SECOND DIVISION, INNER HOUSE, COURT OF SESSION

[2024] CSIH 7
A76/15

Lord Justice Clerk
Lord Malcolm
Lord Pentland

OPINION OF THE COURT

delivered by LORD MALCOLM

in the reclaiming motion

by

SD AS LEGAL REPRESENTATIVE OF LD

Pursuer and Reclaimer

against

GRAMPIAN HEALTH BOARD

Defender and Respondent

Pursuer and Reclaimer: Khurana KC, B. Ross; Balfour + Manson
Defender and Respondent: McConnell, Dundas; Central Legal Office

19 April 2024

Introduction

[1] The pursuer is the mother of LD who was born at Aberdeen Maternity Hospital (AMH) on 24 August 2008 by caesarean section. He suffers from quadriplegic dyskinetic cerebral palsy and requires around the clock care. The pursuer raised an action for damages claiming that the midwives and an obstetrician who had been involved in her care during her time on the induction and labour wards had been negligent, and that this led to the

injuries suffered by her first child. Evidence at the proof indicated that obstetricians undertook thrice daily induction ward rounds. In due course the pursuer asked the Lord Ordinary to uphold an alternative case against them.

[2] The Lord Ordinary held that no breaches of duty had been established. The pursuer now reclaims (appeals) to this court. The grounds of appeal include a challenge to the rejection of the case against the midwives, but it is no longer maintained. The remaining grounds address:

(i) the decisions of doctors during the induction ward rounds;

(ii) whether there is a sufficient connection between any negligent acts or omissions on their part and the injuries suffered by LD following the pursuer's transfer to the labour ward;

(iii) whether Dr Sripada negligently failed to arrange an emergency caesarean section at 0410 hours on 24 August.

[3] The glossary of medical terms provided by the Lord Ordinary is reproduced as an appendix to this opinion.

The background

[4] The background to the events giving rise to the injuries sustained by LD at birth is set out at length within the opinion of the Lord Ordinary ([2022] CSOH 63), and only a summary is provided here. The pursuer was admitted for induction of labour on Thursday 21 August 2008. She was 13 days beyond her estimated date of delivery. The Bishop Score was assessed at 5 and her cervix was not dilated. A first dose of Prostin was administered at 1600 hours. A second dose was not administered that day. The pursuer was contracting

four times in ten minutes. A decision was made to examine the pursuer the following morning.

[5] On the morning of 22 August the Bishop Score was at 6 and cervical dilation at 1cm. A membrane sweep was undertaken. At this stage, contractions were around one or two in ten minutes. Contractions intensified throughout the morning, regular contractions were noted at 1630 hours and of two in ten minutes at 1955 hours. No further Prostin was administered on 22 August.

[7] In the early hours of Saturday 23 August, strong uterine contractions of three in ten minutes were noted. On review, the pursuer spoke of "trickling" and the midwife noted possible "light meconium staining" on the pursuer's sanitary pad. The midwife recorded that the vaginal discharge should be monitored. At 1430 hours, a vaginal examination was performed, Bishop Score was assessed at 8, cervical dilation was unchanged and a further dose of Prostin was administered. There continued to be suspicions of meconium. Contractions were noted.

[8] CTG monitoring of foetal heartbeat and uterine contractions was commenced on 23 August. At 2320 hours, a midwife noted early decelerations on the CTG trace, which responded well to a change of maternal position. The Bishop Score had fallen to 7 and there was no progress in dilation. Dr Sripada, the on-call registrar, reviewed the pursuer at 2340 hours. She noted good variability and early decelerations on the CTG trace, and instructed that the pursuer be transferred to the labour ward for amniotomy.

[9] The pursuer was transferred to the labour ward at around midnight. There was continuous CTG from her arrival until delivery. Dr Sripada assessed the trace as suspicious at 0110 hours. An hour later grade 2 meconium was noted on the pursuer's sanitary pad. A midwife assessed the trace as suspicious at 0345 hours and a senior midwife called for

review of the CTG by medical staff once available (Dr Sripada having been in theatre at that time).

[10] Dr Sripada reviewed the CTG trace at 0410 hours. She performed a vaginal examination and considered obtaining a FBS, but she was unable to do so due to insufficient cervical dilation. She decided that the trace was not bad enough to require a caesarean section. Her plan was to continue and review the CTG in 30 minutes. However, at 0436 hours, the foetal heart rate dropped suddenly. Soon thereafter foetal bradycardia was confirmed and the pursuer was transferred to theatre for an emergency caesarean section. The pursuer's cervix had rapidly dilated to 10cms while the umbilical cord was wrapped around the baby's neck. As his head descended into the birth canal the umbilical cord occluded and stopped the blood supply. He suffered severe acute asphyxia as a result. The injuries that he suffered have left him severely disabled. He was delivered at 0513 hours on Sunday 24 August.

[11] On 3 September 2008, the pursuer met with Dr Danielian, then senior consultant obstetrician, while her consultant, Dr Terry, was on leave. Dr Danielian's notes record his interpretation of the trace as "not reassuring, became abnormal and maybe merited FBS about ½ hour before delivery. Whether this would have made any difference to the outcome is unknown". A letter from Dr Terry to the pursuer's General Practitioner records his discussion with the pursuer on 24 October 2008. Therein, he describes having explained to the pursuer that "looking at the CTG there seemed to be little indication that an earlier delivery was indicated".

A brief summary of the evidence

[12] Factual evidence was led from the pursuer, a number of the midwives involved in

the pursuer's care in the induction ward, and from Dr Sripada. Expert evidence addressing both the actions of the midwives and of Dr Sripada was led from Margaret Richardson, former midwife and independent clinical expert witness; Professor Julia Sanders, professor of clinical nursing and midwifery; Dr Elizabeth Sarah Cooper, obstetrics and foetal medicine consultant at Edinburgh Royal Infirmary; and Professor Deirdre Murphy, obstetrics professor at Trinity College Dublin.

[13] The evidence is summarised only in so far as relevant to the matters put in issue before this court.

The decision-making of the antenatal midwives

[14] The pursuer led expert evidence that Prostin should not have been withheld because the contractions experienced by the pursuer were not of sufficient strength or frequency. There was also a failure to respond appropriately to the suspicions of meconium staining, which ought to have resulted in the pursuer's transfer to the labour ward. Ms Richardson accepted that, in hindsight, a second dose of Prostin would not have changed anything. However, Dr Cooper stated that had LD been transferred to the labour ward when he ought to have been, he would have been delivered before 0450 hours and likely uninjured.

[15] The midwives and the defender's experts maintained that the decision not to administer Prostin was appropriate given the contractions which the pursuer was experiencing. Even when Prostin was not contra-indicated because contractions were not too strong or frequent, Professor Murphy said that the decision to undertake a membrane sweep was a "perfectly reasonable alternative". The midwives had responsibility for decision-making on such matters. The strong uterine contractions on 22 August were a potential indication of the spontaneous establishment of labour. Neither of the defender's

experts considered that transfer was necessary at an earlier stage. It may have been reasonable to do so, but the suspicions of meconium were never confirmed and rupture of the membranes was very unlikely, though not excluded entirely.

The responsibilities of the ward round doctors

[16] It was not disputed that the usual practice of regular ward rounds was in operation at AMH at the relevant time. Dr Cooper opined that, if the pursuer's situation was discussed at a ward round on 22 August, she would have expected a doctor to prescribe or administer a second dose of Prostin. Contractions were only one in ten and there was no change in dilation. An ordinarily competent obstetrician would have given Prostin or performed an amniotomy. There was no reason not to give Prostin at this time or later in the day when contractions were two in ten. An obstetrician, aware of the Bishop Score at 7 and the suspicion of possible meconium staining, would have advised that an amniotomy be performed.

[17] Professor Sanders was of the view that, had the decision not to administer a second dose been inappropriate, the ward round doctors would have intervened. Professor Murphy's evidence went further: the decision to perform a membrane sweep would have been approved. Administering Prostin, though a reasonable and possibly more common approach, was not the only reasonable course of action. Every obstetrician would know that Prostin was not to be given to a woman who was contracting frequently.

Dr Sripada's interpretation of the CTG trace and decision-making at 0410 hours on 24 August

[18] The central issue in dispute was whether at 0410 hours the CTG trace was "suspicious" or "pathological". Dr Sripada accepted in her evidence that, had the trace been

pathological at 0410 hours, she would have proceeded to caesarean section. However, the trace was at no stage worse than suspicious. Taking the whole trace up until 0410 hours, it was switching between normal and suspicious, but the baseline was always normal. She accepted that it was suspicious at 0410 hours. The baseline was normal at between 150 and 155bpm. Variability was "okay". This could be explained by the fact that the pursuer had taken morphine. There were occasional early decelerations. The foetus was always quick to recover. While Dr Sripada wanted to take a FBS, that did not mean the trace was pathological. She did not expect the pursuer, a primigravida at 3cms dilation, to deliver vaginally "very quickly", but there were also risks associated with caesarean section for both mother and baby. The background circumstances were not suggestive of foetal distress. She had balanced all the factors. Her clinical judgement was that there should be a review in 30 minutes.

[19] Dr Cooper and Professor Murphy agreed that the CTG trace was not to be assessed in isolation. Consideration had to be given to all the relevant factors. In Dr Cooper's opinion, these were: the absence of liquor when amniotomy was performed; that the pursuer was primigravida; she was term plus 16 such that there was a risk of placental insufficiency; Dr Sripada was unable to perform a FBS; and the fresh meconium found at 0210 hours. None of the decelerations between 0320 and 0350 hours was typical. The number of variable atypical decelerations, the reduced baseline (from 155 to 150bpm) and the lack of accelerations gave cause for concern. Baseline variability was less than 5bpm. The decelerations were not a mirror image of the contractions. Against this background, the trace at 0410 hours was pathological. The risk of hypoxia meant that the baby had to be delivered within 30 minutes. That Dr Sripada had attempted to take a FBS, which was only taken where there was a reasonable chance that pH was less than 7.2, suggested that she

must have thought the "situation" was pathological. There was an argument for proceeding to caesarean section even where the trace was suspicious in light of the background factors.

[20] Dr Cooper's ultimate position in her evidence was that the only reasonable option at 0410 hours was to proceed to caesarean section. However, during cross-examination, she accepted that: (i) it was indisputable that different obstetricians would interpret the same CTG trace differently at different times; (ii) there was no immediate risk to the life of mother or baby at 0410 hours; (iii) a reasonable and competent obstetrician might reach a different view from her as to the baseline variability between 0330 and 0400 hours; and (iv) contemporaneous reviews of Dr Sripada's actions (e.g. Dr Terry's letter), which were not critical thereof, could be viewed as reasonable.

[21] Professor Sanders acknowledged that if the Royal College of Obstetricians & Gynaecologists Guidance of 2001 was applied very strictly, the CTG became pathological by 0410 hours. However, it was uncommon for the guidance to be applied strictly and it would be "absurd" to so categorise an otherwise healthy situation where there had been two atypical decelerations.

[22] Professor Murphy opined that the trace was normal overall then towards the end, at most, suspicious. Early decelerations were noted at 0320 hours, which were not of concern given that the reading had normalised before the contraction had ended. Between 0330 and 0400 hours the trace was normal or at most suspicious. Baseline heartrate was normal. Variability was borderline at around 5bpm, but acceptable given that the pursuer had taken morphine. Most decelerations were early, and variable decelerations at around 0400 hours could be explained by the position in which the pursuer was lying. Professor Murphy associated herself with the approach taken by Dr Sripada at 0410 hours; she would have done exactly the same. Dr Sripada had not stated that a FBS was necessary. She only

considered whether it was feasible. Caesarean section was a reasonable option, but not the only reasonable option. Waiting 30 minutes to review was very low risk.

The cause of the injuries

[23] Dr Cooper agreed with Professor Murphy's reasoning as to how the umbilical cord occluded and stopped the blood supply, which was three-fold. First, the pursuer's cervix was naturally irregular and had responded unpredictably. Second, the abnormally precipitous progress once she was fully dilated, meaning the cord would have been around the neck and there would have been a dramatic descent with no time or warning to resolve the situation. Third, complete cord occlusion meant that LD could only survive for up to 10 minutes. This rapid progress in labour from 0435 hours was incredibly uncommon in a primigravida.

[24] Dr Sripada described the cause of the injuries as "unknown" and "unavoidable". Professor Murphy gave evidence that the events were unpredictable and not caused by any of the obstetricians' acts or omissions.

A summary of the Lord Ordinary's decision

[25] The Lord Ordinary provided a detailed account of the evidence, see paragraphs 15–143 of her opinion. There has been no criticism of it, so we turn to her findings on the matters in dispute at the proof.

The case against the induction ward midwives

[26] The Lord Ordinary preferred the expert midwifery evidence of Professor Sanders. The evidence did not support the contention that a second dose of Prostin on 22 August or the morning of the 23rd was mandatory absent strong contractions. The decisions not to

administer a second dose were within the professional judgement of the midwives. Carrying out a membrane sweep was a slightly unusual and cautious approach, but not beyond the parameters of normal practice.

[27] Regarding the alleged failure to address the suspicion of meconium and whether a transfer to the labour ward was indicated, there were several examinations where no meconium was noted and the forewaters were felt to be intact. The initial suspicion was never confirmed and there were contra-indications. Normal practice was followed. The overarching criticism was the time spent in the ward before transfer. However the Lord Ordinary accepted the evidence of Professors Sanders and Murphy that the progress of induction was relatively standard, albeit slow. There was never any significant concern as to the well-being of the foetus or the mother.

[28] As to whether a medical review should have been sought on 22 or 23 August, there were ward rounds three times a day. All four experts agreed that by 2008 induction of labour was very much a midwifery led process. There was ample opportunity for the midwives' management to be questioned if it was outside normal practice. At no time was it incumbent on a midwife to call for a medical review.

The alternative case against the ward round doctors

[29] It was contended that if it was sufficient to seek the advice of the doctors on their ward rounds, then that advice was negligent (i) in acquiescing in the failure to administer a second dose of Prostin during the Friday or on Saturday morning, and (ii) in approving a decision not to transfer to the labour ward notwithstanding the possible sightings of meconium.

[30] Counsel for the defender had pointed to the absence of a pleaded case of breach of duty by the unnamed doctors on the ward rounds. However it would be artificial not to take account of the evidence led without objection as to what a careful obstetrician would have done. It was clear that every patient was discussed on each ward round. To some extent the Lord Ordinary had relied on the absence of any medical direction when rejecting the claim of breach of duty on the part of the midwives. However there was an insufficient basis in the evidence to take the absence of any record of direction from the unnamed doctors to the stage of a positive finding that they were in breach of duty. Evidence that certain action would (on balance) have been taken in the exercise of ordinary skill and care did not preclude that there was another reasonable course.

[31] The pursuer's case was not presented as a challenge to the ward round medical decisions, but as a case of fault by the midwives. The evidence about what a doctor would advise had a midwife asked for a medical review seemed more directed to causation in that the pursuer had to prove what the outcome of a review would have been. The Lord Ordinary had relied on Professor Murphy's evidence that she would not have interfered with what she regarded as reasonable midwifery decisions.

The case against Dr Sripada

[32] The Lord Ordinary observed that previous allegations of fault having been withdrawn, the dispute narrowed to whether at 0410 hours on Sunday 24 August there was any reasonable alternative to delivery by caesarean section. The central issue was Dr Sripada's interpretation of the CTG trace at that time as suspicious rather than pathological. Following the approach in *Bolitho* v *City and Hackney Health Authority* [1998] AC 232 (Lord Browne-Wilkinson at 243), at paragraph 159 the Lord Ordinary concluded that

> "this is not a situation where I can determine that the opinion of either of the independent obstetricians is erroneous or even one in which I can prefer the view of one over the other on the critical issue. Both experts agreed that reasonable obstetricians could easily differ on the interpretation of such a trace and I consider there is force in Professor Murphy's view that such interpretation can be affected by knowledge of the adverse outcome."

[33] The competing expert evidence of Dr Cooper and Professor Murphy relating to the trace at 0410 hours indicated that two different but equally supportable interpretations were available. It was possible that another competent obstetrician might come to a contrary view, however Dr Sripada's interpretation of the trace was not inexplicable or unreasonable. No person involved in the pursuer's care while on the labour ward had become concerned that the trace was pathological.

[34] Both experts agreed that Dr Sripada would have to take all of the relevant information about the patient into account when deciding what to do. Dr Cooper expressed the view that the inability to perform a FBS at 0410 hours when the doctor wanted one was sufficient reason to appreciate that only a section would get the baby delivered safely. It was most unlikely that the pursuer would deliver the baby within a reasonable time otherwise as she was only 3cms dilated. However the Lord Ordinary accepted Professor Murphy's evidence, summarised at paragraph 161, that the decision-making process of Dr Sripada at the time was neither inexplicable nor unreasonable.

Causation

[35] The Lord Ordinary addressed causation on the hypothesis that she had found a breach of duty by the midwives. The pursuer contended that but for their failures LD would have been delivered before 0440 hours on the Sunday (when the cord occlusion problems commenced) thus would have been born uninjured.

[36] The defender contested this, but, under reference to *Meadows* v *Khan* [2021] 3 WLR 147, also argued that a scope of duty issue had been overlooked. The cause of the damage was the unforeseen and dramatic pace of labour after 0410 hours when the cord was wrapped around the baby's neck. Until then he was not injured. This could not be the responsibility of the antenatal midwives. If the six questions set out at paragraph 29 in *Meadows* were asked and answered, it was clear that there was no nexus between any fault of the midwives and the harm to LD. They were not involved in or responsible for his delivery.

[37] Counsel for the pursuer stated that the case had been run in reliance on an admission in answer 22 that had LD been born by 0450 hours, ie within ten minutes of cord occlusion, there would probably have been no brain damage. In any event it was known that such a prolonged pregnancy increased the risks for the foetus thus there was a sufficient link. It was novel to suggest that one could separate induction and the labour itself. The harm was caused by the various delays.

[38] The Lord Ordinary concluded that, having regard to how it happened, the injury to LD was too remote from the pursuer's time in the induction ward. There was no sufficient nexus between any failings of midwifery care and the adverse outcome. The real difficulty was that on the evidence the only consequence of breach of duty by the midwives was a delay in transfer to the labour ward. There was no evidence as to how or why an earlier transfer would have altered the outcome. No immediate or identifiable harm was caused to LD by any delay in transfer. There was no evidence of foetal distress prior to 0442 hours on the Sunday. The evidence of the risks of a prolonged pregnancy was very general in nature and was not directed at a case that delivery should have been achieved earlier than 0440

hours that day. No direct connection between midwifery failures and the injuries had been established.

[39] On the other hand the admission on record elided any scope of duty issue regarding the case against Dr Sripada. The defender had accepted that there is a very direct relationship between her alleged failure and the ultimate outcome in that had the decision to deliver been taken at 0410 hours it would probably have been achieved by caesarean section within 30 minutes. If the decision to wait was negligent then causation on a traditional "but for" basis flows in that otherwise the cord occlusion would not have occurred. However there was no intention on the part of the defender to admit that a delivery in the days before would have avoided a precipitous labour and consequential injury.

Ground of appeal 1 and the submissions of the parties on the case against Dr Sripada

[40] The first ground of appeal is that Professor Murphy's evidence, and the Lord Ordinary in relying upon it, proceeded on an erroneous understanding of Dr Sripada's evidence. She indicated that at 0410 hours vaginal delivery was not a realistic prospect. Reference is made to various passages in the evidence of Dr Cooper and Professor Murphy, and to the Lord Ordinary's opinion at paragraph 71 where it is said that she correctly summarised Dr Sripada's evidence.

[41] Dr Cooper's acceptance in cross-examination that there could be genuine differences of view as to the correct classification of the CTG trace was said to be no more than professional courtesy on her part. However, during the oral submissions of counsel for the pursuer to this court it became clear that it is no longer suggested that the interpretation of the trace is of key importance. It was contended that even if it is accepted that at 0410 hours it was no more than suspicious, nonetheless the Lord Ordinary should have decided that,

when regard is had to all the risk factors, there was no reasonable or rational basis for delaying a caesarean section. There was no likelihood of a vaginal delivery which was likely to be some ten hours away. The expectation is that a trace will worsen. The pursuer was a primigravida and 16 days over term. The labour was prolonged and the placenta was dropping off. Meconium had been seen. The anticipated course of events was that a caesarean section would be required. The risks would increase with the passage of time. There was no logic in waiting 30 minutes for a review. If worried about hypoxia, it should be an immediate section.

[42] It was submitted that the notes of Dr Terry and the other obstetricians in AMH were collateral. They had not been led in evidence and no weight should be given to their observations.

[43] Professor Murphy's methodology was flawed. She started with the unforeseeable cause of the injuries and worked backwards. Her opinion on breach of duty ought to have been based on the risks foreseeable at 0410 hours. Furthermore her opinion could not logically be supported. If delivery by caesarean section was inevitable, there was no reason to delay delivery further. The pursuer invited this court to adopt Dr Cooper's analysis.

[44] The defender's counsel began with some over-arching submissions. He observed that no exception had been taken to the Lord Ordinary's narrative of the evidence and there is now no challenge to the decision that negligence on the part of the midwives had not been established. With regard to the case against Dr Sripada, the central plank of Dr Cooper's reasoning was that the trace was pathological. It was the main difference between her and Professor Murphy and was a hard fought dispute at the proof, albeit in cross-examination Dr Cooper accepted that there could be genuine differences of opinion. It is now said that the risks rendered waiting illogical whatever the correct interpretation. However, as the

Lord Ordinary observed at paragraph 174, there was no specific evidence as to the probability of any of the risks occurring. Such evidence would be required if the argument now being presented was to have any potential merit.

[45] With specific regard to ground of appeal 1, it was no part of the pursuer's case at proof that a caesarean section was inevitable. It was never put to any witness, nor to the Lord Ordinary. In any event, absent a pathological trace, there was no evidence that it would be an emergency section, thus no proof that on this scenario the injuries would have been avoided.

[46] The concluding part of the sentence in paragraph 71 of the opinion relied on by the pursuer is not an accurate summary of Dr Sripada's evidence. The transcript is clear that she stated that at 0410 hours she was not expecting an imminent vaginal delivery.

[47] The consensus in the evidence was that the pursuer was making progress towards a normal delivery. Until the emergency, the possibility of a vaginal delivery had not been excluded. There was no evidence that the trace would worsen. In fact shortly after 0410 hours it had improved. The competing risks of the available courses of action, including those of a section, were balanced.

[48] There was no error in the methodology used by Professor Murphy. The Lord Ordinary was entitled to accept the evidence of Professor Sanders and Professor Murphy that an immediate section was not the only appropriate response to the situation at 0410 hours. The views of Dr Terry and colleagues were not collateral.

Analysis and decision on ground of appeal 1

[48] The shifting nature of the case against Dr Sripada causes difficulties. The main issue at the proof concerned her classification of the trace at 0410 hours as suspicious. It is clear

that Dr Cooper's thesis depended in large measure on her view that it should have been assessed as pathological which all agreed would have mandated an immediate caesarean section. She did suggest that given that a delivery would not be expected for about ten hours and that this was a primigravida at term plus 16 who was only 3cms dilated with thick meconium and no liquor, there was "an argument" for a section even if the trace was classified as suspicious but it maybe would not have been done with the same urgency. She was unsure as to what Dr Sripada thought would happen after 30 minutes (transcript pages 2069/70 and 2074).

[49] On the basis of this and similar evidence from Dr Cooper it is now contended that there was no rational or logical basis for delaying a caesarean section at 0410 hours. Even with a suspicious trace, by then Dr Sripada had wanted a FBS, which could not be done; there was a risk of hypoxic injury *in utero*; no realistic prospect of a vaginal delivery; and a section was inevitable. The Lord Ordinary had indicated that it would have been reasonable to decide on a section (paragraph 164), but why wait to see if the trace normalised? Counsel asked, why delay delivery? To do so was illogical and irrational.

[50] Reliance was placed on what is said at paragraph 71 of the Lord Ordinary's opinion. At this passage she is providing a summary of Dr Sripada's evidence as to her thoughts and actions at 0410 hours. It records that she "agreed that a primigravida who was only 3cms dilated would take some hours to deliver and so she was not really expecting the pursuer to undergo a vaginal delivery." On this basis the submission was that the judge should have held that if an obstetrician determined that labour was not going to progress, a caesarean section was the only available course of action.

[51] It was agreed that in this regard the relevant evidence from Dr Sripada is to be found at pages 1147/48 of the transcript. Counsel for the pursuer put to her that at 0410 hours

there was no realistic prospect of a delivery in the near future. The witness asked – what kind of delivery? Counsel said "Well, she wasn't imminently going to deliver", to which the response was "At that point, no." Counsel suggested that a vaginal delivery was a few hours away. Dr Sripada said "Yes. It wasn't as if I was expecting she would deliver vaginally very quickly, no. I didn't expect that." Shortly thereafter she indicated that circumstances can change with a trace returning to normal.

[52] It can be seen that the concluding part of the quoted sentence from paragraph 71 of the opinion does not accurately reflect the doctor's evidence. The most she said, and the most that was put to her, was that she was not expecting an imminent or quick delivery. It is clear from Dr Sripada's evidence as a whole that at 0410 hours she was not thinking that a caesarean section was the only realistic mode of delivery. For example, she explained that she was noting that the pursuer was contracting well. Having examined the pursuer she considered that the labour had progressed. The baby's head was now feeling well applied and was low. "So it is – labour is establishing, and I have written my plan." (transcript 1115/6). Later (1142) Dr Sripada said that there was no length to the cervix, labour was established and progressing in the right direction.

[53] It was not put to Dr Sripada (nor to the Lord Ordinary) that she should have proceeded to a section because she was not expecting a vaginal delivery. This scenario was not discussed in the evidence. Instead, as the Lord Ordinary observed, the central issue was the interpretation of the trace, and in particular whether it should have been classified as pathological thus triggering an immediate section.

[54] Essentially the pursuer is asking the court to start afresh and consider a wholly new argument in favour of a breach of duty. However it has no foundation in the evidence. The submission is that the Lord Ordinary failed to appreciate the importance of Dr Sripada

having excluded a vaginal delivery at 0410 hours; but the only arguable error was in the wording of part of her summary at paragraph 71. It is readily apparent that both the Lord Ordinary and Professor Murphy appreciated that at 0410 hours Dr Sripada had not excluded the possibility of a vaginal delivery.

[55] Looking at the matter more broadly, we have been unable to identify any sound basis for interfering with the Lord Ordinary's decision on this aspect of the case. We are being asked to accept Dr Cooper's evidence notwithstanding that there is no challenge to the decision that it was open to Dr Sripada to interpret the trace as suspicious. It is apparent that Dr Cooper's view on the trace was a key component of her opinion that an emergency section was the only reasonable option at 0410 hours, see for example her evidence at transcript pages 1874/77. Having been asked about how an ordinarily competent registrar would be thinking at 0410 hours, she mentioned the risks arising from a primigravida at term plus 16, with no liquor at amniotomy and fresh meconium having been seen. Dr Cooper then spoke of the need to review the CTG trace which she described as pathological. Her view was that "if you can't at this point, at 0410 when the CTG has been abnormal for really, or suspicious rather, for most of the time and pathological for the last hour, you can't do a foetal blood sample, you're obliged to deliver the baby at that point because of the risk that there may be hypoxia." The witness then confirmed her view that the trace was pathological according to various guidelines, including those used at AMH, and that a competent registrar would take that view if exercising ordinary care.

[56] If Dr Sripada could reasonably and genuinely take the view that the trace was not pathological, Dr Cooper's evidence provides a poor foundation for a case of negligence against her. This would be true even if it stood alone, but it has to be weighed against the

evidence of Professor Murphy who said that in the whole circumstances she would have done exactly the same as Dr Sripada.

[57] The importance of Dr Cooper's interpretation of the trace as pathological was confirmed when she addressed the hypothesis that the trace was no more than suspicious at 0410 hours (transcript 2069/70). Dr Cooper thought that "there would have been an *argument*, even if you thought the trace was suspicious, there would have been an *argument* for saying this is a primigravida at term plus 16 who's only 3 centimetres dilated with thick meconium and no liquor, there would have been an *argument* for proceeding to caesarean section anyway in anticipation of the fact that a normal progress for a primigravida would be, you know, we wouldn't expect her to deliver for about 10 hours." (our emphasis). She added that maybe it would not have been carried out with the same urgency in the absence of a pathological trace. Despite the submissions to the contrary, in our view an argument for a particular course of action, or that at 0410 hours some obstetricians would have decided on a caesarean section, is not sufficient to meet the *Hunter v Hanley* test for professional negligence (1955 SC 200 at 206).

[58] In any event the Lord Ordinary was fully entitled to accept Professor Murphy's evidence, for example as recorded at the transcript pages 2745/48. She explained that in her view the trace was not pathological. Furthermore at 0410 hours there was more than one acceptable course of action. One of them involved a section; another the course adopted by Dr Sripada. Things can progress quickly and traces can return to normal. Labour was "beginning to take off". "Let's watch this CTG closely" and reassess in 30 minutes. The CTG did normalise for a period. That is what she would be hoping to see on reassessment. If it had deteriorated and a FBS could still not be done, then she would go to a section. Events evolved in a very dramatic manner with rapid dilation from 3 – 10cms. However in

normal circumstances a review in 30 minutes involved very little risk to the baby. It was not correct that there was no realistic expectation that she would progress "because clearly she did and women do."

[59] A particular feature of this case is that no one could have foreseen the circumstances which caused the tragic injuries to LD, namely rapid cervical dilation causing the baby to descend quickly while the cord was wrapped around his neck. Professor Murphy is criticised for, it is said, using this as a starting point from which to exculpate Dr Sripada. We see no merit in that, nor any flaw in the Professor's methodology when expressing her opinion.

[60] In short, if the Lord Ordinary was entitled to hold that Dr Sripada's classification of the trace was open to her and that her decision-making was reasonable, and on the evidence clearly she was so entitled, there is no error in her decision on this part of the pursuer's case and no basis for the court to interfere with it.

Ground of appeal 2 and the parties' submissions thereon

[61] The second ground of appeal concerns the case against the doctors in the induction ward. It is contended that the Lord Ordinary's reasoning was internally inconsistent and could not be explained or justified on the evidence. In particular, on the one hand, the case against the midwives was rejected based, in part, on the absence of relevant medical instructions; on the other hand, the case against the doctors was dismissed because of insufficient evidence. The only reasonable conclusion from the evidence was that the doctors did not instruct the midwives to administer a second dose of Prostin nor arrange for earlier transfer of the pursuer to the labour ward. Dr Cooper's evidence highlighted what "the ordinarily competent obstetrician" would do. The treatment options advanced by her

were the only ones which were reasonable, and Professor Murphy's evidence could not logically be supported. The doctors' failures obstructed the achievement of reasonable progress towards induction of labour.

[62] In oral submissions for the pursuer it was suggested that the evidence of Dr Cooper as to what the obstetricians would have done if reviewing the midwives' management of the pursuer was not directed at a causation issue concerning the case against the midwives. It met the *Hunter v Hanley* test. There was no objection on the basis of a lack of pleadings, and there was no contradictory evidence from Professor Murphy. The standard of care to be expected of a doctor differed from that of the midwives on the induction ward. It was a higher standard of care. The midwives, two of whom were very junior, provided the factual basis for the case. The doctors failed to overrule the midwives' decision not to administer a second dose of Prostin on the Friday and the Saturday morning. Had they done so the pursuer would have been transferred to the labour ward sooner than midnight on the Saturday. It was a matter of admission that if delivered earlier LD would probably have been born uninjured (answer 22).

[63] Counsel for the defender observed that, in contrast to Dr Sripada's decisions in the labour ward, there was no pleaded case of negligence in respect of the obstetricians' acts or omissions in the induction ward. The averments in the pleadings concerning the ward round doctors addressed only the causation issue of what would probably have happened if a midwife had sought medical advice – the failure to do so being one of the criticisms of the midwives. Those pleadings were added during the proof. Had the defender appreciated that the intention was to launch a standalone case of fault against the unnamed doctors, a discharge would have been sought to investigate the matter. The Lord Ordinary should not

have entertained the invitation to find the unnamed doctors in breach of their duty of care towards the pursuer and the baby.

[64] Dr Cooper's evidence as to what a doctor would have advised if asked addressed only the causation question. There was no evidence that the *Hunter v Hanley* test was met, nor that in respect of the administration of Prostin or earlier transfer to the labour ward the standard of care differed as between midwives and doctors. It would be surprising if it did.

[65] In any event the evidence was that the decisions in issue were for the midwives. There was evidence from Professor Murphy as to the non-negligent management of the pursuer in the induction ward which the Lord Ordinary was entitled to accept. She said that there had been no undue delay in transfer to the labour ward.

Analysis and decision on ground 2

[66] The pleadings were amended during the proof after evidence had been led as to the induction ward rounds. Nonetheless thereafter the only pleaded case of fault regarding the pursuer's induction was aimed at the midwives, not the doctors. The consensus was that in 2008 induction was midwifery led. They were being blamed for prolonging the period in the induction ward by delaying a second dose of Prostin and not seeking a medical review on this and the suspicion of meconium. It was therefore necessary for the pursuer to attempt to prove that seeking such advice would probably have resulted in an earlier transfer. It is entirely understandable that the defender's counsel so understood the pursuer's pleadings and Dr Cooper's evidence on the matter. We were told that if it had been made clear that a new case of fault was being introduced the defender would have sought a discharge of the proof to allow the matter to be investigated, evidence marshalled and a response added to the written pleadings. It is an unusual, possibly unique feature of

this case that counsel for the defender first appreciated that the ward round doctors were being accused of negligence during submissions at the end of the proof.

[67] We have considerable sympathy with the submission that the Lord Ordinary should not have entertained the matter. It is remarkable to press a case of fault against doctors who have not been identified, who had no awareness that their care of the pursuer was being challenged in court, and who had no opportunity to refute the serious allegations made against them. There is no information as to what they were told, if anything, on the matters in issue, and what decisions, if any, they made. It is also remarkable to propose that the various ward round doctors should seemingly be held negligent as a homogenous group without any differentiation between them, as if they shared some sort of collective responsibility. The professional assessments that each of them must be taken to have made and the reasons for such judgements cannot simply be assumed to have been identical. At one point (transcript 1919/20) counsel for the pursuer pointed to the absence of any entry in the records of a medical decision on or a discussion about Prostin as indicating that neither occurred. Consistently with exploring the consequences of a failure on the part of the midwives to seek a medical review, the questioning was on the hypothesis of what advice Dr Cooper would have expected to be given to the midwives had it been sought.

[68] Another difficulty is that the Lord Ordinary has carefully explained how and why she determined that there was no fault on the part of the midwives in their management of the patient, a decision which is no longer challenged. In short summary, accepting the evidence of Professors Sanders and Murphy, a membrane sweep was a cautious approach, but nonetheless an available alternative to a second dose of Prostin on the Friday or Saturday morning. As to meconium, the suspicion was never confirmed and there were contra-indications. Throughout there was no significant concern as to the well-being of

mother or baby, and the progress of induction was standard, albeit slow. There was never a requirement to seek a medical review in what was a midwifery led process. That the Lord Ordinary noted that no doctor intervened is not inconsistent with her rejection of the case against them.

[69] Against that now unchallenged background, any case that the induction ward doctors ought to have intervened to demand a second dose of Prostin or ordered an earlier transfer faces considerable challenges. The notion that the midwives followed acceptable practice but the doctors did not is hard to comprehend. At a minimum it would have required evidence as to acceptable practice differing as between the midwives and the obstetricians. As it was counsel for the pursuer put to Professor Murphy that regarding the administration of Prostin there was no difference in the standard of care expected from the midwives and the doctors (transcript 2642). (Of course to suggest otherwise might have undermined the case against the midwives.) In any event, simply for Dr Cooper to say that she would expect a competent doctor, if asked, to advise, or as she sometimes put it, suggest or recommend a second dose of Prostin, is wholly insufficient for a case of breach of duty by the doctors on the ward. The question which would need to be asked and answered, and accompanied by a coherent explanation, is why a ward round doctor would, if exercising ordinary care, have intervened to say that the alternative of a membrane sweep was not an acceptable decision for a midwife to take. The evidence for the defender was that such was an unusual and cautious approach, but within available practice. For example reference can be made to the evidence of Professor Murphy at transcript pages 2624/39. The case now pressed against the doctors is difficult to reconcile with the midwives' standard of care being within the scope of reasonable care for the well-being of mother and baby.

[70] It is clear that Dr Cooper's evidence was influenced by her practice of not leaving patients in an induction ward for an extended period; "in limbo" as she put it. She stated (transcript 2110) that "they've not come in to sleep, they've come in to have labour induced. It, it, the induction was just not managed in a normal way." The Lord Ordinary noted that the over-arching criticism was the duration of the induction. However the weight of the evidence, including from Professors Sanders and Murphy, was that there was no imperative to move the pursuer until late on the Saturday, and nothing objectionable or abnormal in the period she spent in the induction ward. The Lord Ordinary was entitled to accept that evidence.

[71] Given the absence of a pleaded case of fault against the doctors, and the now unchallenged decision that the midwives were not negligent, we are not surprised to discover that the evidence fell below what would have been required and that the submission of breach of duty on their part was rejected because of insufficient evidence. On any view it failed to rebut the expert evidence that the pursuer's care in the induction ward fell within acceptable practice. And we see no force in the proposition that it was inconsistent or illogical for the judge when considering the case against the midwives to note that the doctors did not interfere and then also dismiss the case against them because of insufficient evidence that they ought to have done so.

[72] Our decisions on negligence are sufficient for the refusal of the reclaiming motion. However, just as the Lord Ordinary offered her views on other matters on the hypothesis that breach of duty was established, it is right that we do the same. Her discussion included observations on scope of duty, causation, and remoteness of harm.

The parties' submissions on grounds of appeal 3 and 4

[73] The third ground of appeal is that the Lord Ordinary gave insufficient reasons for finding that factual causation was not established. Dr Cooper opined that but for the delays, which had resulted from the ward round doctors' failings, delivery would have occurred earlier and without injury. It was submitted that this evidence was sufficient on causation. The defender admitted on record that delivery by 0450 hours on the Sunday would have avoided brain damage. The Lord Ordinary interpreted this admission restrictively and not according to its natural and normal meaning. It was never put to anyone that the outcome was inevitable. There was no relevant evidence on this from Professor Murphy.

[74] For the defender it was submitted that the Lord Ordinary properly understood the restricted nature and scope of the admission on record. It related to delivery by caesarean section and the case against Dr Sripada, not alleged negligence in the induction process. Answer 22 responded to the causation averments in condescendence 22. The experts agreed on the cause of LD's injuries. Professor Murphy's evidence was that the outcome would likely have been the same regardless of whether he had been delivered vaginally.

[75] The fourth and final ground of appeal asserts that the "scope of duty" question was not addressed in relation to the ward round doctors. It could not necessarily be argued, as it had been in relation to the midwives, that there was no continuing involvement in the pursuer's care post-transfer to the labour ward or that there was no responsibility for securing delivery. If the harm was too remote from the midwives, the same cannot be said regarding the doctors who decided when to transfer the pursuer to the labour ward. In any event *Meadows v Khan* did not apply because the risks of foetal hypoxic injury were known and it resulted from the delay in treatment (*Hughes* v *Lord Advocate* 1963 SC (HL) 31).

Alternatively, the various questions posed in *Meadows* v *Khan* were to be answered in the affirmative (paras 29 and 63).

[76] Counsel for the defender submitted that the guidance in *Meadows* v *Khan*, for example at paragraph 63, was correctly applied. It would not be fair to hold the induction ward doctors liable for the consequences of the sudden and unforeseeable consequences of the onset of precipitous labour after the pursuer left their care. They were responsible only for her safe transfer to the labour ward.

Analysis and decision in respect of grounds 3 and 4

[77] The Lord Ordinary observed, in our view correctly, that the defender's admission in answer 22 did not relate to a scenario where LD was delivered, whether vaginally or otherwise, after an earlier transfer to the labour ward. The averments in the corresponding article of condescendence are focussed on the emergency starting at 0442 hours on the Sunday morning and the ten minute window for a safe delivery.

[78] The admission did mean that for the Lord Ordinary causation was a live issue only in respect of whether any negligent delay in transfer to the labour ward caused or contributed to the adverse outcome. In other words, was it proved that it would have made a difference if the pursuer had left the induction ward earlier?

[79] A notable feature of the present case is the entirely unpredictable direct cause of the injury, namely an abnormally rapid dilation of the cervix which caused LD to descend quickly while the cord was wrapped around his neck. Shortly before 0440 hours it became occluded stopping the blood supply causing hypoxia and foetal bradycardia. From then on there was at most ten minutes to achieve delivery.

[80] We question the Lord Ordinary's analysis by reference to the scope of duty approach discussed in *Meadows* v *Khan* [2021] 3 WLR 147. That was a very different kind of case based on faulty advice from a doctor that the claimant was not a haemophilia carrier. Relying on that information she became pregnant and gave birth to a child who was not only a haemophiliac but also autistic. It was held that the only losses falling within the scope of the duty undertaken by the doctor were those relating to the haemophilia, not the consequences of the autism. The advice addressed only the risks associated with the former condition. Had the advice been correct an autistic child would still have been born. Lord Leggat observed that the matter before the court was concerned solely with the liability of professional persons for giving negligent advice (paragraph 96). The unsuccessful argument was that the principles laid down in *SAAMCO* [1997] AC 191 did not apply in the field of medical advice.

[81] The present case does not involve a professional person advising on a particular subject matter. It does not concern harm arising from unrelated risks. We do not have to inquire as to the purpose of advice sought and given. The midwives and the doctors in the induction ward owed a duty to take appropriate care for the health and well-being of the pursuer and her unborn child. If it could be shown that any failings in that regard caused or contributed to the harm to the child, there would be no room for avoiding responsibility by reference to questions of scope of duty. If it was shown that the baby would have been delivered uninjured if sent to the labour ward the previous day, and failure to do that was in breach of duty, liability would follow. In short the question of liability regarding any negligence on the induction ward can be explored by reference to traditional causation principles.

[82] The problem for the pursuer is that the key causation issues in this context were not addressed in her evidence. In particular, if the pursuer had been sent to the labour ward earlier would the delivery have been uneventful or would the unforeseeable rapid cervix dilation and related cord occlusion problems in all probability still have occurred? If the latter, was it probable that earlier delivery would have allowed the baby to withstand the stresses prior to eventual delivery thereby avoiding, or at least mitigating the damage? We note that the Lord Ordinary recorded the pursuer's midwifery expert as saying that, in hindsight, a second dose of Prostin would not have changed anything.

[83] At paragraph 174 the Lord Ordinary stated that the harm to the child was too remote from events in the induction ward. We would not refer to the concept of remoteness of damage in the present context. The judge was on stronger ground later in the same paragraph when saying that the real difficulty for the pursuer was that there was no evidence as to how and why an earlier transfer to the labour ward would have altered the outcome. She explained that had any of the alleged midwifery failures been established, nonetheless "the necessary direct connection" between them and the harm to the child had not been established. (By extension the same would apply to any failures of the induction ward doctors.) It was not enough simply to rely on an earlier delivery. Essentially the judge was ruling that no causal connection had been demonstrated. We have identified no good reason to interfere with that conclusion.

Disposal

[84] We shall refuse the reclaiming motion and adhere to the Lord Ordinary's interlocutor.

Appendix

Amniotomy/Artificial Rupture of Membranes ("ARM"): The rupture of the membranes ("breaking the waters") containing the amniotic fluid in the uterus either by instrument or by the insertion of midwife or doctor's finger.

Bishop Score: A group of measurements collated after performing a vaginal examination and scoring based on the station, dilation, effacement (length), position and consistency of the cervix.

Cardiotocography ("CTG"): A technique used to monitor foetal heartbeat and uterine contractions during pregnancy and labour using a cardiotocograph machine. Interpretation of CTG tracing involves both qualitative and quantitative description of a number of factors, sometimes summarised in the mnemonic DR C BRAVADO where DR is defined risk, C is contractions (uterine activity), BRA is baseline foetal heart rate ("FHR"), V is baseline FHR variability, A is presence of accelerations, D is decelerations and O is changes in FHR patterns over time.

Foetal Blood Sampling ("FBS"): A procedure to take a small amount of blood from the foetus during pregnancy or labour. In labour this involves using a speculum type device to remove a sample of blood from the baby's head.

Hypertonic Uterus: Where the uterus becomes overstimulated with abnormally frequent contractions. Tachysystole contractions of more than five in ten minutes in two consecutive intervals are indicative of uterine hypertonus, which may result in foetal heart rate abnormalities.

Liquor: The amniotic fluid surrounding the foetus within the membrane sac.

Meconium: A thick green or black tar like substance lining the foetal intestine/bowel; the result of the foetus (usually post term) having a bowel movement.

Membrane Sweep: A procedure, usually performed by a midwife inserting a gloved finger through the cervical canal and using a sweeping motion to separate the foetal membrane from the cervix. The aim of the procedure is to help accelerate the onset of labour by releasing prostaglandins.

Maternal/Obstetric Early Warning Score Chart ("MEWS Chart"): A chart on which midwives record a patient's blood pressure, temperature, pulse and related observation results to assess maternal wellbeing and look for patterns of concern.

pH: The measurement for detecting the level of acid or alkaline in the blood. A value of ≥ 7.25 is indicative of acidosis where the blood is low in oxygen.

Primigravida: A woman who is pregnant for the first time.

Synthetic Prostaglandin: A drug that induces labour by stimulating contractions of the muscles of the uterus. **Prostin** is a brand name of such an artificial prostaglandin.

Syntocinon: A synthetic oxytocin administered to encourage more regular contract.