OUTER HOUSE, COURT OF SESSION

[2026] CSOH 42

A114/18

OPINION OF LADY HOOD

In the cause

AM

Pursuer

against

LOTHIAN HEALTH BOARD

Defender

Pursuer: Smart KC, Swanney; Anderson Strathern LLP
Defender: Doherty KC, E Campbell; NHS Central Legal Office

30 April 2026

Introduction

[1] On 11 September 2010, at the Royal Infirmary of Edinburgh (RIE), the pursuer gave birth to her son, who I shall refer to as L. The RIE is under the defenders' management. When L was born, the umbilical cord was wrapped around his neck. The pursuer's case against the defenders is that shortcomings in their care caused the medical difficulties from which L now suffers. The pursuer brings this case on L's behalf.

[2] It had been determined that a proof before answer should be held, limited to the issue of whether the defenders were in breach of their duties to the pursuer, with issues of causation and quantification of loss considered at a later date if necessary. Evidence was led

over 11 days, with submissions then delivered at a later date (and supported by written submissions, prepared by each side in advance).

Agreed or uncontroversial facts

[3] The pleadings, in the normal way, reflect the extent of agreement and dispute between the parties. In addition, parties helpfully entered into a number of Joint Minutes, as well as preparing an agreed Chronology of Events, a Glossary of Terms, and a Summary of the Background Facts and Issues. Parties were agreed that the copy medical records lodged were what they bore to be, and that copy productions should be treated as equivalent to principals. The uncontroversial factual matters may be summarised as follows.

[4] On 10 September 2010, the pursuer contacted the midwifery team at the RIE, and told them that she suspected that her waters had broken. She was advised to put on a maternity pad, and to telephone later with an update. The pursuer did telephone again, and reported that her pad was soaked through: she was advised to attend the hospital. The pursuer did so, and arrived at the hospital that evening, with her arrival time at maternity triage recorded as 2335 hours. The pursuer was assessed by Midwife Beth Turner at or around 0215 hours on 11 September 2010. The pursuer was 40 weeks pregnant. Midwife Turner saw evidence of meconium on the maternity pad, which she recorded as "meconium light". Cardiotocograph (CTG) tracing of the fetal heart rate and maternal contractions was commenced by Midwife Turner at around 0220 hours. At 0245 hours, Midwife Turner noted that the CTG was non-reassuring, noting the presence of reduced variability and late decelerations. At 0255 hours, Midwife Turner arranged for the pursuer to be transferred to the labour ward for continuous monitoring and obstetric review.

[5] After the pursuer's transfer to the labour ward, the CTG was re-commenced at around 0315 hours. The trace was reviewed by Dr Rajive Joy at 0321 hours, and he decided that close monitoring of the CTG should continue. At 0348 hours Midwife Margaret McMahon noted that the CTG was unreassuring, with reduced variability, few accelerations and one deceleration: she noted that she would ask for a review. At 0410 hours the trace was reviewed by Dr Sarah Martins da Silva, Senior Registrar. She noted that there was acceptable variability, no real accelerations, and "2 x?late unprovoked decelerations". The baseline heart rate was normal. Dr Martins da Silva carried out a vaginal examination, and the fetal heart accelerated in response. The pursuer's cervix was 3 cm dilated. A plan was made to commence the pursuer on syntocinon to advance labour, and to continue to monitor the CTG. It was noted that the pursuer had been made aware that a caesarean section might prove to be necessary if the CTG was unreassuring and she was still in early labour. At 0455 hours Midwife McMahon noted that the pursuer's position in the bed had been changed. Midwife McMahon observed that variability was reduced, and some accelerations were present, but that there had been no further decelerations. Because of high activity in the labour ward, it was decided that the commencement of syntocin should be delayed. Reduced variability on the CTG caused Midwife McMahon to ask for a review, and Dr Joy reviewed the CTG at 0532 hours. He concluded that close monitoring of the CTG should continue, and recommended that there should be a position change, and iced water or ice cubes should be given. This was actioned. At 0546 hours, Dr Joy again reviewed the CTG. His overall impression was that the CTG was satisfactory, and he decided to continue with the plan in place. Midwife Sally Haldane took over the pursuer's midwifery care at 0605 hours, and at 0610 hours syntocinon was commenced. At 0638 hours, Midwife Haldane recorded a late deceleration, a brief recovery, then bradycardia. Syntocinon was stopped,

the pursuer's position was changed, and assistance called. Dr Joy attended at 0640 hours. The cervix remained 3 cm dilated. At 0642 hours, Dr Joy carried out a vaginal examination, and applied a fetal scalp electrode. There was a discussion with the pursuer that a caesarean section might be necessary if the CTG continued to be non-reassuring. At around 0700 hours, the pursuer was seen and consent given to delivery by caesarean section. At 0707 hours, Dr Joy noted that his impression was of fetal distress, and that agreement for delivery by an emergency caesarean section had been obtained. The pursuer was transferred to theatre at 0710 hours. L was delivered at 0731 hours.

Disputed issues

[6] The pursuer alleges that there was negligence on the part of the defenders' midwives in the RIE maternity triage unit, and also on the part of Dr Martins da Silva and Dr Joy, obstetricians. The defenders disputed this. There was also a sharp factual dispute over certain matters. The matters in dispute between the parties can be summarised as follows:

Midwifery care

i. whether the pursuer reported to the midwifery triage team that she had meconium staining, and (if so), when;

ii. when the pursuer arrived at the RIE maternity triage unit;

iii. whether there was a duty on the midwives on duty in the triage unit to assess the pursuer within 15 minutes of her arrival at the unit;

iv. whether there was a duty on the midwives, in light of the pursuer's presentation, to commence a CTG to monitor fetal wellbeing within 15 minutes of the assessment referred to in (iii);

v. *esto* there was not a duty as outlined in (iii), whether there was a duty to assess the pursuer significantly before 0200 hours on 11 September 2010.

Obstetric care

(a) whether there was a duty incumbent on Dr Martins da Silva to conclude at 0410 hours that the CTG was pathological, and (in light of the meconium staining) to proceed to an emergency caesarean section (Category 1 or Category 2) to deliver L;

(b) whether there was a duty incumbent on Dr Martins da Silva not to order the commencement of syntocinon, on the basis that the CTG was pathological;

(c) whether there was a duty incumbent on Dr Joy to conclude at 0532 hours that the CTG was pathological and (in light of the meconium staining) to proceed to an emergency caesarean section (either Category 1 or Category 2) to deliver L;

(d) whether there was a duty incumbent on Dr Joy to conclude at 0546 hours that the CTG was pathological and (in light of the meconium staining) to proceed to an emergency caesarean section (either Category 1 or Category 2) to deliver L;

(e) whether there was a duty incumbent on Dr Joy at 0642 hours to make arrangements for an immediate Category 1 caesarean section.

[7] During the course of the proof itself, after the factual evidence had been led, the pursuer sought to amend her pleadings. This was opposed by the defenders. I refused the pursuer's motion on the grounds that (i) certain of the new averments were not relevant in the context of a proof on the question of breach of duty; (ii) the defenders would be prejudiced, as there would be no opportunity to explore the new matters with the factual

witnesses; and (iii) there was no explanation for the delay, since evidence given by witnesses (which was said to have led to the motion made) could have been anticipated.

Evidence led by parties on the matters in dispute

[8] Parties were agreed that statements given by witnesses to fact should be treated as their evidence in chief, subject to further examination in court.

[9] The pursuer led oral evidence from the following witnesses to fact: the pursuer (AM); the pursuer's partner (PY), Midwife Beth Turner, Christina Perkins (retired clinical support worker), Midwife Jane Telfer, Midwife Margaret McMahon, former Midwife Sally Rutkowska, Dr Rajive Joy, and Dr Sarah Martins da Silva. I did not doubt that each of the witnesses to fact was doing their best to tell the truth. Equally, each faced challenges. For the pursuer and her partner, the memories of that night and the following morning will be vivid and distressing, but the pursuer herself was candid in admitting that as the morning progressed and she became more panicked, her memories became hazier. It is also inevitable that in the intervening years, they must have gone over in their minds many times what happened, as well as acquiring a greater understanding of medical matters than they had at the time. For the midwives and doctors, they had the benefit of their medical knowledge of events - but were being asked about events 15 years before, in the context of a busy job where they will see many patients each day. It was inevitable that they would need to rely heavily upon medical records or statements compiled at, or soon after, those events. I bore all of these factors in mind, in assessing the evidence of the factual witnesses.

[10] The pursuer led expert evidence from Ms Jean McConville (expert midwifery evidence), and Dr Philip Owen (expert obstetric evidence), while the defenders led expert

evidence from Professor Julia Sanders (expert midwifery evidence) and Professor Deirdre Murphy (expert obstetric evidence).

[11] The evidence of the witnesses on the disputed issues can be summarised as follows.

Midwifery care

[12] The pursuer: the pursuer's evidence in chief consisted of her consolidated witness statement and her oral evidence. In her witness statement, the pursuer said that her waters had broken at around 2140 or 2150 hours on 10 September 2010: her experience was of a constant trickle. She did not notice any green mucus in the waters, although the bathroom where she was at the time, was dark. The pursuer called the hospital for advice around 2200 hours. She was advised to put on a pad: if that was soaked within around 30 to 60 minutes, she should telephone again for further advice, and may have to come into the hospital. By the time that half an hour had passed, the pad was completely soaked. The pursuer checked the pad, and it was not clear liquid, but mucus green liquid with black spots. The pursuer telephoned the hospital straight away, and told the woman who answered the telephone about the colour of the spotting on the pad. The pursuer was told to come straight to the hospital. The pursuer and her partner telephoned for a taxi, and they arrived at the RIE around 2230 hours. There were others in front of them, and it was around 15 minutes later before the person at the desk (whose name, she thought, was Kim) took the pursuer's details. The pursuer did not mention anything about her waters or the staining on the maternity pad. Kim took her file and disappeared, telling the pursuer to wait in the waiting room. The pursuer was annoyed that another woman appeared to be given priority over her. The pursuer had to constantly ask for pads and use the toilet: she went through three pairs of trousers. Her partner was unhappy at her treatment. The woman behind the

desk said that she had called the pursuer's name, but that someone else had followed her in. This didn't happen: the pursuer, her partner, or the pursuer's friend GM (who arrived just after midnight) had been in the waiting room throughout. At first the pursuer was taken into the wrong room. The pursuer sat in the room for another hour, before a midwife attended. The pursuer reminded the midwife that her waters had broken, and that the pads had been stained with meconium. The midwife asked to see the pad. The pursuer was then connected for the CTG, and she was taken to the delivery suite.

[13] In her oral evidence, the pursuer confirmed that she was a full-time carer for L. Her memory of the night of the 10 – 11 September 2010 was very clear, as one would never forget going through something like that. Her solicitors had also precognosced her on a number of occasions over the years, starting in 2011. When the pursuer realised that her waters had broken, she went to the bathroom. This was around 2140 or 2150 hours. It was a constant trickle, which got heavier in intensity. The lighting of the bathroom at that time was very poor. The pursuer telephoned the RIE maternity triage department, and she thought it was Kim who answered. It was a brief call. The pursuer was told to put on a maternity pad, and telephone back if it was wet within an hour. She was asked the colour of her waters, and said that it was fine. After about 20 minutes the pad was saturated, and the pursuer went to the bathroom to put on a fresh pad. The waters were an exceptionally dark green or black colour, with dark green or black flecks. This was visible on the pad and within the toilet bowl (as the evening wore on, it began to transfer onto her clothing). There was also a peculiar odour. When the pursuer first saw this, her heart started to race, as she knew that something was not quite right. She telephoned the triage department again: she was not sure if it was the same staff member, or a different woman, who answered the telephone. The pursuer told the staff member that her pad was saturated, and that the waters were not

clear. The staff member told the pursuer to come in straight away. The pursuer and her partner called a taxi, and arrived at the RIE around 2240 hours. They went to the desk, and waited for ages whilst others were dealt with. When her turn came, the pursuer said that she had telephoned less than an hour ago and been told to come in: she was told to take a seat. The pursuer was rapidly soaking maternity pads, and frequently had to obtain fresh pads. The liquid was absolutely black. She had to change her trousers, and went through three pairs of trousers in this way. The pursuer's partner and GM were trying to get someone's attention. Around 0100 hours they were taken into a side room, and waited there for around an hour before the midwife attended. The pursuer showed her the pad: it was black, and the fluid was tacky and of the consistency of mucus. In cross-examination, the pursuer accepted that the interval between the first and second telephone calls could have been between 20 to 30 minutes. It was her belief that she had arrived at the hospital before 2300 hours. In the second telephone call she had said that her waters weren't clear, but she did not think that she had described their exact colour, and nor had she been asked to do so. The "not clear" phraseology came from her being asked in the first telephone call whether her waters were clear. The pursuer had assumed the information would have been noted and understood, and with hindsight wished that she had been more persistent in seeking assistance.

[14] <u>The pursuer's partner</u>: PY is the pursuer's partner, and L's father. In his witness statement taken on 9 May 2018, he explained that he and the pursuer were at home on 10 September 2010, when the pursuer's waters broke around 2140 hours. They did not notice any meconium, but the bathroom was dark. They called a taxi, and arrived at the hospital around 2240 hours. The pursuer's waters were pouring out while they were in the waiting room, and PY found a nurse and asked her for a pad. He remembered from the

antenatal classes that if there were any signs of meconium in the waters, this was not good and required to be checked. PY became stressed and angry because of the length of time that they were in the waiting area without help. The pursuer was not seen by a midwife until around 0130 hours or 0200 hours on 11 September 2010. When the pursuer was taken from the waiting area to a private room, the midwife said that they had called the pursuer's name earlier, but that someone else had followed them in. However, PY, the pursuer or GM had always been in the waiting room, and they hadn't heard this.

[15] In his oral evidence, PY explained that he thought that it was just before 2200 hours on 10 September 2010 that he had become aware that the pursuer's waters had broken. They telephoned the hospital for advice. The pursuer subsequently told him that she might have meconium staining, and he saw the staining on her clothes. They contacted the NHS again, and mentioned the meconium. PY could not recall the exact words used by the pursuer at the time, but she had said that they were seeing staining which they did not expect to see. The pursuer was told to get a taxi straight to the RIE. PY thought that they arrived at the RIE by 2300 hours at the latest, but accepted that it could be 2335 hours by the time they spoke to the member of staff at reception. Staff were attending to a woman in quite severe distress, and they had to wait. PY had to ask for fresh pads, and the pursuer had to make use of a public toilet. It was not very dignified. The pursuer had to change her clothing on at least two occasions. It was several hours before a midwife took them to a private room. In cross-examination, PY said that he thought that it was once they were at the hospital, rather than on the second telephone call, that they had mentioned the meconium: but then said he was sure that the pursuer had made the hospital aware during that telephone call. He was certain that he had told the staff that the fresh pads were needed because of the meconium staining, and disputed that the pads were needed because the pursuer's waters

had broken, irrespective of the colour of the liquor. In his view, it had not been for him to kick up a fuss at the hospital: he was there for the birth of his first son, and was scared and nervous. It would not have been appropriate for him to instruct staff in something in which he lacked their knowledge and experience. He was pressed as to differences between his oral evidence and his earlier statement. In re-examination, PY agreed that his statement was prepared by way of a question-and-answer session with their solicitors, and that he would have discussed the second telephone call if asked to do so. It was just before that call, that PY had seen the greenish/brownish staining in the pursuer's waters.

[16] Midwife Beth Turner: in her statement written on 8 October 2010, Midwife Turner recalled that she had received a telephone call from the pursuer, in which she said that she suspected that her waters had broken at approximately 2200 hours on 10 September 2010. Midwife Turner obtained a history, which was not conclusive of spontaneous rupture of membranes (SROM). She therefore advised the pursuer to put on a maternity pad, and telephone back within an hour with an update. It would be Midwife Turner's usual practice to confirm the colour of the liquor and the presence of fetal movements, but details of this particular telephone conversation were not on the TRAK electronic recording system. At a later stage, the pursuer telephoned back, and spoke with CSW Christina Perkins. Due to high activity levels, Midwife Turner did not speak personally to the pursuer on this occasion. It was Midwife Turner's understanding that the pursuer said to CSW Perkins that she had soaked through a maternity pad. Midwife Turner told CSW Perkins to advise the pursuer to now attend the RIE for review. On at least two occasions between 2200 hours and 0100 hours, the activity levels in the unit were such that Midwife Turner had sought additional midwifery help. Unfortunately, no-one was available to assist. At 0120 hours, Midwife Turner went into the room which the allocations board indicated was where the

pursuer had been placed. Midwife Turner had the pursuer's notes. However, another patient was in the room, who had presented with bleeding. Midwife Turner instructed CSW Perkins to allocate the pursuer to the next available room. Meantime, she dealt with the other patient, as Midwife Turner considered that that assessment could be completed quickly. At 0135 hours, a patient arrived by ambulance, distressed, and with a history of haemorrhage. Her care was prioritised due to the clinical picture, and she was transferred to the labour ward. On returning to the triage unit at approximately 0215 hours, Midwife Turner assessed the pursuer. The pursuer reported SROM at 2200 hours. On being asked to describe the colour of her liquor, she described it as "mucousy". Midwife Turner therefore asked to inspect the maternity pad which the pursuer was wearing, and found evidence of meconium.

[17] Giving evidence, Midwife Turner explained that she had qualified as a midwife in 1998, but now worked full-time as a nursing and midwifery practice educator. She was reliant upon her statement for the events of 10 - 11 September 2010, as she had no independent memory of the events. She was surprised that there was not a record on TRAK of the first telephone call, because she had been sitting at the telephone, with the computer beside her. In accordance with practice at the time, the pursuer would have been invited to attend if Midwife Turner thought that there had definitely been SROM; however, where the position was inconclusive, leakage onto a sanitary towel should be observed and the patient should then telephone back. When the second telephone call was answered by CSW Perkins and Midwife Turner instructed CSW Perkins what she should tell the pursuer, Midwife Turner would assume that the pursuer was still on the telephone. It was not CSW Perkins' role to carry out a telephone assessment. Where a patient was being invited to attend, the midwife or the clinical support worker would write the patient's name, CHI and

reason for attendance, on a whiteboard. Details of arrival were also entered in a file, which would later be used to input this information into TRAK. If the pursuer had reported the presence of meconium in the course of her second telephone call, Midwife Turner would expect to have been informed. This would have been noted on the whiteboard, and would have meant that the pursuer's assessment would have been a higher priority.

Midwife Turner had no memory of when she was first aware that the pursuer was in the triage department. During her assessment of the pursuer, when the pursuer described the meconium as "mucousy", Midwife Turner wanted to confirm through her own observations whether it was meconium, or a mucus plug or "show" (which is often encountered at this stage). Midwife Turner had been interviewed on 17 November 2010, as part of a supervisory investigation into the pursuer's care (such investigations are always held when there is an unexpected admission to the neonatal ward, and this investigation did not result in any action being taken). Midwife Turner was referred to the minutes of this interview. She accepted that they correctly recorded that she was one of two midwives on duty on the night in question, and that it was a busy shift, with six patients in the day assessment beds, one in the scan room, and six in the triage rooms. It was also recorded in the minutes that when Midwife Turner saw the pursuer, she had asked her the colour of her liquor, and that the pursuer was unaware that (as Midwife Turner herself then observed) it was discoloured or meconium stained: Midwife Turner could not now recollect saying that at the interview, and could not say why this had been scribed, although she accepted having been given a copy of these minutes at the time. Midwife Turner was also shown a copy of the discharge letter which was dictated on 8 March 2012 by Dr Dundas: this recorded that at 39 weeks and 6 days the pursuer "ruptured her membranes with meconium and attended Triage" and was formally reviewed after a couple of hours in triage. This did not cause Midwife Turner's

position in evidence to alter. Midwife Turner confirmed that there could be a number of reasons for commencing a CTG, one of which was if the liquor was stained with meconium. Midwife Turner was not aware of there being any policy in 2010 regarding a particular timescale for assessment, and for the application of a CTG: a triage tool was, however, introduced a few years later.

[18] In cross-examination, Midwife Turner explained that women attending triage were prioritised according to their clinical position, with women presenting similar levels of risk seen in the order of arrival. Subsequently, NHS Lothian introduced a tool regarding triage assessment, and thereafter BSOTS (Birmingham symptom specific obstetric triage system) was introduced. The known presence of meconium would increase a woman's priority, but this would still be dependent on the clinical need of other patients in the triage department at the relevant time. Midwife Turner was asked about her recording of "meconium light", when she ultimately saw the pursuer. Of the options which were available on the system, Midwife Turner agreed that "meconium heavy" could have been one of the other options. For Midwife Turner, "light" meconium would suggest that a small amount of greenish fluid was observed on the maternity pad, while "heavy" would connote a greater volume of liquid, or a deeper colour. A mucus plug would not normally be green. The pursuer had not told her that the liquor was black or green: she had said it was mucousy, which would not have indicated to Midwife Turner that it was green in colour.

[19] <u>Christina Perkins</u>: Ms Perkins was a clinical support worker. She had given a statement on 16 May 2025, and in this, she confirmed that she had no recollection of the shift which she had worked on 10 September 2010. Her normal practice was only to answer the telephone if the midwives were busy dealing with patients. The midwives had taught her the information which she had to obtain, record on her notepad, and pass on. These details

were relayed to the midwife as soon as the latter was free, and the midwife would record the information on the electronic system. CSW Perkins' normal practice on answering a telephone call would be to ask about gestation, what was going on, why the person was telephoning, and what her telephone contact number was. Normally CSW Perkins would not give advice over the telephone, or tell a patient whether to come into the hospital or stay at home. Saying that, had the pursuer mentioned meconium, or described black spots with mucus or with green spots, CSW Perkins would have understood that these were symptoms which might need to be assessed, and so might have told the pursuer to come in. In any event, CSW Perkins would have informed the midwife of the call, and in particular would have informed the midwife if the pursuer had reported meconium, black spots with mucus, or green spots.

[20] In her oral evidence, CSW Perkins confirmed that she had retired as a clinical support worker in October 2010. She had not been involved in any investigation into L's birth in 2010, and was only made aware of these proceedings, and asked to give a statement, more recently. CSW Perkins explained that although one of the questions she would ask a patient who telephoned was what was happening, a patient normally told you this before they were asked. If it had been CSW Perkins who answered the pursuer's second telephone call, and the pursuer had said that her waters were not clear, CSW Perkins probably would not have asked about the colour of the waters: to be honest, she would not know how clear the waters ought to be at that point. She would simply have passed on the information to the midwife, while keeping the pursuer on hold on the telephone. The midwife would then have spoken to the pursuer, or told CSW Perkins to tell the pursuer to attend the hospital. When patients arrived at triage, whoever was free would let the patient in through the controlled entry door. If it was herself, CSW Perkins would speak to a midwife and let them

know that a patient had arrived. In cross-examination, CSW Perkins explained that she mainly worked in post-natal units, but did "bank" shifts in triage. The midwives took turns answering the telephone in triage, and if they were short-staffed CSW Perkins would do so. She would not document anything on TRAK, but would note the details. CSW Perkins would never ever give advice to a patient. She would speak with the midwife, and relay any instruction to the patient. If a patient said her waters were not clear, CSW Perkins would have told the midwife that.

[21] Jane Telfer: Midwife Telfer gave a witness statement in May 2025, in which she detailed that she had completed her nursing training in 1980, becoming a Staff Midwife in 1983. In September 2010, she was a full-time Charge Midwife, working night shifts. She had no recollection of the particular night in question, and was reliant on a statement prepared in 2010 (common practice where a baby was admitted to the neonatal unit, as this would be categorised as an "adverse event"). In 2010, the main reception desk was not manned out of hours. After 2100 hours the front door was locked, and patients had to press a buzzer to gain entry: any member of staff in the vicinity would allow the patient to enter. Most patients attending would be expected, as there would have been a prior telephone call. In 2010, there was no target time for patients to be seen in triage. It depended on the patient's history and presentation. Prioritisation was a fluid process, involving a clinical judgment on risk by the midwife. How quickly patients would be seen in triage depended on the risk status of other patients, staffing levels, and the availability of rooms. Around 0300 hours on 11 September 2010, Midwife Telfer wished lower risk patients to be diverted to St John's Hospital in Livingston: this was not a request she would lightly make, and reflected how busy they were that night.

[22] In her oral evidence, Midwife Telfer confirmed that she had retired but continued to do some 'bank' midwifery shifts. Both triage and the labour ward at the RIE had been busy on the night of 10 – 11 September 2010. The request (made in the period after the pursuer's admission) to go on "divert" to St John's Hospital had been granted. At the time of the pursuer's transfer from triage to the labour ward, Midwife McMahon was brought in from another ward to assist. With respect to target times for assessment in triage, it was not the case in 2010 that a patient should be assessed by a midwife within 15 minutes of arrival. Women would probably be seen in order of arrival if there were no particular concerns regarding a patient's presentation: it was a fluid process, and the order could change.

[23] Susan Dewar: parties were agreed that the witness statement of Susan Dewar could be treated as unchallenged evidence, equivalent to oral evidence, without being further spoken to. In her statement, Ms Dewar explained that she was a clerical officer employed by the defenders. In 2010, she was working at the RIE, and on 11 September 2010, would have been working from 0730 hours. She was based mainly in the medical records office. It was Ms Dewar's responsibility to record when women arrived at the triage department, and to input the date and time of arrival onto the TRAK electronic record system. If a woman had arrived at triage after 2200 hours the night before, their arrival would have been recorded (by a clinical support worker or midwife) on a sheet of paper in a folder which sat at the desk in the triage unit: a sticker was taken from the patient's medical records, and this was affixed to the sheet, with a note of the patient's name and time of arrival. The pursuer's TRAK record shows that Ms Dewar carried out the inputting exercise at 0752 hours on 11 September 2010. The appointment date and time information on TRAK (ie, 2335 hours on 10 September) would reflect the date and time entered into the triage department's folder the night before.

[24] Jean McConville: Ms McConville was called by the pursuer to give expert evidence on midwifery practice. She had retired from the NHS in 2011 and, after a period of agency working, retired fully in 2015. She had qualified as a nurse between 1976 and 1979, and as a midwife in 1984. In 2011, she was clinical midwifery manager at the Aberdeen Royal Infirmary maternity unit, a role which was split between managerial and clinical responsibilities (although the latter predominated). Ms McConville had been undertaking medico-legal work since 1996. Her view was that, with regard to the pursuer's second telephone call to triage, a healthcare assistant such as CSW Perkins would not have been expected to ask detailed questions. However, in the course of usual and competent midwifery practice, the pursuer should have been assessed by a midwife within 15 minutes of her arrival at triage. This assessment would involve the midwife taking a history, and personally inspecting the patient's maternity pad. It might only take 5 minutes, but without this assessment, patients could not be appropriately prioritised. In any event, for a patient to be in triage for around 3 hours without being assessed was a breach of duty. Once a patient arrived at triage, the midwife was responsible for her care, and for the care of the fetus: this was the source of the duties which she said had been breached in this case. It was accepted that there was not any national guideline in place then, regarding the order in which patients would be seen in the absence of obvious clinical need. An assessment would reveal any such clinical need. In cross-examination, Ms McConville stated that meconium could come at any time and in any form, but she agreed that if it was dark green in colour, it was unlikely that it would appear to be light green at a later stage. Ms McConville accepted that the BSOTS target of carrying out an initial assessment within 15 minutes of the patient's arrival at triage was not brought in until after 2012, and even then that it required to be adopted by individual units. Ms McConville's evidence seemed to be that the assessment

envisaged by BSOTS was a more involved or full assessment, and not the quick assessment which she said that there was a duty to undertake within 15 minutes of the patient's arrival at triage. The latter could be undertaken whilst walking the patient to the reception desk. Depending on its results, the fuller assessment may be necessary, and this should also be done within 15 minutes. The duty which Ms McConville said that the defenders' midwives were subject to, was one which pertained irrespective of the clinical needs of other patients in the unit at the time. The pursuer should, in any event, have been seen significantly before 0200 hours if she presented with a history of her waters not being clear. Ms McConville confirmed that her opinion was not research-based, but was derived from the general duty of the midwife: the fifteen minute time-period was simply drawn from her own practice. In re-examination, BSOTS was characterised by Ms McConville as a lofty ambition, whereas the assessment which she had in mind could be done when a patient was met at the door by the midwife, teamed with a visit to the toilet to permit the maternity pad to be inspected. It was especially important to do this when the unit was busy. With regard to meconium present on the maternity pad, Ms McConville clarified that what was observed could be affected by how recently the pad had been changed.

[25] Professor Julia Sanders: Professor Sanders was called to give expert midwifery evidence for the defenders. She had qualified as a midwife in 1986, practising continually until her retiral in 2022, when she had continued to work in academia. Professor Sanders had acted as an expert witness since 2007. She explained that while meconium-stained liquor is not a cause for concern in the majority of pregnancies, it can signal dangers. With regard to the second telephone call, it would be common for a clinical support worker to answer the telephone, relay information to the midwife, and for the midwife to indicate whether the patient should attend hospital. Professor Sanders would expect that if a patient

volunteered that her waters would not clear, this information would be passed on to the midwife, and recorded on the whiteboard at the patient's arrival. Ideally, when a patient attends a maternity triage unit, she would not wait to be seen: waiting is stressful, and is frustrating for patients and staff. However, demands on these units have increased, and in 2010 it was usual that (unless a woman presented who was acutely unwell, or known to have urgent clinical need) women would be seen in the order in which they arrived. The increased demand, and a recognition that a system of prioritisation was needed, led to work beginning in 2011 on BSOTS. This is a clinical audit target that 90% of women should undergo an initial, rapid, assessment (including maternal observations, and checking the colour of a patient's vaginal loss where appropriate) within 15 minutes of arrival. Implementation of BSOTS began in 2012, and it is still not fully implemented in all units. Even where BSOTS has been implemented, almost half of all patients may require to wait longer than the target. None of the units which have adopted BSOTS, previously required that patients be seen within 15 minutes of admission. Accordingly, in 2010, there was no guideline in place requiring that a patient be assessed within 15 minutes of arrival at the triage unit. The length of a patient's wait is dependent upon how busy the unit is at the relevant time. Even under BSOTS, where a woman is assessed and it is confirmed that there has been SROM but the waters are clear, she would return to the waiting room: the target would be to review such a patient within 4 hours. On the basis of the information available to Midwife Turner, her prioritisation of patients on 10 September 2010 was appropriate. Professor Sanders explained that when meconium is black or heavy, it would suggest that it is undiluted: this is concerning, because it suggests a low volume of liquor. Light meconium would be heavily diluted. It would therefore be very unusual for a person to present with heavy meconium, and for that to change to light meconium. The constant flow

of liquor through the evening which was described by the pursuer, sounded like a healthy volume of liquor being produced. In Professor Sanders' opinion, the midwifery care received by the pursuer did not fall below the applicable standard. To suggest that in 2010 the Midwifery Code implied a duty on all midwives to assess patients within 15 minutes of arrival at triage, on pain of being disciplined by the regulator for a breach, was completely unrealistic. Even now, it would not be a breach of duty on a midwife's part if the BSOTS target was not met in an individual case. In cross-examination, Professor Sanders explained that it was not a helpful approach to consider whether a rapid conversation and inspection of the pad on the pursuer's arrival could have ascertained whether meconium was present: this was to narrow it down to one clinical scenario with the benefit of hindsight, when a patient could have other needs, such as requiring that her blood pressure be checked.

Obstetric care

[26] The pursuer: the pursuer recalled being transferred to the labour ward, and placed in a room with an attached lavatory, which she often needed to use. The fluid which was coming was still really dark, "horrible" and mucousy. The CTG was attached, and the pursuer was told that she would be monitored. The midwife now attending to her always seemed to have difficulties on the occasions when she had to re-attach the CTG. The pursuer still assumed that she would give birth naturally, but eventually came to realise that delivery might be by way of a caesarean section. When Midwife McMahon took over, she explained what was happening. There was a great deal of hustle and bustle: doctors came in and out to check the trace, but did not converse with the pursuer much. She did not feel there was a great deal of urgency. The pursuer fairly conceded that as the night wore on, and she became more anxious, her memory was not as good as for the earlier parts of her time at the

RIE. The pursuer remembered being told that the baby's heart rate was dropping, and that her cervix was not dilated as much as would be wished. The pursuer was told that she would be put on a drip, to expedite labour. Dr Martins da Silva had mentioned the possibility of a caesarean section, but the pursuer thought that this was a "worst case scenario". The pursuer felt that things were not going well, but had the clinicians bluntly told her the extent of the issues, she would have insisted on a caesarean section being carried out: ultimately, however, the clinicians had medical expertise, and the pursuer did not think that she would be listened to. Midwife Haldane took over around 0600 hours, and was excellent, clearly explaining the position. She told the pursuer that the CTG trace was not good and was being monitored, but that delivery by caesarean section was now more likely. The pursuer thought that Dr Joy took a sample from the baby's head, which caused pain such as she had never before experienced. When a decision was ultimately made to deliver by way of caesarean section, it was clear to the pursuer that it was urgent, and that the only question was whether or not general anaesthetic was used. The discussion was more with Midwife Haldane, as the pursuer felt that Dr Joy talked at her, rather than with her. The pursuer understood that a caesarean section was necessary by this point, and felt that there was no real option other than to proceed in that way. Once the anaesthetic had been administered, it all happened very quickly.

[27] The pursuer's partner: PY did not feel that the obstetricians appeared worried when they looked at the CTG trace. His initial recollection had been that it was Midwife McMahon who told them, between 0530 hours and 0600 hours, that a caesarean section would be necessary: however, on being referred to the medical records, he accepted that it must have been Midwife Haldane. She was very efficient, making sure that decisions were made and action taken. PY thought that fetal sampling was carried out by Dr Joy, and

remembered this being very painful for the pursuer. PY recalled there being a brief discussion with the doctor, before the pursuer was taken to theatre.

[28] Dr Rajive Joy: the evidence of Dr Rajive Joy Chiriyankandath consisted of his witness statements dated 30 October 2010 and 28 February 2025, and oral evidence in court. Reading the two witness statements together, Dr Joy explained in these that he was the registrar member of the on-call team for Obstetrics & Gynaecology at the RIE between 2030 hours on 10 September 2010 and 0830 hours on 11 September 2010. There was intense clinical activity on the labour ward during that shift. Dr Joy's first contact with the pursuer was at 0321 hours, when Midwife McMahon asked him to review the initial CTG trace commenced on the labour ward. Amongst the information which he was given by Midwife McMahon, was that the pursuer had been transferred from obstetric triage in view of meconium-stained liquor and a non-reassuring CTG. Dr Joy's plan for continuous and close monitoring of the CTG was discussed with Midwife McMahon, the pursuer and her partner, and was accepted by all. At 0532 hours, Midwife McMahon again asked Dr Joy to review the trace. Dr Joy assessed the trace to have a baseline rate within normal range, and acceptable variability of 5 beats per minute (bpm), although lacking in accelerations. There was a possible earlier deceleration at a point when the pursuer was recorded to have been mobilised to the toilet. Dr Joy concluded that close monitoring should continue, and recommended a position change and iced water / cubes. This plan was discussed with the pursuer and her partner, and Midwife McMahon, who were all content. A further review of the CTG was requested by Midwife McMahon at 0548 hours, prior to commencing the syntocinon infusion which had previously been prescribed by Dr Martins da Silva. Dr Joy concluded that the trace was satisfactory, with a baseline of 120 bpm, variability of 5 bpm, no accelerations or decelerations and absent uterine contractions. He determined that no

intervention was necessary. Again, the pursuer and her partner, and Midwife McMahon, were content. Between 0638 hours and 0642 hours, Midwife Haldane reported that the syntocinon infusion had been commenced, but that there had been a fetal heart deceleration, and that an urgent review of the CTG was required. When Dr Joy arrived in the room, the syntocinon infusion had been turned off. The fetal heart rate improved in response to a position change by the pursuer. Dr Joy concluded that an abdominal and internal examination was required. Examination revealed that 3-4/5ths of the baby's head was palpable abdominally, the cervix was dilated to 2-3 cm, and meconium-stained liquor was present. The CTG showed a baseline fetal heart rate of 120 with decreased variability, and there had been a previous deep deceleration. Dr Joy explained to the pursuer and her partner that the baby was showing signs of fetal distress as it was not tolerating the augmentation of labour, and that there had not been enough progress for imminent vaginal delivery. Accordingly, he considered that an emergency caesarean section would be advisable. While the pursuer and her partner talked this over, Dr Joy discussed this plan with Dr Martins da Silva, who was in agreement. Midwife Haldane summoned him back to the room, as there had been a further deceleration on the CTG. Dr Joy obtained the informed written consent to an emergency caesarean section, while Midwife Haldane put in hand practical arrangements for the procedure. The pursuer was swiftly reviewed by the anaesthetist and transferred to theatre. Dr Joy and his assistant proceeded to rapidly deliver the baby. The umbilical cord was looped around L's neck on delivery. On the following day, Dr Joy spoke with the pursuer on the post-natal ward, to debrief her regarding these events. The pursuer appeared appreciative of the work of the clinical team.

[29] In his oral evidence, Dr Joy confirmed his medical qualifications, and that he was now working as a consultant obstetrician and gynaecologist in England. He had worked in

the NHS since 2003, and had decided to move into obstetrics around 2007. In September 2010, he was ST3 (a training position in a seven-year programme; loosely speaking a Registrar). The National Institute of Clinical Excellence (NICE) had issued a Clinical Guideline on the interpretation of a CTG trace, which doctors and midwives relied upon to assess the CTG and make management plans, and this was used across the UK. Dr Joy was familiar with the applicable Clinical Guideline in 2010, which was the 2007 NICE Intrapartum Care Clinical Guideline 55. Table 6, on the classification of fetal heart rate trace features, provided as follows:

- "reassuring" features of a trace: baseline of 110-160 bpm; variability of 5 bpm or more; no decelerations; accelerations present
- "non-reassuring" features of a trace: baseline of 100-109 bpm or 161-180 bpm; variability less than 5 bpm for 40-90 minutes; "[t]ypical variable decelerations with over 50% of contractions, occurring for over 90 minutes" or a single prolonged deceleration for up to 3 minutes. If the trace was otherwise normal, the absence of accelerations was of uncertain significance
- "abnormal" features of a trace: baseline under 100 bpm, or over 180 bpm (sinusoidal pattern for 10 minutes or more); variability of less than 5 bpm for 90 minutes; "[e]ither atypical variable decelerations with over 50% of contractions or late decelerations, both for over 30 minutes" or a single prolonged deceleration for more than 3 minutes. Again, if the trace was otherwise normal, the absence of accelerations was of uncertain significance

In an undernote to Table 6, it was stated that if a bradycardia occurred in the baby for more than 3 minutes, urgent medical aid should be sought and preparations made to urgently expedite the birth by way of a Category 1 caesarean section, which could include moving the

mother to theatre if the fetal heart had not recovered by 9 minutes. If the fetal heart recovered within 9 minutes, the decision to deliver should be reconsidered in conjunction with the mother if reasonable. Table 5 of the Clinical Guideline defined the CTG trace as: (i) normal, if all four features (applying Table 6) were classified as reassuring; (ii) suspicious, if one feature was non-reassuring, and the rest were reassuring; or (iii) pathological, if two or more features were classified as non-reassuring, or one or more features was classified as abnormal.

[30] The doctor's presence would be required at many locations in the ward, and it was not necessary for Dr Joy to always be in the room observing the CTG trace, because the midwife was monitoring and would report to him. With regard to the review at 0532 hours, Dr Joy explained that his normal practice was to receive the information from the midwife, and mark his presence in the room on the trace. His particular focus would be on any section causing the midwife concern, and then he would look back to the preceding 30 or 90 minutes of the trace to see if it was persistent. Dr Joy explained that a fetal heart rate, unlike that of an adult, will show a lot of beat-to-beat variation, so it is necessary to find a median or baseline on the CTG. As at 0532 hours there had been a drop in the baseline, and two sharp decelerations with a quick recovery, but that could be due to the change in position. In Dr Joy's opinion, the baseline was steady, and variability was 5 bpm, sometimes 10 bpm. One late deceleration in a thirty minute period would not render the trace pathological: he would be looking for late decelerations occurring after more than 50% of the contractions. Here there were isolated, not persistent, late decelerations. Dr Joy did not classify the CTG as pathological at that stage. Although there were some non-reassuring features, there were also positive features, and therefore he would not have immediately recommended an emergency caesarean section. With regard to the review at 0548 hours,

Dr Joy explained that syntocinon was a synthetic form of a naturally-occurring hormone, which brings on contractions. It is common for a midwife to request a review of the trace prior to commencing syntocinon. In 2007, the NICE guidance did not recognise the concept of a shallow deceleration (this was introduced in 2022). Looking at the CTG trace in the light of the then-applicable Clinical Guideline, the baseline had not changed much, and variability was normal: Dr Joy did not class it as pathological, and thus would not have recommended a caesarean section. As at 0638 – 0642 hours, there were two warning features. The CTG was pathological. Position change by the mother is an immediate method of resuscitating the fetus. At this stage, it was necessary for Dr Joy to determine whether delivery was imminent, so as to ascertain whether it would be quicker to facilitate vaginal delivery or proceed to an emergency caesarean section. Here, delivery was not imminent. However, the recovery of the fetal heart rate did provide a window for discussion with the pursuer. It had to be borne in mind that a Category 1 emergency caesarean section involves the use of general anaesthetic, which can compromise the baby: if the fetal heart rate had recovered and there was time for a spinal anaesthetic to be administered, this was safer for both mother and child. Dr Joy wished to speak to the Senior Registrar before proceeding to theatre. In cross-examination, Dr Joy explained that when reviewing the CTG trace, one was looking for a trend, not a snapshot. In this case, although there might have been periods of reduced variability, he would not say that overall there was reduced variability. Dr Joy clarified that whilst he was now aware of the definition of shallow decelerations, he would not have been in 2010, when it did not form part of the guideline: he would not have looked for shallow decelerations when interpreting a trace at that time. At the time when he had determined that they should proceed to delivery by

emergency caesarean section, there was not the immediate threat to the life of the mother or baby which would indicate a Category 1 caesarean.

[31] Dr Sarah Martins da Silva: the evidence of Dr Martins da Silva consisted of her witness statements dated 5 November 2010, and 18 June 2021 (but re-signed on 15 May 2024), and her oral evidence in court. Taking the witness statements together, the evidence of Dr Martins da Silva was that she was Senior Registrar on the labour ward at the RIE at the relevant time. Dr Martins da Silva obtained her academic qualifications in 1995. She had been a Specialist Registrar trainee since 2004, and a Senior Registrar at the Simpson Centre for Reproductive Health since 2009: in 2010, she was in her final year of training.
Dr Martins da Silva was appointed as a consultant in 2013. When Dr Martins da Silva first met the pursuer at 0410 hours, she had been asked to review the pursuer due to an unreassuring CTG. Dr Martins da Silva explained that the CTG is a means of recording the baby's heartbeat, and maternal contractions. In line with her normal practice, Dr Martins da Silva took a history from the pursuer and performed a vaginal examination. The pursuer was comfortable and contracting mildly. Dr Martins da Silva noted the presence of meconium-stained liquor, and determined that the pursuer was high risk. In reviewing the CTG, Dr Martins da Silva would have used the Dr C BrAVaDO mnemonic. The CTG trace showed a normal baseline of 120 bpm, acceptable variability, and no accelerations, but two episodes of either late or unprovoked decelerations. The fetal heart accelerated in response to examination, which was a reassuring sign. Dr Martins da Silva considered the CTG trace to be acceptable overall, and determined that syntocinon should be commenced to augment labour and expedite delivery. The pursuer was warned that she might need delivery by caesarean section should the CTG deteriorate. Dr Martins da Silva was not aware that syntocinon was not commenced at that time due to concerns about the intensity of activity

on the labour ward. She did not review the pursuer again. She was informed of, and approved, the decision to proceed to delivery by emergency caesarean at 0707 hours.

[32] In her oral evidence, Dr Martins da Silva confirmed that her current role was equally divided between clinical work and research. She explained that the fetus has a cycle of sleeping and awakening. One would not comment upon a trace on a minute-by-minute basis, but must look at the trace over a period of around 40 minutes or so. It was not always easy to interpret a CTG trace, and there was a great deal of training directed to doing so. Dr Martins da Silva explained that a late deceleration was one which came after a contraction, whilst an unprovoked deceleration was unrelated to a contraction. Neither were positive, although there could be a reason for an unprovoked deceleration which was not concerning. The trace simply responded to movement, so was affected by a change in maternal position. Looking again at the CTG trace for the purposes of giving her evidence, she stood by her contemporaneous assessment that variability was acceptable: it was not persistently less than 5 bpm over the period of 40 to 90 minutes. Dr Martins da Silva could not see shallow decelerations on the trace in this case. She was familiar with the 2007 NICE Clinical Guideline, which was applicable at the relevant time. Her interpretation of this was that for late decelerations to be classed as an abnormal feature of the trace, they would require to be a consistent feature over the 30 minute time-period. She accepted that the 2007 NICE Clinical Guideline did not explicitly say that late decelerations had to occur with over 50% of the contractions to be classed as an abnormal feature. The guideline at that time also made no reference to shallow decelerations. In this case, there were not persistent late decelerations: there had been two late decelerations in the period of around 50 or 60 minutes, but there were also some contractions where that did not occur. Accordingly, she classified the CTG trace as non-reassuring. The trace was historical, whereas the vaginal

examination which she carried out indicated what was happening at that moment in time. Had she assessed the trace as being pathological, she would not have recommended syntocinon. Dr Martins da Silva also clarified that when Dr Joy spoke to her prior to carrying out the caesarean section, it was not to obtain her agreement, but so that she was aware lest her assistance be required during the operation.

[33] Midwife Margaret McMahon: Midwife McMahon had been a midwife for twenty-seven years. She adopted her statement dated 18 October 2010, and also gave oral evidence. The labour ward was busy on 11 September 2010, and Midwife McMahon was called from another ward to assist. She was the midwife who received the pursuer's transfer onto the labour ward. Midwife McMahon monitored the CTG trace, as she had been directed to do by Dr Joy. At 0348 hours, the trace was unreassuring, so she reported this. Her main concern had been the reduced variability, but also there were decelerations. She was present when Dr Martins da Silva attended, spoke with the pursuer and performed a vaginal examination. The plan was for syntocinon to be commenced. Dr Martins da Silva also informed the pursuer that a caesarean section might ultimately be necessary, and instructed a change of maternal position, which Midwife McMahon assisted the pursuer with. There was some improvement in the CTG. Midwife McMahon was concerned about the variability on the trace and at 0506 hours asked for Dr Joy to review the CTG. The CTG required to be discontinued to allow the pursuer to visit the toilet. Thereafter, the CTG was recommenced and around 0520 hours Dr Joy attended. He observed the CTG, and decided to return in 10 minutes to consider it again. Around 0540 hours, Dr Joy did return, and informed the pursuer that they would continue with the plan to administer syntocinon.

Midwife McMahon prepared the syntocinon infusion, before handing over to Midwife Sally Haldane at 0605 hours.

[34] Sally Rutkowska: the evidence of Ms Rutkowska (formerly Haldane) consisted of a written statement drafted in June 2021, and signed on 14 May 2024 (which itself drew on a statement written on 20 September 2010, together with patient notes), and her oral evidence. Ms Rutkowska had qualified as a midwife in 2004, but left that employment in 2014 to be a full-time parent, and was no longer a registered midwife. Ms Rutkowska had commenced her shift in the evening of 10 September 2010. It was a busy night on the labour ward. At 0605 hours, Ms Rutkowska took over the midwifery care of the pursuer from Midwife McMahon. She commenced syntocinon at 0610 hours. At 0638 hours, there was a late deceleration on the CTG: this briefly recovered, and Ms Rutkowska assisted with a change of maternal position. However, the fetal heart rate dropped to 50 bpm, and Ms Rutkowska stopped the syntocinon and sought assistance. The pursuer was again assisted to change position, with the fetal heart rate still not recovering. After 3 to 4 minutes, the fetal heart rate was heard at 140 bpm, and by this time Dr Joy was present. He performed a vaginal examination at 0642 hours, and applied a fetal scalp electrode. He directed that the syntocinon remain off, and that the CTG trace be monitored over the next 10 minutes. Ms Rutkowska had a further discussion with the pursuer and her partner, including the possible need for a caesarean section. The CTG continued to be non-reassuring at 0655 hours, with reduced variability and one deep variable deceleration. Ms Rutkowska asked Dr Joy to attend for a further review, and prepared the pursuer for the likelihood of a caesarean section. The further review was carried out at 0700 hours, and consent for a caesarean section was obtained. After L's delivery, Ms Rutkowska took L to the paediatricians waiting to commence his care.

[35] Ms McConville & Professor Sanders: evidence was led from both Ms McConville and Professor Sanders as to their interpretation of the CTG trace at material times. This was

subject to objection, and was led under reservation as to its competency and relevancy. I will explain my ruling, and the rationale for it, in a later section of this opinion.

Ms McConville confirmed that as a midwife she was trained on the interpretation of CTG traces. In her view, if there was one deceleration, one might suggest a change in maternal position. Once there was a further deceleration, there was a pattern. Ms McConville stated that it was her recollection that at the relevant time, late decelerations did not have to occur with over 50% of the contractions to be classified as an abnormal feature of the CTG trace, although this would change with subsequent NICE guidance. Regardless of her position on the proper interpretation of Table 6 of the 2007 NICE Clinical Guideline, Ms McConville had initially not considered that the CTG trace in this case was pathological until 0636 hours. However, the trace she was shown during her oral evidence was an enhanced version: after 0510 hours, the baseline was wandering, and she would have referred matters to a doctor. Ms McConville also made it clear that she would defer to Dr Owen in the interpretation of the CTG trace. Professor Sanders confirmed that both midwives and obstetricians were trained (in the same way) in the interpretation and analysis of CTG traces. This was an integral part of a midwife's role, although the decision on management of the patient was for the obstetrician. Professor Sanders had been involved in the development of the 2007 NICE Clinical Guideline. CTG had been used as a tool since the 1970s, as the fetal heart rate was essentially the only marker available prior to birth (whereas after the birth, there were many markers available for assessment by clinicians). Medical understanding of CTGs had developed over time. The normal fetal heart rate provided the baseline. Variability was common (although would reduce during sleep cycles), and accelerations indicated fetal activity. One had to differentiate normal decelerations which were of no clinical importance, from those which might suggest that the fetus lacked oxygen. The 2001 NICE guidance did

not specify a particular time-period over which there must be late decelerations for it to be an abnormal feature of the trace: but they did require to be uniform, repetitive and periodic. Repetitive, to Professor Sanders, indicates that it recurs over a period of time. There had been no intention to alter this understanding in drawing up the 2007 NICE Clinical Guideline: rather, the intention had been to introduce more clarity, especially around atypical variable decelerations. There had been a concern that too many caesarean or instrumental births were being carried out for healthy babies. In Professor Sanders' view, most people approached the 2007 NICE Clinical Guideline on the basis that late decelerations had to occur with over 50% of the contractions, and that was what would later be incorporated in the relevant 2014 NICE Clinical Guideline. One would not actually seek to calculate a precise percentage in real time. There could be reasons for occasional decelerations, and conservative measures would be the first response if there were concerns. One would be looking, for example, for a common feature repeating over one hour of the CTG trace, not two late decelerations separated by one hour. The 2014 NICE Clinical Guideline did not represent a change to the 2007 NICE Clinical Guideline (given that the 2001 NICE guidance had required that late decelerations be repetitive before this would be classed as an abnormal feature): it was merely a clarification, not a response to new evidence becoming available. At the early stage of labour, late decelerations are not exceptional, but they are uncommon: hence why Midwife Turner sought transfer to the labour ward and medical review. Professor Sanders emphasised that in commenting on the trace now, it was necessary to consider the trace prospectively: one was more likely to look at a trace dismally, if the outcome had not been as hoped. In her view, it was at 0640 hours that the trace would be considered to be pathological.

[36] Dr Philip Owen: Dr Owen was called by the pursuer to give expert obstetric evidence. He was a consultant obstetrician and gynaecologist, who had taken partial retirement in February 2025, but continued to provide on-call obstetric cover at Glasgow Royal Infirmary. He had been involved with the Royal College of Obstetricians and Gynaecologists, which had a major role in training and progression, and in setting standards for practice. Dr Owen had prepared numerous medico-legal reports, with his instructions always equally split between pursuer and defender. Dr Owen explained that whilst the NICE Clinical Guidelines expressly applied to England and Wales, they were adopted in Scotland in the absence of a good reason to do otherwise. In his view, late decelerations were very unusual in the early stages of labour. They generally reflect inadequate oxygenation of the fetus. If these are present in the early stages, then a vaginal delivery is unlikely and a caesarean section will most likely be required. A deceleration can be defined as a drop of 15 bpm or more from the baseline, while in a shallow late deceleration the drop does not quite reach that. The latter were well-recognised in 2010, although it probably makes no difference in clinical approach whether or not a late deceleration is shallow. Dr Owen disagreed with the suggestion that shallow late decelerations would not be classed as late decelerations. The usual practice in 2010 (as it still is today) is to consider the CTG trace in the round, with all the other available information. The 2007 NICE Clinical Guideline was the one which was relevant to care provided in 2010. These guidelines are the product of a great deal of work, with multiple drafts and editing of every word. The terms of Table 6 specified only that atypical variable decelerations had to occur with over 50% of contractions, and not that late decelerations had to occur with that same frequency, in order to be classified (if for over 30 minutes) as an abnormal feature of the trace. If the wording of the Table had altered by the time of the successor 2014 NICE Clinical Guideline, this was of

no relevance to practice in 2010. It was very unlikely that the 2014 NICE Clinical Guideline would mirror what was already practice in 2010. The standard of the ordinarily competent obstetrician in 2010 should therefore be judged solely by reference to the 2007 Clinical Guideline, and not by whether it was in line with the 2014 NICE Clinical Guideline.

[37] Viewing the CTG trace in the current case, from 0315 hours to 0345 hours on 11 September 2010, there were recurring late decelerations. The CTG trace ought therefore to have been classified as pathological by 0345 hours. It was wrong to say that the late decelerations required to be persistent and occurring with over 50% of contractions. The reduced variability here, in the context of late decelerations and a lack of accelerations, in a woman who was not in established labour and had exhibited meconium staining, ought to have made an ordinarily competent obstetrician take notice. The decelerations seen by Dr Martins da Silva were definitely late, rather than potentially late or unprovoked: in any event, there were more late decelerations than she had identified. Dr Martins da Silva had incorrectly interpreted the CTG trace, because she wrongly thought that late decelerations required to be present for over 50% of the contractions. The presence of late decelerations at such an early stage of labour was truly exceptional (whether two or more): everything was pointing to a Category 2 caesarean section being the only way a safe birth could be achieved. Although the response to vaginal examination was a positive feature, it only provided a reassurance that a Category 2, rather than Category 1, caesarean section was appropriate. Instructing that syntocinon be commenced was also inappropriate, once at least two late decelerations had been observed. Dr Joy was likewise wrong to say that, in 2010, late decelerations had to be persistent and occur with more than 50% of contractions for this to be an abnormal feature of the trace. There were further decelerations, and a loss of variability: Dr Joy should have immediately categorised the trace as pathological at

0532 hours. Similarly, at 0548 hours the trace should have been classified as pathological by Dr Joy, and a Category 2 caesarean section carried out. It was not a nuanced decision, but if he was unsure, he could have asked Dr Martins da Silva to review. By 0642 hours, Dr Joy was obliged to recommend proceeding to delivery by Category 1 caesarean section. A small dose of syntocinon had caused a serious deterioration, and that having been stopped, no other conservative measures were available.

[38] In cross-examination, although Dr Owen accepted that a particular CTG trace may not fall into an easily described category, and that there could be other reasonable interpretations of a particular trace, he maintained his position that in this case there was only one correct interpretation of the CTG. He accepted that midwives were capable of interpreting a CTG, and that they followed the same guidance as obstetricians in so doing: but the decision was with the doctor, not the midwife. Dr Owen accepted that knowledge of an adverse outcome can influence the interpretation of a CTG trace: however, even on the research, this only occurred in a minority of cases, and he had attempted to put himself in the position of the obstetricians at the relevant time in arriving at his opinion. With regard to the NICE 2007 Clinical Guideline, if someone involved in their development was able to comment on what was intended, he would not be able to contradict it. Although the word "shallow" did not appear within that guidance, it was in his view very heavily implied. In any event, that Clinical Guideline did not provide the totality of an obstetrician's understanding of CTG traces. Dr Owen rejected the idea that the CTG trace showed fluctuations in the baseline, rather than late decelerations. For the relevant 2014 NICE Clinical Guideline to specify that it would be an abnormal feature of the trace if the late decelerations occurred with over 50% of the contractions represented a change to, rather than a development in, the guidance. He accepted that his criticism of Dr Martins da Silva

for ordering the commencement of syntocinon was dependent on the court accepting that the CTG trace was pathological at that time. It was accepted with regard to the bradycardia at 0636 hours, that the fetal heart rate had recovered within 9 minutes. However, the 2007 NICE Clinical Guideline was an outline of care which sometimes needed modification, or even to be put to one side. In this case there had been a prolonged life-threatening deceleration against the background of a CTG trace which had been pathological for many hours, meconium staining, and the mother not yet being in labour: this demanded a more urgent approach, which would have been the practice of obstetricians in 2010. In the case of both a Category 1 and a Category 2 emergency caesarean section, the clinical team should proceed as rapidly as possible: accordingly, even missing the thirty minute target by one minute would represent a breach of duty.

[39] Professor Deirdre Murphy: the defenders called Professor Murphy to give expert obstetric evidence. She was the head of Obstetrics and Gynaecology at Trinity College Dublin, and continued to practise one day each week. She had been involved in the development of international, and domestic, guidelines, and had been providing medico-legal opinions throughout the UK for over 25 years (in Scotland, predominantly for the defender). Professor Murphy drew attention to literature showing that not only might different professionals interpret a CTG trace differently, but that the same individual can interpret a trace differently dependent on their understanding of the eventual outcome (essentially, what might be characterised as hindsight bias). It was essential that midwives and obstetricians interpreted a CTG trace in the same way, but the responsibility for the treatment decision lay with the obstetrician. The original intention in making use of CTG traces had been to prevent fetal death, but attempts had then been made to extrapolate this to cases of fetal compromise or injury. Studies showed that abnormal features in CTG traces

are a very poor predictor of cerebral palsy. Professor Murphy questioned whether Dr Owen had started from the outcome, and then looked back at the trace, attempting to find reasons for that outcome. In the prospective consideration of a CTG trace, there was a balance to be struck between intervening too soon and recommending an unnecessary caesarean section, and intervening too late and there being an adverse outcome.

[40] Late decelerations in the early stage of labour are concerning, requiring obstetric and midwifery involvement: but they are not exceptional. Shallow decelerations occur only when there is reduced variability. In the 2001 NICE guidance, late decelerations required to be repetitive. For this to be an abnormal feature, they required to be repeated, that is, occurring with most or all of the contractions. Isolated or sporadic decelerations could be caused by, for example, a position change or vaginal examination, and the CTG trace will recover. Like Dr Martins da Silva and Dr Joy, Professor Murphy would have interpreted the 2007 NICE Clinical Guideline as requiring late decelerations to occur with most or all of the contractions to be classified as an abnormal feature. In practice, it was not a mathematical exercise: if there were continuing decelerations, one would then check whether they continued in the face of conservative measures, before moving to the next level of response. If they remained persistent, and other features of the CTG were concerning, then this may be more sinister. In 2014, the Clinical Guideline was explicit that it would constitute an abnormal feature of a trace if late decelerations were present for over 30 minutes, did not improve with conservative measures, and occurred with over 50% of the contractions. This did not represent a change in clinical practice, and would have been a reasonable approach in 2010 too. That there had been two late decelerations over the course of 30 minutes would not be enough to demand that the CTG be classed as pathological, and warranting delivery by caesarean section. In this case, there was an apparent shallow late deceleration at

0350 hours, but variability was normal. It was not necessary for Dr Martins da Silva to conclude that the trace was pathological. Professor Murphy did not agree that the CTG trace at 0420 hours showed a shallow late deceleration: Dr Owen had not taken account of the vaginal examination taking place, and obstetricians of ordinary care and skill viewing the trace prospectively would not have identified a shallow late deceleration at that point. Nor did Professor Murphy agree that the trace was pathological from that time: the baseline was normal, variability was good, and there was a good response to conservative measures. It might be said that there was a deceleration between 0437 hours and 0510 hours, but the recording may not be reliable at that moment, because it followed the pursuer requiring to use the toilet (and thus the CTG machinery being disconnected from the pursuer). After 0512 hours, there was reduced variability which normalised after a change in maternal position. Around 0540 hours, variability was normal, and obstetricians in routine clinical practice would not have identified two late decelerations. It was not necessary for Dr Joy, interpreting the trace prospectively, to declare the CTG pathological. The prolonged deceleration at 0636 hours rendered the CTG pathological. A reasonable and responsible body of obstetricians would interpret the CTG as had the clinicians in this case, and as did Professor Murphy: Dr Owen was the only witness to identify so many decelerations. Where there was (as here at 0636 hours) a bradycardia lasting for 3 minutes, one would prepare for a Category 1 emergency caesarean section: if there was recovery, consideration could be given to the patient's wishes, and whether a Category 2 classification was now appropriate. The caesarean section should still be carried out as quickly as possible, but a re-categorisation would allow for prioritisation between cases. In this case, the fetal heart rate recovered to over 100 bpm by 0642 hours, and accordingly there was a recovery within 9 minutes, which is the time-period identified in Table 6 of the 2007 NICE Clinical Guideline.

It would be appropriate for an obstetrician such as Dr Joy to seek approval from a senior registrar or consultant. Professor Murphy explained that a Category 1 caesarean section required general anaesthetic, despite the patient not having fasted. It also meant that the baby would need respiration on birth, and that the mother would not be able to bond with the baby immediately on birth. In this case, the structure of the placenta and positioning of the cord was abnormal: but the clinicians had no way of knowing this in advance, nor of knowing that the cord had become wound around L's neck. It could not have been predicted. Professor Murphy considered that her views represented that of a reasonable and responsible body of obstetricians. There had been no breach of duty on the part of Doctor Martins da Silva or Doctor Joy.

[41] In cross-examination, Professor Murphy confirmed that the majority of her medico-legal work had been at the instruction of defenders: however, what would not be apparent from that, were the number of reports she provided which were critical of clinician care. In terms of their views of the CTG in this case, it appeared that where she saw variability, Dr Owen saw this as part of a deceleration. Professor Murphy's understanding of repetitive was of something that kept happening: not where something occurred once, then happened again a lot later. When a woman is in labour, the clinicians are trying to support the patient to achieve a safe vaginal birth, while monitoring and preparing for potential untoward events: they were not trying to search for an abnormal feature on the CTG trace so as to meet the threshold for a caesarean section. Individual professionals may differently interpret a trace, but interpretation did not vary on a regional basis. The frequency with which caesarean sections are carried out may vary from hospital to hospital, reflecting different clinicians' thresholds as to when to decide to intervene. In the pursuer's case, one would not argue with a clinician who decided to carry out a caesarean section, but it was not

the only course open to the treating clinicians, and thus there was no breach of duty on their part in not doing so. At the time of Dr Martins da Silva's attendance, Professor Murphy would not have proceeded to a caesarean section, and she did not think that it would have been a commonly taken option at that time, and in the circumstances pertaining. There had been an increase in the frequency of caesarean sections between 2010 and the current day, although the rates of children born with cerebral palsy had not decreased in that period. There was no dispute that the use of syntocinon would be contra-indicated if the CTG was pathological, but Professor Murphy considered its recommendation reasonable in the circumstances. She did not agree that Dr Joy was under a duty to recommend a caesarean section at 0532 hours and at 0536 hours. When Dr Joy had attended at 0642 hours, he rapidly carried out a vaginal examination and applied a fetal scalp electrode. The recovery meant that a Category 1 caesarean section was not needed: Dr Joy was not obliged to recommend that course of action as soon as he walked into the room, without carrying out an assessment of the pursuer. To rush a woman into theatre straightaway, and then return her to the ward when matters stabilised was a frightening experience for the patient.

[42] In preparing an expert report, Professor Murphy asked herself whether the care given to the patient was acceptable for a clinician at the relevant time, whether it reached the high standards which she expected of her own trainees, and whether it reached the high standards which she set for herself? In this case, she believed that the care of the clinical team passed all three of those tests: had Professor Murphy been in their position, she would have acted in the same way, and there would have been the same sad outcome. Dr Owen was entitled to his own opinion and approach, but Professor Murphy disagreed that that was the only correct opinion and approach which could be held by an obstetrician.

[43] At one point in her evidence, Professor Murphy was asked about her recollections of an expert report which had been prepared by Dr Gupta, an expert previously instructed by the pursuer. This was objected to by the pursuer, and the evidence heard under reservation to its competency and relevancy. I accept that such evidence can be admissible, on the basis that it was material which Professor Murphy had seen and might have referred to in her own report. In any event, however, where (as here) the defenders sought to draw some support from the content of Dr Gupta's report being unfavourable to this particular aspect of the pursuer's current case, it was evidence on which I could place no weight at all: I did not have the opportunity to hear from Dr Gupta on his reasoning or conclusions. It was not clear whether he had seen the enhanced CTG trace. I therefore left this evidence out of account.

The legal framework

[44] There was little dispute between parties as to the legal framework within which the evidence falls to be analysed. The test for clinical negligence is as famously expounded in the case of *Hunter* v *Hanley* 1955 SC 200 (per Lord President Clyde, at 206). To succeed, the pursuer must show that there has been a lack of that ordinary care which a man of ordinary skill would display. If it is said that there has been a deviation from ordinary professional practice on the clinician's part, then it must be established that: (i) there is a usual and normal practice; (ii) the clinician has not adopted that practice; and, crucially, (iii) the course the clinician adopted is one which no professional of ordinary skill would have taken if acting with ordinary care. In laying down that test, Lord President Clyde recognised that it is a heavy onus.

[45] Where, as is usually the case, there are competing expert opinions placed before the court, the proper approach to be taken has been set down in the relevant authorities. In the case of *Bolitho* v *City and Hackney Health Authority* 1998 AC 232, Lord Browne-Wilkinson made it clear (at 241-2) that the court is not bound to hold that negligence has not been made out solely because a defender has led evidence from a number of medical experts who testify that the defender's treatment of the patient accorded with sound medical practice. That body of opinion must be responsible, reasonable or respectable – which is to say that it must have a logical basis. But this is necessarily subject to the caveat (at 243) which is worth setting out in full:

> "In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of that opinion. In particular, where there are questions of assessment of the relative risks and benefits of adopting a particular medical practice, a reasonable view necessarily presupposes that the relative risks and benefits have been weighed by the experts in forming their opinions. But if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible.
>
> I emphasise that in my view it will very seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment which a judge would not normally be able to make without expert evidence. As the quotation from Lord Scarman makes clear, it would be wrong to allow such assessment to deteriorate into seeking to persuade the judge to prefer one of two views both of which are capable of being logically supported. It is only where a judge can be satisfied that the body of expert opinion cannot be logically supported at all that such opinion will not provide the benchmark by reference to which the defendant's conduct falls to be assessed."

[46] This reflects the position in Scotland, which has been summarised by Lord Hodge in the case of *Honisz* v *Lothian Health Board* [2006] CSOH 24; 2008 SC 235 (at [39]-[40]) as follows: (i) if there are two opposing schools of thought among responsible medical practitioners as to the appropriateness of a particular practice, it generally is not the function of the court to prefer one over the other; (ii) the court does not defer to the opinions of the

professionals to the extent that it must always conclude that there has been no negligence if a defender leads evidence that other responsible professionals would have acted as the clinician did in the case at hand; and (iii) in exceptional cases, the court may conclude that a practice of responsible clinicians does not stand up to rational analysis. The reason why such cases will be exceptional is, Lord Hodge explained, because:

> "the assessment and balancing of risks and benefits are matters of clinical judgment. Thus it will normally require compelling expert evidence to demonstrate that an opinion held by another medical expert is one which that other expert could not have held if he had taken care to analyse the basis of the practice. Where experts have applied their minds to the comparative risks and benefits of a course of action and have reached a defensible conclusion, the court will have no basis for rejecting their view and concluding that the pursuer has proved negligence in terms of *Hunter v Hanley* …" (at [39]).

Lord Hodge elaborated on this in the subsequent case of *Dineley* v *Lothian Health Board* [2007] CSOH 154 (at [40]),where he confirmed that in such cases the court will be assessing: (i) whether an expert's view has been reached on a mistaken or incomplete understanding of the relevant facts; (ii) whether the expert has carried out a proper assessment of the risks and benefits of the course which was adopted, and the course advocated by the pursuer; and (iii) whether or not there is a logical basis for an expert's opinion supporting the course which was adopted. I was also referred to the English case of *McGuinn* v *Lewisham and Greenwich NHS Trust* [2017] EWHC 88 (QB), which had in turn drawn upon the earlier case of *C* v *North Cumbria University Hospitals NHS Trust* [2014] EWHC 61. This contained a helpful discussion of the principles outlined above, although I did not consider that it represented an alteration of them.

[47] Both parties also referred me to the well-known *dicta* of the UK Supreme Court on the general approach to expert evidence which ought to be adopted, in the case of *Kennedy* v

Cordia (Services) LLP [2016] UKSC 6; 2016 SC (UKSC) 59 (at [52]-[53]). It is unnecessary to repeat these at length here.

Decision

[48] I will deal in turn with each of the disputed issues of fact and law which I listed at the outset.

Whether the presence of meconium was reported to the triage unit, and the time of the pursuer's arrival at triage

The first telephone call to triage

[49] There was no significant dispute about the content of the first telephone call to the triage unit made by the pursuer. Neither the pursuer nor PY had noted the presence of meconium at that stage, although the bathroom lighting was dim. Midwife Turner's normal practice would be to confirm the colour of the liquor with a patient: the pursuer recalled being asked this, and reporting that it was fine. Midwife Turner could not explain why this call had not been recorded on TRAK. However, given the degree of consensus between parties, this does not pose any difficulties for the fact-finding exercise now being carried out by the court.

The second telephone call to triage

[50] I accept the evidence that the pursuer's second telephone call to triage was answered by CSW Perkins. It was clear from the evidence that, as a clinical support worker, CSW Perkins would not input information directly onto the TRAK system. To that extent, little therefore turned on whether or not such a TRAK record existed.

[51] There was a sharp dispute between parties as to whether the presence of meconium had been discussed during the second telephone call. CSW Perkins was clear and straightforward in her evidence. I accepted that she would not quiz a patient about the colour of her waters, nor give advice to a patient, not having sufficient knowledge to do so. I accepted too that she would relay the information which she did receive to a midwife: and that had the pursuer volunteered the information that her waters were not clear, this would have been reported to the midwife. This also found support in the evidence of Midwife Turner as to CSW Perkins' role, and the type of information which she would have expected CSW Perkins to relay to her. However, the only information which Midwife Turner was aware of the pursuer telling CSW Perkins, was that she had soaked through a pad. This was recorded by Midwife Turner in a statement taken soon after the events. Essentially then, their evidence was that the pursuer had not reported the presence of meconium during the second telephone call. I preferred that evidence to the evidence of the pursuer and her partner, for the reasons set out in the following paragraph.

[52] It is recognised that even where a statement-taker is doing his or her best to reflect a person's oral account, and a responsible pleader doing his or her best to frame a party's case from the statements and material available, there may be room for minor errors or misunderstandings to creep in. It would be wrong to approach the pleadings or witness statements like a conveyancing document, in comparing them with oral evidence given at proof. However, even taking a broad approach, it was clear that the pursuer's position on this key issue had altered over time. The pursuer's oral evidence came to be that what she had told CSW Perkins was that her waters were not clear, whereas previously she had recalled telling CSW Perkins about the colour of the fluid or spotting within the fluid. Furthermore, the pursuer's recollection as to the appearance of the mucus throughout the

evening did not seem to cohere with other evidence upon which reliance could be placed. For example, the pursuer's recollection was that when she was assessed by Midwife Turner at 0215 hours, her pad was black with fluid of the consistency of mucus. This conflicts with the contemporaneous note of Midwife Turner of "meconium light", which was an assessment by an experienced professional. This record also casts doubt on the recollections of the pursuer and her partner as to the colour and volume of the meconium throughout the evening, given the view of both Ms McConville and Professor Sanders that heavy meconium would not likely be followed by light meconium at a later stage. PY's evidence was also somewhat confused as to when they had first reported the presence of meconium. I would make clear that none of this is in any way a criticism of the evidence of the pursuer and PY, who have been through a very traumatic experience on which they must have reflected many times over the intervening years, but it is an explanation of why I was unable to rely on their evidence where it conflicted with other evidence.

The pursuer's time of arrival at triage

[53] The TRAK system records the pursuer's arrival at triage as 2335 hours on 10 September 2010. Standing Ms Dewar's unchallenged evidence as to the basis for her entering that date/time into the TRAK system, I accept that 2335 hours must have been recorded in the triage department's folder as the pursuer's time of arrival. The pursuer thought that they had arrived at the hospital around 2240 hours, but had had to wait 15 minutes or so to be attended to. PY timed their arrival as 2300 hours at the latest, but thought that they then had to wait whilst another patient was seen to. With all of the activity and stress of the night, it must be difficult now to recall precisely how long it took for a taxi to arrive at their home, and drive them to the hospital. The fact that the

recollections of the pursuer and her partner are themselves at slight variance may demonstrate that. In all of the circumstances, I accept that the pursuer first spoke to the staff member at the triage reception desk at 2335 hours, but that she and her partner may have arrived around 15 minutes or so earlier, while another patient was being received into the unit.

What was said in the triage unit regarding meconium

[54] The pursuer's own evidence was that when she arrived at the triage reception area, she did not mention anything about the colour of her waters or the staining on the maternity pads. It was clear that the pursuer did require fresh pads and changes of clothing whilst waiting in triage, but I did not accept that the staff were told that this was specifically due to the presence of meconium. The strongest source for that would have been PY's evidence, but his recollection of the evening was understandably somewhat confused in parts. Despite his respect for the knowledge and experience of the staff, I think he would have pressed the point more strongly with them, had he been witnessing the level and colour of meconium which he and the pursuer suggested in evidence was visible at that time.

[55] There was no dispute that Midwife Turner assessed the pursuer at 0215 hours on 11 September 2010. In the course of that, Midwife Turner inspected the maternity pad. As a result of her assessment, CTG monitoring was put in hand, and this ultimately led to the pursuer's transfer to the labour ward.

Conclusion

[56] In assessing the evidence, and forming a view as to what occurred in respect of these areas of factual dispute, I have not drawn the inference that an absence of action on the

defenders' part is explicable only by the pursuer not having reported to them a symptom which would have demanded action. That being so, the issue raised by the pursuer as to the approach where a contemporaneous record which should be kept by a defender is not available to a pursuer (whether or not this is the focus of an alleged breach of duty), does not arise. I will not therefore discuss here the cases cited by the pursuer in this regard.

Whether there was a duty on the midwives on duty in the triage unit to carry out an assessment of the pursuer within 15 minutes of her arrival at triage

[57] It is important to remember that the pursuer framed the midwifery case as one of breaches of duty by the particular midwives, and not as a broader attack on the defenders' system of care in the maternity triage unit: had the latter approach been taken, no doubt the defenders would have sought to lead evidence as to available resources and constraints thereon. In attempting to establish that it would be the usual and normal practice for a midwife to carry out an assessment of the pursuer within 15 minutes of her arrival at triage, the pursuer relied upon the evidence of Ms McConville. However, I was not satisfied that her evidence did establish that this was standard midwifery practice at the time. I did not accept Ms McConville's evidence that the midwives were duty-bound to assess the pursuer within 15 minutes of her arrival at triage. I was not persuaded that the general duty upon a midwife to take care of her patient and the fetus could, with nothing more, be extrapolated into such a specific duty. There was no guideline in place at the time which set such a target. The defenders objected that Ms McConville's evidence was so lacking in objective foundation as to be the bare *ipse dixit* of an expert, and inadmissible. I do not go so far, but the lack of any verifiable or independent support for her position meant that it carried little weight. Midwife Telfer, who gave careful evidence, was not aware of any standard

midwifery practice at that time of carrying out an assessment within 15 minutes of the patient's arrival at the triage unit. The existence of a duty in the terms contended for by the pursuer was also militated against by the information available regarding BSOTS. This was only introduced subsequent to L's birth in 2010, and sets a target time of 15 minutes after arrival at triage, for an initial assessment of a patient. It seemed clear that this was designed to be an improvement on a pre-existing system where patients awaited being seen in turn, with informal triaging being undertaken for those in obvious need of urgent attention. While most maternity units in the UK now aim for the BSOTS target, none of those had previously required patients to be assessed within 15 minutes. Professor Sanders was not aware of any guideline in place in 2010 requiring assessment within 15 minutes of arrival in the triage unit. Nor did I find convincing Ms McConville's insistence that the BSOTS assessment was a fuller assessment than the brief assessment she was describing: if so, for both to be subject to the same timescale seemed illogical. Furthermore, it was not an answer in itself to say that in this case the presence of meconium could have been ascertained by a brief assessment of the pursuer shortly after arrival. To ask only whether particular symptoms which were ultimately identified as important might have been looked for at an earlier moment, may involve the application of hindsight: when a patient first presents, the midwife will require to explore all symptoms and clinical needs of potential relevance, and does not yet have the information allowing sole focus on that which might turn out (with hindsight) to be the most significant. For all of these reasons, I do not accept that there was a usual and normal practice such as the pursuer contends, and from which the midwives on duty in the triage unit could be said to have deviated. I accordingly do not conclude that there was a duty incumbent upon the defenders' midwives to carry out an assessment of the pursuer within 15 minutes of her arrival at triage.

Whether there was a duty on the midwives, in light of the pursuer's presentation, to commence a CTG to monitor fetal wellbeing within 15 minutes of that assessment

[58] This duty was framed by the pursuer to expressly refer to the pursuer's presentation, as being presentation at triage with SROM and meconium-stained liquor. For the reasons which I have already given, I do not accept that the pursuer reported the presence of meconium during the second telephone call, and the pursuer herself did not suggest that she raised this with the staff at the triage unit reception area. More fundamentally, it seemed to me that this asserted duty was bound up with the pursuer's contention that the midwives were under a duty to carry out an assessment within 15 minutes of the pursuer's arrival at triage: indeed, was intended to be ancillary to that duty. For the reasons given above, the pursuer has not established that the midwives were subject to such a duty, and therefore this ancillary duty would also fall away. In any event, there was no dispute that Midwife Turner commenced the CTG trace within around 5 minutes of assessing the pursuer at 0215 hours on 11 September 2010. Thus, if this were intended to be a free-standing duty on the midwives to commence a CTG trace within 15 minutes of the pursuer being assessed and evidence of meconium being observed, that duty was complied with in the pursuer's case. I accordingly do not find the defenders to be in breach of duty in this regard.

Whether there was a duty on the midwives to assess the pursuer significantly before 0200 hours on 11 September 2010, given the pursuer's history and presentation

[59] Ms McConville's evidence was that the pursuer ought to have been seen significantly before 0200 hours if she presented with a history of her waters not being clear. For the reasons which I have already given, I do not accept that the pursuer did report the presence

of meconium during the second telephone call. It was not the pursuer's evidence that she raised this with the staff at the triage unit reception area on her arrival there, and for the reasons already given, I did not accept that the staff were told thereafter that the fresh pads were required due to the presence of meconium. In any event, the alternative duty contended for by the pursuer was vague in its terms, and no specific basis in applicable standards or guidance was relied upon to vouch it. Professor Sanders considered that Midwife Turner's prioritisation of patients was appropriate. Accordingly, I am not satisfied that there was a usual and normal practice such as the pursuer contends, and from which the midwives on duty in the triage unit could be said to have deviated by not assessing the pursuer significantly before 0200 hours. I therefore do not conclude that there was a duty incumbent upon the defenders' midwives to carry out an assessment of the pursuer significantly before 0200 hours on 11 September 2010.

Obstetric care: introduction

[60] There were two disputed issues which were relevant to most of the duties to which the pursuer contended that the obstetricians in this case were subject. It is therefore convenient to deal with these at the outset, before turning to the specific duties asserted by the pursuer to have been incumbent upon Dr Martins da Silva and Dr Joy.

[61] The first important point of dispute was that, in essence, Dr Owen considered the CTG trace to be more decelerative than did Professor Murphy, or the treating clinical team. In particular, Dr Owen attached importance to the concept of shallow late decelerations. In so far as Dr Joy and Dr Martins da Silva had failed to identify these and take these into account in their assessment of the CTG trace, he was critical of them. Professor Murphy's view was that shallow decelerations would occur in the context of reduced variability, which

was not generally present in the CTG trace in this case. She disagreed with many of the instances identified by Dr Owen as late decelerations, and did not think that obstetricians in clinical practice at the time would have identified them as such.

[62] The second disputed issue, which was key to significant elements of the case on obstetrician negligence, is the proper approach to the NICE Intrapartum Care Clinical Guideline 55 (2007). Table 6 gives guidance as to when particular features of a fetal heart rate CTG trace should be classified as "reassuring", "non-reassuring", or "abnormal", with specific reference to baseline, variability, decelerations and accelerations. With regard to decelerations, it is suggested in the Table that these will be an abnormal feature of a trace when there is a single prolonged deceleration for more than 3 minutes, or when decelerations are "[e]ither atypical variable decelerations with over 50% of contractions or late decelerations, both for over 30 minutes". Late decelerations are agreed by parties to be properly defined (as in the previous 2001 guidance) as uniform, repetitive, periodic slowing of the fetal heart rate, with their onset occurring at a particular time which is measured by reference to contractions. There was no dispute that in terms of Table 5 of the Clinical Guideline, where one feature is classified as abnormal, the trace will be considered to be pathological. Subsequently, in the relevant 2014 NICE Clinical Guideline, it was stated that for it to constitute an abnormal feature of a CTG trace, late decelerations would require to be present for over 30 minutes, not to improve with conservative measures, and to occur with over 50% of contractions.

[63] Essentially, the pursuer's position in submissions was that, in line with Dr Owen's opinion, in assessing the obstetric care provided to the pursuer, one should look only to the precise wording of the 2007 NICE Clinical Guideline. Thus, as soon as there was more than one late deceleration, this should have been classified as an abnormal feature of the trace.

This would render the trace pathological. In so far as Dr Joy and Dr Martins da Silva interpreted the 2007 NICE Clinical Guideline as requiring late decelerations to accompany more than 50% of the contractions, they were wrong to do so, and had adopted a position which no careful and competent obstetrician would have done. The 2014 NICE Clinical Guideline represented a deliberate change post-dating L's birth, and so should be left out of account. In contrast, the defenders argued that there was no proper basis for rejecting Professor Murphy's evidence that it was normal at the relevant time to interpret Table 6 on the basis that the inherent need for late decelerations to be repetitive, meant that they required to be present with over 50% of contractions. The 2014 NICE Clinical Guideline was therefore simply a development of the 2007 NICE Clinical Guideline, and represented common practice at the relevant time.

[64] I am therefore faced with competing expert evidence from Dr Owen and Professor Murphy as to whether or not the course adopted by Dr Joy and Dr Martins da Silva in interpreting the CTG trace deviated from usual and normal practice, and was one which no professional of ordinary skill would have taken if acting with ordinary care. As the case law makes clear, it would not be appropriate for me to purport to prefer one expert over the other. For the reasons which I now set out, I do not consider that this is one of those exceptional cases where the court can conclude that a practice of responsible clinicians, as described by Professor Murphy, does not stand up to rational analysis.

[65] There was no suggestion that Professor Murphy lacked key factual information or documentation, in forming her opinion.

[66] Nor did I consider that Professor Murphy's opinion on the two key issues in dispute, or more generally, lacked a logical basis. With regard to Table 6 of the 2007 NICE Clinical Guideline, in its normal usage, "repetitive" suggests a regular frequency, rather than twice

over a prolonged period as Dr Owen suggested. Dr Owen did not proffer any reason as to why a radical change would be made between the 2007 and 2014 NICE Clinical Guidelines, as he contended that it had. Logically, one would assume that guidance is honed and improved over time in the light of research and experience. This is why it would plainly be wrong to hold a professional to a later, higher, standard. However, the pursuer in this case was in the somewhat surprising position of suggesting that if the clinicians used the interpretation made explicit in the later Clinical Guideline, it should be held that they had failed to meet the standard at an earlier time. A more logical explanation would be that the changed wording in the 2014 NICE Clinical Guideline did, as Professor Murphy suggested, represent a development which reflected existing practice. At one point during evidence, the pursuer sought to develop a line that there were differences in practice between Scotland and elsewhere, and thus to undermine Professor Murphy's evidence. I upheld the defenders' objection to this, there being no basis in the pleadings, and it not having been put to previous witnesses. I therefore likewise reject the pursuer's submissions to similar effect. With regard to the number of late decelerations present on the CTG trace, and whether there were shallow late decelerations, again I did not consider Professor Murphy's evidence to lack a logical basis. There was no dispute that the concept of a shallow late deceleration was not expressly referred to in the 2007 NICE Clinical Guideline, and I did not understand the basis for Dr Owen's assertion that these were strongly implied. The example trace reproduced in a contemporaneous textbook had been provided by Dr Owen to vouch that the concept was one with which clinicians of the time ought to have been familiar. Unfortunately, I was left in real doubt whether the example trace was actually captioned within the textbook as showing shallow decelerations, or whether that was Dr Owen's own interpretation. Furthermore, the example trace was very different from the one in this case,

apparently with reduced variability: and in Professor Murphy's view, it was when there was reduced variability, that shallow decelerations occurred.

[67] Nor did I consider that Professor Murphy had failed to carry out a proper assessment of the risks and benefits of the course adopted. She took a nuanced approach to the question of whether a caesarean section (especially when carried out under general anaesthetic) would be appropriate for mother and baby. In contrast, I found Dr Owen somewhat dogmatic in his insistence that a caesarean section ought to have been carried out at an early stage, and that no other approach was open to the treating clinicians. He was also rather prescriptive in his approach to the interpretation of the CTG trace, which seemed at odds with the evidence which suggested that there can inevitably be some variation and subjectivity in interpretation of a trace. Indeed, it was clear from the evidence that knowledge of the outcome could make a difference to an individual's interpretation of a complete trace. In considering the clinicians' care, what was of importance was the prospective interpretation of the trace, as it was generated in real time. Dr Owen's evidence did at times give the impression of a search, with the benefit of hindsight, for a point when it might be said that the threshold for a caesarean section being indicated had been met. The pursuer sought to argue that Professor Murphy's practice was so skewed towards instruction by defenders, that she lacked balance in her approach to the evidence. I did not accept that. Professor Murphy's qualifications were appropriate and relevant, and she had a great deal of experience across practice, and the development of guidance. Her explanations were clear, and her evidence internally coherent. I did not find her to be unduly defensive, or her evidence to be lacking in balance, as the pursuer submitted. Both Professor Murphy and Dr Owen showed appropriate respect for each other's professional judgment.

The objection to the evidence of the midwifery experts on interpretation of the CTG trace

[68] As already narrated, evidence was led from the midwifery experts about the interpretation of the CTG trace, under reservation as to its competency and relevancy. Whilst, of course, the question of what action an obstetrician ought to have taken is one only for the obstetric experts led, I find that interpretation of the CTG trace falls into a slightly different category. It was clear from the evidence that both midwives and doctors required to monitor and interpret CTG traces. It was not intended that there should be a difference in how they interpreted it, and they received the same continuing training while in practice. The midwifery experts plainly could not comment on what action an obstetrician ought appropriately to take in response to the trace. But there is no difficulty in principle with their commenting on what the trace itself says, to those who are trained to interpret it. Their evidence on that matter is accordingly admissible.

[69] Ms McConville qualified her evidence in this regard, as it was only at the time of giving her oral evidence that she had sight of the enhanced trace. On seeing that, she somewhat departed from her initial position that the CTG trace was only pathological at 0636 hours, as she now identified a wandering baseline after 0510 hours, which would have caused her to seek obstetrician review. Professor Sanders considered that the trace would only have been classified as pathological at 0640 hours. She had been involved in the development of the 2007 NICE Clinical Guideline, and her recollection was that the attempt to provide clarity around atypical variable decelerations, had not been accompanied by any intention to change the guidance on the frequency with which late decelerations required to be present in order to constitute an abnormal feature. Most people, as she recalled, did approach the 2007 NICE Clinical Guideline as requiring late decelerations with over 50% of the contractions before it would be an abnormal feature of the trace. The evidence in this

matter from the two midwifery experts served to confirm the conclusions which I had already reached on the basis of the expert obstetric witnesses. However, it did not alter it: I would have reached the same conclusion, had I upheld the pursuer's objection, and left Professor Sanders and Ms McConville's evidence on this matter out of account.

Whether there was a duty incumbent on Dr Martins da Silva to conclude at 0410 hours that the CTG was pathological and (in light of the meconium staining) to proceed to a Category 1 or Category 2 emergency caesarean section

[70] On reviewing the CTG trace, Dr Martins da Silva found the baseline to be normal and variability acceptable. She observed two late decelerations in the section of the trace which she had considered, but there were not persistent late decelerations. In the light of the 2007 NICE Clinical Guideline, she did not consider that the trace fell to be categorised as having an abnormal feature. Professor Murphy did not consider the trace to be pathological at 0410 hours, and did not think that proceeding to a caesarean section at that time would have been a commonly taken option. For the reasons explained in detail above, there is no basis to reject Professor Murphy's evidence that Dr Martins da Silva's approach, including her interpretation of the trace in the light of the 2007 NICE Clinical Guideline, was one which was open to an obstetrician of ordinary skill acting with ordinary care. I accordingly do not find that Dr Martins da Silva was under a duty to conclude that the CTG trace was pathological, and to proceed to a Category 1 or Category 2 emergency caesarean section.

Whether there was a duty incumbent on Dr Martins da Silva not to order the commencement of syntocinon on the basis that the CTG was pathological

[71] There was no dispute that this duty stood or fell with whether Dr Martins da Silva was under a duty to conclude that the CTG was pathological at 0410 hours. Had she concluded that the CTG was pathological, she herself would not have recommended syntocinon. Standing my decision that there was no duty incumbent on Dr Martins da Silva to conclude that the trace was pathological at 0410 hours, I accordingly do not find that there was a duty incumbent on her not to recommend syntocinon.

Whether there was a duty incumbent on Dr Joy to conclude at 05.32 hours that the CTG was pathological and (in light of the meconium staining) to proceed to a Category 1 or Category 2 emergency caesarean section

[72] On reviewing the trace at 0532 hours, Dr Joy considered the baseline to be within normal range, and variability to be acceptable. He was explicit in his evidence that, having regard to Table 6 of the 2007 NICE Clinical Guideline he would have been looking for late decelerations occurring after 50% of the contractions before it would constitute an abnormal feature of the trace. When considering the trace at 0532 hours, he had seen isolated, rather than persistent, late decelerations. Professor Murphy's evidence was that at around 0540 hours, variability was normal and obstetricians in routine clinical practice would not have identified two late decelerations: it was not necessary for Dr Joy to declare the CTG pathological. For the reasons already explained, I do not consider that there is any basis to reject Professor Murphy's evidence that Dr Joy's approach, including his interpretation of the trace in the light of the 2007 NICE Clinical Guideline, was one which was open to an obstetrician of ordinary skill acting with ordinary care. I accordingly do not find that Dr Joy

was under a duty to conclude at 0532 hours that the CTG was pathological and proceed to a Category 1 or Category 2 emergency caesarean section.

Whether there was a duty incumbent on Dr Joy to conclude at 0546 hours that the CTG was pathological and (in light of the meconium staining) to proceed to a Category 1 or Category 2 emergency caesarean section

[73] As at 0546 hours, given his assessment of the baseline and variability, and his approach to the significance of late decelerations, Dr Joy did not regard the trace as pathological. His approach was supported by the expert evidence of Professor Murphy. Again, for the reasons already explained, I do not consider that there is a basis for rejecting Professor Murphy's evidence that Dr Joy's approach, including his interpretation of the trace in the light of the 2007 NICE Clinical Guideline, was one which was open to an obstetrician of ordinary skill acting with ordinary care. I accordingly do not find that Dr Joy was under a duty to conclude at 0546 hours that the CTG was pathological and proceed to a Category 1 or Category 2 emergency caesarean section.

Whether there was a duty incumbent on Dr Joy at 0642 hours to make arrangements for an immediate Category 1 caesarean section

[74] Although the pursuer placed some emphasis on an eighteen-minute period between 0642 hours and 0700 hours in developing their submissions, the focus of the duty pled is what Dr Joy ought to have done at 0642 hours. At 0642 hours the clinical team, led by Dr Joy, identified clear warning signs. However, Dr Joy's view was that the recovery of the fetal heart rate provided a window for him to discuss with the pursuer the need to proceed to a caesarean section. He was weighing up too, the risks of a Category 1 caesarean section

to mother and baby. Although Dr Joy perhaps saw the discussion with Dr Martins da Silva as obtaining agreement, whereas she thought she was being alerted in case her assistance was required, there did not seem any dispute that it was appropriate that Dr Joy and Dr Martins da Silva have a brief conversation about the next steps. Professor Murphy considered it appropriate that Dr Joy carry out the rapid assessment and examination which he had at 0642 hours, rather than recommend a caesarean section immediately on walking into the room. Her view was that whilst the initial bradycardia would trigger preparations for a Category 1 emergency caesarean section, the recovery (as envisaged in Table 6 of the 2007 NICE Clinical Guideline) permitted consideration of the patient's wishes, and whether recategorisation to Category 2 was now possible. There were risks and disadvantages for mother and baby from a delivery necessitating the use of general anaesthetic, and the categorisation also allowed for the appropriate prioritisation of cases. Whilst Dr Owen and Professor Murphy differed in their views, I do not find that this is one of those rare cases where Professor Murphy's opinion falls to be rejected. Professor Murphy was well-qualified, and had considered the necessary factual information. Her opinion is not one which is incapable of withstanding logical analysis: Professor Murphy's view seemed in line with Table 6, in that following the bradycardia there was recovery of the fetal heart within 9 minutes, allowing for a reconsideration of a decision to deliver by way of Category 1 emergency caesarean section. Dr Owen's view to the contrary involved a departure from the terms of Table 6 (which he had otherwise argued ought to be closely followed), with his reasoning significantly dependent on his view that the CTG should properly have been classed as pathological for several hours. I have already explained that I do not reject Professor Murphy's evidence that, applying the appropriate test, neither Dr Joy nor Dr Martins da Silva was under a duty so to classify the trace during that period of time. For

all of these reasons, I accordingly do not find that Dr Joy was under a duty to make arrangements for an immediate Category 1 caesarean section at 0642 hours.

Objections to evidence made during the proof before answer

[75] A number of objections were made by parties during the course of the proof, on which I allowed evidence to be led under reservation as to its competency and relevancy. In some instances, the anticipated line was not further explored, or the evidence led did not transpire to be of any importance in resolving the disputed issues of fact and law. Some were no longer insisted upon by the time of oral submissions. Where the evidence led under reservation was critical to my analysis or decision, I have outlined above my decision on the objection.

Disposal

[76] For all of the above reasons, I repel the pursuer's first plea-in-law, sustain the defenders' second and third plea-in-law, and assoilzie the defenders. I shall, however, reserve all questions of expenses, lest parties wish to address me specifically on that point.