Hilary Term
[2026] UKPC 1
Privy Council Appeal No 0036 of 2025

JUDGMENT

Christopher Isaac Singh (A minor, suing by his mother and next friend, Nicole Singh Nee Mohammed) (Respondent) *v* Dr Prakashbhan Persad (Appellant) (Trinidad and Tobago)

From the Court of Appeal of Trinidad and Tobago

Before

Lord Lloyd-Jones
Lord Briggs
Lord Leggatt
Lady Rose
Lord Richards

JUDGMENT GIVEN ON
19 January 2026

Heard on 28 October 2025

Appellant
Ranald Davidson
Terrance B Neale
(Instructed by Torveny Law Chambers)

Respondent
Michael J Powers KC
Ravi Heffes-Doon
(Instructed by Neela Ramsundar)

Intervener
Ian L Benjamin SC
Vanessa Gopaul
(Instructed by Elena Araujo)

LADY ROSE:

1. Introduction

1. The claimant, Christopher Singh ("Christopher") sues by his mother and next friend, Mrs Singh, claiming damages for the brain injuries he suffered at his birth by emergency caesarean section at the St Augustine Private Hospital ("the Hospital"). He was born at the Hospital at 11:13 am on 9 September 2012. The Hospital was the first defendant to the claim. The trial judge, Lambert Peterson J, held that the Hospital had been negligent because failures in its systems for providing the necessary staff caused delays in carrying out the C-section at a time when the fetus was being deprived of oxygen. Those delays were the cause of Christopher's injuries. The Hospital appealed against that finding but their appeal was dismissed by the Court of Appeal. There is no appeal to the Board from that finding of liability against the Hospital.

2. The second defendant to Christopher's claim was Dr Prakashbhan Persad. He was the consultant obstetrician and gynaecologist engaged privately by Mrs Singh to care for her during her pregnancy and at the birth of her baby. Dr Persad was not employed by the Hospital. As a private consultant he had admitting privileges allowing him access to the Hospital and making available to him the staff he needed. This is not a case, therefore, where the Hospital is vicariously liable for any failures of Dr Persad as the attending consultant. The conduct of the Hospital and Dr Persad and the extent of any failings by them must be assessed separately.

3. The trial judge dismissed Christopher's claim against Dr Persad holding that his conduct had not fallen below a reasonable standard of care. The Court of Appeal allowed Christopher's appeal against that conclusion. They held that the judge had erred in the conclusions she had drawn from the evidence before her and that her dismissal of the claim was inconsistent with factual findings that she had made. In particular, they held that the trial judge had been wrong to absolve Dr Persad of responsibility for the fact that there was no monitoring of the fetal heart rate ("FHR") during the period – about 50 minutes – when Mrs Singh was in the operating theatre waiting for the C-section to be performed. The evidence established that over this period the fetus was being deprived of oxygen. The FHR would have shown abnormalities indicating that the fetus was distressed. Because Dr Persad did not know that the fetus was distressed, he did not act with the degree of urgency in delivering the baby which would have been appropriate and with which he and the team could and would have acted if they had known that fact.

4. Dr Persad now appeals to the Board against the Court of Appeal's decision to overturn the dismissal of the claim against him.

2. The facts

5. Mrs Singh first consulted Dr Persad early on in her pregnancy and had several antenatal consultations with him. Her pregnancy was uneventful and there was no indication that her labour would be problematic. She and Dr Persad agreed that the birth would take place at the Hospital. The key findings of Lambert Peterson J as regards the chronology of events on the morning of 9 September 2012 were set out in her judgment and confirmed at para 12 of the Court of Appeal's judgment.

6. Mrs Singh and her husband arrived at the Hospital at about 05:00 on the morning of 9 September 2012. At this point a cardiotocography ("CTG") machine was attached to her abdomen. The CTG machine measures the FHR and also the uterine contractions. It both produces a paper trace and shows the FHR on a video monitor in real time, emitting an audible pulse. The nurses and midwives are required to monitor the FHR as shown by the machine and to make a note of it on their progress record for the patient.

7. Mrs Singh was on the maternity ward from her arrival at 05:00 until 10:20 at which point she was transferred to the operating theatre. The Court of Appeal noted that the two midwives who were taking care of Mrs Singh over that time were meticulous in recording the FHR. The Court described the first midwife's evidence as follows:

> "37. … As a licensed midwife with experience, she understood:
>
> (a) The typical range for FHR during labour lies between 110 and 160 beats per minute ('bpm').
>
> (b) FHR fluctuations during contractions or pain are common, typically recovering afterward.
>
> (c) Any FHR deceleration prompts immediate consultation with the attending doctor for guidance."

8. The Court noted that throughout her shift, the midwife diligently monitored the FHR to ensure it remained within the normal range, documenting her observations in the Nurse's Progress Record; see similarly as regards the second midwife who came on shift at 07:00 at paras 42 and 43 of the Court of Appeal's judgment.

9. One point that was the subject of much discussion in the evidence and at the trial was that most of the paper trace recording the FHR that must have been produced by the CTG machine over this five hour period was not available. It had been lost by the Hospital. Only one printed sheet, taken at about 05:17 on that morning, could be found by the time Mrs Singh first requested disclosure of her medical records some months after Christopher was born. That portion of paper trace showed the readings covering a period of about 13 minutes. However, it was clear that despite the absence of the paper trace, the judge found and the Court of Appeal agreed that the FHR was regularly monitored whilst Mrs Singh was on the maternity ward: see paras 89-90 of the first instance judgment and para 97 of the Court of Appeal's judgment.

10. Dr Persad arrived at the Hospital to examine Mrs Singh at about 05:30. He discovered that the fetus was in the left occipito-lateral position and so had not descended despite cervical dilation of about 6 – 7 cm. He told Mrs Singh that a C-section might be necessary if the fetus' head did not descend.

11. During the time Mrs Singh was on the maternity ward there were two attempts to resolve the difficulty created by the baby's position. First an infusion of Syntocinon, a synthetic form of oxytocin, was commenced at about 08:00 in the hope that increasing the contractions would encourage the baby to descend to the birth canal. The infusion caused the baby's FHR to decelerate to a low rate of between 86 and 90 bpm and the oxytocin was discontinued. Dr Persad was informed. The FHR recovered to 130-140 bpm and the oxytocin was recommenced. Several further normal readings were recorded by the nurses at 08:30 and after.

12. At about 09:00, Dr Persad attempted to manipulate the baby using forceps but this was quickly abandoned. He therefore told Mrs Singh that an emergency C-section was required to deliver the baby. He also notified the operating theatre to contact the anaesthetist and paediatrician.

13. Mrs Singh was transferred to the operating theatre at 10:20. The anaesthetist, Dr Gangadhararao Narra decided to administer a spinal anaesthetic but initially had some difficulty in inserting the needle. The spinal anaesthetic was successfully administered at about 10:50 and the C-section commenced with the birth recorded at 11:13. At the time of delivery, there was thick fresh meconium in the liquor. Meconium is the tarry black contents of a baby's bowel before the stool changes colour after birth. It is an indication that the fetus must have been significantly distressed during labour. Christopher was recorded as being born flat with no respiratory effort. His Apgar score was low; 3 after one minute and 6 after five minutes. He was transferred to Mount Hope Women's Hospital the following day.

14. According to medical assessments provided by various professionals and institutions, Christopher suffered severe and permanent brain damage affecting both cerebral hemispheres due to birth asphyxia. He was diagnosed with cerebral palsy - spastic quadriplegia. Christopher is unable to perform basic tasks independently, such as walking, talking, sitting or standing. The brain injuries suffered by Christopher were caused by prolonged hypoxia during a period of about 60 minutes before he was resuscitated shortly after his birth.

3. The claim and the proceeding below

15. Christopher issued his claim in September 2016. The trial of the action considered liability only. At the outset of the proceedings, Dr Narra the anaesthetist was also a defendant but the claim was discontinued as against him before trial.

16. It was at all times common ground between the parties that the standard of care expected of Dr Persad and the Hospital is that described in of *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582, 586-587, 121-122. The trial judge noted at para 63 that the *Bolam* test has been applied and approved innumerable times by courts throughout the world including in Trinidad and Tobago. She also said at para 66 that the prevailing standard of care to be observed by ordinarily skilled medical personnel engaged in Obstetric and Midwifery Services in Trinidad and Tobago at the time of the claimant's birth was outlined in the Standard Operating Procedures Manual for Obstetric and Midwifery Services, June 2011 ("SOPM") published by the Ministry of Health, Government of Trinidad and Tobago.

17. There were a number of expert witnesses who lodged reports prior to the trial and who gave evidence at the trial:

(i) Dr Gerald Mason a consultant in feto-maternal medicine gave evidence on behalf of Christopher about Mrs Singh's labour and where, in his opinion, the care provided by the hospital and Dr Persad fell below acceptable standards. The judge was critical of Dr Mason's evidence as largely advocating the claimant's position rather than adhering to the expert's duty of impartiality: para 201. She also noted that he seemed unaware of the importance of the SOPM. Where his evidence contradicted that of other experts she did not rely on his opinion or his interpretation of the material before the court: para 209.

(ii) Dr Wellesley St Clair Forbes and Dr Anna Jansen gave evidence for Christopher based on MRI head scans performed when he was three years old as to the extent and likely cause of his brain injuries.

(iii) Dr Alan Weindling was a retired consultant neonatologist who also gave evidence on behalf of Christopher. The judge largely rejected his evidence because it was based on inaccurate information, namely that first he wrongly assumed that the Hospital's inability to produce a CTG trace meant that there had been no monitoring of the FHR during labour and secondly he wrongly suggested that Christopher's head had been impacted in Mrs Singh's pelvis and had to be dislodged.

18. The expert evidence provided for the Hospital was from Dr Hemant Persad a consultant obstetrician and gynaecologist. His evidence was directed at the division of responsibility between the consultant and the hospital in the private health care sector. He also addressed in detail a series of questions posed to him in his instructions about events occurring at each stage of the labour. Expert evidence on behalf of Dr Persad was given by Dr Spencer Perkins, also a consultant obstetrician and gynaecologist. He also addressed in detail what had happened during the different stages of labour.

19. The judge's primary findings of negligence against the Hospital arose from two periods of delay. The first was the 30 minute delay in contacting the anaesthetist between the time when Dr Persad told the Hospital he needed to perform a C-section and the time when the Hospital first got in touch with Dr Narra and asked him to attend: see para 105 of the judgment.

20. The second delay was caused by the absence of a theatre assistant to help Dr Narra when Mrs Singh was transferred to the operating theatre at 10:20. At para 117 the judge held that it was reasonable for Dr Narra to await the arrival of the theatre assistant in the absence of being informed of any adverse change in the state of health of the fetus or Mrs Singh. She held that had the Hospital operated an efficient and effective emergency calling system, Christopher would not have remained in utero for over two hours from the time when a decision was made to perform delivery by C-section and the time of delivery.

21. The judge's findings as regards the alleged failure to monitor the FHR can be summarised as follows. First, the monitoring required was as mandated by the SOPM so there was no duty to provide continuous CTG monitoring. There had been adequate monitoring by way of continuous CTG trace from 08:00 because the midwives had monitored and interpreted the FHR and analysed the CTG and had regularly communicated their actions and findings to Dr Persad. But Christopher was not adequately monitored in utero from the time Mrs Singh was taken to the operating theatre until Christopher's delivery. The judge held at paras 82 and 83 that the SOPM clearly provides that the responsibility for the monitoring of the FHR throughout labour is that of the midwives. The midwives who gave evidence accepted that as did Dr Mason. She summarised her conclusions as to the liability of the Hospital saying:

> "88. There is no evidence that the fetus was continuously monitored whilst in the Operating Theatre. [Mrs Singh] was at that time engaged in the second stage of labour. The SOPM at Appendix II dealing with the Partogram requires that, once the fetus was not being continuously monitored, the FHR was required to be recorded every 5 minutes. The SOPM does not preclude the Operating Theatre, as a location where the monitoring of the FHR (in the absence of continuous monitoring during for [sic] the second stage of labour) was to take place. I am of the view that the monitoring of the FHR whilst [Mrs Singh] was in the Operating Theatre, was not in keeping with the standard prescribed at page 53 of the SOPM."

22. Further, she rejected Dr H Persad's evidence that monitoring the FHR after Mrs Singh's transfer to the operating theatre was "irrelevant". She held at para 121:

> "The First Defendant had a duty of care to monitor the fetus continuously or intermittently from [Mrs Singh's] transfer to the Operating Theatre until delivery of the Claimant. With due deference to the expert opinion of Dr H Persad, I did not consider the monitoring of the fetus in the operating room to be irrelevant. The information derived from monitoring was necessary to determine whether there was any change in the health of the Claimant or [Mrs Singh]. Dr Narra testified that any adverse change in diagnosis of the health of either would have informed the decisions he took with respect to waiting for the Theatre Attendant and the type of anaesthesia used. The First Defendant breached the duty of care to monitor the fetus whilst NS was in the Operating Theatre."

23. She confirmed that conclusion at para 177 where she said she had made a finding that the Hospital had breached its duty of care to Christopher in failing to record the FHR in accordance with the SOPM in the absence of a CTG trace.

24. The trial judge considered the claim against Dr Persad. At para 43 of her judgment, she listed 10 allegations of negligence against Dr Persad including failure to "Recognise sufficiently or at all the indications of fetal distress;", failure to "Recognise that there was a significant risk of fetal distress developing as labour became established;" failure to "Recognise or record variability in the baseline FHR" and failure to "Adequately and carefully monitor and analyse FHR". She turned to her consideration of each of the allegations at para 125. In fairness to the judge, it appears to have been only at the appellate stages of this case that the absence of monitoring the

FHR during the 50 minutes before Christopher's birth became the most significant allegation of negligence against Dr Persad as well as against the Hospital. Her discussion of the allegations about the failure to monitor the FHR between paras 130 and 146 focused almost entirely on two matters; that is whether the CTG machine had actually been monitoring the FHR when it was attached to Mrs Singh despite the absence now of the paper trace, and then what could be gleaned from the short portion of paper trace available. Thus her response to the allegation that Dr Persad breached his duty of care by failing to adequately and carefully monitor and analyse the FHR did not address at all the failure to monitor the FHR when Mrs Singh was in the operating theatre other than to say at para 143, "I am satisfied that the duty of care to monitor, record and perform a preliminary analysis of the FHR lies on the midwife".

25. She then discussed Dr Narra's role and his evidence to the court. She noted that he had said as regards his choice of anaesthetic that "he had the luxury of making decisions in the interest of the patient, because the fetus was not in distress": para 157. Further, in the absence of fetal distress there was no failure by Dr Persad when he did not escalate the urgency of the surgery (para 164). She appears from that comment and from what she said at para 186 to have regarded the Hospital as entirely responsible for the failure to monitor FHR in the operating theatre and therefore entirely responsible for the fact that Dr Persad and Dr Narra were not aware that the fetus was distressed, and that the C-section needed to be carried out very urgently.

26. She also rejected allegations that Dr Persad had been negligent in being absent from the operating theatre during the administration of the anaesthetic (para 175) or in failing to obtain cord blood gases at delivery (para 176).

27. The Court of Appeal handed down judgment on 26 July 2024 (Bereaux, Wilson and Boodoosingh JJ). They dismissed the appeal by the Hospital holding that the trial judge had been entitled to hold that the Hospital was negligent because of the two periods of delay described above.

28. The Court of Appeal noted that the trial judge had been entitled to reject Dr H Persad's evidence that it was impossible to monitor the FHR in the operating theatre. The Court said:

> "100. Without Dr Persad having the information on the FHR, he could not know that the fetus was in distress (whether he ought to have assumed so is a different matter). The timeline and the presence of meconium suggests that the fetus had to be in distress during the time they were in the operating theatre. The judge's conclusions against the Hospital on the lack of monitoring of the FHR in the operating theatre was a

> conclusion she was entitled to make on the evidence. There was nothing unreasonable about the judge's findings against the Hospital in that regard. There was evidence that FHR monitoring is possible in the operating theatre if not by the CTG machine. It can be done manually."

29. In support of this last conclusion, they quoted from the evidence of Dr Spencer Perkins (on behalf of Dr Persad): (para 101)

> "Q…if the Claimant is significantly distressed during labour -- you've told us what happens -- it's likely that monitoring by whatever means: via enhanced stethoscope, or ultrasound, or CTG; if it's significantly distressed over a period of time, that monitoring will pick that up?
>
> A: It should, yes."

30. As regards their findings in relation to Dr Persad they summarised their conclusions, including:

> "110. Fourth, he knew or ought to have known that no monitoring of the FHR was being undertaken in the operating theatre which at that second stage of labour ought to have been continuous and recorded every 5 minutes. If there was a delay, he ought to have insisted that the FHR be monitored by other means such as by stethoscope. This would likely have shown fetal distress having regard to the later finding of meconium and that hypoxia had occurred, and that this would likely have occurred in an hour or so before. …
>
> 112. Sixth, where no monitoring of the FHR was being done in the operating theatre, this required urgency, since the prudent thing to do would have been to act as if there had been fetal distress at that stage. Since there was no monitoring, the assumption should have been that there was fetal distress which required urgency. All of the experts agreed that even where there was no distress, once an emergency C-section was contemplated, dispatch was required. This was particularly so in light of the change in Mrs Singh's labour status, which was well into second stage."

31. The main point on which they disagreed with the trial judge was in rejecting her conclusion that because the actual monitoring of the FHR would have been carried out by the midwives, that meant that Dr Persad could not be blamed for the fact that no monitoring was carried out in the operating theatre. The Court of Appeal held that Dr Persad's role "was overarching and supervisory of the entire process" (para 117).

32. Dr Persad appeals to the Board. The Hospital, whilst not appealing against the Court of Appeal's decision, was granted permission to intervene by the Board on 7 September 2025.

4. Dr Persad's grounds of appeal

33. Mr Davidson appearing on behalf of Dr Persad argued in his clear and well-presented submissions before the Board that three principal issues arose from the Court of Appeal's decision. The first issue is whether it was Dr Persad's responsibility to ensure that the FHR was being monitored whilst Mrs Singh was in the operating theatre or whether it was solely the responsibility of the midwives attending to ensure monitoring was taking place so that they could alert Dr Persad to any abnormalities indicating fetal distress. The second issue was whether this allegation of negligence had been adequately pleaded by Christopher against Dr Persad and whether it had been fairly put to Dr Persad in cross-examination, allowing him an opportunity to respond to it. The third issue was whether the delay in carrying out the C-section was unacceptable even without any evidence of fetal distress either because Dr Persad and his colleagues should have assumed that the baby was in distress and acted accordingly or because in any event, a two hour period between the decision taken at 09:00 to perform a C-section and the delivery at 11:13 was too long.

34. The Board can therefore group Dr Persad's 10 grounds of appeal as follows:

(i) Ground 1 is an overarching ground that asserts that the Court of Appeal went beyond the appropriate bounds that should constrain an appellate court when reviewing findings of fact by the trial judge.

(ii) Grounds 3, 5, 7, 8 and 9 are the main grounds addressing the absence of monitoring of the FHR in the operating theatre, the consequences of the failure to monitor and Dr Persad's responsibility for the overall conduct of the procedure.

(iii) Grounds 6 and 10 address whether there was unacceptable delay between the decision to carry out the C-section and Christopher's birth even if there had been no fetal distress.

(iv) Grounds 2 and 4 concern other failings for which the Court of Appeal held Dr Persad responsible.

(a) Ground 1: unwarranted interference with factual findings

35. Dr Persad accepts that the Court of Appeal cited the relevant and well-known case law on the role of the appellate court in reviewing findings of fact made following a trial, namely *Beacon Insurance Co Ltd v Maharaj Bookstore Ltd* [2014] UKPC 21; [2014] 4 All ER 418 and *Bahamasair Holdings Ltd v Messier Dowty Inc* [2018] UKPC 25; [2019] 1 All ER 285. But he submits that the Court of Appeal failed to apply these principles correctly and substituted their own findings of fact for those of the trial judge.

36. The Board rejects this criticism. The Court of Appeal explained its approach at the outset of its consideration of Dr Persad's role, stating that it was not the findings of fact that were primarily challenged but rather the inferences that the judge drew from them: para 106. Having described what happened on that morning, Boodoosingh JA said at para 119 that the judge had "reduced Dr Persad's role to one closer to an observer of events until such time as the delivery was imminent". In doing so, she had erred in drawing the wrong conclusions from the evidence about Dr Persad's role and responsibility. That justified the Court of Appeal in this case departing from the usual judicial restraint in interfering with the trial judge's conclusions based on the evidence as she found them. Her conclusions were not reasonable having regard to the whole of the evidence and the duty placed by law in these circumstances.

37. The Board agrees with that analysis of how the Court of Appeal approached its task and finds that the Court was justified in interfering with the trial judge's conclusions. This did not involve disturbing any findings of fact made by her.

(b) Grounds 3, 5, 7, 8 and 9: failure to monitor FHR in the operating theatre and its consequences

(i) Dr Persad's failure to be aware of fetal distress

38. Dr Persad argues that the Court of Appeal misunderstood the division of responsibility between him and the Hospital. The Court of Appeal, he submits, wrongly relied on his supposed role as team leader in allocating to him responsibility for the failure to monitor Christopher's FHR whilst Mrs Singh was in the operating theatre. He argues that the Hospital was in charge of providing services and it was accepted by the experts that it was the midwives' task to monitor the FHR. He was not vicariously liable for their failings and he was not in a position to override the assignment of that role to

them. If he had purported to take charge, he would certainly have been liable for interfering if things had gone wrong.

39. In the Board's judgment the Court of Appeal was right to hold that Dr Persad was negligent in failing to ensure that he kept himself and his team aware of the FHR which would have indicated the distressed condition of the fetus during the crucial period of the second stage of labour in the operating theatre. Although no doubt it is the midwives who would actually have carried out the FHR monitoring in the operating theatre, it was Dr Persad's responsibility to ensure that he had the information he needed to be able to assess the condition of the fetus. He should have been aware throughout of whether or not the fetus was in distress so that he could act accordingly. It is not a matter of holding him responsible for the failings of the midwives or of the Hospital. If Dr Persad had asked the midwives in the operating theatre to start measuring Christopher's heart rate whilst everyone was waiting for the theatre assistant to arrive or whilst Dr Narra was attempting to insert the spinal anaesthetic needle, they could and would have done so. That would have made apparent the distress Christopher was experiencing in utero, the C-section could have been carried out immediately and Christopher would not have suffered such catastrophic injuries.

40. The Court of Appeal were right to say at para 114 that once a surgical process was contemplated, only the surgeon could be in charge of managing the process from that point. As the Court of Appeal said at para 117:

> "Dr Persad's role, when considering his evidence and that of the midwife nurses and experts, was overarching and supervisory of the entire process. He was the team leader. A midwife cannot have responsibility in a surgical procedure. His decisions included the timing of delivery; whether it was by C-section; the degree of urgency; the need for medications; when Mrs Singh went into the operating theatre; the need for other medical interventions; and what additional resources were needed. He had to keep himself informed of the FHR readings as time passed to ensure he could make informed decisions. If adequate FHR monitoring was not being done, Dr Persad was responsible for ensuring it was done so he could be provided with the necessary and relevant information. …"

41. This fundamental point was obscured by the focus at the trial and in the judgment on the output, or lack of it, of the CTG machine which had monitored the FHR whilst Mrs Singh was on the maternity ward. A further point that may have distracted attention from what should have been the main issue was the debate over the difference in the role of the consultant obstetrician in a private hospital compared with a consultant

obstetrician in a public hospital. There may certainly be differences between the position in the public and private health sector as regards the vicarious liability of the hospital for the failures of the consultants it employs. But there has been no suggestion that it is any less important in a private hospital than in a public hospital for the obstetrician to ensure that he or she has the information needed to make the correct decisions as to how to proceed when it becomes clear that a natural birth is not possible.

42. The Board is firmly of the view that the Court of Appeal was right to hold that Dr Persad was negligent in failing to ensure that he and Dr Narra were aware of the baby's condition during the 50 minutes when Mrs Singh was in the operating theatre.

(ii) The case put to Dr Persad

43. The Board then turns to the question of whether this failure was adequately alleged against Dr Persad and whether he had sufficient opportunity to counter it at trial. The Board is satisfied that there has been no unfairness here.

44. Looking first at the issues identified in the parties' pleaded cases, Christopher's pleaded case was set out in the Amended Statement of Claim dated 5 May 2017. The particulars of negligence pleaded against Dr Persad included:

> "(c) The First and/or Second Defendants failing to adequately and/or continuously monitor the Claimant in utero by way of a continuous contemporaneous written record of a cardiotocography (CTG) trace. Alternatively, for the duration such a trace or written record thereof might have been performed or produced, failure to act on or properly interpret the suspicions/pathological nature of that trace as indicative of fetal distress;
>
> (d) Not recognising sufficiently or at all the indications of fetal distress;
>
> (e) Not recognising that there was a significant risk of fetal distress developing as labour became established;
>
> (f) Not recognising or recording variability in the baseline FHR;

> (g) The failure of the First Named Defendant to produce an adequate or full written or any contemporaneous record of the FHR which was sufficient to allow adequate monitoring and analysis of the Claimant's FHR.
>
> (h) The failure of the First Named Defendant and/or the Second Named Defendant to adequately and carefully monitor and analyse FHR;
>
> …
>
> (q) Failure to carry out CTG tracing on the Claimant after the mother was transferred into the theatre for the emergency caesarean section;"

45. In his Amended Defence at para 10, Dr Persad referred primarily to the monitoring of the FHR between Mrs Singh's admittance to the Hospital at 05:00 and her transfer to the operating theatre at 10:20. He pleads as to the proper interpretation of the small section of paper trace from the CTG machine that had been disclosed by the Hospital in the proceedings.

46. As regards the absence of monitoring when Mrs Singh was in the operating theatre his response was twofold: first that it was "practically impossible" to have CTG equipment on her stomach monitoring the FHR whilst she was in theatre and second the period of time during which there had been no monitoring could not have been more than 20 minutes. Given that the expert evidence was that about 60 minutes of chronic partial asphyxia would have been needed to cause Christopher's injuries and given also that the CTG reading prior to her transfer to theatre was normal, he rejected the allegation of negligence.

47. At one point in his Amended Defence he appears to reject the allegation that there was any period at all during which the FHR was not monitored:

> "o. **Failure to Adequately and Carefully Monitor and Analyse FHR.** The Second Defendant contends that throughout the labor period of the mother he continuously reviewed the FHR during delivery and did not observe any indication of fetal distress or other abnormality of the FHR. The Second Defendant accordingly rejects this allegation of negligence."

48. However, later in the Amended Defence he appears to accept that there was no monitoring but asserts that this was impossible because the CTG machine could not be used in theatre. He pleads:

> "x. **Failure to Carry Out CTG Tracing after Transfer to Theatre[.]** The Second Defendant accepts that the hospital notes do not reflect that any CTG tracing was carried out after the CTG equipment was removed from the mother's stomach prior to taking her into the operating theatre. The CTG equipment was not replaced as the physical positioning of the Claimant's mother in the operating theatre while awaiting surgery made it impractical to do so and this would certainly not have accorded with standard medical practice where the midwife would usually be the person responsible for carrying out intermittent auscultation of the fetal heart and reporting to the surgery team if there were any issues. The First Defendant employees were qualified and experienced nursing staff and would have been the persons responsible for the monitoring of the fetal heart rate during the period that the Claimant's mother was transferred to the theatre awaiting surgery. The anaesthetist notes reflect that he was able to record his first blood pressure in theatre at 10.45 am so there would in effect have been a relatively short period of 23 minutes between the last recording of the blood pressure and delivery at 11.08am when there was no fetal monitoring. The Second Defendant therefore rejects this allegation of negligence."

49. Dr Persad was clearly aware therefore that the allegations pleaded by Christopher against him were that there had been inadequate FHR during at least part of the period of Mrs Singh's labour and this had resulted in those involved in her care being unaware that the fetus was in distress.

50. Turning then to the evidence presented to the court, Dr H Persad in his evidence on behalf of the Hospital said in his expert report:

> "… It is the Obstetrician who advises the midwife and by extension, the Private Hospital, what type of monitoring is required, when the midwife should inform or apprise and for what problems. …
>
> "21.1(b) … 6) In second stage labour with actual pushing, fetal heart rate auscultation should be every 5 mins. Both the

> midwife and Obstetrician are competent to look at the readings and decide if it is normal or abnormal, and if abnormal, to do a graphic tracing to document this."

51. Dr Persad's written witness statement reflected what had been his pleaded case. He noted that when he reviewed Mrs Singh in the maternity ward at 07:45 she was connected to the CTG machine and the FHR was normal. He says at para 34:

> "I can confirm that all times while waiting the transfer of the patient to the theatre continuous fetal heart rate monitoring was employed and the fetal heart rate pattern remained normal. I can also confirm that the fetal heart was monitored from the time the patient was admitted to the Hospital until 10.20am when the cardiotocography machine was removed to transfer the patient to the operating theatre for surgery and that there was never any concern for the fetal well being. This contention is also supported by the Hospital notes. I was surprised and disappointed to later discover that the paper record of the CTG trace had been misplaced by the Hospital Records Department."

52. He says nothing further in his witness statement about FHR monitoring after Mrs Singh arrived at the operating theatre except in his comments on the medical report of Dr Weindling. Dr Weindling's opinion was that Christopher's injuries are probably due to hypoxia "lasting more than an hour". Dr Persad's response was that "There is no evidence of an abnormal fetal heart rate for more than an hour during the period of observation. The only time the heart rate was not documented was between transfer to theatre and delivery - approximately 30 minutes".

53. The allegations of inadequate FHR monitoring were put to Dr Persad twice during cross-examination. The first occasion was during his cross-examination by Dr Powers KC acting on behalf of the claimant. Dr Persad was asked by Dr Powers about whether he could have given instructions to the midwives to monitor the condition of the fetus. He was asked about whether there were any protocols at the Hospital telling the midwives what sort of monitoring should be done. Referring back to the evidence of Dr Udit (the Medical Director at the Hospital) the following exchange took place:

> "Q. You mentioned something about verbal protocols, but you may remember that when [Dr Udit] was pushed on that, he said, 'Well, there weren't any verbal protocols from the hospital, but the obstetricians could give their verbal instructions to the midwives.' Do you remember that?

A. Correct.

Q. So the position, then, is this: that the midwives get on and do their own thing as professionals doing the monitoring, unless you, as the obstetrician, tell them to stop, speed up, change the type of monitoring or anything else. Is that fair?

A. That's fair.

Q. But in the end, although they have a duty to monitor, you've got the responsibility, as the obstetrician, to make sure that they monitor the patient in the way in which you want the patient to be monitored. Is that fair?

A. Correct. That's correct."

54. The second occasion was on the following day when Dr Powers returned briefly to the topic of monitoring at the close of the cross-examination and the following exchange took place:

"Q. … I can take the points fairly quickly, Dr Persad. My first is to suggest to you that you had the overall responsibility to ensure that the monitoring of the fetus during this labour was carried out proper. Do you accept that that was your overall responsibility?

A. No. That's – that's the responsibility of the midwives.

Q. Very well. And do you accept that in the absence of a written or oral protocol for the midwives, which Dr Udit has said is the case, that it was your responsibility to direct the midwives to do what you wanted them to do?

A. And that is correct. And they were doing what I wanted them to do.

Q. And that included making sure that they monitor the patient as you wanted the patient to be monitored.

A. Correct.

Q. Now, whether they did that or not, obviously depends on whether the monitoring -- level of monitoring was adequately undertaken. Obviously, that necessarily follows. Whether it fulfils your requirement, depends upon whether the monitoring was properly undertaken, doesn't it?

A. Correct. Correct.

Q. And because you are out of the room up until the time, it depends upon the interpretation of the midwives of such monitoring, as they do, as to whether you need to be called to see the patient, doesn't it?

A. Correct.

Q. Any failure in those areas -- any failure of monitoring -- would have its obvious consequences in that you wouldn't know what was happening to the fetus, would you?

A. Correct.

Q. ... But if fetal distress were present during the intrapartum period for 60 minutes or more, there would have been a failure of proper monitoring if that weren't picked up, wouldn't there?

A. Correct."

55. In the light of those exchanges, against the background of the pleaded case and Dr Persad's written evidence, the Board is satisfied that it was clear that Dr Persad was aware that an important issue in the case was whether Dr Persad as well as the Hospital was responsible for ensuring he and the team had sufficient information through the labour about the FHR so that he would be immediately alerted to fetal distress. Dr Persad had ample opportunity to address that issue.

56. At each stage Dr Persad sought to refute this allegation by asserting that there had only been a brief period during which the FHR was not monitored, by criticising the

Hospital for failing to retain the CTG trace, by asserting that it was not possible to bring the CTG machine into the operating theatre and by asserting that monitoring the FHR was at all times solely the task of the midwives. Each of those defences was rightly rejected by the Court of Appeal. The evidence established there was no FHR monitoring throughout the 50 minutes when Mrs Singh was in the operating theatre; the absence of a full CTG trace was largely irrelevant given that the final reading noted by the nursing staff at 10:20 was normal; it was possible and necessary to monitor FHR in the operating theatre using a stethoscope, and it was Dr Persad's task to ensure that he kept himself properly informed about the state of the fetus throughout the second stage of labour.

57. In light of that evidence, together with the SOPM guidance that FHR should be monitored every five minutes throughout labour, the only rational conclusion was that Dr Persad's conduct had, on this occasion, fallen below an acceptable standard.

(iii) The consequences of the failure to be aware of fetal distress

58. In Ground 3 of his challenge to the Court of Appeal's judgment, Dr Persad argues that even if he had been aware of fetal distress once Mrs Singh arrived at the operating theatre, there was nothing that he could have done to speed the process along. He contends therefore that he is not responsible for the delays that occurred before the C-section was performed, and the same injuries would have been caused to Christopher even if the FHR had been monitored.

59. In the Board's view the evidence fully supported the Court of Appeal's rejection of this submission. The Board accepts that the absence of a theatre assistant was not Dr Persad's fault and that it was the responsibility of the Hospital to provide supportive services to him. But the Court of Appeal was entitled to accept the evidence at trial of Dr Narra when he was questioned by Mr Heffes-Doon on behalf of Christopher about the role of the theatre assistant. Dr Narra's evidence was that the theatre assistant is important, but that if they had been aware of fetal distress and if the obstetrician had told everyone that the surgery had become urgent, then Dr Narra had a "Plan B". If Dr Persad had told him that the surgery was urgent (which he described as moving from a Category 3 to a Category 2 C-section), his evidence was as follows:

> "That 'Plan B' is to get help, whatever help is available, best possible help, and organise myself, and explain to the surgeon, explain to the patient, 'Okay, situation is like this, and now we want to proceed by putting you to sleep, not going with spinal anymore, so because it is Category 2.' So that was my plan, but there was no red flag, saying that it is a fetal distress at Category 2. So we both were waiting there, myself and one of

> the nurse[s]. The scrub nurses and the other, and we were waiting there."

60. By emphasising Dr Persad's overall responsibility for what happened or did not happen in the operating theatre, the Court of Appeal was not, as Dr Persad argues, arbitrarily shifting responsibility for the provision of supportive services from the Hospital to him. Rather they were accepting the evidence of those who were present that they regarded Dr Persad as in charge and that if he had told them that the C-section had to be performed immediately, they would have managed without the theatre assistant and would have given Mrs Singh a general anaesthetic rather than taking up more time to administer the spinal anaesthetic. There can be no doubt that the failure to speed things up in that way extended the period for which the baby was in distress in the womb and that in turn affected the severity of the injuries Christopher ultimately suffered.

(c) Grounds 6 and 10: whether the delay between the decision to deliver by C-section and the delivery was too long in any event

61. The trial judge rejected the allegation that Dr Persad had been negligent in failing to escalate the urgency of the surgery in the absence of fetal distress: see para 164 of her judgment. It is true that Dr Mason's evidence was that the delay between the decision to deliver by C-section at 09:00 and delivery at 11:13 was unacceptable. But there was evidence to the contrary which the judge was entitled to accept. The expert report of Dr Perkins on behalf of Dr Persad stated:

> "If the fetus was not distressed then the urgency to get the baby out would be reduced in favor of ensuring the mother had the safer form of anesthesia for her Caesarean Section. This would assume that the baby was being monitored by EFM [electronic fetal monitoring] either intermittently after contractions or continuously, until delivered. Delivery in 15-30 minutes DDI *[sc decision to delivery interval]* would be what is required/expected in the case where there is a distressed fetus as diagnosed by EFM or cord prolapse."

62. Importantly, Dr H Persad also commented on that aspect of Dr Mason's report saying:

> "I agree that the delay in delivering the baby having made the decision at 9 am is unacceptable BUT ONLY IF THERE WAS FETAL DISTRESS." (Emphasis in original.)

63. On this issue the Board agrees with Dr Persad that there was no basis for the Court of Appeal to overturn the judge's dismissal of this allegation of negligence. There was evidence before the judge that it is safer for the mother if the C-section is performed using a spinal anaesthetic rather than by general anaesthetist. If proper monitoring is taking place and there is no indication of fetal distress or other urgency, it is reasonable to take the extra time needed to perform the C-section using spinal anaesthetic.

(d) Grounds 2 and 4

64. The Board also considers that Dr Persad's criticism of the Court of Appeal is well founded as regards the aspects of his care addressed in these two grounds.

65. By Ground 2, Dr Persad complains that the Court of Appeal wrongly held at para 107 that on the day of delivery, Dr Persad had realised that a C-section "was a possibility, if not a probability" from as early as 7 am because of the relatively advanced stage of the labour and the positioning of the fetus. He ought to have alerted the Hospital at that time and that would have enabled the Hospital to summon an anaesthetist earlier and would have prevented the delay caused by the late arrival of Dr Narra in the operating theatre.

66. In the Board's view that is not a fair reading of Lambert Peterson J's conclusions. The debate before the judge was whether Dr Persad had alerted the Hospital to the need for a C-section at 08:15 hours as he asserted or only at 09:00 as the Hospital asserted. She found that he had only informed them of the need for a C-section at the later time: see para 25 of her judgment and para 12(i) of the Court of Appeal judgment. The discussion of delay refers to a two hour period, that being between 09:00 when the Hospital was alerted to the need for a C-section and the time when Christopher was born. There was no basis for the Court of Appeal to conclude that Dr Persad should have notified the Hospital earlier of a possible C-section, particularly since there was no criticism of his decision to see first whether the oxytocin infusion might obviate the need for surgery. In his written submissions to the Board, Dr Powers, counsel for Christopher, fairly accepts that the Court of Appeal would have been wrong to found liability on this point since any delay between 08:15 and 09:00 could not have had any causative effect.

67. Ground 4 concerns the Court of Appeal's conclusion that Dr Persad should have been present in the operating theatre throughout the time that Mrs Singh was there: see para 109 of their judgment. One of the particulars of negligence alleged in the Amended Statement of Claim was that Dr Persad had been absent from the operating theatre for approximately 15 minutes or more while the anaesthetist struggled to administer the anaesthetic: see sub-para (s) at para 15 of the pleaded case. The trial judge found at para

156 of her judgment that Dr Persad had not been present all the time that Dr Narra was attempting to administer the spinal anaesthetic. However, she concluded at para 175 that Dr Persad had not been negligent when he left the operating theatre for 15 minutes during the administration of the anaesthetic.

68. In so far as this is intended to be a finding of negligence based merely on his absence separate from the wider point about delay, the Board agrees with Dr Persad that there is no basis for concluding either that a consultant is expected to be in the operating theatre for the whole period prior to the start of surgery or that Dr Persad's absence had any effect on the progress of events.

5. Conclusion

69. The Board therefore concludes that Dr Persad's appeal should be dismissed.