

Neutral Citation Number: [2018] EWCA Civ 1882

Case No: B3/2016/2386

IN THE COURT OF APPEAL (CIVIL DIVISION)

ON APPEAL FROM THE HIGH COURT OF JUSTICE, QUEEN’S BENCH DIVISION

Mr Justice Nicol

HC14C05097

Royal Courts of Justice

Strand, London, WC2A 2LL

Date: 29/08/2018

**Before:**

THE SENIOR PRESIDENT OF TRIBUNALS

and

LORD JUSTICE SALES

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**Between:**

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| --- | --- | --- |
|  | **Claire Manzi** | Appellant |
|  | **- and -** |  |
|  | **King’s College Hospital NHS Foundation Trust** | Respondent |

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**Mr Peter Skelton QC and Ms Leanne Woods** (instructed by **Leigh Day Solicitors**) for the **Appellant**

**Mr Michael De Navarro QC and Mr Luka Krsljanin** (instructed by **Kennedys Law LLP**) for the **Respondent**

Hearing date: 6 March 2018

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Judgment Approved by the court  
for handing down  
(subject to editorial corrections)

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**Sir Ernest Ryder, Senior President:**

Introduction:

1. This is an appeal against the order of Nicol J who on 12 May 2016 dismissed a claim for damages for medical negligence and ordered the claimant, Claire Manzi, to pay the costs of the defendant, King’s College Hospital NHS Foundation Trust, on the standard basis. The issue in the case related to the amount of placenta that was retained in the claimant’s uterus following the birth of her son, ‘H’, on 6 April 2011. The judge held that the placental tissue was not substantial and determined liability in favour of the defendant. Permission to appeal was granted by Gloster LJ on 22 June 2017. At the conclusion of the hearing before this court the appeal was dismissed with reasons to follow.

Factual background:

1. On 6 April 2011, the claimant gave birth to H who was her second child. A midwife queried whether the placenta which was delivered by controlled cord traction was complete. There was a suspicion that some of the placenta may have been retained. The claimant was seen by Dr Asem Ali, a specialist registrar, who carried out an examination and an ultrasound scan of her uterus. The discharge summary, completed on 7 April 2011, records that a scan identified a 2cm area of possible placenta left in situ.
2. The claimant was discharged and told that the retained placental tissue should pass spontaneously. For approximately two weeks she was at home under the care of district nurses. Towards the end of that two-week period she experienced pain at such a level that she was admitted to hospital. In hospital an ultrasound scan was performed by Ms Claire Robinson, a sonographer, who recorded *“? retained placenta… measuring 7.0 x 2.2 x 4.4cm”*. On 21 April 2011 the claimant had placental tissue removed under a general anaesthetic, following which she suffered a haemorrhage.
3. The claimant alleged that Dr Ali negligently failed to see on the ultrasound scan that a substantial part of the placenta had been retained. As a result, it is said, she suffered pain and, on 21 April 2011, had to have placental tissue removed under a general anaesthetic following which she also suffered a distressing haemorrhage. In consequence, she says, she suffered two periods of ‘adjustment disorder’. The first was for about one year after H's birth. The second was when she was pregnant with her third child and that lasted for about 8 months until the third child was born. There are claims for pain and suffering, lost income, care and other incidental expenses.
4. The defendant accepts that a small piece of placenta may have been retained after H's birth, but says that it was not substantial. What was removed on 21 April was a small piece of placental tissue together with blood which had clotted and accreted around it. Consequently, the defendant says, there was no negligence by Dr Ali. Alternatively, if that is wrong, and Dr Ali should have identified that a substantial piece of placenta remained in the claimant's uterus, it is not accepted that the claimant would have agreed to undergo another operation to have it removed so soon after she had given birth when there was the possibility that even a substantial piece of retained placenta would have passed without medical intervention. The length of time that the claimant suffered from an adjustment disorder was disputed as was the quantification of the other items of loss. The claim was issued on 5 December 2014 and the trial was heard over four days in April 2016.

The judge’s decision:

1. The parties agreed before the judge that the critical issue of fact determining liability was whether the piece of placenta that was retained after the claimant gave birth was substantial or small i.e. about 7cm or about 2 cm in length.
2. The judge heard and read extensive oral and written evidence on the question. He had witness statements from the claimant, Dr Ali and Ms Robinson. There were expert reports from two consultant obstetricians and gynaecologists, Professor Edward Shaxted for the claimant and Dr Michael Maresh for the defendant. The experts also produced a joint statement which was admitted in evidence. All five witnesses gave oral evidence.
3. The judge’s consideration of the factual evidence is set out in significant detail in his first judgment at [4] to [45]. For the present appeal, the following evidence which was before the court is the most important:
   1. The evidence of Dr Ali. Dr Ali said in his witness statement that he visually examined the placenta and it seemed to be complete. He said that an ultrasound scan is of limited help immediately after birth as blood clots cannot be distinguished from retained products, but he did a scan anyway for training purposes. In oral evidence, Dr Ali agreed that he ought to have recorded the result of the scan, but he didn’t. He had very little recollection and was entirely reliant on his records.
   2. The claimant’s discharge summary, which was apparently not written by Dr Ali said of the placenta: “*Condition: Other - friable broke in pieces at delivery, completeness: Incomplete – scan identified a 2 cm area of possible placenta left in situation”.*
   3. The evidence of Ms Robinson. Her report from the ultrasound scan taken on 20 April 2011 recorded that: “*there is an echogenic area of ? retained placenta seen within the endometrial cavity measuring 7.0 x 2.2 x 4.4cm*”. Ms Robinson explained in oral evidence that the question mark meant that she thought the mass was likely to be a piece of placenta but she could not be 100% sure.
   4. The hospital clinical notes of Dr Hooper dated 21 April 2011. Dr Hooper saw the claimant after the subsequent operation to remove the placenta. The medical records made by DR Hooper state: “*explained removed products with forceps approximately 8cm*”. The defendant did not rely upon a witness statement from Dr Hooper with the consequence that she was not called to give oral evidence.
   5. The evidence of the claimant both in her witness statement and orally. The claimant said in her witness statement that the doctor who spoke to her after the operation said the placenta was a lot larger than expected. In oral evidence she said that the doctor had said the piece of placenta that was removed measured 8cm.
   6. The histopathology report dated 5 May 2011. The report of the sample of tissue removed in the operation recorded that “*sections show blood clot and partly necrotic placental tissue. Retained products of conception are confirmed*”.
4. The judge heard expert evidence regarding the size of the piece of retained placenta as follows:
   1. The experts were agreed that if a substantial piece of placenta was retained in the uterus after birth then it would tend to inhibit the uterus from fully contracting, which would lead to pain and prevent the blood vessels to which the placenta was attached from fully healing and so lead to bleeding. Professor Shaxted thought that these were not invariable consequences, and Dr Maresh agreed that the relationship between blood loss and size of a retained piece of placenta was a loose one.
   2. One indicator of blood loss is a decline in the level of haemoglobin. There was no decrease in haemoglobin levels between 22 March 2011 and 20 April which tended to suggest that the claimant had not suffered any major loss of blood between those dates.
   3. The experts were agreed that if a substantial piece of placenta was present when Ms Robinson conducted her ultrasound scan on 20 April 2011 it must also have been present on 6 April and a reasonably competent doctor in the position of Dr Ali should have seen it on the scan which was undertaken at the time.
   4. Professor Shaxted thought the operation note pointed towards the claimant having retained a substantial piece of placenta because the surgeon had grasped the object with sponge-holding forceps. Dr Maresh considered that sponge-holding forceps could have been used to remove a mass consisting of a small amount of placenta together with a surrounding blood clot which had had time to become organised and fibrous.
   5. Professor Shaxted agreed that a blood clot could increase in size over time and could adhere to an object such as a small piece of placenta. He thought that about 80cc of blood would be required for a blood clot of 5x2x4 = 40cc and he agreed that that there could have been this level of bleeding consistent with the claimant's reported haemoglobin results.
   6. Professor Shaxted thought it significant that the midwife had thought a piece of the placenta was missing on the basis that a missing piece of 2cm would be unlikely to have been detected. Dr Maresh disagreed on the basis that the midwife would have been able to spot a missing piece of about 2cm.
   7. Dr Maresh considered that Dr Hooper’s note was wrong or inaccurate, i.e. that she had told the claimant that about 8 cm of products were removed in the operation.
   8. The experts agreed that it was not possible to tell from the histological report what the proportion of blood clot as opposed to placental tissue was, only that both were present.
5. It is a feature of the care with which the judge set out the detail of everything that was relevant to the issue in this case that these highlights can be taken from his judgment. The judge concluded that he was not persuaded on the balance of probabilities that the placental tissue which was retained in the claimant’s uterus after she gave birth to H was substantial. His reasons are as follows:
   1. Dr Ali conducted an ultrasound scan and although there were limitations on what a scan can show shortly after birth, there was clinical value in conducting the scan. His scan identified a 2cm area of possible placenta left in situ. To have measured 2cm when the placental residue was 7cm would be a very substantial error, which means that it is less likely to have occurred.
   2. The contraction of the uterus, the closing of the blood vessels to which the placenta was attached and the pain experienced by the claimant were not reliable indicators of the size of the retained placenta.
   3. Although Ms Robinson’s ultrasound scan on 20 April was able to identify an echogenic mass measuring 7 x 4.4 x 2.2 cm, she wrote *‘?... Placenta’*. This showed that she could not be sure it was a piece of placenta and the experts agreed it would be difficult to tell the difference between blood clot and placenta on an ultrasound scan.
   4. Professor Shaxted agreed that: (i) the claimant could have had the amount of bleeding required for a blood clot of 80cc consistent with the slight increase in her haemoglobin levels between 22 March and 20 April and (ii) digital detachment and sponge-holding forceps could have been used to remove a small piece of placenta with an attached blood clot.
   5. The histopathology report does not help to resolve the issue.
   6. There is no evidence that Dr Hooper was speaking from first-hand knowledge as to the size of the retained placenta. The use of the symbol meaning ‘approximately’ does not lend itself to a conclusion that Dr Hooper had herself measured the object. She referred to what was removed as ‘products’, which includes the placenta but excludes blood clots, but as the judge said: “*one must also guard against being overly legalistic in the interpretation of such a note*”. There was no witness statement or evidence from Dr Hooper, apart from her note, but the judge held that the circumstances did not lead him to draw an adverse inference against the defendant.
   7. The reasons for declining to draw an adverse inference were explained. The judge distinguished *Wisniewski v Central Manchester Health Authority* [1998] PIQR P324 because the absent witness in that case was the doctor whose negligence was said to have caused the harm. In this case, Dr Hooper’s role was far more tangential. In addition, *Wisniewski* was concerned with the entitlement to draw an adverse inference, not an obligation on the court to do so. The judge did not consider an inference appropriate in light of the factual matrix in this case.
6. The claim was accordingly dismissed. On 20 May 2016 the judge handed down an addendum to his judgment dealing with issues that are not relevant to this appeal.

Grounds of appeal:

1. The claimant pursues eight of the 15 grounds of appeal before this court:
   1. Failing to give proper reasons and / or properly to weigh those reasons.
   2. Failing to give proper weight to Ms Robinson’s evidence and / or failing to apply the standard of proof to her evidence.
   3. Taking a wrong and inconsistent approach to interpretation of the medical records.
   4. Erring in principle in the approach to the measurements recorded by Dr Hooper (and communicated to the claimant) at the post-operative ward round on 21 April 2011.
   5. Failing to take into account and / or give proper weight to the claimant’s evidence that Dr Hooper told her that 8cm of placenta had been removed in the procedure undertaken on 21 April 2011.
   6. Failing to make a finding on the source of Dr Hooper’s belief that 8cm of placenta had been removed and / or approximately 8cm of “products” were removed.
   7. Failing to draw an adverse inference from the defendant’s failure to serve evidence from Dr Hooper.
   8. Failing to give proper reasons for declining to draw an adverse inference from the defendant’s failure to serve evidence from Dr Hooper.
2. The essence of the appeal can be distilled into two issues on the claimant’s own submissions:
   1. The judge was wrong in the way in which he evaluated the evidence of Ms Robinson and Dr Hooper.
   2. The judge failed to draw an adverse inference against the defendant for not adducing evidence from Dr Hooper.

Issue 1 – error of factual evaluation:

1. Although the parties describe in their submissions a common understanding of the principles that an appellate court should apply in considering conclusions of fact, the claimant seeks to focus on discrete parts of what is an holistic exercise to illustrate whether the judge did or did not get the evaluative exercise wrong. Unless the judge’s evaluation can be demonstrated to be perverse, this is rarely an attractive submission because it usually descends into questions about the weight to be given to parts of the evidence which are a matter for the court that hears and sees the witnesses in context, an advantage the appellate court does not have.
2. It is helpful to focus on the test this court must apply. That was most recently described in *Re B (A Child)* [2013] UKSC 33 per Lord Neuberger PSC at [53]:

“…where a trial judge has reached a conclusion on the primary facts, it is only in a rare case, such as where the conclusion was one (i) which there was no evidence to support, (ii) which was based on a misunderstanding of the evidence, or (iii) which no reasonable judge could have reached, that an appellate tribunal will interfere with it.”

1. Having regard to the focus that the claimant wishes to give to the appeal in this case, the words of Arden LJ in *Langsam v Beachcroft LLP* [2012] EWCA Civ 1230 at [72] are apposite and helpful:

“…where any finding involves an evaluation of facts, an appellate court must take into account that the judge has reached a multi-factorial judgment, which takes into account his assessment of many factors. The correctness of the evaluation is not undermined, for instance, by challenging the weight the judge has given to elements in the evaluation unless it is shown that the judge was clearly wrong and reached a conclusion which on the evidence he was not entitled to reach.”

1. Although it might be thought that this is a sufficient answer to the first issue raised in this appeal, in deference to the careful submissions this court has heard, I shall set out the principal examples given. The claimant focusses on case law that demonstrates unsatisfactory reasoning or a demonstrable failure to consider and evaluate relevant evidence and cites as an example *Flannery v Halifax Estate Agencies Ltd* [2000] 1 WLR 377 at 381G-382 for the proposition that the judge must explain why he has reached his decision.
2. The claimant also seeks to emphasise the evidential importance of contemporaneous documents when assessing facts that are in issue. In particular the claimant relies on the judgment of the Court of Appeal in *Synclair v East Lancashire Hospitals NHS Trust* [2015] EWCA Civ 1283, [2016] Med LR 1 where at [14], Tomlinson LJ held that:

“Clinical records are made pursuant to a clear professional duty, serious failure in which could put at risk a practitioner’s registration. Moreover, they are not compiled simply as a historical record, they fulfil an essential and ongoing purpose in informing the care and treatment of a patient. Contemporaneous records are for these reasons alone inherently likely to be accurate.”

1. Neither of these propositions is in dispute, the question is whether the claimant can identify an error of factual evaluation of a nature and extent that vitiates the judge’s conclusion.
2. First, the claimant alleges that the judge’s treatment of the ultrasound scan performed by Ms Robinson is erroneous. Ms Robinson had stated that she had identified an echogenic mass measuring 7 x 4.4 x 2.2 cms of which she wrote in her report *‘? Placenta’*. The claimant submits that the judge’s conclusion is wrong because:
   1. In his judgment, the judge does not come to a clear conclusion whether Ms Robinson’s measurement was rejected.
   2. No satisfactory reason is given for not accepting Ms Robinson’s oral evidence that she could distinguish between the placental mass and the fluid / blood surrounding it and reliance is wrongly placed on Ms Robinson’s evidence that she was not ‘sure’ of the measurement of the placental piece.
   3. There is no recognition of the inherent reliability of the contemporaneous clinical report made by Ms Robinson, who is a skilled and experienced Senior Sonographer.
   4. Too much reliance was placed on the agreed evidence of the parties’ experts that distinguishing between placental tissue and blood will become more difficult over time as the blood takes on solid form. This is only general evidence and does not prove that Ms Robinson must have been wrong.
3. The key to the first example of alleged error is that the claimant acknowledges but fails to take into account the reasons that the judge gave for the conclusion of fact to which he came. It is clear from the findings of fact that I have summarised above, that the judge preferred the evidence of Dr Ali on measurement. He reasoned why and those reasons are directly relevant to the weight that the judge gave to the evidence before him.
4. The reasons included a) the difference between 2 cm and 7 cm would have been a very substantial error for Dr Ali to have made (and hence inherently less likely), b) the evidence of Ms Robinson that she was not sure about measurement, c) the consensus of the experts which was agreed by Ms Robinson about the difficulty in identifying placental tissue from blood and other accretions over time, and d) other contemporary materials such as the discharge summary. In addition, the evidence arose at different times and in different contexts which the judge described. It would be difficult, if not impossible in that circumstance, to dislodge a conclusion based upon a multi-factorial evaluation. It is likewise difficult, if not impossible, on the evidence to say that the judge was wrong in concluding that there are limitations on what an ultrasound scan can show shortly after birth and/or that it would be difficult to tell the difference between a blood clot and placental tissue.
5. There is nothing sufficient in the claimant’s submissions for this court to interfere with the judge’s conclusion. The judge did not need to go further and reject Ms Robinson’s evidence. He did not need to do so having reasoned what he made of it. Furthermore, this is not, as alleged, an example of a failure to apply the civil standard of proof to the evidence. The application of a standard of proof is rarely a binary choice between items of evidence that are of equal weight. Weight is a contextual evaluation for the judge who reads, hears and sees the evidence of the witnesses. It is inappropriate for this court to interfere with that evaluation unless it is perverse.
6. Second, the claimant alleges that the judge was in error in his treatment of the evidence relating to Dr Hooper’s contemporaneous medical note which records that she explained to the claimant that the products removed were approximately 8 cm. The claimant submits that the judge’s reasoning is inadequate because:
   1. The judge failed to recognise that Dr Hooper’s clinical record was inherently likely to be accurate.
   2. The judge failed to draw the obvious conclusion that Dr Hooper must have known the dimensions as she would not have made them up.
   3. The judge advances no reliable hypotheses as to why the measurement explicitly recorded by Dr Hooper in the records was not correct with the consequence that the judge’s conclusion was speculative given that he accepted that Dr Hooper may have been present during the operation and there was no witness evidence as to why her note was inaccurate.
   4. The judge recognised that the word ‘products’ described placental tissue, but then held that such an interpretation would be overly legalistic. That was wrong as the law requires the judge to recognise the likelihood that the contemporaneous notes are accurate unless shown otherwise.
7. The proposition that a contemporaneous clinical record is inherently likely to be accurate does not create a presumption in law that has to be rebutted in the manner submitted by the claimant. It is an important factor in evaluating materials of that kind so that reasoning is necessary to explain how records (or their absence) are being treated on the facts of a particular case. To raise the bar so high that an analysis of what might be sufficient to displace inherent reliability is needed in every case is to make the process of fact finding too onerous and mechanistic. In any event, the judge analysed the circumstances in which the records were made alongside the other evidence in the case. It cannot be said that his evaluation departed from the principles and practice identified in *Synclair,* quite the contrary.
8. The limitations on the use that can be put on the contents of the clinical note of Dr Hooper were clear: a) she did not perform the evacuation procedure, b) there is no evidence that she was present during the operation, c) the unchallenged evidence of all other clinicians is that it would have been very difficult to differentiate between placental tissue and other products on a visual inspection, d) it was not Dr Hooper’s task to analyse the mass removed, and e) she did not measure the mass removed. On that basis, the judge cannot be criticised for describing Dr Hooper’s role as ‘tangential’ to the issue in the case.
9. On the discrete issue of whether the judge was entitled to contextualise what Dr Hooper’s note recorded when he inferred that ‘products’ could refer to both placenta and blood clots: that was the evidence of the expert, Dr Maresh, on whom the judge was entitled to rely. It is, therefore, incorrect to describe the judge’s treatment of Dr Hooper’s note as being unreasoned or speculative. It was based in the evidence that he accepted and was appropriately reasoned.

Issue 2 – failure to draw an adverse inference:

1. The second issue has a resonance in the way it was put with the way the reliability of clinical records was presented by the claimant, namely a desire on her part to derive a principle from case law which she seeks to characterise as being obligatory in its application. The claimant submits that it is a basic tenet of natural justice that it is unjust for a claimant to have to defend herself in the civil courts against calculated silence. This is particularly so in clinical negligence cases where there is an asymmetry between the knowledge of the patient and their doctors. The claimant relies on *Wisniewski v Central Manchester Health Authority* [1998] PIQR P324. In that case Brooke LJ derived four principles from previous case law:

(1) In certain circumstances a court may be entitled to draw adverse inferences from the absence or silence of a witness who might be expected to have material evidence to give on an issue in an action.

(2) If a court is willing to draw such inferences they may go to strengthen the evidence adduced on that issue by the other party or to weaken the evidence, if any, adduced by the party who might reasonably have been expected to call the witness.

(3) There must, however, have been some evidence, however weak, adduced by the former on the matter in question before the court is entitled to draw the desired inference: in other words, there must be a case to answer on that issue.

(4) If the reason for the witness’s absence or silence satisfies the court then no such adverse inference may be drawn. If, on the other hand, there is some credible explanation given, even if it is not wholly satisfactory, the potentially detrimental effect of his/her absence or silence may be reduced or nullified.

1. The claimant submits that the judge should have found that the four principles articulated by Brooke LJ in *Wisniewski* were satisfied. The evidence of Dr Hooper, she says, was material in that it would have substantially strengthened the claimant’s case. There was a case to answer on that issue and no explanation was given for Dr Hooper’s absence. The defendant submits that the judge understood and applied *Wisniewski.*
2. There are three aspects to the claimant’s submissions that demonstrate the difficulty that she has on this issue. First, *Wisniewski* is not authority for the proposition that there is an obligation to draw an adverse inference where the four principles are engaged. As the first principle adequately makes plain, there is a discretion i.e. “the court is *entitled* [emphasis added] to draw adverse inferences”. An appellate court will be hesitant to interfere with the exercise of such a discretion given that it is being exercised in the knowledge of all the nuances of evidence that are in the knowledge of the judge who receives that evidence. Second, the judge in this case did not conclude that an absent witness had to be central to the case, he merely and correctly identified that the doctor in *Wisniewski* was central to that claim as the person who had failed to defend his clinical judgment. By comparison, the judge decided that Dr Hooper’s role and hence evidence was tangential for the reasons I have summarised at [26] above. Third, there was an explanation for absence and that was a decision on proportionality grounds taken by the defendant i.e. this was not a case where a defendant or witness deliberately prevents or avoids the admission of evidence that would undermine their case.
3. There is also a further difficulty that the claimant must face. On 21 August 2015 Master Roberts gave case management directions. The claimant sought a direction for disclosure of information about Dr Hooper but did not seek an order that she file and serve a witness statement. They could have asked for the latter. If the claimant was of the view that Dr Hooper’s evidence was as important to her case as is now asserted and that an adverse inference would be appropriate in Dr Hooper’s absence, they could have asked for a direction which contained the warning that an adverse inference may be drawn if the evidence was not provided. Even without such a direction, the claimant could have made arrangements to obtain evidence from Dr Hooper themselves.
4. If and in so far as the claimant submits that inferentially the defendant was bound by practice or by other non-specific case management directions to file and serve a witness statement from Dr Hooper simply because she was one of a number of people who had evidence, however tangential, relating to the ‘relevant treatment’, I have to disagree. That would be a disproportionate way of preparing litigation.
5. For these reasons I came to the conclusion, subject to my Lord’s concurrence, that the appeal should be dismissed.

**Lord Justice Sales:**

1. I agree.