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Application of *Montgomery* consent principles in cerebral palsy cases

My talk today considers the impact of the Supreme Court's decision in *Montgomery* in 2015 on cerebral palsy cases since that time.

I will review the decided cases, and if time allows, also consider a couple of cerebral palsy cases which my own firm is running on *Montgomery* principles.

I hope this may be helpful to others in running their own cerebral palsy caseloads.

The facts of *Montgomery* are well known, and I won't go over them, save to say that similar facts could obviously found a CP claim. It is self-evident that if a diabetic mother of small stature is not warned of the risks of shoulder dystocia and not offered a caesarean section, and the baby delivered vaginally suffers hypoxia and develops cerebral palsy rather than Erb's Palsy, there will clearly be a viable claim, (provided that she can show she would have elected for caesarean if properly informed)

The principle laid down in *Montgomery* can be summarised as follows:

- An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo.
- The doctor has a duty to inform her of any material risks ,and of any reasonable alternative treatments.
- The test of materiality is whether a reasonable person in the patient's position would be likely to attach significance to the risk, or if the doctor is/should be aware that the particular patient would attach significance to it.

Two further points of significance should be noted.

It is evident from the judgements in *Montgomery* that:

1. *Bolam* does not apply to consent cases; and
2. The assessment of whether a risk is material cannot be reduced to percentages

The decided cases

Webster v Burton [2017] EWCA Civ 62

Webster was the first post-*Montgomery* case to reach the Court of Appeal.

The facts:

The mother had three abnormalities identified on USS at 34 weeks:

- The baby was small for gestational dates (SGA).
- There was asymmetry – the abdominal circumference was significantly less than the head circumference.
- There was polyhydramnios (excess liquor).

The treating obstetrician failed to observe or note these features or act upon them.

Just before term, the mother was admitted to hospital as she felt unwell. (26 December 2002) She expected to be induced at term (27 December). She was not. Her baby was in fact born on 7 January 2003, following induction, but a cord compression had by then occurred on about 4/5 January, causing a significant brain injury to the baby.

At first instance it was admitted that the treating obstetrician had been negligent in failing to organise fortnightly repeat ultrasound scans, following the one at 34 weeks, and also found that he should have researched the significance of these three abnormalities, which he did not do.

Had he done so he would have found that there was an increased risk of perinatal mortality with these three features, although with a small statistical base.

At trial, the Claimant's expert, Professor Soothill, argued that delivery by 38 weeks was strongly indicated, but Mr Tufnell maintained that it was reasonable to attach no importance to this combination of factors.

The claim failed therefore on traditional Bolam principles: there was a responsible body of opinion which would have taken a conservative approach.

The first instance decision was made in fact four months before the Supreme Court's decision in *Montgomery*; on appeal the issue was whether the mother should have been advised of the increased risk of perinatal mortality on 27 December, and if so, whether she would have elected for immediate induction of labour.

The Court of Appeal found that, even though failing to advise her of the risk might have accorded with the practice of a responsible body of obstetricians, nonetheless on *Montgomery* principles it was a material risk of which she should have been informed.

Important points from *Webster*

1. Reinforces that *Bolam* is not the correct test in consent cases
2. Reinforces that percentages do not determine what is a material risk
3. Shows that even where there is emerging but incomplete research material about a particular risk, which in *Bolam* terms, a paternalistic doctor might choose not to tell his patient about, he may be obliged to do so by the *Montgomery* test.
4. Shows the importance of evidence about the particular characteristics of the mother (in a birth injury context) when considering whether she would have opted for a particular treatment. Here the mother had a degree in nursing, and had already demonstrated independence of mind by a decision to leave hospital earlier in her pregnancy
5. May allow a way past the likes of Mr Tufnell stubbornly maintaining that there is a responsible body of opinion which would not warn of a risk, by virtue of the fact that this is not the relevant test.

Tasmin v Barts [2015] EWHC 3135

This was a CP case in which a *Montgomery* argument was run and failed.

The claimant, aged 14 at trial, was delivered by emergency Caesarean section. Minutes before birth the umbilical cord tightened around her neck resulting in a profound hypoxic/ischaemic insult and she suffered a severe brain injury which left her seriously disabled. She alleged negligence in the management of her delivery and a failure to obtain adequate consent from her mother to persevering with labour rather than undergoing a Caesarean section.

The key allegation related to a period between 21.40 and 22.30 when the registrar had failed to interpret CTG readings as pathological. The registrar proceeded with Syntocinon infusions when the correct course of action would have

been to take a foetal blood sample (FBS). The court accepted evidence that, had this been done, the results would have been reassuring and the mother would have been advised to persevere with labour.

The Claimant alleged that at this stage there should have been a discussion with the parents about the risks of the pathological trace and the alternative course of management by Caesarean section. In the absence of such a discussion the decision to proceed with vaginal delivery was made without their consent and was negligent.

Mr Justice Jay preferred the Defendant's expert evidence that good medical practice required an FBS before any consideration of Caesarean section, the pathological CTG not by itself being diagnostic of hypoxia which might lead to acidosis. However the claimant's case was that the issue could not be resolved solely on the basis of expert evidence because it was one of consent: her mother should have been advised of the material risk of injury and been able to elect for a Caesarean at this stage.

The court found that because CTG is not a diagnostic tool, there could not be a sensible discussion of the options before foetal blood sampling had been done. More significantly the risk of serious injury was negligible, of the order of 1:1,000. The judge held that this was not a material risk, citing *A v East Kent Hospitals NHS Foundation Trust* [2015] EWHC where Dingemans J described a risk of 1:1,000 as 'theoretical, negligible or background'. However he preferred to formulate the risk as being 'too low to be material'. The claim therefore failed.

The Supreme Court in *Montgomery* explicitly said that what amounted to a material risk was not a matter of percentages. In *Tasmin* Mr Justice Jay found that a risk of 1:1,000 was too low to be material. In *Montgomery* the risk of shoulder dystocia had been 9-10% and that in itself presented a risk of significant injury. However the risk of a prolonged hypoxia had been 0.1% or 1:1,000, the same as in *Tasmin*. The problem with looking at risk in percentage terms is that it looks only at one of two components: the probability as opposed to the severity of injury. 0.1% may be a negligible risk in the context of a minor injury but many mothers would regard it as material if it could give rise to lifelong disability. Further, percentages do not take into account factors which are specific to the particular patient. No such factors were identified in *Tasmin*.

Was *Tasmin* wrongly decided then? *Webster* has since reinforced again that the materiality of risk is not to be determined by percentages.

I think the reality is that *Tasmin* was probably rightly decided, because the judge found as a fact that the FBS would have been normal, and to offer an emergency caesarean in the face of a normal FBS would have been illogical and inconsistent with national guidelines, while to offer one without carrying out an FBS would be equally illogical, given the speed, ease and reliability of the test.

A v East Kent [2015] EWHC 1038

This is another case in which a *Montgomery* argument failed; it was a wrongful birth case.

Mr and Mrs A were unable to conceive naturally and had IVF. DNA tests on Mr A's sperm prior to undergoing IVF showed that he did not have chromosomal abnormalities 13, 18 or 21, but they were advised that there was still a risk of other chromosomal abnormalities

Mrs A then became pregnant, and at ultrasound scans performed between 21 and 27 weeks, a low AFI (Amniotic Fluid Index) and a low abdominal circumference measurement were noted.

No advice was given to the effect that the baby might be suffering from a chromosomal abnormality. Later scans led to a diagnosis of IUGR. But the baby was born at 37 weeks + 6 days. He was found to have chromosomal abnormalities inherited from his father.

The claim was brought on the basis that Mr and Mrs A should have been advised, once the abnormalities on USS became evident, of a risk of a chromosomal abnormality which would have led them to terminate the pregnancy.

At trial conflicting evidence was given by geneticists as to the level of risk of chromosomal abnormality which ought to have been evident. The Claimant's experts put it at 1-3%. The Defendant's experts put it at 1: 1,000, and described that risk as *"theoretical, negligible or background"*. The judge preferred The Defendant's experts.

He ruled against the Claimant on the basis that *Montgomery* is not authority for the proposition that doctors need to warn about risks which are theoretical and not material.

In my view this part of the judgment is at odds with the later Court of Appeal decision in *Webster,* and paid too much attention to the percentage level of risk (which in any event was strongly disputed between the experts) rather than applying the proper *Montgomery* test of materiality.

However the case also failed on the basis that the judge did not accept that the parents would have terminated, for reasons which I will not go into here.

MC and JC v Birmingham [2016] EWHC 1334

This is another case in which a *Montgomery* argument was run and failed. The claimant was born in 2010, and has CP due to hypoxia suffered during the last 20 minutes of labour.

Labour was induced when his mother was one day overdue; she had swollen legs and there were concerns about pre-eclampsia. Induction of labour began at 1600 on 12 February 2010; the claimant was born at 0603 on 13 February. A CTG trace had been abnormal since 0535, and there was a fetal bradycardia at the very end of labour, up until delivery.

The issue was whether the mother was properly advised as to the pros and cons of induction, and whether or not she would have consented to induction had she had the risks and benefits properly explained.

She claimed that she was not advised that she was being induced because of the risks of pre-eclampsia, but thought it was simply because she was overdue. The judge did not believe her on this point.

Other arguments made on behalf or the Claimant were:

- The mother should have been warned before she was induced that the necessary support might not be available on the ward, or that a delivery suite might not be readily available.
- The consultant did not consent the mother directly, deputing this to a more junior doctor.

The claim failed on both these points.

The case is somewhat unsatisfactory, in that the judge stated that:

- No sufficiently detailed evidence was adduced as to precisely what the mother should have been told about the pros and cons of induction, as against what she was actually told; and
- There was no evidence from the mother in her witness statement or in oral evidence as to what she would have decided if she had been given an account of the relevant pros and cons.

On this basis it seems very understandable that the claim failed.

From my reading of the judgement I would say that a similarly pleaded claim, with certain key differences, might well succeed.

SXX v Liverpool [2015] EWHC 4072

This was not strictly a decision made on *Montgomery* principles. *Montgomery,* which had been very recently decided, was drawn to the judge's attention by Liz-Ann Gumbel, but he specifically stated that he was not relying upon it in arriving at his decision.

The case is of interest, however, in that it concerns a fairly common scenario, in which parents were in effect "persuaded" by a midwife that vaginal delivery was the appropriate course that they should pursue rather than elective caesarean

It was a twin delivery, in which Twin 1, delivered in fact by forceps, suffered an intracerebral haemorrhage, and hydrocephalus and was left with a permanent neurological disability.

The parents had a particular reason for wishing to have a caesarean, namely that seven years earlier they had lost a twin during a vaginal delivery.

The factual scenario was that the parents saw a midwife rather than a consultant towards the end of the pregnancy, and the midwife was very forceful about the benefits of vaginal delivery so effectively they felt coerced into having one. The negligence found at trial was in failing to refer the decision as to mode of delivery to the obstetrician, who would have agreed to caesarean.

Montgomery is not strictly relevant to the facts in this case because there was no withholding of a material risk – the parents were in possession of all relevant information – nonetheless they were denied a *"reasonable alternative treatment"*.

In *Montgomery,* Lady Justice Hale in particular was at pains to make clear the rights of a mother to choose caesarean over vaginal delivery, and for that to be seen as a choice of equal validity.

She stated: [para 115]

"A patient is entitled to take into account her own values, her own assessment of the comparative merits of giving birth in the "natural" and traditional way and of giving birth by caesarean section, whatever medical opinion may say, alongside the medical evaluation of the risk to herself and her baby. She may place great value on giving birth in the

natural way and be prepared to take the risks to herself and her baby which this entails. The medical profession must respect her choice… There is no good reason why the same should not apply in reverse, if she is prepared to forgo the joys of natural childbirth in order to avoid some not insignificant risks to herself or her baby."

In any case where a mother may claim that she was "coerced" into vaginal delivery against her will by an over-zealous midwife, and the baby suffers injury during vaginal delivery, there may well be a viable cause of action even if there was no medical indication for caesarean.

Scenarios in which my firm is running *Montgomery* arguments in ongoing CP cases

- Mother suffering from documented bacterial vaginosis (a condition tending towards preterm birth and preterm rupture of the membranes) in a previous pregnancy, which led to delivery at 30 weeks. Not tested for the condition in a later pregnancy in which baby is delivered prematurely at 24 weeks and has CP. We argue that mother should have been informed of the risks of bacterial vaginosis and given the choice of having screening and antibiotic treatment before 20 weeks. Such antibiotic treatment would, on balance of probability, have avoided very preterm birth and the resultant brain injury. Failure to screen and give antibiotics in this situation probably would not satisfy the *Bolam* test, but failure to advise of the risks would satisfy the *Montgomery* test.
- Claimant suffers from CP as a result of hypoxia during vaginal delivery. Previous pregnancy complicated by shoulder dystocia. We argue, on the basis of *Montgomery*, that mother should have been seen by a consultant at 16 weeks of the second pregnancy, and advised that:
  - Second babies are usually bigger than first babies
  - There was a significant risk of repeat of shoulder dystocia
  - Could opt now (at 16 weeks) for elective caesarean at 39 weeks, or wait for 36 week growth scan and make a decision then.

  Mother's evidence is that she would have opted for caesarean section with this information. In this case the Defendants accept the *Montgomery* point but put the mother to proof that she would have opted for a caesarean section.
- Claimant suffers from CP due to hypoxic brain injury suffered during vaginal delivery. Again there had been a previous pregnancy complicated by shoulder dystocia, of which the mother had not been informed. In her case there was an additional risk factor of BMI above 30, and by 36 weeks the further risk factor of fetal macrosomia would have been present. Again in this case liability has been admitted on a *1* basis, and on this occasion it is also admitted that the mother would have opted for caesarean section, and all brain injury would have been avoided.
- Mother in second stage of labour with pathological CTG. Decision taken to proceed to trial of forceps at 14.00. Baby eventually delivered by caesarean section at 15.32. Among several allegations being made is one that caesarean section should have been offered on a *Montgomery* basis at 14.00 hours, as well as a trial of instrumental delivery. I am not confident that this is our best argument in this case, but it is part of our case at present at least.

About the author

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Simon heads Royds Withy King's Medical Negligence team. He has particular expertise in birth injury and cerebral palsy cases, being described by the independent guide to the legal profession Chambers & Partners UK as *"well regarded for his handling of cerebral palsy cases"* and by The Legal 500 as a *"cerebral palsy expert."*

Simon *"draws considerable praise from market observers, who admire his 'sound judgement'"* (source: Chambers & Partners UK 2018). He is also recognised by Chambers & Partners UK as a "Leader in his field".

Independent legal directory Legal 500 UK describes Simon as *"a very experienced lawyer with excellent judgment"* who has *"an assured touch on difficult cases"* (source: Legal 500 UK 2017).

Simon completed a Master's degree in Medical Law and Ethics in 2010, graduating with Distinction. Simon is a member of two specialist panels, the Law Society's Clinical Negligence Panel, and Action against Medical Accidents (AvMA). He is also accredited as a Senior Litigator with APIL. He has had articles published in Clinical Risk, Medical Litigation, Healthcare Risk Report, the Solicitors Journal and the New Law Journal.

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