Neutral Citation Number: [2021] EWHC 3378 (QB)

Case No: QB-2019-004069

**IN THE HIGH COURT OF JUSTICE**
**QUEEN'S BENCH DIVISION**

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 3 December 2021

**Before**:

**HIS HONOUR JUDGE TINDAL**
**(sitting as a Judge of the High Court)**

- - - - - - - - - - - - - - - - - - - - -

**Between:**

| | |
|---|---|
| **DEBRA FREEMAN (Administratrix of the estate of the late Callum Paul Best)** | **Claimant** |
| **- and -** | |
| **PENNINE ACUTE HOSPITALS NHS TRUST** | **Defendant** |

- - - - - - - - - - - - - - - - - - - - -
- - - - - - - - - - - - - - - - - - - - -

**John de Bono QC** (instructed by **Simpson Millar LLP**) for the **Claimant**
**Charles Feeny** (instructed by **Weightmans LLP**) for the **Defendant**

Hearing dates: 3 December 2021

- - - - - - - - - - - - - - - - - - - - -

# 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.

.............................

HIS HONOUR JUDGE TINDAL

## His Honour Judge Tindal :

## Introduction

1. Callum Best was born on 27 June 2002. Just before his birth he suffered a severe brain injury from being deprived of oxygen because his placenta became detached from the wall of the uterus of his mum, the Claimant (a 'placental abruption'). Both Callum and his mum were very ill after the birth. She suffered a series of heart attacks and remains on medication to this day. Callum developed a number of disabilities including Cerebral Palsy, Microcephaly, Type I Diabetes, Epilepsy, severe learning difficulties, speech difficulties, was blind and was fed by a tube. So, Callum was a severely disabled little boy who required 24-hour care from his devoted parents, the Claimant and Mr Orton (as I shall call him by his current name by deed poll), doubtless with their older children Natalie and Reece. Callum needed a wheelchair and the family moved into an adapted ground floor flat in Rochdale. He had no independent mobility and spent life between his bed and a chair. On Christmas Eve 2014, aged only 12, Callum tragically passed away.

2. Callum's parents hold the Defendant's hospital in Rochdale responsible for his injury and his incredibly difficult short life. Their pleaded case is that on the morning of his birth, having had an ante-natal appointment at 36 weeks' pregnancy which went well, at about 10.30am when they were out shopping the Claimant suddenly experienced sudden intense abdominal pain. They say Mr Orton rang the maternity unit and told them this but was simply told to take the Claimant home to bed and give her some paracetamol. As a result, they say they went to the Claimant's mother's house but the pain continued to get worse and they went into A&E at the Defendant's hospital at about 12 noon and after a wait were transferred to the Maternity Unit and finally seen at 13.10. After urgent examination and emergency Caesarian-section, Callum was born at 13.59. By then, he had tragically already suffered his severe brain injury.

3. The Defendant denies that any such phone call was made, of which it has no record. Moreover, it maintains that no reasonable midwife would have given that advice to a woman who was 36 weeks' pregnant and reporting sudden intense abdominal pain because it would be a warning sign of placental abruption – she would have been told to come in immediately. The parties' Midwifery Experts Angela Cook for the Claimant and Lynn Smith for the Defendant agree that it would have been negligent for a midwife, if told the Claimant was in sudden *intense* abdominal pain, to fail to instruct her to come in immediately, especially as questioning would have elicited she was 36 weeks' pregnant and had a previous placental abruption in 1993. The parties' obstetric experts Mr Duthie for the Claimant and Mr Tuffnell for the Defendant also agree that if there was such a phone call and the Claimant had been told to come in immediately, Callum would probably have been delivered within an hour of attendance: around 11.40 or so. If that had happened, it is accepted on the balance of probabilities that Callum would not have suffered his brain injury.

4. Not only is medical causation agreed but the value of the claim is also agreed at £500,000. However, for the Claimant and Mr Orton, this is not about money: indeed, the Claimant has not brought a claim herself. They say they simply want justice for Callum. The Defendant in turn expresses sympathy but maintains they were not negligent.

5. Therefore, this case turns on an issue of fact: whether Mr Orton called the Maternity Unit and told a midwife that the Claimant was in pain (and if so its intensity) and was told simply to take her home for rest and pain relief. It is not disputed if that happened (which is denied), it was negligent and that it caused Callum's injuries.

6. Since the issue is clear and factual, much of the evidence in the case has been agreed. Two midwives working on the Maternity Unit that day, Ms Mannion and Ms Kovacs who later tended to the Claimant and Callum, gave statements. They maintain there is no record of such a call as it was not the practice on the unit in 2002 to log calls, but that if a call had been received reporting pain, any midwife would ask questions and if a heavily pregnant woman was reporting intense pain, they would have been advised to attend. Ms Ashman at the Defendant also reports there is no record of the Claimant arriving at A&E as it would have been the practice to log pregnant women at Maternity. These witnesses have not needed to come and answer questions.

7. Likewise, the Midwifery experts have not been called to give oral evidence as they are agreed that it is a factual issue as I have described. Whilst there is a dispute between them, it was a narrow one which did not require their attendance. Ms Cook maintains that it was negligent back in 2002 for the Defendant's hospital not to record telephone calls, whereas Ms Smith for the Defendant suggests whilst that would be negligent in 2020 it was not back in 2002 because working practices have changed. Whilst no-one suggests any failure to log any call (as opposed to the advice given on it) would have made any difference to Callum's outcome, Mr De Bono QC for the Claimant argues that were I to find there was a substandard practice of record-keeping, that is relevant to determining whether there was such a phone call. Mr Feeny for the Defendant says there was no 'record-keeping breach' and even if there was, there was no such call.

8. Whilst the Obstetric experts Mr Duthie and Mr Tuffnell agree about causation, they were required for oral evidence at trial because they disagree about the likely progress of the placental abruption during 27th June 2002. While they agree the course of placental abruptions can vary, Mr Duthie says the severity of the placental abruption recorded at Callum's birth is consistent with the Claimant's account of intense pain at 10.30 as the start of that abruption, whereas Mr Tuffnell considers that whilst some pain at 10.30 is plausible, constant severe pain from 10.30am onwards for 3½ hours until Callum was delivered is implausible as it would have been unlikely for Callum to have survived that long. Mr Feeney therefore contends any pain the Claimant experienced around 10.30 was unlikely to have been severe which supports a finding either that no call was made or that even if it was, the pain was not reported as 'intense'. Mr De Bono retorts that the Claimant was later recorded that same day by medical staff as having experienced sudden lower abdominal pain that morning.

9. At the start of trial, I raised with Counsel that the factual issue seemed to be not simply (i) whether there was a phone call but also (ii) whether intense pain (rather than a 'twinge') was reported and if so (iii) whether the advice was to go home. I asked if more Midwifery evidence would be needed were I to find Mr Orton simply said the Claimant was 'in pain'. Both Counsel agreed it was not. Mr De Bono set out his stall that a report of simple 'pain' should have prompted questions from the midwife and would have led to advice to attend. However, Mr Feeny was wary of conceding this at that stage.

10. Therefore, the key witnesses are plainly the Claimant and Mr Orton. Ordinarily they would have been expected to attend Court for detailed cross-examination. However, because of the Claimant's underlying heart condition (which I accept) she is particularly vulnerable to Coronavirus and indeed Mr Orton is highly concerned about inadvertently giving it to her (and is also her carer - in receipt of Care Allowance). Therefore, shortly before trial, the Claimant applied for herself and Mr Orton to give evidence remotely rather than having to travel down to London to attend trial. Indeed, this coincided with Government concerns about the Coronavirus 'Omicron' variant, the reinstated requirement to wear masks on public transport and shops and the intensification of the vaccine 'booster' initiative (neither the Claimant nor Mr Orton have yet had their 'boosters': which he is due to have the day after trial). The Defendant did not strenuously object to the Claimant giving evidence remotely and I agreed that on the papers. However, as it objected to Mr Orton doing so as he does not have an underlying health condition and was the person the Claimant says called and was given the negligent advice, I listed the application the day before trial. Having heard submissions from Mr De Bono and Mr Feeny, I determined under CPR 32.3 that Mr Orton could also give evidence remotely, essentially for three reasons:

11. Firstly, speaking as a Designated Civil Judge, I was extremely experienced in remote trials both of Fast Track and Multi Track claims during the Pandemic, including cases where credibility and reliability were central issues. I am entirely satisfied that if technology works, it is an entirely appropriate means of hearing evidence under detailed and intensive credibility cross-examination. I also sit in the Crown Court where cross-examination by video link in trials of sexual allegations is almost universal. I also referred to <u>*Polanski v Conde Nast*</u> *[2005] 1 WLR 637* where the House of Lords endorsed video-link evidence in a Civil Jury trial including highly contested cross-examination of the film director Roman Polanski who was perfectly capable of coming to the UK to give evidence in his own Defamation claim but did not wish to do so because he would be extradited to the US to face serious criminal charges. Strikingly, almost 20 years ago, Lord Nicholls said at p.14 (characteristically presciently, especially given events over the last 20 months):

> "*Improvements in technology enable Mr Polanski's evidence to be tested as adequately if given by [video conferencing facilities] as it could be if given in court. Eady J, an experienced judge, said that cross-examination takes place "as naturally and freely as when a witness is present in the court room". Thomas LJ said in his recent experience as a trial judge, giving evidence by VCF is a "readily acceptable alternative" to evidence in person and an "entirely satisfactory means of giving evidence" if there is sufficient reason for departing from the normal rule that witnesses give evidence in person [in Court]….*"

Similar views have been expressed during the Pandemic, including by Johnson J in <u>*SC v Southampton NHS*</u> *[2020] EWHC 1445 (QB)*, a clinical negligence case (although that was the height of the first lockdown when the issue was attendance at court generally, which he found could be arranged). *SC* was cited very recently in allowing a witness with an underlying health condition not to travel to the UK to give evidence on an allegation of forgery: <u>*Rahbarpour v Said*</u> *[2021] 11 WLUK 159*. DHCJ Ambrose there rightly observed that whether to permit evidence remotely was a matter for the court's discretion in the light of the overriding objective, fairness and efficiency, and the need for equality of arms between the parties under ECHR art.6.

12. Secondly, I agreed to the Claimant giving evidence remotely because on the evidence of her solicitor Mr Thomas (supported by her medical notes in the bundle), she was plainly 'vulnerable' not only on health grounds to Coronavirus but in that her health may adversely affect her giving of evidence, so that enabling her to give evidence remotely was a direction to facilitate her participation under the new 'vulnerability' provisions in CPR PD1A. Whilst Mr Orton does not have underlying health conditions and so is not himself 'vulnerable' medically, clinically-vulnerable people are at risk during the Pandemic from those close to them inadvertently passing it to them. I accept the Claimant and Mr Orton have had to be incredibly careful about leaving the house and who they see and continue to be so. Attending their solicitors' offices in Manchester in a short taxi journey to give evidence remotely under controlled conditions manages the risk. Expecting her to do so alone without her registered carer, as he travels on public transport to London just as the Government reintroduces mask wearing in response to Omicron, increases that risk dramatically.

13. Thirdly, quite aside from that objective risk to the Claimant via Mr Orton if he travelled to London, to expect him to do so would for those same reasons cause considerable stress and anxiety to the Claimant (who already suffers from anxiety about her health) and indeed to Mr Orton himself. There is an obvious risk both would be so distracted by that risk of inadvertent transmission on his return home that this would interfere with the quality of their evidence. In a case turning on credibility and reliability, this would not only disadvantage them, but also myself in assessing their evidence. Indeed, it may even disadvantage the Defendant itself, as I would have to make allowances for the likely effect of such 'separation anxiety' on their evidence. Allowing them to give evidence remotely from the same place in controlled conditions removed that issue.

14. However, I imposed one condition on my ruling that Mr Orton (and the Claimant) could give evidence remotely: that the technology worked. This has been in my own experience during the Pandemic the real issue with remote hearings – and indeed was for Mr Feeny at the pre-trial hearing with a poor connection from his solicitors' offices. However, we agreed that as we were starting trial with the Claimant's evidence, we would take stock of the technology after her evidence had finished.

15. The Claimant's evidence over CVP in Court was manageable but there were issues with echo etc which required patience from Mr Feeny, for which I am grateful. However, it was improved with the assistance of a Court Associate and I am satisfied that we and the Claimant heard each other clearly enough throughout, even if it was not ideal. It in no way diminished the force of Mr Feeny's detailed and skilled cross-examination. Although afterwards, he renewed his application for Mr Orton to attend physically, he did not object to Mr De Bono's suggestion first to hear the evidence of the Obstetricians remotely over Teams that afternoon rather than over CVP in a Courtroom and to assess how that went before deciding whether Mr Orton had to come to London. After a brief initial hiccup, that worked much better and proceeded very smoothly. At the end of the day, Mr Feeny left the issue of Mr Orton's attendance to me. As I was satisfied that Teams fully remotely had worked well, I decided we would use that for Mr Orton as my three reasons for remote evidence remained. Whilst Mr Orton started a little quietly, I am happy to say his evidence proceeded smoothly and again the cross-examination was undiminished, indeed very effective.

## Legal principles concerning factual evidence in clinical negligence cases

16. Of course, in a clinical negligence trial where liability (but not causation) is disputed, the fundamental question is whether the relevant clinician was in breach of duty under the classic test of McNair J in *Bolam v Friern Hospital* [1957] 2 All ER 118 at 122:

> "*A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art…Putting it the other way round, a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion which takes a contrary view*."

17. The *Bolam* test applies to midwives as well as doctors, and has been approved and applied many times, including by Lord Browne-Wilkinson for a unanimous House of Lords in *Bolitho v City and Hackney Health Authority* *[1998] AC 232* at 242. However, it is also relevant on causation as Lord Browne-Wilkinson said at pg.240:

> *"Where, as in the present case, a breach of a duty of care is proved or admitted, the burden still lies on the plaintiff to prove that such breach caused the injury suffered…In all cases the primary question is one of fact: did the wrongful act cause the injury? But in cases where the breach of duty consists of an omission to do an act which ought to be done (e.g. the failure by a doctor to attend) that factual inquiry is, by definition, in the realms of hypothesis. The question is what would have happened if an event which by definition did not occur had occurred…. However…a defendant cannot escape liability by saying that the damage would have occurred in any event because he would have committed some other breach of duty thereafter…. There were….two questions for the judge to decide on causation. (1) What would Dr. Horn have done, or authorised to be done, if she had attended Patrick? and (2) if she would not have intubated, would that have been negligent? The Bolam test has no relevance to the first of those questions but is central to the second."*

Whilst causation itself is not disputed here, this principle may be of some relevance were I to find that there was a telephone call by Mr Orton reporting pain and the midwife did not ask questions about the intensity of the pain reported.

18. As Lord Browne-Wilkinson said in *Bolitho*, the Claimant bears the burden of proving her case – including on factual issues - on the balance of probabilities. But I must first make such findings as I can on the evidence elicited rather than too readily resorting to the burden of proof and I must give sufficient reasons for doing so as Irwin LJ stressed in Barnett v Medway NHS *[2017]* Med. L. R. 217 (CA) at p.54:

> *There is great virtue in writing judgments concisely. However, the parties do need to know sufficiently what led to the conclusions reached. In this instance, the judgment gave only the briefest explanation. The obligation is all the clearer in a case of such complexity, and in a case where a key issue is decided on the basis that a claimant has failed to discharge the burden of proof…."*

(I bear in mind Males LJ's comments in Simetra v Ikon *[2019]* 4 WLR 112 (CA) also)

19. However, whilst Mr De Bono of course accepts the burden of proof is on the Claimant, he argues that I should draw an inference because the Claimant has been deprived of evidence in support of her case by the Defendant's poor record-keeping practice in 2002 of not recording telephone calls, as admitted by Ms Mannion and Ms Kovacs. As I have noted above, the midwifery experts disagree whether that record-keeping system was substandard in 2002 (although they agree it would be now). I will resolve that dispute below but in purely legal terms, at first this argument seemed to assume what it needed to prove – that there was indeed a telephone call to record. However, Mr De Bono's point was that if I agreed with Ms Cook that the Defendant's record-keeping system in 2002 was substandard in not recording telephone calls, then the Defendant should not be able to rely on the absence of the record of such a call.

20. To make good that submission, Mr De Bono referred me to three authorities:

20.1 In <u>*Keefe v Isle of Man Steamship*</u> *[2010] EWCA Civ 683*, the judge had held a shipowner was in breach of duty in failing to make noise assessments in a galley and that a seaman had been exposed to excessive noise on occasions, but he could not say that happened with any regularity so dismissed the claim. In allowing the appeal and upholding the claim, Longmore LJ said at p.19:

> *"If it is a defendant's duty to measure noise levels in places where his employees work and he does not do so, it hardly lies in his mouth to assert that the noise levels were not, in fact, excessive. In such circumstances the court should judge a claimant's evidence benevolently and the defendant's evidence critically. If a defendant fails to call witnesses at his disposal who could have evidence relevant to an issue in the case, that defendant runs the risk of relevant adverse findings see British Railways Board v Herrington [1972] A.C. 877 at 930G. Similarly a defendant who has, in breach of duty, made it difficult or impossible for a claimant to adduce relevant evidence must run the risk of adverse factual findings."*

20.2 In <u>*Raggett v Kings College Hospital*</u> *[2016] EWHC 1604 (QB)*, this was applied in a clinical negligence context by Macduff J (as he had been) having already found breach of duty referred to *Keefe* briefly at p.134 in rejecting a causation argument that if a leg had been treated properly that it would have been amputated anyway. In reality, this seems to have been the rejection of the Defendant's expert's opinion rather than the true application of *Keefe,* but it was in any event a case (like *Keefe*) where a breach of duty had been found.

20.3 Similarly, in <u>*JAH v Burne*</u> *[2018] EWHC 3461 (QB)*, Martin Spencer J having found breach of duty in a GP failing to refer a patient, found it made no difference to amputation of a leg but on balance of probabilities would have avoided amputation of an arm. Martin Spencer J at ps. 63-6 acknowledged there were a number of imponderables but drew on the principle in *Keefe* and noted its application in a similar context in *Raggatt* in concluding at p.64:

> *"In resolving issues of detail such as how long it would have taken for the Claimant to be seen, how long it would have taken for investigations to be carried out and when a competent vascular surgeon would have appreciated that anticoagulation was the appropriate treatment, the court should err in favour of the Claimant where it is the Defendant's negligence which deprives the court of the best evidence and causes the need to delve into this hypothetical world."*

21. However, neither Macduff J in *Raggatt* nor Martin Spencer J in *JAH* seem to have been referred (no criticism of Mr De Bono for one of the successful Defendants in *JAH*) to Shawe-Lincoln v Neelakandan *[2012] EWHC 1150 (QB).* A GP was in breach of duty when speaking to a patient by telephone in failing to take a proper history and attend on him in which case he would have referred him into hospital urgently, a day earlier than the patient did attend. The issue was what would have happened had he been referred in earlier and the Claimant was obviously at a disadvantage because he did not have the hospital records of the period for which he should have been in hospital but was negligently left at home. Lloyd-Jones J (as he then was) held that it was not appropriate to draw an inference that the claimant's condition had significantly deteriorated in the meantime in part because unlike *Keefe* the GP would not have been under a duty himself to keep the absent (hospital) records and the other medical evidence pointed against deterioration not towards it. He said:

> *"80.....Keefe is not concerned with a reversal of the burden of proof. It is established on high authority (Bolitho) the burden of proof on causation lies and remains on the claimant. Furthermore, I have difficulty in seeing how the benevolent approach adopted...in Keefe could be accommodated within such a reversal; either the burden is reversed or it is not.*
>
> *81. Rather, Keefe is concerned with the weight which is to be attached to evidence and the circumstances in which the court may draw inferences.... Longmore L.J....referred to the observations of Lord Diplock in Herrington .....that failure to call a witness may result in an adverse finding and then applied the same principle to a situation where a defendant has made it difficult or impossible for a claimant to adduce relevant evidence.*
>
> *82. Whether it is appropriate to draw an inference at all and, if so, the precise nature and extent of such an inference will depend on the particular circumstances of each case. Relevant considerations will include the proximity between a breach of duty and the non-available evidence, the effect of the other evidence before the court and what other evidence might have been available but which is not before the court.*
>
> *83....I can see no reason why the principle should not apply in a case concerning causation as opposed to negligence (as was the case in Keefe).*"

22. Coming full circle from *Keefe* a decade on, in McKenzie v Alcoa *[2020] PIQR P6,* Dingemans LJ endorsed that analysis of Lord Lloyd-Jones (as he had become) in *Shawe-Lincoln*, applying it in an industrial deafness case like *Keefe*. He said at p.50:

> *"It seems therefore that it is possible to state the following propositions. First whether it is appropriate to draw an inference, and if it is appropriate to draw an inference the nature and extent of the inference, will depend on the facts of the particular case, see Shawe-Lincoln at [81]–[82]. Secondly silence or a failure to adduce relevant documents may convert evidence on the other side into proof, but that may depend on the explanation given for the absence of the witness or document, see Herrington at 970G; Keefe at [19]...."*

That is the approach I will adopt to the 'missing record' argument in this case.

23. However, this case is not simply about the alleged absence of a contemporaneous clinical note, it is also about the weight to be attached to oral evidence as compared to such clinical notes. In that respect, Mr De Bono referred me to observations of another Justice of the Supreme Court from the High Court bench, namely those of Leggatt J (as he was) in *Gestmin v Credit Suisse [2013] EWHC 3560 (Com).* Having referred to modern psychological thinking on frailty of memory he said at ps.19-22:

> *"19. The process of civil litigation itself subjects the memories of witnesses to powerful biases. The nature of litigation is such that witnesses often have a stake in a particular version of events. This is obvious where the witness is a party or has a tie of loyalty…to a party to the proceedings. Other, more subtle influences include allegiances created by the process of preparing a witness statement and of coming to court to give evidence for one side in the dispute. A desire to assist, or at least not to prejudice, the party who has called the witness or that party's lawyers, as well as a natural desire to give a good impression in a public forum, can be significant motivating forces.*
>
> *20. Considerable interference with memory is also introduced in civil litigation by the procedure of preparing for trial. A witness is asked to make a statement, often when a long time has already elapsed since the relevant events. The statement is usually drafted for the witness by a lawyer inevitably conscious of the significance for the…case of what the witness does nor does not say. The statement is made after the witness's memory has been 'refreshed' by reading documents. The documents considered often include statements of case and other argumentative material as well as documents which the witness did not see at the time or which came into existence after the events which he or she is being asked to recall. The statement may go through several iterations before it is finalised. Then, usually months later, the witness will be asked to re-read his or her statement and review documents again before giving evidence in court. The effect of this process is to establish in the mind of the witness the matters recorded in his or her own statement and other written material, whether they be true or false, and to cause the witness's memory of events to be based increasingly on this material and later interpretations of it rather than on the original experience of the events.*
>
> *21. It is not uncommon (and the present case was no exception) for witnesses to be asked in cross-examination if they understand the difference between recollection and reconstruction or whether their evidence is a genuine recollection or a reconstruction of events. Such questions are misguided in at least two ways. First, they erroneously presuppose that there is a clear distinction between recollection and reconstruction, when all remembering of distant events involves reconstructive processes. Second, such questions disregard that such processes are largely unconscious and strength, vividness and apparent authenticity of memories is not a reliable measure of their truth.*
>
> *22. In the light of these considerations, the best approach for a judge to adopt at the trial of a commercial case is, in my view, to place little if any reliance at all on witnesses' recollections of what was said in meetings and conversations, and to base factual findings on inferences*

> *drawn from the documentary evidence and known or probable facts. This does not mean oral testimony serves no useful purpose, though its utility is often disproportionate to length. But its value lies largely, as I see it, in the opportunity which cross-examination affords to subject the documentary record to critical scrutiny and to gauge the personality, motivations and working practices of a witness, rather than in testimony of what the witness recalls of particular conversations and events. Above all, it is important to avoid the fallacy of supposing that, because a witness has confidence in his or her recollection and is honest, evidence based on that recollection provides any reliable guide to the truth.*"

24. The first and most obvious point to make about this analysis is that whilst it talks about the impact of civil litigation process generally on memory, as Lord Leggatt stressed in that last paragraph, it is an approach he commends *in trials of commercial cases* where there will very frequently be (voluminous) contemporary documents: emails, papers, correspondence, reports etc. Yet in another commercial case (relating to copyright), Martin v Kogan *[2020] FSR 3,* the Court of Appeal said at p.88:

> "*We start by recalling the judge read Leggatt J's statements in Gestmin…as an "admonition" against placing any reliance at all on the recollections of witnesses. We consider that to have been a serious error in the present case. First, as has very recently been noted by HHJ Gore QC in CXB v North West Anglia NHS Foundation Trust [2019] EWHC 2053 (QB), Gestmin is not to be taken as laying down any general principle for the assessment of evidence. It is one of a line of distinguished judicial observations that emphasise the fallibility of human memory and the need to assess witness evidence in its proper place alongside contemporaneous documentary evidence and evidence upon which undoubted or probable reliance can be placed. Earlier statements of this kind are discussed by Lord Bingham in his well-known essay "The Judge as Juror: The Judicial Determination of Factual Issues"…But a proper awareness of the fallibility of memory does not relieve judges of the task of making findings of fact based upon all of the evidence. Heuristics or mental short cuts are no substitute for this essential judicial function. In particular, where a party's sworn evidence is disbelieved, the court must say why that is; it cannot simply ignore it.*"

25. These observations in *Martin* were recently picked up in another context: fact-finding in Family cases by Peter Jackson LJ in Re B-M *[2021] EWCA Civ 1371* at ps.23-5

> "*There is, I think, a distinct difficulty in harvesting obiter dicta expressed in one context and seeking to transplant them into another…..Further and as noted by this court in Kogan…Gestmin is not to be taken as laying down any general principle for the assessment of evidence. Rather, as Kogan states, it is one of a line of distinguished judicial observations that emphasise the fallibility of human memory and the need to assess witness evidence in its proper place alongside contemporaneous documentary evidence and evidence upon which undoubted or probable reliance can be placed. The discussion in Gestmin is expressly addressed to commercial cases, where documentary evidence will often be the first port of call, ahead of unaided memory….*

> *No judge would consider it proper to reach a conclusion about a witness's credibility based solely on the way that he or she gives evidence, at least in any normal circumstances. The ordinary process of reasoning will draw the judge to consider a number of other matters, such as the consistency of the account with known facts, with previous accounts given by the witness, with other evidence, and with the overall probabilities. However, in a case where the facts are not likely to be primarily found in contemporaneous documents the assessment of credibility can quite properly include the impression made upon the court by the witness, with due allowance being made for the pressures that may arise from the process of giving evidence....*"

26. In clinical negligence cases, different judges have taken different views of *Gestmin*. In *Ismail v Joyce [2020] EWHC 3453 (QB)*, HHJ Freedman held that having recorded in a clinical note that his patient was 'sweaty at night', a GP was negligent in failing to explore the issue of TB. HHJ Freedman enthusiastically described *Gestmin* as the *'Locus Classicus'* on fallibility of memory, but there were echoes of *Martin* in his sounding a note of slight caution about applying *Gestmin* to clinical notes at ps.29-31:

> "*29. In evaluating the lay evidence in this case....I have found the dicta in [Gestmin and other cases] of considerable assistance. They are of particular application in circumstances where medical records do not necessarily bear out of what is recalled by [lay witnesses]..... The inherent unreliability of memory does mean that it is fair and proper to test the accuracy of recollections of medical consultations against what is documented in the records.*
>
> *30. On the other hand, it does not necessarily follow that just because the complaint of a particular symptom does not feature in the record of a consultation, it was not, in fact, mentioned by the patient. Sometimes a doctor will obtain an extensive history and make a very detailed record. Sometimes, because of pressure of work or for whatever other reason, [he] may take a less extensive history and will make a somewhat briefer note.*
>
> *31. I must also bear in mind that it is human nature for a patient not always to give precisely the same account of his or her symptoms to every doctor who examines him or her. Much may depend upon the questions which are asked by the doctor. Equally, the patient is likely to emphasise and stress symptoms which are troubling them the most at the particular time of the examination. The medical records need to be scrutinised with these matters in mind.*"

On the other hand, another (former) fellow DCJ, HHJ Gore QC, was characteristically trenchant in his doubts about *Gestmin* in *CXB*, noted by the Court of Appeal in *Martin*. He rejected the oral evidence of a woman and family that she had elected a caesarean section for twins, preferring evidence of a clinician, supported by a contemporaneous note. Yet far from relying on *Gestmin* to support his decision, at p.8, HHJ Gore QC questioned it but also distinguished its very different context of a commercial case where there was no dispute about accuracy of the written contemporary evidence.

27. Recently in *HTR v Nottingham University NHS [2021] EWHC 3228 (QB)*, Cotter J (yet another former DCJ in his first case on the High Court Bench I believe) noted the observations in *Gestmin,* but also endorsed the observations of HHJ Freedman in *Ismail*. He added his own observations: both that when a witness recalls events years later, conscious or unconscious bias may creep in and the effect of delay on evidence should be borne in mind; and that just because a judge rejects one part of a witness' evidence does not mean all of it must be rejected. I respectfully agree with those points, which reflect standard directions to Juries in criminal cases on oral evidence.

28. Moreover, HHJ Gore in *CXB* and Cotter J in *HTR* noted guidance in the context of clinical negligence in *Synclair v East Lancs NHS [2015] EWCA Civ 1283*, where the Court upheld the Judge's acceptance of a claimant's account of his condition, rejecting contemporary clinical notes. Tomlinson LJ said at ps.10-15:

> "*10. [Counsel] reminded us of some of the classical learning on the nature of the judicial fact-finding function. We were shown, in chronological order: the well-known remarks of Lord Pearce in his dissenting speech in Onassis & Calogeropoulos v Vergottis [1968] 2 Lloyds Rep 403 at p 431; the guidance given by Lord Goff of Chieveley giving the opinion of the Judicial Committee of the Privy Council in Grace Shipping v Sharp & Co [1987] 1 Lloyd's Rep 207 at 215-6, in particular founding upon his own judgment in the earlier decision of the Court of Appeal in Armagas Ltd v Mundogas SA (The Ocean Frost) [1985] 1 Lloyd's Rep 1 when he said, at page 57:- "Speaking from my own experience, I have found it essential in cases of fraud, when considering the credibility of witnesses, always to test their veracity by reference to the objective facts proved independently of their testimony, in particular by reference to the documents in the case, and also to pay particular regard to their motives and to the overall probabilities. It is frequently very difficult to tell whether a witness is telling the truth or not; and where there is a conflict of evidence such as there was in the present case, reference to the objective facts and documents, to the witnesses' motives, and to the overall probabilities, can be of very great assistance to a Judge in ascertaining the truth." In Grace Shipping Lord Goff noted that his earlier observation was, in their Lordships' opinion "equally apposite in a case where the evidence of the witnesses is likely to be unreliable; and it is to be remembered that in commercial cases, such as the present, there is usually a substantial body of contemporary documentary evidence." We were reminded that in "The Business of Judging", Oxford, 2000, Lord Bingham of Cornhill observed that:- "In many cases, letters or minutes written well before there was any breath of dispute between parties may throw a very clear light on their knowledge and intentions at a particular time."*
>
> *11. The essential thrust of this learning is the unsurprising proposition that when assessing the evidence of witnesses about what they said, or what was said to them, or what they saw or heard, it is essential to test their veracity or reliability by reference to the objective facts proved independently of their testimony, in particular by reference to contemporary documentary evidence.*

> *12. However it is too obvious to need stating that simply because a document is apparently contemporary does not absolve the court of deciding whether it is a reliable record and what weight can be given to it. Some documents are by their nature likely to be reliable, and medical records ordinarily fall into that category. Other documents may be less obviously reliable, as when written by a person with imperfect understanding of the issues under discussion, or with an axe to grind….I would commend the approach of His Honour Judge Collender QC, sitting as a judge of the High Court, in EW v Johnson [2015] EWHC 276 (QB) where he said, at paragraph 71 of his judgment:- "I turn to the evidence of Dr Johnson. He did not purport to have a clear recollection of the consultation but depended heavily upon his clinical note of the consultation, and his standard practice. As a contemporaneous record that Dr Johnson was duty bound to make, that record is obviously worthy of careful consideration. However, that record must be judged alongside the other evidence in the action. The circumstances in which it was created do not of themselves prevent it being established by other evidence that that record is in fact inaccurate. Dr Johnson, a GP, had made his own note of a consultation at an out of hours walk-in centre at a hospital. After a careful evaluation of all the evidence in the case, the judge found that Dr Johnson's oral account in evidence, based on his contemporaneous note, was reliable. In Welch v Waterworth [2015] EWCA Civ 11 a surgeon was unsuccessful in persuading the court that his own notes of a surgical procedure…one a manuscript note written very shortly after the operation and another a typewritten note made later in the day at home, did not accurately record the order in which he had carried out the constituent parts of the relevant procedure.*
>
> *…14. With those observations in mind, I turn to Mr Colin's detailed criticism of the judge's approach here. His three principal points were:- i) Clinical records are made pursuant to a clear professional duty, serious failure in which could put at risk a practitioner's registration. Moreover, they are not compiled simply as a historical record, they fulfil an essential and ongoing purpose in informing the care and treatment of a patient. Contemporaneous records are for these reasons alone inherently likely to be accurate. No doctor would have any reason to produce a note which misrepresented clinical observations or the patient's concerns. Something more than a patient's assertions to the contrary is required to displace the sanctity, my word…of the notes*."

29. Tomlinson LJ in *Synclair* accepted that and was noted as doing so by Sir Ernest Ryder SPT in <u>*Manzi v King's College NHS*</u> *[2018] EWCA 1882* at p.18, who added p.25:

> "*The proposition that a contemporaneous clinical record is inherently likely to be accurate does not create a presumption in law that has to be rebutted…. It is an important factor in evaluating materials of that kind so that reasoning is necessary to explain how records (or their absence) are being treated on the facts of a particular case. To raise the bar so high that an analysis of what might be sufficient to displace inherent reliability is needed in every case is to make the process of fact finding too onerous and mechanistic.*"

30. I can perhaps summarise my approach to all these authorities in three short points:

    30.1 The burden of proof is on the Claimant, but I should still attempt to make findings on all evidence on the balance of probabilities: *Bolitho* and *Medway.*

    30.2 When assessing allegedly *absent* clinical records and any disadvantage to the Claimant, I apply the approach in *Shawe-Lincoln* as developed in *Mckenzie*.

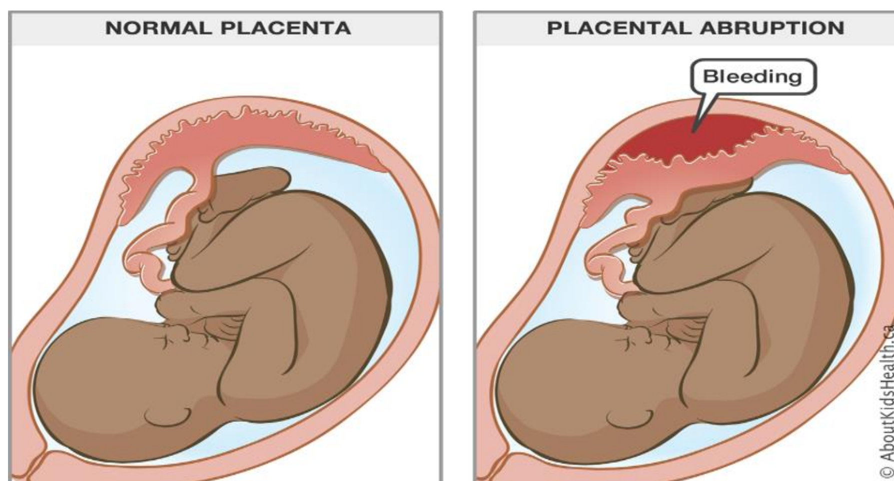
    30.3 When assessing the consistency of oral evidence with *actual* clinical records, I will apply the approach in *Synclair* and *Manzi* that I consider consistent with the approach taken on the facts in *CXB, HTR* and *Ismail*.

**The progress of the placental abruption and Obstetric expert evidence**

31. As I observed when asking questions of the Obstetricians Mr Duthie and Mr Tuffnell, it is not entirely easy in this case to know whether I am being asked to evaluate the lay evidence of the Claimant and Mr Orton in the light of their expert opinion, or whether their expert opinion depends on my findings on lay evidence, or indeed both.

32. However, ultimately my task is to make findings of fact as to whether (i) Mr Orton called the Maternity Unit at around 10.30am on 27th June 2002; (ii) reported that the Claimant was in pain (and if so, how much); and (iii) was nevertheless told to take her home to rest. As the rest of that day's events are not really in dispute, the best way of resolving any 'chicken and egg' quandary about the evidence is to start with the Obstetric Experts' evidence in order to: (1) explain the nature of placental abruptions; (2) explain the course of the placental abruption that day as recorded in the undisputed clinical notes (and where the Claimant and Mr Orton's allegations fit in); and (3) resolve what in the end in my judgment was a fairly narrow dispute between the Obstetric Experts and which as I explain, is not determinative of my conclusion. Having done so, in the next section I will address the Midwifery expert evidence and the Defendant's undisputed evidence, before turning to the evidence of the Claimant and Mr Orton and finally my findings of fact on those three key issues.

33. The nature of placental abruptions was not disputed between Mr Duthie and Mr Tuffnell, and may be very basically illustrated by this simple diagram:




As the diagram shows, a placental abruption is when the placenta tears away from the wall of the uterus before birth (in this case it was 'fundal', i.e. at the top of the uterus). This causes bleeding behind the placenta and eventually may deprive baby of oxygen.

34. As I understood it, with placental abruption, the bleeding starts to clot behind the placenta (a retro-placental clot), irritating the uterus, causing contractions and so pain. The blood can pool behind the placenta (as in the diagram) and/or track down into the vagina (noticeable by the woman) and/or into the amniotic fluid and/or track through the uterus wall ('myometrium'). As bleeding continues, blood can collect under its outer surface initially as patches then blotches (as they grow larger, they are termed petechiae, purpura and echymoses). This in turn irritates the uterus which is tender and causes increasing levels of pain. If placental abruption is so severe that it has led to echymoses, this is called a Couvelaire Uterus. As Mr Duthie graphically put it, this is 'as bad as it gets': it can cause death of both baby and mother.

35. So far as baby is concerned, placental abruption is dangerous because it deprives them of oxygen. It may assist to think of standing on a hosepipe. If done hard enough, no water comes out, but if not as hard, the flow of water may be impeded but not completely blocked and so, if feeding a sprinkler, it may not reach the edges of a lawn. Likewise, deprivation of oxygen ('hypoxia') may be 'acute profound' (i.e. suddenly stops completely) where typically a baby can avoid injury for 10 minutes, but then is liable to suffer increasingly severe brain injury and is unlikely to survive more than 25 minutes. Or hypoxia may be 'chronic' or 'partial' where timescales are not as clear. However, the longer and more severe the hypoxia, the greater the 'acidosis' of the blood, dropping from broadly 'neutral' at about pH 7.2 to increasingly acidic below 7 where brain injury can result and where the baby may die if not delivered urgently.

36. Indeed, both Obstetric Experts accepted placental abruptions can vary significantly not only in where the blood may track but also in their *speed and severity*. That might be most easily understood as forming a spectrum. (I will come below to where on it each of them said the abruption on 27th June 2002 fell). At one end, there are sudden abruptions where a substantial part of the placenta tears away from the uterus wall suddenly causing sudden and severe pain. At the other end, there are slow, gradual abruptions starting with more minor pain which steadily grows over a few hours. Moreover, abruptions characterised by more severe pain and especially vaginal bleeding which is noticed by the woman are 'revealed', whereas those where there is no bleeding and the pain may be mistaken for ordinary contractions are 'concealed'.

37. An example of the former is the Claimant's previous abruption in 1993 when she tragically lost her baby. According to contemporaneous medical correspondence (pg.361), then in her 35th week of pregnancy, she was admitted on an emergency basis (she recalled an ambulance being called as well as a midwife attending her home) with 'heavy vaginal bleeding and contractions' and when admitted this rapidly progressed to the baby being stillborn. The Claimant recalled the whole horrifying experience was only a couple of hours. However, more happily, she went on to have her son Reece. However, the previous abruption increased the risk of another abruption in the future.

38. Tragically, that was to occur with Callum on 27th June 2002. However, I should note that whilst in their Joint Statement both suggested the Claimant's symptoms would have been similar in 2002 as in 1993, in fact the Claimant accepted they were different as I will describe. This point was emphasised by Mr Tuffnell in his oral evidence. I turn now to the uncontested evidence of events in the clinical notes.

39. The Claimant was 30 years old when she became pregnant for the fourth time in 2001. Because of the previous placental abruption, she had more regular antenatal monitoring that would be typical and with consultant involvement. She was due on 23rd July 2002 and booked for antenatal care at the Rochdale Healthcare NHS Trust on the 17th January 2002 at a gestation of 13 weeks. At that time, it was noted that there was nothing of note in the previous medical and surgical histories. There was a family history diabetes mellitus and multiple pregnancy. There was no family history of heart disease, hypertension, epilepsy, Down's Syndrome or other congenital abnormalities. Ultrasound examination was carried out at 19 weeks gestation on the 28th February 2002 and all was normal. The same was true on ultrasound examinations on 2nd May and 13th June when delivery was planned for 38 weeks in w/c 8th July. On 20th June (pg.506), again baby was well and it appeared the placenta was anterior (although it later turned out to be fundal) and the Claimant was told 'to come in if any problems'. I find this is when she recalled being told that she could come in for rest if concerned.

40. Therefore, until 27th June 2002 at 36 weeks, despite her previous history, the pregnancy was progressing smoothly and the Claimant recalled no concerns over her care. Around 9am that day (the scans at pg.556 are timed 8.20am but this may be an error) she went in for another ultrasound scan which was again normal (pg.506):

> "*Well clearly good growth Doppler [ultrasound] is good. Scan shows continued growth. Baby well. Aim for [induction of labour at 38 weeks], See [in a week for the consultant] to do a membrane sweep.*"

There was a slight disagreement between the experts on what would have happened to the scans. Certainly, the Claimant collected the scan pictures after a wait and put them with her records. By 2002, it was common practice for pregnant women to keep a copy of their maternity notes but (contrary to Mr Duthie's belief) not common to keep a duplicate, as expressed in the Nursing and Midwifery Council ('NMC') Guidance (pg.201). This is also consistent with Ms Smith's Midwifery expert evidence (pg.258) and Ms Cook does not address it either way. Therefore, as Mr Tuffnell said, the Maternity Unit would not have had a copy of that scan immediately to hand.

41. This is where there is the critical a roughly four-hour gap in the clinical notes: between the routine ante-natal appointment in the Maternity Unit around 9am and the Claimant's return there as an emergency with established placental abruption around 1pm. In reality, it is only the period until around 10.30am which is seriously disputed.

42. I simply summarise the Claimant and Mr Orton's factual contentions about that time. After the appointment, they went into Rochdale to the Wheatsheaf Shopping Centre which was not far from the hospital to go to 'Crazy Georges' which was a credit shop and arrived around 10.30am. I will come to the detail later, but whilst in the shopping centre, the Claimant says that she experienced intense pain in 'Crazy Georges' and went back to the car where the maternity notes were. They say the Claimant asked Mr Orton to phone the Maternity Unit using the number on the notes and he told the person that answered that the Claimant was in *intense* pain (I emphasise that word which they consistently use in their statements and which is pleaded in the Particulars of Claim). However, the person told him to take her home and give her paracetamol and put her to bed. Both of them were surprised at this advice but took the person's word for it having been told at the scan that morning that everything was fine.

43. Whilst what I have just summarised is entirely denied and hotly contested, as I say what followed in the 'gap' in the clinical notes is not. Therefore, having heard the Claimant and Mr Orton's evidence for reasons I will explain below I will accept the following essential account of the ensuing period on the balance of probabilities.

44. The Claimant and Mr Orton had been planning after shopping to go on to her mother's house which was closer than home, which they did. Her mother was not there but her step-father and sister were. They said they stayed at her mother's house for an hour. By this point the Claimant's pain had grown and she described it in evidence as 'severe' and her step-father went to get her mother to return home. As soon as the Claimant's mother got back, she insisted that the Claimant go to Accident and Emergency (rather than the Maternity Unit, despite the Claimant being told previously to come there).

45. The Claimant arrived at A&E around 12 noon (although Ms Ashman explains that the practice at the time was not to log the arrival of pregnant patients but to send on to the Maternity Unit for their arrival to be logged there). She recalls sitting in a wheelchair in intense pain for a considerable time and seeing a nurse who called someone came from the Maternity Unit to take her there. There is no allegation that this delay in A&E was negligent, or indeed by then even causative of Callum's injuries. As I relate later, Mr Orton's reference in a statement to a nurse referring to the call he was told by the Claimant's family who by now had taken over. I accept that is wrong.

46. This is where the clinical notes resume and I return to them and Mr Duthie's summary. Neither the notes nor the midwife evidence for this period is challenged. By this stage the Claimant was indisputably in severe pain and her recollection is understandably hazy. Her account is not significantly inconsistent with the clinical notes in any event.

47. At 13.10, the Claimant arrived on the Maternity Ward and was seen by Ms Mannion. It was a very busy day on the ward and she was not able to write up notes until 16.50. By this stage, Mr Orton was not with her. Those notes record the Claimant arrived in a wheelchair accompanied by A&E staff reporting abdominal pain and that (pg.92):

> "*On admission, Debra distressed saying she has had contractions and abdominal pain. Assisted into bed. No loss [through] vagina [i.e. bleeding]. Debra says she attended Ante-Natal Clinic this morning and had pain one hour following this appointment (since 10.30)*."

Ms Mannion tried to take fetal heart readings, but the Claimant was in pain and pushed her away (she could not stay still). Ms Mannion called a doctor for assistance about 13.15 when the Claimant was saying she felt like pushing and at 13.16 Ms Mannion recorded slight vaginal bleeding and requested and was given pain relief.

48. At 13.17, the Claimant was seen by the Duty Obstetrician Dr Khalil who was concerned by a slow heart rate of about 70 bpm. A more senior Obstetrician Dr Hassan was called to attend at 13.25 who immediately called for an ultrasound. The scan noted very slow heart rate ('bradycardia') and placental abruption. Vaginal examination by Dr Hassan showed the cervix was 1 cm dilated and forewater amniotomy was carried out releasing clear amniotic fluid. A fetal scalp electrode was applied, the connecting wire was unavailable, someone was asked to 'send for one' and the fetal heart rate was 70 bpm as detected by the abdominal transducer.

49. The note timed 1.30pm presumably made by Dr Hassan recorded (pg.495): *"[Complaining of] sudden lower [abdominal] pain associated with [vaginal] bleeding."* Mr Tuffnell fairly accepted it was not clear whether or not this was suggesting those two things had happened simultaneously. Indeed, given that the vaginal bleeding only started at 13.16 after the Claimant had already been at hospital over an hour, it seems more likely it referred to earlier on.

50. At 13:35 hours Dr Hassan made the decision for an emergency Caesarean Section. At 13:36 the Claimant was prepared for movement to the operating theatre, written consent was obtained by Dr Khalil and the fetal heart rate was 70 bpm. At 13:40 a fetal heart rate was not detected. This appears to be the most likely time when the Claimant remembers one of the doctors saying they had three minutes to deliver the baby or both he and she could be lost. At 13.59, the Claimant underwent emergency Caesarean section delivery of Callum with a birth weight of 2,000g (4 lb 7 oz). Dr Hassan's notes (pg.540) record that: there was a Couvelaire uterus; the placenta was fundal in position; and there was a retroplacental blood clot with a volume of approximately 1 litre. The estimated blood loss during the operation was 1,200 ml and 4 units of blood were transfused. Callum had 'Apgar scores' of 2 at 1 minute and 5 at 5 minutes and a cord blood pH of 6.54 (pg.543) which is extremely acidic suggestive of significant and established hypoxia. Mr Tuffnell and Mr Duthie stressed that Callum was extremely poorly when he was born and was minutes away from dying then. However, as I have noted, tragically Callum was born severely disabled and Dr Mordekar, a Paediatric Neurologist, later confirmed that despite the loving care of his parents over the next 12 years, these disabilities led to his devastatingly early death. It is clear his parents could have done nothing at all to prevent that tragedy.

51. Against that desperately sad background, I turn to the narrow dispute between the Obstetric experts as to the pace of the placental abruption over the course of 27$^{th}$ June.

    51.1 Mr Duthie contends that the combination of the Couvelaire uterus (suggesting a very serious abruption with bleeding which had led to echymoses), severe hypoxia with an extremely low pH suggestive of acute hypoxia, the fundal placenta but also the clear amniotic fluid is suggestive of a concealed abruption. He maintains this is consistent with the Claimant experiencing sudden and intense pain around 10.30am. I asked him whether that opinion was reliant on accepting the Claimant's account and he replied had he seen her after Callum's birth without hearing her account he would have known she would have experienced pain and asked why she had not come in earlier.

    51.2 Mr Tuffnell was more cautious in his opinion. He stressed the course of abruptions can be variable. Sometimes it could be severe and rapid with a sudden substantial abruption and vaginal bleeding, as it had been in 1993. However, sometimes it could be more gradual with the abruption only gradually spreading and the pain gradually increasing. However, left to it, this process too could result in the same eventual outcome of a Couvelaire uterus, serious hypoxia and extreme blood acidosis. Mr Tuffnell did not consider it possible to extrapolate back to decide the pace of the abruption from the end result. However, he did not accept that it was likely that the Claimant could have sustained a severe sudden abruption and been in *severe pain constantly* from 10.30 until 14.00 when Callum was delivered. He considered it entirely unlikely that Callum would have survived so long if that had been the case.

52. So, there are no dramatic and pivotal disputes between the experts, nor was it suggested that one was obviously more qualified or experienced of the two. However, Mr Tuffnell did strike me as the more careful and balanced. He made concessions and admitted some points were neutral, including when I asked him about the clinical notes: he did not simply seize a chance to advance the Defendant's case. This supports his fairness and balance. In (slight) contrast Mr Duthie seemed more reluctant to make even uncontroversial concessions and more partisan. Moreover, I will note he ignored a slight but important shift in the Claimant's account.

53. Therefore, in the event there is dispute between them, I prefer Mr Tuffnell's opinion. I agree it is not reliable to infer the progress of the placental abruption simply from the clinical indicia. Indeed, in fairness to him, Mr Duthie did not say it was. Not even Mr Duthie said he could express an opinion as to the progress of the abruption that day without relying to some extent on the Claimant's account, which begs the very question that I have to decide in this case. Mr Duthie was essentially saying the clinical indicia were consistent with her placental abruption starting **if** she experienced severe and sudden pain 'doubling her up' at 10.30am. Mr Tuffnell was essentially saying the clinical indicia were inconsistent with her being in *constant severe pain* for 3½ hours because that would indicate a severe abruption from the start and Callum was unlikely to have survived so long as he did. However, on reflection, those two views are not intrinsically inconsistent. Mr Duthie was focussing really on the severity of the pain around 10.30am not its constancy afterwards. Mr Tuffnell was focussing on both.

54. Certainly, if the Claimant were saying she had been in *constant severe pain* from 10.30 to 13.10, I agree with Mr Tuffnell that would be implausible. Quite aside from his compelling clinical reasons, more prosaically it would beggar belief that having lost one baby and feeling like it was happening again, if the Claimant were experiencing *constant severe pain* solidly for 3½ hours that she would wait well over an hour until noon to attend hospital, especially as she was surprised by what he told her they said. Both clinically and factually, an account of *constant severe pain* from 10.30 is unlikely. By contrast, if the pain was growing more steadily over time then it makes more sense that the Claimant and Mr Orton would heed that surprising advice.

55. Indeed, as I explain, that was what the Claimant said in evidence: that pain continued from 10.30 to 14.00 but grew from a 'niggle' getting worse and was 'severe' when she was at her mother's house. That was consistent with what Mr Tuffnell would expect but inconsistent with Mr Duthie's hypothesis. In any event, the real factual issue in relation to her pain was not whether it was *constant and severe* from 10.30 to 14.00 on 27th June, but whether it was *intense* at 10.30am. Mr Tuffnell accepts the Claimant may well have been in *pain* around that time. Whether she felt such pain as '*intense*' is an inherently *subjective* question the Obstetricians cannot decide and rightly leave to me. Before I do, I next turn to the Midwifery expert / lay evidence.

### Midwifery expert and lay evidence

56. The striking aspect of all the professional evidence is its unanimity that if a heavily pregnant woman reported intense pain, the advice would just be to come straight in:

    56.1 The Obstetricians agreed placental abruption is a major risk with which any midwife would be familiar and that intense abdominal pain is a 'red flag'. Even were a midwife unaware of a history of abruption, with intense abdominal pain they should tell a woman to attend. Mr Tuffnell said (pg.245):

> "[*I]f a woman makes a phone call indicating she has had a sudden onset of pain to a maternity unit then it would be appropriate to take a history as to when the pain came on and its severity and nature. It would also be important to check whether there was any bleeding associated with it and the mother had any previous pregnancies or pregnancy problems. In this case if the history was obtained of a previous stillbirth due to a placental abruption then there would be no doubt that this woman should be reviewed at hospital…. [A] phone call by a woman with a history of previous abruption indicating a sudden onset of pain should lead to admission to hospital.*"

56.2 The Midwifery experts also agreed that if there were a report of sudden intense abdominal pain any reasonable midwife would have said to come in. In their Joint Statement dated 22nd February 2021, they said (pgs.270-1):

> "*Both experts agreed no reasonable and responsible midwife would fail to advise a woman to attend the maternity unit with sudden intense abdominal pain….[Ms Cook said]….all midwives are educated as student midwives upon recognition, care and management of women with placental abruption. This is regarded as an obstetric emergency situation. [Ms Smith said] I would agree a competent midwife would recognise the significance of the information reported of 'a suddenly experienced intense pain in (her) tummy'. I also agree that a competent midwife would associate such a report with a possible placental abruption and give the advice to attend the maternity unit as soon as possible or if there are transport difficulties, to phone an ambulance.*"

56.3 Indeed, Ms Mannion and Ms Kovacs also agreed. Ms Mannion said:

> "*A telephone call to the Maternity Unit would have been answered by any available midwife. A series of questions would have been asked to assess..including 'How bad is the pain ? Have you had any pain relief and is there any bleeding? If a heavily pregnant patient reported severe pain I would have advised her to attend…labour ward"* Ms Kovacs said:
> *"If a call had been made to the labour ward reporting pain at 36 weeks pregnant I would have asked questions including: 'How severe are the pains coming and going and how far apart?' 'Is her uterus hard to touch?' 'Has she any bleeding or loss by vagina?' 'Has her pregnancy been straightforward? 'Is her baby moving?' If intense pain were reported then I would have advised the patient to attend the labour ward.*"

Whilst these are slightly different questions and Ms Mannion uses the word 'severe' and Ms Kovacs 'intense', the essential point is that with a report of 'severe' or 'intense' pain in a heavily pregnant woman, the advice is to attend.

57. Indeed, it is clear Ms Mannion and Ms Kovacs say they would have questioned someone reporting a heavily pregnant woman was simply *in pain*. This is explicit in Ms Kovacs' statement and implicit in Ms Mannion's first question: 'How bad is the pain?' It would make no sense to ask that if she had already been told the pain was 'severe' (or indeed, 'intense'). The obvious point is that both experienced midwives understood that a report of abdominal pain in a heavily pregnant woman must be *investigated* regardless of her history. As Ms Smith said in her report (pg.258):

> "*It is usual for midwives to glean information and assess the content of phone calls…to advise women in accordance with the history they give….[S]taff would not have access to a woman's maternity records and rely on the responses to standard questions provided by the caller to determine a plan of care. The symptoms Ms Freeman experienced on 27th June and allegedly reported to maternity staff at the hospital, were sufficient to warrant immediate admission to the maternity unit, regardless of past obstetric history...On balance, midwives being informed of such symptoms would be appreciative of the possible obstetric emergency of abruption that required immediate admission.*"

58. Whilst Ms Smith also observed it is most unlikely that Mr Orton would have been given the advice he describes, of course that is a matter of fact for me and is predicated on a report of 'intense pain'. However, as Ms Kovacs explicitly and Ms Mannion implicitly said and for the reasons Ms Smith gave in that passage, if the Claimant felt intense pain, that warranted immediate admission irrespective of her past obstetric history and since midwives did not then have ready access to the notes, any report by telephone of simple 'pain' in a heavily pregnant woman should have led to questions which would have elicited its seriousness. As Ms Smith put it, the midwives would '*rely on the responses to standard questions by the caller to determine a plan of care'*. Given that unchallenged evidence from the Defendant's own lay and expert midwives, it is unsurprising that neither Counsel suggested I would need more evidence were I to find there was simply a report of 'pain' not 'intense pain'. In those circumstances, it would plainly be *Bolam* negligent not to ask the basic question how bad the pain was (as Ms Mannion and Ms Kovacs said) since if it were 'intense' in a woman at 36 weeks, it would require immediate admission irrespective of obstetric history. Indeed, if the history of abruption emerged, the advice was even clearer even if not 'intense' pain. As Mr Tuffnell said: "*A phone call by a woman with a history of previous abruption indicating a sudden onset of pain should lead to admission to hospital."* It is precisely the obviousness of that midwifery advice for a woman in the Claimant's position that leads Ms Smith to doubt that any midwife would not have given it.

59. Ms Smith's explanation that in 2002 the staff would not have a full copy of the maternity notes leads to the issue between her and Ms Cook (who does not express a view on that issue) about whether it was substandard practice of the Defendant not to record telephone calls into the Maternity Unit, as Ms Mannion and Ms Kovacs say. Both agree it would be negligent now, but Ms Cook contends it was in 2002 (pg.137):

> "*Ultimately, even in 2002 it is my view there should have been a method / system in place for documenting telephone calls when women and/or family members telephoned the staff at the maternity unit for advice….*

> *The purpose of record keeping has been explained [in the NMC Guidance] 'Good record keeping helps to protect welfare of patients and clients by promoting: high standards of clinical care, continuity of care, better and communication and disseminating information between members of interprofessional health team, an accurate account of treatment and care planning and delivery and the ability to detect problems, such as change in the patient's or client's condition, at an early stage'. In addition, that Record keeping is an integral part of nursing and midwifery practice. It is a tool of professional practice and one that should help the care process. It is not separate from this process and it is not an optional extra to be fitted in if circumstances allow' (NMC 2002 p7). Therefore, the standard for midwifery practice relating to documentation applies equally to face to face care or to the provision of telephone advice.*"

60. However, those extracts from the 2002 NMC Guidance (pgs.188-205) do not require the logging of telephone calls (which may or may not entail important information as opposed to standard queries), but the accurate keeping of clinical records. Nothing in that Guidance (which I have read) mandates the logging of telephone calls even where brief advice is given. I accept Ms Smith's opinion in the Joint Statement (pg.268):

> "*In 2002, written recording of telephone calls from women/partners and the advice given, varied from maternity unit to unit, some having formalised templates completed whilst others had telephone log books. In other units, details of the call were not formally recorded. The maternity unit in question would have had its own procedure on handling such calls however…this Trust did not require such records to be made…. There was no standard which required such records in 2002 as far as I am aware. Due to there being differing procedures in force by different maternity units, in my view, it was not substandard practice for a unit not to require phone calls to be formally documented.*"

Applying the *Bolam* standard as endorsed and explained in *Bolitho*, it was not negligent of the Defendant in 2002 not to record telephone calls even if other NHS Trusts did so. Indeed, the absence of any specific requirement in the 2002 NMC Guidance reflects there may well have been a variety of practices. It states (pg.198):

> "*The frequency of entries [in clinical notes] will be determined both by your professional judgement and local standards and agreements.*"

Therefore, I find there was no breach of duty by the Defendant in 2002 in its practice of not logging telephone calls from patients and partners.

61. I do not accept Mr De Bono's submission that 'the *Keefe* principle' applies even without breach of duty, which would extend it beyond all the authorities considered above. However, even if I am wrong about that, or indeed wrong about breach of duty itself, as stressed in *Shawe-Lincoln* and *McKenzie*, that principle comes down to this:

> "*First whether it is appropriate to draw an inference, and if it is appropriate to draw an inference the nature and extent of the inference, will depend on the facts of the particular case… Secondly… a failure to adduce relevant documents may convert evidence on the other side into proof, but that may depend on the explanation given for [its] absence….*"

62. The reason for the 'failure to adduce relevant documents' is that they were not kept at the time. That is the unchallenged evidence of Ms Mannion and Ms Kovacs. It is also their unchallenged evidence that they did not personally take any such call and from Ms Mannion that the Claimant did not mention the call when she saw her. What inference could properly be drawn given all the evidence? Surely not that there was not only a telephone call to the Maternity Unit but also that it reported intense pain and yet led to advice to go home and rest – that would be a complete logical leap from all the evidence and indeed inconsistent with the unchallenged evidence Ms Mannion and Ms Kovacs that they would never have given such advice.

63. In my judgment, it would also be a stretch to infer on the facts here that there was in fact a telephone call that morning from Mr Orton to the Maternity Unit simply from a general breach of duty or poor practice in the Defendant not logging calls at this time. The Mr Orton to the Maternity Unit simply from a general breach of duty or poor practice in the Defendant not logging calls at this time. The furthest such an inference could properly go on the facts of this case is that the absence of a log of such a call does not mean that there was no such call.

64. However, the Claimant does not need to rely upon a '*Keefe* inference' for that: it is a straightforward application of the old judicial adage that an absence of evidence is not necessarily evidence of absence, especially given it is the Defendant's unchallenged evidence that they did not keep records of calls. So, it is hardly significant there is no record of such a call. That is entirely neutral as to whether there was such a call. There is no 'short cut' in this case: whether there was such a call or not, whether 'intense pain' was reported and whether the advice given was to go home not come in all must turn, against the background of all the evidence I have discussed, on the evidence of the Claimant and Mr Orton. I must now turn to their evidence.

**The evidence of the Claimant and Mr Orton about the telephone call**

65. Anyone who doubts the efficacy of cross-examination over a video link may very easily watch a Crown Court trial where it happens up and down the country every day. But if interested in the more unusual context of clinical negligence, I would have commended them to watch Mr Feeny's cross-examination of the Claimant and Mr Orton in this case. Mr De Bono candidly accepted it had exposed difficulties with their evidence, which he nevertheless contended had an essentially credible 'core'.

66. Mr Feeny in submissions built on his skilful work in cross-examination by identifying five essential headings under which he invited me to find either that there was never a phone call in the first place, or that if there was the evidence was so unreliable that the Claimant had failed to discharge the burden of proof as to what was said:

66.1 'Elaboration' in the accounts of the Claimant and Mr Orton over time;

66.2 'Inconsistency' between the evidence of the Claimant and Mr Orton;

66.3 'Implausibility' of the Claimant and Mr Orton's accounts of that morning;

66.4 'Lack of corroboration' for their accounts in contemporary medical records;

All of which is most obviously explained by a conclusion the Claimant and Mr Orton;

66.5 'Re-imagined' events that day in hindsight to avoid blaming themselves.

I will deal with those points and Mr De Bono's replies before reaching my conclusion.

67. On 'elaboration', whilst I will discuss below different points about the Claimant and Mr Orton's evidence, Mr Feeny's cross-examination revealed clear change in both of their accounts over time. As they both accepted, they had not raised the allegation of a phone call back in 2002. Indeed they had not thought of making a complaint, let alone a claim, until a decade later in 2012 when approached out shopping by a claims management company. Therefore, there was no *contemporary* account of the call.

67.1 The first account they gave was in their 2015 statements (pgs.55-8, 68-71). The Claimant said that after the appointment on 27th June 2002 as they were in town at a shopping centre, she experienced a *'sudden and severe abdominal pain which left me doubled over with pain'* and *'I thought I was losing the baby'* and Mr Orton (as he now is) *'told the maternity unit I was intense pain. He was told to take me home, make sure I went to bed and for me to take paracetamol'*. Mr Orton's statement was broadly the same then.

67.2 The second account given on their behalf was the letter of claim in July 2016 (pg.3-4). This alleged that at 10.30am the Claimant had experienced a sudden and severe abdominal pain which left her doubled over with pain and she thought she was losing the baby. Mr Orton (as he is) rang the maternity unit and said she was intense pain but was told to take her home etc. This account is not very different from in the 2015 statements.

67.3 The third account on their behalf is the Particulars of Claim in November 2019 (pgs.16-25) (No point is taken on limitation in this case, I should add). Unsurprisingly, ps.11-12 of the Particulars essentially relate the same factual contention of experience and report of intense pain. This is the factual account on which the experts were asked to give their opinions.

67.4 However, in the fourth account, the Claimant and Mr Orton's (as by then he was) statements of September 2020, their accounts start to change and indeed diverge from each other (see ps.9-12 pgs.62-3 and ps.8-10 pgs.73-4). The Claimant said that she told Mr Orton she was in *'severe pain and I was worried about losing our unborn baby'*, whereas he recalled that: *'she complained that her tummy was painful and she was worried she would lose the baby as she had in 1993'* and that he started to panic (a new detail). Moreover, they both said that Mr Orton rang the maternity unit and reported the Claimant had a scan that morning which was fine (a new detail) before going on to describe her sudden experience of 'intense pain' out shopping.

67.5 Moreover, in oral evidence, their accounts changed significantly again.

67.5.1 The Claimant said the pain started not 'suddenly and severely' as before but as a 'niggle in her tummy' in the lift on the way down to 'Crazy Georges'. She added it got worse in the shop and she had to sit down doubled over in pain as Mr Orton was paying. He then helped her back to the car by which time it was stronger still and she asked him to phone the Maternity Unit as she felt like she might be losing the baby. She said he called but she was inside the car and he was outside it, but she heard him say that she was in pain (not 'intense pain') but they had only just been in for a scan that morning. He told her they had told him to hang on, then came back to tell him to take her home.

67.5.2 Mr Orton said that when they were in town, the Claimant told him she was having pain whilst he was paying in the shop. She did not mention niggly pain: she said it was like in 1993 and she was worried about losing the baby again. He took her up to the car and got out the records in 'the little red book' with contact details in it and called the number. By then the Claimant was doubled over in pain in the car. He got through to a lady on the Maternity Unit and explained the Claimant had been for a scan that morning and everything was fine. He later clarified he also said that she was in pain (he did not say 'intense' pain, nor was he asked how bad it was). They put him on hold and came back and said the scan was fine and to take her home to bed and to give her paracetamol. He did not mention the previous abruption or she was worried she would lose the baby. He also confirmed he was not asked any questions and the midwife did not ask to speak to the Claimant.

As Mr Feeny said, the accounts given in oral evidence were different from those in the second statement and in turn different from the earlier ones.

68. Mr De Bono readily accepted that details of the account had changed over time. However, he submitted forcefully the 'core' of their accounts had not changed. That unchanged 'core account' was that around an hour after the ante-natal visit, they had been at the shopping centre when the Claimant had started to experience pain, including in 'Crazy Georges' and had gone back to the car. Even if her account of the precise extent of pain at different times and exactly how she described it to Mr Orton had changed, it was plainly bad enough for her to ask Mr Orton to call the Midwifery Unit which he did. Whether he had mentioned the scan that morning and/or whether or not he had described the pain as 'intense', the crucial thing was that they were consistent in confirming they told the midwife the Claimant was in pain. Why else would they have called if she was not in pain and if not to tell the Maternity Unit that after the appointment that morning had been fine? The Claimant and Mr Orton were unsophisticated and muddled, but they were honest and clear on that 'core' which had not changed over time even if the 'peripheral' details had changed. Those changes were actually plausible concessions that supported their credibility.

69. On 'inconsistency', Mr Feeny submitted the accounts of the Claimant and Mr Orton had also started over time to diverge on key details. Indeed, even in the first statement back in 2015, Mr Orton had referred to a conversation with the nurse in A&E around 12 noon who was looking at the Claimant's notes and explained that they had called that morning and been told to take the Claimant home (p.9 pg.69) whereas the Claimant's statement did not mention that. In oral evidence, Mr Orton accepted that this is what he had been told by members of the Claimant's family, that he was not with the Claimant during triage in A&E and did not go to the Maternity Unit with her, so I can place no weight on it. By the second statements, as I noted, the Claimant and Mr Orton's accounts were diverging about what she told him about the extent of her pain. Likewise, by their oral evidence, the Claimant was describing 'niggily pain' growing in severity but Mr Orton remembered that she was in a lot of pain and was worried about losing the baby.

70. However, Mr De Bono replied that the only significant inconsistency as between the Claimant and Mr Orton (as opposed to mutual changes in their accounts over time) was over what she had told him about how much pain she was in. As Mr Orton had said in evidence, she would know how much pain she was in, but he would only know what she told him which may not be the same. The 'divergence' in oral evidence was similar to but not really greater than in the second statements. Moreover, it was striking Mr Orton admitted not telling the midwife that the Claimant had said she was worried about losing the baby. This was a concession which supported his credibility.

71. On 'implausibility', Mr Feeny also submitted that all the accounts of the Claimant and Mr Orton were implausible. I have already indicated that to the extent the Claimant was saying she was in *constant severe pain* for 3½ hours I agree with Mr Tuffnell that was implausible. However, I put to Mr Feeny that in oral evidence the Claimant was now not saying that, rather that the pain steadily grew in the shopping centre until she asked Mr Orton to call. Mr Feeny accepted this (changed) account was more consistent with Mr Tuffnell's analysis of the likely progress (but inconsistent with Mr Duthie's maintained 'severe from the start' analysis). However, Mr Feeny submitted it was still implausible that if the pain continued to grow they did not come into hospital earlier than they did, which suggested the pain was only bad enough to seek treatment by about 12 noon when they in fact did attend.

72. Mr Feeny characterised Mr Orton's account in oral evidence as 'watered-down' in that he did not assert he had reported 'intense pain' to the midwife, only 'pain' although Mr Feeny accepted this made the advice to 'go home' less implausible. However, Mr Feeny submitted that Mr Orton's suggestion that the midwives went away to check the notes was still implausible because (as I have accepted) they did not have the notes, the Claimant did; and an explanation that one midwife went to speak to another who had undertaken the scan an hour before was implausible because it involved two midwives ignoring a report of 'pain' and not asking any questions.

73. However, Mr De Bono pointed out that the Claimant's changed account of the progress of her pain was consistent with Mr Tuffnell's evidence and so plausible. Once she had checked with a midwife whom she had understood had said to go home, it was not implausible that she faithfully followed this advice, especially as she was unsophisticated and respected the professional's opinion. Moreover, Mr Orton had clarified in evidence that he had started by reporting that the scan that morning had been fine but that the Claimant was now 'in pain' (not 'intense pain'). That and the potential for misunderstanding by the midwife of him made the advice given more plausible even if still negligent. It was not implausible if a busy midwife misunderstood and if they negligently did not explore the information properly, failed to answer questions as they should have done which led them to give negligent advice, even after they had checked with a colleague who had tended the Claimant that the scan was fine (as she would have remembered an hour and half earlier it was).

74. On inconsistency, Mr Feeny submitted the Claimant's account of a phone call was not mentioned in the day's clinical records, specifically the one taken by Ms Mannion timed 13.10 (pg.92):

> "*On admission, Debra distressed saying she has had contractions and abdominal pain. Assisted into bed. No loss [through] vagina [i.e. bleeding]. Debra says she attended Ante-Natal Clinic this morning and had pain one hour following this appointment (since 10.30).*"

75. However, Mr Feeny accepted this was mixed in the sense that whilst it did not mention a call being made, it did mention that the Claimant had been in pain at 10.30. Moreover, it needs to be borne in mind this note was only written hours later at 16.50 and would realistically only record what the midwife recalled as clinically significant.

76. Here, Mr De Bono started to move from the back foot to the front foot on credibility. Far from the Claimant's account of pain at 10.30 prompting a phone call being *undermined* by the contemporary notes, he submitted it was *corroborated* by three:

    76.1 The routine ante-natal appointment at around 9am (pg.506) recorded that the Claimant and Callum were well and planned a membrane sweep in a week. This and the scan are consistent with there being no abruption in progress and no pain at that time, between 60 and 90 minutes before the alleged call. I find on the balance of probabilities that abruption began later.

    76.2 Dr Hassan (or Dr Khalil's) note taken at 13.30 (pg.495) records that the Claimant was *'[Complaining of] sudden lower abdominal pain associated with [vaginal] bleeding'.* As I noted above, that is inconsistent with a description of simultaneous sudden lower abdominal pain and bleeding when the latter began at 13.16 (which is not what Ms Mannion recorded in her note then). As Mr de Bono said, it suggests the doctor 'concertina-ed' the account that day and referred to how the Claimant said the pain had started: as 'sudden' (so soon after the positive scan) but not 'severe' lower abdominal pain.

    76.3 Read in this light, Mr De Bono submitted Ms Mannion's retrospective note of what she was told at 13.10 fits what the Claimant was saying at the time. This 'sudden lower abdominal pain' she mentioned to Dr Hassan was the same pain she had told Ms Mannion that she had at 10.30am. As the Claimant also said to Ms Mannion, the pain continued and she had contractions (consistent with both Obstetricians' description of how pain would manifest itself).

77. Finally, Mr Feeny's overarching submission was the Claimant and Mr Orton had 're-imagined' in retrospect events at the time. They had not raised these concerns for several years until approached by a claims management representative in 2012. Whilst they claimed in their statements to be unaware of their right to pursue a claim Mr Orton in his evidence admitted he was aware of that right. Their failure to do so for a decade reflected that they did not truly blame the hospital because there never was a phone call as they describe. However, having cared for Callum's severe disabilities for a decade, it was understandable to 'transfer responsibility' onto the hospital. They were not dishonest but had simply convinced themselves of their story.

78. Mr De Bono retorted that Mr Feeney's theory about memory reconstruction was itself implausible. If there never had been a phone call that morning, it would be a very strange thing to invent (even if subconsciously as a joint fantasy), especially as there was no evidence in the notes or elsewhere of such a call. Moreover, the little details had the ring of truth even if the account had varied: the pain coming on as they were heading down to 'Crazy Georges', the Claimant sat on a sofa in pain, heading back to the car and Mr Orton remembering calling the number in the little red book of maternity notes. Why invent all this (even if subconsciously) as happening there?

79. As skilful as Mr Feeny's cross-examination and submissions were, I am persuaded by Mr De Bono's analysis of the evidence and take Mr Feeny's points in reverse order:

79.1 Firstly, the Defendant has never suggested the Claimant and Mr Orton were lying about the phone call. Rather, that they subconsciously imagined it to displace blame from the Claimant and Mr Orton for delaying going to hospital they subconsciously recognise in hindsight they should have done earlier. However, as Mr De Bono says, this seems like a very strange thing to invent, especially with all those little details adding to credibility. If the Claimant and Mr Orton were displacing blame, why did they not do so for a decade ? Why on earth would they invent a phone call to 'justify their delay' in going to hospital rather than latching onto and misremembering some comment of the scanning midwife in the appointment that morning ? Moreover, if it was invented or 'imagined' as the Defendant says, the Claimant and Mr Orton would not have made the concessions they did in evidence. They would have stuck to their 'mantra' that they told the midwife the Claimant was in 'intense pain'. With the skill and effectiveness of Mr Feeny's cross-examination putting them under forensic scrutiny, the Claimant and Mr Orton changed peripheral details. However, they both still stuck to the real core of their account: that the Claimant's pain came on an hour or so after the appointment in the shopping centre and that it was bad enough to call the Maternity Unit. Their evidence struck me as unsophisticated and rather muddled, but very clear on the essential points that a phone call happened because the Claimant was in pain.

79.2 Secondly, aside from judicial debate about *Gestmin*, in *Synclair* it was stressed that oral evidence should be compared to contemporaneous notes. It is true there is no note of the telephone call, but as the Defendant at the time did not log calls, it is neutral. It is also true the Claimant was not recorded by Ms Mannion and Dr Hassan as referring to a phone call, but at the time, she was in extreme pain on any view and I accept Mr Orton (who made the call) was not on the Maternity Unit. This is where the observations of HHJ Freedman in *Ismail* echoed by Cotter J in *HTR* resonate. By 13.10, the Claimant was unquestionably in great pain and the abruption well-advanced. It is entirely understandable her focus and that of Ms Mannion and Dr Hassan at that moment was on what mattered at that moment: the pain itself not the earlier phone call. Moreover, for all the Claimant's changes in account, it is striking that she said on that very day to Ms Mannion the pain started at 10.30am and that she reported to Dr Hassan she had 'sudden abdominal pain' which I find on the balance of probabilities was a reference to the start of the pain at 10.30 which was 'sudden' so soon after the positive scan if not initially 'severe'. In other words, contemporaneous notes support the Claimant's account that her pain started suddenly at 10.30.

79.3 Whilst I have rejected as implausible any suggestion that the Claimant was in constant severe pain for 3½ hours, as Mr Feeny accepted her account in oral evidence of pain growing over time was more plausible and consistent with Mr Tuffnell's evidence of likely progression. This also explains why Mr Orton may not have emphasised the suddenness and severity of the pain to the midwife, but instead focused on the contrast between the appointment having gone well and the pain that she was experiencing an hour later.

This account was rather less dramatic (or indeed was 'watered-down' as Mr Feeny put it) and so both more plausible in itself and in provoking the advice described. Mr Orton was worried and not the most articulate of people as he demonstrated in evidence. It is entirely plausible that having told the midwife the Claimant's scan had gone well an hour earlier (and that having been confirmed) that his report of 'pain' (not 'intense' or 'severe' pain) would have elicited the response – negligent though it may have been – to go home for rest and pain relief.

79.4 As to the divergence in the accounts of the Claimant and Mr Orton on the issue of how severe she told him the pain was, this cannot be stretched too far. Firstly, the 'divergence' (as opposed to mutual change) only developed in the second statement and related to whether the Claimant told him that she was in 'severe' pain or simply 'painful'. However, they both say she was worried she may lose the baby after what had happened in 1993. Likewise, in oral evidence Mr Orton said the Claimant told him she was in 'a lot of' pain and thought she was losing the baby, which is actually closer than the statements. As the Claimant also said in evidence the pain was getting progressively worse, it also depended what the Claimant told him about the pain and when. If she was referring to telling him she was in 'severe pain' on the sofas in Crazy Georges this would fit his account in oral evidence of 'a lot of pain'. Insofar as he suggested in his statement at this point that she simply said it was 'painful', this really boils down to a relatively minor inconsistency between them.

79.5 However, as Mr De Bono accepted, there is no getting away from the fact that their accounts have changed over time with the addition of more details. However, this has not been addition of ever greater fantasy and implausibility. As Mr Feeny accepted, in their oral evidence the Claimant and Mr Orton's accounts as augmented were less dramatic and more plausible. In my judgement, this supports their credibility on the 'core' of their account rather than undermining it. Whilst the Claimant contended that she remained in pain, the clear implication of her evidence was that pain grew over time, consistent with Mr Tufnell's opinion. The Claimant accepted it was quite different from the more dramatic and shorter event in 1993 with vaginal bleeding etc. It manifested itself through contractions as the Obstetricians suggested it would, which at 36 weeks added to 'concealment'. It may be that their initial statements in 2015 13 years after the event latched on to the clinical note reference to 'sudden abdominal pain' and this spawned the 'sudden and severe' and 'constant severe pain' narratives Mr Duthie espoused and Mr Tuffnell dismantled. However, to their credit under forensic scrutiny of effective cross-examination, they made concessions and their accounts became more plausible, more reliable and more believable. I accept them as true on the balance of probabilities.

## Conclusions

80. I therefore turn finally to my conclusions on the balance of probabilities as to what actually did happen that morning on 27th June 2002, with the burden squarely on the Claimant. I have already described the ante-natal appointment at around 9am was uneventful and so far as the Claimant and Mr Orton were concerned, the pregnancy remained normal, as indeed had been the last pregnancy with Reece.

81. However, as they travelled down in the lift in the shopping centre to Crazy Georges, the Claimant suddenly felt 'niggly in her tummy'. At that point, she may well have not mentioned it to Mr Orton. This was around 10.30am and described as 'pain' to Ms Mannion at 13.10 in the light of everything that then happened, including the severe pain she was in by that point in time. Moreover, especially so soon after being told that the scan was fine, she would have described this to Dr Hassan as 'sudden pain' as he later recorded. This was different clinicians in different conversations with a slightly different note of the same event (as described in *Ismail* and *HTB*). However, as Mr Orton went to pay at the counter at Crazy Georges, the Claimant's pain increased and she doubled over in pain and sat down on the sofa in the shop. By then she knew something was wrong. As Mr Orton returned, he could see her in pain and she said that briefly but focussed on fears she could lose the baby as in 1993. They were both (understandably) panicking then and decided to go back to the car.

82. By the time they got to the car, the Claimant's pain was worse still. However, it was only just over an hour or so since they had a scan and had been told everything was ok. Pain is subjective but I find if the Claimant had been asked how bad the pain was she would have said words to the effect of 'intense' or 'severe', possibly more bluntly. It was certainly bad enough for her to want to inform the Maternity Unit, especially as had been discussed that morning, her planned induction of labour was by then only a week away and she was thinking about having lost a baby in 1993. It would hardly be surprising if the Claimant's 'threshold' for calling the Maternity Unit would be earlier than for other women who had not had that previous horrific experience. Therefore, the Claimant's pain if measured on a scale of 1 to 10 (as pain often is in my experience of medical reports) would have been consistent with Mr Tuffnell's gradual progression but was getting worse and bad enough to justify seeking clinical advice.

83. As the Claimant sat in the car in increasing pain, doubled over again as Mr Orton recalled, he was understandably panicking about what the Claimant was telling him about fearing losing the baby, called the number in the Midwifery Notes: the 'little red book' commonly used then and which added a little touch of detail to his account. He got through to a midwife on the Maternity Unit, not a receptionist – as Ms Mannion said, it would be 'any available midwife' but was not her or Ms Kovacs (and I have no evidence of what other midwives were working that day). Struggling himself to come to terms with the worrying and swift change from only an hour or so before, Mr Orton started by explaining they had a scan that morning which was fine but that his partner was now in pain. He was not thinking entirely clearly or calmly, otherwise he would have emphasised that the Claimant was worried about losing her baby again. I also accept he did not mention 'intense' or 'severe' pain at that point. However, given that his partner had been doubled over and was worried about losing her baby, if asked how bad the pain was, I find on the balance of probabilities he would have said something to the effect that it was intense, she was doubled over and was worried about losing the baby as she had done before. Alternatively, I find he would have passed the phone to the Claimant who would have made that clear to the midwife.

84. However, contrary to the normal practice explicitly of Ms Kovacs and Ms Mannion, Mr Orton was not asked how bad the pain was. It was doubtless a busy day on the Maternity Unit, which is why Ms Mannion was unable to have the time to write up her notes until several hours after she first met the Claimant at 13.10. Instead, some busy, distracted midwife was faced with an inarticulate father-to-be starting a call with the fact a scan an hour earlier was fine but now mother was in pain. She went to quickly check with a busy colleague and it was confirmed the Claimant's scan had been fine which she then told to the father. That does not mean the advice to go home was a joint decision. It was probably that same midwife's decision alone and without reference to notes explaining the history. She wrongly assumed as the scan had been fine there was nothing to worry about. If she had not been told of the scan, perhaps she might have asked. Yet, I find on the balance of probabilities she was clearly told there was pain, otherwise she would not have recommended pain relief, yet did not ask how bad the pain was. Had she done, she would have known it was intense.

85. Instead, that midwife sought to reassure an apparently nervous father-to-be that bed rest and pain relief would be fine, not considering for a moment (as she should have) that such pain needed to be investigated. In my judgement, in those circumstances, that approach is entirely plausible given the background of the recent positive scan. I appreciate there is no identified midwife who could be questioned about what she said on a call she had recorded taking. I am very clear that I draw no 'inference' from the absence of such a record, whether reflecting the principles in *Keefe* or not. I simply find that if that call had been recorded, then the identity of the midwife I find took it would be known and could be called to give evidence about it. This may be one reason why 20 years later NHS Trusts understandably now routinely record such calls.

86. It is true this is not the original pleaded allegation that Mr Orton called a midwife, reported *intense* pain and was told to take the Claimant home for bed rest and paracetamol. However, it is a finding that he called a midwife, reported pain, was not asked how intense it was, but in the light of the positive scan an hour or so earlier was told to take the Claimant home for bed rest and paracetamol. The core of the account remains essentially the same in my judgment and not only consistent but plausible. It also explains why the Claimant and Mr Orton years later have been consistent on the obviously memorable core of this incident – even if some of the details by then were a little hazy which explains some changes on the peripheries of their accounts.

87. Therefore, I find myself in the situation I raised at the start of trial: of finding that Mr Orton called and spoke to a midwife, told her that the Claimant was in pain and (after a pause which confirmed what he had said that the scan was positive) was told to take her home for rest and pain relief. Whilst it was agreed expert evidence that had he said 'intense pain' this would be negligent, I have found he did not say that. Yet at the start of trial neither Counsel suggested I would need more midwifery evidence were I to find that, as I have. As I said, Mr De Bono submitted I did not need it as it would have been negligent for a midwife when told of pain not to ask how bad it was, which reflected the explicit statement of Ms Kovacs, the implicit approach of Ms Mannion and was supported by Ms Smith. For the reasons given above, I agree. Indeed, whilst Mr Feeny was wary of conceding that at the start of trial, at the end of it he did not dispute that would be negligent in the light of all the Midwifery evidence.

88. The *Bolitho* question then arises about what would have happened had that question been asked as I find it should have been. The burden is still on the Claimant to prove either limb of *Bolitho*: that on the balance of probabilities the midwife would have advised the Claimant to come in or that it would have been negligent not to do so. Here is where the agreed Midwifery expert evidence (and Mr Tuffnell's view quoted above) comes in that if a midwife had been told that the pain was 'intense' or 'severe' or equivalent (on this hypothesis in response to the midwife's question rather than volunteered initially as pleaded), it would have been negligent not to advise immediate attendance. Moreover, both Ms Mannion and Ms Kovacs would have done.

89. Whilst Mr Orton was (understandably) panicking and not thinking straight enough to *volunteer* that the Claimant was doubled over in pain and worried about losing a baby, it beggars belief that if he had been asked how bad the pain was he would not have mentioned that. I certainly find on the balance of probabilities he would have done so. Moreover, reflecting Ms Mannion's and Ms Kovacs' evidence, I find when he would then have been told not to take her home but to bring her straight in to the *Maternity Unit* (not A&E, which was apparently the Claimant's mother's idea) or alternatively given the Midwifery expert evidence that it would have been negligent not to do so.

90. In turn I find that such was the Claimant's anxiety – the reason she asked Mr Orton to call – she would have done as she was instructed and come straight in without a second thought. Indeed, the (I find, negligent) advice to go home surprised her she obediently complied with it. If they had been told to come in, I find on the balance of probabilities they would have returned to hospital relatively quickly and on the Obstetric evidence would have been seen urgently. I find Callum would have been delivered by around 11.40, roughly within an hour and so avoided his brain damage.

91. As it was, having been given the negligent advice to go home, the Claimant insisted on going instead to her mother's as they had planned. Who knows what would have happened had her mother been at home not at the hairdressers' when they arrived. However, despite the Claimant's misgivings, having checked with the Maternity Unit and with a positive scan that morning, it was only as the pain got increasingly severe and her mother returned, fetched by her step-father, that the Claimant finally went to hospital, going to A&E as the Claimant's mother had suggested, around 12 noon.

92. When the Claimant arrived, she waited in A&E a while in considerable pain and has a poor memory of what happened at that time. Mr Orton's memory is also limited because – doubtless in shock – he allowed the Claimant's family to take over as he said. They told him a nurse in A&E had reported the call in the notes, but I find if this happened this was because they had told her about the call that was not recorded. The Claimant was then transferred to the Maternity Unit where her focus was not a complaint about the earlier advice - that for all she knew at that point was reasonable. It was rather her own intense pain and whether her baby would survive. He nearly did not, as the Obstetricians have confirmed. Once Callum was born, the focus of his mother and father would always be him and his challenging needs, not compensation. Whilst the idea was planted in their head by the claims management representative in 2012 and they instructed solicitors, tellingly they did not pursue it until after Callum's death. This claim, as I said, is not about money for them but justice for him.

93. I therefore uphold that claim and award the Claimant the agreed sum of £500,000 but perhaps more importantly for them, vindication of what they said happened to Callum.

94. It is only fair to the Defendant to say that in the intervening years, much has changed, including in NHS practice on recording calls. It may seem hard on the Defendant that one midwife letting her guard and standards drop for a few seconds should have such consequences. However, that is a reflection of the vitally important work that midwives – and the NHS – do, as we all recognise, especially in the current Pandemic.

95. Yet the consequences for the Defendant of this judgment pale into insignificance compared to those of its negligence for Callum and his parents. I hope that when the anniversary of Callum's death comes around in a few weeks on Christmas Eve, this year it will be perhaps just that little bit easier to bear for them.

---