Neutral Citation Number [2020] EWHC 20 (QB)

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

10 January 2020

Before :

THE HONOURABLE MRS JUSTICE LAMBERT DBE

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Between :

ASHLEY PAIGE SANDERSON (By her Litigation Friend, BEVERLY SANDERSON)	**Claimant**
- and –	
GUY'S AND THOMAS' NHS FOUNDATION	**Defendant**

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Mr Hugh Preston QC (instructed by **Simpson Millar**) for the Claimant
Mr Simon Readhead QC (instructed by **Bevan Brittan LLP**) for the Defendant

Hearing Dates: 2nd – 6th December 2019

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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MRS JUSTICE LAMBERT

The Honourable Mrs Justice Lambert DBE :

1. The Claimant, who brings this action by her aunt and Litigation Friend, suffers from moderately severe asymmetrical four limb cerebral palsy with cortical visual impairment and learning difficulties. Her injuries were caused by a short period of acute brain hypoxia in the minutes preceding her delivery at 01.05 on 26 February 2002. The questions for me in this trial have been whether there was any breach of duty by the consultant obstetrician caring for the Claimant's mother in her second stage of labour and if so whether, but for that breach of duty, the Claimant's delivery would have taken place earlier such that the period of hypoxia would have been avoided or shortened. The functional effect upon the Claimant's condition and prognosis of any of my findings, and any arguments concerning material contribution, have not formed part of this trial: those issues together with the quantification of the claim are to be determined if necessary in the light of this judgment.

2. The Claimant was represented by Mr Hugh Preston QC and the Defendant by Mr Simon Readhead QC. I am grateful to them both for their obvious hard work in preparing this case for trial and for the skill and care with which they presented their respective cases.

3. Mr Preston's case focuses on the decisions made by Ms Susan Bewley, a consultant obstetrician at the Defendant Trust, between 00.40 on 26 February 2002 and the Claimant's delivery 25 minutes later, at 01.05. A claim arising from midwifery management during the first stage of labour was abandoned in the Amended Particulars of Claim served shortly before trial and, although the pleaded claim retains some contentious allegations concerning the "background and history" of Ms Bewley's involvement, Mr Preston confirmed during his opening that he did not require me to resolve those issues. It follows therefore that the evidence in the trial was concentrated on a relatively short period of time.

4. Ms Bewley produced a timeline of her involvement in the Claimant's mother's care which she exhibited to her second witness statement in August 2019. It represented her best attempt, over 17 years after the events, at a reconstruction of the main elements of her involvement and the timing of key decisions and actions. By closing, the timeline had been largely accepted by Mr Preston and the factual background of the claim substantially agreed. Although there are a few loose ends for my determination on the facts, the issues which I need to resolve arise from the expert evidence and are narrow in scope.

5. I therefore set out below the factual framework of the claim drawn from the medical records and Ms Bewley's evidence, including her timeline of events.

<u>The Facts:</u>

6. The Claimant's mother was 37 years old at the time of her pregnancy with the Claimant in 2001. The pregnancy was uneventful and she was admitted to hospital with irregular contractions at 17.13 on 24 February 2002. The first stage of labour was prolonged by a long latent phase and failure to progress. The Claimant's mother was labouring in Room 4, which was a small room intended for women in the first stage of labour.

7. Ms Bewley was appointed a consultant in 1994. She had been Director of Obstetrics between 1994 and 2000 and in February 2002 she was appointed Clinical Director of Women's Health at the Trust, a post which she occupied until 2004.

8. It is common ground that the night of the Claimant's delivery was exceptionally busy. Ms Bewley was the consultant on call that night and unusually she had come into the labour ward to help the senior registrar and other staff. The Director of Midwifery was also, again unusually, on the ward helping the team. Both obstetric theatres were occupied and the labour ward rooms were all full. Owing to the volume of work at the Unit, it had been closed for safety reasons but, in spite of this, a number of women were still attending by ambulance or through self-referral.

Ms Bewley's First Attendance

9. Ms Bewley was first called to see the Claimant's mother in the very early morning of 26 February 2002. She made a retrospective note which was timed as 00.50 as follows:

> "*ATS [asked to see] 37 PO [primigravida] long latent*
> *phase FTP [failure to progress] 1st stage*
> *ARM [artificial rupture of membranes] + synto[cinon]*
> *CTG OK but last half hour*
> *[arrow up] baseline & late deceleration.*
> *o/e [on examination] looks OP [occipito-posterior] abdominally*
> *EFW [estimated fetal weight] 3.8*
> *Head 1/5 heavy show*
> *VE [vaginal examination] [diagram] LOP -> LOT [left occipito-posterior to transverse] does not turn with manual rotation.*
> *Moulding +*
> *No caput*
> *Bimanual (1/5)*
> *Plan (1) for FBS [fetal blood sample] (2) await 1 hour before pushing."*

10. Although the entry was timed at 00.50, it is accepted that Ms Bewley must have been called by the student midwife to see the Claimant's mother, not at 00.50, but at around 00.40. The reason for Ms Bewley being called was because the student midwife was concerned by the presence of decelerations of the fetal heart demonstrated on the cardiotocograph trace (the "CTG").

11. Upon arrival, Ms Bewley reviewed the CTG trace. She noted a deterioration in the trace over the 30 minutes or so preceding her arrival with a rise in the baseline and, from around 00.16, recurrent late decelerations. These features indicated to her that the fetus might be becoming distressed through lack of oxygen. In her witness statement, she described the fetal heart trace between 00.38 and 00.40 as showing a single prolonged deceleration. She qualified this view in her oral evidence saying that a better description of the trace during this period was of two late decelerations rather than a single prolonged deceleration given the presence of some recovery in the fetal heart rate within the complex. However the feature was described though, although she was concerned about the deterioration in the CTG, there was no indication to deliver the baby urgently.

12. After reviewing the history and the CTG trace, she performed an abdominal examination and then obtained consent to perform a vaginal examination. For the purposes of the physical examination the bed would have had to be repositioned so that it was completely flat. She told me that the midwife's timing (as annotated on the CTG trace) of the vaginal examination being underway between 00.44 and 00.45 therefore fitted broadly with her reconstruction of having arrived at around 00.40.

13. Her abdominal examination suggested to her that the baby was slightly large (clinical estimate of fetal weight of around 3.8 kgs) and that the baby was likely to be in the occipito-posterior position, that is, presenting head first but the wrong way round: facing the mother's front rather than her back. This was a malposition and, in order for the fetus to be delivered vaginally, the fetus would need to rotate, or be rotated, through 180 degrees to get her into the occipito-anterior position.

14. The vaginal examination confirmed that the fetus was in the wrong position: however, rather than lying in the occipito-posterior position Ms Bewley found that she was lying between the left occipito-transverse and left occipito-posterior position: the fetus would therefore need to rotate, or be rotated, through 135 degrees. During the course of her vaginal examination Ms Bewley tried to manually rotate the baby, using her hand to see if there was any movement. The head was however fixed or, as she put it in her evidence to me, "s*tuck*" or "*well stuck*". She could not rotate the head, nor was she able to move it much up and down. There was some moulding of the sagittal sutures (overlay or bony plates of the skull) but no caput (swelling of the head). She performed a bimanual examination with one hand feeling the baby's head (via the vagina) and the other hand palpating the baby's head through the abdominal wall. This confirmed her earlier impression that the baby's head remained one fifth in the pelvis.

15. Having made her assessment, Ms Bewley decided that the appropriate course of management was to check fetal well-being by obtaining a sample of fetal blood. She did not believe that an instrumental delivery would be successful because the fetal head was fixed and would not move. If an instrumental delivery were to be attempted (a so-called "trial of instrumental delivery") she would have wished to perform the procedure in a place of safety where she had the option to convert to a Caesarean section if the procedure was not successful. The Claimant's mother however was labouring in Room 4 which was a first stage room. Ms Bewley told me that it was tiny. There was no central lighting. It was not designed for deliveries and was far too small to be converted into even a makeshift theatre: there was insufficient space for the necessary staff, no room for the surgical equipment trolley or anaesthetic machine and equipment. A trial of instrumental delivery in Room 4 was therefore not an option.

16. Ms Bewley therefore left Room 4 to get the equipment necessary to perform a fetal blood sample and find out about the availability of the two obstetric theatres. In her timeline she recorded her departure from Room 4 as being at around 00.48/00.49. In her oral evidence she explained to me that she would not have left the Claimant's mother any later than this as, at around 00.48/49, the fetal heart dropped abruptly. Even if she had not been looking at the trace at the time she would have heard the heart rate falling via the audible CTG signal. She must therefore have already left Room 4 by 0048/49.

17. When she left Room 4 she collected all the equipment for the fetal blood sampling from the store cupboard which was situated at the far end of the Unit. She made inquiries

concerning the availability of the two obstetric theatres wishing to know whether they were free and, if not, how close to the end of the procedure each obstetrician was. She spoke to the co-ordinating midwife to inform her of her plan and to instruct her to start preparing Room 18 for use as a temporary theatre. She confirmed that, although in her record (see below) she had noted that she had given the instruction that Room 18 be prepared during her second absence from Room 4, she believed that she had in fact given this instruction during her first absence.

Ms Bewley's Second Attendance

18. As she returned to Room 4 with the trolley containing the necessary kit for performing a fetal blood sample, Ms Bewley told me that she met either the student midwife or the midwifery coordinator who informed her that the trace was now showing a bradycardia. In her timeline (as in her record: see below) Ms Bewley noted that she returned to the room at around 00.53. In her evidence to me she said that, whilst she could not be specific as to when she arrived back in Room 4, it would not have been before 00.53.

19. In her note concerning this second attendance, Ms Bewley recorded:

"*called back 12.53 [because] bradycardia*

@ 5 minutes bradycardia decision to deliver urgently in view of previous findings

Needed trial of instrumental? CS [Caesarean section]

Got anaesthetist to top up

NO theatre available

[therefore] asked for another room to be prepared urgently (->18)"

20. It is common ground that Ms Bewley reviewed the trace again. She appreciated that the CTG was now showing a fetal heart rate running at between 80 and 100 beats per minute. In the light of this, Ms Bewley decided that the Claimant must be delivered urgently. The midwife recorded on the CTG trace between around 00.54/ 00.55 that the Syntocinon was switched off, a step which the midwife would have taken upon instruction from Ms Bewley in recognition that delivery was now urgent. Ms Bewley also annotated the CTG trace with the words "*needs delivery stat*" and with an arrow pointing to the time box at around 00.55 and 00.56. Ms Bewley then left the room once again, this time to obtain the equipment necessary to perform an instrumental delivery, to get help and to make further enquiries concerning the availability of an alternative place in which to attempt to deliver the Claimant. In her timeline, she recorded the timing of second departure from Room 4 as being around 00.54/55, in other words, very shortly after she had made the decision that delivery had now become urgent.

Ms Bewley's Third Attendance

21. In a note timed at 00.59, Professor Bewley recorded:

"*terminal brady[cardia].* *Decision*

To attempt delivery in room

Whatever

No cleaning/draping/catheter. No time. No pack

Findings: LOT [left occipito transverse] moulding +

at spines

applied kiwi x 1 – not

correct, x 2 -> occiput

rotated + descended [with] 1 pull and maternal effort

Delivered [with] second pull

in poor condition -> mother

abdomen

1 min to get cord clamps

2 min -> paeds arrival

Delivery at 17 mins from beginning of bradycardia

3rd stage complete with CCT [controlled cord traction]"

22. During her second absence from Room 4, Ms Bewley collected the equipment for the ventouse delivery from the store at the far end of the Unit; she informed her colleagues (midwifery, anaesthetic, paediatric) about the circumstances of the labour and she established that neither theatre had become free, nor was Room 18 prepared for the delivery.

23. In her timeline, Ms Bewley recorded her arrival back in Room 4 at around 00.57. Having reviewed the trace once again and having realised that the fall in the fetal heart rate was persisting, she made the decision "*to attempt delivery in the room, whatever.*" She told me that she was very reluctant to attempt a potentially difficult, if not impossible, delivery without the facility to convert to a Caesarean section. In her timeline she recorded that the final decision to get on and deliver the Claimant in Room 4 was made between 00.58 and 00.59. Having made that decision, she then explained the position to the Claimant's mother, spoke with other members of staff and made the preparations to start the instrumental delivery. She annotated the CTG trace with the words "*decision to deliver in room*" and an arrow pointing to the time box between 00.59 and 01.00.

24. Ms Bewley performed a vaginal examination which showed that the fetus was lying in the occipito-transverse position and at the spines. There was no time to prepare properly with cleaning, draping or catheterisation. She applied the Kiwi ventouse cup but at her first attempt she was unable to locate it in the correct position on the fetal scalp. On the second, this time successful, application of the ventouse cup she was able to rotate the baby's head and achieve descent with one pull and maternal effort. After

the second pull the Claimant was born in poor condition. Ms Bewley calculated that the delivery was achieved 17 minutes from the beginning of the bradycardia. The cord was clamped at one minute following delivery and the paediatricians arrived two minutes after delivery.

The Issues

25. I pause to note that there is no issue arising from Ms Bewley's management from 00.59. The Claimant accepts that the instrumental delivery itself was managed appropriately. The Claimant makes two main allegations, each freestanding.

26. The first allegation is directed at Ms Bewley's decision to perform a fetal blood sample following her assessment between 00.40 and 00.48/49. The Claimant's case is that the CTG demonstrated a prolonged deceleration between 00.38 and 00.43 which continued over three contractions. It is alleged that this feature was a sign of acute fetal compromise and, as such, the only reasonable management was immediate and urgent instrumental delivery of the Claimant which should have taken place in Room 4 if no other facilities were available at the time. The Claimant alleges that Ms Bewley's finding on vaginal examination of a fixed head did not reasonably indicate that instrumental delivery would be difficult or impossible and Ms Bewley's concern that Room 4 was not a place of safety was therefore misplaced.

27. Linked to this first allegation are the subsidiary allegations that (a) having decided to perform a fetal blood sample, she should not have left Room 4. She should have delegated the task of getting the equipment and making the further inquiries to the student midwife or to another member of staff and (b) that having made the decision to leave the room, she was away from the room for too long. On the timeline, she was away from Room 4 for around four minutes when she should have been able to accomplish all that she needed to within two minutes at most.

28. The second allegation focuses upon Ms Bewley's management following her return with the fetal blood sample equipment and her finding that the fetal heart trace had deteriorated to the extent that there was now a bradycardia. It is the Claimant's pleaded case that the bradycardia started at 00.47. Upon Ms Bewley's return to Room 4 at around 00.53 therefore the bradycardia had been ongoing for 5 minutes. Urgent delivery was mandatory. It is alleged that, overall, the interval of time between Ms Bewley's return at 00.53 and her starting the delivery at 00.59 was too long. Acknowledging that there was a need to obtain the essential equipment for the delivery, it is contended again by the Claimant that Ms Bewley should have delegated the task of obtaining the equipment to others and that her absence from Room 4 for around 3 to 4 minutes (between 00.54/55 and 00.57) was excessive given the bradycardic trace and the risk of hypoxic brain injury. The sort of inquiries which she needed to make should have been completed within seconds and not minutes.

29. Both sets of allegations are disputed by the Defendant. Put shortly, the Defendant disputes that there was an indication for urgent delivery following Ms Bewley's first review between 00.40 and 00.47/48. It denies that there was any delay in performing the instrumental delivery following her return to Room 4 at around 00.53 or at all.

Evidence

Ms Beverley Sanderson

30. I did not hear evidence from the Claimant's mother. The Claimant's mother died in tragic circumstances unconnected with this claim in 2002 shortly after the Claimant was born. Her role in the Claimant's life has however been taken by her sister, the Litigation Friend with whom the Claimant lives and by whom she is cared for. Her sister had been living with her at the time of the Claimant's birth and the Litigation Friend was also present at the Claimant's birth. I therefore heard evidence from Ms Beverly Sanderson. She made a statement dated July 2007 in which she recalled the events surrounding the Claimant's birth and the circumstances on the Unit from her perspective at the relevant time.

31. Although much of Ms Sanderson's evidence was not of central relevance to the issues that I have to determine, her witness statement gives an impression of conditions in the Unit that evening. In a section of her statement in which she describes her recollection of events immediately before Ms Bewley's first attendance, she says that she went out of Room 4 looking for a member of staff. She was "*running up and down the corridor but could not find anyone. Near the lift there was a reception area. This was a desk where the nurses sit. No one was there. I found a nurse and told her that Valerie needed help. The student midwife then came back.*"

Ms Susan Bewley

32. She told me that she was called to see the Claimant's mother at around 00.40 and attended immediately. From that time, the Claimant's mother was her "*entire focus*" in the sense that she did not care for any other patient.

33. Ms Bewley was asked a number of questions concerning the reasoning underlying her decision to perform a fetal blood sample. She confirmed that the CTG was abnormal. However, she did not believe that there was an indication to deliver the Claimant immediately or urgently before the onset of the bradycardia. She told Mr Preston that she thought that the CTG trace between 00.38 and 0043 showed a series of late decelerations, but that even if she had believed that there was a single prolonged deceleration she would have attributed the deceleration to the fact that the Claimant's mother had just become fully dilated or was just "hitting full dilatation" together with possibly the position in which the Claimant's mother was lying. Her rationale for the fetal blood sampling was therefore to make an assessment of the condition of the fetus; if the fetal blood sample had been normal then it would have been reasonable to avoid or at least defer attempting to perform an instrumental delivery and hope that the head rotated and descended further. If the fetal blood sample had been abnormal however she would still have wanted to move the Claimant's mother to a place of safety (ie an obstetric theatre) or, alternatively to a room which could be converted into a theatre for an emergency Caesarean section if necessary. The only suitable room was Room 18 which was larger and could therefore be converted into a temporary theatre.

34. Ms Bewley's view at the time was that an instrumental delivery would have been a dangerous procedure given her findings on examination. The combination of her estimate of fetal weight, the fact that the fetal head was fixed and that the baby remained one fifth palpable in the pelvis made her think that an instrumental delivery would not

be successful. She said that even in normal circumstances, she would only have attempted a trial of instrumental delivery in theatre so that the procedure could have been converted to a Caesarean section in the event of it not being successful. However, in this case, because she considered that the procedure would not have been successful she told me that she thought it would have been "*unprofessional and cavalier*" to have attempted an instrumental delivery in the small first stage room in circumstances in which she could not then convert the procedure to a Caesarean section in the event of it failing. If unsuccessful, the baby might die; at best, it exposed the Claimant to the risk of hypoxic brain injury due to cord compression. If she were unable to deliver the baby vaginally either dead or alive then a subsequent Caesarean section would have been much more difficult and traumatic for mother and baby as it would have involved pulling a baby that was obstructed back up into the pelvis.

35. She told Mr Preston that had she been able to achieve some movement of the fetal head on her vaginal examination then she would have still ideally delivered the baby with instruments in theatre. It would still have been a difficult delivery but it would have been one "*which might work*" as opposed to the situation which she faced in which vaginal delivery which "*could not work*." In either set of circumstances, she would have wished to perform the procedure in theatre.

36. Ms Bewley therefore left Room 4 in order to obtain the equipment necessary to perform a fetal blood sample and to find out whether a theatre had become free and give the instruction that Room 18 should be prepared immediately for the delivery. She was confident that she must have left Room 4 before the fall in the heart rate at around 00.48/49 as she would not have left the room whilst the fetal heart was falling. She would have remained to see if the heart rate remained low not least because there would have been no point in performing a fetal blood sample with the heart rate running at below 100 beats per minute as it may have produced a false positive result.

37. On her assessment of the CTG trace, the bradycardia started at 00.50 (and not 00.48 as the Claimant submitted). Although the fetal heart dropped at around 0048/49, on her review of the CTG the heart rate then recovered to around 120 to 130 bpm at 00.50 before once again falling abruptly and staying low.

38. Ms Bewley was not able to give me the exact sequence of her actions and inquiries during her first absence from Room 4. She knew what broadly she would have done, but not the order in which she did things. She told me that she had to go to the opposite end of the labour ward to retrieve the equipment for the fetal blood sample (light, amnioscope, sterile pack, liquid spray) which she would have then wheeled back to Room 4 on a trolley. She would have spoken to the coordinating midwife in charge to inform her of the plan. She would have found out whether the obstetric theatres were still busy either by personally checking the theatres or by asking the coordinating midwife to do so One way or another though she became aware that there was no prospect of either of the theatres being cleared for immediate use and so she asked the midwife to start getting Room 18 ready to use as a temporary theatre if needed. This was a larger room and one which could be turned into a temporary operating theatre. She told Mr Preston that she did not know how long it would have taken for Room 18 to be made ready, but it would have been a bit longer than the time needed to make an operating theatre clear for use. She did not disagree with the suggestion that it might have been 8 minutes or even a bit longer.

39. She was unable to say exactly when she returned to Room 4, save that by the time she returned there was a bradycardia. In the timeline exhibited to her second statement she noted that she had returned between 00.53 and 00.54. In her evidence to me, she said that it would have been probably no earlier than 00.53. On this basis, she was probably out of Room 4 for the first time for about 4 minutes. It was suggested to her by Mr Preston that it should not have taken her longer than a "*minute or two*" to do all that she had to do before returning to Room 4. Ms Bewley accepted that she had no recollection of how long she was away from Room 4 but that she thought that it "*did and would*" take longer than a minute or two. She told me that she "*was not doing anything else or dawdling.*"

40. She said that she had a strong recollection of coming back into Room 4: she remembered that as she was wheeling the trolley of equipment into the room either the student midwife or the midwifery coordinator told her that there was a bradycardia: "*that was when everything changed from one situation to a much more acute situation so that is why the memory is stronger*." She thought that she made the decision that immediate or "*stat*" delivery was necessary when the bradycardia had been present for around 5 minutes, that is, at around 00.54/55 and that was the point which she was making in her note *"@ 5 minutes bradycardia decision to deliver urgently*." She did not agree that her record indicated that upon her arrival back in the room at around 00.53 the bradycardia had already been ongoing at that stage for 5 minutes, nor did she accept that the note which she made later, that delivery had been achieved 17 minutes after the start of the bradycardia, meant that the bradycardia had started at 00.48. In her view, looking at the trace in 2019, it was clear that the bradycardia had not started until 00.50.

41. She was asked a number of questions by Mr Preston concerning her thinking at this point. She explained to me that in the light of the bradycardia, she knew that she would have to deliver this baby urgently "*one way or the other*" and that if the Claimant's mother was to remain in Room 4 then there was only one way, which was by instrumental delivery without recourse to Caesarean section if it was not successful. She told me that she was very reluctant to perform a potentially difficult, if not impossible, rotational delivery without knowing the condition of the fetus and without the possibility of converting to a Caesrean section which would have been impossible in Room 4. Therefore, before making any final decision about the location of the delivery, she wanted to check whether there was any other option available: whether a functioning theatre had become available and/or that Room 18 had been made ready. She therefore left Room 4 in order to obtain the equipment, this time for the purposes of an instrumental delivery, and to find out about Room 18. On her reconstruction of events, she thought that she probably left Room 4 to make those inquiries and to obtain the equipment at around 00.54 to 00.55.

42. It was put to her by Mr Preston that there was nothing to be achieved by her checking on availability of theatres as she had already found out that they were busy. She told me that she was trying to find out whether Room 18 was ready. She did not accept that this was a pointless exercise and that only a "*minute or two*" had elapsed since she had given the instruction that Room 18 should be converted. She told me she could not remember the sequence of her discussions during her first absence from Room 4 and that if it had only been a minute or two then she would not have tried to find out if Room 18 were ready. When it was put to her that realistically there had been no

prospect of Room 18 having been made ready by that point she responded: "*I do not think so, I thought at the time, I was hoping, maybe against hope, that the extremely good staff at St Thomas's might have got that ready and we might be able to get there*."

43. In her timeline, she estimated that she was back in Room 4, with the ventouse equipment, having ascertained that Room 18 was not a viable option and that no theatres had become free, by around 00.57. She thought that she was out of the room therefore for perhaps 3 to 4 minutes. It was suggested to her that she took too long to obtain the equipment and make her inquiries. She told me that she did not think that she could have done things any more quickly than she did. She would have walked briskly but she would not have run; she didn't think it appropriate to run as this causes panic. She said that it was a labour ward which she knew well. She knew all the people and she knew where everything was. If it could have been done more quickly then she would have done it more quickly. She told me that "*a crashing emergency is now happening on the labour ward. The coordinating midwife needs to know. The anaesthetist needs to know. The paediatricians need to know. We need to know about theatres and I need to get the equipment. So there was a lot of things being done at the same time. It is not just stick your head in the door, there is actually a conversation and calling people*". It was suggested to her that to make her inquiries and get the equipment would have taken only "*seconds or a minute*." Her response was "*this is not how it is on a labour ward.* She was asked why she had not delegated to others. She agreed that she could have done this if there were people available to help and that *"people know what instrument, where it is and there are people to do it and they know what to do*"

44. Having arrived back at Room 4, she then noted that the fetal heart had not improved and at 00.58/59 she therefore made her final decision to proceed with the instrumental delivery in Room 4. She explained the position to the Claimant's mother, communicated the plan to members of staff, positioned the mother in the lithotomy position, opened the equipment, washed her hands and gloved up. She commenced the delivery at 00.59. She told me that, as she started the procedure, she did not think that it would succeed. However, after performing a vaginal examination, she found that there had been a further slight rotation of the baby's head and so she was then more hopeful that the procedure would succeed. As she noted in the records, she had to apply and then re-apply the Ventouse cup. She was able to flex and rotate the baby's head and, once she was rotated into the correct position, she delivered the Claimant at 01.06.

Mr Suresh Duthie

45. Mr Duthie is a recently retired Consultant Obstetrician from Blackpool Teaching Hospital NHS Trust. He gave expert evidence on behalf of the Claimant.

46. Mr Duthie was critical of Ms Bewley's decision to perform a fetal blood sample at the conclusion of her first assessment. In his opinion, she made two mistakes: she failed to appreciate the significance of the CTG trace and she misinterpreted her findings on abdominal and vaginal examination.

47. Mr Duthie told me that the CTG trace demonstrated a prolonged deceleration between 00.38 and 00.43. It lasted 5 minutes and crossed 3 contractions. The NICE Guideline "*The Use of Electronic Fetal Monitoring*" dated May 2001 defines a prolonged deceleration as an abrupt decrease in the fetal heart rate below the baseline that lasts for

at least 60 to 90 seconds and that a prolonged deceleration becomes pathological if it crosses two contractions ie it lasts more than 3 minutes. He did not accept that the presence of recovery in the fetal heart albeit not to the baseline, meant that the feature should not be categorised as a prolonged deceleration as no such qualification appears in the Guideline definition.

48. In his opinion the presence of the single prolonged deceleration was clear evidence of acute fetal compromise which mandated immediate instrumental delivery. He drew my attention to the relevant section of the NICE Guidelines which stated that "*Where there is clear evidence of acute fetal compromise (e.g prolonged deceleration greater than 3 minutes) fetal blood sampling should not be undertaken and the baby should be delivered urgently*" (my emphasis).

49. Mr Duthie told me that there were no findings on abdominal or vaginal examination which could reasonably suggest that the Claimant could not have been successfully delivered by an instrumental delivery in Room 4. He did not accept that the baby was a large baby, as the estimated weight fell upon the 75the centile and was therefore well within the normal range. There was no evidence of disproportion which, had it been present, would have created a risk that an instrumental delivery would not have been successful. Ms Bewley had therefore been quite wrong to have been worried by the estimated weight of the baby. She had also grossly overstated the risks associated with her finding that the baby's head was fixed. Mr Duthie noted that there had been considerable descent since the previous vaginal examination and although Ms Bewley had found the head to be stuck at the time of her vaginal examination that may not have been the case a few minutes later. He told me that labour is a dynamic process and even during the course of a single contraction, the head may turn. There was no caput and the degree of moulding was normal, both of which were favourable indications for a successful vaginal delivery. He did not accept that instrumental delivery would be dangerous and there was nothing to his mind to suggest that vaginal delivery was not going to be possible. In his opinion there was only a remote risk that an instrumental vaginal delivery might result in cord compression and bradycardia.

50. In his opinion therefore Ms Bewley's decision to perform a fetal blood sample was flawed. The Claimant needed to be delivered urgently because she was suffering from acute fetal compromise. There were no real obstacles to a successful instrumental delivery and steps should therefore have been taken to deliver the Claimant in Room 4 following her first assessment. Mr Duthie confirmed that in his opinion, no reasonably competent obstetrician would have elected to delay delivery and perform a fetal blood sample rather than getting on with the delivery in Room 4.

51. Having negligently made the decision to perform a fetal blood sample, Ms Bewley then compounded or added to that breach of duty by failing to remain with the Claimant's mother and delegating to other members of staff the job of getting the necessary equipment and making such inquiries as she thought necessary. She was also away from Room 4 for too long. Although he had not personally been to that Unit, he said that all such Units are reasonably compact and "*not built on a scale of half a mile*;" they are all attuned to dealing with emergencies; fetal blood sampling equipment is usually kept in packs or, if not, then all of the elements of the kit are kept in the same room. In his view, Ms Bewley should have taken no longer than one to two minutes at most to get the equipment and make the various enquiries concerning theatre availability.

52. In his report, Mr Duthie said that the bradycardia commenced at 00.47/00.48. During the course of his evidence he was shown a better copy of the relevant section of the CTG trace. Whilst he maintained his opinion that the bradycardia started at 00.47 to 00.48, he was prepared to accept that on the basis of the clearer trace it was "possible" that the bradycardia had not started until 00.50.

53. However, whether the bradycardia started at 00.47 or 00.50, Mr Duthie's opinion was that urgent delivery was then mandatory. On the basis that Dr Bewley arrived back in Room 4 by around 00.53, he thought that the delay of around six minutes before the start of the delivery at 00.59 was too long. He accepted that there would be a need to obtain instruments and further inquiries but that should not have taken longer than 2 minutes at most.

54. In his opinion, the Claimant should have been delivered well before 01.05.

Mr Derek Tuffnell

55. The Defendant relied upon the expert evidence of Mr Tuffnell, a recently retired consultant obstetrician and gynaecologist from Bradford Royal Infirmary.

56. Mr Tuffnell did not accept that the trace showed a single prolonged deceleration running from 00.38 to 00.43. In his opinion, it is a characteristic of a prolonged deceleration that the heart "*goes down and stays down for a period of time and then recovers back up to the baseline*". In contrast, the fetal heart complex between 00.38 and 00.40 showed an abrupt drop in the fetal heart rate but the heart rate did not remain consistently low: there was a partial recovery albeit not to the baseline as the recovery was interrupted by the onset of a further contraction. He agreed with Mr Preston that a strict interpretation of the definition of a prolonged deceleration in the NICE Guidelines does not require the fetal heart to remain consistently low, only below the baseline but his view was that the Guidelines were "*not as precise in every description as you might wish to make them forensically*."

57. He told me that if he had to categorise the heart complex, he would describe it as an atypical variable deceleration However, in his opinion, the precise classification or categorisation of a fetal heart trace feature is not the main point. The real issue is the clinical relevance of the feature and what action is indicated. In his view, the trace viewed as a whole from midnight was pathological. It mandated action, but what action was mandated depended upon the clinician's view of whether the trace indicated that the fetus was suffering from the effect of acute hypoxia.

58. In his view, the trace did not suggest that the fetus was acutely compromised. The heart rate never fell below around 120 bpm. In his view, the pattern of late decelerations which occurred before 00.38 and the deceleration at 00.38 were a sign that the fetus was suffering from chronic (rather than acute) hypoxia and if he had been managing the labour he would have been worried that the baby was beginning to struggle with the progress of labour. He would have been reassured by the increase in the fetal heart rate during the course of the vaginal examination as if there had been significant compromise, in his experience, the usual response to a vaginal examination would have been a deceleration in the fetal heart. He would have been reassured by the fact that

the fetal heart returned to a normal baseline after 00.43. In his opinion the risk of brain damage occurring within a short time period was "*very very small*". He agreed with Mr Preston that there was always a possibility that the trace would deteriorate into a bradycardia but said that he would not have been expecting an acute event.

59. He therefore disagreed with Mr Duthie that the drop in the fetal heart to around 120 bpm lasting 3 minutes in itself required urgent delivery. He told me that it was very common in labour to get a deceleration lasting 3 to 5 minutes. Frequently the heart rate then returns to the baseline with normal variability and no decelerations. The cause of the deceleration could be due to a change in maternal position or some transient pressure on the cord. Such decelerations frequently return to the normal baseline with normal variability. The appropriate action is therefore to review (or continue to review) the trace: if after 3 to 5 minutes the heart rate recovers, as in this case, then he would not have decided to deliver the fetus urgently. He told me that if the NICE Guidelines were therefore to be interpreted in the way advised by Mr Duthie then unnecessary Caesarean sections would be performed in many labours.

60. Mr Tuffnell agreed with Mr Preston that although the estimated weight of the baby was larger than average, the weight in itself would not be a contraindication to vaginal delivery. However, in his view the malposition of the fetus would make the risks of an operative vaginal birth considerably greater and the fact that the head was fixed or stuck would make the reasonable clinician more concerned that the procedure would not be successful. He agreed with Ms Bewley that to have opted to perform an instrumental delivery in Room 4, in the presence of a fixed head with a malpositioned fetus when the CTG was abnormal and where there was no practical option of converting to a Caesarean section would have been "*cavalier*."

61. Mr Preston put to Mr Tuffnell that nothing was lost by an attempted instrumental delivery. Mr Tuffnell did not agree. Not only would such a course, if unsuccessful, lose time, but the effect of the attempt would inevitably be to bring the head into a tighter fit within the pelvis making an abdominal delivery even more difficult. The attempt would risk causing acute fetal compromise without any option to convert to an open procedure to deal with it.

62. Mr Tuffnell did not accept that Ms Bewley should have delegated the task of obtaining the equipment for the fetal blood sample. He was of the view that if you wanted something to be done quickly it was generally quicker to do it yourself, rather than relying on others who may not know what equipment to fetch and where it was located.

63. Nor did Mr Tuffnell accept that there was undue delay in commencing the delivery following Ms Bewley's return to Room 4 at 00.53 and her decision that the delivery should take place urgently at 00.54/55. In his opinion, embarking upon the instrumental delivery in Room 4, in circumstances in which reasonably the clinician did not believe the attempt would be successful was "*a big call*" and "*incredibly challenging*." He was asked about the time spent by Ms Bewley in obtaining the equipment for the purpose of the instrumental delivery and making her further inquiries about Room 18. He accepted that four minutes "*does seem like a long time to do those things*." It made him question whether in fact she was away from Room 4 for four minutes and/or whether there were other things done by Ms Bewley during her absence which she could not recall. Mr Tuffnell's view was that, precisely how long Ms Bewley was away

from Room 4 was a question of fact for the court to decide but in his opinion it was "*very harsh*" to suggest that there had been any delay in the circumstances.

Legal Principles:

64. There is no material difference between the parties as to the relevant test which I must apply. I apply the "*Bolam*" test which derives from the direction given to the jury by McNair J in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 583 at 587 where the judge stated in connection with a medical doctor: "*he is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in this particular art… Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice merely because there is a body of opinion that would take a contrary view*."

65. In the context of this case, the two central *Bolam* questions for me therefore are: first, whether no reasonably competent obstetrician would have elected to perform a fetal blood sample rather than proceed to immediate and urgent emergency instrumental vaginal delivery in Room 4 following Ms Bewley's vaginal examination. I bear in mind that differences of opinion and practice exist and will always exist in the medical and other professions: a court may prefer one body of opinion to another, but that is no basis for a finding of negligence. See: *Maynard v West Midlands RHA* [1984] 1 WLR 634 at 638E. Second, whether the interval of around 6 minutes between Ms Bewley's return at around 00.53 and her starting the vaginal delivery at 00.59, was excessive when judged against the standards of the reasonably competent obstetrician acting in emergency circumstances; specifically whether her decision to leave Room 4 rather than to deputise the task of collecting the necessary equipment and making inquiries was one which no reasonably competent obstetrician would have made; and whether, having left Room 4, her absence from the room was too long when judged by the standards of the reasonably competent obstetrician.

66. I recognise that in making my assessment of the evidence, I should not delegate the task of deciding the issues in the case to the expert. The issues are for the court to decide taking into account all of the evidence. In making the assessment of whether to accept an expert's opinion the court should take into account a variety of factors including, but not limited to: whether the evidence is tendered in good faith; whether the expert is "responsible", "competent" and/or respectable; and whether the opinion is reasonable and logical. See: *Bolitho v City and Hackney HA* [1998] AC 232.

Discussion:

The Timeline

67. The events in question took place over 17 years ago. A letter of claim was sent in 2012 but the claim advanced in that document bears little relationship to the claim as now formulated. Ms Bewley confirmed that although she has some recollection of the events under scrutiny, her account of her management of the later stages of the labour and delivery has been an exercise in reconstruction from what memory remains, the contemporaneous records and what she believed she would have done and thought from her knowledge of her practice in 2002. She has not been helped by her contemporaneous records partly because they were written in a block after the delivery and also because to the extent that she noticed the timings of events as she was working

they would have been taken from a variety of different clocks, none of which were synchronised. No criticism is made of her for her note keeping. As she observed not only were the early 2000s a different era of note keeping practice, but she was working in high pressure and then in emergency circumstances.

68. Ms Bewley has produced a timeline of events which has been substantially agreed between the parties. However, it is important to be realistic about the times set out in that document. A forensic scrutiny of timings, 17 years after the events in question, is bound to involve an element of imprecision. I recognise that, in a case such as this, where every fraction of a minute of delay in delivery may have an impact upon the Claimant's condition, the court must do the best it can to arrive at a timeline which is both as accurate and as precise as possible. However, there was an element of unreality to some of the questions posed by Mr Preston during his cross examination of Ms Bewley when attempting to refine the timeline down still further from that which had been advanced in Ms Bewley's witness statement. It is impossible now to establish even on the balance of probabilities whether, for example, Ms Bewley arrived back in Room 4 with the fetal blood sample kit at 00.53 exactly or closer to 00.54 or even later. It is impossible now to reconstruct exactly how long Ms Bewley would have spent scrutinising the trace following her arrival back in Room 4 at around 00.53/54 before making the decision that delivery was urgently needed; or drill down to the exact fraction of a minute when she returned to Room 4 and made her final decision to get on and deliver "*whatever*" in Room 4.

69. With this in mind I set out below in tabulated format the timeline of events under scrutiny. I have adopted the approach of the Defendant and for the most part given the times to the nearest minute.

00.40	Ms Bewley is called and arrives in Room 4
00.48/49	Ms Bewley leaves Room 4 to obtain equipment for fetal blood sample and make inquiries concerning theatre availability and Room 18
00.53/54	Ms Bewley returns to Room 4 and notes bradycardia
00.54/55	Ms Bewley makes decision that delivery should be undertaken urgently, the Syntocinon is switched off and Dr Bewley leaves Room 4 for the second time, to get the equipment for an instrumental delivery and to make inquiries concerning Room 18.
00.57/58	Ms Bewley returns to Room 4
00.58/59	Ms Bewley makes decision to deliver in Room 4 and prepares for instrumental delivery
00.59	Ms Bewley starts instrumental delivery
01.05	Claimant delivered

Ms Bewley

70. She was an impressive witness. She gave her evidence in a non-defensive matter of fact way which suggested to me that her evidence was both an honest and, to the best of her ability, reliable reconstruction of the sequence of events and her clinical reasoning. She was careful to give as neutral a factual account of her care and its rationale as she could and to avoid trespassing into areas of expert opinion, notwithstanding her expertise and experience both in 2002 and at the date of trial. I accept her account of her involvement and I accept as matters of fact her explanations for the decisions which she made.

71. There are two aspects of Ms Bewley's evidence which are worthy of emphasis at this stage.

72. First, it is not disputed by Mr Preston that the Unit was unusually busy that night: this is why both Ms Bewley and the Head of Midwifery had come into the Unit. The most vivid illustration of the conditions on the Unit however came from the Claimant's aunt who described coming out of Room 4 to get help for her sister who was in pain, looking up and down the corridor and seeing no one, running up and down the corridor looking for a nurse but being unable to find one and seeing the nursing station deserted. The picture which she paints is relevant to the allegations made by the Claimant arising from the length of time which Ms Bewley spent obtaining equipment and making inquiries during her two absences from Room 4. I will return to the point later.

73. Second, as I have already said, I accept Ms Bewley's evidence both of what she did and why she acted as she did. I have no doubt, having heard her account, that she believed that an attempted instrumental delivery would not be successful given her findings on vaginal examination and her estimate of the size of the fetus. She told me that at 00.59 when she commenced the procedure she did not believe that it would be successful and that if she had not been able to deliver the Claimant at that time she would have died. Whether that belief was *Bolam* reasonable in the circumstances is a question for the experts but, whether reasonable or not, I accept that it was her genuine belief. It explains her wish to explore whether there was any chance of securing a delivery in a place of safety, whether that was an obstetric theatre or a converted Room 18. It also explains her records which, as she pointed out to me, were intended as much as anything to explain to the reader how and why it was that she came to be performing this (in her view) dangerous procedure in Room 4.

74. I invited the parties to draw up an agreed list of issues for my determination. Although the list provided runs to 9 points, there are in fact only two main breach of duty issues which I must decide. The first is whether the decision to perform a fetal blood sample was one which no reasonably competent obstetrician would have made. This question raises the further issues of whether the CTG trace demonstrated that the fetus was or may be suffering from acute compromise due to lack of oxygen such that the only reasonable management following Ms Bewley's vaginal examination was immediate, urgent delivery in Room 4 and whether Ms Bewley's conclusion that instrumental delivery at that stage in Room 4 would be dangerous was a reasonable conclusion. The second issue putting it broadly for present purposes is whether, following the decision to perform a fetal blood sample, there was any culpable delay in commencing the instrumental delivery either due to delay in returning to Room 4 with the fetal blood sample equipment or delay in starting the procedure following

Ms Bewley return at 00.53 and her review of the trace at that time. The other issues for my determination are the hypothetical factual causation issues which I return to at the end of this judgment.

The First Issue: the decision to perform a fetal blood sample

75. I deal first therefore with whether Ms Bewley's decision to perform a fetal blood sample was *Bolam* unreasonable.

76. Mr Duthie's thesis, that the only reasonable management following 00.43 was urgent delivery, rests upon his interpretation of the 2001 NICE Guidelines concerning the use of electronic fetal monitoring. He relies upon the Guideline definition to support his assertion that the fetal heart complex between 00.38 and 00.43 is a single prolonged deceleration; he then relies upon the statement in the Guidelines that a prolonged deceleration greater than three minutes is "*clear evidence of acute fetal compr*omise" and finally he relies upon the statement that, where there is such clear evidence of acute fetal compromise, fetal blood sampling should not be performed but the baby delivered urgently. There are, in effect, therefore three links in his chain of reasoning (all derived from his interpretation of the Guidelines) which lead him to the conclusion that the only reasonable management following the initial assessment was urgent delivery.

77. Mr Duthie's reliance upon the Guidelines to support his contention that urgent delivery was mandated is to my mind highly problematic. Even if I were to accept his interpretation of the definition section of the Guidelines and find that the trace complex between 00.38 and 00.43 is a single prolonged deceleration, the further two links in his reasoning, that the feature is evidence of acute fetal compromise and mandates immediate delivery, overlook the apparent contradiction within the Guidelines concerning the appropriate obstetric management in the presence of this trace feature. As Mr Tuffnell observed, the preceding section in the Guidelines refers to management where "*the CTG falls into the pathological category*." In that section, the authors advise the use of conservative measures and expressly state that fetal blood sampling should be undertaken where appropriate or feasible. Only in circumstances in which fetal blood sampling is not possible or appropriate do the Guidelines recommend expedited delivery. This section is relevant to the question which I must decide because the Guidelines also state that a CTG which falls into the pathological category includes a trace which demonstrates a single prolonged deceleration lasting longer than 3 minutes.

78. Putting it shortly therefore, the Guidelines on their face appear to advocate two contradictory management options in response to a single prolonged deceleration lasting longer than 3 minutes: conservative measures where possible or feasible (expressly including fetal blood sampling) and a few short paragraphs later urgent delivery (fetal blood sampling being contraindicated). On the critical question for my determination, the Guidelines point in two, entirely different, management directions.

79. The difficulty posed by this contradiction is intractable if, as Mr Duthie appears to suggest, the Guidelines are intended to provide the practitioner with the complete description of appropriate management in the presence of a particular trace feature. Mr Tuffnell however provides the answer to the conundrum. He told me that the Guidelines do not provide a complete compendium of either definitions or clinical

management options. The Guidelines are useful so far as they go, but they are limited. The Guidelines do not provide a substitute for clinical judgement but must be interpreted by the clinician and then applied in the light of that judgement. He pointed out that there are contradictions within the Guidelines; that the classification of a trace by reference to the definitions provided is almost a matter of "*obstetric art*" not susceptible to forensic dissection; and that some definitions do not go far enough, in particular what features amount to acute fetal compromise.

80. The contradiction within the Guidelines pulls the rug from under Mr Duthie's thesis. His opinion on Ms Bewley's management relies on his almost formulaic application of sections of the Guidelines taken out of context. Once his reliance on the Guidelines is seen to be misplaced, as I find it is, Mr Duthie offers little in the way of alternative "real world" analysis (as Mr Preston might put it) of how the reasonably competent clinician should respond to the trace in this case. He makes no observation concerning the significance of the recovery in the fetal heart between 00.38 and 00.43 (save to make the definitional point that such a feature does not prevent it being a single prolonged deceleration), nor the recovery of the fetal heart during the vaginal examination, save to observe that the recovery was in the event transient.

81. There are two further curious points which arise from Mr Duthie's evidence. The first is that his real view may have been rather closer to Mr Tuffnell's than might initially appear from Mr Preston's closing argument. He gave a revealing answer to the question of whether, in all contexts, a single prolonged deceleration in the second stage of labour mandated urgent delivery. His response was not, as I might have expected that, following a prolonged deceleration, urgent delivery was mandatory. On the contrary, he agreed with Mr Tuffnell that "*in a general sense..we would wait… if there is a return to the baseline with normal variability and that goes on, then there is no need for immediate delivery*." Although maintaining his view that, in this case, there was a need for immediate delivery as the return to the normal baseline was transient, his response that in general he would continue to review the trace to see if it returned to normality and, if so, then not instigate urgent delivery, was inconsistent with the interpretation of the section of the Guidelines which he urged upon the court.

82. The second surprising feature of Mr Duthie's evidence is his observation that fetal blood sampling would have been an appropriate response to the presence of a single prolonged deceleration if the mother were in the first stage of labour and vaginal delivery therefore not possible. This statement is both illogical and inconsistent with Mr Duthie's evidence that a single prolonged deceleration (as clear evidence of fetal compromise) mandates urgent delivery. In the presence of evidence of acute fetal compromise, the fact that one of the two modes of delivery is not available does not logically justify conservative measures. If, as Mr Duthie submits, the feature indicates a fetus on the brink of brain damage or already suffering the brain damaging effects of hypoxia then logically the only intervention should be urgent delivery - by Caesarean section if that were the only option available.

83. For these reasons, and without hesitation, I reject Mr Duthie's interpretation of the Guidelines that the presence of a single prolonged deceleration is evidence of acute fetal compromise and that it mandates urgent delivery, and nothing other than urgent delivery. Such an approach is both a highly selective interpretation of the Guidelines and one which ignores the apparent contradiction within them to which I have referred. Mr Duthie's deployment of the Guidelines to establish his case against Ms Bewley is

not sustainable and I reject it. Although no doubt a useful resource, I accept Mr Tuffnell's evidence that the Guidelines are a practical tool to be used in conjunction with clinical judgement.

84. Mr Preston's written closing argument invites me to reject Mr Tuffnell's opinion for a number of reasons, all of which are derived from Mr Duthie's strict interpretation and application of sections of the Guidelines. Mr Preston submits that (a) if the authors intended to define a single prolonged deceleration by reference to a heart rate which as Mr Tuffnell suggests "*goes low and stays low*", the Guidelines would have made this clear; (b) the Guidelines state that a single prolonged deceleration is evidence of acute fetal compromise and do not suggest that the only clear evidence of acute fetal compromise is a bradycardic trace and (c) they do not say that it is only in the presence of a bradycardic trace that urgent delivery is mandatory.

85. My rejection of Mr Duthie's use of the Guidelines substantially deals with these points. However, to make clear, I accept that by reference to the definitions section of the Guidelines, the complex between 00.38 and 00.40 may fall within the definition of a single prolonged deceleration, but this is not the point. It takes the clinician nowhere. The application of that definition does not in itself dictate the appropriate response. The only way in which the Guidelines are intelligible and workable is if the reasonable obstetrician also exercises his or her judgement to assess the appropriate response by reference to the trace as a whole, which I find in this case includes the depth to which the heart rate fell between 00.38 and 00.43; the presence of some recovery in the heart rate between 00.38 and 00.43 albeit not to the baseline and the response of the fetal heart during the vaginal examination. I accept that these features would and should be taken into account when determining the appropriate management. As I have already observed, Mr Duthie has no answer to the points save to come full circle and note that these sorts of qualifications do not feature within the Guidelines.

86. Mr Tuffnell's view is that a fall in the fetal heart rate from 160 beats per minute to 120 beats per minute would be a factor which would cause the reasonably competent obstetrician to be concerned, particularly in the light of a trace which was already, by 00.38, pathological. I accept this view. However, I also accept his evidence that a fetal heart rate of 120 beats per minute would not signal to the reasonable obstetrician that the fetus was suffering from the effect of acute hypoxia and that the fetal heart recovery between contractions (although not to the baseline) and response to the vaginal examination were both "positive" features. I accept that overall the reasonable interpretation of the trace was of a stressed fetus suffering from chronic hypoxia rather than an acute event. Absent hindsight, in these circumstances, the reasonable obstetrician would not be concerned that the trace heralded the likelihood of an acute event within the near future. The trace mandated action. But a reasonable response included performing a fetal blood sample to assess fetal acidosis.

87. Dealing with Mr Preston's further points on this topic, I find nothing illogical in Mr Tuffnell's view that a reasonably competent obstetrician faced with a decelerative trace would adopt an expectant approach and wait to see how the trace developed. As Mr Tuffnell told me, decelerative traces are not uncommon in labour due to a variety of different factors such as change in maternal position or transient pressure on the cord and to perform an emergency delivery after only 3 or so minutes would mean that many women would be subjected to the risks of unnecessary Caesarean sections. Mr Duthie's, possibly unguarded, comment (referred to in paragraph 76 above) would

suggest that he agreed with this approach also. Further, although not directly relevant, I do not accept Mr Preston's interpretation of Mr Tuffnell's evidence that urgent delivery would only be mandated in the face of a bradycardic trace with a heart rate running at a level of 60 to 80 beats per minute. This was an example Mr Tuffnell gave to illustrate the circumstances in which urgent delivery would be required, but his point generally was that the clinician must take a view based on the trace as a whole and any other relevant maternal factors. As he said, the Guidelines do not give a comprehensive definition (or range of definitions) of the trace features which point in the direction of acute fetal compromise.

88. This is sufficient to address Mr Preston's first allegation against Ms Bewley. I do not accept that the trace mandated urgent delivery and I accept that a fetal blood sample was an appropriate and reasonable response to the trace between 00.38 and 00.43. My findings above are dispositive of the first issue for my determination. However, there is a further dimension to the Claimant's case which I address below which arises from Ms Bewley's concern that an instrumental vaginal delivery would not be successful. The question is whether that view was misplaced.

89. Mr Readhead's closing submissions invite me to conclude that Mr Duthie's evidence demonstrated a degree of inflexibility. I accept that it can be all too easy for Counsel to submit that a witness who does not accept the various propositions which are put in cross examination is behaving in a dogmatic way. However, in this case, there is considerable force to the submission.

90. Mr Duthie stuck to his opinion that attempting to perform an instrumental vaginal delivery in Room 4 was not a dangerous procedure. His view was that, at its highest, the procedure carried only "*a remote risk*" of not succeeding. This opinion was based upon his thinking that, although the fetal head was found to be fixed at the vaginal examination which Ms Bewley performed, it may have moved by the time of attempted delivery a few minutes later because of the natural dynamic forces of labour. Even taking into account Mr Duthie's further point, which was the extent of the descent of the fetal head from the time of the vaginal examination which preceded that performed by Ms Bewley, Mr Duthie's view that an instrumental delivery would be successful is at best tinged with speculation. The head may have become freed over the next few minutes but, viewed prospectively and without the benefit of hindsight, I find it hard to understand the basis for Mr Duthie's confidence that Ms Bewley's concerns were so wholly misplaced.

91. As against the risk of the procedure not being successful, Mr Duthie was forced to concede that he had no "plan B" as it was described by Mr Readhead. He accepted that if the risk eventuated then Room 4 could not be converted for the purpose of a Caesarean section and the outcome would have been intrauterine death or brain damage. It seems to me that, even if I were to accept that the risk of the procedure not working was remote or very small as Mr Duthie suggested, the catastrophic consequences of the failure were such that the procedure could only sensibly be described as a dangerous one. Mr Duthie's refusal to accept this simple point is surprising.

92. I have already indicated that I accept Ms Bewley's factual evidence that she was concerned that an instrumental delivery would not be successful both immediately following her vaginal examination and at the point when she decided she had no option other than to proceed with the instrumental delivery 10 or so minutes later. I accept

that that view was reasonable. She did not have the benefit of hindsight and the knowledge which she acquired when she came to perform her vaginal examination at 00.59 that there had been some movement of the fetal head. Mr Tuffnell agreed that to have proceeded with a vaginal delivery in Room 4 following Ms Bewley's first vaginal examination would have been cavalier. I find that, even if the risk of the procedure not being successful were not as high as Ms Bewley judged the risk to be at the time, the possibility of an appalling outcome was such that she was right to be cautious.

93. I therefore conclude that Ms Bewley's decision to perform a fetal blood sample was reasonable. It was a decision which would be supported by a reasonable and responsible body of obstetricians. It was not illogical but based upon a reasonable assessment of the fetal heart trace which, although pathological, did not indicate the need for urgent and immediate delivery. Her decision to temporise and obtain a fetal blood sample to assess whether the Claimant was acidotic due to hypoxia was supported by her reasonable belief that proceeding immediately to delivery in Room 4 carried an unacceptable risk of injury or death to the Claimant.

94. I move on to consider the two further arguments advanced on the Claimant's behalf: that Ms Bewley should have delegated the task of seeking the equipment and making enquiries to the student midwife (or another) and/or that having made the decision to leave Room 4 she took too long about it. I can deal with both of these points relatively shortly.

95. The first of these allegations is a "makeweight." Mr Duthie may be of the view that the quickest way to get something done is to deploy others to do it. But it is also reasonable for the person who knows what equipment is needed, where the equipment is kept, who to speak to and where those people are likely to be (or who to ask to find out where they are) to decide to undertake the task him or herself. This is no more than common sense. In the context of this case, much may depend upon the confidence which Ms Bewley placed in the student midwife about whom I heard very little at trial. Of more relevance however is Ms Bewley's knowledge of the circumstances on the Unit that night. Given that everyone was busy, or likely to be busy and perhaps not in the place where they might be expected to be found, I accept fully that Ms Bewley's decision to go herself to make the enquiries and to obtain the equipment was reasonable. As she said, she knew the Unit and she knew the people in it. Given the exceptional circumstances that night, her view that she was best placed to perform the task herself cannot be condemned as being negligent. I reject the point.

96. I also reject the further point that Ms Bewley took an unreasonably long time to perform the tasks of getting the equipment and speaking to her colleagues about the availability of theatres and giving the instruction that Room 18 should be prepared. This is not a pure expert issue. Neither Mr Duthie nor Mr Tuffnell have ever visited the Unit. Nor, to state the obvious, were they present on the night in question. I accept that the experts may have a valid perspective to offer in the sense that they will know in very general terms how long such tasks should take to accomplish in their own Units or in the Units in which they have worked during their professional lives. However, the layout of the Unit at St Thomas's Hospital and the circumstances on the Unit that night are bound to impact upon how long it took Ms Bewley to accomplish all that she needed to during her first absence from Room 4.

97. I accept that everyone in the Unit was working at full tilt. Everyone was busy. The Claimant's aunt described the scene which she encountered when she left Room 4 to find help: putting it bluntly what she saw was like the deck of the Marie Celeste. If this was the scene which also greeted Ms Bewley when she left Room 4, then I can well understand why it took her longer than Mr Duthie suggests is reasonable to accomplish all that she had to. I accept Ms Bewley's evidence that she did not "*dawdle*" and that she did what she had to do as quickly as she could. She herself accepted that the Claimant's mother was her sole concern and she was not diverted to provide care for others. Given this, the fact that she took around 4 minutes to accomplish what Mr Duthie suggests should have been achieved in half the time only begs the question of what Ms Bewley was doing during those 4 minutes if she was not engaged as she described in finding out information and collecting equipment. A question to which neither Mr Duthie nor Mr Preston can provide the answer.

Issue 2: delay in delivery following Ms Bewley's return to Room 4

98. I deal then with Mr Preston's allegation that there was an unreasonable delay in starting the delivery following Ms Bewley's return to Room 4 at around 00.53 to 00.54. The delay which is the particular focus of his concern is the interval between Ms Bewley's decision that delivery was now urgently needed (at around 00.54/55 and her decision that the delivery must take place in Room 4 "whatever" at around 00.58/59. Although Mr Preston's closing submissions on this issue run to 15 paragraphs what they boil down to is that Ms Bewley spent around 3 or 4 minutes away from Room 4 collecting the equipment, informing her colleagues of the situation and making enquiries and then a further minute making the final decision to proceed and preparing for the instrumental delivery. This, he submits, was an unreasonably long period of time given the emergency circumstances which existed. In particular it is submitted that Ms Bewley should have spent no longer than 2 minutes away from Room 4 getting the equipment and making essential enquiries.

99. I start with my finding on the timing of the onset of the bradycardia. I find that I can deal with the point quite shortly. The original CTG trace was disposed of by the Defendant many years ago when the patient records were transferred to microfiche. The parties and the court have therefore been working from copies of the best master copy available. However, the copy is sub-optimal to say the least. At trial a further version of the CTG trace was provided which showed the trace between 00.47/48 and 00.53 rather more clearly. From that better copy, the heart rate can be seen to fall to around 100 beats per minute between 00.47/48 and 00.48/49 but then recover between 00.49 to 00.50 to around 125 beats per minute before then falling again and remaining low with an almost complete loss of variability. On the basis of this trace, I find that the bradycardia started, not at 00.47/48, but at 00.50. This would be consistent with Ms Bewley's record that the bradycardia had been ongoing for around 5 minutes at the time when she made her decision that delivery should be expedited. It is not consistent with her record that delivery occurred (at 01.05) after the bradycardia had been ongoing for 17 minutes but the trace which I have viewed is sufficiently clear for me to be able to see the fetal heart recover to 125 beats per minute at 00.50. Even Mr Duthie now accepts in the light of the better copy that the onset of the bradycardia at 00.50 is a possibility. I find that it is a probability.

100. In fact though, little turns on the timing of the start of the bradycardia as Ms Bewley was aware that she had a very different situation on her hands when she returned to

Room 4 at 00.53/54 irrespective of the timing of the onset of the terminal trace. Ms Bewley told me, and I accept, that she was aware that the situation which she faced was a "*crashing emergency*." Having made her assessment, she told me (and I accept) that there were people who needed to be aware of the situation; they included the coordinating midwife, the anaesthetist and the paediatricians. She told me, and again I accept this, that before she embarked on what she considered to be a dangerous procedure she wanted to find out whether the excellent staff with whom she worked had managed to get Room 18 ready. On the one hand this was an emergency, on the other, she was contemplating a procedure which risked the life of the Claimant and the health of the Claimant's mother. She told me that she would not have bothered to make enquiries concerning Room 18 if she had only issued the instruction that it be prepared a minute or two earlier. This was a difficult situation for her. I accept that she was "*moving as quickly as she could*" that she knew the labour ward well, that she knew the people working in it and that if she could have accomplished all that she needed to more quickly, then she would have done so.

101. My finding that Ms Bewley acted as quickly as she could to achieve all that was required during her second departure from Room 4 in conjunction with my reasoning in dismissing the allegation of delay during Ms Bewley's first departure from Room 4, is sufficient to dismiss the Claimant's further argument on delay during Ms Bewley's second departure from the room. However out of deference to Mr Preston's detailed arguments I make the following further observations.

102. I accept Mr Preston's closing submission that this was an acute emergency and that every minute of delay in delivering the Claimant risked brain damage but as I have already observed, Ms Bewley was only too conscious of those facts: it was a "*crashing emergency*." I also understand his reliance upon the evidence of Mr Tuffnell that 4 minutes "*seems like a long time*" to do what Ms Bewley told me she did during that period of time. I do not however accept his submission that Mr Tuffnell was massaging the evidence in order to explain the time delay in starting the procedure. All Mr Tuffnell was saying was that the interval between the decision to deliver at 00.54/55 and the start of the delivery at 00.59 included the preparation for the delivery which Ms Bewley describes in her timeline as having been undertaken between 00.58 and 00.59 and which I accept. Nor do I find that no good explanation for the time taken away from Room 4 was provided by the Defendant. The explanation, if one is needed, is provided by the circumstances on the Unit at the time. Mr Preston accepts that I should keep in mind the practical difficulties "in the real world" of limited staff being available but on my assessment of the evidence, his submission that Ms Bewley took an unreasonably long time collecting the equipment and speaking with colleagues fails to acknowledge, or at least sufficiently acknowledge, the real world of the Unit that night.

103. Mr Preston makes the further point in closing submissions that speaking to an anaesthetist and checking on the availability of Room 18 were inessential "optional extras" which should not have held up the instrumental delivery. I do not accept this argument either. Given Ms Bewley's view that the instrumental delivery was unlikely to succeed, it was both reasonable and understandable for her to have wished to know whether Room 18 was prepared or on the point of being prepared. Likewise, there was, I find, a need for an anaesthetist to provide some form of analgesia, by local perineal infiltration if necessary, to assist with the procedure. This was not a point which was put to Ms Bewley, but Mr Tuffnell observed that having some form of pain relief is

likely to make the procedure more straightforward and give the procedure a greater chance of success.

104. I therefore reject Mr Preston's submission that there was a culpable delay by Ms Bewley in returning to Room 4. I also reject his additional submission, again a makeweight, that Ms Bewley should have delegated the task of getting the equipment and speaking to colleagues to another member of staff. It is not tenable to suggest that Ms Bewley should have either asked the student midwife to explain the obstetric emergency which she now confronted to all of those who needed to know or that she should have pressed the buzzer and hoped that someone might be free to attend Room 4 so that that person could then be despatched to make the necessary enquiries. As Ms Bewley said, this was a situation in which, if possible, face to face discussions were necessary.

105. My conclusions above therefore deal with all of the allegations of breach of duty in the claim. I am against the Claimant on each of the allegations and for this reason the claim is dismissed. However, in order to complete the analysis I make the following findings concerning the time by which, on three different scenarios, hypothetically the Claimant would have been delivered.

106. I find that the earliest that a decision to perform an instrumental vaginal delivery would or could have been made was following the conclusion of the vaginal examination which was underway by 00.44/45. I accept Mr Readhead's submission that without a vaginal examination it would have been impossible for Ms Bewley to have known whether the Claimant's mother was fully dilated. My best judgement is that on balance the vaginal delivery would have concluded by around 00.46 and I accept Mr Preston's closing submission that the delivery process itself at around this time would have taken 10 to 12 minutes. However some time must be allowed for Ms Bewley to obtain the equipment and to at least enlist the help of an anaesthetist; however given that the concern that the procedure would not be successful would not exist on this scenario, then this trims the number of conversations which Ms Bewley would have had. She would not have had the same interest in the availability of an obstetric theatre or an alternative room as she did, in fact, have. I find therefore that the delivery process itself would therefore have commenced at around 00.48 with delivery 10 to 12 minutes later.

107. The further hypothetical scenario which I am invited to address is the likely timing of delivery assuming that Ms Bewley had spent only 2 minutes collecting the ventouse equipment and making enquiries following her decision to deliver urgently at 00.54/55. On this basis the delivery process would have commenced 2 minutes earlier than in fact it did and on Mr Tuffnell's evidence which Mr Preston is prepared to adopt, the delivery would have taken place 2 minutes earlier than in fact it did: that is, by 01.02/3.

108. The final scenario which Mr Preston asks me to address assumes that Ms Bewley had remained in Room 4 following her vaginal examination or returned to Room 4 after only 1 – 2 minutes. On my analysis above therefore Ms Bewley would have been in the room at the time when the fetal heart rate fell at 00.50 or shortly thereafter. She would have needed to allow the trace to run and having made her decision to deliver urgently obtain the necessary instruments. She would probably not have needed to make enquiries concerning an alternative venue for the delivery given that either she, or her colleague, would have, only a minute or so earlier, been informed that the theatres were in use and insufficient time would have elapsed for even the excellent staff of St Thomas's to have prepared Room 18. That said, I do not see how, on this scenario, the

delivery could have started before 00.55/6. In these circumstances, adopting Mr Tuffnell's evidence, the Claimant's delivery would have been achieved only two minutes earlier than in fact she was delivered.

Conclusion:

109. However, for the reasons which I have given, I dismiss this claim. I do so recognising the disappointment and distress which this will doubtless cause the Litigation Friend who has, I am aware, provided devoted care for her niece following her sister's tragic early death.