COMMONWEALTH OF THE BAHAMAS

IN THE SUPREME COURT

Common Law & Equity Division

2023/CLE/gen/00214

BETWEEN

WIDLINE GUILLAUME

Claimant

AND

DR. AGATHA FOULKES-MACKEY

First Defendant

AND

PUBLIC HOSPITALS AUTHORITY

Second Defendant

JUDGMENT

Before: The Honourable Mr. Acting Justice Raynard S Rigby KC

Appearances: Miss Myra E. Russell for the Claimant
Miss Melissa Wright, Mrs. Pamela Jones and Mrs. Mia Ramsey for the First & Second Defendants

Trial Dates: 15, 16 and 17 June 2026

Closing Submissions: 8 July 2025

Medical practitioner – Negligence – Duty to take care – Burden of proof – Claimant giving birth in Second Defendant's hospital – First pregnancy – COVID protocols – Emergency caesarean section surgery – Claimant's baby dying – Whether breach of duty of care – Test for clinical negligence – Whether negligence proved – Caused of baby's death – Expert evidence – Conflicting Evidence

Rigby J. Actg.

Introduction

1. This action centers on the sad and untimely death of a female infant born to the Claimant on 2 August 2022.

2. The Claimant is the mother of the deceased baby girl named Elizabeth Lundy ("**baby Elizabeth**"). Baby Elizabeth died on the day of her birth, just a little over 2 hours after her delivery. As can be expected, the mother and father, Ocasio Lundy, were devastated by the loss. Nothing, I am sure, can restore the hope that they had in raising their precious baby girl.

3. The First Defendant, Dr. Agartha Foulkes-Mackey, at the material time was employed with the Public Hospital Authority ("**PHA**" or "**the Authority**") in the capacity of Registrar. Dr. Foulkes-Mackey is a medical doctor specializing in Obstetrics and Gynaecology. She is also a member of the American College of Obstetrics and Gynaecology ("**ACOG**") and the Royal College of Obstetrics and Gynaecology ("**RCOG**"). She was the attending senior doctor on duty at the Princess Margaret Hospital, when the Claimant was admitted and delivered baby Elizabeth.

4. The Second Defendant is a statutory authority formed pursuant to the provisions of the Public Hospital Authority Act, 1998 ("**the Act**"). By section 3 of the Act, it is charged with responsibility for "**the management of the hospitals known as the Princess Margaret Hospital, the Rand Memorial Hospital and the Sandilands Rehabilitation Centre**". It can be sued in its corporate name (see section 3(3)). Section 5 of the Act sets out the functions of the Authority and provides:

> **5. The functions of the Authority are —**
> **(a) to control, regulate and administer all matters related to the management of any hospital;**
> **(b) to ensure the application of efficient and appropriate techniques, systems and standards for the delivery of health care in its hospitals;**
> **(c) to appoint such employees as it considers necessary on such terms and conditions (including salaries, allowances, other remuneration and disciplinary control) as the Authority may determine;**
> **(d) to fix qualifications and terms and conditions of service relating to its employees;**
> **(e) to consult with the Minister on matters of national health policy and capital development programmes for hospitals;**
> **(f) to operate, construct, equip, furnish, maintain, manage, secure and repair all its property for use by the general public;**

(g) to facilitate the use of its hospitals for service, teaching and research;
(h) to establish and develop relationships with national, regional and international bodies engaged in similar or ancillary pursuits;
(i) to collaborate with educational institutions, such as the University of the West Indies and any other recognised training institution, in the education and training of persons and in research in medicine, nursing, dentistry, pharmacy and biomedical and health science fields, as well as any related ancillary and supportive fields.

5. The Claimant seeks compensation for the loss of baby Elizabeth by the alleged negligence of the Defendants. It is a claim formed on tort and medical negligence.

6. I am only addressing and deciding the issue of liability. If damages are to be assessed, the assessment will be referred to the Registrar of the Supreme Court.

The Pleadings

7. The Amended Claim Form filed on 29 April 2024 sets out the allegations of negligence. I set out below several paragraphs from the Claim Form:

2. d) Mr. Ocasio Lundy (the presumed father) and the Claimant are the parents of the Late Miss. Elizabeth Lundy, deceased, who was born at PMH at 5:20am on the 2nd August, 2022 and who died on same date at 7:37am.

e) The Claimant was a patient of PMH during the period of 1st August 2022 to the 4th August 2022. On or about 11:10pm on the 1st August, 2022, the Claimant presented to the public ward of PMH with symptoms of labour (water breaking, contractions and/or tightening). The Claimant was admitted to the public maternity ward at PMH for the delivery of the baby. The Claimant emphasized during the visit to the First Defandant that she was 39 weeks and 3 days gestation and that she had suffered from these symptoms since about 10:50pm on same date.

f) Upon being admitted to the public maternity ward at PMH, the Claimant was, *inter alia*, administered a drip, was swept at 7cm dilation and was administered the abdominal transducer to monitor the baby's vitals. The Claimant heard the steady heartbeat of the baby over the

monitor. Sometime later, the Claimant was administered an enema.

g) On or about 12:30am on the 2nd August, 2022, the Claimant was being prepped for delivery. The delivery process started and later the Claimant began to push. She did this for some time up to 3:00am. The midwife noticed that the delivery was not progressing and called for the First Defendant. The First Defendant arrived 30-45 minutes later and advised that the Claimant needed to have an emergency cesarean section and transported just outside of the theatre. The Claimant had to wait in the hallway by the theatre door for a considerable amount of time before entering the theatre.

h) Whilst in the theatre, the cesarean section operation was performed on the Claimant. It was not performed under local or general anesthetic as the Claimant was awake during the entire procedure. During this procedure, a curtain was placed in front of the Claimant and instruments were used to deliver the baby. After the delivery of the baby, the midwife called the time of the birth as at 5:20am and she was handed the baby. The midwife then showed the Claimant the baby to confirm the gender. The baby appeared to the Claimant, weak, pale but was not blue or purple and appeared apnoeic. Minutes later, the baby was taken from the Claimant and the Claimant observed a procedure being performed on the baby to which she then heard the baby give a blatant loud cry.

i) On or about 7:45am on the same date, a family conference was held with the Claimant where the First Defendant explained that, on the way to the maternity ward, the baby was noted to be blue and was rushed to the Neonatal Intensive Care Unit ('NICU").

j) The Claimant's loss and damages were caused by the professional negligence and/or breach of duty of care and/or contributory negligence of the First Defendant, as servant or agent of the Second Defendant.

k) The particulars of negligence are:

i. Failing to properly assess the Claimant's overall condition if at all to effect a successful delivery and live birth;
ii. Failing to properly assess the Claimant's overall condition if at all to effect a successful delivery and cesarean section;
iii. Failing to observe the necessity of another scan of the Claimant prior to delivery;
iv. Failing to provide the Claimant with a cogent birth plan or any at all before she went into labour and delivery;
v. Failing to exercise skill, care and diligence in the treatment of the Claimant and her baby;
vi. Failing to exercise skill, care and diligence in the delivery of the Claimant's baby;
vii. Failing to assess or properly assess the Claimant as an urgent case requiring a caesarean section delivery;
viii. Failing to achieve an earlier delivery of the baby;
ix. Such delay was a consequence of failings by the midwives and obstetricians in both the planning for the birth and in the delivery;
x. Causing the death of the Claimant's baby;
xi. Failing to advise the midwife to contact a pediatrician post-delivery at all;
xii. Failing to advise the midwife to contact a pediatrician post-delivery in a timely manner;
xiii. Failing to provide suitably experienced staff to examine the deceased post-delivery;
xiv. Failing to provide adequate post-delivery treatment either by having any or any proper regard for the baby's symptoms or by taking notice of the baby's complaints, the Claimant will further contend that PMH knew or ought to have known that *"prenatal asphyxia"* is a reasonably foreseeable consequence of the time delay/lapse in making the decision to process with a cesarean section operation and the ultimate delivery of the baby and should have been on the look-out for any symptoms; and
xv. Failing to have any proper regard for the baby's symptoms post-delivery namely poor skin color, low heart rate, weak muscle tone, gasping or weak breathing and meconium stained amniotic fluid.

n) The special damages are:

i. Loss of wages (3 months)	**$3,600.00**
ii. Medical Fees:	**$3,500.00**
iii. Medication:	**$150.00**
iv. Funeral expenses:	**$3,700.00**

8. The Defence filed on the 17 May 2023 denies the allegations and pleads as follows:

> **2. a. The Defendants deny the contents of paragraph 2(a);**
>
> **b. The Defendants admit the contents of paragraph 2 (b) and (c) of the Amended Claim form;**
>
> **c. The Defendants make no admission to the contents of paragraph 2 (d) of the Amended Claim Form;**
>
> **d. Save and except the Claimant that the Claimant was a patient of the PMH during the period of 1st August 2022, the Defendants deny the contents of paragraph 2 (e) of the Amended Claim Form and the Claimant is put to strict proof;**
>
> **e. The Defendants make no admission to the contents of paragraph 2(f) of the Amended Claim Form and the Claimant is put to strict proof;**
>
> **f. The Defendants deny the contents of paragraph 2(g) and the Claimant is put to strict proof;**
>
> **g. The Defendants out rightly deny the contents of paragraph 2(h) and state that no patient is granted a caesarean section without the use of some anaesthesia because it would be considered inhumane. The Claimant is put to strict proof;**
>
> **h. The Defendants make no admission to the contents of paragraph 2 (i) of the Amended Claim Form and the Claimant is put to strict proof;**
>
> **i. The Defendants deny the contents of paragraph 2 of the Amended Claim Form and avers that every patient admitted to any one foe the hospitals under the Public Hospitals Authority is given the best of care that is expected in a medical institution.**
>
> **The Particulars of Negligence are:**
>
> **i. The Defendants deny the contents of paragraph 2(k)(i) and avers that the Claimant delivered a live female infant, in the presence pf a Paediatrician, that was placed in her**

arms immediately following delivery, and prior to being taken to the NICU;

ii. The Defendants deny the contents of paragraph 2(k)(ii) and avers that the Claimant was properly assessed, and a successful delivery was affected;

iii. Save and except the medical practitioner makes the decision whether a client needs a second scan, the Defendant denies the content of paragraph 2(k)(iii) a of the Amended Claim Form and the Claimant is put to strict proof;

iv. The Defendants deny the contents of paragraphs 2 (k) (iv, v, and vi) of the Amended Claim Form and the Claimant is put to strict proof;

v. The Defendants deny the contents of paragraph 2 (k) vii, viii and ix) of the Amended Claim Form and the Claimant is put to strict proof;

vi. The Defendants totally deny the contents of paragraph 2 (k)(x) of the Amended Claim Form and the Claimant is put to strict proof thereof;

vii. The Defendants deny the contents of paragraph 2(k)(xi) and (xii), and the avers that a Paediatrician is always present during and post a caesarean section;

viii. The Defendants deny the contents of paragraphs 2 (k)(xiii) and avers that the Defendants only take into their employment persons that are of a skill that is higher than that of the ordinary man to provide adequate care to its clients.

ix. The Defendants deny the contents of paragraph 2(k)(xix) and avers that emergency equipment is a part of each delivery and is utilized once it is needed. The newborn infant was placed in the Claimant's arms, and she made no complaint of respiratory distress or of any blueness in her infant's skin colour.

x. The Defendants outrightly deny the contents of paragraph 2(k)(xi) of the Amended Claim Form and states that a paediatrician was present when the female infant

was delivered and administered the necessary resuscitative measures.

xi. The Defendants make no admission to the contents of paragraph 2(k)(xv) of the Amended Claim Form.

9. The parties appeared before the Court, and each called witnesses who were subject to cross-examination. They each had an expert witness. I will set out more below the evidence adduced during the course of the trial, which was conducted over three days.

10. At the trial I was presented with a Trial Bundle that contained the witness statements for both parties along with an Agreed Documents Index. At the start of the trial, I inquired of Counsel if the documents in the Agreed Documents Index were "agreed" for the purposes of the trial. Counsel for the Claimant and the Defendant indicated that the documents were not agreed. We proceeded on that premise until the second day of the trial when both Counsel informed the Court that the documents were agreed. In light of the confirmation, I treated the documents in the Agreed Documents Index as being agreed at the trial.

11. The effect of the documents being in an agreed bundle was addressed by the Court of Appeal in **Colina Insurance Limited v Enos Gardiner SCCivApp & CAIS no. 117 of 2015.** Giving the decision for the Court, Crane Scott JA (as she then was) stated:

> 90. To this end, prior to the start of the trial, counsel for Colina reached agreement with counsel for the respondent for the *DPH Summary* and the several other documents on which Colina proposed to rely for its defence to be included in the agreed trial bundle and produced at the trial. This is in line with the long-standing practice in this jurisdiction which requires parties in Supreme Court Civil proceedings to file a trial bundle prior to the commencement of the trial, separating those documents which are agreed from those which are not.
> 91. The practice stems from Supreme Court Practice Direction No. 2 *(1974-1978)* issued by Knowles C.J., the relevant portions of which provide as follows:
> **"LISTS AND BUNDLES OF DOCUMENTS:**
> **The attention of members of the Bar is called to Order 24 rule 2 of the Supreme Court Practice concerning the discovery by parties without order. The rule seems to be observed more in the breach than in the performance.**
> **When a case is set down for hearing the Plaintiff should deliver to the Clerk of the Judge who is to hear the case at least two bundles of documents. One bundle will contain all the relevant pleadings and other documents**

which have been filed, each page being numbered. Another bundle will contain all the relevant correspondence and other documents, each page being numbered. All documents should be copied on foolscap and all pages should be of uniform length.
The bundles should be agreed beforehand with other parties, if possible, the Defendant or Defendants supplying to the Plaintiff those documents which they wish to be included. If any document cannot be agreed, they should be bound in a separate bundle.
A copy of each bundle should be provided for the Judge, for each Counsel appearing in the case, and one copy for witnesses.
Documents which are not included in the bundles will be admitted in evidence only in exceptional circumstances."

92. We note that the wording of Practice Direction No. 2 is different from the UK and Malaysian Practice Directions discussed in the cases of **Charnock** and **Yeo Inq King** *(above)* to which Mr. North drew our attention. Practice Direction No 2 is, for instance, silent as to whether the documents which are included in an agreed bundle are admitted as evidence of their *contents*, whereas the English and Malaysian directions expressly state that the documents in an agreed bundle are admissible at trial *"as evidence of their contents, unless objection is taken."*

93. The last line of Practice Direction No. 2 *(extracted above)* is, however, significant. It strongly suggests that documents in an agreed bundle are already in evidence by agreement, whereas documents not agreed and not contained in the agreed bundle are not in evidence, and will only be admitted in evidence in exceptional circumstances. It therefore seems to us that although Practice Direction No 2 is silent as to whether the documents in an agreed bundle are admitted as evidence of their *contents*, the position in the Bahamas is no different from that in England or Malaysia. Accordingly, documents in an agreed bundle are admissible at trial as evidence of their *contents*, unless objection is taken.

94. As we have already observed, while documents are in the agreed bundle by consent and are therefore in evidence before the court, the relevance and weight which will be accorded by the judge to them are, however, an entirely a different issue.

95. In **Colco Electric Co. v. Gold Circle Co.** [2003] BHS J. No. 53. Lyons J. considered the "raison d'etre" of Practice Direction No. 2. He made the following observations about the reason for trial bundles with which wholeheartedly agree:

> **"8. The concept of the bundle of documents was designed to overcome the need to have witnesses come before the court simply to give formal evidence of admissibility of a particular document. The agreed bundle comprises documents which both counsel agree are relevant and admissible. The question of what weight to attach to a document is a matter for the Court.**
> **Counsel can agree as to whether the documents are tendered by consent as to admissibility alone, or as to accuracy and/or veracity. It is usual to refer to the documents at trial and have them explained by witnesses. In this trial some of the documents were left unexplained so that I was left with little or no idea what they mean or what their relevance is..."**
> 96. It seems to us that the inclusion of a document in an agreed trial bundle in accordance with Supreme Court Practice Direction No. 2 means that it is admitted in evidence before the trial judge by agreement, without the party wishing to rely on it having to call a witness to formally produce it or to authenticate it. That said, it is obvious that while the document is undeniably in evidence by consent, its relevance and significance to the issues-in-dispute will usually only become evident when witnesses who are actually called to testify at the trial are referred to the document and give *secondary* evidence about its *contents*.

The Claimant's evidence

12. The Witness Statement of the Claimant, Widline Guillaume, filed on 9 April 2025 sets out the salient facts that led to her delivery of baby Elizabeth. She recalls that she was awake during delivery. She notes that she entered the Princess Margaret Hospital ("**the Hospital**") on 1 August 2002 at about 11:10 pm and that around 12:30 pm she was being prepared for delivery of her baby. I set out below the following paragraphs from her witness statement:

> **4. On or about 11:10pm on the 1st August, 2022, Mr. Ocasio Lundy ("Mr. Lundy") and myself presented to the public ward of PMH with symptoms of labour (water breaking, contractions and/or tightening). I was admitted to the public maternity ward at PMH for the delivery of the said baby. At this time, I emphasized to Dr. Tamara Evans that I was 39 weeks and 3 days gestation and that I had suffered from these symptoms since about 10:50pm on same date.**

5. Upon being admitted to the public maternity ward at PMH, I was, *inter alia*, administered a drip, was swept at 7cm dilation and was administered the abdominal transducer to monitor the baby's vitals. At this time I heard the steady heartbeat of the baby over the monitor.

6. On or about 12:30am on the 2nd August, 2022, I was being prepped for delivery. The delivery proess began at approximately 2:00am and the medical team informed me that the labor was progressing normally, despite some signs of prolonged labor. At the same time, I began to push. I did this for some time up to 3:00am. At this time, the midwife noticed that the delivery was not progressing and called for Dr. Tamara Evans. Dr. Tamara Evans arrived 30-45 minutes later and advised me that I needed to have an emergency caesarean section. PMH then booked me in for the emergency caesarean section and transported me just outside of the theatre's door. I had to wait in the hallway by the theatre door for a considerable amount of time (1 hour) before entering the theatre.

7. Whilst in the theatre, the caesarean section operation was performed. It was not performed under local or general anaesthetic, as I was awake during the entire procedure. During this procedure, a curtain was placed in front of me instruments were used to deliver the said baby.

8. After the delivery of the said baby, the midwife called the time of the birth ant 5:20am. The midwife then showed me the said baby and confirmed the gender. I noted that the said baby appeared to me weak, pale, but was not blue or purple and appeared apnoeic. Minutes later, the baby was taken from me and I observed a procedure being performed on the baby to which I then heard the baby give a blatant loud cry.

9. On or about 7:45am on same date, a family conference was held between myself and the medical team where the First Defendant and a Dr. Hepburn explained that, on the way to the maternity ward, the baby was noted to be blue and was rushed to the Neonatal Intensive Care Unit ("NICU") but later died.

13. In her evidence in chief, the Claimant confirmed that baby Elizabeth was delivered around 5:20 am on 2 August 2022.

14. The Claimant shared that she attended the Fleming Street Clinic for pre-natal care and performed an ultrasound at ASA Ultrasound Services on 2 June 2022 which showed that "**the uterus is gravid and contains a single intrauterine gestation of sonographic age 30W0D... Good fetal tone, movements and respiration are noted. No gross uterine or fetal anomaly is seen. There is adequate amniotic fluid for gestational age**". The impression on the scan read: "**Fetal development of 30W0D gestational age. EDD= Aug. 11, 2022. Follow up suggested at 32 weeks.**" It was signed by Dr. E. Itza Major.

15. The evidence confirmed that the Claimant was admitted to the public ward of the Hospital and was under the care of the midwife who was principally in charge of the delivery unless matters were complicated. The midwife called Dr. Azaria Clare, the Senior House Officer on duty, around 3:19 am and she went to the Labour Ward to attend to the Claimant. Around 3:54 am Dr. Agatha Foulkes-Mackey, the Registrar on duty at the Hospital, was called by Dr. Clare and they both took the Claimant to the operating theatre around 4:38 am. The baby was delivered by emergency caesarean section at 5:20 am on 2 August 2022.

16. It is perhaps hard to recall, but 2 August 2022, was during the COVID pandemic. The Claimant was swabbed for a COVID test around 4:10 am before entering the theatre, which appeared to be the protocol of the Hospital at the time. The evidence indicates that the COVID negative result was received at 5:10 am on 2 August 2022. Much attention was made during the trial of why the COVID test could not be taken earlier and the absence of the Hospital's COVID protocols from the documents at use of the trial.

17. The Claimant intimated during her evidence-in-chief that she started "pushing" for the baby around 2:00 am. This time is critical in the factual analysis of the evidence and whether the Hospital fell below the standard of care.

18. During her examination-in-chief she shared the moments that occurred prior to the delivery of baby Elizabeth:

> **Q:** And the doctor? Did the doctor say anything to you upon arrival?
>
> **A:** When the doctor came she did a sweep or did examination of my vaginal area to see how it's progressing and she insisted, instructed me to push a few times again and then after that she's like ok no we have to do caesarean section, emergency C-section.
>
> **Q:** What was your understanding of why an emergency C-section was required?
>
> **A:** They said second stage arrest or the baby wasn't getting

out like the head was going in and coming back in going out and then coming back in after they decided that's what had to be done.

Q: So let's talk about the actual caesarean section.

After the decision was made for the emergency caesarean section, what happened next?

A: A few personnel came in one person in particular came with a form for me to sign.

I guess to for any no guess, sorry, my apologies.

What a worker came in for with a form for me to sign to sign off on as protocol or policy protocol policy of the hospital.

And then another person had me do a swab for COVID and during that I was pushed out into the hall ...

19. The Claimant also shared the events that she recalled occurred in the hallway leading to the entrance to the operating theatre. That exchange between the Claimant and her Counsel, Miss Myra Russell, is set out below:

Q: So how long were you? How long were you in the hallway?

A: That was for some time.

Q: What is some time you can given? You can give an estimation for the court, please. One hour, 2 hours.

A: 45 minutes, Yeah, more than 30 minutes.

Q: And the 30 minutes, how did you know it was 30 minutes? That's the estimation. Or while you were in the hallway, did you receive any information about the baby?

A: That's the estimation.

Q: No.

A: No, no information.

Q: Or any information about your condition.

A: My condition, no. But the only thing I was instructed not to do is not to push.

20. Upon the birth of baby Elizabeth, the Claimant says her recollection is that the baby's gender was confirmed and she was handed to the Paediatrician. The Claimant also recalled hearing a loud cry from the baby and that she "**appeared weak, pale but was not blue or purple and appeared apnoeic**".

21. The Claimant stated that she was awaken by two doctors before 9:00 am on 2 August 2022 and told about the death of baby Elizabeth. Baby Elizabeth was cremated on 25 August 2022 at Cedar Crest Crematorium, and an autopsy was not performed.

22. Under cross-examination, the Claimant was questioned about her paediatric history and whether she had a "childhood heart condition". A referral form from the South Beach Health Centre dated 17 September 2002 was disclosed in the Agreed Bundle of Documents which showed that the Claimant was referred to Dr. Jerome Lightbourne on 12 November 2002. Dr. Lightbourne's notes of 12 November 2022 showed that the Claimant had a normal cardiovascular exam. The Claimant insisted that the only family history that she had was asthma, which was corroborated by an entry in her medical records of family history. There was also no evidence in the pre-natal records of the Claimant at Fleming Street Clinic which suggested that she presented with a congenital heart issue.

23. The Defendants' Counsel, Mrs. Jones, questioned the Claimant on when she attended Fleming Street Clinic for pre-natal care and when she discovered that she was pregnant. The Claimant was clear in her evidence that she recalled that late November, about the Thanksgiving holiday, and around Christmas she knew that she was pregnant.

24. Counsel for the Defendants also spent time questioning the Claimant on when and who informed her that she was in prolonged labour or second stage arrest. She said that her recollection is that "**the doctor in particular used the term second stage arrest that the baby head was going in but it wasn't passing the cervix**". The Claimant further stated that she was pushing for the baby until 3:00 am when "**the midwife basically made an alarm and said that she would call a doctor**".

25. The Claimant's evidence is that when she inquired about what happened to baby Elizabeth that she was told by the doctor "**that on the way from theatre there's a change of events, the baby colour change and had we rushed to NICU and they called her to attend the situation**".

26. The Claimant also disclosed what was said to her by the doctors on the morning of 2 August 2022.

A: They, well the nurse spoke about it a bit saying that on the reason, well, the doctor, ok, the doctor herself said she's the one on and she's dealing with the situation and that on the way from theatre there's a change of events, the baby colour change and had we rushed to NICU and they called her to attend the situation.

Jacob Thacker

27. The Claimant also called the mortician, Jacob Thacker, to give evidence. In his witness statement filed on 4 June 2026 he recalls that on 25 August 2022 Newbold Brothers Chapel "**received the remains of the newborn baby, Elizabeth Lundy, from the Princess Margaret Hospital. The remains were accompanied by the requisite documentation, including a medical certificate indicating that the cause of death was perinatal asphyxia, as recorded by the attending medical practitioner**". I highlight below paragraphs 5, 6, 7 and 8 of his witness statement:

> **5. Upon receipt, baby Elizabeth Lundy was presented as a still and lifeless body, wrapped in a hospital blanket. The body was not small in size for a newborn baby but was consistent in appearance with that of a newborn infant.**
>
> **6. I did not conduct, nor am I qualified to conduct any medical or pathological examination, and my observations were limited to those ordinarily made by a funeral home in the course of receiving remains.**
>
> **7. Following receipt of the remains, all required statutory and administrative procedures were complied with prior to cremation. This included verification of identity, review of the medical documentation and receipt of the necessary authorisation and instructions from the Ms. Widline Guillaume and Mr. Ocasio Lundy. At no time did the funeral home make any independent medical determination regarding the cause of death.**
>
> **8. On the 25th August , A.D., 2022, I took the remains of Baby Elizabeth Lundy to be cremated by Cedarcrest Funeral Home, situate Robinson Road and First Street, Nassau, The Bahamas.**

28. No questions were put to Mr. Thacker by the Defendants' Counsel.

29. The Claimant's expert witness was a Barbadian Obstetrician and Gynaecologist with 31 years of experience. I address his evidence below under the heading – expert evidence.

The Defendants' evidence

Dr. Azaria Clare

30. The Defendants called Dr. Azaria Clare. She specializes in Obstetrics and Gynaecology and was active on duty at the Hospital on 2 August 2022 when the Claimant was admitted. Her witness statement filed on 11 April 2025 confirms that she was "**the Senior House Officer on duty when I got a call at 3:19 am on the 2 August 2022 to come and see a patient on the Labor Ward who was in the second stage of labor and on the care of her midwife**." She sets out the further details of the events that transpired on 2 August 2022 in paragraphs 7, 8, 9 and 10 of her witness statement, which are set out below:

> **7. I arrived and assessed the patient who was noted to be actively pushing. The Cardiotocographic ("CTG") monitor was attached to mother's abdomen and the fetus was having continuous monitoring. Gynae III Dr. Foulkes was called and informed that there was noted to be minimal fetal head decent, with maternal effort. The patient was reviewed by the First Defendant and diagnosed as an arrest of "Second Stage of Labor." The patient was prepped for an emergency caesarean.**
>
> **8. The First Defendant and I proceeded t push the patient to the operating theatre where she had to wait in the foyer because Covid 19 restrictions were still in place, and she had no Covid 19 results.**
>
> **9. The paediatrician was informed of the pending caesarean and I along with Dr. Foulkes and the patient waited in the hallway of the operating theatre. The Covid specimen as taken at 4:09 a.m. but the results were received at 5:10 a.m. During this time there was a delay in people being admitted to the operating theatre without the requisite Covid 19 results. There were certain emergency COVID Protocol in place that had to be adhered to before one could proceed with a surgical procedure of a patient.**
>
> **10. The anaesthetist administered spinal anaesthesia at 4:45 a.m. and Dr. Foulkes made the abdominal incision made at 5:15 a.m. A live female infant was delivered at**

5:20 a.m. The infant was handed over to the Paediatrician while Dr. Foulkes completed the surgery.

31. Dr. Clare described her duties as a Senior House Officer to include having responsibility for

> "... **first encounters with the patient. After the nurse sort of seeing the patients. You're responsible for admissions. You're responsible for initial blood investigations. This would include taking blood from patients as well as ordering necessary laboratory investigations. You're, you're responsible for initial assessment of patients as well as triage to determine the risk stratification for patients and the level at which they need to be managed. You're responsible for preliminary investigations and primary assessments and then you're also responsible for escalation at the necessary rate with which they should be invested, escalated to senior assessment for secondary investigations... In terms of surgical duties, you're also responsible for minimal or minor procedures, as well as assisting consultants and registrars in major procedures. That include Caesarean sections for obstetric procedures as well as gynaecological procedures such as minor investigations like the urine evacuation as well as major investigations like a hysterectomy**".

32. Dr. Clare confirmed that she saw the Claimant on the ward around 3:19 am and she was "**in active first stage of Labor. Say labor is divided into 3 stages. You have first, second and third. The first is divided into a latent and an active stage. The latent phase would be between 1:00 and 3:00 [hours].... So when she presented it would have been active second, sorry, active first stage**". She clarified that the Claimant was "**in second stage because she would have been fully dilated**".

33. In respect of monitoring of a patient, Dr. Clare confirmed that continuous monitoring was carried out by way of the CTG. A monitoring of the mother and baby. She described the monitoring as follows:

> **"There are two probes that are placed on the woman's or the patient's abdomen.**
> **1 is to monitor contractions, the rate at which the mother is contracting and the intensity of the contractions.**
> **... and the cardio, so it's called cardiotocography. So you have cardio which is the baby's heart rate. That's the second probe that's used to actually measure the baby's heart rate during labour. So cardiotocography.**

Topography is the contractions and cardio is the actual fetal's heart rate and it's continuously meaning that it doesn't come off until the baby is delivered".

34. She further indicated that the lower limit of the fetal heat rate is 110. When asked about the 108 beats at 1:55 am, Dr. Clare's response was that it showed "**an abnormal CTG, but it would depend on what's happening at that time because during contractions, the heart rate is expected to decrease, but it would you would need the entire CTG to assess what's happening at that time. But at that time I wanna weigh heart rate. If you just, if that's all you have, that's not a normal heart rate**".

35. It was noted during Dr. Clare's evidence that the CTG records in the Agreed Bundle did not have accurate time stamps; however, the dates were correct. She explained the deceleration that showed on the CTG as a type 1. She further stated that

> **"a type 1 deceleration is basically synonymous with what we call an early deceleration. And that's basically a drop in fetal heart rate that could be due to contractions, because the mechanism of contractions means that the uterus is basically getting hard or firm and it's compressing the baby's head as well as the umbilical cord. And that in and of itself causes decelerations. But those are what we would say are acceptable deceleration because it's happening because of the contractions. There are decelerations which are not acceptable".**

36. It was also Dr. Clare's evidence that "prepping" for the caesarean section took 40 minutes. That included when the decision was made for the Claimant to have a caesarean section at 3:54 am and when she arrived at the entrance to the theatre at 4:09 am. Additionally, Dr. Clare confirmed the timeline to get the Claimant to the theatre.

> **"And that would have been when her COVID swabs were taken and it said COVID test was taken at 4:09. So we so we would have well, we would have taken her from CDF to that point.**
> **And then the COVID swabs were taken.**
> **And then the note said that COVID was taken at 4:09 and the results were received at 5:10.**
> **And then it says that we arrived in theatre at 4:25. So we would have been there between 4:09 and 4:25.**
> **And then it said that we pushed her into theatre so that would be the three basic entrances to theatre. You get to the hallway at COVID. During COVID, you had to stop. You**

couldn't advance to where the actual operating theatres were. You got to stop kind of at the entrance of the main theatre hallway.
So and that's where her COVID test would have been taken. So it took us basically a minute or within a minute to get her from CDs to that entrance point. And then it's at 4:25. We would have arrived to the second entrance of theatre.
So we would have been there between 4:10 and 4:25 so 15 minutes".

37. Dr. Clare also confirmed during examination-in-chief that baby Elizabeth was delivered at 5:20 am and received Apgar scores of 7 and 8. She also said that the baby was shown to the mother and "**if there were any concerns the baby would not have left the theatre and the paediatrician would have called any necessary assistance in the theatre. But the paediatrician was happy and the baby was taken**".

38. Dr. Azaria Clare was extensively cross examined by the Claimant's Counsel, Miss Russell. Dr. Clare was asked about the ACOG and RCOG in relation to monitoring. She said (in part) **"the guideline suggests that a patient, sorry, the RCOG guideline suggests that a patient who is a primate and pushing and push for an hour, that's acceptable at this time, this patient was pushing for 45 minutes ... that can be extended to two hours with an assessment and a maximum of three hours based on ACOG guidelines, with an assessment**".

39. Dr. Clare confirmed that her assessment at 3:19 am when she saw the Claimant was that she required an emergency caesarean section. She confirmed that the midwife was in the room at all times with the Claimant and disputed that there was a delay in the treatment of the Claimant. She said:

> **"I disagree because my immediate management at that time was to escalate to get a report by, or rather a decision as to what needed to be done and to get those things done. She was taken to theatre within a minute and the swab done. And if she left the central delivery suite at 4:10 and got to theatre at 4:10 and the swab was taken at 4:10, then there would have been no delay".**

40. Dr. Clare was further questioned about what Claimant's Counsel described as a delay in treatment. Dr. Clare rejected this assertion and noted that it took one hour; from 4:09 am to 5:10 am to get the Claimant from the ward to the start of the emergency caesarean section.

41. Dr. Clare also clarified that she did not make a decision to have an emergency caesarean section at 3:19 am because she had to confer with her senior. In her evidence she said the decision was made at 3:54 am. Dr. Clare also confirmed

that she had a call with the midwife at 3:19 am and did not attend to the Claimant until 3:30 am.

42. When re-examined, Dr. Clare confirmed that a patient can "**push for an hour, you have an assessment, and then you can actually push for another hour. If by the end of the third hour she's not delivered, a decision has to be made. Pushing for 45 minutes is acceptable once the CTG is normal. That's acceptable in both ACOG and RCOG.**"

43. Dr. Clare confirmed when asked by the Court that she first spoke to Dr. Foulkes-Mackey at 3:48 am and then again at 3:54 am. She reiterated that the decision was made at 3:54 am. She said, "**... between 3:54 when that decision was made, she was at the theatre's door at 4:09. When the swab was taken 4:09, You said she was at the theatre door at 4:09, yes, where the COVID 12 was taken ...**".

44. Dr. Clare also explained the late entry in her notes at 5:30 pm. She said she had other medical matters to attend to which caused the delay.

Dr. Agatha Foulkes-Mackey

45. The First Defendant, Dr. Agatha Foulkes-Mackey, filed a witness statement on 7 March 2025. I find it necessary to set out several paragraphs of that statement.

> **2. I am a medical doctor, and I am duly registered and licensed by the Bahamas Medical Council to practice medicine in the Commonwealth of The Bahamas. My Medical license number is S-1921.**
>
> **3. I am the holder of a specialization in Obstetrics and Gynaecology from the University of the West Indies.**
> ...
>
> **5. At the time of the said incident, I was employed with the Public Hospital Authority as a Registrar, I am presently self-employed as an independent Obstetrician and Gynaecologist.**
>
> **6. I was the subject Registrar on duty when I got a call at 3:48a.m. on the 2nd of August 2022 to come and see a patient who was in prolonged labor.**
>
> **7. I assessed the patient at 3:54 a.m. and the diagnosis of "Second Stage Arrest" was made and a decision was made to deliver the baby by caesarean. I assessed both mother and baby and found both to be stable. I informed**

the on-call Consultant Dr. Charles that there was patient in prolonged labor on the Labor both mother and baby and found both to be stable. I informed the on-call Ward and that I was going to take her to the operating theatre to deliver the baby by caesarean. He agreed with my decision.

8. The heart monitor attached to the mother's abdomen indicated that the baby was not in any distress which was quite reassuring to me.

9. Ms. Guillaume was prepared for the operating theatre, and she and I proceeded to the operating theatre.

10. The Paediatrician was informed of the pending caesarean and I along with the patient waited in the hallway of the operating theatre. The Covid specimen was taken at 4:09 a.m. but the results were received at 5:10 a.m. During that time there was a delay in people being admitted to the operating theatre because there were certain emergency COVID Protocols that had to be in place in order to proceed with a surgical procedure with an unknown COVID status.

11. The anaesthetist administered spinal anaesthesia at 4:45 a.m. I made the abdominal incision at 5:15 a.m. and a live female infant was handed over to the Paediatrician and I completed the surgery.

12. The following day the patient was informed by both Dr. Braham, the Department Head, and me about the demise of her infant. She was counselled and allowed to express any concern that she may have had. She said nothing.

46. She explained during her examination-in-chief that she is a fellow member of both ACOG and RCOG. She served in the role of the Registrar at the Hospital when the Claimant came to the Hospital. She explained the role of the Registrar is to have "**the responsibility would be that of overseeing the ward. I would also and too, in overseeing the ward, I would relay any, any challenges, any issues that I have to the consultant for us to collectively make a decision in terms of management. So I was not solely making any management decisions, but I would be responsible for managing the labour ward, the antenatal wards, the OBGYN wards, the accident emergency as well as performing surgeries**". She also confirmed that she was employed at the Hospital from 2014 to 2024.

47. Dr. Foulkes-Mackey testified that she was called at 3:48 am and Dr. Clare told her that "**she made her assessment and she said that the patient wasn't pushing for a 45 minute period, ... So she catheterized the I told her, you know, just to catheterize and allow her to, to progress right. In that time I was making preparations to come and review the patient. So she said despite adequate, you know, pushing, there was no dissent of the baby's head. So at that time I said we made the decision to proceed with an operative delivery**".

48. She intimated that she was asleep in her car on 2 August 2022 because she was on call. When she is on call, she would do her rounds and be in the precincts of the Hospital. She often sleeps in her car during the breaks.

49. Dr. Foulkes-Mackey was asked a series of questions about prolonged labour and if the Claimant was in prolonged labour. Her answers are set out below"

> **"Well, like I said, back to the ACOG guidance primigravida first time pregnancy, she has three hours of pushing in second stage of Labor before making that assessment of prolonged labor. And even after then in some instances when you assess that patient and you deem that you know deem them stable and that there's still progress of Labor, meaning that the head is still descending and you allow them a bit more time. But generally the that after three hours we can make that assessment and you would want to expedite the delivery at that point".**

50. Dr. Foulkes-Mackey also described the three stages of labour when asked by Miss Russell during cross-examination. Her answer is set out below:

> **"Right. So that I would have mentioned there are three types of Labor, right, Definitions of Labor, it's first stage and you can be in first stage may not be accurate with this, but up to 24 hours, right? Second stage, First stage of Labor. First stage labor. Meaning that you have contractions, right, That you have contractions.**
>
> **Dilatation. But your cervix has not dilated to a point.**
>
> **So first stage of Labor has early right and late, right? The early part meaning that the cervix hasn't dilated to 3 centimeters late, meaning that the cervix has dilated new guidance past five centimeters after 5. After the patient reached 5 centimeters, right, the patient's in an active stage of Labor.**
>
> **And at that point, we anticipate that the patient would dilate**

at least 1cm per hour after that. So the patient is 5 centimeters, right? And if we referenced Dr. Zaria's note at 2:14, right, she would have been 5 centimeters at that time, right? So in this patient, if I was just on label one, I looked at her primigravida because they tend to dilate slowly.

If she dilated at 5 at a centimeter per hour, I would anticipate or expect this patient to deliver at 5:14 AM, right?"

51. Dr. Foulkes-Mackey suggested that the Claimant as a primigravida, first time mother, could expect to be in vaginal delivery for 8 hours. She stated that "**now for that patient who this would have been her first pregnancy, ACOG guidance allows for three hours of pushing before actually making the assessment of prolonged labor. So by true it called guidance, it would have not really met prolonged labor because if she would have in reviewing the notes, if she would have gone into labor, I think it was 2:05, I don't know 2:05 really she would have been allowed three hours, ... before we made the decision like hey, this is prolonged labor**".

52. She provided this further clarification:

> **"And if she began set at 5:14 and if she began second stage of Labor at 5:14, then she would have, we would have given her three hours, which means that she would have technically at 8:14, then at 8:14, we would have made the diagnosis of prolonged, prolonged labor. I don't know if you're following me. So at the end of this point, so active stage is from from 5 centimeters uh huh, until 10 centimeters dilation. How long you say that will last? That's a centimeter, an hour, a centimeter uh huh".**

53. Dr. Foulkes-Mackey agreed that a mother and baby can be at risk if they are not "**appropriately managed**" during prolonged labour.

54. Under cross-examination, she insisted that she had the first call with Dr. Clare about the Claimant and that was at 3:48 am and that she went to the ward at 3:54 am. The first call made by the midwife was to Dr. Clare, who was the SHO, because that was the first line of contact by the midwife.

55. Dr. Foulkes-Mackey agreed with Miss Russell that once a patient is diagnosed at second stage arrest, delivery of the baby becomes a priority; and that the one accepted method of management is a caesarean section, which was the course chosen. However, the witness did not agree that there was a delay between the diagnosis and delivery of the baby. Dr. Foulkes-Mackey was clear that once the baby and mother were stable 2 hours or 80 minutes (between 3:54 am and 5:20 am) was not prolonged delay. She further stated that the Claimant did not fall in

category 1 of an emergency caesarean section (like cord collapse). She placed the Claimant in category 3 "**because she there was no evidence of distress to mom and or to the fetus. Both were stable**".

56. The witness also confirmed that she and Dr. Clare pushed the Claimant through the hallway to the theatre and she was administered the spinal anaesthesia because her COVID status was not known, with the result being received at 5:10 am.

57. There was also much discussion about the CTG results before the Court. Dr. Foulkes-Mackey indicated that there was no evidence of hypoxia and that the Claimant and fetus were within the normal ranges for contractions and heart rate.

58. She relied on the Apgar scores of 7 and 8 given by the Paediatrician to baby Elizabeth after delivery and confirmed that "**it's the way that it's a tool that the paediatricians use to assess and it also guides their resuscitative method right when meaning that it's oxygen if they need intubation at the time it assess, you know, the need of resuscitation**".

59. When re-examined by Mrs. Ramsey, Dr. Foulkes-Mackey confirmed that she assessed the patient at 3:54 am and made the decision to deliver the baby by caesarean. She assessed both mother and baby and found both to be stable. She "**informed the on call consultant, Doctor Charles, that there was a patient in prolonged labour on labour ward and that both mother and baby found to be stable**". In discussing the view that the baby was not in distress Dr. Foulkes-Mackey referred to the CTG and said:

> **"And so in terms of a non reassuring or CTG that would show fetal distressed, we expect to see deceleration, we expect to see prolonged bradycardia, right? Meaning if it's less than that 110 for more than 10 minutes, you expect to see the different there are other different parameters, the deep decelerations or in terms of the variability that I was discussing, if that variability is more than a 25 beats per minute, then that can be an indicator as well. 120 minutes, sorry, the no variability if it's more than 25 beats per minute in terms of the change, the change in that baseline or less than 6 beats per minute change in the baseline, which means that it is less and the strip will be very flat. And that can also be a sign that something is happening.**
>
> **So they're different parameters.**
>
> **None that I saw and none that, you know, prompted me to think that the baby was in distress".**

60. Dr. Foulkes-Mackey further confirmed that the baby was not monitored in the hallway when they were waiting to go into the theatre because there is no CTG monitor outside of the theatre area. She also confirmed that there "**wasn't a blood pressure cuff and all of that outside of theatre in the corridor door, No, but the midwife, they usually would do the contractions and hear the heart rate while they are with the patient**".

The expert evidence

61. The Claimant and the Defendant both called expert witnesses at the trial. They both agreed that their respective witnesses were experts and should be treated as such. The relevance of how the Court should treat expert evidence was addressed by Winder J (as he then was) in **Henfield v. Carey [2019] 1 BHS J. No. 23**. He said at paragraph 21:

> **21 In National Justice Compania Navierasa S.A v Prudential Insurance Company (Ikarian Reefer) (1993) 2 LLR 68, Justice Creswell examined the duties and responsibilities of the expert. He stated:**
> **(i) Expert evidence presented to the court should be, and should be seen to be, the independent product of the expert uninfluenced as to form or content by the exigencies of litigation;**
> **(ii) An expert witness should provide independent assistance to the court by way of objective unbiased opinion in relation to matters within its expertises. An expert witness in the High Court should never assume the role of advocate**
> **(iii) An expert witness should state the facts or assumptions upon which his opinion is based. He should not omit to consider material facts which could detract from his concluded opinion;**
> **(iv) An expert witness should make it clear when a particular question or issue falls outside his expertise;**
> **(v) If an expert's opinion is not properly researched because he considers that insufficient data is available, then this must be stated with an indication that the opinion is no more a provisional one. In cases when expert witnesses who has prepared a report could not assert that the report contain the truth, the whole truth and nothing but the truth without some qualification, that qualification should be stated in the report;**
> **(vi) If after the exchange of reports, an expert witness changes his view on a material matter having read the otherside's expert report or for any other reasons, such change of view should be communicated (through legal**

representatives) to the otherside without delay and when appropriate to the court.
22 Ordinary witnesses of fact are not allowed to give opinion evidence. They can only say what they saw and what they heard. Expert witnesses however, are able to give opinion evidence. They are nonetheless witnesses and in the same way that I must assess the evidence of every witness, I assess the evidence of these professional witnesses, including their expert testimony. The caution here is that before throwing out or discarding the evidence of an expert witness I must think carefully before doing so. But because an expert expresses an opinion, it doesn't mean that I have to accept it. Here however, where competing opinions are lined up on the two sides of this dispute, it's really a matter of assessing and attributing weight to the various opinions.

62. Klein J in **TK (An Infant, by his Next Friends TK and LK) v Dr. Gregory Carey 2015/CLE/gen/01125** provides a helpful extract on the principles to assess expert evidence. I set out below paragraph 30 of his decision:

> **30. In C v North Cumbria University Hospital NHS Trust [2014] EWHC 61 (QB), Mr. Justice Green summarized the principles and considerations which apply to the assessment of expert evidence in clinical negligence cases as follows, a passage which admits of careful study:**
> **"(i) Where a body of a body of appropriate expert opinion considers that an act or omission alleged to be negligent is reasonable a Court will attach substantial weight to that opinion.**
> **(ii) This is so even if there is another body of appropriate opinion which condemns the same act or omission as negligent.**
> **(iii)<u>The Court in making this assessment must not however delegate the task of deciding the issue to the expert. It is ultimately an issue that the Court, taking account of that expert evidence, must decide for itself</u>.**
> **(iv) In making an assessment of whether to accept an expert's opinion the Court should take account of a variety of factors including (but not limited to): whether the evidence is tendered in good faith; whether the expert is "responsible", "competent" and/or "respectable"; and whether the opinion is reasonable and logical.**
> **(i) Good faith: A sine qua non for treating an expert's opinion as valid and relevant is that it is tendered in good faith. However, the mere fact that one or more expert**

opinions are tendered in good faith is not per se sufficient for a conclusion that a defendant's conduct, endorsed by expert opinion tendered in good faith, necessarily accords with sound medical practice.

(ii) Responsible/competent/respectable: In Bolitho Lord Brown-Wilkinson cited each of these three adjectives as relevant to the exercise of assessment of an expert opinion. The judge appeared to treat these as relevant to whether the opinion was "logical". It seems to be that whilst they may be relevant to whether an opinion is "logical" they may not be determinative of that issue. A highly responsible and competent expert of the highest degree of respectability may, nonetheless, proffer a conclusion that a Court does not accept, ultimately as logical. Nonetheless these are material considerations.

[...]

(vii) Logic/reasonableness: By far and away the most and important consideration is the logic of the expert opinion/tendered. A Judge should not simply accept an expert opinion; it should be tested both against the other evidence tendered during the course of a trial, and, against its internal consistency. For example, a judge will consider whether the expert opinion accords with the inference properly to be drawn from the Clinical Notes or the CRG. A judge will ask whether the expert has addressed all the relevant considerations which applied at the time of the alleged negligent act or omission. If there are manufacturer's or clinical guidelines, a Court will consider whether the expert has addressed these and placed the defendant's conduct in their context. There are two other points which arise in this case which I would mention. First, a matter of some importance is whether the expert opinion reflects the evidence that has emerged in the course of trial. An expert's report will lack logic if, at the point in which it is tendered, it is out of date and not reflective of the evidence in the case as it has unfolded. Secondly, a further issue arising in the present cases emerges from the trenchant criticisms that Mr. Spencer QC, for the Claimant, made of the Defendant's two experts due to the incomplete and sometimes inaccurate nature of the summaries of the relevant facts (and in particular the Clinical Notes) that were contained within their reports. It seems to me that it is good practice for experts to ensure that when they are reciting critical matters, such as Clinical Notes, they do so with precision. These notes represent short documents (in the present

case two sides only) but form the basis for an important part of the analytical task of the Court. If an expert is giving a precis then that should be expressly stated in the body of the opinion and ideally, the Notes should be annexed and accurately cross-referred to by the expert. If, however, the account from within the body of the expert opinion is intended to constitute the bedrock for the subsequent opinion then accuracy is a virtue. Having said this, the task of the Court is to see beyond stylistic blemishes and to concentrate upon the pith and substance of the expert opinion and to then evaluate its content against the evidence as a whole and thereby to assess its logic. If on analysis of the report as a whole the opinion conveyed is from a person of real experience, exhibiting competence and respectability, and it is consistent with the surrounding evidence, and of course internally logical, this is an opinion which a judge should attach considerable weight to.

Dr. Carlos Athelstan Chase

63. The Claimant's expert was Dr. Carlos Athelstan Chase, a qualified Obstetrician and Gynaecologist employed at ProMed Inc., Mayfield Medical Centre, Bridgetown, Barbados. His extensive curriculum vitae indicated that he possesses 31 years of experience in the field of obstetrics, gynaecology and antenatal care. He determined that the care provided to the Claimant was "substandard" and concluded in part that "**the failure to escalate care following the diagnosis of a necessity of a caesarean section constitutes a deviation from the standard of care expected of a reasonably competent medical practitioner**". Dr. Chase concluded that "**had the appropriate steps been taken at PMH on the 2 August 2022 the outcome may have been avoided and altered.**"

64. In his expert medical opinion, he summarised his findings as 8 failures and stated the following opinion:

> **It is my opinion that:**
> 1. **There was failure in the duty of care of Ms. Guillame such that she was not properly monitored during her labor.**
> 2. **There was failure in the standard of care to Ms. Guillame such that her monitoring was not up to the Princess Margaret Hospital or international standards.**
> 3. **There was failure in the duty of care in the nursing care of Ms. Guillame.**
> 4. **There was failure in the standard of nursing care given to Ms. Guillame.**

5. **There was failure in the duty of care in the medical care of Ms. Guillame.**
6. **There was failure in the standard of medical care given to Ms. Guillame.**
7. **The Princess Margaret Hospital did not meet the standard of care for emergency caesarean sections.**
8. **Ms. Guillame suffered harm during labor.**

65. The basis of the 8 failures of care is set out in the expert comments, which encapsulates 24 comments, I set them out in full below:

> **1. A Vaginal examination (VE) should have been performed on presentation of Ms. Guillaume with rupture of membranes to rule out cord prolapse which is a medical emergency that is life threatening to the fetus and is the standard of care.**
> **2. After arrival at the Hospital, the patient spent 1 hour in the bathroom after receiving the enema and was subsequently given a bolus of 500ml of normal saline by the nurse.**
> **3. The fetal heart rate was documented at 108 best per minute with is abnormally slow and is [6]bradycardia.**
> **4. The reason for the bradycardia is not stated.**
> **5. The CTG on admission was reviewed and signed off on by the Senior House Officer. A more senior doctor should be reviewing the CTGs.**
> **6. Patient was seen and examined at 12:40 am and 1 hr and 15 minutes later the midwife is reexamining her without a stated reason. The provided labour ward protocol[7] states that normal labour patients are examined every 4 hours.**
> **7. Patient was started on oxytocin even though she was contracting 3:10 as ordered by the SHO.[8]**
> **8. There is no clear documentation as to when Ms Guillame was fully dilated. The records state that the doctor was called at 2:50 am after she had bene pushing for 45 minutes. This implies that she had been fully dilated for that length of time, that is from 2:05 am which was 10 minutes after she had been examined by the midwife.**
> **9. At 3:30am the documentation by the SHO was that she was fully dilated.**
> **10. A review of the charting of the contractions recorded 5:10 contractions lasting 35-40 seconds with oxytocin in progress. This can be considered tachysystole.[9]**

11. The CTG strips showed fetal bradycardia, tachysystole, late decelerations, saw toothed CTG with loss of variability that were abnormal.
12. Some of the CTG strips were not time or date stamped.
13. CTG traces showed pathological abnormalities that required intervention.
14. During the second stage of labor, the standard of care is to record the fetal heart rate every 5 minutes. There was no documentation of this for the 1 hour and 50minutes after full dilatation.
15. The indication for the caesarean section was stated as arrest of second stage of labour.
16. There was no recognition of the fetal distress (fetal hypoxia) in this case.
17. At caesarean section from the notes, there was no comment on the position of the fetus, caput, moulding or condition of the baby on delivery, only that it was suctioned and handed to the paediatrician.
18. The Apgars assigned to the baby did not reflect the serious condition that it was in as evidenced by the clear and detailed description of events documented by Nurse Cartwright.
19. The decision to delivery time was 1 hour and 50 minutes biut the patient was pushing for an additional 45 minutes before delivery making it a total of 2 hours and 35 minutes of pushing before delivery with an abnormal CTG and oxytocin in progress.
20. The response time of the SHO of 40 minutes on a Labor Ward unit was unacceptable.
21. The Princess Margaret Hospital failed in its duty of care in not having a written administrative protocol re expected response times on the labor unit for each level of staff.
22. A delay of 1 hour and 50 minutes to perform an emergency cesareab section was below the expected standard of care[10].[11]
23. It was questionable to transport a baby in an open cot instead of a temperature controlled transport incubator.
24. The SHO (OG 2) made and entry into the notes dated 2022-08-02 5:30pm which was 12 hours and 10 minutes after the delivery of Ms. Guillaume, detailing events in the notes. The question is why?

66. I also set out below the following paragraphs from the witness statement of Dr. Chase:

14. That I have reviewed the following documents:
a) Antenatal notes from the Ministry of Health and from *PMH;*
b) Booking visit record;
c) Ultrasound scan reports;
d) Midwife visit entries;
e) Consultant clinic notes;
f) Blood test and screening results;
g) Birth plan and delivery notes; and
h) All relevant Guidelines or standards for antenatal care.

15.That the antenatal notes show that the Claimant was booked for delivery at *PMH* at 39 weeks and 2 days gestation and her initial risk assessment indicated a low-risk pregnancy.

16. That prior to being booked at PMH, regular appointments were attended at the Flemming Street Clinic, Ministry of Health with recorded observations of blood pressure, urine dipstick, fetal growth and movement all within expected limits until the 2nd August, A.D., 2023.

17. That whilst being at *PMH*, the Claimant was booked for a caesarean section after no progress at an attempt of natural birth.

18. That the Claimant awaited entry into the surgical theatre in the hallway of *PMH* for a caesarean section for approximately 2 hours.

19. That at this time, warning signs were missed, there was a delay in escalation and there was deviation from medical guidelines.

...

21. That in my professional opinion, the antenatal care provided to the Claimant at *PMH* was inadequate based on the documentation.

22. That the failure to escalate care following the diagnosis of a necessity of a caesarean section constitutes a deviation from the standard of care expected of a reasonably competent medical practitioner.

67. When Dr. Chase was cross-examined by the Defendant's Counsel, Mrs. Mia Ramsey, she tested him on the prenatal care that the Claimant received and whether he took that into account at arriving at his opinion. Dr. Chase agreed that **"the antenatal notes from the Ministry of Health [show] this patient didn't book for any visits until 20 weeks and six days"**, essentially attending in the second trimester. He did not deem this to be unusual and stated during cross-examination that most patients present during the second trimester.

68. During cross-examination, Dr. Chase further explained the rationale for his view that the Claimant waited in the hall of the Hospital for 2 hours before she received the caesarean section. He explained that the 2 hours was from "**the time of the decision until she went for the caesarean section**". When further questioned on ACOG, he agreed that it provides a standard guideline of "**12 to 18 hours active labor is normal for a first time mother**".

69. Much discussion centered on the Apgar scores of 7 and 8 given to baby Elizabeth by the Paediatrician when she was delivered. These scores are used as a standardized assessment to evaluate a newborn's health immediately after birth. Typically, they are recorded at 1 and 5 minutes after delivery. Dr. Chase confirmed during cross-examination that the score is used to rate the baby's appearance, pulse, grimace, activity and respiratory effort. It has a maximum score of 10 and the lowest score of 0. A score of 0 is fatal for the newborn baby. Dr. Chase was adamant in his evidence that he did not believe the scores of 7 and 8 were truly reflective and accurate of the state of baby Elizabeth.

70. Dr. Chase when asked about the report of Dr. Paul Ward, the expert for the Defendants, disagreed with his conclusion that baby Elizabeth died from a congenital heart condition. He rationalised his disagreement by stating that "**there's only one anomaly that we may present like that. It's called transposition of the great vessels, and usually that would be detected on ultrasound scan. Transposition of the great vessels of the heart. The aorta and the primary vessel are switched around**". He also disagreed that the Claimant had a family history of an abnormal heartbeat and was clear that there was no report from a cardiologist of such an abnormality.

71. The evidence around the CTG readings also featured heavily during cross examination. CTG refers to cardiotocography and it is a medical test/monitoring device used during pregnancy and labor to simultaneously monitor the fetal heart rate and the mother's uterine contractions. In his report, he says the following about the CTG readings:

> **CTG 68447 to 68448 time and date stamped 21:44 2022-08-01 contractions every 2 minutes - tachysystole**
>
> **Tachysystole refers to excessive uterine contractions on a CTG, defined by too many contractions (more than 5 in**

10 minutes) or contractions that are too long (over 2 minutes), often resulting in negative fetal heart rate changes such as decelerations. It indicates compromised utero-placental blood flow and requires management, such as reducing or stopping the causative labor-inducing medication, to prevent fetal distress and hypoxia.

CTG 77419 to 77420 no date or time stamp - show abnormal ctg trace, see saw heart rate pattern indicating fetal hypoxia

CTG 77415 to 77416 signed and dated 2022-08-01 11 pm shows and abnormal CTG interpreted as normal. This is the beginning of the strip which continued and has loss of variability and some instances of fetal bradycardia

CTG 68454 to 68455 dated 00:00 2022-08-02 showed loss of contact but prolonged deceleration and fetal bradycardia. Late deceleration is seen.

72. Dr. Chase disagreed that the Claimant's contractions were in the normal range. He was challenged during cross-examination on whether the CTG had readings below 120. I set out below the exchanges that occurred on the CTG readings:

> **A:** So the soft pattern, yes, the soft and down below I'm seeing healthy contractions, mountains, those are the contractions. They are peaking on the cross.
>
> And between, I said between two solid lines, it's 1 centimeters, halfway it's 1 centimeter.
>
> So it's running at 1cm per minute at the speed.
>
> So therefore in the two solid bars you can see the mountain goes up and down and up and down.
>
> So what happens is that the heart rate is not only heart rate will go up, accelerate, we've got to increase the heart and come down and up and down when it's lost. We call this variability.
>
> **That means there's a problem with the baby's oxygenation. The see sawing pattern here is not good.**
> ...

Q: And 8113 that you just gave us that wonderful explanation of would be the same CTG reading where you indicated Tachysytole was present, that there would have been more than 5 and 10 minute contractions over 2 minutes long. And yesterday you admitted and agreed with us that that CTG did not show that correct.

A: Right. So yes, I did say.

Q: And then we also had 8115 where we saw your report said that it showed the bradycardia and you have your own standard falling below 120 when the ACOG standard is falling below 110. And today we go by ACOG standard, but yesterday we went by your standard, correct?

A: None.

Q: Yesterday you agreed with us that the ACOG standard was 110, but some people use 120 and you use 120.

So yesterday it was correct.

A: Yes, I said.

73. Dr. Chase maintained during cross-examination that there were instances of bradycardia and late deceleration. He also said that the CTGs showed a "**see-sawing pattern" meaning that "the baby is not compensating properly, meaning the baby is in distress**". He also questioned the Apgar scores and preferred the notes of Nurse Cartwright who wrote that the baby was "**pale and floppy**".

74. Dr. Chase also confirmed under cross-examination that there was delay in getting the Claimant to the theatre to perform the caesarean section. He also addressed the COVID protocols suggesting that they should not delay emergency surgery; saying that the "**protocols, that I am aware of do not delay. Certainly, they have to determine what route the patient takes and what protection measures did the staff take**".

75. This further exchange with Dr. Chase occurred during cross-examination:

Q: Paragraph 18, you state that the claimant awaited entry into the surgical theatre in the hallway of PMH for a Caesarean section for approximately 2 hours.

Where did you get that information?

A: From my report I looked at the time patient [was] fully dilated, the time patients started and I draw a table or might be the interval between the time from decision and to delivery.

76. In the report, Dr. Chase sets out the following table of the timeline and what he referred to as the "delays":

	Time	Date	Duration HR: MIN
Presentation to Hospital	**11:40 pm**	**2022-08-01**	
Full dilation	**3:30am**	**2022-08-02**	**3hr 50m**
Delivery	**5:20am**	**2022-08-02**	**1 hr 50min+45 min**
Fetal death	**7:37 pm**	**2022-08-02**	**14hr 17 min**

77. He agreed that "**the ACOG guideline says it takes 12 to 18 hours for active labor for a first-time mother**".

78. He also confirmed that he preferred the notes of Nurse Cartwright.

Q: Are you saying that nurse, and I believe you're referring to Nurse Cartwright. Nurse Cartwright notes are absolute.

Is that your opinion?

A: Presentation absolute is actually very detailed and very clear as to what went down in sequence and that was consistent with what the picture or what of which I took regarding the presentation, the delay going to the CDN section, the CTG pattern, the delay act delivery and the outcome that happened maybe afterwards.

79. On the evidence of Dr. Chase, he determined that the Hospital was negligent because of the failure to monitor the baby and mother by taking readings and recording those readings every 5 minutes. He says that there was no documentation of monitoring for 1 hour and 50 minutes after full dilation. When cross examined by Mrs. Ramsey on this aspect of his report, he stated the following:

Q: So Doctor Chase, is there anywhere in your report or your opinion where you state that the checks for the mother and the baby?
Should have been every 5 minutes. I recall saying 30 minutes, but I don't recall saying a 5 minutes.

A: Right. So in the second stage they actually became fully dilated.
She should mark every 5 minutes.

...

A:It produces a reading, so the reading would be produced and that reading will be produced on a strip of paper.

So even the even the machines recording changes in the baby's heartbeat, no one is checking to see whether the heartbeat is normal or abnormal.

If you have a system that will alert you when the baby's heart is abnormal, that is called monitor trace. Or if someone's going to interpret that trace at specific intervals or intervals, say the trace is normal abnormal, that's called monitoring.

Q: But Doctor Chase, would it not also follow that a CTG strip cannot be flagged as abnormal if there are no abnormal readings?

A: That's true. You recognize that's abnormal.

80. During cross-examination Dr. Chase was also asked to comment on his "**expert comments**" in his report. He agreed that there was no cord prolapse shown during the vaginal examination and that there was only one reading when the baby's heart rate was 108 beats per minutes. He indicated that there was evidence of bradycardia on one of the CTG reports before the Court.

81. Dr. Chase was also clear during re-examination that there was an inordinate delay between decision and delivery. He suggested that "**the prolonged nature of the consult would have contributed to the injury that the baby suffered**". He also suggested that the caesarean section should have occurred within 30 minutes of the decision. He stated the following under re-examination:

A: Within 30 minutes of the decision to have caesarean section, yes. So the caesarean section should be performed within 30 minutes of the decision being made to have a caesarean section done. And what should happen in 30 minutes?

A: The patient should be prepared for caesarean section. The counsel advise of the risks, inform the risks, get here to where the staff comes in.

She should be informed and come to of course informed the risk benefits prepare for the caesarean section.

So once she's read and sign the consent form, she'll then be catheterised.

Normally given medication to prevent aspiration of something on the procedure.

Q: Does it include the actual procedure the 30 minutes?

A: No to start the procedure, nothing to it to start just to get done with to start with the decision.

82. When questioned about ACOG, his response was that he uses it as a guide in his practice with adjustments to suit the population. He also stated that within the last 5 years ACOG and RCOG recently changed their guidelines to "**suit their populations what they were seeing ... what they have developed are quite frankly for their populations and we extrapolate it for the most part to our populations, but it's not always 100% interchangeable**". He also confirmed that ACOG address continued assessment during the second stage of labor and not during a caesarean section.

83. He also confirmed during re-examination that the CTGs showed signs of variability which justified monitoring and "**increased vigilance**". He reiterated that the see saw patten "**usually means the baby is not compensating properly**", meaning that the baby is in distress. He further explained that

> **A:** The longer the abnormal pattern goes on, the worse the energy to the baby and the poor the outcome is for the fetus.
>
> So because the pattern, there's not enough oxygen going to the baby and longer this goes on, then more is the insult to the baby and worse it will be for the baby.

84. Dr. Chase further discussed the lack of monitoring by the midwife and the delay between the decision and delivery during re-examination.

85. He likewise maintained his opinion that congenital heart defect was not diagnosed antenatally and not a probable cause of death.

86. When asked by Miss Russell about COVID testing, Dr. Chase maintained that the patient's status is not a reason for a delay. His evidence was that "**if the patient's COVID negative, pretty straightforward. You know what we do if the patient positive, again, we know what we do. If the patient's unknown status, then**

we need to know what steps that patient is so one we can protect the staff and before the patient is not housed with COVID positive patients and get COVID now or housed COVID negative or COVID positive". The Court notes however that Dr. Chase did not have the Hospital's COVID protocols and they were not part of the documents at use at the trial.

87. He disagreed with the Apgar scores and maintained his answer during cross examination that he preferred to use the Nurse's notes which said that "**the baby was floppy**".

Dr. Paul Ward

88. Dr. Paul Ward was called by the Defendants to give expert testimony. He is a practicing obstetrician and gynaecologist for 33 years. He served on the medical staff at the Hospital and as medical adviser at the Public Hospitals Authority. He indicated that he is a fellow of ACOG and RCOG and is on the specialist registry of the Bahamas Medical Council.

89. For the purposes of preparing his report, Dr. Ward confirmed that he "**reviewed a copy of the patient's records, the nurses records, and I also reviewed the labor ward records and the operative reports that were written**". He concluded that after "**reviewing this case and from my past experience in dealing with similar case that this baby crashed post after birth, shortly after birth and this is a classical presentation of a congenital heart disease**". He disagreed with the cause of death proposed by the Claimant's expert and the cause of death on the death certificate. He said:

> **"I strongly disagreed with that because perinatal asphyxia, which is, that is, which by definition is lack of oxygen around. But before, during and after birth is a very rare event.**
>
> **And the baby normally will show you some signs during labour if it has issues with oxygen through its heartbeat, through it's not true. It's a heartbeat pattern.**
>
> **And not only that, the baby will pass meconium when it's very, very stressed.**
>
> **Meconium is actually the first set of stool inside the baby's gastrointestinal tract. And when there's a lack of oxygen, it causes the muscle in the gastrointestinal tract to contract.**
>
> **And that greenish stool comes out and color the meconium, the amniotic fluid.**

So the staff members will see the amniotic fluid coming down greenish.

That's a sign of distress.

In this case, amniotic fluid was clear throughout the entire process.

And this is this is the reason why we monitor these babies in labor because we are above 165 and remain above that we call that fetal bradycardia. The medical term is fetal bradycardia, high heart rate or below 110, persistently below 110. So these are the early warning signs that the baby is having some issues with oxygenation and when you say persistent.

It doesn't, it's not, it's not just a dip, it's not dipping. It just it stays down there for how long?

A minimum of 15 minutes, minimum of 15 minutes is the is the agreed protocol.

And when I reviewed this patient non stress test the the fetal heart rate pattern, I did not see any evidence of that".

90. In his witness statement filed on 3 March 2026 Dr. Ward summarised that there were "**legitimate indications for an emergency Caesarean section**" and the "**decision to incision time for the emergency Caesarean section was two (2) hours**". He opined that the interval was not unusual due to the location of the operating theatre, the logistics and the staffing after midnight.

91. Dr. Ward highlights the following in his report:

Other relevant Factors:

1. The fetal heart rate measured normal in labor was normal. This contradicts fetal distress or imminent danger to the fetus. In the womb when a fetus in the womb is Hypoxia lack of oxygen from the placenta (asphyxia) the heart rate will be too high or too low as measured by a fetal heart rate monitor. The fetal heart rate as measured was considered to be within the normal range.

2. The amniotic fluid was clear (not green – meconium stained). When the fetus is stresses (lack of oxygen) the fetus will pass stool (meconium) in the womb in the amniotic fluid. This was not the case. The amniotic fluid was clear (no evidence of meconium staining). This strongly suggests no lack of oxygen from the placenta.An emergency Caesarean Section was performed in the early hours of the morning of August 3rd, 2022. Staff had to wait for the results of the mandatory Covid testing.

Condition of infant at Birth

Apgar Score

This is a standardized measurement of newborns at birth to give an account of the baby's condition. A maximum score is 10.

The Apgar score of the infant was 7 at one minute and 8 at five minutes. These scores contradict the allegation of perinatal asphyxia (lack of oxygen during labour and delivery).

The medical team felt comfortable transporting the new newborn from the operating theatre to the maternity unit. This is standard operation procedure for an infant showing no evidence of medical issues.

Importunely the infant (crushed) coded on the way to the Maternity Ward. Standard operating procedures were performed and the infant was relocated to the Neonatal Intensive Care Unit (NICU).

Appropriate advanced cardiac life support measures were preformed by the Medical Team. Despite all repeated resuscitation efforts, the neonate unfortunately demised.

No Autopsy was Performed on the Infant

It is my opinion that this case suggests a congenital heart condition in the newborn. Once the infant was delivered and the placenta supply of oxygen is discontinued the infant will subsequently code (cardiac arrest).

Signs and Symptoms of Perinatal Asphyxia

Perinatal Asphyxia is a condition in which a fetus or newborn does not get enough oxygen before birth during of shortly after birth. Because the brain and other organs are especially sensitive to lack of oxygen the signs can appear in the baby. The mother or the fetal monitoring that is done during labour.

Signs

Abnormal fetal heart rate patterns high and low heart rate non-reassuring patterns on fetal monitor. This was not seen in this case.

Meconium stained amniotic fluid (passage of meconium (stool) by the infant before birth can be a sign to hypoxia (lack of adequate oxygen) this was not the case. The meconium amniotic fluid was clear.

Apgar Score

A score less that or equal 3 at five minutes is strongly suggestion asphyxia. In this case the newborn apgar score was 8 at five minutes. This strongly suggest no evidence of asphyxia (lack of oxygen).

Conclusion

The Obstetric team followed the usual and customary protocol in this case. The absence of an autopsy is unfortunate. I suspect this neonate had a congenital heart condition resulting in its coding after delivery.

I see no fall below the standard of care in this matter. I suspect that an autopsy was not done as a National Pandemic (Covid) was ongoing and more urgent autopsies had to be performed on adults dying of suspected Covid infections.

92. Dr. Ward concluded that the "**team followed the usual and customary protocol in this case. The absence of an autopsy is unfortunate. I suspect that this neonatal had a congenital heart condition resulting in its coding after delivery. I see no fall below the standard of care in this matter**".

93. When asked by Mrs. Ramsey during examination-in-chief about the monitoring, Dr. Ward explained that

> **You can't remove the monitor from the labor ward because it has to stay there for other patients. So logistically we do not have the number of monitors that accompany the patient ongoing the operating room to continue monitoring.**
>
> **So that's a sort of a period whereby there's no continuous monitoring occur. That is the standard practice in Princess Margaret Hospital.**
>
> **Now occasionally some midwives will take a handheld monitor and will do intermittent auscultation to listen, to make sure while the preparation is being done. Listen to what? To the heart beat, the yeah, to the abdomen. Yes, they will do intermittent, we call that intermittent auscultation.**
>
> **Some midwives do do that. If they have, again, this is based on it's a, it's a fetal monitor that they just put on, put on the abdomen and they can hear through the head a handheld monitor.**
>
> **And again, this is based on availability logistics resources because I know we had a few and they don't last that long. They're not very robust.**
>
> **So a lot of times we don't have it.**

94. Dr. Ward further explained that the CTG would not give any signs of the baby having a congenital heart condition. He explained that is because "**most the problem with congenital heart conditions that remember now the baby is connected to the mother through the placenta and it's getting oxygenated blood from the placenta. So it is compensated it, it does not show up in the womb because now it's relying on the mother's oxygenated blood to survive. But as soon as you remove that baby from that environment and you cut the umbilical cord and now the baby is outside, that is when it starts showing you its true colors**".

95. Dr. Ward also suggested that with Apgar scores of 7 and 8 perinatal asphyxia "**traditionally your Apgar scores tend to be like 2 to 3 very low**". He also questioned why an autopsy was not done saying "**perinatal asphyxia is a more slow onset chronic condition. You will start seeing signs after a while, the babies start seizure, neonatal seizures, and then the babies start having issue of not developing. And these babies by this time are still in the NICU, in the neonatal intensive care facilities. And then when we do the CT scans**

and we do the MRI, then we see evidence in the brain that the brain had a serious assault because what happened? Lack of oxygen to the brain tissue. The brain is very sensitive to oxygen".

96. When cross-examined by Miss Russell about whether baby Elizabeth inherited the congenital heart condition from the mother, Dr. Ward's response was that **"I cannot say that the baby inherit anything from the mother or I can say that if a mother has a condition genetically, the offspring has an increased risk of having that condition. That's what that's what I'm insinuating**".

97. Dr. Ward confirmed that the midwife is the first line of care and that she would call the doctor if a problem presents. He said:

> **Will the midwife be expected to deliver the baby? Yes, if it's a normal with patient. Yes, Sir. Yes. Yes, That happens in over 80% of the patients. The midwife, you don't need to call the doctor, correct? Yes, I see.**
>
> **The doctors are called if there are any unusual presentation or unusual complication.**

98. When questioned by Miss Russell about the ACOG, Dr. Ward stated that "**I'm a board certified doctor for both the Caribbean and UK and ACOG made these guidelines as a general guideline for us to follow. But big countries all have different resources"**. He further stated:

> **A:** So you could tell, you could say ACOG also recommend that the decision to incision interval versus you in section is 30 minutes right now in the American Hospital. That's right next on Miami Cleveland Clinic Baptist out the laboring room that you are doing that you're managing the patient in is an operating theatre.
>
> So if you make that decision, all they do is swing around, pull the light down, turn it on the anaesthetic machine on and you have your section. Now let's go to PMH. All right, you're in PMH.
>
> Yeah, but I'm telling you what the. That's our system. That is what we live in.
>
> Yeah, we live in. We live in our system. So you come to PMH now the labour ward is downstairs.

> You make you make a call for a caesarean section. You have to tell the duty sister, who then informs the nurses and certain people inform operating theatre.
>
> Then you have to go find a trolley. If you can find one, then you have to go to the elevator, which may not be working right there. So you may have to go down to the other elevator.

99. Dr. Ward when questioned about the 30 minutes window for delivery in the ACOG was clear that it amounted to resources of the Hospital. He also said that "**everybody wants to pay 50, wants to register and pay $15.00, but they want the Cleveland Clinic treatment**".

100. Dr. Ward was clear in his evidence that a decision to proceed to an emergency caesarean section is made in cases of **"fetal compromise, we, we always have the trump card of doing a caesarean section, whether the heart rate goes up or goes down or if there's breach presentation or if there's mild presentation, we do a caesarean section. We don't wait. We have a clear cut indication for emergency caesarean sections**".

101. Miss Russell also questioned Dr. Ward about labor progression under ACOG. His evidence was that the Hospital engages in "**active management of labour**". He stated:

> **A:** Well, what we do, we still practice a philosophy of active management of Labor. So if you come into the labor ward and let's say you're 3 centimeters dilated, mild contractions, in most cases we will put up a drip on you and give you oxytocin. 2 expedite labour. We call it the active management of labour. We just don't wait for nature to take this course. We want you to get it on with it and get the baby out.
>
> Now in regard to the second stage of labour, when you become fully dilated after about half an hour pushing, I say caesarean section, I say this baby ain't coming out. In fact, I just had a case last week that no one is fully dilated.
>
> The head is right there, coming down, coming back up, coming down, coming back up inside of a channel canal. The husband's right there. I say, Sir, we have to do a caesarean section because I think there's cord around the neck and this baby, that's why the baby's not coming out for the breaking knob within half an hour. I was, it was a private hospital. I was in the operating theatre and just like I say, the cord was tied around the baby neck, but I was a private hospital.

102. On COVID testing, Dr. Ward was asked why was the Claimant "swabbed when she was in the hallway about to go in the theatre?" He answered as follows:

> I don't know. I can't answer that question. I don't, I don't know.
>
> **Q:** Are you aware that that was it was not done previously?
>
> **A:** I don't know if they were doing universal COVID testing on everyone that came into the labor ward or they were reserving the reagents only to do those who are going to operate. Because again, I worked as a manager before on the system and I know we have to manage our resources as if you do it on every pregnant woman, you know, no symptoms, asymptomatic, you run out of reagents and then you then you don't really have then you have no reagents. Those who come with shortness of breath and have signs of COVID.

103. Dr. Ward was questioned about the Apgar scores of 7 and 8 given to baby Elizabeth. He confirmed that he took the scores into account when forming his opinion. I set out below the exchange:

> **Q:** We already discussed the Apgars of 7-8 and determined that you're not a paediatrician and that that's you. You made whatever reference to the Apgars from the notes that you read, so I can say we can fairly say that these scores were recorded by someone else.
>
> So you don't have any independent knowledge to say that the baby was not floppy or was not pale?
>
> **A:** I can only go by with the documentation, said counsel.
>
> **Q:** Are you aware that there's documentation that says the baby was floppy and pale?
>
> **A:** I saw, I saw something where they say the baby was floppy and blue.
>
> **Q:** No, no, not blue, floppy and pale.
>
> **A:** Yes, yeah, floppy and pale. Basically says the same thing.
>
> **Q:** Did you factor into your opinion that the probability that it could be lower than 7 or 8?

A: No, I had to, I had to. I had to rely on trust what the professionals wrote at that time because they were there.

I could I did not challenge the validity of their assessment.

Q: Is it designed to determine the cause of death?

A: No, not at all. The Agar scores are the, the first one at one minute determine how the baby fared in utero during labour.

The second one at 5 minutes determine how good your resuscitation was.

That's all resuscitation. But basically what we do, my Lord, when the baby comes out, we dry off the baby, we clear it's airway, we suction it's mouth and we make, sometimes we stimulate it to do a cry because when the cry gets the lungs start going. So those are the basic stuff that we do in the neonate when it comes out.

That's the basic resuscitation for a baby, a newborn.

Q: Would you agree that the Apgar scores alone cannot exclude perinatal asphyxia?

A: Yes, it can because that's why I mentioned earlier, if you have perinatal asphyxia, you'll have extremely low Apgar scores less than four at birth.

Q: I can leave that alone, but earlier you agree with me that you weren't sure of the 7-8 you would use.

A: And this is written by ACOG as well.

If you look at the definition of perinatal asphyxia, you cannot have Apgar scores 7 and 8 at birth and say it's perinatal asphyxia. It goes. It contradicts itself.

104. When challenged by Miss Russell on his "theory" of congenital heart disease, Dr. Ward said "**the baby just crashed**". He stated:

A: My suspicion, yes, my index suspicion is very high for that, yes, because of the the way the clinical presentation occurred.

It occurred within hours of birth.

The baby just crashed, just just crashed.

Q: Does congenital heart disease cause? Well you say it caused the baby to crash.

Does every person die from having a congenital heart condition?

A: It depends on the nature of their congenital condition because now remember now the heart contains of muscle, it contains of partition the septum and it contains blood vessels and each of those areas can be malformed during embryological development.

Q: So how long can an person live who has congenital heart condition in the first instance?

A: It depends on the type of heart condition that they have. Some of them can be corrected surgically by a cardiac surgeon. Some of them cannot be corrected by a cardiac surgeon and they die before they reach the age of 12.

Q: How would how long would you live?

A: It depends on the situation. It depends on. I cannot give you a straight answer to that because it does so much variance, so much clinical presentations, depends on the nature of the lesion, how severe it is.

It depends on a lot of things. Counsel. It's just not. It's not fixated. The answer is not a fixed answer for all. Congenital heart disease doesn't work like that.

Some of them do well with cardiac surgery when there's a minor, but if you have someone who have transportation of the great vessels, tautology of follow where and holes in the heart, they don't do well because there is too much multiple abnormalities in the anatomical structure of the heart. You can't save those babies.

Whereas it's just one, let's say there's a hole in the heart, the doctors can go in and close that hole up and the baby go on to do fine.

So it depends on the clinical presentation.

105. Dr. Ward maintained under cross examination his objection to the cause of death on the death certificate. His evidence is set out below:

> **Q:** I put it to you that perinatal asphyxia is more probable than the retrospective examinations and explanations. Would you have to say that?
>
> **A:** I agree. I disagree strongly with that statement. First of all, perinatal asphyxia is a very rare condition.
>
> OK, two per 10,000 and it's all. It's also very difficult to diagnose even universally. We have not had full agreement between the Europeans and the Americans on the definition of perinatal asphyxia.
> And we, the American College and the World college are trying to correct this because it is very easy to blame perinatal asphyxia as the germane cause of any adverse outcome because that is what lawyers like because they can get money for it. And so they're trying to correct that because often these babies that don't do well, the problem started sometime before labor started, I think, I think.

106. When asked by the Court about the monitoring in the period when the Claimant was waiting to enter the theatre, Dr. Ward said that while he expected the nurse to do some monitoring, he did not expect anything to change with the course, that is, the caesarean section.

> **Judge:** In a situation where a patient is deemed to require an emergency caesarean section, would you expect there to be some monitoring in the period until she gets into the emergency room?
>
> **A:** Yes, I expect the midwife to do some intermittent auscultation.
>
> But it's not going to change the price of cheese because let's say they listen and they got a heart rate of 108.
>
> We still plan it for a caesarean section. It's not going to, it's not going to cost us not to do a caesarean section. The patient needs a caesarean section. So we are now moving towards a caesarean section. That decision is being made.
>
> It's the logistics that work against us in the healthcare system.

We have to wait for them to get the instruments out, take them, get them ready, set up the trade.

They wait in a pandemic situation. They have to wait for COVID testing.

It's a lot of little things that are going on. They might sometimes they have to wait until a gunshot wound is coming out and you're out there on the corridor waiting and they're just closing up a gunshot wound or an ectopic pregnancy. So it's the logistics that we're it's not textbook. I always tell people, you know, we read these things and guidelines and it's perfect.

107. When further questioned on the monitoring in the period when waiting to go to the theatre, Dr. Ward provided a further explanation:

Q: If monitoring was done and they discovered that the baby was in distress, he asked what would you expect and you said you would expect them to still continue with the caesarean.

What would you expect to see? Would there be any signs if that was the case? If that baby was in distress, you get into C-section. Would there be anything that you see to confirm that?

A: We don't know the fact that the baby come out and the baby heart is beating, the baby cried, the baby, you know, is alive.

That tells you that the baby survived the stress that it was going through.

That's what that that's the implication for that.

Now if the baby came out as a fresh still birth, then that tell you, Oh well, that distress was seriously enough to kill the baby.

But the baby came out alive.

108. Dr. Ward also spoke to the signs of distress in the baby.

Yes, yes, meconium is a very important clinical factor that we take pay attention to in labour because that is telling us the baby has some degree of distress.

And so when the baby passed its stool, it's actually fetal stool. When that baby passed that stool on the amniotic fluid, it stains it and it looks green.

That gives us some hints that you need to get on with this labour or you need to get this baby out.

If we saw meconium stain, how many are the fluid coming from the mother that would have told us that the baby has another level of fetal distress? That for my review of the records, I never see any documentation of meconium stain like her that tells me the baby is stable and OK at that time.

109. During re-examination Dr. Ward was clear in his evidence that the timing of the delivery would make no difference if the baby had congenital heart diseases.

It's no different same outcome baby would have thing, baby would have crashed because you removed the baby now from the mother maternal oxygenation and the baby would crash over the next couple of hours.

Even if you did the section within 5 minutes removing the baby from the oxygenation from the mother.

Q: So the catalyst is what is the catalyst?

When you when you clamp that cord and now you have the baby that the physiological systems going on the baby to adapt that it's breeding on its own.

That is the catalyst and if the heart is not right, it will not, it will not support the baby.

A: So 2 minutes, 2 hours doesn't make a difference.

A: In fact, I would say most of these babies are quite resilient. And the reason for that is that they have something called fetal haemoglobin in their blood.

And the fetal haemoglobin can hold on to oxygen tighter than the adult haemoglobin that is in our body.

So a baby could withstand lack of oxygen for a very long time. I, I had proven it three hours and I got a live baby.

They're, they're very resilient, extremely. So when you see a baby crash, you need to look for some more answers.

110. When questioned during re-examination on the autopsy, Dr. Ward provided the following response:

> **A:** What my learning friend asks you some questions related to the death certificate versus the autopsy report.
>
> Can you kind of differentiate those documents for us?
>
> **A:** The autopsy report is the definitive conclusion on the course of that.
>
> A death certificate is again a suspicion by whatever the doctor signed off on. Now I don't know if the doctor looked at the entire case and investigated thoroughly like how it's being investigated now, but perinatal asphyxia is a is a rare diagnosis and a serious diagnosis with implication. An autopsy really should have been done in this case.
>
> **Q:** And what kind of doctor would do an autopsy?
>
> **A:** A pathologist, I suppose. We have Doctor Karen Sands who is our forensic pathologist. She is board certified in in general pathology and forensic pathology. She's a director of pathology at Princess Margaret Hospital and she is very well capable of doing these cases.

Issues for determination

111. The Agreed Statement of Facts and Issues filed on 28 October 2025 was not materially helpful in identifying the facts that were agreed by the parties. It is in large part a replication of the allegations of negligence set out in the Claim Form. It is helpful however in setting out the agreed issues. The four issues that were agreed by the parties are:

> **(iii) Whether the Defendants owe the Claimant and baby Elizabeth Lundy a duty of care in tort for negligence?**
> **(iv) Whether the Defendants breached that duty by failing to exercise reasonable care and skill?**
> **(v) Whether such breach caused or materially contributed to the infant's death?**
> **(vi) If there was a breach of duty of care, would the Claimant be entitled to damages?**

112. The agreed facts are set out at paragraphs 1 to 7 (inclusive) of the Statement. I highlight paragraphs 1, 2, 3, 5 and 6:

> **1. The Claimant is the parent and lawful next of kin of Baby Elizabeth Lundy, who was born on the 2nd August, A.D., 2023 at Princess Margaret Hospital ("PMH"), Nassau, New Providence, The Bahamas.**
>
> **2. The Defendant(s) were, at all material times, engaged in the practice of medicine and/or midwifery at the said hospital and owed the Claimant and her infant a duty to exercise all reasonable care, skill, and diligence expected of competent medical practitioners.**
>
> **3. On or about the 1st August, A.D, 2023, the Claimant was admitted to *PMH* under the care of the Defendant(s) for the purpose of labour and delivery.**
> **...**
>
> **4. The Claimant pleads that as a result of the said acts and/or omissions, Baby Elizabeth Lundy was born in a severely compromised state and subsequently died on the 2nd August, A.D, 2023 at *PMH*.**
>
> **6. The Claimant further pleads that as a result of the negligence of the Defendants, the Claimant suffered and continues to suffer mental anguish, emotional distress, and loss of the expectation of life of her child.**

113. Ultimately, the Court must find on a balance of probabilities what was the primary or prominent cause for the unfortunate death of baby Elizabeth 2 hours after her birth. Therefore, the primary issue in dispute is whether or not the Defendants and particularly, Dr. Agatha Foulkes-Mackey, breached the duty of care owed to Ms. Guillaume during and/or after the delivery of baby Elizabeth.

The Law

114. The usual starting premise of the law of medical negligence is the now celebrated dicta of McNair J in **Bolam v Friern Hospital Management Committee [1957]1 WLR 582**, where he said:

> **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 responsible body of medical men skilled in that particular art. I do not think there is much**

difference in sense. It is just a different way of expressing the same thought. 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. At the same time, that does not mean that a medical man can obstinately and pig-headedly carry on with some old technique if it has been proved to be contrary to what is really substantially the whole of informed medical opinion. Otherwise you might get men today saying:

"I do not believe in anaesthetics. I do not believe in antiseptics. I am going to continue to do my surgery in the way it was done in the eighteenth century." That clearly would be wrong.

115. I adopt the principles of law pronounced by Smith JA in **Dr. Raleigh Butler v Marsha Stuart SCCivApp No. 75 of 2023** and set them out below. They, in my view, appropriately describe the state of Bahamian law on medical negligence.

> **(b) Medical Negligence and expert evidence**
> **20.** In cases involving allegations of medical negligence a doctor is not guilty of negligence if he acted in accordance with a practice accepted as proper by a reasonable body of medical men skilled in that area of medicine, even if there is a body of opinion which takes a contrary view.
> **21.** Those principles are derived from the case **Bolam v Friern Hospital Management Committee** [1957] 2 All ER 118 and subsequent decisions which have adopted and defined it. One local case which was cited by the trial judge is **Lendeisha Culmer-Hanna v. Dr. Leslie W. Culmer et al** 2013/CLE/gen/01365 at paragraphs 90 to 92 and I quote from paragraph 90:
>
> "**[90] ...**
> **The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent. It is well established that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art... A doctor is not guilty of negligence if he acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. Putting it the other way round, a doctor is not negligent if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view. [Emphasis**

added]"

22. Further, while it is the Plaintiff's duty to plead and prove negligence, it is the trial judge who decides on the issue of negligence. The trial judge is not bound to accept the opinion of any expert or to prefer any expert's opinion over others based solely on their qualifications. However, the trial judge should give due deference to what is proffered as a competent and reasonable body of opinion. The trial judge cited with approval the following dicta at paragraph 82 of her judgment:

"[82] ...
In resolving conflicts of expert evidence, the judge remains the judge, he is not obliged to accept evidence simply because it comes from an illustrious source: he can take account of demonstrated partisanship and lack of objectivity. But save where an expert is guilty of a deliberate attempt to mislead (as happens only very rarely), a coherent reasoned opinion expressed by a suitably qualified expert should be the subject of a coherent reasoned rebuttal, unless it can be discounted for other good reason..." [Emphasis added] (see Eckersley v Binnie [1988] 18 Con LR 1, 77).

23. Similarly, at paragraph 95 of her judgment the trial judge quoted Lord Browne-Wilkinson, in Bolitho v City and Hackney Health Authority [1997] 3 WLR 1151, 1158 which sets out the position that:

"...in my view, the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical practice. In the Bolam case itself, McNair J. [1957] 1 W.L.R. 583, 587 stated that the defendant had to have acted in accordance with the practice accepted as proper by a "responsible body of medical men." Later, at p. 588, he referred to "a standard of practice recognized as proper by a competent reasonable body of opinion." Again, in the passage which I have cited from Maynard's case [1984] 1 W.L.R. 634, 639, Lord Scarman refers to a "respectable" body of professional opinion. The use of these adjectives – responsible, reasonable and respectable all show that the

court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter." [Emphasis added]

116. It is accepted by the authorities that a doctor is not guilty of negligence if he followed and adopted a practice accepted as proper by a responsible body of medical practitioners skilled in that particular art. This follows even if there is a body of contrary opinion.

117. In **McCulloch and others v Forth Valley Health Board [2023] 4 All ER 943** the UK Supreme Court described the test as the "**professional practice test**" where the question of what constitutes a reasonable alternative treatment. In the judgment delivered by Lord Hamblen and Lord Burrows the duty of care on a doctor was discussed. I set out below the following paragraphs from the decision.

[1] The legal test for establishing negligence by a doctor in diagnosis or treatment is whether the doctor has acted in accordance with a practice accepted as proper by a responsible body of medical opinion. In this judgment, we will refer to this test, for shorthand, as the 'professional practice test'. This test was most clearly laid down by McNair J in Bolam v Friern Hospital Management Committee [1957] 2 All ER 118 at 122, [1957] 1 WLR 582 at 587('Bolam') and is consistent with what Lord President Clyde said in the leading Scottish case of Hunter v Hanley 1955 SC 200 at 206('Hunter v Hanley'). A qualification of this test is that, as recognised in Bolitho (administratrix of the estate of Bolitho (decd)) v City and Hackney Health Authority [1997] 4 All ER 771, [1998] AC 232('Bolitho'), a court may, in a rare case, reject the professional opinion if it is incapable of withstanding logical analysis.

[2] In the case of *Montgomery v Lanarkshire Health Board (General Medical Council intervening) [2015] UKSC 11*, [2015] 2 All ER 1031, [2015] AC 1430('Montgomery') this court decided that the professional practice test did not apply to a doctor's advisory role 'in discussing with the patient any recommended treatment and possible alternatives, and the risks of injury which may be involved'

(para [82]). The performance of this advisory role is not a matter of purely professional judgment because respect must be shown for the right of patients to decide on the risks to their health which they are willing to run. 'The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments' (para [87]). The courts are therefore imposing a standard of reasonable care in respect of a doctor's advisory role that may go beyond what would be considered proper by a responsible body of medical opinion.

118. I note that the Claimant makes no complaint in the action before the Court of a failure of the attending doctors to advise her of any inherent risk in the selection of a caesarean delivery as opposed to a vaginal delivery. I therefore do not have to decide the issue of reasonable alternative treatments. The sole issue before the Court is the care provided to the Claimant on 2 August 2022.

119. In arriving at my decision, I must therefore be satisfied, on the balance of probabilities, that the Claimant established that the Defendants owed her and baby Elizabeth a duty of care; that they breached that duty through their negligence or omissions; (iii) that their negligent acts or omissions caused the injuries which were foreseeable (factual and legal causation); and (iv) that there was resulting damage or injury from the breach.

120. I am cognizant that my duty in this case is to review the evidence adduced and to determine whether the claim for negligence is met. I therefore will analyse the evidence presented at the trial inclusive of the treatment given by the Hospital before and up to delivery and the post-natal period. My task was greatly assisted by the expert evidence and the answers proffered during cross-examination by the Claimant and Drs. Clare and Foulkes-Mackey.

121. In **Bolitho (administratrix of the estate of Bolitho (deceased)) v City and Hackney Health Authority [1997] 4 All ER 771** the House of Lords in the speech of Lord Browne-Wilkinson addressed the Bolam test and causation:

> **Where, as in the present case, a breach of a duty of care is proved or admitted, the burden still lies on the plaintiff to prove that such breach caused the injury suffered (see Bonnington Castings Ltd v Wardlaw [1956] 1 All ER 615, [1956] AC 613 and Wilsher v Essex Area Health Authority [1988] 1 All ER 871, [1988] AC 1074). In all cases, the primary question is one of fact: did the wrongful act cause the injury? But in cases where the breach of duty consists of an omission to do an act which ought to be**

done (eg the failure by a doctor to attend) that factual inquiry is, by definition, in the realms of hypothesis. The question is what would have happened if an event which by definition did not occur, had occurred. In a case of non-attendance by a doctor, there may be cases in which there is a doubt as to which doctor would have attended if the duty had been fulfilled. But in this case there was no doubt: if the duty had been carried out it would have either been Dr Horn or Dr Rodger, the only two doctors at St Bartholomew's who had responsibility for Patrick and were on duty. Therefore in the present case, the first relevant question is 'what would Dr Horn or Dr Rodger have done if they had attended?' As to Dr Horn, the judge accepted her evidence that she would not have intubated. By inference, although not expressly, the judge must have accepted that Dr Rodger also would not have intubated: as a senior house officer she would not have intubated without the approval of her senior registrar, Dr Horn.

122. On the Court's treatment of expert evidence, Lord Browne-Wilkinson stated:

Mr Brennan renewed that submission both before the Court of Appeal (who unanimously rejected it) and before your Lordships. He submitted that the judge had wrongly treated the Bolam test as requiring him to accept the views of one truthful body of expert professional advice, even though he was unpersuaded of its logical force. He submitted that the judge was wrong in law in adopting that approach and that ultimately it was for the court, not for medical opinion, to decide what was the standard of care required of a professional in the circumstances of each particular case.

My Lords, I agree with these submissions to the extent that, in my view, the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical practice. In Bolam's case [1957] 2 All ER 118 at 122, [1957] 1 WLR 583 at 587 McNair J stated that the defendant had to have acted in accordance with the practice accepted as proper by a 'responsible body of medical men' (my emphasis). Later he referred to 'a standard of practice recognised as proper by a

competent reasonable body of opinion' (see [1957] 2 All ER 118 at 122, [1957] 1 WLR 583 at 588; my emphasis). Again, in the passage which I have cited from Maynard's case, Lord Scarman refers to a 'respectable' body of professional opinion. The use of these adjectives—responsible, reasonable and respectable—all show that the court has to be satisfied that the exponents of the body of opinion relied on can demonstrate that such opinion has a logical basis. In particular, in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter.

There are decisions which demonstrate that the judge is entitled to approach expert professional opinion on this basis. For example, in Hucks v Cole (1968) (1993) 4 Med LR 393, a doctor failed to treat with penicillin a patient who was suffering from septic places on her skin though he knew them to contain organisms capable of leading to puerperal fever. A number of distinguished doctors gave evidence that they would not, in the circumstances, have treated with penicillin. The Court of Appeal found the defendant to have been negligent. Sachs LJ said (at 397):

'When the evidence shows that a lacuna in professional practice exists by which risks of grave danger are knowingly taken, then, however small the risks, the court must anxiously examine that lacuna—particularly if the risks can be easily and inexpensively avoided. If the court finds, on an analysis of the reasons given for not taking those precautions that, in the light of current professional knowledge, there is no proper basis for the lacuna, and that it is definitely not reasonable that those risks should have been taken, its function is to state that fact and where necessary to state that it constitutes negligence. In such a case the practice will no doubt thereafter be altered to the benefit of patients. On such occasions the fact that other practitioners would have done the same thing as the defendant practitioner is a very weighty matter to be put on the scales on his behalf; but it is not, as Mr Webster readily conceded, conclusive. The court must be vigilant to see whether the reasons given for putting a patient at risk are valid in the light of any well-

known advance in medical knowledge, or whether they stem from a residual adherence to out-of-date ideas ...'

Again, in Edward Wong Finance Co Ltd v Johnson Stokes & Master (a firm) [1984] AC 296, [1984] 2 WLR 1, the defendant's solicitors had conducted the completion of a mortgage transaction in 'Hong Kong style' rather than in the old-fashioned English style. Completion in Hong Kong style provides for money to be paid over against an undertaking by the solicitors for the borrowers subsequently to hand over the executed documents. This practice opened the gateway through which a dishonest solicitor for the borrower absconded with the loan money without providing the security documents for such loan. The Privy Council held that even though completion in Hong Kong style was almost universally adopted in Hong Kong and was therefore in accordance with a body of professional opinion there, the defendant's solicitors were liable for negligence because there was an obvious risk which could have been guarded against. Thus, the body of professional opinion, though almost universally held, was not reasonable or responsible.

These decisions demonstrate that in cases of diagnosis and treatment there are cases where, despite a body of professional opinion sanctioning the defendant's conduct, the defendant can properly be held liable for negligence (I am not here considering questions of disclosure of risk). In my judgment that is because, in some cases, it cannot be demonstrated to the judge's satisfaction that the body of opinion relied on is reasonable or responsible. In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of that opinion. In particular, where there are questions of assessment of the relative risks and benefits of adopting a particular medical practice, a reasonable view necessarily presupposes that the relative risks and benefits have been weighed by the experts in forming their opinions. But if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible.

I emphasise that, in my view, it will very seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable.

The assessment of medical risks and benefits is a matter of clinical judgment which a judge would not normally be able to make without expert evidence. As the quotation from Lord Scarman makes clear, it would be wrong to allow such assessment to deteriorate into seeking to persuade the judge to prefer one of two views both of which are capable of being logically supported. It is only where a judge can be satisfied that the body of expert opinion cannot be logically supported at all that such opinion will not provide the bench mark by reference to which the defendant's conduct falls to be assessed.

123. In **Meadows v Khan [2021] 4 All ER 65** the issue for the court's determination was whether a medical practitioner was liable in negligence for the costs of bringing up the child who had an associated hereditary disease and autism. The medical practitioner was approached by Ms. Meadows to test her to determine if she was a carrier of a hereditary disease. The tests which were undertaken were inappropriate to provide the answers. She was not advised that she needed to undergo a genetic test to establish whether she is a carrier of the relevant gene. When she gave birth, the baby had the hereditary disease and was autistic. In the course of the decision, the UK Supreme Court made some helpful statements on causation, which I set out below.

[28] In our view, and as explained in more detail below, a helpful model for analysing the place of the scope of duty principle in the tort of negligence, and the role of the other ingredients upon which Mr Havers has relied in this context, consists of asking six questions in sequence. It is not an exclusive or comprehensive analysis, but it may bring some clarity to the role of the scope of duty principle which SAAMCO [South Australia Asset Management Corp v York Montague Ltd [1996] 3 All ER 365] highlighted. Those questions are:

(1) Is the harm (loss, injury and damage) which is the subject matter of the claim actionable in negligence? (the actionability question)
(2) What are the risks of harm to the claimant against which the law imposes on the defendant a duty to take care? (the scope of duty question)
(3) Did the defendant breach his or her duty by his or her act or omission? (the breach question)
(4) Is the loss for which the claimant seeks damages the consequence of the defendant's act or omission? (the factual causation question)

(5) Is there a sufficient nexus between a particular element of the harm for which the claimant seeks damages and the subject matter of the defendant's duty of care as analysed at stage 2 above? (the duty nexus question)
(6) Is a particular element of the harm for which the claimant seeks damages irrecoverable because it is too remote, or because there is a different effective cause (including novus actus interveniens) in relation to it or because the claimant has mitigated his or her loss or has failed to avoid loss which he or she could reasonably have been expected to avoid? (the legal responsibility question)
Application of this analysis gives the value of the claimant's claim for damages in accordance with the principle that the law in awarding damages seeks, so far as money can, to place the claimant in the position he or she would have been in absent the defendant's negligence.

[29] It is quite possible to consider these matters in a different order and to address more than one question at the same time; for example, in many cases the second and the fifth questions can readily be analysed together. We address the relationship between the second and fifth questions in the context of a claim to which the reasoning in SAAMCO applies in paras [38] and [48]–[52] below.

[30] But this analysis serves to demonstrate that the answers to the questions of factual causation and foreseeability, on which Mr Havers relies, cannot circumvent the questions which must be asked in relation to the scope of the defendant's duty.

[67] First, the economic costs of caring for a disabled child are of a nature that is clearly actionable. Secondly, the scope of duty question is answered by addressing the purpose for which Ms Meadows obtained the service of the general medical practitioners. She approached the general practice surgery for a specific purpose. She wished to know if she was a carrier of the haemophilia gene. Mr Havers accepted as accurate Nicola Davies LJ's statement of the purpose of the consultation in para [27](i) of her judgment in the Court of Appeal:

'The purpose of the consultation was to put [Ms Meadows] in a position to enable her to make an informed decision in respect of any child which she conceived who was subsequently discovered to be carrying the haemophilia gene.'

Dr Khan owed her a duty to take reasonable care to give accurate information or advice when advising her whether or not she was a carrier of that gene. In this context it matters not whether one describes her task as the provision of information or of advice. The important point is that the service was concerned with a specific risk, that is the risk of giving birth to a child with haemophilia.

[68] Thirdly, Dr Khan was in breach of her duty of reasonable care, as she readily admitted. Fourthly, as a matter of factual causation, Ms Meadows lost the opportunity to terminate the pregnancy in which the child had both haemophilia and autism. There was thus a causal link between Dr Khan's mistake and the birth of Adejuwon. But that is not relevant to the scope of Dr Khan's duty. In this case, fifthly, the answer to the scope of duty question points to a straightforward answer to the duty nexus question: the law did not impose on Dr Khan any duty in relation to unrelated risks which might arise in any pregnancy. It follows that Dr Khan is liable only for the costs associated with the care of Adejuwon insofar as they are caused by his haemophilia. One can also apply the SAAMCO counterfactual as an analytical tool by asking what the outcome would have been if Dr Khan's advice had been correct and Ms Meadows had not been a carrier of the haemophilia gene. The undisputed answer is that Adejuwon would have been born with autism. Sixthly, given the purpose for which the service was undertaken by Dr Khan, and there being no questions of remoteness of loss, other effective cause or mitigation of loss, the law imposes upon her responsibility for the foreseeable consequences of the birth of a boy with haemophilia, and in particular the increased cost of caring for a child with haemophilia.

Claimant's submissions in summary

124. The Claimant in advancing a finding that the Defendants were negligent due to the delay in the delivery of baby Elizabeth said that the central issue is "**not whether**

a caesarean section was eventually performed. The central issue is whether it was performed with the urgency required by the clinical circumstances". She argued that the delay was when the Claimant "**remained in the hallway without any sufficient, adequate and/or proper monitoring of herself and Baby Elizabeth Lundy (*Cross-Examination of Dr. Agatha Foulkes-Mackey Viva Voce*)**".

125. Miss Russell in her closing address and written submissions also highlighted the inadequate monitoring as a basis for the Defendants' negligence. She concluded the delays occurred as follows:

> **4.13 The Claimant submits that both maternal and foetal monitoring should have assumed heightened importance in the hallway irrespective of her undetermined COVID 19 status. The Claimant's evidence, supported by the medical records and the expert evidence of Dr. Chase, confirms that there was a prolonged and unreasonable delay between the decision to perform the emergency caesarean section and the ultimate delivery of Baby Elizabeth Lundy.**
>
> **4.14 The Claimant submits that the Defendant's knew, or ought reasonably to have known, that prolonged delay in delivery created a foreseeable risk of Perinatal Asphyxia.**

126. On the issue of causation, Miss Rusell urged the Court to find that "**the Defendants' failures caused or materially contributed to the death of Baby Elizabeth Lundy, not by reason or assertion of a childhood medical defect. Further and alternatively, the Court is invited to find that the negligent acts and omissions materially *increased* the risk of the injury that ultimately occurred and thereby materially contributed to the fatal outcome**".

127. Miss Russell argued that the Court should accept the evidence of the Claimant's expert, Dr. Chase, because his evidence was "**neither shaken nor undermined during cross-examination**". Miss Russell highlighted that Dr. Chase's evidence that baby Elizabeth should have been delivered within 30 minutes of the decision to have an emergency caesarean section. She criticized the Apgar scores given by the paediatrician and suggested that the Court should prefer the description of the baby by the nurse that she was "**pale and floppy**" leading to an accurate score of between 0 and 3.

128. In assessing the evidence of Dr. Clare and Dr. Foulkes-Mackey, Miss Russell made a swiping attack on their decision and the delay. I highlight below her submission:

4.45 Dr. Azaria Clare's evidence ultimately advances the Claimant's case rather than the Defendants'. She confirms that an obstetric emergency existed. She confirms that the Claimant was prepared for an emergency caesarean section. She confirms that substantial delay occurred before surgery was performed. She confirms that the delay was attributable to administrative COVID 19 protocols rather than clinical necessity. She offers no evidence that the CTG was reassuring, no explanation for the delay preceding the decision to operate, and no medical basis for disputing causation. When her evidence is examined carefully, it does not rebut the criticisms made by Dr. Carlos Athelston Chase, indeed, it provides factual support for them. The Court is therefore invited to find that the Defendants failed to act with the urgency required by accepted obstetric practice and that those failures materially contributed to the tragic outcome in this case.

129. Miss Russell assessed the evidence of Dr. Paul Ward, the Defendants' expert, as revealing **"a number of significant concessions which materially undermined the Defendants' case and, in several respects, support the opinions advanced by Dr. Carlos Athelston Chase**". Given the importance of Dr. Ward's evidence, I find it necessary to set out below some of the criticisms made by Miss Rusell to his evidence in her written submissions:

4.49 Considerable reliance was placed by the Defence upon guidance issued by the *ACOG* concerning the duration of labour in first-time mothers (From 12 – 24 hours for vaginal delivery). However, Dr. Ward accepted that the time is significantly less when dealing with first-time mothers who require cesarean sections.

4.50 Critically, Dr. Paul Ward accepted that such guidance does not justify delay once there are signs of fetal compromise, fetal distress, non-reassuring fetal heart tracings or suspected hypoxia. He further accepted that once fetal compromise is identified, the issue is no longer how long labour may continue, but rather how quickly delivery should be achieved.

4.52 He further accepted that APGAR scores do not determine the cause of death, cannot exclude perinatal asphyxia, cannot determine whether fetal distress occurred during labour, represent only one aspect of neonatal assessment.

4.53 Accordingly, Dr. Paul Ward's reliance upon APGAR scores provides no basis for rejecting the contemporaneous diagnosis of perinatal asphyxia or the conclusions of Dr. Carlos Athelston Chase.

4.58 Dr. Ward accepted that perinatal asphyxia refers to oxygen deprivation occurring around the time of birth. He nevertheless suggested that the cause of death was congenital heart defect. Most significantly, Dr. Paul Ward accepted that no congenital heart defect was ever established upon examination of the Pediatric Cardiology Follow Up Notes on *page AD 37 of the Trial Bundle*, as the Claimant did see a pediatric cardiologist at the age of 10, but was determined to have a normal heart (*Page AD 37 of the Trial Bundle; Court Audio Transcripts at 1 hour and Thirty-Six minutes and Sixteen Seconds*) and was described as being *asymptomatic* aka having *no symptoms.* The follow up notes revealed that the examination normal and the Claimant was discharged from clinic. Therefore, the Claimant strenuously argues that Dr. Paul Ward cannot soundly state with certainty that congenital heart defect caused Baby Elizabeth Lundy's death.

130. In wrapping up her address, Miss Russell argued that the "**evidence establishes failures in monitoring, failures in escalation, failures in emergency obstetric management and an unreasonable delay in effecting delivery after the decision for emergency caesarean section had been made**". She said that these failures and breaches "**caused and/or materially contributed to the perinatal asphyxia suffered by Baby Elizabeth Lundy and ultimately to her death"**, which "**was the foreseeable result of negligent failures in the provision of obstetric and neonatal care**" by the Defendants.

Defendants' submissions in summary

131. Mrs. Ramsey in presenting the closing submissions for the Defendants accepted that the doctor patient relationship existed between the Claimant and the Defendants and that a duty of care was owed. She submitted that the duty was not breached by the Defendants because the conduct did not fall below the standard required by law. The Defendants relied on the statements made by Charles Snr. J (as she then was) in **Lashonda Poitier v The Medi Center & Anr. [2019] 1 BHS J. No. 58** in explaining the standard needed to establish medical negligence - the need "**to prove (1) that his mishap results from error and (2) that the error is on that a reasonably skilled and careful practitioner would not have made. It**

is therefore crucial to establish how the mishap occurred and that he should have expert evidence that any error made was a negligent error".

132. On the issue of monitoring, the Defendants relied on the CTG machine as evidence of "**continuous monitoring of the baby's fetal heart rate and the uterine contractions during the stages of labour**". The Defendants also submitted that the "**fetal monitoring, the observations of the amniotic fluid and the Apgar scores assigned by the paediatricians supports the Defendants' position that there was no fetal distress**".

133. Mrs Ramsey urged the Court to reject Dr. Chase evidence that the CTG showed that the fetus was in distress. She argued that the evidence before the Court of the CTG strips showed "**normal baseline of 120, good visibility and good recovery when the beats per minutes (bpm) dropped during contractions or vaginal examination**" further confirming that the decelerations **"were normal and expected and when considering the full CTG strip, the strip did not indicate fetal distress**". Mrs. Ramsey said that the evidence of the clear amniotic fluid was the best evidence that the fetus was not in distress.

134. The Defendants relied on the Apgar scores of 7 and 8 and wholly rejected the Claimant's contention that the "true" scores were between 0 and 3. The Defendants argued that if the scores were 0 and 3 "**a code would have been called, senior paediatricians and senior anaesthetists would have been called to come to the theatre to attend to the baby and perform more rigorous resuscitative measures (such as intubation) and the baby would have been ordered to go directly to the Neonatal Intensive Care Unit."**

135. Mrs. Ramsey also highlighted the Claimant's evidence that she heard baby Elizabeth make a loud cry and that evidence is **"inconsistent with a baby that is suffering from asphyxia**".

136. Turning to her expert witness, Mrs. Ramsey urged the Court to find that there was no breach of duty, but if a breach is found, the Court should agree that the evidence does not support that any breach caused the death of baby Elizabeth. I highlight the following paragraphs in the Defendants' written submissions:

> **45. Dr. Paul Ward in his testimony, explained that perinatal asphyxia (which is lack of oxygen to the brain before birth) and congenital heart disease infants are very rare. He further explained how they present after birth. Dr. Ward's testimony was that infants who suffer perinatal asphyxia normally live up to twelve (12) to sixteen (16) years and suffer from cerebral palsy caused by the lack of oxygen.**
>
> **46. Contrastingly, congenital heart disease normally materialises a few hours after birth when the mother is no longer oxygenating the blood for the baby and the baby's heart is not pumping the blood**

through the lungs and back to the body as designed. Dr. Ward testified that in these cases, you see a 'crash' of the baby. In this case, baby Elizabeth Lundy 'crashed' two (2) hours after birth. Unlike, cerebral palsy patents, babies who suffer congenital heart disease die within hours after birth without surgical intervention. The evidence before the Court, is that congenital heart conditions are not detected before birth.

47. The only way to definitively determine the cause of death is an autopsy. In the absence of an autopsy, the totality of the circumstances must be examined. Normal CTG readings, normal fetal heat rates, high AOGAR scores, clear amniotic fluid, no escalated paediatric response at birth, no immediate transfer to NICU, and a mother who heard her baby make a loud cry just after birth does not support a diagnosis of fetal distress and perinatal asphyxia. Rather, the above circumstances support a normal delivery of an infant that suddenly 'crashes' due to a congenital heart condition.

48. The Defendants furthers submit (sic) that congenital heart diseases by its very nature cannot be caused by any breach.

137. In summing up the Defendants' closing arguments. Mrs. Ramsey suggested that the evidence of the Defendants in totality should lead to the Court dismissing the Claimant's claim because there was no breach of duty of care by the Defendants.

Analysis & determination

138. At the closing of the case, Counsel for the Claimant and the Defendants agreed to a schedule of the time of the events of the Claimant's admission to the Hospital and the delivery of baby Elizabeth. There was one time variance of disagreement at 3:00 am that I elected to not include below. This agreement was helpful in analysing the evidence and coming to the findings of facts below.

Event	Time
Patient was seen by Gynae 1st and Gynae II	12:14am
Patient received enema	12:41am
Patient underwent a Vaginal Examination. Baby Elizabeth Lundy said to have a heart rate of 108 bpm	1:55am
....	...
Dr. Azaria Clare called by the Operator to review patient	3:19 am
Dr. Azaria Clare arrived on LW to assess Patient	3:30am

Event	Time
Patient was seen by Gynae 1st and Gynae II	**12:14am**
Patient received enema	**12:41am**
Patient underwent a Vaginal Examination. Baby Elizabeth Lundy said to have a heart rate of 108 bpm	**1:55am**
....	...
Patient was prepped and booked	**3:48am**
COVID 19 specimen taken	**4:09 am**
Patient was pushed into theatre while anesthesia was still prepping	**4:37am**
COVID 19 results received	**5:10 am**
Incision made	**5:15 am**
Baby Elizabeth Lundy delivered	**5:20 am**

139. It is clear after hearing the evidence that the Claimant presented with the need for an emergency caesarean on 2 August 2022 due to her prolong labor and the failure to progress the labour to delivery. I find that she commenced labour around 2 am and was in the care of the midwife. I note that the midwife was not called to give evidence in this matter.

140. The expert doctors disagreed on whether 2 hours wait to decide to proceed to emergency caesarean was appropriate in the circumstances. The difference of the experts' opinions rest on when labour started and if the mother was in distress. The CTG readings were the principal evidence adduced at the trial that showed the status of the mother and baby prior to the decision for an emergency caesarean section. The evidence is clear that the CTG machine is used to monitor the mother and the fetus during labour and delivery. The CTG strips were in the agreed bundle and were referred to by both Drs. Ward and Chase.

141. I found both Drs. Chase and Ward to be credible and knowledgeable in the fields of obstetrics and gynaecology. I however preferred the evidence of Dr. Ward and the evidence of Drs. Clare and Foulkes-Mackey that the CTG showed that the mother and baby were not in distress. There are various records of the CTG monitoring in the agreed trial bundle. I highlight below several recordings of the fetal heart rate (FHR) in the medical records of the agreed bundles:

(i) 22 August at 11:40 pm – FHR 132-138 bpm
(ii) 22 August at 12:14 am – FHR 130 bpm
(iii) 22 August at 1:55 am – FHR 133, 140, 156, 151 bpm
(iv) 22 August at 1:55 am – FHR 108 bpm

142. Dr. Ward's evidence was that the fetal heart rate and the colour of the amniotic fluid were clear signs of no distress. The amniotic fluid was clear was supported by the Operative Notes which had a notation of "**Liquor: Clear**". In his report, Dr. Ward states that "**[t]he plaintiff had spontaneous rupture of her amniotic membranes and amniotic fluid was noted to be clear. This denotes no obvious distress in the baby in the womb**".

143. Dr. Chase suggested that there was "**no clear documentation as to when Ms. Guillame was fully dilated. The records state that the doctor was called at 2:50 am after she had been (sic) pushing for 45 minutes. This implies that she had been fully dilated for that length of time, that is from 2:05 am which was 10 minutes after she had been examined by the midwife**". Dr. Ward states in his report that "**Two and a half (2½ hrs) later on the labour ward the plaintiff cervix was noted to be fully dilated (imminent delivery once maternal pushing is successful)**". The medical records show that the Claimant was fully dilated around **3:30 am**. That is the time of the entry in the medical notes. Dr. Chase did not place much weight on the medical notes, save for those recorded by Nurse Cartwright. In this regard I prefer the time reported in the medical records, which correspond to the time when Dr. Clare was phoned by the midwife. That was the time, on the evidence adduced at the trial, that Dr. Clare arrived at the ward to assess the Claimant at 3:30 am. Dr. Clare's evidence of the initial assessment was that the Claimant was fully dilated, and she asked the Claimant to push to assess the head descent.

144. There was also some suggestion by Dr. Chase that the decision to proceed to an emergency caesarean section was delayed. He states in his report "**[t]he decision to delivery time was 1 hour and 50 minutes but the patient was pushing for an additional 45 minutes before delivery making it a total of 2 hours and 35 minutes of pushing before delivery, with an abnormal CTG and oxytocin in progress**". This conclusion assumes that the Claimant was fully dilated around at 2:05 am. I found on the evidence that she was fully diluted around 3:30 am when she was attended to by Dr. Clare. I also find on the evidence that Dr. Clare was phoned by the midwife at 3:19 am and was advised that the patient was pushing for 45 minutes. That means that the patient was pushing and possibly fully dilated between the hours of 2:34 am and 3:19 am (representing 45 minutes). Dr. Chase did not provide a logical rationale for his conclusion.

145. Additionally, both Dr. Ward and Dr. Chase agreed that a first-time mother can be in the process of delivery for up to 12 hours. I accept this evidence and agree that it seems logical and reasonable that if the Claimant was "pushing" for 90 minutes as suggested by Dr. Chase was not by itself indicative of negligent care provided to the Claimant in the early hours of 2 August 2022.

146. I find that the timeline of the care and the decision to move to an emergency caesarean section and to get the Claimant to the theatre was not unreasonable in the prevailing circumstances and was not prolonged by delay. I accept the

overwhelming evidence that the decision to have an emergency caesarean section was made by Dr. Foulkes-Mackey when she arrived at the ward at 3:54 am, that was a mere 6 minutes from the call with Dr. Clare at 3:48 am. Dr. Clare arrived at the ward at 3:30 am, only 18 minutes before Dr. Foulkes-Mackey arrived.

147. Whether the decision should be made earlier, that is, before 3:10 am or 3:48 am, requires evidence which was not adduced during the trial. The medical notes in the agreed bundle paint a picture of the midwife attending to the Claimant's delivery and no further evidence was presented which could lead me to conclude that the decision to undertake an emergency caesarean ought to be made earlier or that an earlier decision was warranted in the circumstances.

148. Having found that the Claimant was dilated at 3:30 am, which is 90 minutes when she started pushing at 2:05 am, does not in my judgment appear to be an unreasonable period to amount to a delayed decision for an emergency caesarean section.

149. On the evidence I also find that the Claimant arrived at the entrance of the theatre at 4:10 am when a COVID test was administered and entered the theatre at 4:37 am. The COVID test result was received at 5:10 am. Dr. Foulkes-Mackey made the incision at 5:15 am and the baby was delivered at 5:20 am. The time between the decision to proceed to an emergency caesarean section, which was at 3:54 am, and the delivery at the baby at 5:20 am in the prevailing circumstances was not in my view long or delayed. The efforts of Dr. Clare and Dr. Foulkes-Mackey in searching for a trolley and rolling the Claimant themselves to the theatre's entrance were acts which manifest that they understood the emergency and did all they could in the circumstances. I find no fault in their actions.

150. I do note, with some regret, that no monitoring of baby Elizabeth and the Claimant was carried out once the CTG was removed. The lack of monitoring occurred between the hours of 4:10 am and 4:37 am when the Claimant was making ready for the emergency caesarean section. That could be a vital 30 minutes in a case of an extreme emergency. Dr. Ward's evidence was that no monitoring is usually carried out during this period because the resources of the Hospital are such that no handheld monitors are available or they may not be in abundance. He further stated that nothing further could be done in any event because the decision was made to proceed to an emergency caesarean section and they were at the entrance of the theatre. Dr. Ward also suggested in his evidence that he expected some level of monitoring during this period. On the other hand, Dr. Chase felt that this was a vital failure. He posited that if there was fetal distress then the lack of monitoring was fatal in the circumstances.

151. In my judgment and considering the totality of the evidence led at the trial, I accept that there ought to be monitoring of the mother and baby in the period when the CTG was disconnected and the mother was awaiting entry to the theatre. I have to consider if the lack of monitoring was below the standard of care and caused

the death of baby Elizabeth. Dr. Ward's evidence was that no further decision could be made even if the baby was in distress in the 30 minutes window. The critical decision was made to proceed to an emergency caesarean section at 3:54 am; and that was the vital decision in this case.

152. Dr. Chase's evidence favoured some monitoring of the baby and mother in this period. My preference is the view of Dr. Chase on this issue, principally because Drs. Clare and Foulkes-Makey as well as the midwife knew of the reasons why they determined that an emergency caesarean was required, and they also knew of the baby's state. Given these facts, it was reasonable, in my view, to have some form of monitoring of the baby and mother until she entered the theatre. This was necessary to protect the mother and baby. The failure to monitor in this window of time in my judgment fell below the standard of care.

153. The CTG monitors prior to the decision to have a caesarean section was prominently discussed during trial. Only three of the CTG charts formed part of the agreed bundle of documents. Dr. Chase concluded that they showed, fetal hypoxia, tachysystole and fetal bradycardia. The view of Dr. Ward was the clear color of the amniotic fluid showed that the fetus did not pass stool or meconium in the womb which would pass in the amniotic fluid. He therefore concluded that there was no lack of oxygen from the placenta.

154. Dr. Clare and Dr. Foulkes-Mackey indicated that the CTG showed that the fetal heart rate did not fall below 120 bpm. They also indicated that the heart rate is normal to escalate during contractions. They recorded the FHR (fetal heat rate) to 130 bpm, which is the baseline. One of the CTG charts showed poor contact or loss of contact, which occurs when the patient is pushing and that recorded the FHR as 120 bpm.

155. There was also a dispute on the evidence as to the effect of a T1 deceleration. This occurs when the foetus' heart rate drops during labor. This usually occurs during contractions. In the medical notes it was noted that T1 decelerations occurred at **3:30 am**. Dr. Clare was attending the patient at this time and made the decision to call Dr. Foulkes-Mackey at 3:48 am. That was 18 minutes later.

156. In considering the totality of the evidence adduced before me, in my judgment I come to the conclusion that the CTGs showed signs of distress by the T1 deceleration. I conclude "some signs" because the full picture of the CTGs were not in evidence. However, the decision was made quickly to proceed to an emergency caesarean section; and this was around the time of the T1 deceleration. Drs. Clare and Foulkes-Mackey must have therefore been satisfied of some distress or the likelihood of distress to the baby to decide to proceed to the emergency caesarean section after the T1 deceleration.

157. The evidence of the T1 deceleration at 3:30 am, in my judgment, on balance, show that continuing monitoring of the mother and baby was required, and perhaps vital.

The T1 deceleration occurred immediately prior to the decision for an emergency caesarean and perhaps aided in the decision. This fact too led me to conclude on the evidence that the Defendants fell below the standard of care by not monitoring the patient and baby in the period of 4:10 am to 4:37 am.

158. One aspect of the case for negligence also centers on whether baby Elizabeth had fetal hypoxia. On the evidence, this refers to a situation where a fetus is deprived of adequate oxygen supply. Dr. Chase appears to base his view on what he described as "fetal distress". During cross examination Dr. Chase referenced the baby head being jammed and there being some obstruction. He also referred to the T1 deceleration. Dr. Ward disagreed with this view and used the CTG strips to support a baseline of 120 bpm to suggest that there was no evidence of hypoxia. The death certificate notes that the baby died from perinatal asphyxia (commonly meaning a medical condition where a newborn experiences an inadequate supply of oxygen and blood flow just before, during, or immediately after birth).

159. In arriving at my decision, I also considered the evidence led about the importance of the Apgar scores post the delivery of a baby. The evidence led is that it is a score given by the paediatrician at the delivery. I note that the paediatrician who was at the delivery of baby Elizabeth did not give evidence at the trial and no party elected to call a paediatrician as an expert.

160. Based on the totality of the evidence adduced at the trial, I am satisfied that the Apgar scores on a balance of probabilities accurately reflected the state of baby Elizabeth at 7 and 8 in 1 and 5 mins respectively after birth. The evidence was that the baby's condition worsened on the way from the theatre to the ward. This fact, by itself, in my view does not change the scores given when the baby was delivered. Those scores are given in 1 and 5 minutes. No evidence was adduced at the trial of what likely led to the change of the condition of the baby. The only evidence before the Court was Nurse Cartwright's notes, which states that "**while waiting for the elevator door on 2nd floor to close infant was observed by RM Cartwright and noted to be much more pale than initially and cyanosis of face along with hands and feet. Chest was very pale. Paeds II Innis was noted to the changes and a closer inspection done. Hence, she made the decision to transfer infant immediately to Neonatal Intensive Care Unit. Infant was quickly transferred from elevator along corridor 2nd floor and into NICU @ about 5: 45 am. On arriving Dr. Inniss called for assistance from staff and immediately began chest compression and code 999 ensued".**

161. I note that Dr. Chase disagreed with the Apgar scores and deem them inaccurate because the notation in Nurse Cartwright's notes was that the baby was "**pale and floppy**". He deems this to have led to a lower score. I further observed that Nurse Cartwright wrote her notes at 9:28 am on 2 August 2022, some 4 hours after the birth. While Dr. Chase criticised the time when Dr. Clare wrote her notes at 5:30 pm he makes no similar criticism of the notes of Nurse Cartwright.

162. In fact, the notes of Nurse Cartwright, who too was not called to give evidence and was not subpoenaed, makes a reference to the Apgar score of 7 and 8. She records that "**infant assessed by Paeds and apgar scores given of 7 and 8...Infant declared alive and announced to theatre staff and Drs. Clare and Foulkes. Infant shown to mother prior to be swaddled and placed in open cot for transfer to ward nursery**".

163. It is startling that no evidence was led at the trial of the monitoring of baby Elizabeth after her delivery. The Court was not provided with any details of what steps were taken post-delivery relating to her vitals and the administration of any care to her by the Hospital. The evidence was limited to her being taken to the ward and then to the Neonatal Intensive Care Unit at the Hospital. What led to this decision did not form part of the evidence before the Court. The only evidence before the Court was Nurse Cartwright's notes, which to my mind raised more questions than answers. The note entry of Nurse Cartwright that the baby was **"much more pale than initially and cyanosis of face along with hands and feet. Chest was very pale"**, also raises the question of the accuracy of the Apgar scores, particularly as the condition changed in a short time and almost immediately after the scores were given.

164. Dr. Ward says that the baby "crashed" and this is systematic of a congenital heart condition. Dr. Chase says that the baby died from perinatal asphyxia as appears on the death certificate.

165. Both Dr. Ward and Dr. Chase agreed that the absence of an autopsy of the infant was fatal. They said that it would be indicative of the cause of death. I do not have to decide what led to baby Elizabeth's sudden and sad demise. I note the competing theories of both experts. I however take special note of the evidence of Dr. Ward that the amniotic fluid was clear and the CTG did not show repeated signs of fetal distress; suggesting that the baby was stable. A critical component in my finding is the lack of monitoring of the baby and mother when the mother was disconnected from the CTG monitor when she left the ward for the theatre. In that period no evidence was produced by the Defendants to show that the fetus was not in distress.

166. I also accept the cause of death inscribed on the death certificate. The death certificate is issued in accordance with the provisions of the Births and Deaths Registration Act. The Act sets out a regime for the registration of deaths and imposes criminal sanctions for "**false statement with intent to have the same entered in any register of births or death**" (see section 32 of the Act). Sections 18 and 25 of the Act provide:

> 18. Where a person dies in a place which is not a house it shall be the duty of every relative of such deceased person having knowledge of any of the particulars required to be registered concerning the death and, in default of such

relative, of every person present at the death and where a dead body is found elsewhere than in a house it shall be the duty of any person finding and of any person taking charge of the body and in both the above cases of the person causing the body to be buried, within twenty one days after such death shall have taken place or such body shall have been found, to give to the registrar or assistant registrar such information of the particulars required to be registered concerning the death as the informant possesses.

25. (1) All registrations of births and deaths effected and all acts performed under the Acts hereby repealed shall be deemed to have been registered and performed in accordance therewith and shall continue to be regarded as good and valid.
(2) All certified copies of any entry in the register kept by the Registrar General or a registrar in accordance with the provisions of this Act or any of the Acts by this Act repealed purporting to be signed and certified by the Registrar General or a registrar as true copies shall be admissible as prima facie evidence of the facts contained therein in any court of justice or before any person authorised by law or by consent of the parties to hear, receive and examine evidence, without further proof of such entry.

167. The death certificate for baby Elizabeth notes the "**diseases or condition directly leading to death due to or as a consequence of perinatal asphyxia**". Although an autopsy was not performed, and there are cases where an autopsy may not be warranted under the Act, Dr. Carlos Thomas, the doctor that signed the death certificate, did not appear at the trial. However, the death certificate requires the doctor to certify that "**to the best of my knowledge and belief, death occurred at the time and date and due to cause(s) stated**".

168. In civil proceedings, public documents such as the register of death are generally admissible as evidence of facts stated in them. However, in **Bird v Keep [1918] 2 KB 692** the court concluded that a certified copy as to a death is no evidence of the cause of death as the registrar does not have to satisfy himself as to the accuracy of the information either by a medical certificate or a coroner's inquest.

169. I have two competing views of the cause of death of baby Elizabeth after her delivery. I am unable to agree with the view expressed by Dr. Ward primarily because the evidence before the Court showed that the Claimant did not have a congenital heart defect. The evidence showed that Dr. Lightbourne found that she had a normal cardiovascular exam.

170. Although the Court may have been greatly assisted by the evidence of Nurse Carwright and Dr. Inniss, the Paediatrician on duty on the early morning of 2 August 2022, and their lack of appearance before the Court was unfortunate, however on the totality of the evidence before me, it seems probable, and I so find, that baby Elizabeth died from perinatal asphyxia. I prefer the evidence of Dr. Chase on the cause of death as well as the likely T1 deceleration. Dr Chase's conclusion was based on the "**contractions lasting 35-40 seconds with oxytocin in progress ... can be considered tachysystole**". He explained that tachysystole can lead to poor fetal oxygenation and fetal distress.

Conclusion

171. On the pleaded allegations of breach, at the highest I find that the Defendants should have monitored the Claimant and the baby during the period when she was rolled to the theatre from the ward and await the start of the caesarean section. While Drs. Clare and Foulkes-Mackey acted promptly once the decision was made, the critical issue is the state of the baby in the period between 4:10 am and 4:37 am. No evidence was led about the baby's state in this period. Having found that there was no fetal distress when the CTG was being monitored, a T1 deceleration at 3:30 am led me to not be satisfied that the baby remained stable during this period. I do accept that this period may not be inordinate. Given the decision to have an emergency caesarean section, I deem it incumbent on the Hospital to ensure that there was some form of monitoring as Drs. Clare and Foulkes-Mackey knew that a COVID test was required and the result was needed prior to the start of the surgery. The attending doctors also knew the mother's and baby's state; more reason to require some monitoring by the midwife until the surgery commenced.

172. I find therefore on the balance of probabilities that the failure to monitor the mother and baby in the period between 4:10 am and 4:37 am was negligent and the Defendants fell below the standard of care.

173. In considering the causal link between the negligent act and the death of baby Elizabeth, that is, would the injury not have occurred but for the Defendants' breach of duty. The ultrasound performed on 2 June 2022, just two months before the delivery, showed no fetal abnormality. It also notes that there was "**adequate amniotic fluid for gestational age" and "good fetal tone, movements and respiration are noted**". While the expert evidence conflicts, given that the signs were that baby Elizabeth was healthy at 30 weeks, I find on a balance of probabilities that lack of monitoring in the 30 minutes window caused the injury to the baby which was foreseeable in the circumstances. I highlight that the decision to undergo an emergency caesarean section required a higher degree of monitoring and supervision of the baby and the mother and this failure was fatal.

174. I therefore find on balance and bearing fully in mind the maxim that he who asserts must prove, that the Claimant discharged the burden of proof at the trial. There

was no compelling evidence led by the Defendants why no monitoring was conducted on the baby between 4:10 am and 4:37 am. Dr. Ward's explanation of there being no handheld monitoring devices is not adequate in the circumstances.

175. I therefore find the issue of liability in favour of the Claimant and order that damages be assessed by the Registrar.

176. I also order the Defendants to pay the Claimant's costs of this action to be assessed if not agreed.

Postcript

177. I cannot leave this Ruling without commenting on the need for Counsel to seek alternative means to resolve conflicts. This case is an ideal one for mediation. A qualified mediator would more likely have led the parties to a sensible compromise. The claim advanced is not an exorbitant one. In the Amended Claim Form, the special damages claimed total $10,950.00 and when I inquired if there were settlement discussions prior to trial, both Counsel indicated that no efforts were made to seek a settlement of this claim.

178. I must also state the Court's disappointment that the ACOG and RCOG as well as the Hospital's COVID protocols were not put into evidence. They were discussed extensively during the trial. Similarly, the decision not to call Nurse Cartwright and the attending paediatrician, as well as Dr. Carlos Thomas, was not helpful to the Court. They were critical witnesses that could have assisted the Court.

179. I also thank Counsel for the Claimant and Defendants for agreeing to a swift turn around in their Closing Submissions, which greatly assisted the Court in its decision.

DATED the 28 day of July 2026

RS Rigby J. Actg.

Raynard S. Rigby KC
Acting Justice