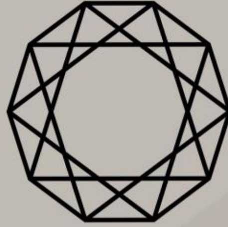

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Maternity and Birth Injury Claims: Legal Update

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Maternity and Birth Injury Claims

- NHS Resolution report states that in 2021-2022 maternity related claims make up 62% of the total number of clinical negligence claims.

- Key challenges for NHS is the increasing demand for maternity services, which puts a strain on resources and staffing levels.

- Interestingly for litigators in 2021-2022 77% of clinical negligence claims settled without court proceedings.

- Donna Ockenden independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust published in March 2022.

SPRING BUDGET 2024

10th March 2024 Government announced:

- £35 million investment to fund specialist training for staff and additional midwives to improve maternity services.
- £9 million dedicated to prevent avoidable brain injuries in childbirth.
- Women’s voices and experiences to be prioritised with funding allocated to improve care
- To be provided over the next 3 years.

Findings of Fact

CDE v Surrey and Sussex Healthcare NHS Trust [2023] EWCA Civ 1330

Background:

- C suffered a severe brain injury at birth due to profound hypoxic ischaemia (PHI) before, during and following birth. As a result, C suffers from quadriplegic cerebral palsy with severe global developmental delay.
- C's case was that following M's admission at 36+1, as a result of negligent care, C's delivery was not competently managed: there was a delay in delivery, transferring M to the labour ward; and commencing monitoring of the foetal heart rate which caused or materially contributed to the injury.
- Ritchie J made detailed findings of facts on the timings, which were key. The emergency occurred just as M was arriving on the labour ward at 17:49. On detecting the bradycardia it was found that the midwife would have called for obstetric assistance within one to two minutes, or a maximum of three. **That the on-duty consultant N probably would have entered M's room at 17:52 upon hearing bradycardia.** Thereafter it would have taken 17 minutes from that time to delivery of C, as it did in real life.
- Despite making findings of breach of duty, Ritche J held that C's claim failed on the but for causation. On the BoP the baby would have been brain-damaged in any event, the brain damage was caused by PHI, but this would have occurred even if D's staff were not negligent on the antenatal ward before bradycardia started at 17:48/17:49.

Findings of Fact

CDE v Surrey and Sussex Healthcare NHS Trust (2)

- Claimant sought to overturn a finding of fact made by Ritchie J as to the time that the on-duty consultant entered M's room on hearing bradycardia coming from the transducer.
- Appellate courts will not interfere with findings of fact by the trial judge, unless ***compelled to do so*** or they were ***'plainly wrong'***

Warnings set out in *Staechelin v ACLBDD Holdings Limited* [2019] EWCA Civ 817):

- "Trial is not a dress rehearsal. It is the first and last night of the show" [49].
- Appellate court will only be island hopping and cannot have regard to the whole sea of evidence.
- In practice, it is not possible to duplicate the trial judge.

‘*Plainly Wrong*’

Henderson v Foxworth Investments Ltd [2014] UKSC 41

“It does not matter, with whatever degree of certainty, that the appellate court considers it would have reached a different conclusion. What matters is whether the decision under appeal is one that no reasonable judge could have reached.”

Findings of Fact

CDE v Surrey and Sussex Healthcare NHS Trust (3)

Grounds of Appeal

- Appeal eventually turned on a narrow issue: did the judge fall into error in finding that the on-duty consultant would probably have walked into M's room at 17:52.
- Nicola Davies LJ giving the lead judgment reasoned that the consultant N had been outside the mother's room at 17:50, the time of the start of her notes, and so on hearing bradycardia would have immediately entered the room **by 17:51** and **not 17:52** as found at first instance.
- There was no need for the judge to postulate what the midwife would or should have done when the trace became bradycardic at 17:48/17:49. The judge incorrectly applied the *Bolam* test as to what a responsible midwife would have done, when on the facts it was more akin to a *Bolitho* scenario.
- On the evidence it was known what N would have done had she heard the bradycardia at 17:50 which would have occurred on the 'but for' scenario. On hearing the bradycardia at 17:50 when N arrived outside M's room, N would have gone into M's room by 17:51, which would have led to a saving of one minute and delivery of C at 18:07.
- This was a flaw in the judge's reasoning, an incorrect finding of fact perhaps, but an error occurred, **and a minute was lost!**
- The appeal was allowed. But what, if any difference, would one minute have made to the issue of medical causation? Experts at first instance not addressed this – case was remitted to Ritchie J for specific consideration.

Key Points

CDE v Surrey and Sussex Healthcare NHS Trust (4)

- There remains a very high bar for turning over findings of fact.
- Crucial to ensure that the correct test for causation is applied at all relevant points in the chronology.
- C's case on when delivery should have happened evolved from PoC, amended PoC, trial, and even at appeal.
- From a C perspective one of the takeaways from CDE is that causation may not crystallize until trial judge has made findings on facts/breach. Therefore, C should not pin their colours too rigidly to the mast in pleaded case.
- Think about pleading alternative counterfactual scenarios.

Consent, Causation, Material Contribution

CNZ v Royal Bath Hospitals NHS Foundation Trust [2023] EWHC 19 (KB)

Background:

- Twins were born on **3rd February 1996**. Twin One delivered healthy at 00:01. Twin Two (claimant) was born at 01:03.
- C suffered 16 minutes of acute profound hypoxic ischaemic insult (PHI) which began at 00:50am. 13 minutes before birth, 3 minutes after birth. As a result, C has quadriplegic cerebral palsy.
- C's claim was that she had requested a c-section, but this was refused/delayed and when hospital did deliver C, delivery was carried out negligently as it was late and caused the hypoxic ischaemic insult.

Findings of Fact:

- By 00:26 - "*Montgomery applied at this point*" - Dr T should have given the parents the right to choose c-section and explained the risks and benefits of treatment options [299]. Had the options been explained and the parents asked to choose, they would have chosen c-section as they did 9 minutes later at 00:35 [301].
- The total negligent delay caused by the clinician's breaches was 6.5 minutes. C should have been delivered by 00:55 - 00:58. On the but for prognosis had birth been achieved earlier the resuscitation would have been reduced by 1-2 minutes.
- The first 10 minutes of PHI were non injurious (from 00:50 to 01:00), the following 6 minutes (01:00 to 01:06) were injurious.
- Delay caused by the breaches was causative of the whole of C's brain damage. Saving 6.5 minutes of PHI would on BoP have avoided all of C's brain injuries.

CNZ v Royal Bath Hospitals NHS Foundation Trust (2)

But For Causation:

- Was the evidence sufficient to prove that the breach PHI caused injury to C, rather than the non-breach PHI?
- It was agreed that every minute of acute PHI over the first 10 minutes caused increasing or incremental brain cell deaths. The damage minute by minute was more than de minimis.
- Each minute caused increased functional outcome disability and injury [326].
- BUT, judge found that *"medical science is unable to identify with generality, accuracy or detail the functional effect of each minute of brain cell deaths."*

CNZ v Royal Bath Hospitals NHS Foundation Trust (3)

Material Contribution and Apportionment

- D should only be liable for the brain damage which it caused and not that which would have occurred in any event.
- Ritchie J found 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 [366].
- Should damages be apportioned? Ritchie J found that it was impossible to differentiate between the negligent and non-negligent damage, and determine C's functional outcome but for the negligence, as such damages for the totality of injury should be recovered by C.
- Whilst this sets interesting precedent, the court could still take a pragmatic approach to apportionment and assessment of damages. Permission to appeal sought by D, granted by Ritchie J on one ground concerning this issue of apportionment. Watch this space.

Key Points

CNZ v Royal Bath Hospitals NHS Foundation Trust (4)

- Both C and D lawyers should bear in mind the material contribution test in these types of cases and ensure that expert evidence considers whether 'but for' causation is established, and addresses material contribution in the alternative on all realistic counter factual scenarios and findings of breach.
- Both C and D should be aware of the important distinction between the divisible brain injury caused by PHI and the indivisible functional *outcome* where it is not possible, due to the scientific gap, to determine the extent of harm arising from negligence or non-negligence.

Callaghan v South Tees Hospitals NHS Foundation Trust [2023] EWHC 1199 (KB)

Breach of duty – findings of fact – Expert witnesses

- Death of 7 day old newborn from bacterial meningitis and septicaemia;
- Alleged: midwife had failed to take proper and timely observations and had discharged the baby (at 2 days old) before a normal feeding pattern was established and without adequate advice;
- Following discharge baby deteriorated over 16 – 18 hour period. Admitted back to A&E with severe infection

Callaghan **cont…**

- The lack of a record / entry of an overnight feed did not mean that there was no feed in that time;
- There was evidence that a feed had taken place (wet nappy, for instance);
- All evidence suggested that the baby had been clinically well prior to discharge (and C was not advancing otherwise);
- Poor feeding was one clinical sign (not a red flag) of meningitis. The NICE guidelines / internal guidance did not *mandate* that a baby should be monitored further / not discharged / feeding plan put in place. It was a matter of clinical judgment.

Callaghan **cont….**

- The advice given on discharge was adequate, albeit advice regarding feeding should have been more specific (feeding every 3-4 hours, not simply that it should take place ‘ regularly’). No causative consequence to this;
- Discussion regarding experts is interesting. C argued D’s expert evidence inadmissible / less weight should be attached given that D’s expert was no longer a practicing midwife, had not been a midwife at the relevant time (2014) and had not been a practicing midwife when the relevant NICE guidelines (2012) were adopted.
- Note that, despite this, the Defendant’s expert faired rather better than the Claimant’s expert at trial!

CCC (by Mother and LF) v Sheffield Teaching Hospitals NHS foundation Trust [2023] 1770 (KB) Permission to leapfrog appeal granted

- C aged 8. Maximum severity CP case. Severe spastic quadriplegia couldn't sit unaided or log roll or speak, visually impaired, cognitive function 6m – 18m level of cognition;
- First trial of quantum in case of this type since *JR v Sheffield Teaching Hospitals NHS Trust* in 2017.
- Key points:
  - No deduction on past gratuitous care
  - Hydrotherapy pool claim succeeded
  - Assessment of night time care – C recovered 2:1 waking night carers
  - Accommodation costs and deduction of rent
  - Lost years claim – leap frog appeal
  - Critical findings re expert evidence

Hydrotherapy pool:

Ritchie J :

(1) Does C have a reasonable need for the expense as a result of her injuries, pain, suffering and loss of amenity with the twin aims of gaining some benefits and taking steps towards putting her back into the same position she would have been but for those injuries?

(2) Is the Claimant's expense reasonable compared with other less expensive methods of satisfying the reasonable need and taking those steps?

Hydrotherapy pool cont…

- Argued it was the only environment in which C would undertake any form of exercise and that immersion in water brought her pleasure, a degree of freedom, societal participation with her family and other physical benefits.
- Coming together of video evidence, factual evidence and expert evidence.
- C's claim £607,100 installation including extension;
- Annual costs £17,385 pa = £368,736
- D said to have failed to prove reasonable alternative provision.
- Ritchie J estimated alternative provision @ 4 sessions pw £38,400 p.a. = £479,219.

Gratuitous care

- C argued 0% reduction for gratuitous care, to reflect the complexities and challenges faced by her family in providing care before commercial care put in place.
- Deductions for gratuitous care : Jury question :
  - 33% Nash v Southmead HA
  - 25% Fairhurst v St Helens, Evans, Hogg v Doyle
  - 20% Massey v Tameside, Glossop Acute Services NHS Trust
  - 0% Newman v Folkes, Wells v Wells, Warren v Northern General Hospital, Brown v King's Lynn & Wisbeach Hospital

Housecroft and Burnett **[1986] 1 ALL ER**

"the court should look at it as a whole and consider whether, on the facts of the case it is sufficient to enable the Plaintiff, among other things, to make reasonable recompense to the relative.. Where given up work… natural that the plaintiff would not wish the relative to be the loser and the court would award sufficient to enable P to achieve that result, the ceiling would be the commercial rate.."

Evans v Pontypridd [2002] PIQR Q5

"Circumstances vary enormously and what is appropriate and just in one case may not be so in another…. The services are not in fact being bought in the open market so that adjustments will probably need to be made….such adjustments are no more than an element in a single assessment.. Not by means of a conventional percentage".

Factors per Ritchie J

Para 146

(a) Commercial value assessed gross no tax/NI

(b) Weight, complexity, difficulty, nature and intensity of care may vary between equivalent of nursing care and a low level of fetch and carry support work

(c) The hours when the care was provided (incl waking night and weekends)

(d) Other calls on time of the care giver juggle with and income foregone

(e) Fact due to love/support some care but for (f) Whether has lived rent free

Night time care

- C & D’s approach diametrically opposed
- D costed next 11 years of night time care on basis of mother continuing to provide care;
- C had costed two waking carers
- C evidenced need for two waking carers, and that it was reasonable, proportionate and likely to be implemented.

Experts

Accommodation: Chartered surveyor, valuation surveyor, chartered builder etc… v Architect had not spoken to mother nor visited property.

Care / case managers – D's expert inexperienced in maximum severity CP cases. Not acting with CPR 35 responsibilities

Paediatric Neurology – D's expert's approach to life expectancy 'unusual' (agreed between parties before trial).

Leapfrog appeal

- Life expectancy had been agreed between the parties pre-trial as age 29 (based upon C's Paediatric Neurology expert evidence, which relied upon adjusted Strauss data – as opposed to median survival data relied upon by D's Paediatric Neurologist).
- Lost Years claim for LOE and Pension was not recoverable as the court was bound by *Croke v Wiseman*
- Permission to a leapfrog appeal to the SC on the issue of entitlement for a child with a shortened life expectancy to claim damages for 'lost years' (re future LOE and Pension).
- Cs should be reserving their position to plead this loss. D's should be denying in the meantime.

CCC v Sheffield Teaching Hospital NHS FT **[2023] EWHC 1905 (KB)**

Pre trial C made a Part 36 offer to settle her claim consisting of:

- A gross lump sum of £7,000,000; and
- A periodical payments order (PPO) of £360,000 p.a. for life.

The gross lump sum awarded by the court was: lower than the

- £6,866,615 – lower than the part 36 offer and not 'better in money terms'.
- £394,940 p.a. – higher than that offered.

C argued that, overall, the offer was 'more advantageous / better in money terms and Part 36 cost consequences should apply.

Ritchie J rejected this argument

- Offer letter was a combined offer (lump sum and PPO) and to get costs protection you had to beat both elements;
- No basis for reintroducing the multiplier (agreed as part of the lump sum award) when considering the PPO element (the purpose of the PPO is to avoid the uncertainty of the multiplier)
- The way in which offer phrased is critical. Could have made two distinct offers on each part of the award where one or the other was capable of acceptance. In that scenario, the PPO offer would have been beaten with costs consequence on that aspect.

Turner v Sheffield Teaching Hosp. NHS FT [2023] EWHC 3452 (KB) Master Brown

- C suffered severe brain injury shortly after his birth (unsafe breast feeding latch). The Healthcare Safety Investigation Board (HSIB) carried out an investigation and accounts were taken from midwives caring for C.
- C sought specific disclosure from D and third party disclosure from HSIB. Former failed and latter succeeded.
- Trust not in possession of the documents and no basis for demanding that the HSIB provide the documents to the Trust (safe space principle would be subverted if employer could simply demand transcripts);

Turner **cont….**

Third Party Disclosure pursuant to CPR 31.17 succeeded.

(1) Any documents sought would likely support or adversely affect the case – perfectly plausible that facts that were in dispute in the proceedings would have been discussed;

(2) Disclosure necessary to dispose fairly of proceedings - given the contemporaneous nature of the accounts and factual disputes going to the heart of the claim (see para 12-27). It was irrelevant that disclosure might be achieved by a different route (i.e. asking the midwives to provide the same). Necessity to achieve a fair trial is a high bar and won't be overcome in every case (see para 68);

(3) It was appropriate to exercise discretion to order disclosure: confidentiality attaching to the investigation process was not without limit. Clinicians given notice / warning their account might be disclosed. Balancing all interests and noting the importance of the claim to all parties, it was appropriate to order third party disclosure.

Points to note…

- This is not going to apply in all cases where there has been an HSIB investigation. Consider how the cases are pleaded, the factual evidence available and any inconsistencies which are likely to assist the resolution of the claim.
- Please note:
  - maternity investigations now under remit of CQC under the Maternity and Newborn Safety Investigation (MSNI).
  - HSIB now handed over to HSSIB which has enhanced powers and the Health and Care Act 2022 formalised HSSIB's position that material obtained as part of its investigation has the benefit of legal privilege.

Maternity Claims: Hints and Tips

- Tip for preparation: A detailed timeline with counter factual arguments identified and each factual causation scenario worked through;
- Identify your evidential needs: There might be any number of counter factual scenarios to be addressed in evidence. This may call for expert evidence as to what a reasonable clinician would have done in that scenario (Bolam) or factual evidence as to what would happened in the 'but for' scenario (as is CDE).
- Identify wider evidential needs re factual causation: You may need evidence of what was going on in theatre/where other clinicians were occupied at the relevant time (not just what would a reasonable midwife have done, but whether it factually possible or likely on factual causation).

Quality of evidence: experts and factual

- Experts: CV so important. Speak with counsel about your expert choices if possible.
- Do they have the relevant expertise at the relevant time;
- Case managers – have to be skilled and have hands on experience case managing clients with the particular needs of the Claimant.
- Proportionality is important – but beware the desktop reports based on online research only. Ask yourself if it leaves you vulnerable – quality of the evidence is important.
- Ensure all experts go back to Part 35 – give a range of opinion where there is one, say why a head of loss is supported or rejected on evidential grounds (refer to the medical needs and the benefit gained).
- Factual evidence of benefit gained (potentially supported by video)
- D’s must properly evidence alternative regimes in a similar level of detail – cost, practicality, benefit, limitations.

Cont…

- Does material contribution come into play? Was the injury triggered by a single event (indivisible injury), or is it a dose related injury (divisible injury). Or is it a severity case where the consequence / functional outcome is indivisible? If latter, look out for *CNZ* appeal.
- Note: material contribution often pleaded where it doesn't come into play. Has no place in material increase in risk – must prove on balance more than a de minimis contribution.
- Don't forget your CPR tools – Part 18's, specific disclosure / 3rd Party disclosure, Notice to admits facts which might narrow the issues (or agreement of a list of issue in correspondence or at JSM).
- Quantum – think carefully about whether the facts take you beyond the routine / typical awards / discounts on quantum. See *CCC* and 0% deduction to gratuitous care and the discussion therein. Facts sensitive and evidence driven.
- Do you have a vulnerable client or witness participating in proceedings: familiarise yourself with PD1A and Vulnerable Witnesses. Evolving area.

Looking ahead…

- Material contribution is an area of law "*That has been bedevilled by apparent inconsistency and imprecision at the highest level on multiple occasions*." (*Holmes v Poeton Holiding Ltd* [2023] EWCA Civ 1377). More to come on MC….
- Did *Paul* close the door for secondary victim claims in birth / maternity cases? Will facts arise that could be regarded as an external force / accident in a birth case?
- Impacted Fetal Head (IFH) at C-Section – standardised training to improve confidence and consistently of approach. Seeing more and more cases where this is an issue.
- Lost years claims for a minor with reduced life expectancy – look out for the *CCC* SC appeal – reserve position in meantime
- Patient Safety Incident Response Framework 2022 – should have been in place by Autumn 2023 – PSII's should start to filter through – focus on improving healthcare systems (moving away from root cause analysis).
- Fundamental Dishonesty in clinical cases – less frequently seen, but we need to have an eye on it and the substantial injustice qualification (*Williams – Henry v Associated British Ports Holiding Ltd* [2024] EWHC 806 (KB)).
- 17th Edition of JC guidelines published

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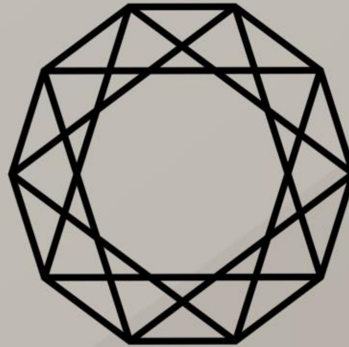
Thank you for your attention.

Questions?



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