Supreme Court of New South Wales Decisions

Bruce v Kaye [2004] NSWSC 277 (8 April 2004)

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NEW SOUTH WALES SUPREME COURT

CITATION: Bruce v Kaye [2004] NSWSC 277

CURRENT JURISDICTION: Common Law

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JUDGMENT DATE: 08/04/2004

PARTIES:
Kristy Jane Bruce (by her Tutor Jody Colleen Winbank) v Alan Lester Kaye

JUDGMENT OF: Michael Grove J

LOWER COURT JURISDICTION: Not Applicable

LOWER COURT FILE NUMBER(S): Not Applicable

LOWER COURT JUDICIAL OFFICER: Not Applicable

COUNSEL:
A.J. Bartley SC with L. Whalan (Plaintiff)
D. Higgs SC with J. Lonergan (Defendant)

SOLICITORS:
Maurice Blackburn Cashman (Plaintiff)
Tress Cocks & Maddox (Defendant)

CATCHWORDS:
MEDICAL PRACTITIONERS
OBSTETRICIAN
ALLEGED BREACH OF DUTY OF CARE
BIRTH OF HANDICAPPED CHILD
TRIAL OF ACTION

ACTS CITED:

DECISION:
Judgment for the Defendant.

JUDGMENT:

IN THE SUPREME COURT
OF NEW SOUTH WALES
COMMON LAW DIVISION

MICHAEL GROVE J

Thursday 8 April 2004

20230/01 - KRISTY JANE BRUCE by her Tutor JODY COLLEEN WINBANK v ALAN LESTER KAYE

JUDGMENT

1 HIS HONOUR: The plaintiff Kristy Jane Bruce was born at 13 minutes past midnight on 21 March 1989 at the Royal Hospital for Women. Her perilous condition was reflected in total APGAR scores of zero at one minute of life and an increase to score only three at five minutes. At 11.35 am that morning she was transferred to the Prince of Wales Children's Hospital. In due course it was discovered that she was suffering from cerebral palsy. She is profoundly incapacitated. Her palsy is described as being of the spastic quadriplegia type. She is wheelchair bound although she can be exercised by taking a few halting steps if she is fully supported by an adult person. She is non-verbal but is sentient and can make known

various feelings such as joy and irritation. She has some capacity for communication by activating an electronic board with her forehead. She is totally dependent upon others to perform the ordinary activities of daily living.

2 The relationship between the plaintiff's parents ceased when she was aged about four years and, both before and after the separation, the plaintiff's mother (Ms Chevelle) has lavished care and affection upon her. As I am impelled to make some criticism of Ms Chevelle's reliability as a witness, I seek to make it clear that that criticism does not extend to the devotion with which she has applied herself to her daughter's safety and well being. Contrary to being critical, I would join in the expressions of admiration proffered by senior counsel for the defendant in those regards during his final address.

3 The plaintiff brings action by her tutor, who is her sister, and it was commenced by statement of claim filed on 30 March 2001 against the defendant who was a specialist obstetrician first consulted by Ms Chevelle on 17 October 1988 and who attended on the delivery of the plaintiff. It is claimed that the plaintiff's handicaps and her consequential losses were caused by breach of duty of care (negligence) of the defendant. There is no need to deal separately with coordinate issues upon an alternative cause of action pleaded in contract.

4 It is important at the outset to identify the relatively narrow basis upon which negligence is alleged. In opening the case, senior counsel for the plaintiff specified that it was based upon the defendant's blameworthiness for permitting the term of Ms Chevelle's pregnancy to continue beyond forty two weeks. As the evidence has emerged, there is no real dispute that a prudent obstetrician in 1989 would have intervened to seek to induce birth if a mother had not come into spontaneous labour once that point had been reached. It was emphasized that no allegation was made against the defendant concerning his actions in the emergency situation which had developed on the night of 20/21 March 1989. Indeed, it is plain that his actions were responsible for overcoming threats to the lives of mother and child. I shall later turn to detail of these actions. It was also stated that no criticism was levelled at hospital staff either at the Royal Hospital for Women or Prince of Wales Hospital. Thus, the allegation of breach of duty was almost entirely focussed upon the term of pregnancy and what the defendant knew or ought to have known about it.

5 It is of interest to note, in the light of the way the plaintiff's case came to be presented, that the statement of claim as originally filed gave particulars of damage, the first stated of which touched upon causation by reciting:

"Severe hypoxia secondary to (Ms Chevelle's) uterine rupture".

6 An amended statement of claim filed in Court on 4 March 2004 altered this particular to:

"Severe hypoxia caused or contributed to by diminished placental perfusion".

7 The particulars of breach of duty were pleaded in constant form and were:

"a. failed to adhere to an estimated date of confinement of +/- 2 March 1989 when he knew or ought to have known that this was the most appropriate estimate having regard to the ultrasound report of 22 August 1988;

b. permitted Sharon (Ms Chevelle) to continue the pregnancy past the estimated date of confinement when he knew or ought to have known that the pregnancy was not entirely normal in view of Sharon's obstetric history (forceps delivery with extensive episiotomy in 1971, vaginal delivery with perineal tearing in 1972 and emergency Caesarean delivery for foetal distress in 1985) and the fact that Sharon had chronic abdominal pain and discomfort;

c. failed to recognise that on 16 March 1989 Sharon was already 42 weeks pregnant and ought not to have been permitted labour past that date;

d. failed to assess or properly assess the well being of the foetus from either 2 March 1989 or 9 March 1989;

e. failed to induce or otherwise perform an assisted delivery of the plaintiff prior to 20 March 1989. "

8 It is necessary to trace what is known of the course of the pregnancy. It is difficult to understand the reasons for some conduct of Ms Chevelle and, although it is recognized that she is not the plaintiff (nor the plaintiff's tutor) she was a vital source upon whom the defendant necessarily had to rely to make relevant assessments.

9 On 3 March 1988 Ms Chevelle was operated upon for termination of a pregnancy by curettage. Undated notes of a follow-up visit referring to termination six weeks ago, would place that visit in mid April, and there is there recorded a history of last menstrual period (LMP) "1st January". The operation and follow-up note refer to Ms Chevelle by surnames of Winbank and Anderson respectively, however there is the same imprint of what appears to be a hospital identification number. In various documents she is referred to by five surnames (Chevelle, Winbank, Anderson, Owen and Bruce) and three hyphenated combinations of some of those names. It is not surprising that an observation entry at Prince of Wales Children's Hospital (23 March 1989) reads: "this babe of many names has had a quiet night". The plaintiff's father, Mr Mark Bruce, was described in a consent form for her transfer to Prince of Wales Hospital as Mark Anderson-Chevelle. I do not find that there is anything sinister about these multiple identities and although there might be some potential for confusion, it was not suggested that any confusion was actually caused. It will be convenient to refer generally to Ms Chevelle and Mr Bruce as such although they are from time to time otherwise described in documentation.

10 Ms Chevelle testified that she was feeling guilt about the termination and that there was a desire to achieve a continuance of Mr Bruce's family line and so she immediately planned to become pregnant again. When he gave evidence Mr Bruce was not asked whether he knew about the termination. In any event, at some point she must have become aware that she had possibly become pregnant again. 1st May 1988 has been given by her as the date of LMP but for reasons detailed by the various experts I find this specification unreliable. The statement of claim pleaded that the date of relevant LMP was uncertain.

11 On 23 June 1988 Ms Chevelle consulted a Dr Hepburn. Medicare records confirm a prolonged consultation and pregnancy testing by immunochemical method and by referral for blood pathology. Ms Chevelle said that she does not recall Dr Hepburn. On 5 July 1988 similar records reveal a consultation with a Dr Chalmers and again a reference for pregnancy test by pathology. Ms Chevelle said that she does not recall this consultation either.

12 Next, the records demonstrate consultations with Dr Godfrey whose practice is conducted under the

title Immediate Health Care. On 6 July 1988 (prolonged), 8 July 1988 (standard length), 12 August 1988 (long) and 23 August 1988 (standard). Ms Chevelle recalls Dr Godfrey. Exhibits 1 and 2 are copy referrals by Dr Godfrey, which I infer have been produced from the files of a Dr Szirt to whom Exhibit 2 is addressed. Exhibit 1 is simply addressed to "Dear Dr". It is dated 12 August 1988 and conveys that Ms Chevelle has had a positive pregnancy test but is uncertain of her dates. She has been pregnant five times (including current) and has delivered three children (P3 G5) and there is a request to take care of the pregnancy. Exhibit 2 is dated 23 August 1988 and conveys that Ms Chevelle has been pregnant six times and has delivered three children (P3 G6) and has just had an ultrasound and is 12-13 weeks pregnant. There is a request to "look after her".

13 An ultrasound report on Sharon Anderson (as Ms Chevelle is referred to in Exhibits 1 and 2) was prepared by Dr Warren and issued on stationery of Royal Hospital for Women (ward indicated as Outpatients Department) under date 22 August 1988. It reported no abnormality or unusual features. The measurements of crown-rump length (CRL) and bi-parietal diameter (BPD) of foetus resulted in the estimate of amenorrhoea abovementioned. Also mentioned was that the placenta was located on the upper part of the posterior uterine wall towards the right side. On 12 September 1988 Ms Chevelle was seen by a specialist obstetrician, Dr Szirt. For various reasons Ms Chevelle formed a dislike for Dr Szirt, at least she lacked confidence in him, and she decided to consult elsewhere. She was, of course, perfectly entitled so to do. However, she did not return to Dr Godfrey and on 5 October 1988 she saw another general practitioner Dr Lum. At the time Dr Godfrey's relevant practice was in Oxford Street, Bondi Junction and Dr Lum's in Bronte Road, Bondi Junction. She saw Dr Lum a second time on 14 October 1988 and he referred her to the defendant. On that date he wrote a very abbreviated referral indicating that Ms Chevelle was four and half months pregnant.

14 Ms Chevelle saw the defendant for the first time on 17 October 1988. I shall return to detail that and subsequent consultations, the next of which was on 14 November 1988. At the time of the visit the defendant arranged for Ms Chevelle to have an ultrasound examination. This was also performed by Dr Warren (who had had her referred to him at Royal Hospital for Women by Dr Godfrey as Ms Anderson) and whose report emanated from the rooms of private practice at Oxford Street, Paddington. The report of 19 October 1988 recorded normal observations with no unusual features. Measurements of foetus resulted in a calculation of twenty weeks amenorrhoea.

15 Between the first and second visits by Ms Chevelle to see the defendant, she made what she described as a couple of quick trips to Canberra with her son. She had resided near to Canberra until about the end of 1987. She claimed to have forgotten this visit until about twelve months ago when her son reminded her that on one of these trips she had called on a Dr Buchanan who had previously been her family doctor. Dr Buchanan sent her for another ultrasound. A report of this was produced at the hearing (MFI 4) but not tendered. Ms Chevelle suggested that her memory had so lapsed about this event that all that came to mind was that she may have just "popped in" to see Dr Buchanan. Dr Buchanan was not called. I do not accept that Dr Buchanan sent Ms Chevelle for an ultrasound examination as an incident of a casual social call. I cannot, of course, infer what did happen but Ms Chevelle's quite unacceptable description surrounding this matter is an accumulating factor with others which cause me to find her an unreliable witness.

16 After the excursion to Canberra, Ms Chevelle limited her obstetric consultations to seeing the defendant.

17 As mentioned, Ms Chevelle first saw him on 17 October 1988. Neither he nor she has a detailed recollection of the occasion. I am satisfied that the clinical record which was kept in Dr Kaye's rooms is an honest recording for relevant purposes. There has been criticism of the defendant's record keeping, in particular by Dr Caldwell, and there was some acknowledgement by himself. It needs to be remembered however that the notes are kept for the purpose of enabling the doctor to manage the patient. The notes are not created as a log of every incident and exchange between them. They are not a detailed chronicle presenting a complete description of the progress of pregnancy. There needs to be a sufficiency of notes but I accept that there would be no purpose in simply recording everything particularly things which are routine and satisfactorily progressing. The result is that some things will be noted and others not. I recognize that there is also a purpose in the notes in that, should a situation arise that Dr Kaye could not continue management (for example if he became ill), they could be made available to a succeeding obstetrician. I expect that they would be useful to such a professional but I am unconvinced that they are always useful in the hands of others, such as lawyers, seeking to make hindsight deductions.

18 I have found that the record is one of integrity. Paradoxically, this finding is fortified by an apparent inconsistency on the face of it. When opening the case senior counsel for the plaintiff drew attention to the duplication of the figures "38" representing the number of weeks of pregnancy for the visits on both 16 February 1989 and 23 February 1989. As the case against Dr Kaye was founded upon allegation that he permitted the pregnancy to continue too long, that is past forty two weeks, it was suggested that this double entry might be a pointer to how error came about.

19 Explanation was called for. It was given. The recordings in the notes were figures of whole weeks. The first entry in what became the table was on 14 November, the occasion of the second visit. The calendar shows that in the course of visits Ms Chevelle's appointment day was changed from a Monday to a Thursday. However, several subsequent entries were made simply by adding whole weeks to the initial figure. The adjustment which resulted in the appearance of a figure being repeated was a reasonable way of recording what, on the information available, was a truer picture. What is significant is that what appeared from a study of the records to be a mistake can be shown not to be so, however there was no attempt to disguise what gave an appearance of error. As I have said, I am satisfied that the records are bona fide.

20 It is convenient to deal with a matter related to this topic which was raised in final address. At T829 (and possibly on interpretation of a question at T818) Dr Kaye agreed in cross examination that by 9 February 1989 he had made his "rounding up and rounding down". That date was often referred to, as it was the date upon which an entry had been made on an antenatal cooperation card about which I will later deal. The clinic record shows the repeat entry of 38 weeks on 23 February. Although the answer I have described was obtained, it was not put that the defendant had contradicted himself in relation to evidence earlier given. In that absence I am not prepared to reach an adverse conclusion. It was his third successive day giving testimony and I assess the situation to be little different from occasional slips by questioners. There was necessary examination of a very large number of dates, and linkages between them and a large variety of actions. The answer upon which reliance is sought to be placed was followed by a question about the entry of a date on the antenatal cooperation card and that entry was indeed made on 9 February. It can be noted that a few questions later the defendant confirmed that the recalculation which led to the second entry of 38 weeks was consequent on recalculation which he had done on 23 February. He had given that evidence on several occasions and I place no weight upon the isolated inconsistency.

21 I return to the initial visit on 17 October 1988. Ms Chevelle told Dr Kaye that this was her fourth pregnancy and that she had delivered three children (P3 G4). This was only partly true. She had had seven pregnancies, two of which had been terminated and one miscarried. In addition her three children had been born. She did not reveal that she had had a termination very recently before becoming pregnant on this occasion. She did not reveal the series of medical practitioners she had consulted that I have already listed. Of critical significance was the fact that she did not reveal to him that she had had an ultrasound (as ordered by Dr Godfrey) during the first trimester. She testified that she could not think of a reason why she would not have given the report (which she thinks she may have had) to Dr Kaye, but it is plain that she did not.

22 In a letter from Dr Lamont of Prince of Wales Children's Hospital to a Dr Abrahams dated 3 September 1989 (Exhibit 3) which was primarily about Kristy it is mentioned that "mum changed obstetricians half way through her pregnancy for personal reasons and did not inform the second obstetrician about her first obstetrician ....". Ms Chevelle said (both in evidence and in a document (Exhibit 5) in 1990) that she had a conversation with Dr Kaye's secretary about changing doctors and was advised to tell him that she had just moved from interstate. Whether inspired by that advice or not, it seems that she did make that representation. It is hardly likely, therefore, that she would have presented Dr Kaye with an ultrasound report of a procedure performed in Sydney in August or told him about it. What Ms Chevelle does say militates against acceptance of her evidence that she can't remember whether she told him about the earlier ultrasound and that she did not think that she would not have told him. If she had told him of it he would have recorded the fact and, if necessary, set about getting a copy of the report. He would not have ordered a second ultrasound. The experts (including the defendant) are unanimous that a first trimester ultrasound is a more accurate tool for assessing the extent of pregnancy than one performed later. The defendant ordered an ultrasound in October because he had no other option and he had no knowledge from any source that an earlier scan might be in existence.

23 I should refer to the nature of the accuracy of ultrasound scanning and foetus measurement relative to equipment available in 1988. It is common ground that a first trimester scan (such as the one performed on 22 August 1988) can be used for measurements to calculate an estimated date of confinement (EDC) of plus or minus two to three days accuracy whereas in the second trimester (such as the scan ordered by the defendant) the accuracy is plus or minus seven to ten days. The exercise does not establish a range as some questioning in the course of trial appeared to suggest. The measurements establish an EDC with the stated qualifications. It would not be appropriate use of ultrasound scanning to conclude an EDC in terms of a range of twenty or twenty one days by assuming the extremes on either side of a calculated date.

24 The report of the August ultrasound and notes about the termination of pregnancy in March 1988 have been accumulated in the Royal Hospital for Women file. It was suggested in cross examination that the defendant, as a visiting medical officer with rights to introduce patients into the hospital, could have accessed the file. I expect he could but I cannot conceive any reasonable cause for him so to do. If a patient gives no history of any such procedure or examination, it is not the duty of a medical practitioner to conduct an investigation into whether he has been deceived. There was no clinical or other reason for the defendant to go to the hospital files.

25 Ms Chevelle told the defendant her LMP was 1 May 1988. She also told him that her cycle was a regular twenty eight days. There is no indication in the defendant's notes as to the degree of certainty attached to the stated date. Ms Chevelle gave evidence about her cycle. She was insistent that her period

"is always at the beginning of the month". She reiterated that it was always in the first week of the month although the exact day may alter between first, second or third. On a regular cycle of twenty eight days, given that only February in three years out of four has that number of days, whereas the other eleven months have thirty or thirty one days, it is impossible for a recurring event on that cycle to be always located in the first week of the month.

26 A statement by Ms Chevelle to which I will make reference on other matters (Exhibit 4) is contradictory of her evidence:

"My (menstruation) was usually irregular and I was never 100% of my cycle. Since the termination it was usually between the first and second week each month (around the same time as my eldest daughter.)"

27 The "follow-up" note after the termination which is deduced to have been made in mid April records "no period since" the LMP of 1 January. As the pregnancy with Kristy must have at least been established in June, the basis upon which a pattern was established "since the termination" is not detectable. These matters contribute to my assessment of Ms Chevelle's unreliability as a witness.

28 The clinic notes also confirm that Ms Chevelle told the defendant that she had been in Thailand and had suffered some diarrhoea. In her evidence she recalled the trip and calling a hotel doctor, but was not certain that diarrhoea was involved and unsure of exactly when the trip was taken. The trip extended for about three weeks. The only time frame into which such a trip would seem to fit with the various medical consultations is between 8 July 1988 and 12 August, on each of which dates she saw Dr Godfrey. Referring to the hotel doctor she said,

"He gave me some pills, a pill. I was not happy about taking it. I asked him for an extra one to take back and show Dr Kaye. I was quite worried taking medication in a foreign country or foreign doctors and all that."

29 The evidence of obtaining a pill to show Dr Kaye cannot be correct. She had no contact with Dr Kaye until referral by Dr Lum in October. She said that she had made some enquiries of his secretary but this would not have happened before she had seen Dr Szirt in September and decided that she did not want him to manage her pregnancy.

30 Ms Chevelle's reference to this trip in her statement (Exhibit 4) similarly lacks credibility. She said the trip was planned for September-October 1988 and "our first consideration was to check with Dr Kaye, as we did with most everything we did. Dr Kaye said this would be fine, he said there was no reason why not."

31 When she saw Dr Kaye for the first time on 17 October 1988 she gave him a history, which he noted, that she had already been to Thailand. She could not have "checked" with him beforehand. It was not possible that she has confused the timing with another overseas trip during her pregnancy as this was a Christmas visit to Mr Bruce's family in New Zealand.

32 Relevant history was provided by Ms Chevelle about the birth of her three children. Of greatest significance was the delivery of her third child, Dimity, by lower segment caesarean section (LSCS). Understandably, Ms Chevelle could not provide clinical detail about this and the defendant immediately

wrote an appropriate letter of enquiry to Dr Munro, a Canberra obstetrician who performed the procedure. On 1 November 1988 Dr Munro replied, having identified the patient known to her as Owen, and she supplied relevant information.

33 It is of interest to observe that it seems to have been the defendant's practice to initial documents, which he had seen, and which were presumably to be filed by his staff. Such initialling appears on copies of letters to Drs. Lum and Munro, and the latter's reply and on the ultrasound report which he had ordered and was done on 19 October 1988. It was not suggested that any copy of the August ultrasound bore such initialling, or for that matter, any report of the ultrasound ordered by Dr Buchanan in Canberra.

34 The defendant was therefore aware that Ms Chevelle had a scar consequent upon LSCS. She and the defendant agree that it was her wish to achieve natural birth and his notation that she should be suitable for trial (of scar) is consistent with a recognition of this and the precaution which the earlier LSCS dictated. On abdominal examination Dr Kaye's estimate was that the pregnancy was at twenty weeks and he recorded accordingly. The ultrasound performed by Dr Warren two days later (19 October) reported the measurement of the developing child as corresponding to those usual at twenty weeks amenorrhoea.

35 The clinical record contains other notations not requiring comment and continues as progressive visits were made. The records show, and I am satisfied of the facts, that there were no untoward signs or symptoms being manifested. The baby's growth, position, sound and movement gave no cause for alarm or any particular action by the obstetrician.

36 If Ms Chevelle was of twenty weeks amenorrhoea on 19 October 1988 as estimated by the examination and the ultrasound, then by simple calendar count she reached term of forty weeks on 8 March 1989. On 9 March Ms Chevelle was seen by Dr Kaye. He recorded her then as forty weeks pregnant. The one day difference is not significant. A comment on the art and science of obstetrics that only one in every twenty children arrives on the calculated due date was a statistic which no one challenged. At that consultation the defendant noted that the cervix was soft and one centimetre dilated. There were no abnormal signs. It was reasonable at that stage to wait for Ms Chevelle to come into spontaneous labour.

37 Before dealing with events from forty weeks (on 9 March) onwards I should return to particular of negligence (a) which referred to an EDC of plus or minus 2 March 1989. In terms of part of the particular, I repeat my findings that the defendant had no knowledge nor should he have had knowledge of the ultrasound report of 22 August 1988. I interpolate that during cross examination Dr Kaye was questioned about the location of the placenta within the uterus and he referred to it being on the right hand side as shown in ultrasound. That location was mentioned in the August report but not in the October report. It is obvious that in the course of preparation for the action against him Dr Kaye would have become aware of the content of the earlier report and it was not put to him that that reply revealed that he had seen the August report during his management of Ms Chevelle's pregnancy. I do not infer that his evidence that the report was never seen by him during management of the pregnancy was false.

38 The Royal Hospital for Women made available for distribution an antenatal cooperation card. Printed instructions on the pro forma were (for the patient) to bring the card on each visit (to the obstetrician) and to the hospital. The card was prepared by the defendant and given to Ms Chevelle on 9 February

1989. On that date the first of the available spaces for information to be completed by the obstetrician was filled in. The calculated duration of pregnancy was written as thirty seven weeks. This is the same as the record in the clinic card kept by the defendant. The other recordings of uterine size (fundal height), presentation and position, engagement, foetal heart sounds and maternal blood pressure were normal. The general information sections of the card were also completed by the defendant including Ms Chevelle's past obstetric history, accurately translating what had been told to him and noted during the consultation on 17 October 1988.

39 I accept the defendant's evidence that he endorsed the EDC as plus or minus 2 March 1989 simply by adding three weeks to the calculated duration of pregnancy statement of thirty seven weeks, thus fixing what on that arithmetic was a forty week point. As I have earlier found, this endorsement made on 9 February antedated the recalculation of pregnancy duration which allowed for the nearer rounding made appropriate by the change in day of the week of Ms Chevelle's appointments. That this had happened after 9 February is detectable from the next endorsement of examination findings on the card which is dated 2 March. 2 March is in fact three weeks after 9 February but the duration of the pregnancy is marked to increase only by two weeks, that is, from thirty seven to thirty nine weeks. What the defendant did not do was alter the EDC marked on the card to coordinate with the calculated duration entries.

40 It was vigorously asserted to and through witnesses that it was a principle of good obstetric practice that once an EDC had been calculated, the obstetrician should adhere to it. I accept that, as a general principle, that is so. I do not accept that it is necessarily bad practice to depart from the principle if there is a good reason for so doing.

41 However, the evidence does not persuade me that Dr Kaye made such a change. What was referred to as a change in questions put to him, was a change, not in calculated date, but in his records to which he would have reference if need be. He would not himself be using the unaltered date on the antenatal cooperation card as a reference.

42 The use of rounded weeks and the change in the day of visit upon which consultations recurred combined to make it appropriate to make the repeat entry of "38" to give a truer picture upon the information available. In the background of keeping figures is a consciousness, I would expect, of the statistical certainty that nineteen out of twenty infants will not arrive on the EDC.

43 The defendant testified that he always had in mind an EDC of 9 March 1989. That is consistent with his clinical impression of pregnancy when he saw Ms Chevelle on 17 October 1988 and also consistent with the measurements on the ultrasound which he obtained. It is true that, based on an examination of inks apparently used, the defendant accepted that he probably did not write the EDC of 9 March 1989 on the clinic card until 21 February 1989. He treated the clinic records in his room as essentially notes for himself. That is what they were. He would have had in mind the progress of the pregnancy to term as he recorded the weeks of duration. I find it entirely understandable, when he realized on 23 February, that he should repeat the "thirty eight" weeks record, he would at that point endorse a particular note of the EDC. If, for example, he came back to his records and saw the "double thirty eight" entry and did not immediately have in mind how that came about, he would have the precise recording of EDC which he had put onto the card.

44 The question arises whether anything flows from the failure to amend the date on the antenatal

cooperation card or in leaving it to read as it was originally completed, that is showing an EDC plus or minus 2. 3. 89. The evidence is that cards of this type were introduced in about the decade of the eighties. There was not universal practice in hospitals concerning the use to which they would be put. Dr Lyneham, the Head of Gynaecology at Royal Prince Alfred Hospital/King George V Hospital, who was called by the defendant, experienced the use of the card solely for administrative purposes to secure a booking for the mother. The practice at Royal Hospital for Women was different in that it was an information resource, particularly if a woman came to the hospital in an emergency, herself or the child in utero, in need of care or treatment. The use would not, I apprehend, be limited to emergency. When this distinction was drawn to Dr Lyneham's attention he accepted that a limit of purpose to administration was not appropriate but he adhered to his view that no clinical action would be taken on the basis of a date entered on a card of this nature.

45 Relevantly, in the present case, no clinical action was taken on the basis of the date written on the antenatal cooperation card. No one at the hospital or anywhere else took any action or refrained from taking any action by reference to the EDC entered on that card.

46 If in fact the defendant had calculated the EDC at or about 2 March, it would have to follow that the recordings, at least in part, of the extent of weeks duration of pregnancy on the clinic record in his rooms, had been falsified. I reject any such notion and refer to my findings of the genuineness of those records.

47 Obviously hindsight reveals that it was unfortunate that the entry was made on the cooperation card. Unexplained and viewed in isolation it does not require obstetrical skill to reason that if pregnancy is advanced to forty weeks on 2 March, a baby delivered on 21 March has been delivered in the forty third week. A great deal of investigation and opinion seems to have been based upon this hypothesis. Whilst it is understandable now how such a hypothesis might be developed, it does not accord with the facts.

48 It should finally be noted in relation to the ante natal cooperation card that the endorsements by the defendant following his consultations on 9 and 16 March record duration as forty and forty one weeks respectively. Again this is exactly compatible with the clinical record kept in his rooms. The final consultation includes (for the first time) in the space for remarks, a reading "induce next week". This is in harmony with the defendant's evidence that he would seek to intervene if spontaneous labour had not been achieved by week forty two.

49 The defendant was cross examined and Ms Chevelle gave evidence about remarks that all the "February ladies" had been delivered. I do not accept that the defendant had told Ms Chevelle as at the time that she went to New Zealand for two to three weeks over Christmas that she was "due" in mid to late February. Attention was also directed to a list of women endorsed, and then usually struck through, in pages of a diary kept by the defendant. The plaintiff's case was pleaded as above set out on the basis of a failure to adhere to an early March date. The raising of these matters seemed to suggest differently that perhaps the due date was in February. The diary entries were obviously not clinical records but had a use in enabling the defendant to be aware of budgetary progress which was reflected ultimately in a number of confinements attended per annum. If the entries had any clinical significance they would not be simply a list but be diarised in accordance with various EDCs. Any reference to "February ladies" being delivered was likely to have been an expression designed to comfort and encourage a mother whom an experienced obstetrician would recognize was likely to feel jaded towards the end of her term.

50 On the evening of 20 March 1989 Ms Chevelle became afflicted with pain, variously described, but in a statement (exhibit 4) setting out a version of events as she recalled them "excruciating, niggly pains". A telephone call was made to the hospital and while talking to a nurse she felt "the most agonizing pain which made me shriek". She had, a little beforehand, noticed a blood discharge but by this time she was passing obvious blood. Mr Bruce took her to the hospital. She used a towel to absorb the blood. On the way to hospital she was conscious of her waters breaking. On arrival the towel was saturated by the combined liquids. She said her clothes were covered in blood and she was given a hospital gown but the nurses had to change her twice because of the bleeding. The probability is that these intense afflictions started that evening. Ms Chevelle has given evidence suggesting that the defendant failed to react to earlier complaints of pain by her. She had been seen by him on 9 and 16 March. On those occasions her blood pressure was within normal range and there was nothing untoward in the results of conventional examination of the child's position and sounds. I accept that Ms Chevelle was by that time in discomfort and was, as she said, fed up. In a colloquial sense the birth was "due" and the EDC of 9 March had been reached. There seems to be no real dispute that there were exchanges between obstetrician and mother about "old wives tales" and folk remedies for bringing on due birth and that Dr Kaye said things like "you had better talk to your baby". I find nothing sinister, nor negligent, in relation to these exchanges which I view as amiable encouragement in a situation where no doubt Ms Chevelle wanted her passage through the pangs of childbirth to be over. I am not persuaded that any complaints of pain or discomfort described to him before 20 March would have caused a prudent obstetrician in his position to take any particular action and his decision to await spontaneous labour, but intervene by induction if it had not occurred by the week following the consultation on 16 March, was reasonable in all the circumstances.

51 I return to the events after the arrival at hospital. There is some obscurity about the time of arrival. This is hardly surprising as I would expect Ms Chevelle and Mr Bruce to be concerned about her symptoms and the staff focussed upon assessing her condition rather than watching a clock and diarising its reading. By reference to a television programme they were watching Ms Chevelle estimates a time of arrival at 10.30pm. The hospital integrated notes show an admission time of 11.15pm, however one entry describes administration of pain relieving drug at 11pm.

52 Ms Chevelle was seen by a midwife, Sister Luschwitz. Ms Chevelle's distress and presentation was such that the midwife could not palpate her abdomen. She noted the presence of meconium on vaginal examination and that Ms Chevelle was three centimetres dilated. A foetal scalp electrode (FSE) was applied. The midwife made a record of "late & deep type 1 decelerations". Type 1 decelerations would not, but late decelerations would, be very ominous. The record was ambiguous.

53 Dr Kaye was telephoned at his home. At that hour he had retired to bed. He ordered blood cross matching and asked that the Registrar see Ms Chevelle and call him back. This instruction led to some cross examination of the defendant about his opinion of the particular midwife, whom he described as average. The relevance of the cross examination was not immediately apparent but I comment that the internally contradicting note of the FSE trace might support that view. However, the Registrar was reported as unavailable and this was conveyed to Dr Kaye who responded that he would himself come in immediately.

54 He arrived at 11.35pm. Inter alia, he found Ms Chevelle six centimetres dilated and read the FSE trace as type 2 decelerations with variable dips. It is common ground that, fifteen years later, the actual trace, if it is still in existence, cannot be located.

55 Dr Kaye determined and directed immediate LSCS. It is unnecessary to examine all aspects of what occurred after this point, but it needs to be remembered that no allegation of breach of duty is made in relation to the defendant's conduct. The necessity for examination of what occurred arises from derivative arguments directed to supporting the assignments of negligence and the particulars of causation which I have earlier detailed.

56 There were descriptions by Ms Chevelle concerning encounters with Dr Kaye at this critical time and of his asserted absences. She also described what she regarded as deprivation of pain relieving gas. I do not think that her memory of the detail of what must have been, to say the least, a frightening experience, is reliable.

57 In fact, when Dr Kaye arrived Ms Chevelle was on her hands and knees in a very distressed state. He made the necessary observations, gave the appropriate instruction and set about organizing an operating theatre. It so happened that what I expect may have been the ordinarily available theatre (it was approaching midnight) was being used to operate on a woman with a ruptured ectopic pregnancy. Dr Kaye told staff that Ms Chevelle's condition was such that she could not wait until that operation was finished. A second theatre was opened and prepared. Dr Gatt, an anaesthetist engaged in the operation in the first theatre left his Registrar to carry on and came to attend to Ms Chevelle.

58 It is informative of the promptness and professionalism of all concerned that Dr Kaye had arrived at hospital at 11.35pm, about fifteen minutes after the telephone call, and the plaintiff was delivered in theatre by LSCS at thirteen minutes past midnight.

59 In March 1990 Ms Chevelle wrote a letter to a Mrs Caswell, apparently the "Quality Assurance Coordinator" at Royal Hospital for Women (exhibit 5). She related "disappearances" by Dr Kaye who was "calmly" waiting because he said "she wants a natural birth". She claimed that the defendant was in effect goaded into action by Mr Bruce. The assertions by Ms Chevelle about these matters are contradicted by what happened and the records are consistent with the defendant's descriptions.

60 Although the terms of the letter express a wish to have this matter "investigated", it conveys a clear impression that Ms Chevelle was seeking to be able to cast blame on Dr Kaye and/or hospital staff for what no one would dispute was a tragic outcome of her pregnancy.

61 After delivery of the plaintiff, Dr Kaye manually extracted the placenta. It was passed, routinely and correctly, for later pathological examination. What he then observed was that, although the previous LSCS scar was intact, there was a posterior uterine rupture extending laterally to the left broad ligament. He estimated the length of the rupture as ten centimetres. He observed blood in the peritoneal cavity. He recorded this at 300 mls. He agreed in cross examination that this was a guess. It would obviously not have been possible to measure the volume but I did not understand the concession to mean that the recorded volume was random, rather that it described as best he could, what he saw.

62 What had been encountered was a very rare occurrence. One of the reasons that is important for an obstetrician to have a history of previous caesarean sections is that the residual scar is vulnerable to dehiscence, that is scar separation. Such separation may not, however, penetrate the uterine serosa but, uncommonly, it may. Uterine rupture is, as stated, very rare. What was extraordinarily rare was that, in this instance, there was a previous LSCS scar but it remained entirely intact while there was a major

rupture elsewhere in the uterus.

63 Upon this discovery, the defendant was able to secure the attendance of a senior consultant Dr Harris and a hysterectomy was performed. As I have previously noted the overall effect was lifesaving surgery.

64 Upon delivery the plaintiff was passed into the care of neonatal staff. She required resuscitation. Upon transfer to Prince of Wales Children's Hospital she was accompanied by a note which appears to have been signed by a Dr Catherine Bowie on behalf of Dr Peter Campbell. The latter has been identified as relevantly concerned with neonates at the Royal Hospital for Women. Part of the history recorded and passed to the Children's Hospital was that at LSCS there had been found "posterior uterine rupture with placental abruption". It is common ground and consistent with all opinion, that there had been no placental abruption, which is a description of a particular occurrence and the statement in the letter was erroneous. This led to the acquisition of some unnecessary opinion but, in the event, nothing turns upon the error.

65 The final submissions on behalf of the plaintiff drew attention to assertions by Ms Chevelle that Dr Kaye had said in explanation of Kristy's condition that the placenta had "come away". Dr Kaye agreed that when faced with the symptoms being displayed and complained of when he arrived at hospital and he organized the emergency LSCS, one of the possibilities he considered was that there might have been placental abruption but at operation he became aware that there was not. Questioned, Ms Chevelle spoke of recalling many people including Dr Kaye speaking of the placenta coming away. It is possible that she got some information which was the same as the error in the letter accompanying transfer that I have mentioned. I do not accept that she was misinformed by the defendant.

66 Upon admission to Prince of Wales Hospital the plaintiff was examined by a Dr Chong and he made notes. He was not called. A considerable issue arose about one part of the notes, the handwriting of which is very small. I read the relevant parts as follows:

"Dry, parched skin

Palmar + sole creases ++

Meconium + blood stained skin

No dysmorphic features."

67 It is a well known method of medical recording and observable in the documentation in this case, to indicate degrees by the use of the plus sign. The larger the number of signs the greater intensity being indicated. I acknowledge that the plus sign is often used, within and outside medical practice, in lieu of an ampersand to indicate the word "and".

68 Hence the second and third lines above quoted may mean "palmar and sole creases to the degree of two plusses" and "meconium and blood stained skin (without any particular degree specified)." Or, it may mean "creases to the degree of one plus on palmar surfaces" and "to the degree of two plusses on sole surfaces" and "meconium to the degree of one plus sign" and "blood stained skin (without any degree specified)."

69 The issue acquired importance by reason of opinion that meconium staining as distinct from the presence of meconium as yet unwashed from the skin, provides an indication of extended time in which the child was exposed to meconium in utero.

70 I am unpersuaded, on the balance of probabilities, that Dr Chong was recording, and therefore had observed, meconium stained skin and the probability is that he was recording that the baby on arrival had meconium still on its body. The emergency of resuscitation would, as was suggested by evidence, have made the routine washing and cosmetic appearance a secondary consideration. I accept as correct the comment by Dr Evans that the emergencies surrounding care of sick babies would generally result in bathing being delayed. Blood does not stain the skin and I think it likely that Dr Chong was simply describing a state in which he first saw the child. In addition, the double plus in the previous line concerning the observations of creases suggests his use of the plus sign to denote intensity rather than as an ampersand. Further, there is no other reference in the Prince of Wales Hospital notes to meconium (staining or otherwise), which suggests that any meconium that Dr Chong observed was in due course removed, I would infer when it was appropriate to bathe the baby. The presence of blood on skin (misdescribed as staining) offers confirmation that the infant had not been bathed before transfer. My interpretation of Dr Chong's note is the second of the alternatives set out above. Meconium was present but the skin was not meconium stained.

71 Pathological examination of the placenta was undertaken and reported on by Dr Bierre, a histopathologist at the Royal Hospital for Women. His report is contained in exhibit D. His findings do not support the proposition advanced on behalf of the plaintiff that hypoxia caused or contributed to by placental perfusion was causative of the plaintiff's cerebral palsy.

72 What eventually became a substantial (in quantitative terms) body of expert evidence was tendered. The parenthetical qualification is not a criticism of content but as I drew to attention several times throughout the hearing, my task was not to conduct a commission of enquiry into all the events from Kristy's conception to the present day, nor on the issues of liability, to opine beyond what was relevant to determine whether or not damage flowed from breach of duty by the defendant. Dr Caldwell was an expert obstetrician called in the plaintiff's case. The evidence includes his medical report dated 12 June 2000 (part of exhibit C). His opinion insofar as it is based upon an assumption that the defendant had been supplied with, or ought to have known of the content of the ultrasound report of 22 August 1988 must be discarded. Nor do I accept the opinions based upon a "change" of EDC from plus or minus 2 March 1989 to 9 March. For reasons given above I have found there was no "change". These are principal matters upon which the plaintiff's case was founded. I do not deal with every aspect of his evidence but I will deal with opinion concerning placental insufficiency as a relevant cause of the ultimate injury. The defendant postulates that the sole cause of injury was the posterior uterine rupture.

73 Placental insufficiency is not something which occurs as a sudden event. Other evidence, which I accept is that, if it is present, it will affect the nutrition of the foetus before other consequences. There is no evidence that Kristy was seen to be malnourished on examination of her after birth. Much attention was paid in cross examination of Dr Caldwell (and in the examination and cross examination of other experts) to a published article on Uterine Rupture After Previous Caesarean Delivery by Dr Anna Leung and others (exhibit 9). In order to contextualize the present case with some of their findings, much attention was devoted to the amount of bleeding manifested by Ms Chevelle, in particular reference was made to the relatively small volume of blood in the peritoneal cavity recorded as detected at operation.

74 The various statements of Ms Chevelle about this and her evidence are not altogether harmonious. In her letter to Mrs Caswell she reported that Mr Bruce told hospital staff that she was haemorrhaging heavily. She did not suggest to Mrs Caswell that this was inaccurate. I have already mentioned the descriptions of changes of clothes at hospital because of blood staining. In that blood loss can ultimately be causative of a drop in blood pressure and that such a drop did not manifest until Ms Chevelle was in the operating theatre does not contradict a finding that Ms Chevelle was losing blood significantly from the time she and Mr Bruce were at home and realized that something very untoward was happening. Hence I do not find useful opinions based upon assumptions of minor blood loss.

75 However, significant concessions were made by Dr Caldwell in cross examination. He admitted that counsel for the defendant had advanced good reasons for contending that there had not been placental insufficiency, and in particular he said:

"I honestly don't think you could say definitely that you have not got placental insufficiency. I think that there are some matters which I have mentioned that suggest a possibility that there is some placental insufficiency. As I said, my case is not proven. I am not absolutely sure that yours is entirely proven either." (T381).

76 There had been late service on behalf of the defendant of a report by Professor Evans. With that in mind but principally having regard to the potential damages if the plaintiff became entitled to them, I gave leave to the plaintiff to call expert evidence which appears to have been gathered during the hearing which had commenced on 11 February 2004.

77 On 26 February 2004 obstetrical opinion was sought on behalf of the plaintiff from Professor Ellwood of the Canberra Clinical School of the University of Sydney. It might be noted that on the basis of the October ultrasound scan (the only one upon which the defendant could possibly have relied) Professor Ellwood calculated an EDC of 8 March 1989. The calculation of 9 March 1989 by the defendant is inconsequentially different. Obstetricians are apparently supplied with "pregnancy wheels" by various commercial entities and application of what is called Nagele's rule on different wheels seems to produce insignificantly different exact dates.

78 Specifically Professor Ellwood was not critical of the assumed due date of 9 March 1989 nor of allowing the pregnancy to proceed to 20-21 March 1989 (T576-7). He also agreed that a reasonable obstetrician in the position of the defendant would not seek to intervene (by induction) unless the patient, with a previous history of LSCS had a pregnancy duration which had gone beyond forty two weeks.

79 In an initial report Professor Ellwood opined that the uterine rupture may have occurred relatively late. This opinion was based upon very incomplete briefing concerning the signs and symptoms displayed by Ms Chevelle on the night of 20 March. Focussing upon the dichotomy between placental insufficiency and uterine rupture as the cause of damage, it can be noted that Professor Ellwood confirmed that placental insufficiency itself should not cause pain. Ms Chevelle was extremely afflicted by pain at relevant times. This is more obviously a sign of rupture than placental insufficiency. I am satisfied that the rupture, in commencement, manifested while Ms Chevelle was at home and this was quite likely to be at about the time of that what she described as an excruciating pain afflicted her.

80 Professor Colditz of the University of Queensland was consulted on approximately 17 February 2004

and he gave an initial report on 23 February. Therein he answered affirmatively a question posed as to whether the plaintiff's brain damage was more likely to result from an intrapartum event than developmental deficiency. He also answered affirmatively to a proposition that the notes by Dr Chong at the Prince of Wales Children's Hospital which I have above set out were indicators of post maturity. It was assumed however, that the entry on the third line which I quoted was "meconium and blood stained skin" which is not my interpretation of the note. Professor Colditz's opinions emphasized that meconium staining (as distinct from presence) was significant. My finding is different from what he was asked to assume.

81 The signs manifested by Ms Chevelle on admission and the anaesthetic record were consistent with foetal compromise. But, more importantly, they were also consistent with what Dr Kaye observed on arrival and his uncriticised decision to proceed to caesarean delivery immediately.

82 There was conflict between the opinions of Professors Evans and Colditz particularly on the issue of whether it could be deduced that Kristy's condition was the result of chronic placental insufficiency. Each expert, aware of the difference of view then pointed to matters claimed to support their respective opinions. Professor Colditz pointed to an asserted discordance between her birth weight and head circumference. Professor Evans pointed to the absence of raise in her nucleated red blood cell count (nRBC).

83 The significance of any discordance between head circumference and birth weight must be derived from the application of calculation to statistical tables. The latter are not universal and choice must be made out of tables which result from surveys of different groups. Each measurement requires grading within a statistical percentile band. I am unpersuaded that a conclusion of chronic placental insufficiency as a cause of the cerebral palsy should be drawn upon the thesis advanced. The margins involved do not convey to me sufficient precision for such a conclusion.

84 Counts were taken in respect of sample when Kristy was twelve hours old. The nRBC and lymphocyte count were in the middle of normal range. It is, of course, indisputable, that asphyxia did occur and this led to the cerebral palsy. It is argued for the plaintiff that the "best explanation" is that she simply fell into the category of foetuses that do not display an increase in either count and that therefore it cannot be concluded that "the hypoxic event was a consequence of uterine rupture as opposed to diminished placental perfusion."

85 Professor Evans opined that the nRBC within normal limits was consistent with an acute insult such as uterine rupture. Unless the foetus fell into the category submitted on behalf of the plaintiff, the normal counts contra-indicated chronic placental perfusion. The probabilities support Professor Evans' opinion.

86 It is the defendant's case that the sole cause of the plaintiff's damage was the acute uterine rupture. Whether there has been a shift in the evidential burden as argued on behalf of the plaintiff or not, that case advanced by the defendant is established on the evidence.

87 A special initiative (subsequent to Kristy's birth but that is not relevant) was established seeking to define an objective template of evidence to better identify cases of cerebral palsy where the neuropathology began or became established during labour and birth. A consensus statement was published in the British Medical Journal and by reference to an author it has been referred to as the

MacLennan Template.

88 Following analysis, Dr Lyneham opined that:

"I believe that there is little doubt that on the basis of the template necessary to establish a link between an acute intrapartum event and subsequent neurological damage in an infant, it is likely that, on the balance of probabilities, the plaintiff's condition is a direct consequence of the acute uterine rupture. There is hardly an acute uterine event that is more dangerous to an infant than acute uterine rupture 10 cms in size, and in my opinion the causal link is established."

89 I find that opinion borne out by the evidence on the whole and I accept it. The acute uterine rupture was a "sentinel" event about which there is no dispute concerning occurrence and that it was capable of causing the damage. The alternative contended for (and pleaded) by the plaintiff is a hypothesis which is undermined in my view into legal insignificance. I am conscious that it was conceded by Dr Lyneham that one never says never in medicine. That expression is an admission that possibility can be speculated and not that a possibility reasonably exists on the evidence in the case. Kristy's state of nourishment contradicts, and the pathology results of examination of the placenta do not support, that the placenta failed in a causative way. Her body was not meconium stained in a relevant sense and the observations of post mature features (dry skin, scaling and the like) are not, in my view, probative. Professor Ellwood pointed out that a foetus with characteristics of post maturity may be born earlier than forty two weeks whilst the converse was also true that many babies born beyond forty two weeks do not have post mature features.

90 Given the unanimity of experts, save some unconvincing qualifications by Dr Caldwell at one stage, that it is well in accord with good obstetrical practice to allow a pregnancy to proceed to forty two weeks I would express my acceptance of these observations of Dr Lyneham:

"The neurological harm suffered by the plaintiff was a direct consequence of the acute intrapartum event of the ruptured uterus, and this is extremely important to appreciate. Despite coming into spontaneous labour and having no augmentation of labour with oxytocin or prostaglandins, the contractions that the mother experienced were of sufficient strength to result in the posterior uterine wall rupture. Whether this rupture occurred spontaneously as a consequence of her normal contractions, or whether there was a weakness in the posterior wall of the uterus as a consequence of previous uterine perforation associated with a therapeutic abortion or curettage (to my mind more likely but not provable), had labour been induced prior to 20 March 1989 with either an oxytocin infusion or prostaglandins, neither of which was contraindicated under the circumstances of this case, then in my opinion it is more likely than not that exactly the same sort of uterine rupture would have occurred. If labour had been induced the contractions probably would have become stronger even more quickly, and it is more likely than not that the outcome would have been the same uterine rupture with sudden severe foetal compromise. That is, in my view, the only way that such an outcome could have been avoided would have been for Dr Kaye to have performed an elective caesarean section before 20 March 1989, and as I have already discussed there was no clinical indication to perform an elective caesarean section. No harm came to the plaintiff as a direct consequence of the failure to induce labour prior to 20 March 1989, and the pathological process that resulted in the plaintiff's injury was, to my mind, unpredictable and unforeseeable but almost certain if labour had been induced."

91 As Dr Lyneham pointed out no one can know what it was that caused the weakness in the posterior

wall of Ms Chevelle's uterus. From her understanding, she had given a history of a tear which she said was not repaired following the birth of her second child in 1972. But against inculpating that, is the birth of Dimity without rupture occurring in 1985. As Dr Lyneham pointed out the weakness could have been a consequence of a complication in one of Ms Chevelle's previous abortions or a procedure by dilatation and curettage to remove an intrauterine contraceptive device (such had been implanted by Dr Munro after Dimity's birth). As he comments, it is entirely feasible that at one of these procedures there was an inadvertent perforation of the posterior wall, which at the time did not result in any clinical manifestation. As a matter of hindsight, considerable suspicion must be directed to the very recent termination which Ms Chevelle underwent just prior to becoming pregnant with the plaintiff. As stated, a conclusion cannot be reached other than that there was nothing to suggest that there was any relevant matter of which the defendant ought to have been aware and reacted to.

92 Professor Evans confirmed that rupture of the uterus is a rare and often devastating complication of labour. It is one of the main defined hypoxic sentinel events. The others, by reference to the MacLennan Template are placental abruption, cord prolapse, amniotic embolism and foetal exsanguination. None of those was present in this instance.

93 A submission that the sentinel events include inter alia uterine rupture and low APGAR scores overlooked the distinction between possible sentinel hypoxic events, which are as listed and only one of which (uterine rupture) was here present and relevant criteria, one of which is low APGAR score.

94 It is not necessary to recite at length Professor Evans' evidence and I am satisfied that he is correct in opining that the plaintiff suffered an intrapartum hypoxic ischaemic brain injury as a result of a catastrophic intrauterine event in the form of a uterine rupture. I also accept the evidence to similar effect of Dr Lyneham. The evidence is not consistent with late gestation severe intrauterine compromise due to placental failure.

95 In final submissions the allegations of breach of duty by the defendant were articulated in part in slightly different terms from the particulars above recited. The restatement was in these terms (what were particulars (a), (c), and (e) are now submissions (e), (c), and (d)).

"Dr Kaye breached his duty of care because he:

(a) failed to recognize the risk of injury should the foetus remain in utero for longer than 42 weeks.

(b) if the defendant did recognize the risk of injury referred to in (a) above, he failed to act on it by:

(i) selecting an estimated date of confinement (EDC) that obviated or substantially reduced the risk, or

(ii) having selected an EDC which obviated or substantially reduced the risk of injury, failing to adhere to it.

(c) failed to recognize on that on 16 March 1989 Ms Chevelle was already 42 weeks pregnant and ought not to have permitted labour past that date.

(d) failed to induce or otherwise perform an assisted delivery of the plaintiff prior to 20 March 1989.

(e) failed to adhere to an estimated date of confinement of + or – 2 March 1989 when he knew or ought to have known that this was the most appropriate estimate having regard to the ultrasound report of 22 August 1988.

In breach of the duty he owed, Dr Kaye permitted the plaintiff to be born post mature, exposing her to a risk of cerebral palsy."

96 I summarize my findings in respect of these allegations.

97 The defendant did recognize the risk of injury should the foetus remain in utero for longer than forty two weeks. He did not "select" an EDC but calculated one on the basis of all the information that was reasonably available to him. That calculation resulted in a date of 9 March 1989. He did not fail to adhere to that date. On the probabilities Ms Chevelle was not at forty two weeks on 16 March 1989 nor was there any reasonable basis upon which the defendant ought to have thought that she was. The plan to proceed to induce birth in the week following consultation on 16 March 1989, if Ms Chevelle did not come into spontaneous labour (as she did) was reasonable and in accord with good obstetrical practice. The defendant had no opportunity to have regard to the ultrasound reported on 22 August 1988 as, for reasons of her own, Ms Chevelle withheld from him any knowledge that it had been performed. There was no reason why he should have made enquiries or searches as she also withheld from him information that she had previously consulted other medical practitioners (with the exception of Dr Lum) about her pregnancy. The date of plus or minus 2 March 1989 on the antenatal cooperation card was of neither clinical nor legal significance.

98 The cause of the plaintiff's injury was the catastrophic uterine rupture discovered at operation, which had started to manifest itself at Ms Chevelle's residence provoking the urgent dash to the hospital. As she recorded in one statement the perception of urgency was such that traffic control installations were ignored on the journey. The plaintiff's injury was not caused by placental insufficiency because the pregnancy had extended too long or at all.

99 No one could fail to be moved by Kristy's plight nor fail to acknowledge the dedication and devotion of her mother and family to her care. But Kristy's plight was not a consequence of breach of duty of care by the defendant. In short, he took reasonable care in the relevant management of Ms Chevelle's pregnancy in all the circumstances, and in treating her he exercised the care and skill to be expected of a competent obstetrician.

100 I conclude that there must be judgment for the defendant.

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