BRIEFING
March 2023

CLINICAL NEGLIGENCE

Welcome to the March 2023 edition of the Clinical Negligence briefing. Here, Laura Begley and Ella Davis bring you commentary on some of the notable clinical negligence cases reported over the last few months, touching upon a range of issues from consent and causation, to civil procedure.

Laura and Ella are experienced clinical negligence barristers. Laura has considerable experience in brain, spinal and other catastrophic injury claims. In 2022 she won Personal Injury Junior of the Year at the Chambers UK Bar Awards and in 2018 she won the Legal 500 Personal Injury/Clinical Negligence practitioner of the year.

Ella acts for claimants and defendants in a wide range of clinical negligence claims. She handles substantial claims without a leader, and acts as junior counsel in high value and complex claims. She is ranked by Legal 500 for Clinical Negligence.

Here at Deka Chambers we have a large clinical negligence and healthcare team which includes 9 silks and over 60 juniors, many of whom are recognised leaders in this field. The team has a wealth of experience in acting for Claimants and Defendants across the full range of clinical negligence work.

Further, the cross over with other practice groups within Deka Chambers gives us the opportunity to offer a uniquely comprehensive service, whether that be:

- Cross Border clinical negligence claims;
- Linked inquest and/or inquiries;
- Clinical negligence claims where issues arise under the Human Rights Act 1998 and/or where there are questions over the existence and/or scope of a duty of care;
- Court of Protection issues;
- Claims where there may be a regulatory / disciplinary issue and/or criminal prosecution on the horizon (or already arisen), and
- ADR

Which reminds me to take this opportunity to shamelessly promote Dominque Smith's book "A Practical Guide to Cross-Border Clinical Negligence Claims", published in February 2023. Dominique Smith is a barrister at Deka Chambers, specialising in travel law, inquests, clinical negligence, and personal injury. I wholeheartedly recommend this book to anyone practising in this field.

Here's wishing you all a sun filled spring and we will touch base with another Deka Clinical Negligence briefing shortly.

Lisa Dobie

Joint Head of the Clinical Negligence Team

MIDDLETON v FRIMLEY HEALTH NHS TRUST [2022]

By Laura Begley

Beware slavish reliance on guidelines : clinical judgment determines what 'urgent' means and the court will where required examine the redacted records of other patients to determine priority.

This case concerned the status of guidelines and the prioritisation of patients for surgery. The Claimant alleged that the Defendant negligently delayed revascularisation of the deceased's right leg for a period in excess of 6 hours and that this delay resulted in his suffering additional leg symptoms for approximately 1 month between November and December 2015 after which he had further surgery. He died 6 years later of unrelated causes. Initially the claim had been put on the basis that loss of power and sensation in the leg from the date of surgery to death was attributable to the delay but this was abandoned part way through the claim due to lack of support from the Claimant's neurologist.

The Claimant relied on guidelines set out in literature by Rutherford & Ors '*Recommended Standards for reports dealing with lower extremity ischaemia : revised version.*' Both parties agreed that the presentation of the deceased at 1100 hrs on 15th November placed him within category IIB for acute limb ischaemia defined as '*Immediately: Salvageable with immediate vascularisation.*' Both parties also agreed that the deceased's case did not fall into the *'immediate'* category within the classification for intervention set out by the National Confidential Enquiry into Patient Outcome and Death (NECPOD) and that he fell into the *'urgent'* category within that system of classification. But the Defendant's treating team and experts did not accept that this mandated surgery within 6 hours. They insisted that an operating theatre would not be booked until a CTA was available and that this would take at least 1 hour to obtain and 15 minutes to be reported. The Defence position was that the imaging was critical because the deceased had a complex history and only in the case of a really serious emergency would one bypass this stage. The Claimant's expert [Prof Linda Hands] accepted it was reasonable to obtain a CTA though she herself would not have waited for one. She contended that once assessed pre CTA an operating theatre ought to have been put 'on hold' for the Claimant, or alternatively that his surgery ought to have been prioritised over another patient known as patient 2 who had in fact gone into the operating theatre at 1410hrs. She relied on a paper by *Henke 'Contemporary Management of Acute Limb Ischaemia: Factors associated with amputation and in -hospital* which it was contended demonstrated likely permanent nerve damage with severe ischaemia unless surgery was performed within 6 hours. The Defendant [through its expert Dr Coleridge Smith] relied on the fact that in the literature *'the time frame depends upon the degree of collateral perfusion in any given instrument,*' that.... *Temporal criteria... are not included in these reporting standards*... and that the findings on examination and CPA indicated reduced but adequate blood flow and that 6 hours was something one would aim for but was not mandated noting that a patient such as the deceased with a long history of vascular disease was better able to withstand occlusion. Surgery was therefore required 'as soon as possible' or 'as soon as was feasible.' Further, with the benefit of hindsight it was clear that there was in fact no ischaemic damage to the leg following surgery *and* there was no note of the deceased's leg being cold and mottled which would have been recorded had it been present. The experts disagreed as to causation, each expert accepting that their view amounted to a theory only.

In considering the competing contentions the court had regard (at the invitation of the Defendant, para 78) to the approach of Yip J in *Dalton v Southend University Hospital NHS Foundation Trust* [2019] EWHC 832 where she said of the experts' competing views of guidelines in that case : '*however, my preferred interpretation of the guidelines is not in fact relevant. It is not for me to weigh up the competing views and decide which is 'right'. I am entirely satisfied that prof Wishart genuinely takes the same view as Miss Gray [the treating clinician] as to the application of the guidelines. The issue for me then is whether that is unreasonable or incapable of withstanding logical analysis.'*

The Claimant lost on breach. The guidelines were *not mandatory tram lines* for clinical decision making [para 85]. The second paper relied on by the Claimant did not directly apply due to the deceased's significant history of vascular disease. Where a patient fell within the 'urgent' category was a question of clinical judgment. It was reasonable for the CTA to be obtained before surgery and capillary blood flow supported this as a reasonable decision. The notes did not suggest the limb was cold or pale or that there was excruciating pain. It would be truly exceptional to put an operating theatre 'on hold' and per Jonathan Glasson KC sitting as a deputy High Court Judge *'wholly unrealistic and unreasonable'*... and '*would ignore the realities and competing demands placed on hospitals and surgeons seeking to prioritise scarce resources.'* Finally there was also a conflict between the pleaded case (that surgery ought to have been commenced by 1500hrs) and the evidence of the Claimant's expert and the Claimant that surgery ought to have been commenced by 1700hrs. In any event, the surgery did successfully restore blood flow, so the outcome supports the approach and was logical.

The court examined the records of patient 2 who had been taken down to theatre, during the timescale it was alleged the Claimant ought to have been taken down (there was only 1 operating theatre potentially available). The court found they were both 'urgent' cases but patient 2 was already in the operating theatre *before* the Claimant had his CPA and it would have been wholly unreasonable to reverse the decision on proceeding on patient 2 in those circumstances (even if the Claimant had been able to show that it was mandatory to be in surgery by 1500 hrs).

The court added for good measure that even if breach had been made out, the case on causation would have failed. Mr Coleridge Smith's approach and hypothesis won the day.

This case provides a reminder if one were needed that caution is required when reliance is placed on guidelines and literature which appears to mandate a certain course of action within a certain timescale in a certain category of case. Per Yip J the issue for the judge is whether the clinician's view on the *application of the guidelines* is unreasonable or incapable of withstanding logical analysis. The court will, when required and central to a case, examine the (redacted) records of other patients to determine priority but will take a realistic and reasonable view of the pressures on the finite resources of the NHS.

DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST v UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST [2023]

By Laura Begley

In *Dorset County Hospital NHS Foundation Trust v University Hospital Southampton NHS Foundation Trust [2023]* EWHC 367 KB Master Stevens grappled with the question of examination of a Claimant by the Defendant's causation expert in a neurosurgical Cauda Equine Syndrome (CES) case prior to service of a Defence. The Defendant's application was for a stay for 2 months pending such an examination.

The Claimant's case was that the First Defendant (D1) caused a negligent delay in transfer to the Second Defendant's (D2) hospital resulting in later surgery which, it was argued resulted in a poorer neurological outcome, there was also an allegation of delay against D2. The Claimant's case was that earlier surgery would have resulted in recovery to near if not full motor function in L2 and S1/2 bilaterally. D1 admitted breach but denied causation. D2 denied breach and causation (D1 & D2 were represented jointly). Following service of the POC, the Defendants sought examination of C by their neurosurgeon and C initially agreed and sought a domicillary visit but then queried why that was necessary pre-service of the Defence given that their expert had been able to give a pre-issue opinion on causation absent such an examination. C suggested the expert could examine her post exchange of witness evidence prior to service of expert liability evidence. Three days before the hearing of D's application their expert wrote an email saying that in order to comply with his obligation to the court as an independent expert, he required to examine the Claimant before opining on causation. He cited pre-injury condition, co morbidities and some internal inconsistencies in some measurements of condition taken by C's expert in her C&P report.

It was agreed that the legal test was per *Laycock v Lagoe* [1997] P.I.Q.R. 518 :

1. Is it in the interests of justice for the examination to proceed?
   If so then
2. Does the opposing party have a substantial reason for the test not being undertaken?

It was agreed that the court had the power to stay the proceedings CPR 3.1(2)(f)

D's approach was that the interests of justice and the overriding objective favoured them and that C had been inconsistent, her responses inadequate and unreasonable. Her only concern had really been as to timing. D submitted they would have to plead 'holding' Defences which would result in late amendment and increased costs further down the line if the application were not granted. C pointed to D's LOR on causation and observed that generally cases are refined through disclosure, witness evidence and examination and exchange of expert evidence, this case was no different and that D had not explained *how* an examination could assist in opining on the factual causation timeline, early examination could result in the need for a second examination post witness evidence and co morbidities were not an unusual feature of similar cases and did not take this case out of the normal pathway. *Laycock* was a case about absolute refusals. The instant case was about the timing. C's reasons under part 2 of the test were that it was 'likely' that such an examination 'may not yield' all the information needed such that a 2nd examination would be requested and increase costs. This would be intrusive, painful and distressing for a vulnerable Claimant (who was very psychologically impaired and had been experiencing suicidal ideation).

Master Stevens declined the application on the basis that D had failed to show that it was in the interests of justice to divert this case from '*the usual order of play in multi track clinical negligence directions.*' Co-morbidities and pre-existing back pain were not uncommon in this type of case and did not justify diverting from the usual rule. Any perceived unfairness was '*pretty much hard wired into the* CPR by the requirement to serve a C&P report with POC. C's C&P expert may not be the same as her causation expert and to *my mind there would need to be something exceptional to depart from the normal directions concerning medical examination by an opponent, as those have been designed to accord with the overriding objective.*' [para 24].

She noted that no precedent was supplied for a stay having been ordered ahead of Defences and that multiple examinations by an expert should be avoided where one could suffice. D's expert said he could not see why he would need a second examination post exchange of witness evidence but D's counsel would not agree a direction that expert evidence be limited to one examination only if the examination went ahead now. She was unimpressed that the letter from D's expert had only been produced 3 days prior to the hearing and considered that there was a difference between an expert committing to a signed disclosable report which would not happen until after an examination in any event and the requirement for him to give his opinion privately to the Defence team to enable the pleading to be drafted. She thought it was important and in the interests of justice to have regard to C's vulnerability and her parlous psychiatric state (from the C&P report). If she allowed D's application this would increase the scope for a further examination in circumstances where D declined to accede to a single examination only. She said [para 31] '*even if the stage one test had been satisfied, I am persuaded that the C has demonstrated substantial reasons for declining the examination now. Her health is one, her anxiety cannot be described as minor... neither imaginary nor illusory.*' There was a significant overlap on issues of delay and expense and no proven time saving over all, the same went for submissions on expense. C's mental health was a '*real objection which firmly pushes the balance in her favour for resisting examination before exchange of liability witness statements in the usual way*'.

Comment

The lack of any precedent for a stay pending a medical examination prior to a defence, plus the usual running order for clinical negligence claims per the QB Bench Guide allied to the lack of good evidence that either time or expense would be saved, and the vulnerabilities of the injured Claimant were powerful reasons to decline D's application for a stay pending examination pre Defence.

GBOLOAHAN O SOMOYE v NORTH WEST ANGLIA NHS FOUNDATION TRUST [2023]

By Laura Begley

Withdrawal of an admission pursuant to CPR 14.1A(4) and PD 14 para 7.

C made a claim for the death of the deceased due to alleged clinical negligence in March 2018. The deceased had undergone a laparotomy, been discharged 3 days later, then suffered a seizure at home and re-attended hospital, was discharged and thereafter collapsed and suffered a cardiac arrest after her second discharge. D made a pre-action admission on 24.3.20 one day before the inquest was due to commence which was re-iterated as a full admission by a further letter on 20.4.21, one day before the adjourned Inquest actually commenced. On 26.1.22 the Coroner confirmed the cause of death per the post mortem report but found it was not possible to say whether aspiration led to cardiac arrest or cardiac arrest caused aspiration. On 22.3.22 D notified C that it was re-considering causation and requested further disclosure on quantum. A limitation extension was offered and agreed to 29.7.22 and then extended for a further 4 months. C served proceedings on 11.7.22 with an application to enter judgment. The POC was in short form and relied only on 'failings in the Trust's provision of care following the deceased's surgery' and the admissions. On 13.7.22 D applied to withdraw the admission.

D had undertaken a Serious Incident Report and its Root Cause analysis identified numerous care and delivery issues primarily on the basis that the deceased had possible infection from the date of re-admission and D had inappropriately failed to follow a sepsis pathway. An external report by an independent gynaecologist highlighted lack of records and conflicting retrospective accounts but did also find failings in care.

The Coroner instructed Prof Winslet (gastroenterologist) who considered that the cause of aspiration was vomiting, from a mechanical small bowel obstruction or wall hernia or ileus. The cause of the appearance of the bowel 5 days post death was unclear. There may have been some autolytic changes or the deceased developed a rare bowel abnormality, necrotising enterocolitis which would not be diagnosed pre-post mortem. If autolytic changes then the cause of death was aspiration pneumonia which could have been avoided by nasogastric decompression.

The pathologist Dr Wright (with sight of Prof Winslet's view) said she thought that the cause of death was likely due to post operative hyperkalaemia given the elevated potassium in the blood.

Prof Winslet said that if the court found in favour of the pathologist's view the cardiac arrest would have happened in any event. However, if the court found that aspiration was the cause of the cardiac arrest this would have been avoided.

D re-affirmed its admission of liability the day before the adjourned inquest.

At the Inquest Prof Winslet said that the deceased would have survived if the source of the sepsis was amenable to surgical control and as the whole bowel was abnormal it would not have been so amenable. Antibiotics would have been supportive not curative. If aspiration caused the cardiac arrest then with treatment it would not have happened at that time but if the cardiac arrest came before aspiration it would be due to the sepsis and the outcome would have been the same. However he also said that different treatment would not have prevented death as whatever was going on in the abdomen she would not have survived after that. The condition of the entire bowel could not be explained solely by autolysis. The Coroner adjourned the inquest again for Dr Wright to be asked further questions. She considered that the pan enteric changes were adequately explained by ileus (so did not accept there was gross abnormality of the bowel) and her opinion on the cause of death remained the same.

The Coroner found on 22.3.22 the cause of death as per the post mortem ; 1a. multi organ failure, 1b. abdominal sepsis, 1c. small bowel ileus, 2. uterine myomectomy. He further found that it was not

possible to say whether aspiration led to cardiac arrest or whether cardiac arrest caused aspiration on a balance of probabilities.

D's application to withdraw their admission (re. causation) was made on the basis of the evidence of Prof Winslet they relied on the shift in his opinion, the Coroner's finding that it was not possible to say whether the admitted breach (failure to insert a nasogastric tube) led to the cardiac arrest or whether the cardiac arrest was caused by something else. They were a publically funded body which took several months to obtain cardiology and intensive care advice which was served shortly before the application was heard.

Master Sullivan was mindful of her discretion pursuant to PD 14, all the circumstances of the case and the specific factors below:

a) The grounds.. and whether or not new evidence has come to light

b) The conduct of the parties

c) The prejudice caused by withdrawal

d) The prejudice caused by refusing the application

e) The stage of the proceedings

f) The prospects for success if the admission is withdrawn

g) The interests of the administration of justice

a) The grounds of the application were essentially the shift in view of Prof Winslet as to which of the two theories (which had always been on the table) was the more compelling The evidence now relied on (by the cardiologist and intensivist) was evidence in support of the application but not the grounds for the application.

b) C was right to criticise D's conduct. '*A defendant is expected to take independent legal and medical advice at an early stage and before making an admission'.* This was especially so where an expert not instructed by the defendant raises issues which show there may be an argument on causation would provide a defence to the claim. [para 36]. D's second admission was made to spare C a full inquest but also to save costs. *'that is obviously something to be encouraged but it is proper to take into account the context in which such an admission is made.'* She observed that a Trust was likely to have representation at an inquest whether an admission is made or not. ' *family of a deceased may or may not be, especially if the costs of the inquest are unlikely to be recovered in civil litigation. That is largely the case where liability is admitted. That leads to the consequence that a Claimant's opportunity to investigate for the purposes of a civil claim may be affected by the admission. In this case it led to agreement that the factual clinical witnesses need not be called. The expectation that a defendant who has access to proper representation should be held to an admission has particular force in that context.* She also noted the delay between Prof Winslet's shift in opinion (Sept 21) notification that D would investigate causation (March 22) and no expression of intention to resile until July 22 which she adjudged a '*significant delay in the context of the claim given the time that had passed since the date of the death and the admissions*.'

c) D contended prejudice for obvious reasons if not able to rely on a Defence and argued C still could investigate and bring the claim which would stand or fall on expert evidence. C contended there would be significant prejudice in a case with poor medical records with conflicting retrospective accounts which '*compromise the goal of triangulating the key elements of evidential material*.' C had investigated quantum and wouldn't have taken those steps or that expenditure until after liability evidence and possibly a split trial. There was personal prejudice to C and the family. That factor did not have significant weight in the balancing of the factors by the Master. She considered that the balance lay with C noting the issues with poor records and the lost opportunity at the Inquest to investigate the factual matrix further closer in time to the events. She noted D would be able to challenge the extent of the losses claimed.

d) In relation to the prospects of success if the admission were withdrawn she found that

the three reports available all of which were based on the notion that there was an unknown gross abnormality of the bowel (Prof Winslet, the cardiologist and intensivist) would, if found proved, provide a good defence to the action. C's position was that per Dr Wright (the pathologist) there was not a gross abnormality of the bowel, and that they had evidence that post operative ileus normally resolves within 2-3 days and it would be rare to progress to non viability of the bowel. She also took into account the admission was that treatment of the deceased following her surgery (not only on re-admission) had been substandard and caused her untimely death but this had not been further particularised.

e) In relation to timing she said : '*it is right that in civil proceedings the application has been made at the first opportunity and at a very early stage. But that is of limited weight in the circumstances of this case given the time that has passed both since the accident and the admission and that there has been an inquest investigating the facts albeit to answer different questions to those in the civil proceedings.* [para 48]

f) In relation to the interests of the administration of justice, D argued that it had good cogent evidence at an early stage of the proceedings and it would be against the interests of justice to allow the trial to proceed on an artificial basis that death was caused by negligence when the evidence suggested the deceased had been critically unwell and even if she had survived she would not have lived for any significant period of time. C argued that it would be contrary to the interests of justice to allow withdrawal. Claimants would not be able to rely on admissions pre-inquest in case there was a tactical decision to admit pre-inquest and then withdraw later, they would have to bear the expense of fully investigating matters at the inquest. C also argued this was a full admission so D would not be able to argue that the deceased would not have recovered when considering life expectancy and the prognosis had she lived. Master Sullivan said : '*I accept the defendant would be able to raise arguments going to the claimant's condition and life expectancy had she lived. An admission on liability leads to a judgment on liability for damages to be assessed. That leaves open to a defendant an ability to argue about the extent of the injury and loss provided that the defendant does not raise an argument in consistent with some injury (including death) having been caused by the negligence. That is the well recognised position. It seems to me that would not cause a judge any difficulty or cause any problems with the administration of justice.'* [para 58].

Over all Master Sullivan held that D should be held to its admission weighing the different factors. '*whilst the fact that the defendant at this stage has a realistic defence is a strong factor in favour of giving permission it seems to me to be outweighed by the conduct and prejudice issues discussed above.'*

Comment

This case demonstrates that if a defendant fails to take independent legal and medical advice at an early stage before making an admission, even though an expert not instructed by it has raised issues to show there may be an argument (on causation) and in reliance on this the Claimant takes steps and/or omits to take steps that it would otherwise have taken, this may well shift the balance against the Defendant on a withdrawal application. This is so even where D can by the time of the application demonstrate compelling evidence of a realistic defence to an action.

CNZ v ROYAL BATH HOSPITALS NHS FOUNDATION TRUST [2023]

By Ella Davis

CNZ (by her Litigation Friend MNZ) v Royal Bath Hospitals NHS Foundation Trust [2023] EWHC 19 (KB) is an important recent birth injury decision addressing interesting issues of consent, in particular in relation to historic cases, as well as causation and material contribution.

The claim arose out of the Claimant's birth at the Royal United Hospital Bath (The Hospital) on 3 February 1996. The Claimant's twin sister was born about 1 hour before her. The Claimant suffered acute profound hypoxic ischaemia before and for three minutes after birth, leading to cerebral palsy. It was her case that her mother (M) should have been offered elective caesarean section (ECS), that M's requests for caesarean section (CS) were refused or delayed and that the eventual delivery by CS was negligently late.

The Application of Montgomery to Historic Cases

Ritchie J noted that *Montgomery,* itself a case arising out of events in 1999, "clarified in arrears" the duty of clinicians when consenting patients. The question is, however, how far back can this be applied. While making no decisions, he doubted that it could be taken as far back as the 1950s or 1960s and wondered whether it could be applied to clinical practice in the 1980s. He posited that in the 1990s there may be a tipping point at which the growth of the internet, the changes in societal values and GMC guidelines and the passing of the Human Rights Act 1998 mark the movement from paternalism to patient choice. While noting that 1996 was before the internet had developed much and the passing of the Human Rights Act 1988, Ritchie J held that *Montgomery* did apply to the facts of this case from February 1996.

Reasonable Alternative Treatments

In relation to the still tricky question of what is a reasonable alternative treatment, Ritchie J said he would take into account the Scottish decision of *McCulloch v Forth Valley [2021] CSIH 21.* In this the Court of Session Inner House ruled that the test of what was a reasonable alternative treatment was a medical (*Bolam*) one and not a *Montgomery* one. Interestingly Ritchie J did not cite any of the English cases which grapple with this issue (including notably *Bayley v George Eliot Hospital NHS Trust [2017] EWHC 3398 (QB)* which reached a different conclusion), nor did he expressly say that he was following the *McCulloch* decision. This is perhaps because on the facts of *CNZ* the precise test to be applied was unlikely to affect the outcome. It will be interesting to see what judges in other cases make of the *McCulloch* case however.

Antenatal Care and Offer of Elective Caesarean Section

It was the Claimant's case that ECS was a reasonable treatment which she should have been offered. The Defendant's lay and expert evidence was to the effect that this was not a reasonable antenatal treatment option since M had had two previous normal vaginal births, she was healthy and so were her twins who were in a cephalic position. Nevertheless, the Defendant's evidence was also to the effect that if M had requested CS and, despite two or three sessions counselling against CS, persisted in her request for CS, they would and should have agreed to that choice. Ritchie J noted the inherent illogicality in this approach.

Interestingly the Claimant's expert obstetrician also gave evidence that he would not have offered ECS in 1996, although acknowledged the tension between this and *Montgomery.* Again, he would have agreed to a maternal request for CS.

Ritchie J held that if the obstetricians would have agreed to CS, even after counselling against it, applying *Montgomery* it probably is a reasonable treatment option which should have been discussed.

On the facts, however, he found that M only requested CS on one occasion antenatally. On that occasion she was properly counselled against it. M

then agreed to continue with her previous preference for a normal vaginal delivery with as little intervention as possible. Although there was an illogicality in the Defendant's approach, Ritchie J found that M wanted a natural childbirth and would have accepted advice to agree to normal vaginal delivery as the least invasive and safest option, with a fallback of CS if medically necessary.

Refusal of or Delay in Agreeing to Caesarean Section and Negligent Delay Delivery

Ritchie J found a number of failings in the period between 00:25 and delivery at 01:03. By 00:25 (24 minutes after the birth of the first twin) he found that urgent transfer to theatre was the only safe option for the Claimant and M, and CS under general anaesthetic was the best reasonable treatment option at that time (subject to a quick vaginal examination in theatre to check whether the baby had descended sufficiently during transfer to avoid CS). At 00:26 the parents requested CS.

The Claimant relied on a video taken from the birth of the first twin to 00:39 which evidenced both the clear requests for CS, and the lack of urgency in the treatment by the attending SHO (acting as a registrar) who in fact responded to the request for CS at 00:26 by saying "*we'll slowly get things ready.*" The doctor then made two calls to the consultant for advice, failing to relay M's expressed wishes. The doctor persisted in a plan for artificial rupture of membranes (ARM) in theatre, despite M's clear refusal of this (maintained throughout the antenatal and intrapartum period) and request for CS.

Setting out the full extent of the criticisms made of the treatment between 00:26 and delivery at 01:03 is beyond the scope of this article (Ritchie J's detailed consideration of the evidence and allegations contributed to a 107 page judgment). His findings on breach are at paragraphs 314 to 319 of the judgment. In brief summary:

- The doctor failed to discuss the necessary reasonable treatment options with the parents, failed to fully inform them of the risks and benefits of the reasonable options and failed to act on their informed choice.
- The doctor failed to act urgently. She should have had in mind the need to take M to theatre as the 30 minute intertwin mark approached.
- She ought to have explained the risks and benefits of vaginal delivery with high ARM, and of CS, and sought to persuade M to choose CS.
- If full information had been given to the consultant in the first telephone call, he would have approved CS.
- The time of setting off to theatre, transfer to theatre, induction of anaesthetic and the time taken to complete the CS were all delayed by the doctor taking matters "*slowly".*
- The doctor failed to agree to M's choice of CS and the documented consent which was taken at 00:35 for ARM/CS was not informed consent.
- The doctor failed to appreciate that after the CTG was stopped as a result of transfer to theatre at 00:40, two FHR readings taken at 00:45 and 00:52 were insufficient to assume foetal wellbeing.
- The CS should have been performed in around 6 minutes (up to a maximum of 10 minutes) but took 13 minutes.

In total the negligent delay was probably a minimum of 5 minutes and a maximum of 8 minutes, with a mid point of 6.5 minutes being the most probable delay. Had birth been achieved earlier, the resuscitation time would have been reduced by probably 1-2 minutes.

Causation in Fact

Ritchie J found that the likely duration of profound hypoxic ischaemia (PHI) was approximately 16 minutes (between 14 and 18 minutes). The experts agreed the Claimant's brain damage would not have occurred in the first 10 minutes of PHI and only started to accumulate after 10 minutes. Saving 6.5 minutes of PHI (a minimum of 5 and a maximum of 8 minutes), would on the balance of probabilities have avoided all of the Claimant's brain damage. Ritchie J therefore held that the negligent delay was causative of the whole of the Claimant's brain damage.

Causation in Law

Despite that clear finding, in deference to the detailed arguments he had heard, and noting that he had found a range of timings for the negligent delay and duration of PHI, Ritchie J went on to consider material contribution and apportionment. His consideration of this issue contains a useful summary of the issues raised and the key cases. For practitioners grappling with these issues this part of the judgment is worth reading in full.

Ritchie J found that every minute of acute PHI beyond the first 10 minutest caused damage in the form of brain cell deaths which increased functional outcome disability and injury. To that extent causation was proven on the but for test. However, he found that medical science is unable to identify with generality, accuracy or detail the functional effect of each minute of brain cell deaths. He then asked himself if, having found that even a minute of PHI made a material contribution to the Claimant's brain damage, the court should apportion quantum and if so how. He continued at paragraph 331:

"In my judgment applying only fairness as the test the answer is clearly that apportionment should be applied. The 1st Defendant should only be liable for the brain damage which it caused not that which would have occurred in any event. But there are evidential challenges to that simple answer which undermine it. The experts agree that there is no linear relationship between minutes of PHI and functional outcome. It is scientifically unclear. So what should be the correct answer in law on causation? 100% recovery or apportionment?"

At 339, he identified five main types of tricky causation issues identifiable in scientific gap cases. In this case the issue was that, applying the extremes of the ranges he had found, part of the PHI was caused by negligence and part would have arisen anyway.

Ritchie J held that the Claimant's brain injuries were not indivisible. The spread of brain damage due to PHI is wholly dose dependent. However, he considered that the functional outcome caused by one or more minutes of acute PHI may be indivisible.

He held that the relevant test in brain injury caused by acute PHI is firstly the but for test, and then in relation to the functional outcome the material contribution to the injury (not to the risk of injury) approach. This then left the question of whether damages should be apportioned.

He rejected the Defendant's expert's Aliquot theory which was put forward to suggest that the functional outcome could be apportioned by reference to 5 minute intervals of negligently damaging PHI.

The judge found that the Claimant had proved causation of brain injury on a but for basis in that it was proved that the negligent delay caused significant brain damage. There was, however, a clear scientific gap in the ability of the experts to accurately predict the "but for" outcome for the Claimant if she had suffered say 1 to 3 minutes less acute PHI.

He held that in law where there is such a gap making proof of causation of functional outcome, and therefore also quantification, impossible and not merely difficult, the Claimant will recover 100% of the damage suffered due to acute PHI, so long as she can prove that the breach made a material contribution to the reduced functional outcome.

If the evidence had permitted such an approach, he would have ruled that apportionment of quantum is fair on the basis of a percentage tied to the relative duration of PHI. However, quantification of the Claimant's functional outcome but for each minute of negligently caused acute PHI was impossible and not merely difficult and he therefore held that she was entitled to 100% of her damages.

The First Defendant, responsible for the Hospital but not the antenatal care, is seeking to appeal the decision.

DEKA CHAMBERS
5 Norwich Street, London EC4A 1DR
T +44 (0)20 7832 0500
E clerks@dekachambers.com **W** dekachambers.com