Case No: D89YJ8180

IN THE COUNTY COURT AT OXFORD

St Aldate's, Oxford OX1 1TN

Date: 18 December 2019

Before:

HER HONOUR JUDGE MELISSA CLARKE

- -

B e t w e e n:

MRS BEVERLEY DOCHERTY	**Claimant**
- and -	
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	**Defendant**

- -
- -

Mr Johnathan Payne (instructed by **Falcon Legal Solicitors**) for the **Claimant**
Mr Thomas Crockett (instructed by **DAC Beachcroft LLP**) for the **Defendant**

Hearing dates: 25, 26 and 27 November 2019

- -

JUDGMENT

Her Honour Judge Melissa Clarke:

I Introduction

1. This is the judgment following the liability and quantum trial of a claim of clinical negligence on or around 24 and/or 25 May 2014.

2. The Claimant, Mrs Docherty, was admitted to the John Radcliffe Hospital, Oxford, in labour, on 23 May 2014. Her husband accompanied her. She laboured throughout the night of 23 May and at 09.35hrs on 24 May 2014, after catheterisation, manual rotation, epidural spinal block, episiotomy and use of Neville Barnes Forceps; she was delivered of her son, Taron. Her episiotomy was sutured with five stitches. It was noted that Mrs Docherty had blood loss then estimated at 800mls, which is sufficient to be classified as a post partum haemorrhage ("**PPH**").

3. Mrs Docherty was moved to the observation area (which is an intensive care/high dependency area) at about 10.30hrs and given into the care of Midwife Centofanti, who looked after her until 19.50hrs, when she was handed over to the night staff of that area. At about 01.30hrs on 25 May 2014, Mrs Docherty was taken with her baby into a postnatal ward and put into a side room. Her catheter was removed.

4. Shortly before 9.00hrs Mrs Docherty wished to have a shower. She walked down the corridor to the midwives' station to ask where the shower and towels were. She returned to her room, collected her things and her baby in his wheeled cot, and returned down the corridor to the shower, which was near the midwives' station. At 09.00 she was found lying on the floor outside the shower room, having fainted and/or fallen.

5. Unfortunately, Mrs Docherty displaced/dislocated and fractured her left ankle in the fall. Fortunately, her baby was unhurt, remaining safe in his cot. Mrs Docherty's ankle was found to have a Weber B fracture of the left fibular with loss of alignment of the talus. It was promptly treated by surgically with an open reduction internal fixation with lateral metalwork.

6. Mrs Docherty's blood haemoglobin ("**Hb**") was checked after the fall and found to be 7.4g d/l. It is not disputed that this showed her to be severely anaemic at the time and that this anaemia was caused by blood loss at delivery. The expert obstetrician/gynaecologists agree that Hb level suggests she had lost at least 1500ml of blood in the PPH, and so the 800ml blood loss noted was a significant under-estimate.

7. The particulars of negligence pleaded against the Defendant are found at paragraph 28 of the Particulars of Claim. They are:

   i) Failing to adequately handover the Claimant in the early hours of 25 May 2014

   ii) Failing to adequately handover the Claimant to include specific reference to PPH in the context of the Claimant having not mobilised to standing

   iii) Failing to advise the Claimant that she had a PPH, and the significance of this in relation to mobilisation

   iv) Failing to warn the Claimant of the risks of mobilisation following her loss of blood and that she should summon assistance

   v) Failing to provide assistance and/or escort the Claimant in visiting the shower for the first time following her PPH

   vi) Failing to transport the Claimant to the WC in a wheelchair

   vii) Failing to take observations of the Claimant between the removal of the catheter and 6 hrs and provide advice in relation to mobilisation

   viii) Failing to identify or check that the Claimant's Hb had dropped to 7.4gd/l and/or underestimating her blood loss

   ix) Failing to adequately risk assess patients who had undergone forceps delivery and had PPH to reduce risk of injury

   x) Failing to give the Claimant a blood transfusion or course of iron tablets

   xi) Having a rigid rather than dynamic plan for women who had undergone a large blood loss, catheterised, moved in early hours, then use the shower the next day

xii) Failing to accompany the Claimant on the first mobilisation

8. It is Mrs Docherty's case that but for the breaches of duty pleaded, she would not have suffered the fall which caused the injury to her ankle.

9. The Defendant denies breach of duty and causation.

10. Mr Johnathan Payne represents the Claimant and Mr Thomas Crockett represents the Defendant. I thank them for their helpful and concise skeleton arguments and the civilised and efficient manner in which they conducted the trial over three days.

II. Witnesses

11. I heard from two witnesses of fact for each of Mrs Docherty and the Defendant; two expert midwives; two expert obstetrician and gynaecologists; and two expert orthopaedic surgeons.

12. Mrs Docherty's witnesses of fact were herself and her husband. I found them both to be honest witnesses who came to court to assist it to the best of their ability and recollection. Mr Docherty's evidence was of limited assistance but I consider it is both credible and reliable. Mrs Docherty was candid and careful to limit her oral evidence to what she actually recollected, although that highlighted some areas of her witness statement which she had been less careful to do so. What became apparent in her oral evidence is that her recollection of relevant events is poor, perhaps unsurprisingly given the difficult and long labour and traumatic instrumental birth she had been through. In addition, there were some parts of her witness statement which she did not understand and which were not in her words. To her credit she did not try to hide that when challenged with it. Accordingly I prefer her oral evidence to her written evidence, and though I accept her as credible, I do not find her a particularly reliable witness, for reasons which are no fault of her own.

13. The Defendant's witnesses of fact were Midwife Michaela Centofanti and Midwife Jill Blincowe. I found MW Centofanti to be a very impressive witness. In the witness box she presented as intelligent, thoughtful, professional and principled. Her notes and recorded observations are

meticulous. None of the experts or witnesses makes any criticism of them. She is no longer working for the Defendant, having returned to Italy and taken a job in the Chivasso hospital in Turin. I therefore consider her to have more than a measure of independence from the Defendant.

14. MW Blincowe also appeared to be a straightforward, honest and professional witness. At the time of the index fall she was a senior midwife with over 30 years experience. She has now retired. Accordingly she, too, is now independent of the Defendant. In August 2014, after Mrs Docherty had made an email complaint to the hospital, MW Blincowe made manuscript notes of what she could remember of her involvement with Mrs Docherty. Those are in the witness bundle. She has also filed a witness statement. She was careful to distinguish between what she remembers now and what she noted then, when she accepts her memory was stronger then than it is now.

15. I am satisfied that both MW Centofanti and MW Blincowe came to court to give truthful evidence and assist the court to the best of their ability.

16. I will deal with the expert witnesses after making my factual findings.

III. Detailed Chronology and factual findings

Labour

17. On 23 May 2014 Mrs Docherty went to the John Radcliffe Hospital to report that her waters had broken the night before, but contractions had not started. She was assessed, and given the option to stay in or return home. She went home, and returned to hospital that evening, where she was admitted and put on a Syntocinon drip to stimulate contractions at 21.00hrs. She was put on IV antibiotics at the same time, as her waters had broken over 24 hours previously.

18. Mrs Docherty's contractions started strongly. As she was having difficulty passing urine, she was catheterised. A full blood count was taken at about 03.30hrs on 24 May 2014, which showed a normal Hb level of 11.2g/dl. She laboured through the night, and was fully dilated at 06.13hrs on 24 May 2014.

She started pushing at about 7.45hrs, but the baby was in a difficult position, and its heart rate was dropping, indicating distress. Mrs Docherty was also getting tired.

In Theatre for birth and third stage

19. Following a medical consultation at about 08.50hrs, it was agreed that Mrs Docherty should have an epidural anaesthetic and an episiotomy in preparation for forceps delivery. That happened at 09.18hrs on 24 May 2014. Labour notes also document an attempt to manually rotate the baby. Although the operating theatre documentation shows that Keiland's Forceps were opened and ready for use if necessary, Taron was born with the application of Neville Barnes Forceps at 09.35hrs.

20. The operating notes show that Mrs Docherty was injected with Syntometrine and Ergometrine to contract the uterus (reducing bleeding) and speed up the third stage. She was noted to have suffered blood loss of approximately 100ml with instrumental delivery, 500mls with delivery of the placenta and membranes, and 200mls at the perineal repair. The operating notes state, *"Is this a PPH? Yes. Clinical Plan: Sudden Gush after placental delivery. Settled after ergometrine. FBC tomorrow. Catheter out when mobilises."*

21. The Claimant's husband, Mr Scott Docherty, is a Royal Engineer in the British Army, and an Explosive Ordnance Disposal Specialist. He was present during his wife's labour and the birth of his son. His witness statement focuses mainly on the time after the fall, the care he had to provide to his wife and baby and the effects of the events of the fall on his wife. In relation to the time of the delivery itself, he says merely, *"I was aware she had to have stitches for a cut, but I wasn't made aware of her losing a lot of blood, but I did see the medical staff operate and winced when I looked towards them and saw the blood on the bed sheets and doctor. At the time I wasn't overly concerned as I have worked alongside some of the best medical staff in the world in austere conditions that has founded a trust in what they can achieve"*. He described himself as having, due to his military experiences, a *"numbness to blood"*.

22. Mrs Docherty's own evidence from her time in theatre is scant. In oral evidence she said *"I remember a lot but there are elements that I don't remember"*. She says that she consented to the episiotomy and remembers be baby being delivered and being stitched after the birth, but nothing else. She says that nobody told her in theatre that she had bled, and she did not see any blood because she was lying prone. I accept that, which was supported as likely by the lay and expert midwives. Mrs Docherty said in oral evidence that she remembers the doctors and midwives at the time of her delivery talking to her and keeping her appraised of what was going on, but does not remember them telling her what would happen next. She said, *"They probably were telling me, but I was in a tired and exhausted state. Not everything was making sense*".

23. **I am satisfied on the balance of probabilities that neither Mrs Docherty nor Mr Doherty were told in theatre that she had suffered a blood loss above normal levels, nor that it was estimated at 800ml, nor that it was categorised as a PPH.**

In Observation area after delivery

24. Mrs Docherty was moved to the care of MW Centofanti in the observation area at 10.30hrs. Midwife Centofanti fairly states that she has no memory of Mrs Docherty or her treatment, but has reviewed Mrs Docherty's hospital records, including the clinical notes and observation chart, and she identifies her own handwriting on both.

25. MW Centofanti's evidence is that in her experience a blood loss of 800ml would not be considered particularly significant, and would be classified as a minor PPH. She said that Mrs Docherty was in the observation area because she had: (i) a spinal block; (ii) an episiotomy; (iii) an instrumental delivery; and (iv) a PPH. She can see from her notes that she introduced herself and noted Mrs Docherty's history, and that at 10.35hrs Mrs Docherty's legs were still blocked by the spinal anaesthetic. She said that taking account of her usual practice, she was likely to have introduced herself and the ward, and told Mrs Docherty why she was there: namely that her legs were numb and she had

suffered more than usual blood loss, so she needed more and closer observation than normal. In both her written and oral evidence MW Centofanti said that she would not use technical words like 'post-partum haemorrhage', but would say that her blood loss was 'more than normal'.

26. MW Centofanti says that she took and recorded regular observations during Mrs Docherty's time in the observation area and they were all stable and within normal limits. Those are recorded and not disputed.

27. Mrs Docherty's evidence relating to her time in the observation area is also scant. She can in no way be criticised for this and I would not dream of doing so. She had just gone through a very long and exhausting first labour, with the added stress of concerns about the baby, the need for an episiotomy, and the physical insult of an instrumental delivery. She had suffered a blood loss, unknown to her or anyone else at that time, which was likely to be least 1500ml. For the first time in her life, she had a tiny new baby to care for and attempt to breastfeed. As she very fairly said in oral evidence, *"I had been through a trauma and there are things I can't remember"*. It is a testament to her resilience, frankly, that she can remember anything at all of the first hours and days after the birth. That does cause challenges in the production of reliable evidence, however.

28. Mrs Docherty remembers speaking to and being cared for by a number of midwives in labour and after the birth, but cannot name them and did not recognise MW Centofanti in court. She said in cross-examination that she remembers the midwives caring for her in the observation area asking her how she was feeling, how she was getting on with breastfeeding and whether she was comfortable, but she doesn't remember them saying any more than that. She remembered they carried out her observations. She remembers feeding the baby when she was in the observation area, and that he was in a cot beside her bed so she did not have to get out of bed to do it.

29. In Mrs Docherty's witness statement she says, *"I believe I suffered blood loss of 800ml, but I was not advised. I was not advised that I had suffered a post-partum haemorrhage (PPH) or the consequences of the PPH. I was not told*

that due to PPH I might be unsteady on my feet when mobilising for the first time I was out of the bed or that I should not mobilise or walk without assistance." The questions for the court include whether she positively remembers not being advised of these things, or whether she cannot remember whether or not she was advised. If her evidence is that she positively remembers not being advised, the next question for the court is whether this memory is reliable.

30. In her witness statement, Mrs Docherty initially states that when she was in the observation area, *"I was still catheterised and tangled in those wires therefore I was unable to mobilise in any event"*, but later on states that she had *"got out of bed once*".

31. Asked about this contradiction in cross-examination, Mrs Docherty said, *"I remember getting out of bed by sitting on the side of the bed, still catheterised with the bag on a trolley, and lowering myself onto a chair"*. In cross-examination she accepted she did not put this detail in her witness statement. She said she doesn't remember standing, doesn't believe she fully stood up, and doesn't recall having any assistance from a midwife either getting from bed to chair or from chair back to bed. However she was adamant in cross-examination that she was not given any advice on mobility, and so it appears that her evidence is that she was not advised at all, rather than she cannot remember whether she was advised or not.

32. MW Centofanti's notes show that at 16.00hrs, Mrs Docherty was *"up and seated on a chair"*. MW Centofanti said in cross-examination that she was certain that did not mean that she found her sitting in a chair, because she could not remember a time when a patient in the observation area had ever got up and into a chair without any assistance (the implication being that she would remember it if it had happened with Mrs Docherty). In re-examination she said that she would normally note if someone had stood up independently without help and assistance. She says the note she did write means that she got Mrs Docherty up and seated on a chair as part of an early mobilisation process, and this would be in accordance with her usual practice.

33. MW Centofanti gave a full description of her usual practice in undergoing such mobilisation, which she said would usually take between 10 and 20 minutes, at para 11 and 12 of her witness statement and in oral evidence. She said that this was a process she usually carried out with all her patients in the observation area and which she still carries out in her current practice, and she has no reason to think she would not have carried it out with Mrs Docherty. That involved taking observations, checking that Mrs Docherty felt well and happy to attempt to mobilise, asking her to move to the edge of the bed and swing her legs over the side, pressing her hands against Mrs Docherty's feet to check the anaesthetic had worn off, asking Mrs Docherty to place her feet on the floor, then mobilising her to standing, staying close by in case she felt dizzy or needed support. Once standing, she would have asked Mrs Docherty to stand still for a moment to check she was not unsteady or dizzy, and then walked with her to the chair. She accepted that the chair was right beside the bed (as can be seen from a photograph of Mrs Docherty sitting in it, in the bundle), and so she can only have walked a step or two.

34. In MW Centofanti's witness statement at para 13 she said, *"As part of the mobilisation process, I would have discussed with the Claimant the reason we were carrying out the process (e.g. that it is vital to start mobilising to help recovery and reduce the potential risks of DVT). In this case, my usual practice would have been to explain that, as the Claimant had undergone a spinal anaesthetic and had suffered blood loss, she may be initially unsteady on her feet or feel dizzy… I know that the Claimant must have been mobilised successfully without concern because I did not record any issues in my note at 16:00. If the Claimant had had any issues with dizziness or unsteadiness during the course of the mobilisation process I would have taken her straight back to bed, made a note in the records and taken the Claimant's observations again. If I had any particular concerns about the Claimant, my usual practice would have been to seek medical review from an Obstetrician."*

35. MW Centofanti said that she did not accept that Mrs Docherty was unaware of the post partum haemorrhage (although she accepts she may only have known it as a higher blood loss than normal rather than as a PPH) or the particular

risks of mobilisation, as that was one of the reasons why she was on the observation ward, so she would have explained this to her.

36. As I say, I found MW Centofanti to be an impressive and professional witness. I accept her evidence. **I am satisfied on the balance of probabilities that although Mrs Docherty doesn't remember it:**

i) **MW Centofanti assisted Mrs Docherty to mobilise from bed to chair in a careful process that took between 10 to 20 minutes;**

ii) **as part of that mobilisation process, MW Centofanti told Mrs Docherty she had a higher level of blood loss than normal and both that and her spinal anaesthetic might cause her to feel dizzy or unsteady;**

iii) **as part of that mobilisation process, Mrs Docherty mobilised to standing and took a few steps;**

iv) **MW Centofanti was happy with that mobilisation as she did not write down any concerns and did not repeat the observations afterwards, as she would have done if Mrs Docherty had showed signs of dizziness or weakness.**

37. Mr Docherty stayed with Mrs Docherty in the recovery room until the afternoon, when he went home for a while before returning to the hospital. In oral evidence Mrs Docherty remembers that she was sitting in the chair when her husband returned to the observation area from his brief visit home, and she remembers that he was carrying flowers. I think it is more likely than not that this recollection is correct, as the flowers are visible in the photograph of her sitting in the chair. **Accordingly I am satisfied on the balance of probabilities that he was not there while the mobilisation process was carried out by MW Centofanti, and so did not hear any explanation that MW Centofanti may have given Mrs Docherty about why she was being mobilised carefully and that she needed to be careful of dizziness or unsteadiness.**

38. Turning next to the question of whether Mrs Docherty had been informed by MW Centofanti that her blood loss was estimated at 800ml. MW Centofanti said that she did not note that she had told Mrs Docherty her estimated blood

loss was 800ml, and as she had no memory of Mrs Docherty, she could not add anything further. **I think it is more than likely that MW Centofanti did not give the estimated volume of blood loss, given what she had said about not using technical language, and because she didn't note it down. I think it is more likely than not that she only told Mrs Docherty that she had a higher blood loss than usual, the possible effects of that, while she carried out her careful mobilisation of Mrs Docherty.**

39. In cross-examination Mr Crockett questioned Mrs Docherty closely about when she learnt that her estimated blood loss was 800ml. Mrs Docherty said that was not until she reviewed her medical notes after she started these proceedings that she discovered (i) she had a PPH and (ii) that was estimated at 800ml. She thought those medical notes were obtained by her second and current solicitors, Falcon Legal, about a year after the index fall. Mr Crockett put it to her that she may have been told this in hospital, but can't remember, and she said she didn't think so. In fact, Mrs Docherty wrote a complaint email to the hospital on 22 July 2014, a few months after the index fall, saying *"The reason I collapsed was due to me losing a more than usual amount of blood (800ml) in delivery"*. When Mr Crockett showed her this letter, Mrs Docherty accepted that she must have known she had an estimated blood loss of 800ml, but said she did not know that it was classified as a PPH. Given my findings about what MW Centofanti told her, I am prepared to accept that she did not know her blood loss was classified as a PPH. Mrs Docherty said she thought she must have read the volume of her blood loss somewhere rather than being told in hospital. I think this is merely speculation on Mrs Docherty's part. **I think it is more likely than not that Mrs Docherty was told the volume of her blood loss some time after MW Centofanti handed over care to the night staff at the end of her shift, and Mrs Docherty leaving hospital after her fracture was operated upon. I cannot know whether she was told before or after her fall.**

40. At the end of her shift, MW Centofanti handed over care of Mrs Docherty in the observation area to Midwife Kirsty Walton at 19.50hrs on 24 May 2014. She says that her usual practice would have been to provide the receiving

midwife with a brief history of the patient which in this case would have included that Mrs Docherty had had a forceps delivery and had lost 800ml of blood. She says that in accordance with her usual practice, she would have summarised the drugs Mrs Docherty was taking, that her observations were stable, and that she had mobilised to standing. Mrs Docherty has no memory of being present during this handover, and it is not noted that she was.

Transfer to postnatal ward

41. Mrs Docherty was transferred to the postnatal ward at 1.12hrs on 25 May 2014. She accepted in oral evidence that she was transferred in a wheelchair so must have mobilised from the bed to the wheelchair and back into bed in the new ward. She remembers she was still catheterised at the time of transfer, and knows that the catheter was removed at some point on the ward, but does not know what time, or who did it. Nonetheless, in her witness statement she says *"I am sure that I was not given any advice on mobilising after it had been taken out (post epidural and catheter)"*.

42. It was MW Walton who handed over care of Mrs Docherty to the post-natal ward. The notes show that MW Walton used the SBAR system (Situation, Background, Assessment, Recommendation) to do so, and none of the experts criticise this method. It is noted at handover that Mrs Docherty was mobilising, knew to contact someone if she had any concerns, and was shown a buzzer to call for help. Observations taken at 1.30am were normal.

43. Mrs Docherty says in her written evidence that on waking on the ward in the morning she felt *"fine but very tired and weak. Considering I had just been through labour and given birth for the first time, I thought that was a relatively normal way to be feeling"*. I accept that evidence. She says that she *"really wanted to go for a shower and to use the toilet. Although I had only sat out of bed once, it was my first time mobilising after having had an epidural and the first time to the toilet".* **I am satisfied it was not her first time mobilising, as she had mobilised with MW Centofanti's assistance the previous afternoon, and had also been transferred between wards in a wheelchair.**

44. There are significant differences in Mrs Docherty's evidence and MW Blincowe's evidence about what happened next. Mrs Docherty says that she remembers her baby was sleeping in his cot, and she didn't want to disturb him, so she left him sleeping in the side room she had been put in (Room 7), and went to the midwives' station to ask where the shower and towels were. She describes the station as being just outside her room and a few metres away. They were pointed out to her, and she said she also had a discussion about the practicalities of showering with a stitched perineum. She says the midwives did not offer to escort her to the shower or offer any assistance, and *"at no point did any member of staff raise concerns over mobilising after Epidural or take my observations to ensure that I was fit to walk to the showers or to have a shower on my own"*. I pause to note that her notes show that she had her observations taken at 07.10hrs. She says she went back to her room and sat on her bed. She collected her wash bag, change of clothes and the baby which were all within reach from her sitting position. She described herself again as feeling weak, tired and exhausted, but thought that was normal because she had just given birth, *"and was told no different. I did not know that I had a PPH or what that meant, and I was give no instructions about the consequences of my PPH and/or the effect it may have on my body"*. I pause again to remind myself that I have found that MW Centofanti did tell her she had suffered a greater than usual blood loss, and that may cause dizziness and unsteadiness when mobilising. Of course she had not been told of the extent of her blood loss, and that she was anaemic with a very low Hb level, because this was not yet known. MW Blincowe's evidence is that the order made in theatre for a "*FBC [full blood count] tomorrow*" would have been carried out that morning when the phlebotomist visited the ward, at about 10.00hrs. Mrs Docherty walked to the shower, which was close to the midwives' station, pushing her baby in front of her in his cot, shortly before 9am.

45. Mrs Docherty says *"I had an odd feeling, but thought all was well. I have never passed out or fainted before. I remember opening the door to the shower, but then I began to black out and I collapsed to the floor. Although very hazy, I remember trying to steady myself on a flimsy type bin near by to prevent the fall, but it couldn't support me and as I fell I felt my ankle going. I*

vaguely remember hitting the floor… It all happened very quickly". She confirmed this account in cross-examination.

46. MW Blincowe says that she recalls Mrs Docherty clearly. She says that she would have started her shift on 25 May at 07.30hrs, and that it was her usual practice at the start of shift to review the list of patients and have a handover from the night team, which generally took about half an hour or 45 minutes. She said Mrs Docherty's PPH would have been worthy of note at that handover, although at 800ml she would not have considered it particularly large. She remembers seeing Mrs Docherty for the first time shortly before 09.00hrs walking down the corridor from her room to the midwives' station.

47. MW Blincowe's manuscript note of 5 August 2014, some 3.5 months after the index fall, states *"Later that morning [on 25 May] around 9, she walked down the corridor with her baby in her arms, and asked at the desk if she could take a shower and where were they? She said she felt fine. She was told always to put her baby in his cot when moving between areas in case she felt faint etc. She was shown where [the showers] were and told to either wait for her husband or there was room for the cot in the showers. She was offered help to collect her belongings and a cot but said she was fine and would be happy to do this. She then walked back to the showers and as she opened the door felt faint and fell over"*.

48. In her witness statement, MW Blincowe described her as *"Walking down the corridor… carrying her baby in her arms and was walking normally at that stage. She was not supporting herself on anything and both her arms were being used to hold the baby. The walk from room 7 to the midwives' office is not far and I would estimate it as around 30 yards."* MW Blincowe said that she told Mrs Docherty she should move her baby about in a cot, and then: *"I said that we should go back to her room to get the cot. I offered to go and get it but she said she was fine and walked with me. I would have offered to carry the baby for her. I remember telling the Claimant, in particular, that she might feel dizzy or faint and these feelings could arise very suddenly so she really ought to have her baby in the cot so that he would not get hurt if she fell over"*. She says that they walked back to Mrs Docherty's room together, and

once there, MW Blincowe asked her again if she was ok and needed any help. She said *"...she told me she was feeling fine. She did not request that I accompany her to the shower"*.

49. Mr Payne put it to MW Blincowe in cross-examination that she did not return to Mrs Docherty's room with her, and that was why she didn't mention it in the manuscript note. She said she did, but must have forgotten to put it in the note. Mr Payne asked her whether she was of the opinion that Mrs Docherty had been mobilised, and MW Blincowe said that according to the handover, she had been mobilised while in the observation area, and she had also seen Mrs Docherty walking from her room to the midwives' station and back again without difficulty. She said *"I asked if she felt OK and she said she was fine. If she said she felt weak and wobbly I would have called for a wheelchair to take her back… I would have told her not to shower so soon or get assistance with showering."*

50. **I am satisfied on the balance of probabilities that, although Mrs Docherty cannot remember it:**

i) **She walked to and back from the midwives' station with her baby in her arms, although he may well have been asleep at the time. MW Blincowe specifically noted this and the conversation she had with Mrs Docherty about it in her August 2014 note. I think she is unlikely to be mistaken and there is no reason for her to lie about whether she was carrying her baby or not;**

ii) **The nurses' station was further away from Mrs Docherty's room, Room 7, than the few metres Mrs Docherty describes, and was closer to the 30 yards that MW Blincowe describes. I believe Mrs Docherty accepted that possibility in cross-examination;**

iii) **MW Blincowe returned with Mrs Docherty to her room. I do not consider that she would have allowed Mrs Docherty to return to her room alone, given her concerns about Mrs Docherty carrying her baby in the ward;**

iv) **MW Blincowe offered Mrs Docherty help and advised her to wait for her husband before showering, and Mrs Docherty refused, saying she felt fine. Again, MW Blincowe noted this in her August note when her memory was relatively fresh. In addition, it seems**

highly unlikely to me that a midwife who was concerned about Mrs Docherty carrying a baby so soon after giving birth would not also offer help, especially not one as experienced as MW Blincowe.

51. Mr Docherty had left his wife in the observation area to return home for the night. When he arrived at the post-natal ward to find Mrs Docherty in the morning, she had just fallen. Mr Docherty does not say specifically in his written evidence that nobody told him his wife had suffered a PPH, however he did say that the attending doctor who treated Mrs Docherty after her fall *"had said to her that she was probably anaemic and that this was what caused the fall, at that point I recalled the blood loss during birth"*.

IV. The Law

52. The law in relation to liability for breach of duty by medical professionals is well established. McNair J in **Bolam v Friern Hospital Management Committee** [1957] 1 WLR 583 described it as follows:

> "*I myself would prefer to put it this way, that he is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a respectable body of medical men skilled in that particular art… putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view."*

53. **Bolam** established that, in determining whether a defendant has fallen below the required standard of care, regard must be shown to responsible medical opinion, and to the fact that reasonable doctors may differ. In **Hunter v Hanley** [1955] SLT 231 at 217 it was stated that

> *"In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion and one man clearly is not negligent merely because his conclusion differs from that of other professional men … The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care … "*

54. That test in **Hunter v Hanley** was approved in **Maynard v West Midlands Regional Health Authority** [1985] 1 All ER 635 where Lord Scarman stated:

> "It is not enough to show that there is a body of competent professional opinion which considers that theirs was a wrong decision, if there also exists a body of professional opinion, equally competent, which supports the decision as reasonable in the circumstances…"

V. Royal College of Obstetrics and Gynaecology ("RCOG") Guidelines

55. It is common ground that RCOG Green-top Guideline No.52 on Prevention and Management of Postpartum Haemorrhage (published in November 2009 and revised in April 2011) ("**RCOG Guideline on PPH**") was applicable at the time of the index fall. This identifies the traditional definition of primary PPH as the loss of 500ml or more of blood from the genital tract within 24 hours of the birth of a baby, and that a PPH can be minor (500-1000ml estimated blood loss) or major (more than 1000ml estimated blood loss). It identifies a blood loss of more than 40% total blood volume (approx. 2800 ml) as generally regarded as 'life-threatening'. In section 4, entitled '*Definition of postpartum haemorrhage'* it recommends (emphasis in the original):

> "**Primary PPH involving an estimated blood loss of 500 – 1000ml (and in the absence of clinical signs of shock) should prompt basic measures (close monitoring, intravenous access, full blood county, group and screen) to facilitate resuscitation should it become necessary.**
>
> **If a woman with primary PPH is continuing to bleed after an estimated blood loss of 1000ml (or has clinical signs of shock or tachycardia associated with a smaller estimated loss) this should prompt a full protocol of measures to achieve resuscitation and haemostasis.**
>
> …
>
> As visual blood loss estimation often underestimates blood loss, more accurate methods may be used, such as blood collection drapes for vaginal deliveries and weighing swabs. Participating in clinical reconstructions may encourage early diagnosis and prompt treatment of post partum haemorrhage. Written and pictorial guidelines may help staff working in labour wards to estimate blood loss".

56. In section 6, entitled '*How should PPH be managed?*' it provides the following recommendation (emphasis in the original):

> "**Once PPH has been identified, management involves four components, all of which must be undertaken SIMULTANEOUSLY: communication, resuscitation, monitoring and investigation, arresting the bleeding.**
>
> …Each of these components is discussed in turn in the guideline but it must be emphasised, these components must be initiated and progressed simultaneously for optimal patient care. It is important to be aware that minor PPH can easily progress to major PPH and is sometimes unrecognised".

57. At section 6.3 it provides (emphasis in the original):

> "*What investigations should be performed and how should the woman be monitored?*
>
> **Basic measures for MINOR PPH (blood loss 500-1000ml, no clinical shock and bleeding ceasing):**
>
> - **Consider venepuncture (20ml) for**
>   - **group and screen**
>   - **full blood count**
>   - **coagulation screen including fibrinogen**
>   - **pulse and blood pressure recording every 15 minutes**
>
> **Full Protocol for MAJOR PPH (blood loss greater than 1000ml and continuing to bleed OR clinical shock):**
>
> - **Consider venepuncture (20ml) for:**
>   - **crossmatch (4 units minimum)**
>   - **full blood count**
>   - **coagulation screen including fibrinogen**
>   - **renal and liver function for baseline**
>
> …Once bleeding is under control, transfer to an intensive care or high-dependency unit on deliver suite should be considered, depending on the severity of the blood loss…"

VI. Midwifery Expert Evidence

58. The Midwifery experts are Mrs Sandra Reading for the Claimant and Ms Dawn Johnston for the Defendant. Both wrote breach of duty and causation reports. The report of Mrs Reading is dated 15 March 2017 and that of Ms Johnston is dated 15 May 2019. They met and produced a joint statement dated 29 August 2019.

59. Counsel each submitted that the expert midwife for the other side was partisan, not impartial, evasive when challenged and strayed beyond the areas of their expertise. I did not find either of them so. It was put to Mrs Reading that she accepted disputed facts as true and opined on that basis, but I consider that criticism was equally levelled at Ms Johnston, in terms of the joint statement at least. I do not think that either of them did it intentionally and were quick to correct themselves when it was pointed out to them in the witness box. In oral evidence I found them both to be careful to maintain their impartiality and fair. Ms Johnston in particular was careful to defer to the obstetric experts when she felt it appropriate to do so. In those circumstances, I do not consider that the fact that Mrs Reading had been criticised for taking a less than impartial view in a previous case in which she acted as expert, has any real relevance to this case. I accept that both midwives had the expertise and experience to act as experts in this matter.

60. They agree on the following:

    i) A patient who has experienced a PPH should be told about it, should be told that a FBC will be taken to check Hb level in case medication is needed, and should be provided with information about mobilisation. This should include being advised (a) to observe for blood loss and call for assistance if concerned or if needs assistance with babycare; (b) that she may feel lightheaded when getting out of bed for the first time or getting up suddenly; (c) that extra support is available to help get out of bed, sit in a chair and go to the bathroom.

    ii) A patient with an 800ml PPH should have her vital signs checked at least hourly and then four hourly over the next 24 hours.

    iii) A patient who has experienced a PPH is at a higher risk of collapse when mobilising.

iv) Mrs Docherty would have been known to be at risk of being anaemic based on her having had a PPH. Her Hb levels would need to be known to diagnose anaemia.

v) The midwives do not record that Mrs Docherty demonstrated clinical signs of anaemia prior to her fall. The maternal observations recorded at 007.10hrs were within normal limits.

vi) When handing over Mrs Docherty, what would need to be recorded in relation to the PPH is the amount of blood loss and any continuing blood loss, maternal observations, whether she had mobilised and any plan of care proposed including post-natal FBC. In relation to mobilisation that should cover whether the mother has been out of bed, if she is mobilising independently, what support is needed, has she been up to the bathroom.

61. They disagree on the following issues in the joint statement:

i) Mrs Reading considers that the FBC should have been taken on day 1 or 2 post-delivery, but certainly before discharge. Ms Johnston considers that FBC is usually taken on day 3 post-delivery. The timing of the FBC remains in dispute, however in oral evidence both midwives said that a plan for FBC had been put in place by the registrar in theatre, and that would only be changed following a medical consultation. They agreed that Mrs Docherty's observations were carried out and recorded as normal, she reported as well at all times, and she had mobilised to standing, and so there were no reasons which mandated calling for a medical consultation at any time between leaving theatre and the fall.

ii) Mrs Reading considers that it was not reasonable not to perform a FBC to check Mrs Docherty's Hb levels following a PPH with estimated blood loss of 800mls. Ms Johnston considers that in the circumstances where Mrs Docherty did not demonstrate clinical signs of anaemia prior to the fall, her observations were stable and her estimated blood loss was 800ml it was reasonable not to carry out FBC until 3rd post-natal day.

iii) Mrs Reading does not consider that Mrs Docherty had satisfactorily mobilised before her fall such that she was able to walk to the toilet without observation or assistance, because she had only taken a few steps from her bed to a chair so was not satisfactorily mobilising. Ms Johnston considers that the evidence of MW Blincowe was that Mrs Docherty was walking normally, carrying her baby, not supporting herself on anything and saying that she felt 'fine' shortly before the

fall, was evidence of satisfactory mobilisation. In doing so, she was accepting disputed evidence as fact, but in fact I have accepted MW Blincowe's evidence on this point. In oral evidence Mrs Reading clarified that if the court accepts MW Blincowe's evidence about the distance Mrs Docherty walked to the nurses station and back, that, together with the previous day's movement from bed to chair was sufficient mobilisation.

iv) Mrs Reading considers that a responsible body of midwives would expect a patient with a PPH of 800mls to be escorted on their first walk to the bathroom. Ms Johnston considers that MW Blincowe's evidence that she was OK and did not need any help, and did not ask to be accompanied, shows that the midwife took the appropriate actions. In doing so, she was accepting disputed evidence as fact, but again, I have accepted MW Blincowe's evidence on this point. In oral evidence Mrs Reading clarified that if the court accepts MW Blincowe's evidence, she does not criticise MW Blincowe for not escorting Mrs Docherty to the shower.

62. There was also a dispute between the expert midwives about whether Mrs Docherty's transfer from the observation area to the postnatal ward in the early hours of the morning was 'not best practice' (Mrs Reading) or 'not unreasonable' (Ms Johnston), but in oral evidence both agreed that it was not negligent.

63. I will consider the outstanding disputed issues of the midwives together with my discussion of the evidence of the obstetric and gynaecology experts.

VII. Expert Obstetric & Gynaecology Evidence

64. The Obstetric & Gynaecology Experts are Professor Dimitrios Siassakos for the Claimant and Mr Andrew Leather for the Defendant. They each wrote a report on breach of duty and causation. Professor Siassakos's report is dated 24 June 2019 and Mr Leather's is dated 27 April 2019. They met and produced a joint statement dated 16 September 2019.

65. Professor Siassakos is a Reader and Associate Professor in Obstetrics at University College London and an Honorary Consultant at University College Hospital. He is Chair of the Clinical Care group of the International Stillbirth Alliance, Vice Chair of the UK Intrapartum Care Clinical Study Group and an

Executive Editor of BJOG, an international Journal of Obstetrics and Gynaecology. He does extensive work providing training to trainees, and their trainers, nationally and internationally. He thought he had trained consultants in almost every hospital in the UK. In cross-examination he estimated that his workload is split 50/50 between his academic and clinical duties. He said he spent one day per week and one evening and night per fortnight on the labour ward, and the rest of his clinical time in clinic or surgery.

66. Mr Leather is a consultant obstetrician and gynaecologist at Ipswich Hospital NHS Trust for which he was the Clinical Director from 2007 to 2013, responsible for obstetrics and gynaecology at 7 hospitals within the trust. He has been a consultant since 2001 and also has a private practice. He is a current council member of the Royal College of Obstetricians and Gynaecologists, the current Chair of the Part 2 MRCOG EMQ Committee, a standard setter for the Part 1 & 2 MRCOG Exam and a Part 3 MRCOG Examiner. He has been fulfilling similar roles at the RCOG since 2011. He is the Unit lead for undergraduate teaching in Obstetrics and Gynaecology and a member of the Norwich Medical School Faculty. He examines undergraduates for that medical school and Cambridge University.

67. I have no doubt that both have the expertise and experience to assist the court as Part 35 Experts.

68. The experts agree on a number of important issues:

    i) Mrs Docherty's blood loss was under-estimated, but this underestimation was not a breach of duty *per se*.

    ii) Mrs Docherty's blood loss was over 1500mls which would classify it as a major PPH.

    iii) The antenatal blood results confirm the normal physiological changes that occurred in Mrs Docherty's pregnancy, and the Hb fall from 11.2g/dl antenatally and 7.4g/dl after her fall post-delivery was as a result of the blood lost during delivery.

    iv) There was a small rise in Mrs Docherty's Hb from 7.4 to 7.8g/dl in the afternoon after the fall, which was likely as a result of fluid restriction and the postnatal diuresis.

v) Mrs Docherty had acute anaemia after the PPH.

vi) Mrs Docherty needed close monitoring following the recorded PPH of 800mls.

vii) Competent care involved monitoring symptoms and signs; careful mobilisation; and a postnatal full blood count ("FBC") check. They do not agree on the timing of the postnatal FBC.

viii) The RCOG Guideline on Post Partum Haemorrhage published in 2009 and revised in 2011 is applicable. It recommends an FBC test to check Hb levels during a PPH even if the PPH is minor. This did not occur. It does not give any guidance on further blood testing after the event.

ix) Mrs Docherty was monitored post delivery using the MEWS chart. Using the MEWS chart scores for Mrs Docherty alone, this did not necessitate escalation of Mrs Docherty for a clinical review.

x) The operative notes described the operative birth in sufficient detail.

xi) A blood transfusion would have been offered to Mrs Docherty if and when it was discovered that her Hb was less than 8.0g/dl, and this would be appropriate.

69. The main areas of difference are:

i) Professor Siassakos considers that the probable blood loss suffered by Mrs Docherty was about 2340ml, and in any event more than 2000ml. Mr Leather considers that it is most likely that Mrs Docherty lost between 1500 to 2000ml. I do not consider that it is necessary to resolve this point, as both agree it was likely over 1500ml and so a major PPH.

ii) Professor Siassakos considers that with competent care, Mrs Docherty would have had a FBC performed 6 hours after birth at around 15.30 hrs. On the balance of probabilities the Hb would have been found to be less than 8g/dl and so (i) she would have been diagnosed with acute anaemia; and (ii) she would have been offered a transfusion. If she had accepted the offer, she would have been materially less likely to faint the next day and sustain a fracture. Mr Leather considers that Mrs Docherty had a minor PPH which was not on-going, she was closely monitored for signs of hypovolaemia over 12 hours without concern, and she was clinically well. Given that, there was no good clinical indication to alter the postoperative instructions of the registrar in theatre to do the FBC the following day.

iii) Professor Siassakos considers the operative notes are below reasonable standards with regards to the post partum haemorrhage, and considers the lack of precise documentation may have been the reason why the PPH was not taken as seriously when she was admitted to the postnatal ward, and she was not supported to mobilise to the toilet the first time. He is also concerned that there is no explicit documentation of the previous PPH during handover. Although he defers to the midwifery experts, in his opinion, the lack of documentation was negligent and indicative that the PPH was likely neglected. Mr Leather is happy with the operative notes. He considers they indicate that a PPH had occurred, when it occurred, what action had taken place and that the problem had been resolved. It also put a plan in place for observations, catheter removal and when the FBC should be taken.

iv) Professor Siassakos considers that there are failures in the postnatal monitoring, in particular the lack of FBC 6 hours after the PPH, the lack of vigilance for symptoms of anaemia, the lack of specific documented handover to the ward midwife that the PPH had occurred, and that she had only mobilised previously to a chair; and the failure to ensure that Mrs Docherty was accompanied the first time she mobilised to the shower. Mr Leather has no such concerns and considers her care fell within normal practice.

Operation notes

70. In Professor Siassakos's report, he opined that "*The operative notes about the forceps birth that are available to me, are negligent with regards to the lack of detailed documentation about the birth and about the haemorrhage afterwards"*. After he wrote this report and in time for the joint statement, the Defendant disclosed additional operative notes which were not available to him at the time of his initial report. These caused Professor Siassakos to alter his opinion so to the position he maintained at trial, namely that the operative notes were sufficient in relation to the birth, but insufficient in relation to the PPH and perineal repair. The operation notes include a photocopy of the labels of the various instruments and tools opened in surgery. Those include Keiland's forceps, a retractor, five clamps (which Professor Siassakos described as mosquito clips but which Mr Leather thought were slightly larger than that), and two swabs. Professor Siassakos describes the retractor and 5 clamps as *"additional instruments used in suturing"* but criticises the lack of

documentation explaining why these were necessary, if there had only been an episiotomy and an episiotomy repair. He says that although the retractor would be useful even for an episiotomy repair in some instances, the additional clamps would not be used in a routine episiotomy repair *"and indicate that there were likely bleeding vessels in the perineum beyond what is normally found"*. He speculates that this may be one of the sources of bleeding.

71. The court does not readily indulge in speculation. Mr Leather's opinion is that these instruments may have been opened and ready for use, but that does not mean they were used. For example, it is no part of either party's case that the Keiland's forceps were used, but it can be seen from the documentation that a packet containing such forceps was opened. Mr Leather's opinion is that there is no evidence to say whether they were used or not.

72. **It is for Mrs Docherty to prove a breach of duty by inadequate documentation, and I think it would be quite wrong for the court to find that the documentation is inadequate because it is silent about the use of the clamps, when there is a real possibility that they were only opened to be at hand in case they were required, but never used.** This is particularly so when there is evidence that other equipment (Keiland's forceps) was opened and readied for use if necessary, but not in fact used.

73. **Accordingly there is no reliable evidence before me from which I can find that any steps were needed to control the bleeding from Mrs Docherty's perineum or vagina beyond the sutures placed in the episiotomy repair. Putting the question of the timing of the FBC and the estimate of blood loss to one side for a moment, I find no breach of duty in rest of the operation notes insofar as they relate to the PPH.** I agree with Mr Leather that they adequately describe the fact of the PPH, the timing and location of the bleeds, an estimate of blood loss from each location, that the bleeding had stopped and how it was stopped.

Estimate of Blood Loss

74. Professor Siassakos accepts in his report and in oral evidence that estimating blood loss is not an accurate science and blood loss is often underestimated even when best efforts are used in the estimation. In the joint report he agreed that an underestimation of blood loss is not a breach of duty *per se*. However in oral evidence he opined that the obstetrician's lack of effort in proving the estimated blood loss (which he later re-worded as a *"failure to make best efforts to estimate the blood loss"*), and the gross underestimation that was reached, were breaches of duty. He said that level of underestimation would trigger a serious incident in every Trust he had ever worked in. This point was not put to Mr Leather so I do not know whether or not he would agree with it.

75. Professor Siassakos said that an estimate can be made more accurate if methods other than visual estimation are used, including weighing swabs and drapes (as per the RCOG Guideline on PPH). In his report he opined that every effort should have been made for a more accurate estimation of blood loss, particularly as the bleeding was coming from at least two sources being the uterus and perineum, and possibly also vagina. I pause to note that I have found that there is no evidence that any steps were needed to staunch the bleeding from the perineum and vagina save for the episiotomy repair by sutures. Professor Siassakos opines that on the balance of probabilities, with competent care, this would have led to identification that the estimated blood loss was over 1500 ml.

76. Mr Leather's opinion is that the weighing of swabs and drapes is always a possibility, but whether it is done is a matter for the clinical judgment of those attending the birth. He opined in the joint statement and in oral evidence that the weighing of swabs was often more helpful following a caesarean section than following a vaginal birth where blood often ends up on the floor, doctor's scrubs etc., and swabs may be contaminated by, and absorb, other bodily fluids including amniotic fluid, urine and faeces. Weighing them would not, therefore, give an accurate estimate of blood loss. I remind myself that Mr Docherty's evidence was that he did see Mrs Docherty's blood on the doctors.

77. Professor Siassakos accepted in cross-examination that it is difficult to estimate blood loss in these circumstances because of the presence of other

bodily fluids, but in his opinion weighing swabs and drapes improves the estimate.

78. I note that the RCOG Guideline for PPH does not mandate the weighing of swabs and drapes. Professor Siassakos's opinion was that those were national guidelines and the RCOG was careful not to mandate, but rather use wording which reflects the weight of the available evidence and the strength of feeling. However, the section on weighing of swabs is not phrased even as a recommendation (to which the RCOG attaches a box marked A, B, C or D to indicate the grade of recommendation – this section has no such grade), but rather it is phrased as a point of practice which clinicians may consider. Nor does it appear to be standard practice, although I accept Professor Siassakos's evidence that he would teach it as best practice. **In my judgment, Mr Leather's opinion that a reasonable body of surgeons would not have weighed swabs and drapes in circumstances such as this where the main blood loss came as a gush of blood while the placenta was delivered, where that bleeding was stopped by the provision of syntometrine and ergometrine to contract the uterus, and where the bleeding appears to have been under control by the time of the perineal repair, is logically defensible.**

79. **Accordingly I am satisfied that although the underestimate of blood loss was regrettable, it was not a breach of duty.**

Timing of FBC

80. At trial, Dr Siassakos opined that a FBC should have been carried out at the time of the PPH, as recommended by the RCOG Guideline on PPH although he did not raise this a concern or a breach of duty in his report or in the joint report. He was asked whether his opinion was that an FBC was mandated at the time of PPH or whether it should be considered. He replied, "Should", however he said that an FBC was mandated after six hours. Mr Leather in his oral evidence said that the purpose of carrying out an FBC at the time of PPH was to get a baseline HB level, group and save, but an FBC had been carried out only a few hours earlier, in the course of Mrs Docherty's labour, so there

was no purpose to repeating it. It was his opinion that a FBC obtained during the course of a PPH could not assist the obstetrician in theatre in estimating the blood loss, because the physiological changes during PPH included vasoconstriction of the extremities to maintain the Hb levels and so it would likely be virtually the same as that obtained a few hours previously. Professor Siassakos was not asked to comment on this, but as I say he did not appear to place any particular significance on the failure to carry out an FBC during the PPH in either his report, the joint statement or his oral evidence when his criticism was very much focussed on the failure to carry out an FBC after 6 hours postnatally. As Professor Siassakos said in his report (my emphasis):

> "**However, what mattered was not the accuracy of the blood volume lost (Hancock et al). What mattered was that Mrs Docherty bled much more than usual, and needed additional steps to stop the bleeding – she therefore needed additional monitoring in the first 24 hours postnatally**. With competent care, Mrs Docherty would have been monitored on labour ward at the very least, with a full blood county test 6 hours after the birth – at around 13.30. The results would have been available within 2-3 hours or…at the latest that evening. With competent care, Mrs Docherty would have been diagnosed with anaemia and would have been reviewed in the evening of 24 May by an obstetrician would have been [sic] offered transfusion… If Mrs Docherty had accepted the transfusion, she would have been materially less likely to faint the next day in the shower and would have avoided the fracture".

81. I also note that the RCOG Guideline on PPH describes the basic measures which should be put in place for a minor PPH, including the full blood screen, as being *"to facilitate resuscitation should it become necessary"*. This supports Mr Leather's opinion that it is not recommended for the purposes of estimating blood loss, but to be ready in case the situation gets worse and blood products are required. Finally, in section 6.3 in which the basic measures for a minor PPH are expanded, it says: *"**Consider** venepuncture (20ml)…"* (my emphasis). Again, in my judgment that supports Mr Leather's opinion that venepuncture may not in all circumstances be necessary and there is an element of clinical judgement and discretion to be exercised by the obstetrician in deciding whether it is or not in the circumstances of his or her case. **Accordingly I accept Mr Leather's evidence that the decision not to**

carry out an FBC during the PPH was one which was within the discretion of the obstetrician and which would be supported by a reasonable body of obstetricians in the circumstances of this case, as it appears to be logically defensible when considering the RCOG Guidelines on PPH in full.

82. Turning then to the postnatal FBC, in oral evidence Professor Siassakos agreed that a plan had been put in place by the obstetrician in theatre that a FBC should be carried out 'the next day' and that seemed to be recorded in the electronic patient notes for Mrs Docherty. He agreed that a midwife looking after Mrs Docherty postnatally did not have to repeat a plan which had been put in place by the obstetrician in theatre, but said that if the midwife had concerns, she should ask for an obstetric review to consider it, and could order an earlier FBC. Professor Siassakos accepted that all records showed Mrs Docherty's postnatal, pre-fall observations as entirely normal, and that she was noted as saying she felt well on a number of occasions, and never noted as saying that she was not well, however, he said "*in my experience, not everything which is said is recorded in the notes*". I do think this shows a certain fixity in Professor Siassakos's position. From my assessment of MW Centofanti at least, I consider that if Mrs Docherty had said she was not well, MW Centofanti would have noted it as part of her professional duties. MW Centofanti in oral evidence said that she didn't see any reason in Mrs Docherty's case to request an obstetric consultation to bring the FBC forward. She said in re-examination that "*I would have done an FBC if I had any concern*". I also note that the expert midwives do not make any criticism of the postnatal midwives' notes or observations, and it is not Mrs Docherty's case that she said at any time that she was unwell but that was not acted upon.

83. In relation to the plan put in place in theatre, Professor Siassakos maintained his position in oral evidence that an FBC was mandated after 6 hours, and that the failure to order it and carry it out within this time was a breach of duty. He said that it was carried out after 6 hours (once the greater risk of haemoconcentration from postnatal diuresis had passed) to identify both those women in whom blood loss had been underestimated, but also to identify

those women where it was safe to scale down their care. In cross-examination he said that in his experience he had not encountered a woman where a FBC was not carried out within six hours of PPH, and that he knew that from as far back as his time in medical school. He said that obligation was not set out in the RCOG Guideline on PPH or the NICE guidelines because it was *"so common and well known in practice that it was not considered to be an important point to address"*. Mr Crockett for the Defendant asked him if it was his opinion that *"nobody would say anything other than it was mandated after 6 hours?"* and he said *"That is my interpretation of common practice"*.

84. Professor Siassakos said that he was surprised to learn that in relation to this case, he was isolated in his opinion that an FBC was mandated after 6 hours following any PPH or in fact, as he clarified in oral evidence, any haemorrhage in theatre in any surgical discipline. Mr Leather considers an FBC 'the next day' to be sufficient timing for a suspected blood loss of 800ml, as do both of the expert midwives and MW Centofanti. However Mrs Reading, the expert midwife for the Claimant, said that there should always be an FBC in the first 24 hours after a PPH, and if the patient has been in the observation area for 12-13 hours as Mrs Docherty was, the usual practice would be that FBC would be taken before her discharge to the postnatal ward. However she accepted that a plan had been put in place by the obstetrician in theatre, and that a transfer from the observation area may happen sooner than planned, and in that case maintaining the plan to take the FBC the next day was sufficient.

85. MW Centofanti did, however, say that *"it is possible that we would have performed an FBC that same day based on the actual protocols that we have now"* if she had known that the actual blood loss was over 1500 ml. Similarly, Mr Leather accepted in cross-examination that if it had been known that Mrs Docherty had a major PPH, she should not have been permitted to get out of bed and mobilise without an FBC being done and the results returned. He would not put a timing on that, but agreed that because of the physiological changes identified by Professor Siassakos, it should not be done until after 6 hours had passed.

86. **Taking all of this evidence into account, Mrs Docherty has not satisfied me that it was mandated to take an FBC after 6 hours of a PPH with an estimated blood loss of 800ml**, because I cannot accept Mr Siassakos's evidence that no reasonable clinician would fail to carry out an FBC in this timescale when it is neither mandated in the RCOG Guideline for PPH, nor accepted by Mr Leather, nor mandated in that timescale in the experience of the expert midwives or MW Centofanti. **I accept Mr Leather's evidence that the plan that was put in place for an FBC 'the next day' is one that a competent body of professional opinion would support as reasonable in the circumstances, which includes that there was a working diagnosis of a minor, not major, PPH.**

Postnatal monitoring

87. I consider that Professor Siassakos is also isolated in his criticisms of the lack of post-natal midwifery care. Mrs Reading, the Claimant's midwifery expert, stated in oral evidence that she considered the record of care in the observation area to show care was given to a high standard with regular observations in line with the Guidelines of the Trust. She said that if the accepted the evidence of MW Centofanti that her usual mobilisation process was followed, then Mrs Docherty had been appropriately helped to get out of bed into a chair in 1st stage mobilisation and she did not criticise that. She did not criticise the handover from the observation area to the postnatal ward using the SBAR system, which she said was good practice, and would have resulted in the postnatal ward being given the history of delivery and any significant events including blood loss and mobilisation to a chair which were specifically noted. She said that at the time of handover Mrs Docherty was clinically well, her observations had all been stable, her first stage mobilisation was complete and there were no clinical concerns. Finally, she noted that Mrs Docherty's observations scheduled at 06.00hrs were not taken until 07.10hrs but she did not criticise this as a breach of duty. She agreed that Mrs Docherty had shown no signs of anaemia, such as tachycardia or shortness of breath.

88. Finally, it was Mrs Reading's opinion that despite the first stage mobilisation to a chair undertaken in the observation area, and the further mobilisation in a chair to the postnatal ward, Mrs Docherty should have (i) had assistance to go to the bathroom or shower for the first time and (ii) been shown the call bell if she needed help. However she said that if the court accepted MW Blincowe's evidence that Mrs Docherty had walked 20 to 30 yards to the nurses station and back, and was offered assistance to go to the shower but refused it, she would not criticise MW Blincowe for not accompanying her as you can only offer a patient assistance and advice, you cannot make them take it. I have made that finding.

89. **For those reasons, and following my factual findings, I am satisfied there was no breach of duty in the midwifery care provided to Mrs Docherty postnatally.**

VIII. Conclusions

90. My findings mean the claim must fail as the allegations of breach of duty are not made out:

i) Failing to adequately handover the Claimant in the early hours of 25 May 2014: This is not supported by Mrs Reading. I am satisfied on the balance of probabilities that the handover was adequate.

ii) Failing to adequately handover the Claimant to include specific reference to PPH in the context of the Claimant having not mobilised to standing: This is not supported by Mrs Reading. I am satisfied on the balance of probabilities that the handover did specifically refer to Mrs Docherty's PPH and I have found that Mrs Docherty had mobilised to standing with MW Centofanti in the observation area.

iii) Failing to advise the Claimant that she had a PPH, and the significance of this in relation to mobilisation: I have found that she was so advised by MW Centofanti in the observation area.

iv) Failing to warn the Claimant of the risks of mobilisation following her loss of blood and that she should summon assistance: I have found that she was warned by MW Centofanti in the observation area. There are a number of references in the notes to Mrs Docherty being shown where the call bell was.

v) Failing to provide assistance and/or escort the Claimant in visiting the shower for the first time following her PPH: This is not supported by Mrs Reading in the facts as I have found them. I have found that she was assisted to first stage mobilisation, that she was seen to mobilise 20-30m to the nurses station, escorted the same distance back to her room, offered assistance to the shower and refused it.

vi) Failing to transport the Claimant to the WC in a wheelchair: I have found that Mrs Docherty had mobilised at the time she went to the shower.

vii) Failing to take observations of the Claimant between the removal of the catheter and 06.00hrs and provide advice in relation to mobilisation: this is not supported by Mrs Reading who does not criticise the fact that her 0, observations were carried out at 07.10hrs. I found MW Centofanti gave her advice on mobilisation.

viii) Failing to identify or check that the Claimant's Hb had dropped to 7.4gd/l and/or underestimating her blood loss: I have found that the plan to carry out an FBC the next day was not a breach of duty. That would have been carried out at about 10.00hrs, but unfortunately Mrs Docherty fell before this time.

ix) Failing to adequately risk assess patients who had undergone forceps delivery and had PPH to reduce risk of injury: I have found that the Claimant was closely monitored and assisted to first stage mobilisation, in the observation area before transfer to the postnatal ward. This was personalised care in accordance with a plan put in place by the obstetrician, and the expert midwives do not criticise the care provided. I accept MW Centofanti's evidence that she had no concerns about Mrs Docherty and if she did she would have called for an obstetric consultation. The expert midwives agree that the observations and notes (including self-reports) do not show any clinical suspicion of anaemia before her fall.

x) Failing to give the Claimant a blood transfusion or course of iron tablets: there was no clinical indication for a blood transfusion until an FBC was carried out and so falls with the allegation in respect of failing to assess Mrs Docherty's Hb. I heard no submissions about a course of iron tablets: any such course would not have taken effect until after the fall.

xi) Having a rigid rather than dynamic plan for women who had undergone a large blood loss, catheterised, moved in early hours, then use the shower the next day: I have not found that there was a rigid

plan in place for Mrs Docherty, but that she was provided with personalised close care.

xii) Failing to accompany the Claimant on the first mobilisation: I have found that this is not made out for the reasons already given.

91. Finally, in respect of causation, Mrs Docherty's case is that she would have accepted assistance to the shower if she had taken it, and this would have prevented her fall and injury. I have found that she was offered assistance to the shower and did not accept it. Accordingly the claim fails on both negligence and causation and I will not go on to consider quantum, or the evidence of the two orthopaedic experts I heard, Mr S. T. Moyes for the Claimant and Mr S. Hepple for the Defendant.

92. I know this will be a very disappointing decision for Mrs Docherty. I have a great deal of sympathy for her because I can imagine just how painful, frustrating, disappointing, confusing and distressing it must have been to have to deal with a broken ankle, recovery from a difficult labour and birth and a first newborn in the days and weeks after her fall. My findings do not detract from what she has been through in any way. However, for the reasons I give, and having considered this case very carefully, I am satisfied that the circumstances which led to that fall did not arise from negligence on the part of the Defendant. I wish Mrs Docherty and her family all the very best for the future.