and she was given an infusion of syntocinon and intramuscular syntometrine.

44. The bleeding had stopped by 1620, although she was noted to be still very upset at 1800. She remained in Hospital for two nights and was discharged on 23rd April 2011.

45. 60mm of the haemorrhagic tissue from the operation was sent for histopathologic examination. The report of this sample found,

> 'sections show blood clot and partly necrotic placental tissue. Retained products of conception are confirmed.'

The expert evidence regarding the size of the piece of retained placenta

46. Professor Edward Shaxted gave evidence for the Claimant. He is a Consultant Obstetrician and Gynaecologist at Northampton General Hospital and has been a consultant in this field since 1984. He is responsible for 500 obstetric patients and about 1,000 gynaecological operations per year. He is now part time.

47. Dr Michael Maresh gave evidence for the Defendant. He has been a Consultant Obstetrician/Gynaecologist at St Mary's Hospital Manchester since 1986. He, too, now works part time.

48. The experts were agreed that while the placenta is a single entity, it is relatively common for it to be delivered in pieces after a birth. Regularly the pieces correspond to one of the 15-20 subdivisions of the placenta known as 'cotyledons'. The dimensions given in Ms Robinson's report would correspond to the approximate size of one cotyledon. On other occasions, the placenta might divide into smaller pieces or a smaller piece might be retained.

49. The experts also agreed that a USS could reliably distinguish between a solid and a liquid. If there was bleeding into the uterus then over time the blood would clot. As the blood became organised and more fibrotic it took on a more solid form. It was then more difficult to distinguish such a clot from tissue such as a part of the placenta. Distinguishing the two became harder over time, because tissue (such as a piece of placenta) which was retained after birth would become softer as it became necrotic.

50. If a substantial piece of placenta was retained in the uterus after birth then it would tend to inhibit the uterus from fully contracting. That in turn would tend to cause the woman to experience pain and prevent the blood vessels to which the placenta had been attached from fully healing and so lead to bleeding. While these were tendencies, Professor Shaxted thought, they were not the invariable consequences of retained placenta. There was, he said, a very loose relationship between bleeding and pain on the one hand and retention of a piece of placenta on the other. Dr Maresh agreed that the relationship between blood loss and the size of a retained piece of placenta was a loose one. It was possible but not probable for a woman with a significant piece of retained placenta not to have pain.

51. One indicator of blood loss was a decline in the level of haemoglobin. That could be seen, for instance, in the measurement of haemoglobin in the Claimant's blood on 22nd April 2011 (10.6 g/dL) by comparison with what it had been on 20th April 2011 (13.6 g/dL). In between the Claimant had suffered a major haemorrhage while in the car park on 21st April. By comparison, there had been no decrease in the haemoglobin level between 22nd March 2011 (when it had been 13.2 g/dL) and the 20th April (when it had been 13.6 g/dL). This tended to suggest that the Claimant had not suffered any major loss of blood between those dates.

52. The experts were further agreed that, if a substantial piece of placenta was present when Ms Robinson conducted her USS on 20th April 2011, it must also have been present on 6th April and a reasonably competent doctor in the position of Dr Ali should have seen it on the scan which he did then.

53. For Professor Shaxted, the operation note was an important pointer towards the Claimant having retained a substantial piece of placenta. The surgeon noted that he had separated the object from the wall of the uterus digitally. He had then grasped it with sponge-holding forceps. That was indicative of a reasonably substantial mass and one which was firm enough to be held with forceps. Had this been a blood clot (or substantially clotted blood) it would have been more the consistency of blancmange. The histopathological report had said that the tissue was partly necrotic. If that was the case, it would have been softer than at the time of birth, but it was still sufficiently firm for the surgeon to have used forceps to remove it. If what had been inside the Claimant's uterus had been a small piece of placenta surrounded by a blood clot, Professor Shaxted would have expected it to be capable of being removed by suction and for the surgeon to use this method for all of what was in the uterus.

54. While Professor Shaxted agreed that a blood clot could have adhered to the retained placenta, he thought it was more likely than not that the piece of placenta was larger than 2 cm. He observed that Ms Robinson in her report had identified the echogenic mass as '? Placenta'.

55. Professor Shaxted agreed that a blood clot could increase in size over time and could adhere to an object such as a small piece of placenta. If the echogenic mass which was removed on 21st April was a mixture of a 2 cm piece of placenta and adhered blood clot, the clot would have been about 5x2x4 = 40cc. To produce that size of clot would have required approximately double the volume of liquid blood i.e. about 80cc. Professor Shaxted agreed that there could have been this level of bleeding consistently with the Claimant's reported haemoglobin results.

56. Professor Shaxted also thought it significant that the Claimant had reported pain on one side of her abdomen. This suggested that it was caused by something other than the type of pains which women often experienced after giving birth. Dr Maresh, on the other hand thought that pain on the left side meant that it was not necessarily caused by the uterus. The cause of pain was unclear.

57. Professor Shaxted also thought it significant that, immediately after Harry's birth, the midwife had thought a piece of the placenta was missing. While the placenta was soft and malleable and, for that reason, the absence of a whole cotyledon would not be as obvious as one might think, on visual inspection it would have been reasonably obvious if a whole cotyledon had been missing. A piece of the size of 7 x 4.4 x 2.2 cm would have represented approximately one twentieth of the volume of the whole placenta. If the missing piece was only 2 cm, it was unlikely that a midwife could have detected its absence. Dr Maresh disagreed with this comment. The placenta had been delivered by pulling on the umbilical cord. It had taken 17 minutes which was noticeably longer than the usual 3 – 5 minutes that such a procedure takes. The midwife would have expected the placenta to have been disrupted and would have looked out for gaps in it. In Dr Maresh's view a midwife would have been able to spot a missing piece of about 2 cm. The absence of such a piece would, understandably have led her to seek the doctor's opinion.

58. Dr Maresh considered that sponge holding forceps could have been used to remove a mass consisting of a small amount of placenta together with surrounding blood clot which had had time to become organised and fibrous. He considered that it would be standard practice for the surgeon to explore the uterus digitally first. A piece of placenta and a blood clot might feel different if they were separate, but 2 weeks after the birth they were not likely to be separate. A smaller piece of tissue would also be likely to become necrotic more quickly and so even more difficult to distinguish.

59. Dr Hooper had told the Claimant that about 8 cm of products (according to her note in the records or placenta according to the Claimant) had been removed with forceps. Dr Maresh considered that this was wrong or inaccurate.

60. In his report and in his evidence, Dr Maresh said that he understood that it was part of what had been removed by the suction curette which was sent for histological analysis. The report found that the sample contained both blood clot and placental tissue but both experts agreed that it was not possible from this report to tell the proportion of blood clot as opposed to placental tissue, only that both were present.

61. Professor Shaxted agreed that, if what was retained by the Claimant had been a piece of placenta of substantial size, it should have been identified by Dr Ali on the USS which he performed on 6th April. So soon after the birth, there would not usually have been blood clots in the uterus and so the difficulty of distinguishing blood clot from placental tissue would not have faced him.

Decision regarding size of retained piece of placenta

62. I am not persuaded on the balance of probabilities that the piece of placenta which was retained in the Claimant's uterus after she gave birth to Harry was substantial.

63. My reasons are as follows.

    i) I have to consider the evidence as a whole and I have done so. I have also taken into account the very helpful oral and written submissions of Ms Woods for the Claimant and Mr Krsljanin for the Defendant.

    ii) I accept that the Claimant did her best to give honest and truthful evidence. The birth of Harry and the following few weeks were traumatic for her. They were plainly distressing events for her to have to recall.

    iii) Dr Ali could remember virtually nothing of his treatment of this patient. He was, effectively, reliant on the contemporaneous notes. His record keeping was poor. He, himself, made no note at all of the findings of the USS scan which he conducted on 6th April. He said that he had conducted that scan for training purposes. I did not accept this part of his evidence. First, he was asked to attend to the Claimant by the midwife because she was concerned that the placenta might have been incomplete. He did a USS very shortly afterwards. There are limitations on what a scan can show shortly after birth, but it would not be a pointless exercise to use a USS to help assess whether parts of the placenta had been retained. There was a clinical value in conducting the scan. Furthermore, as Dr Ali accepted in his evidence, if he was carrying out the scan for training rather than clinical purposes, he ought to have obtained and

recorded the Claimant's consent. He did not do so. That might have been another example of his poor record keeping. However, the midwife noted that the repair of the tear to the Claimant's perineum was delayed because the ward was busy. If the ward was busy that would be another reason why Dr Ali would not have allowed himself to be diverted to carry out a USS which had no clinical purpose.

iv) The placenta was delivered by Controlled Cord Traction ('CCT') and was in pieces, as the midwife noted. The midwife's note read '? Complete'. She was therefore uncertain as to whether it was or was not complete. Had there been a whole cotyledon missing or had a piece of placenta 7 x 4.4 x 2.2cm been absent that, according to Professor Shaxted, would have represented about $1/20^{th}$ of the volume of the whole placenta. In his evidence he initially made the point that the absence of a piece of that size would not have been as obvious as one might think because of the soft and malleable nature of the placenta. However, he did then agree that a missing piece of this size would have been reasonably obvious. If that was so, it is unlikely that the midwife would have expressed doubt (as represented by the question mark) as to whether the placenta was complete. On the other hand, because the placenta had been delivered by CCT, Dr Maresh said that the midwife would have been alerted to the possibility that it was incomplete. The discharge summary recorded that the placenta had indeed broken into pieces on delivery. In Dr Maresh's view, if what was missing was just a 2 cm piece, that would or might have been apparent, although the difficulty of deciding accurately would have been consistent with the midwife calling for a second opinion from the doctor.

v) Although Dr Ali made no note himself of the result of the USS on 6^{th} April, there is no doubt that he did conduct one. The Claimant agrees that happened and Midwife Barrow says that he was bleeped and asked to conduct a scan. Furthermore, the discharge summary says that a scan identified a 2 cm area of possible placenta left in situ. That information can only have come, directly or indirectly, from Dr Ali.

vi) The USS will measure the distance between the two points marked by the operator. The Claimant's case has to be that Dr Ali selected points 2 cm apart when, what he should have done, was identify points on the piece of placenta which were 7 cm apart. That would have been a very substantial error. Mr Krsljanin described it as inherently improbable. Ms Woods is entitled to say that gross clinical errors do sometimes occur, and that, indeed, is what the Claimant alleges in this case. I accept that. Nonetheless, the size of the error which would have been required makes it somewhat less likely to have occurred.

vii) Dr Ali was still undergoing basic training on the use of USS in the UK. I do not think that made it *more* likely that his scan would be accurate (as Dr Maresh suggested in his report). On the other hand, I think that it is relevant that he had had many years (about 11) of practice specifically as a Specialist Registrar or Senior Specialist Registrar in obstetrics and gynaecology in Syria and Saudi Arabia before coming to the UK and a further 2 years of practice in this country. He had completed two of the necessary three OSATs [Objective Structured Assessment of Technical Skills] as part of his UK training in USS.

The poor quality of his record keeping suggests that he still had more to learn. While that might call into question his clinical competence, it does not necessarily do so.

viii) Professor Shaxted and Dr Maresh are both eminent in the field of obstetrics and gynaecology. Both gave careful and well-considered evidence. Both made concessions where appropriate. There was nothing in their backgrounds or manner of giving evidence which led me to prefer one over the other. Indeed, on a great many matters they were in agreement.

ix) Mr Krsljanin argued that, because the Claimant's uterus was well-contracted after she gave birth to Harry, she could not have retained a substantial piece of placenta. The expert evidence appeared to be that, while a woman who had retained a substantial piece of placenta would tend not to have a well-contracted uterus, this was not invariably so.

x) Similarly, the retention of a substantial piece of placenta in a woman's uterus would tend to make it more difficult for the blood vessels to which the placenta had been attached to close off. That in turn would tend to lead to bleeding. From the haemoglobin measurements taken on 22nd March 2011 and 20th April 2011 we can deduce that the Claimant did not suffer a substantial loss of blood between those dates. However, both experts agreed that the connection between bleeding and retention of a substantial piece of placenta was only a loose one and so the absence of a substantial quantity of bleeding is not determinative.

xi) There were, as I have observed already, periods between the birth of Harry and the Claimant's operation on 21st April when she was in pain and other occasions when her uterus was noted as tender. The retention of a substantial piece of placenta would tend to cause pain in the Claimant's abdomen. But pain is also an unreliable indicator. Many women who do not have retained placenta may suffer afterbirth pains in their abdomen. The Claimant had also suffered a tear to her perineum. The repair was not successful. That itself would have been a cause of pain. In addition, on the Defendant's case, the Claimant may have had a small piece of retained placenta which became a bigger obstruction as blood clotted and accreted to it. That itself may have given rise to pain, especially in the days leading up to the Claimant going to hospital on 20th April.

xii) It is right that Ms Robinson's USS on 20th April was able to identify an echogenic mass measuring 7 x 4.4 x 2.2 cm. In her report she wrote of this '? Placenta'. She said in evidence that she had thought it likely to be a piece of placenta, but the '?' showed she could not be sure and the experts agreed that it would be difficult to tell the difference between blood clot and placenta on a USS.

xiii) For the object that was removed from the Claimant in the operation to have been a small piece of placenta surrounded by a blood clot, there would have had to be some bleeding into the uterus. Professor Shaxted estimated that it would have required about 80cc. He agreed that the Claimant could have had

that amount of bleeding consistently with the slight increase in her haemoglobin levels between 22nd March and 20th April.

xiv) Professor Shaxted also agreed that a small piece of placenta surrounded by a blood clot could have been digitally detached from the wall of the Claimant's uterus by the surgeon in the course of the operation on 21st April. Dr Maresh said that this would have been a prudent way of proceeding even if there was not a large piece of placenta in the uterus. I understood Professor Shaxted to agree by the end of his evidence that a small piece of placenta with attached blood clot could have been removed by sponge-holding forceps. As the blood clotted it would have become more organised and fibrotic so that it could have been gripped and removed in this way.

xv) The histopathology report does not help a great deal to resolve this issue. Dr Maresh thought that the sample sent for analysis had been taken from the curette suction tube. If right, that would not help to determine the composition of the object taken out by the forceps. In any case the laboratory report said that both placental tissue and blood clot were present, but did not say in what proportions.

xvi) Dr Hooper's note records what she said to the Claimant after the operation. I have no reason to doubt its accuracy of what was said in that conversation. There is no evidence that Dr Hooper was speaking from first-hand knowledge. The note of the operation lists the consultant, Dr Krueger and anaesthetist. It does not mention Dr Hooper (although the Defence accepts that Dr Hooper may have been present). Her note gives the size of the products removed as 8 cm. This is not identical to the dimension given in Ms Robinson's USS report, but it is preceded by a symbol meaning 'approximately' and this would not lead me to conclude that Dr Hooper had herself measured the object. Dr Hooper refers to what was removed as 'products'. Strictly speaking, while a piece of the placenta would be a product of conception, a blood clot would not. A doctor should, of course, be careful to convey accurate information to a patient, but one must also guard against being overly legalistic in the interpretation of such a note. I observe, for instance, that the note also said that a suction curette was used 'to remove any further products'. The suction would, of course, have been used to remove not only the products of conception, but any other matter which might have been in the uterus. Ms Robinson's USS had reported that the echogenic mass was surrounded by '?fluid/blood' and so there was likely to have been such other matter. There was no witness statement or evidence from Dr Hooper, apart from her note, but these are not (when taken together) circumstances which lead me to draw an adverse inference against the Defendant because it did not call Dr Hooper.

xvii) After this judgment was distributed in draft, the Claimant invited me to expand on my reasons for declining to draw an adverse inference against the Defendant because of its omission to call Dr Hooper. Ms Woods had submitted that I should take this course in reliance on *Wisniewski v Central Manchester Health Authority* [1998] PIQR P324 CA. There was, she submitted, no evidence as to why a witness statement from Dr Hooper had not been served and Mr Krsljanin's suggestion in closing that this was a relatively small clinical negligence case to which the Defendant was entitled to take a

proportionate approach was not evidence. Besides, Dr Hooper could still have given material evidence. In *Wisniewski*, though, the absent witness had been the doctor whose negligence was said to have caused (or whose actions could have avoided) the harm which the Claimant suffered. His role was absolutely central to what the Court had to decide. The trial judge had observed in the course of the hearing that 'he had never come across a case before where a person had chosen not to come to defend his clinical judgment' (see p.342). Dr Hooper's position was far more tangential. She was not the doctor who was alleged to have been negligent. She *may* have been present at the operation on 21st April 2011, but she was not the surgeon. The Defendant took no issue with the account which Dr Hooper gave in her note of her conversation with the Claimant after the operation, but that has the limitations on which I have already commented. Furthermore, in *Wisniewski* the Court was concerned with whether the trial judge was *entitled* to draw an adverse inference. The Claimant seems to be suggesting that I was *obliged* to draw such an inference, but *Wisniewski* does not go so far and it would be surprising if it had. The fact finding process is more nuanced than that. The factual matrices of cases inevitably differ and, as I have already said, in the present circumstances, I do not consider such an inference is appropriate.

Conclusion

64. The parties were agreed that a necessary step for the Claimant to succeed was a finding in her favour that a substantial amount of placenta was retained in her uterus following Harry's birth. I have not been able to make that finding in her favour. It must follow that her claim is dismissed.