

Lady Justice Nicola Davies :

1. The claim in this appeal arises from the brain injury suffered by the appellant/claimant around the time of her delivery on 4 June 2018 at East Surrey Hospital (“the Hospital”). The claimant, a severely brain-damaged child, is represented by her mother (“M”) and litigation friend. She was born by caesarean section having suffered acute profound hypoxic ischemia (“PHI”) before, during and following her birth. She suffers from quadriplegic cerebral palsy with severe global developmental delay.
2. It is the claimant’s case that following M’s admission to the Hospital at 36 weeks and 1 day gestation, as a result of negligent care provided to her, the claimant’s delivery was not competently managed. It is agreed that the injury resulted from a short period of near total hypoxic ischaemic injury. The claimant contends that the delay in delivery, which resulted from a delay in transfer of M to the labour ward and thereafter a delay in commencing the monitoring of her heart rate during delivery, caused or materially contributed to her injury.
3. In this appeal, the claimant seeks to overturn a finding of fact made by Ritchie J (“the judge”) as to the time at which Miss Nicks, the consultant obstetrician on duty, would have entered M’s room in the labour ward having heard sounds representing bradycardia (reduction of the foetal heart rate (“FHR”)) emanating from the transducer linked to the cardiotocograph (“CTG”) which was set up to monitor FHR had the CTG been set up earlier and had the sounds representing bradycardia been heard by Miss Nicks when she was first outside M’s room.
4. The judge made findings of fact in the liability-only trial, which included the following:
 - i) on 4 June 2018 M and her husband had arrived at the defendant’s hospital because M was suffering from abdominal pain. At 14:55 Midwife Reeves examined M on the antenatal day unit. She noted that M’s abdomen was too tender to palpate and that she had polyhydramnios. A CTG was commenced at 15:04 and ran until 15:43, it was assessed as normal and reassuring. The midwife noted: “? Preterm labour”;
 - ii) at 15:51 M was examined and assessed by an obstetric SHO acting up as registrar, Doctor Emmanuel. He looked at the CTG trace and observed that it was normal and that M’s abdomen was generally tender. A vaginal examination found the cervix to be 1cm dilated and 2 cm long. Doctor Ekanem made a two-point plan: M was to be admitted to the antenatal ward and given analgesia;
 - iii) at 16:45 M’s pain had increased and she was offered and accepted cocodamol;
 - iv) at 16:50 Doctor Ekanem decided to re-write the notes of his examination an hour earlier. He wrote the time at the top left of his new notes as “16:50” and then wrote a substantially similar but also partially different set of notes in the antenatal clinical records. He noted that M’s pain was “sharp” and that the abdomen was “tensed”. Doctor Ekanem did not make clear that no new examination had taken place. He expanded his original two-point plan to seven points, the focus being on M’s pain. He noted that obstetric consultant, Ms Srivastiva, was informed and the plan was to transfer M to the labour ward.

5. For reasons which the judge described as not having being adequately explained, M was not transferred to the labour ward but instead was transferred to the antenatal ward. During the transfer M suffered severe pain and made that verbally plain. The transfer to the antenatal ward occurred between 16:50 and 17:20. At 17:20 Midwife Reeves noted: "Transfer to ward pain has increased 3-4:10 D/W SPR Emmanuel for Transfer to D/S. LWC informed awaiting a room on D/S". Between 17:20 and 17:50 no further entries are made in the clinical notes. During this period M was in severe pain but was not reviewed by an obstetrician.
6. M arrived on the labour ward just before 17:50. She was in pain and visibly so. Introductions took one minute after which M was hooked up to the CTG by Midwife Reeves, which took one minute. By 17:51 the transducer was sounding out the claimant's heartbeat, which was bradycardic.

Evidence of Miss Nicks

7. At [98] the judge recorded that Miss Nicks was carrying out her ward round at 17:50 and was standing outside the room into which M had been transferred. She heard what appeared to her, from the sounds being made by the CTG transducer, to be bradycardia. She entered the room at 17:52, the CTG trace started at 17:53 (the sound was being emitted before the trace started) and bradycardia was becoming apparent. Miss Nicks carried out an ultrasound and confirmed bradycardia. She did a quick examination of M. At 17:55 she had decided a crash super-fast caesarean section under general anaesthetic was needed. Her working diagnosis was a partial abruption of the placenta. Doctor Heath was sent to prepare the theatre. The procedure commenced at 18:05 and significant blood was found in M's abdomen before the uterus was opened. The claimant was born at 18:08 with meconium-stained liquor. A period of 17 minutes occurred between the start of the CTG transducer sounding out the bradycardia and the claimant's birth. Delivery was achieved in 13 minutes from the decision to operate.
8. Miss Nicks stated that had a CTG been instigated earlier on the labour ward she could not say whether the emergency caesarean section would have occurred earlier save that a useful trace to diagnose bradycardia would take three minutes and the decision would have been made after that [99]. Miss Nicks would have taken action earlier in the labour ward if M had been brought in earlier and the bradycardia had started earlier [101]. The judge found Miss Nicks to be a credible and impressive professional witness.

Breaches of duty

9. The findings of fact and breach of duty made by the judge included the following:
 - i) the decision made at around 16:50 to transfer M to the labour ward was not implemented by Midwife Reeves, it represented a breach of duty [164];
 - ii) the labour ward would have been able to accommodate M by 17:10-17:15 [166];
 - iii) the failure of the defendant through Midwife Reeves and Doctor Emmanuel to transfer M to the labour ward by 17:15 or 17:20 at the latest was a breach of the duty which led to a delay in a full obstetric assessment of M and her baby's condition and to a delay in commencement of a CTG trace [169].

10. Having considered the evidence of obstetric experts, Miss Leonce on behalf of the claimant and Mr Tuffnell on behalf of the defendant, the judge made additional findings on the balance of probabilities which included the following:
 - i) a CTG trace applied to M's abdomen to measure M's heart rate and the FHR at around 17:10 to 17:20 would have appeared normal at the start. As that trace continued up until 17:48/17:49 it would have become more suspicious but not sufficiently suspicious to lead to a category one c-section decision [226];
 - ii) the obstetric care provided to M represented a breach of duty owed to M and the claimant. The note made at 16:50 by Doctor Ekanem that the consultant had decided that M should be transferred to the labour ward was not acted upon, no transfer took place for one hour and during that period of delay no assessment or chasing took place by Doctor Ekanem [228];
 - iii) Doctor Ekanem failed to inform the consultant on duty from 17:00, namely Miss Nicks, of M's increased pain which occurred at 17:10. In addition Doctor Ekanem wrote misleading notes which gave the impression that he had carried out a second review of M at 16:50 when he had not [229], [230].
11. The judge found that M should have been transferred to the labour ward within 10 to 20 minutes of the decision made by the consultant at 16:50 hours. She should have arrived at the labour ward by 17:10 hours [233]. Applying the "but for" scenario, the judge found that soon after arrival on the labour ward M would have been assessed by an obstetrician and a vaginal examination would have shown the cervix was only 1 cm dilated. A CTG would have been attached. M's blood pressure would have remained normal. The obstetric registrar would have had placental abruption as the more likely diagnosis than threatened pre-term labour [234].
12. The judge considered expert evidence given by neonatologists, a paediatric neurologist and neuroradiologist and made findings of fact in relation to factual causation which included the following:
 - i) the claimant was born at 18:08 hours. The clinical records show that her FHR did not recover to over 100 bpm until 3 minutes and 36 seconds after her birth as measured on a stopwatch. The PHI continued until 18:11 and 36 seconds after her birth and the likely time for the end of the PHI was 18:12 hours [284], [285];
 - ii) the period of PHI suffered by the claimant was around 23-24 minutes. Working backwards, the PHI and the bradycardia commenced at or around 17:48-17:49 [286], [288];
 - iii) in the 10 minutes leading to 17:48-17:49, the claimant's heart was being deprived of oxygen as her mother's circulatory system was coping with her uterine bleed by closing off the blood supply to the uterus. This partial and increasing hypoxia would have affected the claimant's FHR and that effect would have shown on the trace [291];
 - iv) the CTG trace between 17:20 - 17:48/17:49, and the assessment results of maternal examination which should have taken place, would have led the

obstetricians on the labour ward to have had placental abruption or uterine rupture in mind for M [292];

- v) the midwife attending M would have been aware of the possibility of bradycardia and/or the need for an urgent call to the obstetricians for a decision on c-section. The increasingly abnormal and/or ominous CTG trace would have led the midwife to have called the obstetricians for an assessment. The obstetricians would not have decided to carry out a superfast category one c-section at any time before the bradycardia emerged [292], [294].

13. At [296] and [297] the judge stated:

“296. I find as a fact that when the CTG trace became bradycardic at 1748-1749 hours the midwife would most probably have called for obstetric assistance within one to two minutes, or a maximum of 3 minutes, so by 1749 at the earliest and by 1752 at the latest.

297. I find as a fact that Miss Nicks was standing outside M’s room on the labour ward at 1750 and so on the but for scenario she would probably have walked into the room at the same time as she did in the event. I do not know where she was in the two minutes before 1750.”

14. The judge found that it would have taken 17 minutes from the time that Miss Nicks walked into M’s room to the time of delivery of the claimant on the “but for” scenario as it did in real life on the 4th of June 2018 [298]. Upon this basis he concluded that despite the findings of breach of duty the claim failed on factual causation [299]. On the balance of probability the baby would have been born brain-damaged in any event. The brain damage was caused by PHI. This would have occurred even if the defendant’s staff had not been negligent in their care for her mother on the antenatal ward before the bradycardia started [300]. The injury was caused by an extremely rare vascular malformation of the mother’s uterus which led to a bleed but which did not lead to a drop in the maternal blood pressure or a substantial increase in the maternal heart rate. It led to an unforeseeable reduction and then cessation of placental perfusion to the baby which created an emergency when bradycardia occurred alongside the PHI [301]. In real life the emergency occurred just as M was arriving on the labour ward at around 17:49 hours and it was picked up very fast by Miss Nicks. The judge stated that Miss Nicks and her team acted with hugely impressive professionalism and speed to deliver the baby within 17 minutes of the emergency [302].

Duration of PHI and resultant injury

15. Expert evidence from neonatologists was given by Professor Mitchell on behalf of the claimant and Doctor Jane Hawdon on behalf of the defendant. Doctor Mike Pike, a paediatric neurologist, provided a letter of advice on behalf of the claimant. There was agreement between the experts that the first 10 minutes of PHI would have been compensated by the foetus, as a result it was likely that the claimant would have survived without brain injury. Doctor Pike’s evidence was that insults lasting 15 to 20 minutes result in increasingly severe brain injury but survival, while insults of 25 minutes or more are likely to result in death.

16. Professor Mitchell explained the “older view” of categorising damage caused by PHI, namely that following the initial of 10 minutes of non-damaging PHI, there were three periods each lasting 5 minutes where damage occurred with reasonably predicable results. The first 5 minutes produced mild damage, the second 5 minutes produced moderate damage and the third 5 minutes produced severe damage [252]. Professor Mitchell was “firm in his view”, that any saving of time or duration of PHI would avoid some injury. The shorter the duration of PHI, the lower the level of primary injury which would have been suffered by the baby [254]. He stated that if PHI was of shorter duration then the period of resuscitation needed after birth likewise would be shorter. The judge noted the double benefit of a reduced period of PHI [257].
17. Doctor Connolly, a neuroradiologist, gave evidence on behalf of the claimant. He concluded that had delivery been achieved before 17:53 all of the brain damage would have been avoided, had delivery occurred before 18:08 some brain injury would have been avoided [262]. Doctor Hawdon calculated that damage began at around 18:00 hours, following 10 minutes of compensation by the foetus [272].
18. The judge preferred Professor Mitchell’s explanation of the likely duration of the PHI and found at [280] that any reduction in the period of PHI would have reduced primary injury to the claimant’s brain neurones. There is no respondent’s notice in relation to the judge’s findings as to the likely duration of the PHI and his finding that the shorter the duration of PHI the lower the level of primary injury to the claimant.

The law

19. The judge set out the relevant principles contained in the authorities, in particular *Bolam v Frien Hospital* [1957] 1 WLR 582 (“*Bolam*”) and *Bolitho v City and Hackney HA* [1998] AC 232 (“*Bolitho*”). In *Bolam* McNair J stated that in the case of a medical man, negligence means a failure to act in accordance with a practice accepted as proper by a responsible body of medical men.
20. In *Bolitho* Lord Browne-Wilkinson restated the test and added:

“....The use of these adjectives - responsible, reasonable and respectable - all show that the court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter.”
21. As to causation in the context of a medical negligence claim, the judge cited the authority of *Bolitho* as follows:

“306. In relation to causation and the correct test in medical negligence claims, this was considered in *Bolitho v City and Hackney HA* [1998] AC 232 at page 239 by Lord Browne-Wilkinson:

“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: *Bonnington Castings Ltd. v. Wardlaw* [1956] A.C. 613; *Wilsher v. Essex Area Health Authority* [1988] A.C. 1074. 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. In a case of non-attendance by a doctor, there may be cases in which there is a doubt as to which doctor would have attended if the duty had been fulfilled. But in this case there was no doubt: if the duty had been carried out it would have either been Dr. Horn or Dr. Rodger, the only two doctors at St. Bartholomew’s who had responsibility for Patrick and were on duty. Therefore in the present case, the first relevant question is ‘What would Dr. Horn or Dr. Rodger have done if they had attended?’”

Grounds of appeal

22. The grounds of appeal now relied upon are:

“1. The Learned Judge erred in applying the wrong legal test to his findings that the Claimant’s fall in heart rate would have commenced at 1748/49. The Learned Judge asked what time would have elapsed with a midwife exercising competent care within the parameters of the *Bolam* test (and found she could have waited 3 minutes before calling an obstetrician). The Learned Judge should instead have asked what the consultant Ms Nicks would have done applying the *Bolitho* test.

2. Applying the *Bolam* test the Judge found that Ms Nicks would not have attended the Claimant’s mother any earlier than 1752, the time when she actually attended. Applying the *Bolitho* test the Learned Judge should have found she would have attended at least 1 minute earlier that is by 1751 at the latest. Ms Nicks’ evidence was that as soon as she heard the heart rate fall she entered the labour room and that this would also have been the case if she had heard the heart rate fall earlier. Ms Nicks did not wait 3 minutes to establish a bradycardia as the Learned Judge found would have been acceptable applying the *Bolam* test.

The Learned Judge failed to apply his own findings of fact as to the timings so as to determine that with the bradycardia beginning at 1748/49 the Claimant could and would with the same consultant in the same place have been delivered at least 1-2 minutes earlier.”

23. Permission to appeal was given by Stuart-Smith LJ on 28 March 2023, his reasoning includes the following:

“3. The proposed appeal is based upon the propositions that (a) Ms Nicks was within earshot at 1748 or 1749 when the bradycardia commenced; (b) had the CTG been in place and operational at 1748/1749, Ms Nicks would have heard the bradycardia when it commenced; and (c) had Ms Hicks (sic) heard the bradycardia when it commenced she would have entered the room and acted as she in fact did on hearing the bradycardia at 1751; (d) had that happened, the PHI would have been 2 or 3 minutes shorter; and (e) the injury suffered by the Claimant would have been reduced.

....

5. The Defendant is right to point out that the case outlined in 2 above was not one of the Claimant’s pleaded cases. It is also right to point out that the Judge held at [297] that he did not know where Ms Hicks (sic) was in the two minutes before 1750. If the absence of any finding about where Ms Nicks was in the two minutes before 1750) is sound, any appeal must fail because the rest of the proposed appeal is dependent upon Ms Nicks being within earshot so that she could respond as she in fact did at and from 1751.”

24. The skeleton arguments of the claimant and the defendant each addressed this specific aspect of the appeal. At the hearing, Ms Gumbel KC did not pursue this point and instead relied on the two original grounds of appeal above.
25. The grounds of appeal can be summarised thus: the judge’s findings at [296] and [297] take no account of the fact that Miss Nicks was outside the labour ward by 17:50. Miss Nicks’ evidence was that, as soon as she heard the bradycardia she went into M’s room. Had the CTG been operating as it should have been, Miss Nicks would have heard the bradycardia at 17:50 and entered M’s room by 17:51. This represents a timing of one minute earlier than the judge’s findings which were postulated on what the midwife would have done. There was no need to invoke what a midwife observing the trace would have done because Miss Nicks accepted that had she heard the bradycardia earlier she would have immediately entered M’s room. On the “but for” scenario, Miss Nicks would have heard the bradycardia as soon as she arrived at 17:50 and would have entered. The flaw in the judge’s findings were that they omitted to take account of the fact that Miss Nicks was in fact outside at 17:50.

The claimant’s case

26. The claimant contends that the judge applied the incorrect legal test namely that set out in *Bolam* as to what a responsible midwife would have done rather than the test set out in *Bolitho* which is what Miss Nicks would have in fact have done. On the judge’s findings, the CTG should have been running prior to Ms Nicks’ arrival. It follows that as she was outside at 17:50 she would have heard the bradycardia, which started at 17:48-17:49 and gone straight into M’s room. Accordingly, Ms Nicks’ entry would

have been at 17:51 not 17:52 as the judge found. Ms Nicks would have proceeded exactly as she did upon entering with the result that delivery would have occurred one minute earlier at 18:07.

27. The flaw in the judge's reasoning was to find that the midwife would probably have called for obstetric assistance within one to two minutes or a maximum of three minutes of detecting the bradycardia. There was no need to build this into the timings as it did not reflect the real life situation. The judge wrongly elided the situation of a midwife taking three minutes before she called the obstetrician, with the situation of the consultant who is outside the room at 17:50 and who would have heard the bradycardia as the CTG was running on the "but for" scenario.
28. On behalf of the claimant Ms Gumbel KC, accepts that the point raised in this appeal is a narrow one which results in a finding that delivery should have taken place one minute earlier. She contends that, relying upon the evidence of Professor Mitchell, every minute of PHI counted in terms of causation and to the assessment of whether the total period of PHI caused or materially contributed to the claimant's injury.

The defendant's case

29. Mr Sheldon KC, on behalf of the defendant, contends that the appeal is concerned with a straightforward factual conclusion made by the judge namely that, even if the CTG trace had become bradycardic at 17:48/17:49, Miss Nicks would probably have intervened at the same time as she did, namely 17:52. There is no *Bolam/Bolitho* error of law.
30. At trial, the claimant's case was not that Ms Nicks would have entered the room one minute earlier. There was no evidence before the court, nor was the judge invited to find, that there was a 60 second period when Miss Nicks was standing in a static position outside M's room in circumstances where she might have heard a bradycardia had a CTG commenced earlier. The judge was not asked to analyse where Ms Nicks was, and what she would have been able to hear between 17:50 and 17:51. Ms Nicks was not questioned about it, Midwife Bond was not called as a witness and the evidence of Doctor Heath did not address the issue.
31. A Respondent's Notice was filed which addressed the argument which the appellant was then seeking to advance, namely that Miss Nicks was present outside the delivery room at 17:48/17:49 and would have delivered the claimant 2-3 minutes earlier had a CTG been running at that time. It was submitted that such a claim formed no part of the claimant's pleaded case at trial. As previously noted, Miss Gumbel KC no longer pursued this aspect of the appeal.
32. The defendant relies upon the fact that Miss Nicks' evidence, written and oral was prefaced by the word "around" in respect of her memory of timings. In her witness statement, Miss Nicks stated that she was "...doing my routine ward round on the labour ward and at around 17:50 hours I arrived outside the room where (M) had been transferred to. From recollection I heard what appeared to be bradycardia so entered the room. I entered the room at around 17:52 hours to assess (M). A CTG was started and I heard what I suspected was a fetal bradycardia". The defendant contends that within the contemporaneous record and the factual evidence were critical gaps in the

timings because Miss Nicks was not asked the relevant questions and Ms Bond was not called as a witness.

33. The findings contained at [297], in particular the first sentence, fall within the judge's analysis of factual causation. The findings of fact relating to Miss Nicks' timings were made earlier in the judgment for a different purpose namely recording findings from the "general run of evidence", they were not being applied to the issue of factual causation. The findings are set out at [140] and [141] as follows:

"140. I find that M arrived on the LW just before 1750. She was in pain and visibly so, as Dr. Heath noted. Introductions took 1 minute and then she was hooked up to the CTG by Midwife Reeves which took one minute.

141. By 1751 the transducer was sounding out the baby's heartbeat which was bradycardic and at the same time Samantha Bond, the LW midwife, was outside the room talking to Miss Nicks who was on her ward round with Dr. Heath. Miss Nicks wrote the start of her note at 1750 and then heard the bradycardia at 1751 and went into the room at 1752. The CTG trace started to come out indicating bradycardia at 1753 and Miss Nicks examined M, did a quick ultrasound and diagnosed bradycardia. At 1755 the emergency bell was pulled the decision having been taken to do a super-fast crash c-section."

It is the defendant's case that the court should not use findings made in a different section of the judgment to undermine or impugn that part of the judgment which is relevant for the purposes of this appeal.

34. The defendant submits that as the court is being asked to overturn a finding of fact, a very high threshold has to be met. The first sentence of [297] represents a reasonable conclusion for the judge to have reached. There was nothing in the evidence which compelled a conclusion that there was a one minute period of potential action on the part of Miss Nicks which was lost as a result of the defendant's negligence. The contemporaneous medical records paint an unclear picture of precisely who was where and when, there was some evidence on approximate timings in the witness statement of Ms Nicks that she was outside at 17:50 talking to Midwife Bond. Midwife Bond wrote a contemporaneous note timed at 17:51 stating that she was introducing herself to the patient.
35. Finally, the case now relied upon by the claimant, namely one 'lost minute' was not pleaded nor argued before the judge.

Conclusion

36. This tragic case involves the birth of a severely brain-damaged child. At the trial, the court received evidence from those responsible for the clinical care of the claimant and her mother together with a number of experts called on behalf of the claimant and the defendant. The judge approached the analysis of the factual and expert evidence with care. He made clear and detailed findings of fact, findings of breach of duty in respect of the midwifery and obstetric care provided to the claimant's mother in the period prior

to the claimant's birth and following from that, findings of factual and medical causation. The sequence of events on 4 June 2018 from 16:50 to the delivery of the claimant at 18:08 is critical to the assessment of what in fact happened and what should have been done by those at the defendant's hospital responsible for the care of M and her child.

37. The claimant's case has undergone a number of iterations in respect of when it is alleged delivery of the claimant should have taken place. In summary they are:

Case 1 para 5.2a Particulars of Claim.

The CTG monitoring should have been commenced on the antenatal ward on arrival at 17:20, obstetric review should have occurred by 17:23 and a decision made for immediate transfer to the labour ward. Delivery should have occurred within 30 minutes by 17:53. The totality of the claimant's brain injury would have been avoided.

The claimant's response to the defendant's Part 18 Request for Further information dated 15 February 2021, para 8:

"8. When, on the Claimant's case, is the latest point at which earlier delivery would have made a material difference to the nature and/or extent of the Claimant's injury?"

RESPONSE

8. A bradycardia was heard at 1750 and on the balance of probabilities for 10 minutes the Claimant will have suffered no irreversible damage. Delivery and resuscitation achieved before 1800 would, on the balance of probabilities, have avoided all damage. Every minute of delay between 1800 and 1811 when the Claimant's heart rate rose to over 100 bpm caused or contributed to the overall catastrophic damage suffered by the Claimant. Delay in delivery increased the damage suffered by the Claimant prior to delivery and made resuscitation more difficult. Delivery shortly before 1800 should have allowed for resuscitation to be achieved quickly and avoided all damage. If delivery had been achieved between 1800 and 1808 resuscitation would have taken less than the 3 minutes it took at 1808 so that saving each minute before delivery would have saved up to an additional two further minutes after delivery. All delay in delivery therefore made a material contribution to the injury suffered by the Claimant but medical science cannot determine the precise extent of such contribution." (emphasis added)

Case 2 para 5.2b Amended Particulars of Claim dated 26 September 2022.

The claimant's amendments reflected the expert evidence that it would take 5-10 minutes to commence CTG monitoring. This altered the timings in the original pleading by some 10 minutes, the alternative chronology identified delivery by 18:03.

Case 3 para 5.2 of the Amended Particulars of Claim.

M should have been transferred to the labour ward arriving by 17:10, CTG monitoring would have commenced within 5 – 10 minutes of arrival, it would have been abnormal, and on review by an obstetrician a decision would have been taken to proceed to a category 1 caesarean section. Delivery would have been achieved within 30 minutes of the decision and by 18:03 at the latest.

Case 4 para 5.6 Amended Particulars of Claim.

If the CTG monitoring had been running at 17:43 then the bradycardia would have been recognised at that point. The result would have been recognition of bradycardia 7 minutes earlier than was in fact recognised by Miss Nicks at 17:50. Assuming the same decision to delivery time as in fact occurred (13 minutes) the claimant would have been delivered 7 minutes earlier at 18:01.

38. At trial the claimant's case did not proceed upon the specific basis that delivery should have taken place at 18:07. The closest the claimant came to such an allegation is set out in para 5.6 of the Amended Particulars of Claim as follows:

“Alternatively if the Claimant had been delivered at a later point between 1753 and 1808 the Claimant would have suffered either no damage or less severe damage. That is the delay between 1753 and 1808 made a material contribution to the Claimant's severe injury. Had a CTG been attached at any time prior to 1743 when the bradycardia started then the bradycardia should with competent care have been recognized then (instead of at 1750 when heard by Miss Helen Nicks). As accepted in the claimant joint statement of the obstetricians dated 3 July 2022, once a bradycardia was recognised, the decision to delivery time should and would with competent care have been 13 minutes. Recognition of the bradycardia 7 minutes earlier should and would have resulted in delivery 7 minutes earlier. As accepted by the neonatology experts in their joint statement dated 18 August 2022, delivery 7 minutes earlier would have made a material difference to the outcome.”

39. The claimant's written closing submissions concluded with these words:

“Earlier delivery even by 1, 2 or 3 minutes would have made a material difference but medical science cannot determine the extent to which the outcome would have been different. The Claimant should therefore recover on the basis of the cases set out above for the entirety of her injury.”

40. At this appeal, there was a further shift in the claimant's case namely the abandonment of the first point in this appeal for which permission had been granted (paras 23 and 24 above). Mr Sheldon KC, who has represented the defendant throughout these proceedings, is to be commended upon the calm yet cogent professionalism with which he has dealt with the changes in the claimant's case which the defendant has been required to meet.

41. This appeal now turns on a narrow issue: did the judge fall into error in finding that Miss Nicks would probably have walked into M’s room at the same time as she did, namely 17:52? (First sentence [297]). The time Miss Nicks walked into M’s room is identified at [141] of the judgment (para 33 above).
42. Unchallenged is the evidence, now found as fact, that Miss Nicks was outside M’s room at 17:50, timed the start of her note at 17:50 and heard the bradycardia at 17:51. Miss Nicks’ note is set out as follows:

1750	<i>“Miss Nicks WR 37 yr CiPo 36+1 Rh- Post TIL Polyhydramniuous Admitted TPTL SGTG GDM Booked” S Bond</i>
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43. Based upon this evidence, logic would indicate that Miss Nicks began her note at 17:50 but upon hearing the sound of bradycardia she immediately entered M’s room. It follows that there was a short period after 17:50 when Miss Nicks was in fact outside M’s room writing her note. Upon the judge’s findings, the CTG should have been operating at 17:50. It follows that upon her arrival outside M’s room, Miss Nicks would have heard the bradycardia and would have immediately entered the room.
44. I accept the defendant’s contention that in her written evidence Miss Nicks prefaced her timings by the word “around”. In my view this does not overcome the fact that the judge, having considered the evidence, made findings of specific timings. I do not consider there is any force in the argument that the judge’s initial findings as to timings relating to Miss Nicks were set out in an earlier part of the judgment which was not addressing the issue of factual causation.
45. In my judgment, given the unchallenged evidence of Miss Nicks that she was outside at 17:50 and would have entered M’s room earlier had she heard the bradycardia, there was no need for the judge at [296] to postulate what a midwife would or should have done when the trace became bradycardic at 17:48/17:49. Specifically, there was no need for the judge to build into the scenario the 1, 2 or 3 minutes allowance for a midwife calling for obstetric assistance when it was noted that the trace became bradycardic at 17:48-17:49 because, on the evidence before the court, within one minute (17:50) Miss Nicks was outside M’s room and would immediately have entered upon hearing the bradycardia. That being so, Miss Nicks would have entered M’s room at 17:51, not 17:52 as found by the judge, which would have led to a saving of one minute and delivery at 18:07.
46. In considering why the judge felt the need to postulate what a midwife would or should have done as set out in [296] and, as a result, timed Miss Nicks’ entry into M’s room at 17:52, I think it likely that he based these findings upon the scenario set out in paragraph 15 of the defendant’s written closing submissions which stated:

“15. As to the likely sequence of events if the bradycardia had started while (M) was being monitored by the midwives through a CTG running, there is no dispute:

- i) It would take the midwives c.3 minutes to recognise a developing bradycardia; all the experts were agreed on that...
- ii) An obstetrician would be called to attend urgently to review and would likely arrive in 3-5 minutes....
- iii) An obstetrician attending in these circumstances would take 3-5 minutes to assess the situation (including the CTG) and make a call as to management ...

16. So, if (M) had been taken directly to the (labour ward) at about 17:10, and following establishment of CTG monitoring and obstetric review (completed by c.17:30) had been monitored by the midwives, and if the bradycardia started shortly before 17:50 (when it was in fact heard, fortuitously, by Miss Nicks whose ward round happened to bring her to a point just outside the door of Room 2 at that point) then it would have taken at least 9 minutes to get to the point of decision to proceed to cat 1 CS. That is, 17:55 (the actual time of decision) even if one takes 17:46 as the start of the bradycardia.”

47. I understand the claimant’s contention that the judge appears to have incorrectly applied the *Bolam* test as to what a responsible midwife would have done. The judge’s assessment of a midwife’s action appears to have been based on a proposition put by defence counsel as recorded at [208] that “reasonable” timing would have included a period of three minutes for the midwife to recognise the bradycardia and call the obstetrician commencing at 17:49. The concept of what is reasonable invokes the wording of the *Bolam* test as to what a responsible midwife would have done. In my judgment, there was no need to approach the facts in this way as this was more akin to a *Bolitho* scenario. On the evidence before the court, it was known what Miss Nicks would have done had she heard the bradycardia at 17:50 which would have occurred on the “but for” scenario. On hearing the bradycardia at 17:50 when she arrived outside M’s room, Miss Nicks would not have begun writing her note but would instead have gone into M’s room, which would take her in at 17:51.
48. I therefore accept the claimant’s contention that there was a flaw in the judge’s reasoning and that his finding that Miss Nicks would probably have walked into the room at the same time as she did, namely 17:52, does not in fact represent what would have happened on a “but for” scenario. The flaw could be categorised as an error of law or straightforwardly as an incorrect finding of fact. Whichever approach is adopted, the fact is that on the judge’s timings an error occurred and a minute was lost.
49. An appellate court is conscious of the approach to be adopted when considering interfering with findings of fact made by the trial judge. They are set out by Lewison LJ in *Stachelin v ACLBDD Holdings Limited* [2019] EWCA Civ 817 at [29]:

“29. If I may repeat something I have said before (*Fage UK Ltd v Chobani UK Ltd* [2014] EWCA Civ 5, [2014] FSR 29 at [114]):

“Appellate courts have been repeatedly warned, by recent cases at the highest level, not to interfere with findings of fact by trial judges, unless compelled to do so. This applies not only to findings of primary fact, but also to the evaluation of those facts and to inferences to be drawn from them. ...The reasons for this approach are many. They include

- i. The expertise of a trial judge is in determining what facts are relevant to the legal issues to be decided, and what those facts are if they are disputed.
- ii. The trial is not a dress rehearsal. It is the first and last night of the show.
- iii. Duplication of the trial judge’s role on appeal is a disproportionate use of the limited resources of an appellate court, and will seldom lead to a different outcome in an individual case.
- iv. In making his decisions the trial judge will have regard to the whole of the sea of evidence presented to him, whereas an appellate court will only be island hopping.
- v. The atmosphere of the courtroom cannot, in any event, be recreated by reference to documents (including transcripts of evidence).
- vi. Thus even if it were possible to duplicate the role of the trial judge, it cannot in practice be done.”

50. As to the meaning of “plainly wrong” in *Henderson v Foxworth Investments Ltd* [2014] UKSC 41, [2014] 1 WLR 2600:

“Given that the Extra Division correctly identified that an appellate court can interfere where it is satisfied that the trial judge has gone “plainly wrong,” and considered that that criterion was met in the present case, there may be some value in considering the meaning of that phrase. There is a risk that it may be misunderstood. The adverb “plainly” does not refer to the degree of confidence felt by the appellate court that it would not have reached the same conclusion as the trial judge. It does not matter, with whatever degree of certainty, that the appellate court considers that it would have reached a different conclusion. What matters is whether the decision under appeal is one that no reasonable judge could have reached.”

51. Notwithstanding the care which the judge brought to this trial, and the detailed and clear analysis of complex evidence which is contained within the judgment, I am satisfied that he was wrong to find on the facts that Miss Nicks would not have entered M's room until 17:52 for the reasons which I have identified.
52. I understand the concern of the defendant that the case, as now formulated, was not specifically before the judge at trial. That said, the claimant's pleadings and written submissions did eventually postulate a delivery of 1 – 3 minutes earlier and following from that, a submission that the same would have made a material difference in respect of the issue of causation and injury. It was not until the judge made specific findings that either party knew with certainty the factual basis for breach of duty and for factual and medical causation. The judge accepted the claimant's expert evidence that in terms of injury, every minute of PHI would count. The injuries sustained by the claimant are of the utmost severity, a fact which would be reflected in any award of damages.
53. It follows, and I so find, that the finding of fact that Miss Nicks would have entered M's room at 17:52 and at the same time as in fact she did ([297]) must be quashed and the appeal allowed upon the basis that Miss Nicks would have entered the room at 17:51. The issue which now falls to be considered is what, if any difference, one minute would have made to the issue of medical causation. At trial this case did not proceed on the basis of a lost minute. None of the experts called to address the issue of medical causation were asked to specifically focus upon a delivery a minute earlier at 18:07 and what, if any difference, this would have made to the primary injury sustained by the claimant and the resultant period of resuscitation. Given the complexity of this issue I have concluded that this case should be remitted to the same judge for specific consideration, supported by further expert evidence, as to the effect upon the claimant's injuries and functional disability of a delivery at 18:07.
54. To this extent, and for the reasons given, this appeal is allowed.

Lord Justice William Davis:

55. I agree with both judgments.

Lord Justice Peter Jackson:

56. I also agree that the appeal should be allowed for the reasons given by Nicola Davies LJ and add my own concurring view in relation to four matters.
57. First, in a case where the judge assessed the evidence and made findings of fact with such meticulous care, I agree that we could not possibly depart from a finding of fact that was open to him on the evidence. However, the single error here was not one of fact-finding but of legal logic: on the judge's own findings the claimant would have been born a minute earlier.
58. Second, there are many contexts in which short periods of time make no difference to the outcome of a trial, and it unnecessary for a court to be at all precise about timings. There are other contexts, of which this is one, where very short time periods may be critical. The judge rightly considered the evidence minute by minute and at paragraph 280 he made a broad finding that any reduction in the period of PHI would have reduced the primary injury to the claimant's brain neurones. It was therefore not suggested to

us that in a case of this kind, a minute of PHI is too short to be capable of mattering. Indeed Mr Sheldon rightly accepted that if there was a ‘lost minute’ the case would have to be remitted. As to his submission that the timings given by witnesses were approximate, I agree with Nicola Davies LJ. Once the judge had made findings on timings, they became fixed points. Now that the delay is measured at a minute, it will be a matter for the judge, having heard further expert evidence, to determine whether that period would as a matter of probability have spared the claimant any material part of her injury.

59. Next, Mr Sheldon very fairly made clear that the Respondent did not seek to defeat the appeal on the basis of any technical defect in the pleadings. However, he argued that it would be unfair to the judge to set aside his finding on the basis of a case that had not been specifically pleaded. It is true that, as seen at paragraph 37 above, the claimant’s case has been pleaded in a number of different ways. As to that, the judge rightly took account of the evidential difficulties caused by the defendant’s failure to start the CTG trace earlier (see paragraph 307). Further obstacles to clarity were introduced by the unreliable evidence of Midwife Reeves (paragraphs 75-96) and the misleading note and unreliable evidence of Dr Ekanem (paragraphs 113-125). But in any case it seems to me that everyone understood that the claimant’s irreducible case was that her injury had been caused by *any* delay in her delivery, and that on more than one occasion in the pleadings and submissions, this case was preserved. Moreover, the defendant expressly pleaded to three alternative periods of delay between 17:53 and 18.08 (judgment paragraph 24). I agree with Ms Gumbel that, given the forensic position in which this claimant had been placed, it would be harsh to penalise her for insufficient precision in the pleading of her case.
60. Lastly, a question arises as to the terms of the remitter, and whether the Trust should be allowed to call further witness evidence about exactly what occurred at the point of Ms Nicks’ arrival outside the labour ward. Mr Sheldon argued that, if there had been a focus on a minute’s delay, different evidence may have been called. For example, further questions would have been asked of Miss Nicks about what exactly happened outside the labour ward, and Midwife Bond might also have been called to give evidence. I do not accept that further evidence of that kind could make any difference. Miss Nicks’ undisputed account was that she arrived at 17:50 and was standing writing her note when she heard the CTG. Her oral evidence was that “if you are just outside the room you can hear the fetal heart. The fetal heart sounded slow so I went in.” (SB198). In closing submissions, the defendant noted that Miss Nicks’ ward round happened to bring her to a point just outside the door (SB9). There is therefore no room for the Trust to seek to recover the lost minute by calling evidence to challenge the conclusion that Miss Nicks would have heard the CTG at 17:50, and would have gone into the room directly.
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