Case No: HQ15C03059

Neutral Citation Number: [2017] EWHC 2460 (QB)
IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 15/09/2017

Before:

SIR ROBERT NELSON

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Between:

Jade Michelle Palmer	**Claimant**
- and -	
Portsmouth Hospitals NHS Trust	**Defendant**

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- -

Jane McNeill QC (instructed by **Coffin Mew LLP**) for the **Claimant**
Katie Gollop QC (instructed by **DAC Beachcroft LLP**) for the **Defendant**

Hearing dates: 26th to 29th June 2017

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Judgment

Sir Robert Nelson:

1. The claimant, Jade Palmer, was born on 30 August 1994 at St. Mary's Hospital in Portsmouth. She suffered oxygen deprivation immediately prior to her birth and as a consequence sustained brain damage causing cerebral palsy. Her limbs are seriously affected and there is a constant shake with involuntary movements and dystonic posturing. She is mobile but has an ungainly gait and her movements are awkward. Her cognitive function is intact.

2. The claimant alleges that her condition was caused by the negligence of the midwifery and obstetric/gynaecology staff at the hospital between 20:40 hours and 20:58 hours on 30 August 1994. The birth had been entirely normal up to 20:40 hours but thereafter, the claimant contends, it became increasingly apparent that Jade was suffering from foetal distress. The midwife should have called for medial assistance before she did, and if that had been done, and a Doctor attended, Jade would have been delivered at or before 20:58 hours by forceps, and her injury would have been avoided. In fact no doctor arrived to carry out an assisted delivery and as a consequence Jade was born at 21:00 hours with cerebral palsy.

3. The defendant, which is the NHS Trust responsible for St. Mary's Hospital, denied negligence and contended that the midwife should not have called for medical assistance any earlier than she did, and that even had she done so, the assisted delivery would have been too late to have avoided Jades's injury. During the trial however which was on the issue of liability only, the defendant conceded that there had been a breach of duty in failing to call for the doctor earlier than 20:50 hours when medical assistance was in fact summoned. This concession was rightly made.

4. It is also admitted that the claimant's cerebral palsy was caused by asphyxia, and that had Jade been born by 20:57 – 20:58 her circulation would have been restored within one minute by 20:58 – 20:59 and her injuries would have been avoided. What remains strongly in dispute between the parties is whether any breach of duty by the defendants caused such asphyxia, or whether it was unavoidable in that no properly summonsed doctor could have attended in time to have effected the delivery before the damage was done. The burden of proof is upon the claimant, and the defendant contends, she has failed to establish that the second on-call registrar was available to attend, or that if he was available there would have been sufficient time for him to have got to the delivery room and deliver the baby before 20:58 hours. This central dispute on causation is not merely factual but also relates to the test to be applied to determine if causation has been established where a hypothetical issue, i.e. what would have happened if the doctor attended, is to be determined.

5. I heard evidence from Jade's mother, Ms Kim Wadey, her grandmother, Carol Wadey, the midwife with responsibility for Jade's delivery, midwife Kim Piper, Mr David Davies a retired consultant obstetrician gynaecologist who had worked at St. Mary's Hospital as a registrar and consultant including in 1994, and also Ms Sharon Hackett, the Senior Midwifery Manager Clinical Governance at the defendant trust. I also heard expert evidence on midwifery from Mrs Sandra Tranter for the claimant, and Ms Fiona Sommerville for the defendant, and from experts in obstetrics and gynaecology from Dr Gareth Thomas for the claimant, and Professor Phillip Bennett for the defendants. There was also an agreed note from experts in paediatric neurology, Dr Miles and Dr Neil Thomas.

The Facts

6. Kim Wadey's pregnancy and labour had been normal until 20:40 hours. At 20:25 her cervix was fully dilated and the baby's head had descended 1 – 2 centimetres below the ischial spines. The baby was in the optimal position of O-A (Occipito-Anterior).

7. Midwife Piper, who had been caring for Kim Wadey from 15:00 hours, made detailed clinical notes which were recorded shortly after each event until 20:42 hours when she made the decision to attach a cardio tachograph (CTG) to record the foetal heartbeat and the uterine contractions. After that time the notes were probably made retrospectively, mostly after the baby was born. They contain amendments and one passage, it is agreed, which is difficult to interpret, but on the whole are competent.

8. Midwife Piper listened to the foetal heartbeat on a regular basis up to 20:40 using a hand held ultra sound foetal heart monitor, a Sonicaid. This did not produce a printout but did have a microphone which enabled the noise of the foetal heartbeat to be heard by those nearby.

9. At 20:30 hours active pushing was commenced by Kim Wadey and hence the second stage of labour began. At that time the vertex i.e. crown or top of the head was just visible at the height of the contractions. The foetal heartbeat was in the normal range of 120 – 160 bpm (beats per minute) at 135 bpm.

10. At 20:40 hours Midwife Piper made an entry in the clinical notes as follows:

> "Vertex visible at entroitus, descending slowly with contractions, clear liquor draining FHHR 130 bpm, variable,"

11. The word "just" has been inserted between the words "vertex" and "visible".

12. The word "variable" is unclear in this context. Midwife Piper in supplementary statements has stated that she used "variable" in the sense that the heart "was changing rhythm which was normal" or in the sense that it meant "an increase in heartbeat but not enough to warrant being an acceleration".

13. From 20:25 hours when the cervix was fully dilated and the head 1 – 2 cm below the ischial spines Midwife Piper had been listening to the foetal heart every 5 minutes. After 20:40 hours, however, she listened again some 2 minutes later at 20:42 hours. On this occasion she heard the foetal heart decelerate to 90bpm with a contraction and fair recovery to 120bpm. Having heard this she attached the CTG so that she would be able to determine normal baseline variability in the foetal heart-rate which the Sonicaid was incapable of doing. She also called a senior midwife, Midwife Van Dongen to assist her.

14. Midwife Piper certainly heard a deceleration of the foetal heart rate at 20:42 hours but there was a dispute as to whether she did so at 20:40 hours. Whenever a deceleration is heard it is a cause of potential concern. An early deceleration begins at or after the onset of the contractions, reaches its lowest point at the peak of contractions and returns to the baseline rate by the time the contraction has finished (Myles Textbook For Midwives 178). An early deceleration may be associated with compression of the foetal head as it engages, and hence benign, but it may also indicate early foetal

hypoxia. A late deceleration begins during or after a contraction, reaches its nadir after the peak of the contraction and has not recovered by the time the contraction has ended. Sometimes decelerations barely recover by the onset of the next contraction. Where the time lag between the peak of the contraction and the nadir of the deceleration is more significant in severity than the drop of the foetal heart rate, foetal hypoxia is always indicated and the doctor must be informed (Myles).

15. Doctor Thomas told me that early decelerations are usually shallow as can be seen in Figure 12.7 in Myles, returning to much the same baseline rate on each occasion. There was no disagreement with Myle's statement that even an early deceleration may indicate foetal hypoxia.

16. Whatever the precise nature of what Midwife Piper heard at 20:40 hours I am satisfied that she was concerned by it. That is why she listened again some two minutes later at 20:42 hours rather than 5 minutes later. What she heard at 20:42 confirmed her concerns. There was a deceleration to 90 bpm with only a "fair" recovery to a lower bpm of 120. The pattern which followed of further deceleration to below 80 bpm, (nearly 75 bpm with the bpm then remaining at 80 – 90 or 75 – 80) confirms that what Midwife Piper probably heard at 20:40 was the beginning of the developing foetal distress. Whether she could have heard a deceleration or not, what she did hear caused her concern about the foetal heart rate which rightly led to her listening again in two minutes, rather than five minutes, leading to her hearing the deceleration at 20:42.

17. The first section of the CTG dated 30/08/94 is timed at 20:42. It was agreed between the parties, after the evidence of Professor Bennett who had experience of this particular make of CTG, that the recordings actually start at 20:43 and finish at 20:45:30 on the first series of the CTG readings and commence at 20:47 on the second CTG. It appears therefore that it took about one minute from hearing the deceleration at 20:42 for the CTG to be attached in time for it to commence at 20:43. It is to be noted that on neither occasion when the CTG was attached was the tocograph attached, with the consequence that the contractions and their relationship to the bpm could not be measured. It took about one minute and a half from detachment of the CTG at 20:45:30 to reattachment at 20:47:00.

18. The first tocograph commencing at 20:43 showed three decelerations, as the experts now all accept. The second one, which was the only one recorded in Midwife Piper's notes, is described by her as decelerating to 85 bpm but slower to recover to 110 bpm. The notes and her statement make it clear that it was the slowness of the recovery, which brought about her decision to move Kim Wadey to the delivery room. The second deceleration recovered from below 80 bpm to just under 110 bpm between 20:44:30 into the beginning of 20:45. The third deceleration is from just under 110 bpm down to below 80 bpm before the CTG was removed.

19. The decision to move Kim Wadey to the delivery room was correct and essential. There had been a deceleration at 20:42 and three shown on the first part of the CTG by the time Kim Wadey was moved. There had therefore been four decelerations in total or five if what had occurred at 20:40 was also a deceleration. Two of the decelerations indicated a slow recovery and two of them did not recover to the same baseline, the second deceleration to only just under 110 bpm. The midwife could not

have known at that stage for certain what was happening but the information available necessitated calling for medical assistance as the decelerations were consistent with foetal distress and potential death of/or serious injury to the baby. In fact, Midwife Piper did not ask for medical assistance at that time but says in her statement and in evidence that she decided to make the office aware that a doctor might be required.

20. In cross examination, Midwife Piper thought there were three decelerations, which she thought were to be early. She moved Kim Wadey to the bigger delivery room in case the situation became worse. She then accepted that it would have been the right thing to do to call for medical assistance when Kim Wadey was moved and accepted that she should have asked for medical assistance then.

21. The following morning on the second day of the trial on 27 June 2017, Counsel on behalf of the Defendant, Katie Gollop QC, formally conceded that the time Kim Wadey was transferred to the delivery room was the time when the midwife should have asked for the doctor to be called, and conceded that the Defendant was thereby making an admission of breach of duty. Miss Sommerville, the Defendant's midwifery expert confirmed her agreement with that concession, stating that the midwife should have asked for medical assistance as she passed the midwives desk on her way from the labour room to the delivery room. Professor Bennett withdrew in evidence his outlying proposition that even at 20:48 there was no need to call medical assistance, and said that having heard the evidence he accepted that it was correct that a doctor should have been called when Kim Wadey was moved.

22. The rooms were close to each other and the midwifery desk was on route. It would have taken only seconds to reach the midwives desk and call for medical assistance (Mrs. Tranter). It took one and a half minutes to detach and reattach the CTG. Midwife Piper's notes record 20:44 as the time when the foetal heart decelerated to 85 bpm and slowed to recover to 110 bpm and Kim Wadey was moved to the delivery room. The CTG records the slow recovery of the second deceleration to 110 bpm as being in the early part of 20:45. There may not be a significant time difference between these two, as some of 20:44 would have been taken up observing the deceleration and its recovery on the CTG.

23. When the CTG was reconnected in the delivery room there was in effect, as Midwife Piper said in the notes, a loss of contact. The trace of the second CTG from 20:47 is very difficult to read but what is clear is that it gives no reassurance.

24. There was a powerful sense of urgency from 20:42 when the deceleration was heard and assistance called from Midwife Van Dongen. It was at this time that there was a shift change for the midwives and at the time of the move and in the delivery room there were no fewer than five midwives present. Kim Wadey and her mother, Jade's grandmother, described panic or panic stations when the heart rate could be heard to alter. Whether or not Midwife Piper or any of the other Midwives panicked, I am clear that the atmosphere could well have seemed like that to Kim Wadey and her mother. There was loud and persistent shouting at Kim Wadey to push and a great urgency about the need for the baby to be delivered. Whilst this was going on, the equipment in the room was being prepared for an assisted delivery.

25. Midwife Piper said in cross examination that from 20:50 she was expecting a doctor to arrive at any moment and the room had been fully prepared for an instrumental

delivery. She said in evidence that she anticipated delivery when the move to the delivery room was made because the vertex was visible. It is a reasonable inference to draw that although she knew of the great urgency, she must still have thought that a vaginal delivery was imminent otherwise she would not merely have told the midwifery desk that a doctor might be required rather than that he was required.

26. At 20:48, the notes recall that the foetal heart was staying around 80 – 90 bpm; that Kim was given oxygen and was put into a sitting position, but no recovery was achieved with the bpm staying at 90.

At 20:50, the notes recall that the perineum was infiltrated with 1% lignocaine, the FH was staying at 75 – 80 bpm and the paediatrician and registrar contacted.

At 20:52, it is recorded that Midwife Piper performed an episiotomy and Kim was encouraged to push. There was descent of the head but the head was not delivering. The foetal heart was staying at 70 – 80 bpm. "Registrar in theatre"

At 20:54, the episiotomy was extended, head still not delivered with pushing, FH staying at 70 – 80 bpm.

20:56, the episiotomy extended further, with maternal effort encouraged to push. Foetal heart 60 – 70 bpm. Not recovering.

21:00. Delivery of live female infant in very poor condition (flat).

21:06. Third stage complete

27. The delivery notes made by Midwife Piper (B/386) record, inter alia, "fetal bradycardia" to 70 – 80 bpm. The notes also record the episiotomy being sutured by Mr. El Rabiey the obstetric registrar, and the first registrar on call that night. The Labour Summary (B/388) records that there was a "second degree perineal tear" and that the perineum was sutured by the registrar Dr. El. Rabiey.

The On Call System

28. At the Defendant trust hospital, a rota was operated whereby both an Obstetric Registrar and a Gynaecology Registrar were on call out of hours. St. Mary's is a very substantial hospital and two registrars is something smaller hospitals cannot always achieve.

29. The Obstetric Registrar on duty on the evening of 30 August 1994, Dr El Rabiey, had been called to carry out an emergency caesarean section in the maternity theatre on the fourth floor of the maternity block. The decision to carry out that operation had been taken at 19:30, Dr. El Rabiey arrived at 19:55, delivered the baby at 20:34 and left after suturing the mother at 21:05. He is the registrar referred to as being "in theatre" in Midwife Piper's notes. He was not released from the call to attend Kim Wadey and went to the delivery room where she was, immediately after he had left the theatre at 21:05, arriving some two floors down at 21:06. He then, as noted above, sutured Kim Wadey's episiotomy.

30. By that time the Paediatric SHO, Dr. Wright, had already attended and resuscitated Jade. He had been called, like Dr. El Rabiey, at 20:50 and arrived shortly before Jade

was born. A Paediatric SHO is not qualified to deliver a baby whereas the Gynaecological Registrar is of equal skill and status for that task.

The Second Doctor on Call – The Gynaecological Registrar

31. It appears that the Defendant was not aware of the identity of the second on call registrar that evening until during the course of the trial. When Mr Davies, the retired consultant obstetrician who had worked at St. Mary's Hospital for many years both as registrar and consultant, gave evidence, he did not know who the second registrar was, or where he was, or indeed whether he was called or not. Nor was Professor Bennett aware of the identity of the second registrar when he wrote his reports. Nor was Dr. Thomas. It is to be presumed that Midwife Hackett did not know either as she had been in charge of gathering documents for discovery and none were produced in relation to the work or activities of the second registrar that evening.

32. At the end of re-examination of Mr. Davies, Katie Gollop QC on behalf of the Defendant drew attention to the registrars weekly timetable for the hospital (B/316) and the fact that this document identified the obstetric registrar on duty as being Dr. El Rabiey, and the Gynacological Registrar on duty as Dr. Perkins, during the course of that evening. It appears the identity of the second registrar was only appreciated by the Defendant during the trial as a result of the observation of either counsel or Senior Midwife Hackett.

33. When she gave evidence the following morning, Miss Hackett said that the Weekly Timetable form (B/316) identified the second on call registrar that evening as Dr. Perkins. This was, she said, an Australian registrar who would have been with the hospital on the reciprocal arrangement which the trust had with a hospital in Perth. His name was Roger Perkins.

34. In its defence, the Defendant Trust pleaded that the second registrar was called (Paragraphs 8 and 11.11 B/10, 13). The Defendant does not plead that the second on call registrar was unavailable. No documents in relation to the gynaecological wards upon which he might have been working have been disclosed, nor anything else to show where he was or what he was doing that evening, i.e. whether he was available or unavailable. Having discovered for itself for the first time during the trial the identity of the second on call registrar, the Defendant trust asserted that there was no property in witnesses and as the burden of proof remained upon the Claimant it was the claimant's task to discover from the documents who the registrar was, make enquiries and call him as a witness. Given that it did not discover for itself until the trial the identity of the second on call registrar from its own documents, this is a somewhat purist submission. The Defendant itself made no attempt to contact Dr. Perkins being unaware until Ms Gollop's announcement in court of his identity.

35. Mr Davies said that having a second registrar on call was unusual for most maternity units in England at that time. It was normally the case that one registrar was on call and if he was unavailable, the consultant would be summoned from home and expect to be available within 30 minutes if an emergency had arisen. The second on call registrar at St. Mary's Hospital, he said, would either be in the on call room close to the gynaecology unit, if not engaged with work at the time, or in the gynaecological unit also at the far end of the hospital. The gynaecological registrar could have been working in the Gynaecology Emergency Admission Unit or looking after post-

operative patients on his ward or otherwise examining or consulting a patient. He might also have had to deal with another obstetric emergency. It could be busy between 20:30 and 21:00.

36. Mr Davies said that it was expected that the second registrar would be able to attend within 10 – 15 minutes. In evidence he said that this was the expectation in his own experience in the 1980s when he was a registrar at St. Mary's.

37. He described the distance between the far end of the hospital and the maternity block as being 250 yards. The registrar may have to stop examining a patient. It would probably take him ten minutes to get from the far end of the hospital to the delivery room, and five minutes would be pushing it, with six flights of stairs as well. It could be done in five minutes if every throw of the dice went the right way. This ties in with Mr Davies evidence earlier in cross examination, when he said he thought the distance could be covered in five minutes if the registrar wasn't doing anything at the time. He also made reference to being able to cover the distance in five minutes maybe one time in a hundred, or if you had your running shoes on.

38. This issue, as Ms Gollop QC submitted, is a matter of fact, but the experts expressed views upon it. Professor Bennett said 10 – 15 minutes conformed with the NHS standard at the time and Dr. Thomas said that the response should have been within 5 – 10 minutes given that between 20:30 and 21:00 hours the registrar would be dressed and awake. Because he did not know the hospital he was not able to say whether 10 – 15 minutes was unreasonable but said that an obstetric registrar should respond in 5 minutes, though the Defendant submits that the obstetric registrar is considerably closer to the labour ward than the gynaecology registrar.

39. At the end of the evidence Ms. Gollop was given leave to put in the plan dated July 1999 which showed the hospital as it was in August 1994. The plan has a scale of 1:1250 and the measured distance from the furthest point of the site where the gynaecological registrar could have been to the delivery room is about 112.5 metres or 123 yards.

The Experts

40. I found both the Midwifery experts to be of assistance to the court and have used the evidence of both of them in reaching my conclusion in this Judgment. My only reservation is that the admission of breach of duty confirmed by Ms. Sommerville in evidence in chief after the Defendant's counsel had formally admitted a breach, should have been admitted earlier, before it was forced by concessions in cross examination of Midwife Piper, given the number and nature of the decelerations which the notes and the CTG revealed.

41. The latter comment applies equally to the obstetric evidence given by Professor Bennett. His evidence as to how the CTG operated was valuable and conceded by Dr. Thomas, but in many other respects, Professor Bennett's evidence was unhelpful. His contention that it was reasonable not to call for medical assistance even by 20:48 was an outlying proposition and on the basis of the evidence given and indeed recorded, very difficult if not impossible to sustain. His report contained a number of errors which were all significant, and all in favour of the Defendant. He omitted to refer in the first part of his report to the clear two and a half minutes of the first CTG trace. He

accepted that this was a significant omission as the first trace showed the decelerations. In spite of the fact that he had appreciated the night before he gave his evidence that this omission had been made, he did not correct it in his evidence in chief. When he did refer to the decelerations later in his report, he did not do so accurately. Thus in referring to a deeper deceleration at 20:44, he said it descended to 85 bpm and took a longer time to recover to 110 bpm. In fact the deceleration was to 75 bpm and not 85 bpm. When referring to the CTG after it had been reattached in the delivery room, Professor Bennett stated that the foetal heart rate was around 80 – 90 bpm whereas in fact it was 70 – 80 bpm. He accepted that his figure was wrong and that he was not sure why he had done that.

42. Professor Bennett also failed to make reference to the entry relating to 20:40 when Midwife Piper's note referred to the word "variable". Professor Bennett accepted that the interpretation of this word was relevant as to what had been heard at 20:40 and what significance that had. He accepted that it was a material fact, which he had omitted but should have set out. He stated it was not done to deceive.

43. Professor Bennett also referred to a report by the Audit Committee of the Royal College of Obstetricians and Gynaecologists (RCOG) as if it were from RCOG itself, which it was not.

44. Jane McNeill QC, counsel for the Claimant, did not suggest that Professor Bennett was intending to deceive the court but submitted that his omission had the effect of his report crossing the boundary from objective comment to advocacy. For my part, I concluded that the omissions were careless, and significantly reduced the report's reliability.

45. By contrast, Dr. Gareth Thomas's report and evidence was expressed in a fair accurate and reasonable manner and in his evidence he showed a willingness to concede points against him in an open fashion. Where the evidence of Professor Bennett and Dr. Thomas differs, I prefer that of Dr Thomas.

Breach of Duty

46. Although it has been admitted that medical assistance should have been called at the time of the transfer, and that the failure to do so amounted to a breach od duty, the time when that request should have been made is not agreed between the parties. The claimant contends that the timings in the notes, which would have been taken from the Midwife Piper's FOB watch, should be used whereas the Defendant relies on the timing of the CTG. Thus the claimant, who does not contend for any earlier time other than the time of transfer, argues that the time should be 20:44 when it was recorded in the notes that the move to the delivery room took place, and the Defendant contends for 20:46 based on the CTG time based of 20:45:30 where the transfer took place, plus thirty seconds to clear the room and get to the corner of the block where the midwife desk was.

47. I am satisfied Midwife Piper's notes were as accurate as circumstances permitted and can be relied upon. It is probably the case sometime after 20:40 and at least by the time of arrival in the delivery room, that the notes were no longer taken contemporaneously as they had been earlier, but retrospectively.

48. There is no evidence on whether either the FOB watch or the CTG was showing the correct time. But the apparent difference between them may not be that substantial when it has been taken into account that only one time is put in the notes, when the activities or the events described in them may take the whole or the most of a minute. Thus, the move to the delivery room is described under the time 20:44 but only after Midwife Piper has auscultated the foetal heart and noted that it had decelerated to 85 bpm, and slowed, to recover to 110 bpm. She may have been counting and doubling up, but even so the move to the delivery room would undoubtedly have taken place towards or at the end of 20:44, i.e. at the beginning of 20:45. The CTG at the point when the foetal heart rate did not get above 108 or 110 shows 20:45:15 and when the connection was severed 20:45:30.

49. Based upon the evidence I find that the transfer to the delivery room took place between somewhere towards the end of 20:44 (Notes) and 20:45:30 (CTG). Some additional time must be added for Midwife Piper to go to the midwifery desk which was very close indeed to the labour room. Given the urgency of the situation and the fact that she was not pushing the bed herself which was done by Ms. Wadey's relatives, she would probably have got to the desk somewhat ahead of the bed. I assess the time inclusive of the time to get to the midwifes desk at 20:45:30, though on the evidence I cannot exclude the possibility that the request would have taken until 20:46 before it could have been made.

Causation

50. In view of the admission of breach of duty during the course of the trial the central issue became that of causation. A number of questions upon this factual issue arise, the two principal ones being firstly, if available and if called, how long would it have taken for the second on call registrar to arrive in the delivery room, and secondly how long would it have taken after arrival to deliver the baby. There is also an interlinked legal issue raised by the Defendant upon the basis of the case of Bolitho v City and Hackney Health Authority [1998] AC 232. The Defendant submits that in proving causation the Claimant must not only show what would in fact have happened, but also show that the Defendant's employees were medically negligent in failing to ensure that it did.

51. Katie Gollop QC is right in warning the court of the risks of looking at the factual issues in retrospect rather than in prospect. I must avoid looking at the end point of 20:57/20:58 and counting back from that. That time is the time agreed by the paediatric neurologists as the point Jade must have been born for her circulation to have been restored in time for her to avoid injury. I construe the time by the paediatric neurologists of 20:57/20:58 as meaning that Jade would have avoided injury had she been born before the end of 20:57 or the end of 20:58. That is the correct interpretation of paragraph 7 of the agreed note by the paediatric neurologists.

52. I propose to deal firstly with two important preliminary matters before turning to the Bolitho question and the two principal issues on causation.

The urgency of calling medical assistance

53. The midwives were not qualified to carry out an assisted delivery. This had to be done by a qualified doctor. The first on call obstetric registrar and the second on call

gynaecology registrar were both qualified. That the situation was really urgent by the time that Midwife Piper transferred Ms. Wadey to the delivery room is clear. The pattern and progression of the decelerations should have made it clear to her that medical assistance was needed. Although she did not call for medical assistance until some four to four and a half minutes later at 20:50, her actions suggest that she was well aware of the urgency. Kim Wadey, the Claimant's mother, and Carol Wadey, the Claimant's grandmother, both describe panic or panic stations when the baby's heartbeat started to get slower. I doubt if Midwife Piper or those with her were showing panic though there was undoubtedly great rapidity of action and noise which created the impression on the Claimant's mother and grandmother of "panic stations". Midwife Piper and others were shouting at Kim Wadey to push, clearly delivering their strong sense of urgency. At the same time, the room was being prepared for an assisted delivery so that it would be ready for the doctor if and when he arrived. It must be recalled that whilst all these preparations were being made and the urgency shown, Midwife Piper was still at that time thinking that the delivery would in any event have been imminent.

54. Any registrar on call when beeped and told of the decelerations would be well aware of the urgency required. He would know that this was not a situation in which a doctor could casually make his way to the delivery room, but a journey that he would have to make fast. All the experts accepted that the situation was critical and that there was a need to get the baby out as soon as possible. Professor Bennett added that it was nevertheless not the greatest of emergencies as there was not an established bradycardia. I reject that evidence and prefer that of Dr. Thomas and the other experts that the situation was critical. It is also to be noted that the paediatric neurologists both described the situation as one of bradycardia (B/290 Para 2) as did Midwife Piper in the delivery notes.

The checking of the first on call registrar's availability

55. Even though the lead midwife would on the evidence, have known that the first on call registrar was in theatre, I am satisfied it was reasonable to contact him first as he was only a minute or so away on the floor above, and it would make sense to see if he was available or just about to become available before contacting the second on call registrar. Mrs Tranter said it would take a few seconds to check whether he had nearly finished in theatre whereas the Defendant contends it would take about one minute. It was a hospital rule that phones were not permitted in theatre so the phone would have been answered outside theatre and then the message taken into Mr El Rabiey to find out whether he was about to become available. Had such a call been made, it is not known what Mr El Rabiey would have replied, though it is known that when he was called at 20:50 he was able to reach the delivery room some 16 minutes later at 21:06.

56. The Defendant's system required that if he had been called at 20:45:30 or 20:46 and said that he was not immediately available, the lead midwife should have beeped the second on call gynaecology registrar and if he too was not available, contacted the consultant.

57. Allowing thirty seconds for contact to be made with the first on call registrar and the discovery that he was not immediately available, leads to the time of 20:46/20:46:30 (20:45:30 +: 30 and 20:46 +: 30) at which the lead midwife would have beeped the second on call registrar. If the contact with the first on call registrar had taken, as the

Defendant contends, one minute the timings would have been 20:46:30 – 20:47. Both times are possible, and the court is not able to conclude which is the more likely.

Was the Second On Call Registrar available to be called?

58. The second on call registrar could have been attending to a gynaecological emergency at the time, or on one of the wards dealing with a non urgent matter, or in his room, or in the on call room waiting for, and ready to deal with, any call that was made. At that time of the evening around 20:45, he could have either have been busy, or not actually working but waiting for any call that might come. I accept the evidence of both Mr Davies and Dr Thomas that that time of the evening could be busy or as Dr Thomas said equally might not be busy.

59. The limited state of knowledge of 'Dr Perkins' whereabouts that evening is as follows:

    i) He was on duty as the second on call registrar

    ii) There was no evidence of what he was doing or had done

    iii) The Defendant has pleaded that Dr. Perkins was called but does not plead that he was unavailable

    iv) There has been no disclosure given or sought of the gynaecological ward theatre logs or any other document which might show whether Dr. Perkins was in theatre or not or otherwise occupied in an emergency situation or otherwise unavailable.

    v) There is no note referring to his whereabouts or activities that night whether from him or a midwife. This is to be compared with the note relating to Dr. El Rabiey's presence and timings in theatre (B/315).

    vi) There is no note recording that the consultant had been called because the second on call registrar was unavailable (which should have occurred according to the Defendant's systems)

60. There is no evidence to suggest that Dr. Perkins was on an emergency or otherwise unavailable but there is evidence that he was on duty and it is reasonable to infer in the circumstances, as the Claimant submits, that on the balance of probabilities he was either carrying out routine, normal (non emergency) duties on the ward, or with a non-urgent patient, or in the on call room or in his own room preparing to respond to a call. I find that the second on call registrar that night, Dr. Perkins was available to be called.

Was the second on registrar called?

61. Midwife Piper noted "Paediatrician and Registrar contacted" at 20:50 and "Registrar in theatre" at 20:52.

62. The Defendant submits that Midwife Piper thereby had discovered that the obstetric team was in theatre, and that it was not possible to release a doctor from theatre to attend. Whilst from the timings which Dr. El Rabiey gives (B/317) it can be inferred

that he would have been engaged in dealing with the repairing of the caesarean section he had performed between 20:45 and 20:52, he was not in fact released by the lead midwife. The first registrar on call, Dr El Rabiey did attend Ms Wadey immediately after he had left the theatre at 21:05, arriving at 21:06. He attended as soon as he had finished in theatre upstairs, consistent with not being released by the lead midwife. The paediatric SHO, Dr. Wright, attended, I find on the balance of probabilities, shortly prior to Jade's birth.

63. The Defendant submits that as it was known that Dr. El Rabiey could not be released from completing the caesarean to attend to Ms. Wadey, the second registrar must have been called but was not available. All knew that that was the system and it is inconceivable that it was not followed by beeping the second registrar. But the notes do not demonstrate that Dr. El Rabiey would not be able to attend at any relevant time, merely that he was "in theatre" when asked if available. The note does not say, nor was any evidence given, as to how long he said he was likely to be in theatre or how soon he might be available. What is known that is he did attend Ms. Wadey at 21:06 very shortly after he had concluded in theatre. It appears therefore that Dr. El Rabiey had not been stood down, had still expected, and was still expected, to attend Ms. Wadey. It does not follow from the fact that he was not stood down, that Dr. Perkins was known to be unavailable or had been beeped or was found to be unavailable. It could equally be that Dr. El Rabiey was not stood down because he thought he could get to the delivery room sooner than was in fact the case. He was completing the process of the caesarean between 20:45 and 20:50 and he was only one minute away from the delivery room.

64. There was nothing in Midwife Piper's notes to say that Dr. Perkins was called. If however the on call system required, as Mr Davies says in Paragraph 8 of his witness statement, the obstetrics registrar to determine how long he and his team were likely to be occupied for, and advise the midwife accordingly of the need to put out a call for the second registrar, one might expect that if Dr. El Rabiey had said he was and would be unavailable and the second registrar accordingly needed to be called, the calling of the second registrar would be recorded in the notes and Dr. El Rabiey stood down or released. A simple entry such as "registrar in theatre, second registrar called" or words to that effect would have demonstrated that the Defendant's system had been followed. Whether or not a note was written to that effect, one would have expected Dr. El Rabiey to have been stood down or released from the call had he been unavailable rather than attending as soon as he possibly could within one minute or so of leaving the theatre upstairs.

65. Another factor may have been that Midwife Piper, as she says in Paragraph 31 of her witness statement and in evidence, anticipated delivery, but wanted to ensure that there was sufficient room for, and appropriate equipment available, if an assisted birth was required. That she anticipated delivery imminently was no doubt one of the factors in her consideration that it was still not appropriate at the time to summon a doctor, but only to give warning that one might be needed.

66. In Paragraph 37 of her witness statement, Midwife Piper states that if she was informed that the obstetric registrar was in theatre it was her usual practice to ensure that the second on call registrar was summoned, although she also knew that the midwifery desk would automatically request on call. There is no evidence that she herself followed her usual practice of ensuring the second on call registrar was

summoned in this case. Again, her belief that the birth was in any event imminent may have been relevant to her failure to so ensure on this occasion.

67. I am satisfied taking into account all the circumstances that, on the balance of probabilities, Dr. Perkins was not called. The factors which particularly weigh with me are:

i) Dr. Perkins was on duty and so described in the timetable for the day (B/316)

ii) The first on call registrar, Dr El Rabiey, was called at 20:50. He was in theatre at the time.

iii) There was no evidence that the first registrar advised Midwife Piper or Midwife Van Dongen or the lead midwife or anyone else of a need to call the second registrar in accordance with Mr Davies's description of the Defendant's system if the first registrar was thought to be unavailable.

iv) The first registrar was not released or stood down from that call but attended immediately after leaving theatre at 21:05, arriving at Ms Wadey's delivery room at 21:06. He sutured Ms. Wadey's episiotomy.

v) Midwife Piper's notes make no reference to the second registrar at all. She did not follow her usual practice of ensuring that the second registrar was summoned.

vi) The second registrar at no time attended Ms. Wadey, or arrived at her room, or made any note of the fact that he had been called or of his availability (CP Dr. El Rabiey).

vii) There is no evidence that the second registrar was called or that he was unavailable or indeed what he was doing that night.

viii) No documents have been disclosed or sought which show, or are relevant to whether Dr. Perkins was called or whether he was unavailable because he was working elsewhere or for any other reason. The Defendant pleads that Dr. Perkins was called, but does not aver that he was unavailable. It pleads in Paragraph 11.12 that there were occasions on which some delay in the provision of emergency obstetric assistance was unavoidable, but does not plead that in relation to Mr Perkins specifically.

ix) There was no record of the consultant having been called or attending in Midwife Piper's note or in any other document. The consultant would have or should been called in accordance to the Defendant's practice if the first and second registrar were unavailable.

68. These matters are sufficient on the balance of probabilities to establish that Dr. Perkins was not called. The burden of proving that he was called therefore passes to the Defendant, which has not discharged that burden. I am satisfied on the evidence that Dr. Perkins was not called.

69. It was not argued before me that a failure to call the second on call registrar in breach of the Defendant's system was a negligent breach of duty and I make no finding upon

the matter. I am however clear that the fact that some hospitals did not have a second registrar on call system does not excuse the Defendant from such a failure. Nor is the absence of a duty to have an obstetrician or gynaecologist on call in accordance with government guidelines relevant in 1994. The hospital did have such a second on call system in place and having established that, it was their duty to operate that system with due care. Where the system was in place and any failure to call would lead to a reasonably foreseeable risk that death or serious injury might occur to the baby, the duty existed. It cannot therefore be successfully argued by the Defendant that there was in any event no obligation upon the second on call registrar to attend and answer to a call and hence no liability. Of course, if the second registrar had been engaged in emergency gynaecological work and was and would have remained unavailable, there would have been no duty to ensure his arrival though the Consultant should then have been contacted. This does not arise in any event on my findings, namely that the second on call registrar was available to be called but was not called.

The Bolitho Question

70. The Defendant submits that the Claimant cannot succeed on the issue of causation unless, in answering the hypothetical question of when the second registrar would have arrived in the delivery room and how long it would have taken to deliver the baby, she is able to prove that it would be negligent for the Defendant to fail to meet the time she has set. It is not sufficient for the Claimant to establish what would in fact have happened, she must also establish it was mandatory for the second call registrar to arrive in a certain time and to deliver the baby within the certain time and that failure to do so would amount to a negligent breach.

71. The Defendant submits that on the facts only a failure to take longer than fifteen minutes to arrive would amount to negligence and that six minutes delivery time was not realistic but unlikely and any failure by the Defendant to meet that target within a few minutes could not amount to negligence. If the Defendant is right in these contentions, the Claimant must fail on the issue of causation as a time of the order of fifteen minutes for arrival and over six minutes for delivery could not have prevented injury to Jade.

72. The Defendant's submission is based upon Miss Gollop's interpretation of Bolitho on the issue of causation. She submits that Bolitho requires two questions to be answered in respect of both of these issues, namely what time would the second on call registrar have arrived had he been called (the factual question) and was he Bolam negligent if he arrived after a certain time (Bolitho negligence question); and secondly at what time would Jade have been delivered and would the second on call registrar have been Bolam negligent if he had delivered her later than six minutes after his arrival.

73. In Bolitho v City and Hackney Health Authority [1998] AC 232, Lord Browne-Wilkinson said that the burden still lies on the Claimant to proof that a breach of duty of care caused the injuries suffered. In all cases the primary question was one of fact: did the wrongful act cause the injury? But in cases where the breach of duty consisted of an omission to do an act which ought to be done (e.g. the failure by a doctor to attend), the factual enquiry is, by definition, in the realms of hypothesis. The question is what would have happened if an event which by definition did not occur, had occurred (239G). In that case two doctors had failed to attend when one of them should have done which amounted to a breach of duty, but the trial judge was satisfied

that had they attended the patient, she would not have been intubated, as a result of which she would have still have suffered the injury she suffered. Lord Browne-Wilkinson said that in that case the question "what would have happened" was not determinative of the issue of causation. Lord Browne-Wilkinson relied upon the dicta of Hobhouse LJ in Joyce v Merton, Sutton and Wandsworth Health Authority [1996] 7 Med LR 01 where he said,

> "Thus a plaintiff can discharge the burden of proof on causation by satisfying the court *either* that the relevant person would in fact have taken the requisite action (although she would not have been at fault if she had not) *or* that the proper discharge of the relevant person's duty towards the plaintiff required that she take that action. The former alternative calls for no explanation since it is simply the factual proof of the causative effect of the original fault. The latter is slightly more sophisticated: it involves the factual situation that the original fault did not itself cause the injury but that this was because there would have been some further fault on the part of the defendants; the plaintiff proves his case by proving that his injuries would have been avoided if proper care had continued to be taken. In the *Bolitho* case the plaintiff had to prove that the continuing exercise of proper care would have resulted in his being intubated."

74. Thus, Lord Browne-Wilkinson said, there were two questions for the trial judge in Bolitho on the issue of causation. Firstly, what the doctor would have done or authorised to be done if she had attended the patient and secondly if she would not have intubated would that have been negligent. The Bolam test, he said, had no relevance to the first of those questions but was central to the second (P240 B-G).

75. In referring to the Bolam Test, the House of Lords was referring to the Judgment in Bolam v Friern Hospital Management Committee [1957] 1 WLR 583, 587 where the trial judge said considering the standard of care required of a doctor:

> "I myself would prefer to put it this way, that 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… 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."

76. Counsel on behalf of the Claimant, Jane McNeill QC submits that the second Bolitho question only arises where the factual situation (i.e. what would have happened) involves some potential further negligence. That, she submitted did not arise here as the Trust had not called Dr. Perkins to say what he would have done if had been asked to attend at the relevant time on 30th August 1994. Had he been called and had he given evidence that it would have taken him ten minutes to arrive and ten minutes to deliver Jade for example and had the court accepted his evidence as a matter of fact, the court would then have then been required to go onto consider whether those times were Bolam compliant. That is not what happened in this particular case and the Bolam second question does not arise.

77. I accept Jane McNeill's submissions. It is only necessary to ask whether there is continuing or a secondary act of negligence, i.e. the second Bolitho question, if that has to be proved by the Claimant for the claim to succeed. Thus, in Bolitho the doctor

was negligently late, but even if she had arrived on time she would not have intubated. Thus the question arose as to whether it would have been negligent not to have intubated. If however she would, had she arrived, successfully intubated the patient, the second Bolitho question would not have arisen, as it did not on the facts of Gouldsmith v Mid Staffordshire General Hospital NHS Trust [2007] EWCA Civ 397.

78. Lord Browne-Wilkinson in Bolitho makes it clear that the Bolam test has no relevance to the factual issue of what would have happened, and that alone may be determinative of the issue of causation (240 B-C)

79. Here, the second Bolam question does not in my judgment arise. The failure of the midwife to call for medical assistance soon enough was a continuing act of negligence and the only causation questions which arise are the factual questions in relation to whether the second on call registrar, if he had been called, would, on the balance of probabilities, have arrived in time to deliver Jade before 20:58. The Claimant does not have to prove negligence either in relation to the arrival time or the delivery time, only that the second on call registrar would on the balance of probabilities have arrived in time to deliver Jade by the end of 20:58. Proof of that would entitle the Claimant to damages and no further fault would have to be established.

80. Causation is in essence a factual issue and save where it is necessary to prove further fault, the facts will determine it. See Gouldsmith, and Bright v Barnsley District Hospital [2005] 2 Lloyd's Rep Med 450.

<u>How long, on the balance of probabilities, would it have taken for the second on call registrar to arrive at the deliver room?</u>

81. Mr Davies, who had been an obstetrics registrar in the 1980s and a consultant in 1994 at this hospital, gave evidence that ten to fifteen minutes was the expected arrival time for the gynaecology registrar. He based that time upon his own experience, not upon any protocol or official guidance, neither of which existed.

82. Dr. Thomas pointed out in evidence that Mr. Davies's estimate of ten to fifteen minutes would have covered a 24 hour period including when the second registrar on call would have been asleep, which he would not have been at 20:45. It is also to be noted that the Defendant's pleaded case is that the second on call registrar was some five to ten minutes walk away from the delivery room.

83. Mr Davies said that the distance from the gynaecology wards, at the far end of the hospital buildings to the labour ward was some 250 yards with six flights of stairs. He did say in cross examination that the distance could be covered in five minutes if the registrar was not doing anything at the time but that he may have had to stop examining a patient so that the time was probably ten minutes, and five minutes would have been pushing it. This estimate of ten minutes is inclusive of the time to disengage from any patients. Mr Davies also said that the journey could be covered in five minutes if you had your running shoes on or if every throw of the dice went the right way.

84. When Mr Davies's evidence is taken as a whole, it is clear that the ten to fifteen minute expectation is not writ in stone; his account is more consistent with an overall time of somewhere between five and ten minutes, rather than ten to fifteen. Support

for this is gained from the plan, which the Defendant produced at the end of the evidence. This is an NHS map of the hospital site dated July 1999, showing the situation, I was informed, as it was August 1994. The scale is 1:1250 and if the distance is measured between the labour ward and the gynaecological wards, taking the latter at its furthest point from the labour ward, the distance is 112.5m (i.e. 122.5 yards), not 250 yards as Mr Davies estimated. I have no reason to believe that this plan, put in by the Defendant, is inaccurate or shows anything other than what I was informed during the hearing.

85. There was some expert evidence input upon this issue, although as the Defendant submitted it is essentially a factual one. Professor Bennett said that ten to fifteen minutes conformed with the standard of care in NHS Hospitals at the time and was acceptable, though without knowing distances it is difficult to assess the weight of that evidence. Dr. Thomas said that five to ten minutes was the time within which the second on call registrar should have been able to respond, although he emphasised that he did not know this hospital and could not therefore say whether ten to fifteen minutes was unreasonable. Ms. Gollop submits that Dr. Thomas's estimate of five minutes was illogical as he had allowed that time for the first on call registrar who was very much closer to the labour ward than the second on call registrar.

86. The evidence shows that a second on call registrar could have been in the gynaecology ward with a patient at the time, or in the on call room or in his own room ready to respond to a call. I shall assume that he was with a patient who did not require urgent attention and to whom he would have to apologise for leaving her because of the emergency call. He would then have to descend the stairs and go along the corridor and then ascend the stairs at the other end. The distance he would have to cover would be at most 250 yards or about half that depending on whether Mr Davies's estimate or the scale plan are taken.

87. As he would know of the urgent nature of the summons, and that therefore every minute would count, he would use, at the least, a brisk walk. Senior Midwife Hackett said that once called in such a situation the doctor would come as soon as humanly possible. A brisk walk in such circumstances would be of the order of 4 mph and certainly not less than 3 mph. At that speed, the second on call registrar would have covered the flat part of the journey, if 250 yards, in just over two minutes (two minutes thirteen seconds) at 4 mph and 1.065 minutes to cover 125 yards at 4mph. If the same distances were travelled at 3 mph the time taken is 2.84 minutes for 250 yards and 1.42 minutes for 125 yards. On the basis of this evidence and these figures, it is difficult to see why running shoes would be required to cover the relevant distance. Five minutes would not merely be possible, but excessive if the walk, as I am satisfied would have been, was at a brisk pace.

88. Taking into account all the evidence I have allowed 2.5 minutes for the brisk walk along the flat, which is a generous allowance if the distance to be travelled was only 125 yards. To that figure must be added the time to disengage with any patient he had, and descend and ascend the stairs at each end. There is no clear evidence as to the time it might take to apologise and cease to examine a patient and take leave of her. Mr Davies's evidence is unclear on this issue as the additional five minutes he allowed in concluding that the overall time was "probably ten minutes" did not state how much of the additional five minutes was taken to cover the distance itself, including the stairs, and how much to disengage from the patient. The process would

involve answering the beep, appreciating the urgency, ceasing to examine the patient and explaining to her the need to attend an emergency. I see no reason why a time greater 1.5 minutes would, on the balance of probabilities be taken to carry out that process. It is probable that any patient with whom he was having a consultation or examining, would understand the need for him to leave as soon as possible given that he was dealing with an urgent situation, which in terms of childbirth can lead to death or serious injury to the baby.

89. I have also allowed an additional one minute to ascend and descend the stairs at either end of the journey. The total is therefore one of five minutes (2.5 minutes plus one 1.5 minutes and one minute). I am satisfied on the balance of probabilities that the second on call registrar would have made the journey in that time given his knowledge of the critical urgency of the situation. He would therefore on the balance of probabilities have entered the delivery room at about 20:51 – 20:52 (20:46 + 5 minutes or 20:47 + 5 minutes – see paragraph 60).

How long would the delivery have taken after the doctor's arrival?

90. When the doctor arrived in the delivery room the evidence establishes that he would be faced with a CTG which showed serious and consistent decelerations. As he was looking at the CTG, Midwife Piper would be telling him that the FHR had been staying around 80 – 90 bpm at 20:48 and staying down at 75 – 85 bpm at 20:50. The combination of the CTG and the account given to him by the midwife would make it absolutely clear that the baby would have to be delivered immediately without any delay. Professor Bennett accepted that the situation was critical and that the baby must be got out as soon as possible. His reservation that this was nevertheless not the greatest emergency because it was not an established bradycardia, is contrary to Midwife Piper's notes in the summary sheet and also contrary to the view of the paediatric neurologists who treated it as bradycardia. Whether or not a foetal bradycardia was established the situation required great urgency.

91. I also accept Dr. Thomas's evidence that given the nature of the urgency the second on call registrar would have been carrying out several of the tasks at the same time. Thus he would have been examining the patient at the same time as listening to the account given to him by Midwife Piper. He would be told or would observe whilst carrying out his own examination that the room had already been fully prepared for an assisted delivery that the head had descended, but was not yet delivering.

92. He would, whilst examining the mother, appreciate from what he could observe and was told that the foetal head was in the optimum O/A position and that there were no contrary indications for a forceps delivery.

93. Whilst examining the mother he would administer a pudendal block. I accept Dr. Thomas's evidence that if the timing of contractions necessitated it, a doctor would not necessarily wait for the full two minutes for the block to take effect, and might not administer a pudendal block at all. It would depend on how quickly he read the situation, but the potential death or serious injury to the baby would be a powerful influence upon the doctor faced with it. If the episiotomy had not been carried out by the time of his arrival, the doctor would, if necessary perform the episiotomy himself. The choice of forceps, low or mid cavity, would depend on how far the foetal head had descended.

94. This issue was the subject of considerable evidential debate during the trial. Dr. Thomas considered that the perineum must have been thinned because the head had been slowly descending since 20:30 and was at least 2 cm below the spine, which is low. He considered that once the vertex was visible, as it was, there would have been some thinning of the perineum.

95. The foetal head was recorded by Midwife Piper as 1 – 2 cm below the ischial spine at 20:25 with the vertex visible when the mother started pushing at 20:30. Dr. Thomas thought that the later description of "descending slowly" (20:40) probably indicated another 1 cm further descent which meant that at the time it had to 2 – 3 cm or less to descend before delivery. It was difficult, he said, to cut the perineum if it was not already partially thinned by the descent of the head. The Claimant submits that it is unlikely that Midwife Piper, only four months qualified, would have performed such a difficult episiotomy herself if the perineum was not thinned, when a considerably more senior midwife was already assisting her. The fact that Jade was delivered at 21:00 without forceps suggests that delivery was imminent at 20:52 as Midwife Piper accepted that she had thought at the time.

96. The Defendant submits that the episiotomy was cut early, even though the perineum was not distended, in order to try expedite delivery as Midwife Piper says in Paragraph 38 of her witness statement and repeated in evidence. She disagreed that the cut was inadequate.

97. The reason the head did not deliver after the first of the three episiotomies, was the Defendant submits, not because the first episiotomy was insufficient as had been originally alleged, but because the head was not far down enough to thin the perineum. Both midwife experts, Mrs Tranter for the Claimant and Ms. Sommerville for the Defendant accepted in evidence that the head was not distending the perineum, as did Professor Bennett.

98. There is conflicting evidence about the existence of a tear. The Defendant submits that, as Professor Bennett had said, if the head was stretching the perineum, there would have been a tear with the next contraction. Bur there can't have been a tear, as if there had been, there would not have been any need for an extension of the episiotomy and the second extension. There is however a second agreed perineal tear noted in the labour summary (B/387, 8). Though it is not noted in the delivery note

99. Dr. Thomas gave the possible explanation that the mother wasn't pushing hard enough to explain why the head was not delivering after the episiotomy. The problem with that explanation is that Ms Wadey had only been pushing for 20 minutes by 20:50 and a mother can push for two hours. It is only after one hours pushing that doctors become concerned. Ms. Wadey was healthy and young and there is no reason to believe that she was not following the loud exhortations to push by all around her.

100. I find that on the balance of probabilities that the baby's head was not as low as Dr. Thomas considers and that the perineum was probably not thinned. As noted above delivery nevertheless took place within a further eight minutes from the cutting of the first episiotomy so delivery was clearly close from 20:52 onwards.

101. How long would it therefore have taken on the balance of probabilities for the doctor to have effected and assisted delivery after his arrival?

102. Doctor Thomas said six minutes but he has also given times of 3, 4 or 5 minutes. Professor Bennett produced several articles which varied in their relevance. Eldridge (B/233) was a medical legal paper considering a very small sample of vaginal deliveries in order to determine whether particular delivery times were negligent. Professor Bennett referred to the list of the steps to be taken in a forceps delivery in that paper (B/234, 235) but many of those steps had already been taken in Ms Wadey's case. Delivery time was found to be within eighteen minutes in 50% of babies once the decision to act had been made. The shortest time was six minutes but that was stated not to have been the usual time. Speed of delivery depended on maternal cooperation and whether the head had to be delivered during one or three contractions. As the forceps are used during a contraction, the interval between contractions is relevant. Here, in Ms. Wadey's case, the interval was two minutes.

103. The Oxford Paper (B/236) was not relied upon by Professor Bennett as he accepted in evidence that the time for a ventouse delivery and the forceps delivery was very much the same. It was observed in the Oxford paper that the mean decision to delivery time was 34 minutes with the range being from five minutes to 101 minutes. The Eldbridge paper states that 50% of babies are delivered in eighteen minutes once the decision has been made or sixteen minutes where there was an abnormal CTG. 10% of babies were delivered in less than ten minutes and the data showed that it was possible to deliver a baby with forceps in six minutes.

104. The Murphy paper, which both Professor Bennett and Dr Thomas regarded as the best of those available (B/241), found that the mean decision to delivery time was 14.5 minutes in a labour room. Two babies in that study, out of a total 1021 were delivered in three minutes, of those one died within two days and the other had cerebral palsy. (B/244, 245)

105. Professor Bennett said that the CTG gave no reassurance after it was reattached at 20:47; the situation was critical and the baby had to be got out as soon as possible. I have, as considered above, treated Professor Bennett's evidence as meaning "as soon as possible" in spite of his stated reservation about whether this was the greatest emergency as there was not an established bradycardia.

106. Professor Bennett accepted that there were several midwives in the room, and that everything was ready for an instrumental delivery. He accepted that there was every possibility that the baby could be delivered with one contraction and forceps. He was not sure however that he would have been able to get the baby out in six minutes.

107. Dr. Thomas expressed the view that the mean times set out in the articles produced by Professor Bennett were not particularly helpful when one was considering what would actually happen in the given set of circumstances. He conceded, as he had in the joint statement, that the mean time may be relevant to determining whether there had been Bolam negligence, and accepted that, in that context it would have been reasonable care for a registrar to deliver within fifteen minutes.

108. When asked for clarification of this answer by the Court, Dr. Thomas changed his mind and said that it would have been Bolam negligent to have taken longer than six minutes.

109. I prefer the view that he expressed in the joint statement namely that if Bolam negligence were being considered, failure to deliver within six minutes would not necessarily be negligent when mean times were taken into account. The caveat has to be expressed that each case would depend on its individual facts. Dr. Thomas was however firm in the view that whatever the standard for Bolam negligence might be on delivery times, in practice, when actually faced with the situation which presented itself here, a registrar would on the balance of probabilities, deliver within six minutes even if he could not be blamed for taking longer than that.

110. I accept the evidence of Dr. Thomas that the instrument of choice in 1994 would have been forceps rather than the ventouse, even though the ventouse was becoming more popular and had been recommended by the Audit Committee of the Royal College, though not the College itself. The dispute as to whether forceps or ventouse would have been chosen is however of little material relevance as the evidence established, as Professor Bennett accepted, that the time taken with the two different types of instruments was pretty much the same. I also accept Dr. Thomas's evidence that if the lithotomy poles had not been put in place by the time of the doctor's arrival (which they might well have been as the room had been prepared for instrumental delivery) it would have only taken a few seconds to achieve that.

111. I also accept Dr. Thomas's evidence that there would be little or no material difference in the use of low cavity or mid cavity forceps. Whether the baby was delivered on the first or second contraction would depend, Dr. Thomas said on where the head was. But the delivery would be within one or two contractions. Professor Bennett accepted in cross examination that there was every possibility that the baby would be delivered within one contraction, but whether it was one or two Dr Thomas was satisfied that delivery would take place, on the balance of probabilities, in six minutes or even five minutes he said in evidence.

112. Professor Bennett was less confident that he could have achieved such a timing. In the joint statement, Dr Thomas and Professor Bennett had agreed that there were various factors which would influence the speed of delivery. These included the interpretation of the foetal heart rate, the station and position of the foetal head, the speed and effectiveness of pudendal block, the contraction frequency, and whether necessary packs and instruments were immediately available, as well as the skill and experience of the registrar. (B/261)

113. I accept that it is possible that a delivery time of six minutes could have been achieved from the arrival of the second on call registrar in the delivery room. The information in the articles produced by Professor Bennett make it clear however that this is very much the exception rather than the rule.

114. Dr. Thomas is undoubtedly right in stating that delivery time will depend upon the facts of the individual case, and that where, like here, the room had already been fully prepared for an instrumental delivery, delivery time was likely to be shorter. But there are also facts known here, which might well have militated against a fast delivery. Firstly, the position of the head. I have found it had not descended as Dr. Thomas considered, and that the perineum was not thinned. The extent to which the head had descended and the speed of its descent would influence the delivery time. In particular it would influence whether delivery was likely at the first or second contraction, making the second contraction more likely. It is probable, given the other activities

and preparation which would have had to have taken place first, that this contraction would have been no earlier than the one at 20:58, assuming one had occurred at that time. If not, it would have been the following contraction at 21:00.

115. Secondly, if a pudendal block had been given and allowed the normal two minutes for it to take effect, it is likely that Jade would not have been delivered before the end of 20:58. It is also to be noted that the problems with the descent to the head required two extensions to the episiotomy underlining the extent of the problem.

116. Thirdly, it is not known how quickly the second on call registrar would have read the situation, and how quickly the decisions would have been made. Any slightly longer time along the decision route could have taken the time beyond 6 minutes. I am satisfied that such a short time is the exception, not the rule.

117. Even if it was to be assumed that Dr. Perkins was of high skill and experience, I cannot regard it as being more than possible, given the tasks that would have had to be done before the baby could be delivered by forceps, that she would have been born before the end of 20:58. It is certainly possible, but cannot in my judgment be described in all the circumstances as probable. It is equally likely that the process would have taken an extra minute or more and hence Jade would have been delivered at the time she was actually born namely 21:00. Six minutes is possible but so is a slightly longer time of seven minutes or even more. I am not able to find that on the balance of probabilities that the delivery time would have been six minutes or less.

Conclusion

118. Whilst I am satisfied that there was a breach of duty by the Defendant, I am not able to find that causation is established. I have found that the second on call registrar was available to be called, that he was not called, but that even if he had been, I am not satisfied that the delivery time would on the balance of probabilities, have been any different to that which in fact it was i.e. 21:00. That time would have been too late for Jade to have avoided injury. This is a sad and unusual case, in which labour had been entirely normal until 20:40 when, without any prior warning, the foetal heart rate altered and a pattern of deceleration developed leading to foetal distress and birth asphyxia. The whole process from the first altered heart rate to birth was some twenty minutes. Even if medical assistance had been called as soon as it ought to have been, the evidence does not demonstrate that on the balance of probabilities a different result would have been achieved.

119. I must accordingly dismiss the claim.