Case No: D96YJ039

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
LEICESTER DISTRICT REGISTRY

Date: 06/01/2020

Before :

H H JUDGE HAMPTON

- -

Between :

EAXB	**Claimant**
- and -	
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	**Defendant**

Satinder Hunjan QC and Anna Diamond (instructed by **Affinity Law**) for the Claimant
Bradley Martin QC (instructed by **Browne Jacobson**) for the Defendant

Hearing dates: 4-8 November 2019 and 6 January 2020

Approved Judgment

H H Judge Hampton :

(Unless otherwise stated all page numbers refer to the trial bundles, e.g. 2/963 = bundle 2 page 963)

Introduction

1. In October 2013 the Claimant had a positive pregnancy test. Through her General Practitioner she booked an early pregnancy scan, as she had previously had an ectopic pregnancy. The scan was carried out on 1st October 2013. This confirmed a viable pregnancy. The report to that scan noted that a dating scan was recommended.

2. The Claimant had a further ultrasound scan when visiting Poland, on 2nd December 2013. The Obstetrician who performed the scan expressed concern about markers for genetic abnormalities which suggested an increased risk of Down's syndrome. She recommended that the Claimant sought a combined test (CT) on her return to the UK.

3. On 12th December 2013, the Claimant attended an appointment with Midwife Kerry Foot. She told the Midwife that she had undergone a scan in Poland and been advised to undergo testing because of an increased risk of Down's syndrome.

4. Unfortunately, the deadline for the period during which a CT can be carried out (11 weeks +2 days to 14weeks +1 day), was missed. The Claimant then underwent a dating scan on 14th January 2014 and a Quadruple Test (QT) on 21st January 2014 which produced a reassuring result. The Claimant underwent an anomaly scan on 28th January 2014.

5. On 2nd June 2014 the Claimant's son DXAB was born. Shortly after his birth he was found to be suffering from hypoplastic aorta and a ventricular septal defect (VSD). Subsequent testing confirmed Down's syndrome.

6. Neither the heart condition nor the Down's syndrome had been detected in the course of the pregnancy. It is the Claimant's case that had she and her husband been informed in time during the pregnancy that the fetus she was carrying was affected by Down's syndrome she would have elected to terminate the pregnancy.

7. The Claimant now brings this claim asserting that had her antenatal care been properly managed she would have elected to terminate the pregnancy. Accordingly, she brings this action against the Defendant in respect of damages for the pain and discomfort of continued pregnancy and birth and the distress and additional costs caused by caring for a disabled child. (A wrongful birth claim).

8. The trial which commenced on 4th November 2019 was listed to determine breach of duty and causation only.

The Claim

9. Proceedings were commenced on 19th June 2017. The Claimant's case concerns two aspects of her antenatal care. Firstly, management during the first trimester when the opportunity for her to undergo the CT was missed. Secondly, she complains of the conduct of the twenty week anomaly scan, which failed to identify potential heart defects which could be markers for genetic abnormalities, including Down's syndrome. In summary, the Claimant asserts that the Defendant was in breach of duty in failing to arrange a CT for Down's syndrome before fourteen weeks' gestation, notwithstanding the early pregnancy scan. She complains that there was no direct referral after that early scan to the Defendant's maternity services, and there was no failsafe mechanism. She asserts that Midwife Foot failed to arrange the CT as a matter of urgency after the Claimant's booking appointment on 12th December 2013 so that it could be carried out before the deadline.

10. It is the Claimant's case that the CT is a more reliable indicator of Down's syndrome and had the test been undertaken the syndrome would have been detected and the Claimant would have opted for termination.

11. Thereafter it is claimed that the sonographer who conducted the anomaly scan on 28th January 2014 negligently failed to identify "a large and obvious ventricular septal defect" and concluded that the heart was normal when it was not. Accordingly, there was a negligent failure to refer the Claimant to a fetal medicine or fetal cardiology expert. It is pleaded that had such a referral been made, the Claimant would have been offered amniocentesis which would have confirmed the diagnosis of Down's syndrome and the Claimant would have opted for termination.

12. The Defendant defends the claim in summary on the basis that it operated a reasonable system for offering screening tests such as the CT. That it was reasonable to require the Claimant to see a Midwife to give informed consent before a CT could proceed. It is asserted that the Claimant booked with the Defendant's maternity services too late for the CT to be undertaken. In any event, the Defendant pleads that the failsafe mechanism was a QT. The Defendant contends that in the light of all the images taken at the anomaly scan, it was reasonable for the Sonographer to have diagnosed normality.

13. Additionally, on causation, the Defendant put the Claimant to proof that she would have accepted the offer of the invasive test of amniocentesis and/or that she would have proceeded to termination.

14. After an application by the Defendant during case management, I gave permission for the Defendant to rely on the report of a Paediatric Cardiologist, with the Claimant having corresponding permission. Thereafter at a hearing on 2nd August 2019, I gave permission for amendment of the Particulars of Claim and the Defence. On the Defendant's amendment, the case was put on the basis that the heart defect that DXAB was born with was not that which is apparently to be seen in <u>one</u> of the images from the scan undertaken on 28th January 2014. If a defect had been suspected and referral to a specialist had proceeded, the actual defects diagnosed after birth would not have been detected and that amniocentesis would only have been offered after specialist scanning confirmed the heart defect, which on the balance of probabilities it would not.

15. The Defendant's Defence demonstrates a change in position from that adopted after the Claimant made formal complaints about the management of her antenatal care, firstly to a Midwife in January 2014 after she had missed the opportunity for a CT and thereafter after DXAB was born, by a letter dated 30th June 2014. (2/946).

16. In response to the first complaint, by a letter dated 17th March 2014 (2/963) it was accepted that "missing the window for a nuchal translucency scan ... is not acceptable". (An NT scan is part of the CT test). An apology was given. After the second complaint the apology for missing the opportunity for the CT was repeated. As to the anomaly scan, the Claimant and her husband were informed that the images had been reviewed by the Defendant's specialists, a Paediatric Cardiologist, a Consultant in Fetal Maternal Medicine and the Superintendent Sonographer as well as Dr Khare, a Consultant in Fetal Maternal Medicine and they had agreed that there was a definite VSD visible on an image. (2/837). This admission was relied upon in the Claimant's Particulars of Claim. Nevertheless, the Defendant has based its arguments at trial on the basis that, as the VSD reported, in July 2014, by the Defendant's own specialists to have been visible on the scan, is not that which was diagnosed after DXAB's birth, the Sonographer cannot be said to have been negligent in concluding that the heart was normal.

The Issues

17. The principal issues in the case are:

    (i) Whether the Defendant had appropriate systems to ensure that a CT could be carried out before the fourteen week plus one day cut-off for such tests.

    (ii) Whether through Midwife Foot, appropriate steps were taken to arrange a CT in time after the booking appointment on 12th December 2013.

    (iii) Whether the CT could have been undertaken within time in any event, that is by 17th December 2012.

    With reference to the twenty week anomaly scan:

(iv) Whether a VSD or other defect was actually present or should have been suspected or detected on the scan.

(v) If suspected or detected whether on referral to the appropriate specialist a diagnosis of the heart defect would or could have been made.

(vi) Whether the Claimant would have been offered amniocentesis if a defect had been suspected or detected at the twenty week scan in any event, whether or not further detailed scans did not confirm the defect.

(vii) Had the diagnosis been confirmed, whether the Claimant would have opted for termination either at the early or later stage of her pregnancy.

18. Other factual issues arise as to whether the Claimant showed the Polish scans to Midwife Foot at her booking appointment on 12th December 2013. It is the Claimant's case that not only were these discussed (which is accepted by the Defendant) but that she had copies of the scans with her, which the Midwife considered, but did not have the training to interpret. Nevertheless, the Midwife accepts that she recorded in the booklet that the nuchal fold was 2.8 millimetres and that the Claimant had been recommended to have a "DRT" (Down's risk test).

19. There is also a factual dispute as to what was reasonably detectable at the time of the anomaly scan on 28th January 2014.

20. The latter issue gives rise to consideration not only of the factual evidence but also the expert evidence before the court. Other less relevant issues arise, for example in the course of a telephone conversation 27th December 2012, when the Claimant was offered a test that day, but she was actually abroad. The relevance of this issue is not central to the case.

21. To help me determine the issues, I have heard evidence from the Claimant and her husband and also from Midwife Foot and the Sonographer Ms Nagar. I have also heard evidence from those involved with the administration of the screening tests and Ms Broughton, the Head of Midwifery for the Defendant. In addition, I have heard evidence from Dr Khare and Professor Bu'lock, who

were two of the Consultants who reviewed the images taken on 28th January 2014 prior to the Defendant's response to the complaint in August 2014.

22. I have also received expert evidence in sonography, midwifery, feto maternal medicine and paediatric cardiology.

23. I am satisfied that all the factual witnesses have done their best to give a truthful account of the matters relevant to the case. Inevitably they are attempting to recollect events which occurred well over five years ago.

24. The Claimant has argued that it is significant that two of the Defendant's own specialists who reviewed the images in 2014, namely Dr Siddiqui and Ms Fairs have not been called. The Defendant has argued that it is significant that that the Polish Obstetrician who carried out the scan in Poland has not been called.

25. I also note the absence of any factual evidence concerning those who actually considered the Claimant's "maternity booklet" after it was delivered to the Leicester Royal Infirmary (LRI) by Midwife Foot after she finished her clinic in the early evening of 12th December 2013 (which was a Thursday). The booklet was not date stamped by the hospital until 17th December 2013, the following Tuesday. Save for the fact that this was a busy department and the weekend intervened, I have been given no factual evidence as to the reason for the interval, e.g. pressure of work, lack of staff.

26. When reaching conclusions on the facts I apply the civil standard, namely the balance of probabilities. I take into account all the factual evidence which I have heard, but I do not propose to rehearse it at length.

The Legal Background

27. The law which applies to claims alleging clinical negligence is now well-established. It does not require lengthy discussion in a first instance decision. I am familiar with the judgments of the principal decisions referred to below.

28. The definition of the standard of care required of medical practitioners is set out in McNair J's direction to the jury in **Bolam v Friern Hospital Management Committee [1957] 1 WLR 582** at 586. This definition has been adopted and

further explained in Court of Appeal judgments such as **Maynard v West Midlands Regional Health Authority [1984] 1 WLR 634** at 638. More recent and well-known guidance has been provided by the House of Lords in **Bolitho v City and Hackney HA [1998] AC 232.**

29. The guidance provided by Lord Browne-Wilkinson in that case makes it clear that a Defendant doctor cannot escape liability for negligent treatment or diagnosis, because he leads evidence from a number of medical experts who are generally of the opinion that the Defendant's treatment or diagnosis accorded with sound medical practice. The court has to be satisfied that the exponents of the body of opinion relied upon, can demonstrate that those opinions have a logical basis. Lord Browne-Wilkinson also observed that 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. He referred to the well-known quotation from Lord Scarman's judgment in the **Maynard** case, advising that it would be wrong to allow the assessment of medical evidence 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. These remarks are equally applicable to other health professionals such as Midwives and Sonographers.

30. My attention has also been drawn to the Supreme Court decision in **Montgomery v Lanarkshire Health Board [2015] AC** at 1430. That case concerned disability resulting from the complications of delivery. In paragraph 44 of the judgment it was observed that if a patient suffers damage as a result of an undisclosed risk which would have been disclosed by a doctor exercising reasonable care to respect the patient's right to decide whether to incur the risk and the patient would avoid the injury if the risk had been disclosed, then the patient will in principle have a cause of action based on negligence. That judgment also observed that the doctor's advisory role involves dialogue, the

aim of which is to ensure the patient understands her condition and the anticipated benefits and risks of proposed treatment and any reasonable alternatives. In **Webster v Burton Hospitals NHST [2017] EWCA Civ 62**, the decision in **Montgomery** was considered by the Court of Appeal which advised that in general terms the doctor's obligation is to present material risks and uncertainties (in that case a different treatment) and to allow patients to make decisions that will affect their health and wellbeing on proper information. The significant risks and uncertainties, including the possibility of alternative treatment, being sensitive to the characteristics of the patient.

31. In the present case, it is accepted by the Defendant, that if the CT had been carried out within time, on the balance of probabilities Down's syndrome would have been diagnosed. In addition, it is not controversial that had amniocentesis been offered, it is for the mother to decide whether to take the risks involved in that test, which is intrusive and can cause miscarriage. In the present case a decision she would no doubt have taken on discussion with the father. It is in issue, as to whether the Claimant would have opted for termination.

32. The issues arising as to the Defendant's systems for referral for CT within the timeframe and what could or should have been detected or suspected on the scan undertaken on 28th January 2014 and the options that would or should have been offered to the Claimant thereafter, have been a subject of much of the evidence, factual and expert. Although, the question relating to the Defendant's systems and what can be seen on the scan are issues which mix both factual and expert evidence, it is useful to take into account the guidance given in the Appellate decisions referred to above when analysing the expert evidence.

Factual Evidence and Findings

33. It has been suggested on behalf of the Defendant that I should be cautious about accepting the Claimant's evidence on factual matters which are in dispute, in particular the discussions with Midwife Foot at the booking appointment on 12th December 2013. It is suggested that the Claimant's evidence is given with knowledge of the unhappy outcome of her pregnancy and is affected by hindsight and her inevitable distress, that notwithstanding the concerns raised

about Down's syndrome with the Midwife at that booking appointment, the syndrome and heart defects were not diagnosed before DXAB was born.

34. I take these matters into account when considering the Claimant's evidence. Having heard evidence from both the Claimant and her husband, I conclude that they are both well-educated and intelligent people. They are graduates following their profession as Surveyors. The Claimant has not yet completed her training as a Chartered Surveyor. She had intended to do so, and was supported in this by her husband. The Claimant's anger and personal criticism of the management of her pregnancy by the Defendant's staff was clear as she gave her evidence. Despite this, she gave her evidence with great dignity and commendable forbearance. Her unhappiness with the care afforded by the Defendant's staff is entirely understandable.

35. In the course of evidence and argument, the Defendant based its case, in part, on the fact that the Claimant presented as the Defendant would put it late in pregnancy for her booking appointment with the Midwife. From the Claimant's point of view this is difficult to understand. She consulted her General Practitioner very early in the course of the pregnancy, on 11th October 2013 seeking a viability scan. This was carried out on 1st November 2013. She telephoned her GP's surgery the following week, her evidence, which I accept, was that she was told she had to attend the surgery to fill in appropriate forms, but she was unable to attend in person because her daughter was unwell and her husband was away from home. She was able to attend on 13th November 2013, when she was about 8 weeks pregnant. She was persuaded not to put the date of a forthcoming absence in Poland on the booking form, so that when she was finally given a booking appointment, it fell within that period (3rd December 2012). A date was not rearranged until nine days later, namely 12th December 2013, nearly one month after she had been to the surgery. By that time, two months after her first scan, the opportunity to undergo the CT was rapidly coming to an end. Accordingly, I understand the Claimant's frustration, which I find to be justified. Nevertheless, I found her to be a reliable and truthful witness.

36. I also heard from the Claimant's husband. His anger was more palpable. He did not deal with the matters which arose from the first appointment which he had not attended, however he was a joint signatory to the letter of complaint that was made on 30th June 2014 after DXAB was born. He clearly was very supportive of his wife. He too gave his evidence with dignity. Insofar as his evidence is relevant, in particular to matters relating to causation, I find that it is reliable and truthful.

37. Where issues of fact arise I find the Claimant's evidence and that of her husband, both reliable and convincing.

38. As to whether Midwife Foot was shown the Polish scans on booking, I take into account her evidence that had these been given to her to look at by the Claimant, she would have taken copies. None appear in the notes. It is common ground and the Midwife's record does record that the Claimant raised the question of a Down's risk test and would prefer to have the CT test. It was clear that the Midwife accepted that the Claimant wished the CT test to be expedited. I accept that she took particular care to deliver the Claimant's notes to the LRI in the evening after her clinic closed. However, for reasons further discussed below, I find it was poor practice to notify the urgency of an appointment for a scan by simply putting a Post-it on the Claimant's notes, before placing it in the appropriate pigeon hole, the relevant department at the LRI being closed when she dropped the notes off.

39. It is of relevance that in the letter dated 30th June 2014 after DXAB's birth, notwithstanding that the Claimant says at the time the letter was written she was very emotional about what had occurred, she refers in that letter to having "passed all the documents, scans, recommendations and concerns given from the Polish doctor ... we translated the content of these documents to her". (2/946). The letter written on behalf of the Defendant in response on 21st August 2014 does not dispute this (942).

40. Accordingly, I find on the balance of probabilities that the Claimant not only discussed the Polish scan with Midwife Foot, she also showed the relevant documents, which the Midwife did not copy. Poor practice in failing to do so, is

consistent with the Midwife's poor practice in placing something as insecure as a Post-it note on top of the Claimant's notes, when she delivered them to the LRI. One hardly needs expert evidence to establish that the use of such convenient items to convey important and urgent messages is hardly ideal. They are in wide use in the legal profession and elsewhere. A feature of such items is that they can be easily removed, without leaving a trace on the paper to which they have initially been attached. That is part of their utility. It is also a reason why if one wishes to emphasise the urgency of a document or a note, it is not a good practice to use them. This was confirmed, if confirmation was necessary by the Claimant's expert Midwife evidence given by Ms Walmsley. In addition, given the Claimant's concerns, caused by the results of the Polish scan, carried out by an appropriately qualified doctor, it was poor practice not to follow up the request for an urgent scan with a telephone call. Although I accept that the Midwife is not to be criticised for her inability to interpret the scans, one does not have to be an expert linguist to see that the description of the Polish doctor on the Polish documents, was that of an Obstetrician and Gynaecologist who was qualified to raise the concerns the Claimant discussed with the Midwife.

41. As to the telephone conversation between the Claimant and Ms Taylor on 27th December 2012, not a great deal turns on what was actually discussed. Insofar as it does, I found Ms Taylor to be a rather rigid witness, unnecessarily critical of the Claimant. Insofar as it may be necessary to determine the same, I prefer the evidence of the Claimant, that she expected a further appointment to be provided, when she was not available for the one on offer on 27th December 2012. Ms Taylor's suggestion that the Claimant said she did not know when she would be back is contradicted by the fact that the notes in the maternity booklet specifically refer to her absence between 27th and 31st December (3/221). It is also contradicted by the account of the Claimant's complaint to Midwife Ford recorded by that Midwife on 21st January 2014, less than one month after the telephone call.

42. As to what the Claimant and her husband told the Sonographer at the anomaly scan on 28th January, Ms Nagar has no recollection. The scan was carried out

well over 5 years ago and it was no doubt one of many that Ms Nagar has undertaken. There is no evidence that she was asked to comment on the Claimant's complaint, or the views of the Defendant's specialists at the time the complaint was being investigated in the summer of 2014. Accordingly, I accept the evidence of the Claimant and her husband that they told the Sonographer about the Polish scans and their concerns to establish whether or not their baby had a risk of Down's syndrome.

The Scan on 28th January 2014

43. There is a factual issue as to what could or should have been seen at this scan. The evidence as to this is in mixed fact and expert evidence.

44. Ms Nagar gave evidence as to her usual practice, which I accept. She understandably has no independent recollection of the Claimant or this scanning appointment. Inevitably therefore, her evidence is a reconstruction of the events based on her usual practice. She retained 39 still images from the scan itself. The process of the scan is, a dynamic examination during which the fetus will move. I note that the Claimant is slender and has a relatively low BMI. Accordingly, this will make it easier for the Sonographer to see the fetus. Ms Nagar has commented, based on the comment she made on the scan, that the Claimant's baby was moving during the examination.

45. Whilst I find it was reasonable for the Sonographer not to rely on anything seen on the Polish scan but to undertake her own independent examination, I find that the Claimant did raise the concerns arising from the Polish scan and this made it all the more important to consider whether any potential heart defect or other anomaly which might be seen or suspected. Ms Nagar, using a drop-down box available on the computer programme, selected the option "No obvious fetal defect".

46. At least one of Ms Nagar's still images was reviewed by Professor Bu'lock on 9th June 2014, when DXAB would have been 7 days old, and before any formal complaint had been made by the Claimant and her husband. In an email dated 9th June 2014 (2/919), Professor Bu'lock commented "VSD pretty clear here to me". She attached an image from the anomaly scan which she was referring to.

47. In her evidence to the court, Professor Bu'lock became distressed by her belief that she had made a textbook mistake when reporting her conclusions in that email, so that erroneous information was given to the Claimant and her husband. She said that conclusion had been drawn on the evidence of only one image and she should not have reached such a conclusion on that basis. However, it can be seen that on a subsequent occasion she apparently reached the same conclusion having viewed the other images. In an email from Dr Khare dated 7th July 2014, written as part of the internal enquiry after the Claimant's written complaint had been received by the Defendant (2/874), Dr Khare observed that the images (in the plural) were reviewed by Professor Bu'lock with Dr Siddiqui and Tina Fairs. She commented "we all agree that there is a definite VSD".

48. Accordingly, I find that Professor Bu'lock together with the other Defendant's specialists named in Dr Khare's email, reviewed all the images on suitable diagnostic equipment. Only Professor Bu'lock and Dr Khare gave evidence at trial about this review. They both agree that the opinion expressed in the email was incorrect, as the heart defect diagnosed after DXAB was born, was not in the same position as the appearance they considered to be a VSD on the image and therefore, they must have been wrong. Nevertheless, both confirmed in their evidence that it was reasonable for the court to conclude that as they gave this opinion in early June or July 2014, had they been asked to consider the scans on referral by the Sonographer in January 2014, they were likely to have concluded that a VSD was present.

49. Their evidence was that this would have been a reason to advise further, more detailed imaging should be undertaken, which both Dr Khare and Professor Bu'lock had the expertise to undertake. Dr Khare told me that she knew that this was a serious matter and she therefore took care when reviewing the images in June/July 2014. She went on to say that over the intervening five years things have changed as to how she looks at and interprets such images. She knows now that there can be what was described in the evidence as "drop out". Professor Bu'lock confirmed that if a baby is born with an unexpected heart abnormality, it is routine to look at the prenatal scan images to see if anything

can be learned from them. The evidence of both these specialists, was that if the Sonographer had referred the images to either of them, an appointment with a fetal medical specialist would have been available within two or three days. Professor Bu'lock told me that a review by a fetal cardiologist would be available either the same or the following day. Both confirmed in their evidence, that if a mother requested amniocentesis, this would be offered after suitable counselling, irrespective of whether she was awaiting a specialist review or further scan. Clearly there would have to be appropriate counselling as to the small risk of miscarriage from amniocentesis.

50. The expert evidence as to what can actually be seen on the relevant images, or alternatively watch should have been suspected, has been the subject of much debate in the course of the trial. All the experts who have considered this issue had the appropriate expertise. I have been provided with their CVs. In addition to independent expert Sonographers, the Claimant's experts Professor Anumba, a fetal maternal medicine expert and Professor Burch, a paediatric cardiologist have experience of carrying out scans and reporting upon them, as has Prof Simpson the Defendants expert paediatric cardiologist.

51. The Defendant's expert Sonographer Ms Butcher concluded in her initial report that the optimum fetal position to assess the atrial and ventricular septum is with the septum at 90% (I assume she means degrees) to the ultrasound beam. She says "no images are available to review at this angle" (1/342). She also went on to offer the opinion that she could not confirm based on the one image that a VSD was diagnosable at the time. She had also observed at paragraph 55 of her first report that the images were extremely difficult to assess retrospectively as static images.

52. However, in a supplementary report dated 30th September 2019, after the joint meeting with Dr Chudleigh, the Claimant's sonography expert, and after the disclosure of cardiology evidence, Ms Butcher observed that "the image at 11:35:41 shows no sign of a VSD and is in the optimal position. Similarly image 11:41:24 is a good view". These images had not been referred to specifically in her first report, nor did Ms Butcher offer such an opinion at the expert meeting. The comments appeared to contradict her original conclusions

about the quality of the images. I am of the view, that with hindsight, having been asked to consider the matter again in the light of the cardiology evidence, Ms Butcher has completely altered her first expressed view that there were no images available in the optimum position and that they are extremely difficult to assess retrospectively. This complete change of view undermines the credibility and reliability of her evidence.

53. I found Dr Chudleigh's evidence in its written form more measured and more detailed. She offered the opinion that imaging the heart with the IVS lying in the horizontal plane is important in confirming or excluding the integrity of the IVS (1/216/3.8). In paragraph 4.4.6 (1/220) she offers her views as to the four most relevant images. She considers that the relevant image, which the Defendants now argue showed an artefact or "drop out" was suspicious of a VSD. Her opinion was that the Sonographer should recognise the abnormal appearance of the IVS and seek further four chamber views with the IVS in a horizontal position in order to determine whether a VSD was present or the appearance was artefactual due to drop out. In her conclusions she observed that the Sonographer should have questioned the views obtained of the IVS and sought further views to better assess whether or not the IVS was normal. In cross-examination she reinforced this opinion and I accept her evidence that where an apparent anomaly is or could be seen, it is necessary for the Sonographer to continue to assess in order to exclude abnormality, but that the other images taken by the sonographer were not of sufficient quality to do so.

54. I note that at their meeting, the Sonographers agreed that image 11:36:16 did not confirm normality and further assessment would be required (1/657). At question 12 on page 659 they agreed that if further views were taken to confirm did not totally exclude the VSD, it would have been appropriate to refer the Claimant to a specialist. The view now expressed by Ms Butcher about image 11:21:24, appears to me to be completely at odds with the opinion of this image expressed in the course of the experts' meeting, that the image did not confirm normality (page 662).

55. Professor Anumba has also considered the scans. He has experience in undertaking scans himself and in reviewing scans. He discussed the relevant

scans with Professor Soothill in the course of their experts' meeting. Professor Anumba concluded that the relevant image was acceptable for the purpose of diagnosing or excluding VSD. He concluded that the appearance on the image was most likely to result from a defect. Professor Soothill was not prepared to go that far. He concluded that whether the Sonographer acted reasonably during a routine low risk screening scan in interpreting the appearances as drop out was not a matter for fetal medicine experts. (1/688).

56. Professor Simpson and Professor Burch both considered the scans. As expert fetal cardiologists, they have experience in conducting and interpreting scans. Although they agreed that the defect apparently seen on the images did not correspond with the VSD diagnosed after birth, they both accepted that a VSD can close spontaneously (1/714).

57. Accordingly, I find on the evidence that although the images obtained on 28th January 2014 did not identify the cardiac abnormality which was actually present at birth, this is not the relevant issue. That relevant issue is, whether what can be seen on the scan was sufficient evidence of a suspected abnormality to lead to a referral for specialist opinion. Clearly it was the view of the Defendant's own specialists after the birth, that the scan images showed an abnormality, notwithstanding the location of the heart defect, which was by that time known.

58. Accordingly, I conclude on the balance of probabilities that the scan provided sufficient evidence to cause the Sonographer to conclude that a VSD was or might be present. She did not have sufficient evidence to exclude such a defect. I find she should have referred the Claimant for a further specialist opinion. The Claimant and her husband raised their concerns at the time of the scan and accordingly, the fact that the images did not exclude a VSD, made it all the more important to refer for a specialist opinion.

The Result if the Claimant had been Referred

59. Both Dr Khare and Professor Bu'lock confirmed that if the Claimant had been referred, amniocentesis would have been offered, if requested in addition to further detailed scans. There was a debate in the expert evidence as to whether

the actual defect diagnosed postnatally could have been seen on more detailed scanning. Nevertheless, both Dr Khare and Professor Bu'lock confirmed, that if there was maternal concern and a request for amniocentesis, it would have been offered after appropriate counselling, whatever might have been found on further specialist scanning.

60. It is not disputed that an amniocentesis test would have led to a diagnosis of Down's syndrome.

If the Diagnosis had been Made

61. The Defendant has put the Claimant to proof that her assertion that she would have requested the intrusive amniocentesis test with its accompanying risk of miscarriage, even if specialist referral had been more reassuring. Having heard from the Claimant and her husband, I conclude that they are well informed and supportive of each other, that they had undertaken some further reading about Downs after the Polish Obstetrician's initial concerns and they had some experience of other parents with Down's children, after an amniocentesis, they would have opted for the test and termination. They already had a healthy child. The Claimant wished to pursue her career and qualify as a Chartered Surveyor, an ambition which her husband supported. The Claimant's husband had employment which took him away from home on a regular basis. The Claimant's evidence was clear. I conclude that she is a woman who knows her own mind. She had a supportive husband. I find on the facts on the balance of probabilities that the Claimant would have opted for amniocentesis and thereafter termination.

Breach of Duty

Referral for the CT

62. The Claimant's allegations as to breach of duty refer to the failure to organise a CT between eleven weeks and two days and fourteen weeks and one day in her pregnancy. This involves consideration of the Defendant's systems for referral and testing. Consideration of systems failures on the part of public organisations such as the Health Service are matters that Judges should always

approach with care. A Judge is not an administrator. Whilst, with hindsight, it is tempting to conclude that the system could have been much better, or operated more effectively, a court should look for convincing evidence supported by independent opinion, that a system was inadequate and/or has been operated inadequately before reaching a conclusion that there has been a breach of duty. The exercise when dealing with large, complex organisations such as a Hospital Trust is not as straightforward as, for example, assessing systems of work in employers' liability cases where considerable guidance is given in Statutory Regulations and HSE guidance notes.

63. In this case criticisms have made with regard to whether the Defendant should have been aware at an early stage of the Claimant's pregnancy, which should have triggered a direct referral for dating scan and the CT procedure on the part of the Defendant's Midwives. In addition, Midwife Foot is criticised for failing to successfully arrange an urgent CT, before the Claimant's departure to Poland.

64. On this issue, there was competing evidence as to the Claimant's Expected Date of Delivery (EDD). This was the subject of some debate. By the time the Claimant's notes were processed, on one view of the EDD, the window of opportunity for the CT had ended. In fact, as no test was offered until 27th December 2013, by which time on any view the window of opportunity for the CT procedure had closed, determination of this issue is not material to my decision.

65. I find the Defendant's explanation as to the inability to arrange an urgent test unpersuasive. It is suggested the Claimant presented late, as her booking appointment did not take place until 12th December 2013. There was, I considered, a discernible attitude about the Claimant within the Defendant's witnesses. The inference was that a pregnant mother who presents late for a booking appointment, cannot expect her desire for a CT to be treated with urgency. She should not expect to have her wish for a CT, to take priority over the needs and wishes of other expectant mothers who have presented for a booking appointment at an early stage. This attitude does not reflect the true picture. I accept that if the first presentation for booking is within days of the window of opportunity for CT closing, it may be a counsel of perfection to

allow a late presenting mother to have the testing carried out as priority over mothers who present at an earlier stage.

66. However, I find that the Claimant should not have simply been treated as a late presenting pregnancy. She had taken the trouble to request a viability scan, which had been reported as early as 1st November 2013. She had a genuine and unavoidable difficulty in attending her GPs surgery to fill in the relevant request for maternity services from the Defendant, namely her daughter's illness. She had been offered a booking appointment, at a time when she had informed her doctor's receptionist she would not be available so that it had to be cancelled and with the clock ticking against her, there was a nine day wait for an alternative appointment.

67. Whilst I accept that there may be good reasons for not having a system of automatic referral from the Early Pregnancy Advisory Unit, which is a gynaecological service to maternity services. Someone may not wish to continue with the pregnancy. They may wish to have their pregnancy manage privately, or by another trust. However, I was given no adequate explanation, nor was any policy document referred to by the Defendant to explain why a mother could not be given the opportunity to request such a direct referral, if she wished to have her pregnancy managed by the Defendant's maternity services. This Claimant's earlier pregnancy had been managed by the Defendant.

68. In any event, the Claimant did not delay in contacting her GP's surgery, after a viable pregnancy had been confirmed. Her inability to attend as the receptionist insisted she should was not down to any unwillingness on her part. Her daughter was unwell and I accept her evidence on this point. Similarly, I accept the Claimant's evidence as to the reason she was unable to attend the appointment offered on 3rd December, so that the first appointment which took place with the Defendant's maternity service was on 12th December 2013. There is clear evidence that Midwife Foot was aware of the urgency of the Claimant's situation and the Claimant's concerns, she has noted part of the discussion about the Polish scans. She has demonstrated her awareness by taking the Claimant's notes to the LRI herself after her clinic on 12th December 2013 rather than relying on the internal post. However, she did not follow this

up, either by requesting, over the telephone, that the Claimant's notes be processed urgently and/or that an urgent CT appointment was offered.

69. Her explanation given in paragraph 13 of her witness statement and repeated in her oral evidence as to why she could not telephone for an appointment did not appear to be based on any written protocol, but only at the past experience of which Midwife Foot gave no details of. Having heard her give evidence I find that Midwife Foot struggled to give a reasonable explanation for her perceived inability and therefore failure, to take the simple step of following up her commendably prompt delivery of the Claimant's notes with a simple telephone call.

70. The explanation given by the other witnesses involved in managing maternity services as to why an urgent scan could not be arranged by telephone did not reflect the true position. This was not simply a late presenting mother, who could not be allowed to request her desire for a CT to be given priority over those who efficiently booked earlier in their pregnancies. There had been a catalogue of events for which the Claimant is not to be criticised, which led to the late booking appointment. Moreover, there was a properly founded maternal anxiety about the risk of Down's syndrome. One of the reasons, it is suggested, that a scan could not be arranged over the telephone was that the Claimant had no maternity number. Again, I have not found any logical explanation for this being good reason not to seek to arrange an urgent appointment. The Claimant's records for this pregnancy, had the same maternity number as that used in her earlier pregnancy. Midwife Foot was clearly aware that the Claimant already had a healthy daughter, she is referred to in the maternity booklet. Midwife Foot also said that there was a need for the core Midwives to triage the Claimant's notes to determine whether there was a need for an urgent scan. However, Midwife Foot had already determined, on good grounds, that there was urgency in the Claimant's case. Midwife Foot was a qualified and experienced Midwife, with the knowledge and experience to determine this for herself. Again, I was given no logical explanation as to why the Hospital Midwives should have to approve the apparent urgency.

71. It is also worthy of comment, that when the Claimant's dating scan did not take place as expected, Midwife Foot was able to arrange this, by telephone, as a matter of urgency. I did not find the explanation given for this to be impressive.

72. Other witnesses gave evidence as to the Defendant's systems for booking scans and managing pregnancy. That evidence, given principally by Ms Ulyett and Ms Vickers, confirmed that urgent scans could be arranged by telephone in the cases of what they described as "clinical need". The concept first arose in the course of oral evidence. It was not a phrase used in the written factual evidence or in the course of the experts' meetings. The factual evidence was that examples of clinical need were maternal bleeding, a reduction in fetal movements, a low lying placenta, slow growth or a known problem with the baby. It was suggested by one of the Defendant's witnesses, that urgent slots could not be used to undertake the NT scans required by the CT, because the second part of the CT, namely a blood test, had to be carried out at the latest by 2.40 p.m. in order to get the results. Urgent scanning slots were usually available at 4.30 and 4.50 pm. I find this logic inexplicable. Just because one cannot get blood test results back from a laboratory on the same day as a scan which is required urgently, does not seem to me to prevent the scan itself being carried out and the witness was not at all convincing on this point.

73. Ms Ulyett emphasised the need for all pregnant mothers to be treated fairly. I was provided with the Defendant's figures for the relevant period, which established that 66 mothers booked after twelve weeks. They could not all be given urgent scans within the timeframe required. However, this emphasis on the Defendant's systems and treating those who present late for booking in a way that prevented them from taking priority over other mothers who presented in good time, ignores the reality of this case. Objectively the Claimant had not presented late due to any lack of efficiency on her part. Moreover, she had a properly investigated risk of Down's syndrome which she raised with Midwife Foot. I can find no logical explanation as to why the lateness of the booking appointment and the Claimant's realistic and reasonable concerns about a potential risk of Downs syndrome, supported by evidence, namely the Polish scan, did not amount to a clinical need. I take into account that at the time of

year, there were a limited number of appointments available. Scans per practitioner, have to be limited, because of the risk of repetitive strain injury. I have not been provided with any evidence that it would not have been possible to arrange an urgent scan at all due to the lack of available appointments or sonography practitioners.

74. The experts in fetal medicine, Professor Anumba and Professor Soothill discussed the Defendant's systems at their meeting. Professor Anumba, as can be seen from his CV, clearly has the expertise to comment on such matters. He refers to the role of screening at question 3 at the joint meeting (1/676). He emphasised the screening programme is intended to ensure that antenatal services ensure screening is offered to all pregnant women in a timely fashion, ensuring adequate failsafe processes are in place. He considered in the Claimant's case that a reasonable failsafe was to ring through an expedited request to the ultrasound department. Professor Soothill did not agree, commenting that the Quadruple Test was the failsafe and was one of the approved national policy options. There was further discussion of this issue at question 7 on page 678. Professor Anumba repeated his criticisms, but Professor Soothill considered that this was a matter for antenatal care or routine obstetric ultrasound policy and not a matter within fetal medicine. He repeated this opinion in answers to questions 8 and 9.

75. I accept that Professor Anumba is entitled to comment on these matters. I find his criticisms of the Defendant's practice, and the failure to provide for telephoned arrangement of scans for the CT to be persuasive.

76. I have already commented above on the use of a Post-it note. There is no evidence about what became of it. There is no evidence from the Midwives at the LRI as to why the Claimant's notes do not appear to have been processed until 17th December.

77. Having considered the evidence of Professor Anumba, and the fact that Professor Soothill was not prepared to comment on the screening process, I accept the opinion of Professor Anumba. I have also considered the evidence of the expert Midwives. Ms Walmsley considered that she could not give an

opinion on the organisational management of antenatal services, however she did consider that the Defendant's system did not appear flexible and appeared to show potential gaps for women who only receive a booking consultation at eleven to thirteen weeks of pregnancy. Ms Francois simply commented that the Trust's systems were like any other that she had worked for.

78. Having considered all of the evidence on this important issue I consider that the apparent inability of Midwife Foot to follow up her request for an urgent appointment with a telephone call lacks any logical basis. The lack of a maternity number, does not appear in my judgment to be a good reason for failing to take action on the apparent urgency in the Claimant's case. In any event, the number given on the notes indicates that the Claimant in fact retained the maternal number given on her earlier pregnancy.

79. I find that Ms Francois' reliance on the QT as a failsafe system in cases where the late presentation precludes a CT, does not deal with the particular circumstances of the Claimant's case. The manner in which she dismissed the matters raised by the Polish scan and the Claimant's concerns resulting from it, were inappropriate and ill informed. She appeared to accept this, when I questioned her in her oral evidence. This attitude undermines the reliability of her other evidence.

80. Accordingly, I conclude that the use by Midwife Foot of a Post-it note to emphasise the urgency of the Claimant's need for the CT was a breach of duty. I also find that the failure to follow up the delivery of the notes with the simple measure of a telephone call was a breach of duty. I accept that it is not reasonable for all ladies who present late to be given priority over all others. However, the circumstances where the booking date was late through no fault of the Claimant and the Claimant had already been given advice by an apparent expert that there was a risk of Down's about which she was concerned, and she raised these concerns with the Midwife, put the case in a different category from the general situation where a mother presents to maternity services late.

81. Whilst I recognise the pressure on resources in all public services, the lack of flexibility in the Defendant's screening programme in the circumstances which related to this Claimant, I find amounts to a breach of duty.

82. In reaching this conclusion I note that the content of the letter written on 31st March 2014, in response to the Claimant's first complaint about the management of her pregnancy, before DXAB was born, accepted that the delay in arranging a scan was not acceptable. It made no reference to the reasons given for not being able to arrange such a scan by telephone. Accordingly, I find that if the Defendant had not been in breach of duty, a CT test would have been undertaken on Friday 13th December 2013 or Monday 16th December 2013.

The scan on 28th January 2014

83. I have already commented on my conclusions as to the anomaly scan carried out on 28th January 2014. My findings on the facts are referred to above.

84. It follows that I find that there was a breach of duty in concluding that there was no obvious fetal defect. I accept Dr Chudleigh's opinion, that the images retained by the Sonographer failed to properly exclude a defect despite an image which the Defendant's own specialists concluded in 2014, showed a VSD.

85. I have considered carefully the Defendant's argument that the Sonographer cannot logically or legally have been negligent for failing to suspect the presence of a defect which did not exist. The Defendant refers to the decision of the Court of Appeal in **Penney v East Kent Health Authority [2000] EWCA Civ 3005**. In paragraph 28 of the judgment it was observed that the judge had to make his own finding on the balance of probabilities as to what was actually on the cervical screening slides before proceeding to the next step in answering the question of negligence or no negligence. In paragraph 51 of the judgment it was observed:

> "All the judge had to be satisfied was that the reasonably competent screener should be able to recognise abnormalities which were present, and be unable to conclude with confidence that there was an innocent explanation for their presence".

86. The Defendant's argument does not take into account the evidence of both Professor Simpson and Professor Burch that a VSD can spontaneously close. Accordingly, it has not been established, that there was, in fact, no defect present in January 2014. The argument fails to take into account the factual reality of the situation in 2014, namely that the Defendant's own specialists considered that there was a definite VSD visible. Dr Chudleigh's opinion, which I accept, was that given there was one image on which a defect is apparently seen and that the other images taken, did not rule out an anomaly, whatever in fact could be seen on that image, a referral should have followed. I have found on the facts that such a referral would ultimately have led to amniocentesis and a termination.

87. The Defendant's argument is superficially attractive but it falls into the trap of ignoring the actual factual situation as I have found it to be. I conclude that the Sonographer having produced one image that showed her an apparent abnormality, with other images that did not rule out an abnormality, should have referred to the appropriate specialist. Had she done so and those images been reviewed by any of the Defendant's specialists referred to in the email from Dr Khare dated 7th July 2014, following which an amniocentesis would have been discussed and offered and/or further detailed scanning provided.

Conclusions

88. For the reasons given above I find, that there was a breach of duty in the management of arrangements for the CT test for the Claimant. I find that there was a breach of duty in the way in which the Sonographer carried out the scan and assessed the images provided on 28th January 2014. As a result, I find that the Claimant lost the opportunity which she would have taken to undergo amniocentesis and to terminate the pregnancy. It follows that in those circumstances she would have been spared the pain, suffering and discomfort of continued pregnancy and birth and the distress and emotional turmoil caused by DXAB's disability and his resultant health complications.

Dated this day of 2019

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HER HONOUR JUDGE HAMPTON