SUPREME COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**Nouri v Australian Capital Territory**
Citation:	**[2018] ACTSC 275**
Hearing Dates:	27 September 2017 – 28 September 2017; 3 October 2017 – 19 October 2017; 23 October 2017 – 24 October 2017; 7 February 2018 – 8 February 2018; 27-31 August 2018
Decision Date:	28 September 2018
Before:	Elkaim J
Decision:	Judgment for the defendant. Plaintiffs to pay defendant's costs.
Catchwords:	**TORTS – NEGLIGENCE –** where a child was born with significant disabilities – whether the parents of the disabled child had been or ought to have been warned about the prospect of the condition – content and scope of the duty of care – causation – whether a termination would have been available – whether a termination would have occurred
Legislation Cited:	*Civil Liability Act 2002* (NSW) s 5D(1) *Civil Law (Wrongs) Act 2002* (ACT) ss 42, 45 and 46
Cases Cited:	Australian Taxation Office, *ATO Interpretative Decision,* 2003/617, 15 July 2003 *Container Terminals Australia Ltd v Huseyin* [2008] NSWCA 320 *Cattanach v Melchior* [2003] HCA 38; 215 CLR 1 *Fox v Percy* [2003] HCA 22; 214 CLR 118 *Gaynor N v Warrington Health Authority* [2003] Lloyds Rep Med 365 *Groom v Selby* [2002] Lloyds Rep Med 1 *Mason v Demasi* [2009] NSWCA 227 *Meadows v Khan* [2017] EWHC 2990 (QB) *Neville v Lam (No 3)* [2014] NSWSC 607 *Nominal Defendant v Cordin* [2017] NSWCA 6; 79 MVR 210 *Parkinson v St James & Seacroft University Hospital NHS Trust* [2000] QB 266 *Rogers v Whitaker* [1992] HCA 58; 175 CLR 479 *Veivers v Connolly* (1995) 2 Qd R 326 *Waller v James* [2013] NSWSC 497
Parties:	Einas Nouri (First Plaintiff) Musab Shaor (Second Plaintiff) Australian Capital Territory (Defendant)

Representation:	**Counsel** Mr M Cranitch SC, Mr A Campbell and Ms U Okereke-Fisher (4 and 5 October 2017) (First and Second Plaintiff) Mr D Higgs SC and Ms K Sant (Defendant) **Solicitors** Gerald Malouf & Partners (First and Second Plaintiff) ACT Government Solicitor (Defendant)
File Number:	SC 358 of 2013

ELKAIM J:

Introduction and summary of findings

1. There are two plaintiffs in this matter. Although they have different surnames, they are a married couple. They are the parents of Saba Nouri, who was born on 3 November 2011 with severe disabilities. For convenience, I will refer to the first plaintiff as Ms Nouri and the second plaintiff as Mr Shaor. During the antenatal stage, Saba is variously referred to as Twin 2 or Twin B.

2. The defendant is effectively the Canberra Hospital and its staff.

3. Saba's disabilities have been categorised as VACTERL association. This refers to abnormalities in the following areas: vertebral, anorectal, cardiac, tracheao-esophageal, esophageal, renal and limb. In addition, Saba suffers from developmental delay, although this is probably a product of events that occurred after birth.

4. A trachea-esophageal fistula (a "TOF") is an abnormal connection between the oesophagus and the trachea. Esophageal atresia is a condition in which the oesophagus ends in a pouch instead of connecting to the stomach.

5. By way of brief summary the plaintiffs' case is that the hospital should have provided them with certain information. Had that been done, the pregnancy of Twin B (and if necessary Twin A) would have been terminated and the extensive costs associated with Saba's upbringing would have been avoided.

6. The plaintiffs said the failure to provide the information was a breach of the duty of care the defendant owed to the plaintiffs. The defendant denied that there was a breach of the duty owed to the plaintiffs and added that if there was a breach, the breach did not cause the loss claimed.

7. The central point on breach of duty was whether or not information about Twin B's condition (or potential condition on birth) was disclosed to the plaintiffs. The central point on causation was whether the plaintiffs would have, or could have, secured a termination at the late stage in the pregnancy when the information should have been supplied.

8. A significant point on damages was whether the losses should be calculated to the extent of Saba's agreed life expectancy of a further 31 years, or until she reached the age of 18. Effectively almost every aspect of the damages claim was challenged. The plaintiffs' assessment of about $9 m was countered with an assessment of about $53,000.

9. As will be seen below I have found that:

(a) The defendant breached its duty of care.

(b) The plaintiffs failed to prove their damages were caused by the breach.

(c) If the plaintiffs had succeeded, the damages would have been assessed at $1,813,807.

(d) The calculation of damages was based on the loss not extending past Saba's 18th birthday.

Background

10. As at the beginning of 2011, the plaintiffs had two children. Ms Nouri became pregnant again on or about 20 February 2011. The pregnancy was unplanned. The plaintiffs resolved to proceed with the pregnancy but, on their case, did not want a child with a disability.

11. On 8 July 2011, Ms Nouri had an ultrasound at a private clinic in Canberra, National Capital Diagnostic Imaging (NCDI). She was informed that she was pregnant with twins. The plaintiffs were prepared to terminate the pregnancy if either twin was likely to be disabled. This resolution included a termination, if necessary, in respect of both twins.

12. NCDI was concerned about the condition of one fetus. The plaintiffs were referred to the Fetal Medicine Unit at Canberra Hospital (the FMU) to investigate the health of Twin B.

13. According to the referral from NCDI dated 8 July 2011 (Exhibit B), the ultrasound disclosed that:

> **Twin B** corresponds to 18 weeks 4 days amenorrhea size.
>
> | | | |
> |---|---|---|
> | Head circumference: | 15.73 cm | 18 weeks 5 days |
> | Abdominal circumference: | 13.08 cm | 18 weeks 0 days |
> | Femur length: | 2.98 cm | 19 weeks 0 days |
>
> The discrepancy in biometry between the two twins is significant although not significantly different from the gestational age of 19 weeks 5 days from the LMP.
>
> **Twin B has a two vessel cord** and this is the likely cause of the growth restriction in this twin.
>
> The **foetal heart** in twin B also appears slightly larger than usual with poor visualisation of the interatrial septum. I feel that this twin needs further expert evaluation and I've referred her to the foetal medicine unit for further assessment.
>
> No other definite abnormality is seen.

14. The first appointment at the FMU was on 15 July 2011. An ultrasound was carried out and the plaintiffs spoke with a Dr Tan, a trainee obstetrician. He recommended an amniocentesis test. The test was performed. Its purpose was to identify chromosomal abnormalities and fetal infections. Down Syndrome is an example of a chromosomal abnormality.

15. The plaintiffs say that the ultrasound on 15 July 2011 revealed abnormalities in Twin B. There is little dispute about this although the defendant would probably characterise the findings as anomalies rather than abnormalities. The gestation term was then 20 weeks and 5 days.

16. Following this first consultation, the plaintiffs' case is that they were never given full and correct information about the condition of Twin B. They said that, had the correct information been given, they would have elected to terminate the pregnancy. Their first choice would have been to only terminate the pregnancy of Twin B. This is called a selective termination.

17. However, if necessary, they would have terminated the pregnancy of both Twin A and Twin B. A termination is also referred to as feticide. The plaintiffs' say the failure to inform was a breach of the hospital's duty of care owed to them.

18. The plaintiffs say that their personal experiences had made them very alive to the difficulties faced in raising disabled children, such that they would have had no hesitation in undergoing the termination. In addition, they pointed out that the pregnancy was unplanned and that they had a right to choose to plan their family as they desired.

19. There was no dispute that the hospital owed a duty of care to the plaintiffs. The defendant accepted that whatever the content of the duty, it was owed to both the mother and the father, as parents of Saba, and not only to the mother who was the FMU's patient.

20. A fundamental issue is the nature and content of the information provided to the parents and when, if at all, it was provided. This is a credit issue and is dependent on whether I accept the evidence of the plaintiffs or that of the defendant, given through its various witnesses. Mr Cranitch SC, for the plaintiffs, confirmed in the course of the hearing that this was the extent of the contest on breach of duty (T 384 – T 385). Mr Cranitch SC also confirmed that there was no allegation of negligence on the part of the FMU other than the failure to inform (T 384).

21. If breach of duty was established, causation was strongly contested. A major issue is whether the plaintiffs could have terminated the pregnancy even if they had been provided with the information that would have led them to choose a termination. In general terms, a termination can be carried out, with little risk, up to 20 weeks' gestation. In Australia, subject to some differences between the States and Territories, any termination in a public hospital, after 20 weeks' gestation, requires the permission of an ethics committee.

22. The plaintiffs say that, in the circumstances of this case, they would have obtained the necessary permission. In addition, they say that if the permission had not been forthcoming they would have travelled elsewhere, probably to the United States of America (the USA), where the termination would have been available. They would have been prepared to make the journey and would have been financially able to incur the necessary expenses.

23. The plaintiffs' claim for damages was made under the following heads: general damages; past expenses incurred in caring for Saba; the cost of the future care of Saba; and past and future economic loss suffered by the plaintiffs.

24. The claim for general damages was specifically expressed to not include a claim for nervous shock.

25. It was accepted that a claim for gratuitous services for past care was not available.

26. Other than a concession that a duty of care was owed by the hospital to the plaintiffs, the defendant contested the claim at almost every level. The content of the duty was in dispute, causation was in dispute and most elements of the damages claim were challenged. Some parts of the damages claim, like general damages, were disputed both as to entitlement and quantum.

27. Saba's life expectancy was initially in issue, but was later agreed at 31 years from the present.

28. Initially the costs of future care did not seem to be heavily contested because the plaintiffs relied on the report of Ms Moylan, an occupational therapist retained by the defendant. However, following evidence given during the hearing, including the viewing of a short video, the defendant's position changed so that it effectively withdrew its reliance on its own report.

29. Ultimately the defendant agreed that Saba required 24-hour care.

The witnesses

30. The first witness was the second plaintiff, Mr Shaor. He was born in Sudan in 1975. He has five siblings. His parents were well-off and, notably, frequently travelled to Egypt for medical treatment.

31. My summary of his, and other, oral testimony should not be regarded as being a substitute for the transcript. Rather, it simply highlights portions of the evidence that I think deserve specific mention.

32. Mr Shaor attended high school and then, in 1995, entered a military college. He hoped to be an officer. He did not finish the course because he took a different political view to the Sudanese Government. In 1997, he completed an accounting degree at a university in Sudan.

33. In 1997, Mr Shaor was detained for about six months as a result of his political views. During his detention he developed Post-Traumatic Stress Disorder (PTSD). Following his release, he travelled to Egypt for treatment. He also required some treatment for his knee.

34. Mr Shaor remained in Egypt for about three years. He was supported by his family both emotionally and financially. A contribution was also made towards his treatment by the United Nations High Commissioner for Refugees (UNHCR).

35. Mr Shaor had a niece with severe disabilities. The child required full-time care until her death in 2014. He noticed the toll it took on the family.

36. Mr Shaor came to Australia in 2001 with his brother, Luay Shaor. The migration to Australia was arranged through the UNHCR on the basis of Mr Shaor being a refugee. An application had also been made for him to reside in the USA, but this was rejected. Mr Shaor said that it was rejected because he revealed that he was familiar with the use of guns, having received military training.

37. Mr Shaor and his brother were initially located in Tasmania. His brother moved to Sydney, where he established a construction business. While in Tasmania, Mr Shaor carried out seasonal agricultural jobs. He also continued his treatment for PTSD at the University of Tasmania clinic. He was on antidepressant medication, which he took for about two years. He said that he continues to suffer from PTSD. It is a condition that never ceases.

38. In 2003, Mr Shaor returned to Sudan where he met his future wife, Ms Einas Nouri. They were married in November 2004 and came to Australia together in early 2005. By this time they had obtained jobs with the Saudi Arabian Cultural Mission. Mr Shaor was

employed as an auditor. His wife was employed as an academic advisor. They were based in Canberra.

39. The plaintiffs had their first child, Al-Mohammed, in January 2006. He was born at Canberra Hospital. While there were no complications with the birth, Ms Nouri suffered from Postnatal Depression. In addition, the plaintiffs were not happy with the subsequent treatment that Ms Nouri received for septicaemia, which had developed after the birth of their son. Ms Nouri also developed severe back problems after this birth.

40. The family went to Sudan for a short period and returned with Mr Shaor's mother, who came to Australia to assist with the new child. She remained in Australia for about a year. Ms Nouri became pregnant again in early 2008. The pregnancy was terminated at about seven to nine weeks' gestation because Ms Nouri was concerned about her back pain. This termination effectively put an end to the defendant's assertion that, as a Muslim, Ms Nouri would not have undergone a termination of a pregnancy.

41. In 2009, Mr Shaor returned to Sudan. He volunteered at a children's cardiac facility. He assisted with the funding of a child to travel to Italy for heart surgery.

42. Ms Nouri became pregnant again in 2009 and delivered a daughter, Safinaz, on 18 March 2010 at Calvary Hospital. The plaintiffs chose a private hospital because they had engaged a specialist, Dr Tam, and wished to have access to him as required. This was a consequence of their experience of Ms Nouri contracting septicaemia after the first birth. At this stage, the plaintiffs were not insured and paid the costs associated with the birth personally. This included an operation to deal with postpartum bleeding. The total cost incurred was about $18,000. Mr Shaor's mother again came to Australia to assist.

43. Mr Shaor travelled to Sudan in June 2010. The political climate had improved and he was invited by the Government to attend an investment conference. After about 10 days, he was informed that his mother was ill. He promptly returned to Australia. When he arrived, his mother was in Canberra Hospital on a saline drip. She had liver problems and was in and out of hospital over the next few months. In December 2010, she lapsed into a coma.

44. Mr Shaor said that the doctors had informed him that a liver transplant was not available in Australia because of his mother's visa status. After his mother came out of the coma, Mr Shaor made some enquiries about the possibility of obtaining treatment in Germany. He contacted a clinic that specialised in stem cell transplants.

45. Mr Shaor made arrangements with XCell-Center. He initially transferred a deposit of €1,000 to the clinic and, subsequently, as part of a visa application, made a further payment of €4,000. The total cost of the treatment was €9,925 (Exhibit P). Mr Shaor travelled to Germany with his mother, wife and two children.

46. After spending about four days at the clinic, Mr Shaor's mother, and the family, spent a further 15 days in a hotel in Germany. They then travelled to Khartoum, where Mr Shaor continued his involvement in a business venture concerning the development of some residential buildings.

47. The purpose of this, and other like evidence, was to demonstrate that the plaintiffs were used to, financially able to, and prepared to, travel abroad for medical treatment.

48. In January 2011, the plaintiffs informed the Saudi Arabian Cultural Mission that they wished to resign from their employment. This was to enable Mr Shaor to pursue a commercial venture in Sudan. The Cultural Attaché persuaded Mr Shaor not to resign but, rather, to take unpaid leave.

49. While the family were in Sudan, Ms Nouri told Mr Shaor that she thought that she was pregnant. The plaintiffs returned to Australia with the intention of having the child. They intended to return to Sudan after the pregnancy, as they thought it would be easier to raise a large family with the domestic and family assistance that was available to them in that country.

50. Mr Shaor enrolled in a Bachelor of Politics and International Relations at the University of Canberra when he returned in 2011. He intended to complete one semester and then, armed with the credits of the subject he had completed, continue the degree in Sudan.

51. Upon returning to Australia, Ms Nouri consulted her general practitioner, Dr El Sherif. He referred her for an ultrasound at NCDI. The appointment was on Friday 8 July 2011. The length of gestation was then 19 weeks and 5 days. Following the ultrasound, the plaintiffs were informed that Ms Nouri was pregnant with twins. They were pleased with the news. However, Dr Lomas informed them that one of the twins had a single umbilical artery, which might indicate a heart problem. They were referred to the FMU and were informed that they would be contacted. They were also told that one twin was a boy and the other was a girl. The potential problem was with the female twin.

52. The plaintiffs did not hear from the FMU on 8 July 2011 or in the early half of the following week. Mr Shaor made a number of attempts to contact the FMU to no avail.

53. The plaintiffs knew of a Sudanese doctor who worked at Canberra Hospital. They contacted this doctor, Dr Latif, and asked him to see if he could get in touch with the FMU about their appointment. Dr Latif suggested that a copy of the NCDI report from 8 July 2011 be faxed to the hospital (Exhibit B). An appointment was then made for the following morning on 15 July 2011.

54. On 15 July 2011, gestation now being 20 weeks and 5 days, the plaintiffs saw Dr Tan. A further ultrasound was carried out. Dr Tan asked the plaintiffs what they had been told. They related the information that had been provided to them at NCDI. Dr Tan said that a single umbilical artery was associated with a chromosomal abnormality. He suggested an amniocentesis test. The plaintiffs agreed and the test was carried out. They were told that if any abnormality was found, they would be informed.

55. The next appointment at the FMU was on 25 July 2011, gestation now being 22 weeks and 1 day. The plaintiffs had received no word about the results of the amniocentesis test. On this occasion the plaintiffs saw Dr Robertson, the Director of the FMU.

56. Dr Robertson confirmed that the amniocentesis test result was negative and another ultrasound was carried out. No suggestion of any abnormality, other than a cardiac abnormality, was raised. No mention was made of Twin B's abdominal circumference or about the length of her femur, despite appearing as possibly abnormal on the Wellbeing Report, dated 15 June 2011 (Exhibit 1, page 82).

57. This is a convenient point at which to note that 'abdominal circumference' does not relate to the size, or even presence, of a stomach. It is a measurement of waist or 'belt'

size. The entries in relation to abdominal circumference are not as relevant to the main issues in this case as might have appeared at first sight.

58. During the ultrasound, Dr Robertson said that she would organise a cardiac test in Sydney. She said that a selective termination was possible if one of the twins was suffering from a heart condition. The conversations with Dr Robertson about termination should be noted here:

> MR SHAOR: …She said organised (indistinct) to go to Sydney to see whether there is something wrong with the heart or there isn't and then I say to her if the heart condition be confirmed in Sydney then (indistinct) the baby is an option available. She looked at me she said will you consider this option? I said yes and she said I agree with you because the heart condition which we suspect carries the risk or actually high risk of cardiac failure for the foetus.
>
> MR CRANITCH SC: Of what?
>
> MR SHAOR: Cardiac failure for the foetus and it is always better to lose one baby than it is both of them.
>
> MR CRANITCH SC: So you discussed with her effectively selective termination?
>
> MR SHAOR: Yes…And she said we talk about it when you come back from Sydney, it has been confirmed.
>
> MR CRANITCH SC: What did you understand from that conversation about the availability of termination of at least one of the babies?
>
> MR SHAOR: It's available, it was available.
>
> MR CRANITCH SC: Thank you. Did she talk to you on that occasion about anything else that had been disclosed then on the early ultrasound?
>
> MR SHOAR: Not at all.
>
> MR CRANITCH SC: Did she talk to you for example about the abdominal circumference?
>
> MR SHAOR: No.
>
> MR CRANTICH SC: Did she talk to you about the leg length of the femur?
>
> MR SHAOR: No.
>
> MR CRANITCH SC: Nothing?
>
> MR SHAOR: Nothing.
>
> MR CRANITCH SC: Did she show you the results of the ultrasound and explain it to you?
>
> MR SHAOR: No, no, no.
>
> MR CRANITCH SC: The only conversation so far as you can recall was about the cardiac condition and the possibility of terminating one of the twins?
>
> MR SHAOR: Yes.
>
> MR CRANITCH SC: Did this change the discussion that you and your wife had had earlier about terminating both if need be?
>
> MR SHAOR: No…
>
> MR CRANITCH SC: So that was always an option so far as you were concerned?
>
> MR SHAOR: It was always an option.
>
> MR CRANITCH SC: Did you raise that with Dr Robertson?
>
> MR SHAOR: No, no.

MR CRANITCH SC: The only discussion was terminating one of the foetus?

MR SHAOR: Yes.

MR CRANITCH SC: Was it your understanding on that occasion that the only risk about the pregnancy proceeding was this cardiac condition?

MR SHAOR: Yes.

59. The plaintiffs understood that a termination was available. The plaintiffs had undertaken a previous termination in the Australian Capital Territory and had no reason to believe that the procedure was not available.

60. It is very important to note here that the discussion about termination arose from the heart condition. It was not 'generalised' to include any abnormality. This is to be contrasted with the opening of the case, where it was stated:

> What is the thrust of the case is the plaintiffs will say that had there been any abnormality whatsoever they would have had a termination selectively if possible but if inevitably both twins had to be aborted, both twins. (T 2.28)
>
> Now, the plaintiffs will say they had a conversation when this was disclosed to them with Meiri Robertson, a doctor at the hospital, and told her if there was any abnormality they'd wish to abort the child or children if need be. (T 2.41)
>
> I'm not sure what her specialist qualifications in fact were, but your Honour will hear from the plaintiff that he had this conversation with Dr Robertson that if there was any abnormality at all they would seek a termination of the pregnancy and he understood from her reply that she agreed with that as a proposition. (T 12.15)

61. This was confirmed in the cross-examination of Mr Shaor:

> MR HIGGS SC: Can you repeat that, sorry?
>
> MR SHAOR: When we talked about the termination, [Dr Robertson] said "I agree with you and the abnormality which we suspect is a heart – there is a high risk of cardiac failure or heart failure and it is better to lose one baby than lose both of them"
>
> MR HIGGS SC: This is something that she said on 25 July?
>
> MR SHAOR: That is what she said.
>
> MR HIGGS SC: Beforehand?
>
> MR SHAOR: Yes.
>
> MR HIGGS SC: As I understand your evidence, that was in relation to a discussion about termination of pregnancy. That was it. That was the whole of the conversation that you had with her on this occasion?
>
> MR SHAOR: Yes.
>
> MR HIGGS SC: In terms of anything to do with the possibility of terminating both twins or selective termination or anything of that sort to do with termination, this on your evidence is the sum total of what was said in that regard between you and her at the time?
>
> MR SHAOR: Can you repeat the question, please?
>
> MR HIGGS SC: That was the whole of what she said in respect of anything to do with termination at all?
>
> MR SHAOR: Yes.
>
> MR HIGGS SC: For that matter, that specifically was the only conversation that you allege that was ever had with her about the possibility of termination. Is that right?

MR SHAOR: No, we had said on 6 September, when she said because of the heart and then I repeated the question that the heart was cleared by Sydney. She said "I'm not concerned with it here" and then I bent down – I was standing up. I bent down and said "What do you mean?" She said "I'm not agreeing with this from the beginning and I have been planning to send you to Sydney Hospital to see somebody else". They I say to her "Look, we have made our view clear, Mary". That's what I said.

62. I will return to Ms Nouri's overall evidence below, but in relation to this important aspect, the relevant passages from her evidence are as follows:

> MR CRANITCH SC: Did you say or have any discussion with [Dr Robertson] about what you would do if the baby was abnormal?
>
> MS NOURI: Yes, yes, I said to her it's really [indistinct] I asked her if the baby is [indistinct] she said yes and she agreed but it would be a very good decision because normally it would be cardiac failure as well.
>
> MR CRANITCH SC: So were you prepared to wait until you got an opinion from Sydney before going ahead with an abortion on that occasion?
>
> MS NOURI: Yes.
>
> MR CRANITCH SC: Was there any discussion about whether you would terminate one twin or both twins with Dr Robertson?
>
> MS NOURI: Yes, she said it's possible one baby live.
>
> …
>
> MR HIGGS SC: Yes?
>
> MS NOURI: She said although the chromosome test were normal we're still going to transfer you to Sydney to see the foetal cardiologist and I'm going to do that today, do the call today, then my husband ask her if that suspected heart abnormality has been approved by Sydney doctor will the termination be an option, she said yes and I agree with you because such abnormality could carry cardiac failure and losing one baby better than lose both. We talk about this option when you come back.
>
> MR HIGGS SC: Now I know that given that answer I perceive that you might disagree with what I'm about to suggest to you, but I just have to – I'm duty bound to put this to you and tell us whether you agree or not. What I'm suggesting to you is that on that occasion – neither on that occasion nor on any other occasion was there any discussion with Dr Robertson about the prospect of having a termination; do you agree with that or not?
>
> MS NOURI: No.

63. The evidence from both plaintiffs never met the description stated in the opening.

64. On 2 August 2011, the plaintiffs saw Dr Murphy, a paediatric cardiologist, at Sydney Children's Hospital. Dr Murphy carried out an ultrasound. He said that the only problem with Twin B was a variable abnormality. This was of no significance because the heart was structurally sound. He reassured the plaintiffs and told them to go to the beach (T 100.15). They did so.

65. On 8 August 2011, the plaintiffs attended the FMU. They saw Dr Robertson. She confirmed what they had been told by Dr Murphy. She carried out another ultrasound.

66. The plaintiffs returned on 22 August 2011. A technician carried out a further ultrasound and told them that there was no change and that all was well.

67. Before the next appointment, Ms Nouri suffered pain in her right side. Dr Robertson was informed and, on 5 September 2011, carried out a further ultrasound. Dr

Robertson said that there was excess fluid around Twin B (polyhydramnios). She suggested an amnioreduction (removal of the excess fluid).

68. At this appointment, Dr Robertson also advised the plaintiffs that she had not been content with Dr Murphy's decision "from the beginning". When asked to explain this comment, she said that she had been planning another referral, this time to a cardiologist at Westmead Hospital. Mr Shaor told Dr Robertson that he had medical insurance which he could access if that would help to speed up the appointment.

69. On 12 September 2011, the plaintiffs returned to the FMU. Dr Robertson carried out a further ultrasound and Ms Nouri was given steroid injections.

70. The plaintiffs returned to the FMU on 15 September 2011. The amnioreduction was carried out by Dr Tan, which helped alleviate the pain in Ms Nouri's right side. Mr Shaor asked if the appointment in Sydney had been arranged. Dr Robertson said that it was in train.

71. On 22 September 2011, the plaintiffs returned to the FMU and again saw Dr Robertson. On this occasion, Professor Ellwood, a fetal medicine specialist who was head of the unit, observed the ultrasound.

72. The plaintiffs again asked Dr Robertson about the Sydney appointment and were informed that it was being arranged. No mention was made of Twin B having a small stomach or a possible TOF. There was also no mention of a referral to a geneticist or any other specialist, or of a High Risk Meeting that had apparently taken place in the FMU on 6 September 2011.

73. On 5 October 2011, a further ultrasound was performed. Enquiries were made about the appointment in Sydney. Dr Robertson repeated that she was still organising it.

74. On 15 October 2011, Ms Nouri was again suffering from pain in her right side. She was admitted to the maternity ward at Canberra Hospital. The plaintiffs provided the staff with a history of Ms Nouri's condition as they understood it, referring to Twin B's condition as being the source of the problem. Ms Nouri was discharged the following day. It was suggested that Ms Nouri return to the FMU at an earlier date than already scheduled.

75. The admission notes dated 15 October 2011 make no mention of a TOF (Ex 1, from page 149).

76. Dr Robertson saw the plaintiffs again on 18 October 2011 and another amnioreduction was attempted but this was very painful for Ms Nouri so the procedure was stopped.

77. Enquiries were again made about the doctor in Sydney. Dr Robertson repeated that an appointment was being arranged. The plaintiffs were "fed up" with this oft repeated explanation. They attended Calvary John James Hospital in Deakin and enquired if a cardiologist was available. They were informed that one was not.

78. When Dr Robertson was again asked about a cardiologist, she told the plaintiffs that it was her intention to admit Ms Nouri to the hospital and then transfer her to Sydney by ambulance. This never took place.

79. On 26 October 2011, Dr Robertson said that there was no longer any need for a trip to Sydney. She told the plaintiffs that everything was fine and even made a joke about a dairy product.

80. On this occasion, Dr Robertson asked if the plaintiffs would like Dr Latif to attend the appointment, because she knew that he also spoke Arabic. They replied in the affirmative and he attended. Professor Ellwood also attended, apparently to discuss delivery. The plaintiffs said that they would like a caesarean delivery because of Ms Nouri's bad back, her previous experience with postpartum bleeding and because of the excessive fluid surrounding Twin B.

81. Professor Ellwood disagreed and said that a natural birth was appropriate. After further discussion, he agreed to speak to Dr Tam, who had attended to Ms Nouri during her previous delivery. The plaintiffs also asked Dr Latif to discuss a caesarean procedure with Professor Ellwood. When they left the meeting, they understood that he would do so and that it was likely that a caesarean birth would occur. They were also expecting the birth of 'normal' twins. Other than the cardiac issue, they were never told of any other possible abnormality.

82. Mr Shaor described his relationship with Dr Latif. He said that, prior to the birth of the twins, the doctor was simply someone they knew in the Sudanese community. Since the birth of Saba, they had become close friends and carried out some financial transactions together. In addition, Dr Latif has provided, and continues to provide, financial help to the plaintiffs.

83. Under cross-examination, it emerged that there had been a financial transaction involving Dr Latif when Mr Shaor took his mother to Germany. Mr Shaor had needed about $20,000 worth of Euros and they had been made available through Dr Latif. The money was necessary in case a medical emergency arose on the journey to Germany. Mr Shaor later repaid the loan by providing funds to Dr Latif's family in Sudan.

84. The plaintiffs were also receiving financial support from family in Sudan and from two friends in Canberra. The latter were providing funds informally, secured by the equity in the plaintiffs' home.

85. Following the meeting with Professor Ellwood and Dr Latif, which occurred on 1 November 2011, an ultrasound was arranged for the next day and an appointment made for delivery on 3 November 2011.

86. At this stage, Mr Shaor said there were no concerns expressed about the health of Twin B.

87. Mr Shaor was present for the birth. The male baby was delivered first. After delivery, Saba was taken to the Neonatal Intensive Care Unit (NICU). Mr Shaor was surprised when this occurred. He went to the NICU, where he spoke to Dr Latif. He was told that the baby needed some tests and to return to his wife.

88. The baby was taken to theatre. Later in the day, Mr Shaor met a Dr Simpson and a Dr Angelica. Dr Simpson told him that Saba had a TOF. He drew a diagram to explain the condition. He asked Mr Shaor if he had been informed that this was likely. Mr Shaor replied that he had not been so informed. Dr Simpson observed to Dr Angelica: "They haven't been consulted about that abnormality". Dr Angelica shrugged her shoulders. Dr Simpson said:

> We need to get involved to counsel the parents… [a]bout the procedure and the side effects of it… What I'm going to tell you now, the most common side effect is leakage. (T 121.6 – T 121.16)

89. Dr Simpson then had to return to theatre, where he was operating on another patient.

90. Mr Shaor later spoke to Dr Latif in his office. He explained VACTERL to Mr Shaor, using a whiteboard to assist.

91. Mr Shaor told his wife that there were some issues but kept the details to a minimum to avoid distressing her. He said the baby needed a simple procedure.

92. Since birth, Saba has undergone a number of surgical procedures, usually in Sydney. She requires further surgery in the future.

93. Mr Shaor related one occasion where he was contacted by the head of NICU, Dr Kecskes, who wanted to talk to him about a mishap that had occurred with ambulance arrangements. During this conversation, Mr Shaor complained about his experiences at Canberra Hospital. The doctor responded that Saba should not be brought to Canberra Hospital and observed: "we didn't know anything about Saba's condition until Saba was delivered" (T 125.19 – T 125.20).

94. Mr Shaor said that he has not worked since Saba's birth. Most of his day is taken up with the care of Saba or her siblings. It is effectively a full-time job, commencing at 5.00 am, when preparations for the day begin. Little time is left for socialising, although it does occur on rare occasions.

95. Mr Shaor said that after Saba has been bathed and had her various medical issues attended to, he takes her for a walk in order to generate circulation in her limbs. Hygiene is especially important to avoid infections. She can walk unaided but is supervised because she might fall over. It is necessary for her feedbag to be carried. The feeding machine is permanently connected to her through the day. It is also necessary to monitor her oxygen saturation levels, and take appropriate action when the low level alarm sounds. After the walk, Saba is placed on an exercise bicycle for a short time.

96. Saba's medical expenses are currently being covered by the National Disability Insurance Scheme (NDIS), but there is still a shortfall of about $350 per month for medications that are delivered through a Percutaneous Endoscopic Gastrostomy (PEG).

97. Mr Shaor said that he has had some health problems of his own recently and has needed to engage a carer from the Sudanese community. She was paid $45 per hour. He also said that he took antidepressant medication.

98. Mr Shaor was questioned about his assertion that he spent almost every day at the hospital following Saba's birth. He was taken to some hospital notes (Exhibit 3) which suggest a much lower level of attendance. He rejected any such inference arising from the notes, saying that he had looked at the notes from time to time and observed omissions concerning attendance. In this regard, I am mindful of the warnings given by Basten JA in *Mason v Demasi* [2009] NSWCA 227 and *Container Terminals Australia Ltd v Huseyin* [2008] NSWCA 320.

99. I observe here that the FMU's notes also display a distinct lack of detail and accuracy.

100. In 2012, Ms Nouri became pregnant again. The pregnancy was terminated because the plaintiffs did not wish to have another child.

101. Mr Shaor said that he generally agreed with the recommendations made by Ms Moylan, the occupational therapist retained by the defendant. He added, however, that

he believed Ms Moylan had been selective in her approach, preferring matters that favoured the defendant.

102. Under cross-examination, Mr Shaor was challenged about his activities during the day. It was put to him that he visited the Saudi Arabian Cultural Mission more frequently than he had previously suggested. He said he could not remember any precise dates but did accept that he had been there quite often, especially since August 2017. This was to assist the Sudanese Embassy, which was being set up in Canberra. He wrote some letters and ordered equipment on its behalf. He did not have the appropriate software on his computer at home to do these tasks.

103. Mr Shaor was shown some video footage of his comings and goings to the Saudi Arabian Cultural Mission (Exhibit 6). He accepted that the footage reflected visits to the embassy but could not be specific on the times and dates. He also said that, from time to time, a driver from the Sudanese Embassy would take him home. The footage was not of particular significance other than to perhaps highlight that Mr Shaor was attending the mission more often than he had recalled earlier in his evidence.

104. Of more significance is that cross-examination revealed that Mr Shaor owed the Cultural Mission about $130,000, a debt which had accumulated from August 2011. This is money that had been deposited into Mr Shaor's HSBC account and was equivalent to the wage that he would have earned had he been working. He insisted, however, that he had not been working, raising a distinct issue about his credit and the soundness of his past economic loss claim.

105. Another area of economic loss that came under scrutiny concerned a claim that had been made, but has since been abandoned, for commissions on property sales. The claim was for about $30,000, which Mr Shaor said was a similar amount to the sum he had earned before Saba was born. It was put to him that his tax returns did not substantiate this claim.

106. There were other indications that Mr Shaor had been working on a part-time basis. The indications include the contents of a letter of particulars from the plaintiffs' solicitors to the solicitor for the defendant, dated 13 September 2013, and a hospital note in which it is recorded that Mr Shaor said to a staff member that he could not attend the hospital because he was working. Mr Shaor agreed that he might have said this but said it would have been in relation to assisting the Sudanese Embassy and not in regard to any paid work. Mr Shaor said that he had not been paid for his work for the Sudanese Embassy.

107. Regarding the $130,000 that is owed to the mission, Mr Shaor said that, some years ago, he assisted the then Cultural Attaché, Dr Ali Albishir, with an internal accounting issue concerning a very large sum of money. When, in 2011, the plaintiffs wished to resign from their employment with the mission, the attaché persuaded Mr Shaor not to resign but to take unpaid leave instead. He agreed. When he returned in 2011, the attaché suggested an arrangement, to be secured against the equity in Mr Shaor's home, whereby he would receive payments equivalent to his wage. He then received a series of payments on a monthly basis said to be equivalent to the salary he had previously received, and also including salary increases.

108. I suggested to Mr Shaor that this arrangement might be viewed as "unusual". He responded that the attaché was a sympathetic man and that the arrangement was consistent with his cultural background.

109. The arrangement was said to have been confirmed in a letter. The letter is no longer available. A new cultural attaché took over in 2013. He stopped the arrangement and the payments ceased.

110. Mr Shaor was cross-examined about Saba's capacity to walk. He said that she could walk alone but needed to be supervised. The short video of events on 6 September 2017 suggested that Saba had a reasonable capacity to walk on her own, although the video is too short to draw any firm conclusions (Exhibit 7). The medical reports are united in setting out the degree of disability that she suffers.

111. Mr Shaor said that Saba had recently been shown to have a narrowing of her oesophagus, which amounted to "10 steps back". She was encouraged to eat but would quite often vomit if she took food orally. The same applied to her drinking water. He said that some foods were more suitable, like tomatoes, cucumbers, mashed potatoes and squashed "fries".

112. Mr Shaor did not think that the 24-hour PEG feeding system could be discarded. If it was not used for a period of time, feeding would need to be increased at other times.

113. Mr Shaor was asked about the information he had been given by the hospital about Saba's injuries antenatally. He was taken to a statement that he and his wife had prepared for a medical opinion from Dr Cole. The document suggests that he was told about the possibility of a blocked oesophagus on the day before the delivery. He denied this and said that the statement had been amended. I note firstly, that this proposition is consistent with Mr Shaor's version and, secondly, that the defendant's case is not assisted if the disclosure was only one day before delivery.

114. In addition, Mr Shaor said that an amended statement had been sent to his solicitors because the original statement contained errors. A number of calls were made for this amended statement but it was not produced. However, when Mr Shaor came to be re-examined, he said he had found the statement. The defendant, quite properly, objected to its tender. It was marked for identification so that the defendant's lawyers could read it and, if necessary, Mr Shaor could be further cross-examined on its contents. It later came into evidence as Exhibit J. Mr Shaor was later cross-examined about the document. He said it had not been prepared in cooperation with his wife. Her signature only appeared at the end because his solicitor had requested that she sign the document.

115. Mr Shaor was asked about the passage relating to the consultation with Dr Murphy. It was suggested to him that the questions asked of the doctor went beyond enquiries as to Saba's heart but extended to her condition and generally. He said that they were concerned only with the baby's heart. Having regard to Dr Murphy being a cardiologist and the parents having been sent to him in relation to a possible heart condition, I thought that his answer reflected a logical response. I accept his evidence in this regard.

116. Mr Shaor emphasised that termination had only been discussed with Dr Robertson on 25 November 2011 and on one other separate occasion. He also said that the discussion about polyhydramnios had been restricted to it being connected to Twin B's cardiac anomaly. The mechanics of how the fluid might have accumulated were never explained.

117. When asked about what he would have done had an abnormality been disclosed, Mr Shaor said that he and his wife would have chosen a termination no matter how late the gestation period. He would have travelled overseas if necessary. He would have sought medical advice on whether it was safe for Ms Nouri to travel but, had that advice been that it was not safe, he would have rejected that opinion unless the doctor could point to a real probability of a risk to his wife's health. He said that his wife's history of postpartum bleeding would not have affected the decision to travel.

118. Mr Shaor said that he had the funds to make the trip, which would have included remaining in the USA until the other twin was born and well enough to return. This may have involved staying in the USA for up to three months. Mr Shaor said that he would have applied for a visa to America through the "ESTA" online application facility. Mr Shaor said that, as he is an Australian citizen, the visa would have been promptly granted. If the family needed to remain for more than three months (being the extent of a visit allowed under the visa) he would have sought an extension on medical grounds. If a prolonged stay was necessary, the family could have sought support from relatives and friends who lived in Dallas.

119. Mr Shaor emphasised that a termination would have been chosen for "any abnormality, whether simple or not simple" (T 322.10 – T 322.11).

120. Mr Shaor said that the family's present intention was to move to Sydney and therefore be closer to anticipated medical intervention. He also hoped that Saba would be able to attend school in Sydney. Saba attended an early learning Centre at Canberra Grammar School in early 2017. The arrangement proved unpractical and ended after about five weeks. I understood there to have been two main problems: firstly, the school required that a parent be on the premises while Saba was in class; and secondly, difficulties arose with her feeding arrangements. It was necessary to cease feeding during class attendance and then compensate with extra feeding through the rest of the day or night. This led to vomiting.

121. Mr Shaor was asked about his dealings with the FMU. He agreed that, at the first consultation on 15 July 2011, he and his wife had seen Dr Tan and a technician called Debbie (Ms Debra Paoletti) or Tegan. He agreed that Dr Tan had recommended a further ultrasound take place but he said this was because of the baby's heart. It was not because the baby was very small. He said the size of the baby was not apparent until her birth.

122. Mr Shaor agreed that an amniocentesis test was suggested and performed immediately. He said Dr Tan had referred to the need for a cardiac scan and that he would arrange an appointment with a Sydney cardiologist. Mr Shaor was adamant that it was Dr Tan, not Dr Robertson at a later time, who undertook to arrange the appointment.

123. Mr Shaor agreed that Dr Tan had mentioned the possibility of a cardiac issue, but he did not mention a "hole in the heart". He said Dr Tan had referred to there being a single umbilical artery and this was the reason for the amniocentesis test. Dr Tan also mentioned that there may have been a chromosomal abnormality. He did not include Down Syndrome as an example.

124. Mr Shaor said that Dr Tan did not mention a short femur or a small abdominal circumference. I note here that the ultrasound reports in Exhibit 1 consistently suggest the presence of a short femur and a small abdominal circumference.

125. Mr Shaor was taken through all of the consultations at the FMU. Suffice to say that he disagreed with a lot of the suggestions put to him about the events during these consultations. The disagreement extended to the following:

    (e) Whether the consultation was with Dr Tan or Dr Robertson;

    (f) Whether a sonographer or a doctor had carried out the ultrasound;

    (g) Whether any saved 'shots' (as in Exhibit 10) were ever shown to the plaintiffs; and

    (h) What advice, if any, was given by the doctors to the plaintiffs.

126. Mr Shaor was adamant about the following in relation to the consultations:

    (a) Dr Robertson specifically spoke about termination at the consultation on 25 July 2011. She agreed with the plaintiffs' attitude to termination;

    (b) Dr Robertson was the only person spoken to about termination. This was because she was the person "in charge";

    (c) Dr Robertson would sometimes sing when conducting an ultrasound and discuss the song, or its writer, with the technician;

    (d) The plaintiffs were never made aware of a venous drainage problem. It was never suggested the right atrium was larger than the left atrium. A ductus venosus is a shunt that regulates the amount of blood that travels through the fetal heart;

    (e) The plaintiffs were never shown any of the 'shots' (Exhibit 10);

    (f) Dr Robertson always carried out the ultrasound when she was present;

    (g) There was no occasion prior to delivery when Dr Carlisle was consulted during a consultation;

    (h) The only explanation about the polyhydramnios was that it was caused by Twin B's heart condition. The plaintiffs were never told that continued monitoring was to discover the cause for the polyhydramnios;

    (i) The need for continual monitoring of the pregnancy was because twins were involved. It was not because of a risk of heart failure on Twin B's part;

    (j) The plaintiffs understood that Twin B's heart had a variable anomaly, but was structurally in good order. Had there been anything more serious a termination would have been chosen;

    (k) Ms Nouri did not request an early delivery.

127. A portion of the cross-examination concerned Mr Shaor's knowledge of the risk of lung damage when a baby was born prematurely. The defendant's case, however, was not that Saba's difficulties arose from a premature birth. This was also not part of the plaintiffs' case, which is that the likelihood of disabilities were evident during the pregnancy and that this should have been communicated to the plaintiffs.

128. Mr Shaor was cross-examined about why he did not consult Google about Twin B's condition, in the same way that he had researched his mother's condition. He said he did not think there was a need to do so. As far as the plaintiffs were concerned, Twin B

had been cleared by Dr Murphy, who they regarded as the senior specialist. After Dr Robertson said that she disagreed with Dr Murphy and was arranging another appointment, this did not lead to a change in the plaintiffs' position.

129. Mr Shaor was asked about his adherence to the Islamic faith. Chapter 5 verse 32 of the Koran was quoted to him. He was also taken to some interpretations of this passage to suggest that an observant Muslim would not have allowed a termination to take place late in the pregnancy. Mr Shaor said that he followed the Koran but not necessarily all interpretations of it. He was of the view that terminations were allowed, as evidenced by his wife having had two terminations.

130. Mr Shaor was also asked about his love for his wife and whether they would have flown to the USA if there was any threat to her wellbeing. He confirmed his love for his wife but emphasised that he would have only made the decision not to fly if he was factually convinced that the risk to her heath was real. His evidence on this point was a little different to that of his wife. She said that she would have made the journey even if advised not to and in the face of a real risk to her health and that of Twin A.

131. Had his wife chosen not to have a termination, Mr Shaor said that he would have respected her decision.

132. Mr Shaor pointed out that his wife's parents owned a private hospital in Sudan. He said that they could have travelled to Sudan for a termination. However, he also said that the standard of medical treatment in Sudan was not of an acceptable standard. This was why his father was currently receiving medical treatment in Egypt.

133. Ms Lita Giersch gave evidence. She is a retired real estate agent who had come to know Mr Shaor over a number of years. I gathered that her agency was located near a coffee shop frequented by men, including diplomats, who visited a nearby mosque.

134. Ms Giersch said that, after the twins were born, Mr Shaor was in financial trouble to the extent that he could have lost his home. After being shown a corroborating letter from a bank, she began to provide him with a series of cheques to assist him. In addition, in about 2012, she loaned him a Mazda 6 motor vehicle. This is the vehicle that can be seen in Exhibit 6.

135. Ms Giersch estimated that, including the value of the Mazda, she had loaned Mr Shaor about $200,000. She had also paid insurances on the vehicle and its registration until she retired.

136. The relevance of this evidence was not to form the basis for the loaned money being part of the damages claimed, but rather to explain the plaintiffs' financial state, including entries in the bank statements. Mr Shaor's financial position was the subject of detailed scrutiny through his cross-examination.

137. Ms Nouri then gave evidence. Although an interpreter was present, almost all of her evidence was in English. As a general statement, her evidence was consistent with that of her husband, although there are two important points on which it differed. I will return to these below.

138. Ms Nouri was born in Sudan in 1978. Her father was in the military and the family moved around as he was posted to different locations. Ms Nouri completed high school and commenced university studies focused on histopathology in 1997. The degree was full-time and took five years.

139. Ms Nouri was diagnosed with depression and took appropriate medication until she felt better, towards the end of 2000. In 2004, she married Mr Shaor. They came to Australia at the beginning of 2005. She found a job with the Saudi Arabian Cultural Mission as an adviser for scholarship students. She was paid about $5,000 per month.

140. Ms Nouri recounted that she had a cousin who was disabled due to fluid in the brain. Her cousin required 24-hour care and died when she was 14 or 15 years of age. She was also aware of a child of her sister-in-law who needed considerable care. She had seen the effects the disabled children had on their respective families.

141. Ms Nouri has a thyroid condition which can result in irregular menstrual periods. She first fell pregnant in 2006. She gave birth to a son in December of that year. Towards the end of the pregnancy, and after the pregnancy, she suffered significant lower back pain. As a result, she terminated a pregnancy in 2008, at about 8 weeks' gestation.

142. Ms Nouri fell pregnant again in 2009 and, in order to manage her back pain, saw a Dr Tam at the Calvary Private Hospital. Her daughter was born in March 2010.

143. After the birth of each of the two children, Ms Nouri returned to work. She was entitled to, and took, two months of maternity leave.

144. The family went to Germany with Ms Nouri's mother-in-law in 2011. The intent was to then travel to Sudan to reside there. In May 2011, Ms Nouri thought that she was pregnant. A decision was made to return to Australia for the birth of, as then expected, a baby. The clear intent of the family was that, if the baby was likely to be disabled, Ms Nouri would undergo a termination of the pregnancy.

145. After returning to Australia, the plaintiffs' general practitioner was consulted. He referred Ms Nouri to NCDI for an ultrasound scan. This took place on 8 July 2011. Dr Lomas, at NCDI, said there was poor visualisation of Twin B's heart and there was a single umbilical artery. He referred her to the FMU "urgently".

146. The FMU did not contact Ms Nouri as expected, so her husband chased up the matter through Dr Latif. She saw Dr Tan on 15 July 2011. Dr Tan asked the plaintiffs what they had already been told by Dr Lomas. Ms Nouri described the poor visualisation and the single umbilical artery. Dr Tan recommended a chromosome test. He said the test could be done that day and posed a risk of 1% above normal of a miscarriage occurring. The test was carried out.

147. On 25 July 2011, Ms Nouri was introduced to Dr Robertson by Dr Tan. Dr Robertson said that the first result from the amniocentesis test was negative and she expected a follow-up test to have the same result. Dr Robertson was told about Ms Nouri's experience with histopathology.

148. Dr Robertson said that she would arrange an appointment with a paediatric cardiologist in Sydney. The question of an abortion was discussed and Dr Robertson agreed with Ms Nouri and her husband that a termination was an appropriate option if Twin B was "not normal". Dr Robertson made the observation that it was better to lose one twin than both.

149. Dr Murphy was seen in Sydney on 2 August 2011. He checked both twins because he said that Canberra Hospital often made mistakes in identifying which twin might need examination. Dr Murphy said that Twin B had a normal heart although the 'connections'

were slightly different. He said that the artery or vein started where it should and ended where it should.

150. When asked about the wellbeing of the twin generally, Dr Murphy replied that he was only looking at Twin B's heart and that any other matter should be discussed with the FMU.

151. Fortnightly ultrasound appointments then continued. This frequency was due to there being twins. Ms Nouri said that at no stage was she told about a difference in size in the twins, that one had a smaller abdominal circumference or a short femur. She was not told that the continuing appointments were necessary because of Twin B's heart condition.

152. She said that, generally, the sonographer did the ultrasound although Dr Robertson did it once. After each ultrasound, the only information that was provided was that there was "no change". Ms Nouri noticed that Dr Robertson would discuss songs and general topics with the sonographer.

153. Towards the end of August 2011, Ms Nouri felt short of breath and experienced pain in her right side. She reported this to Dr Robertson on 5 September 2011. After an ultrasound, Dr Robertson told her that there was excess fluid in the placenta due to Twin B's heart condition. She said she was "shocked" at this news. In addition, she said that Dr Robertson told her that she was not content with Dr Murphy's opinion and was planning to send Ms Nouri to a different cardiologist at Westmead Hospital. Her husband informed Dr Robertson that private insurance was available, in an attempt to speed up the process.

154. Under cross-examination, Ms Nouri said that Dr Lomas had told her that Twin B's heart was slightly larger than normal. He had referred to there being "something wrong" with the heart. It was for this reason that she had been referred to the FMU.

155. Ms Nouri described, in general terms, the same daily routine as that described by her husband. She was asked a number of questions about Exhibit 7, which is the video taken on her husband's birthday earlier this year. She said that the home she visited was the home of a good friend of her husband. This is one of the significant differences I refer to above. Her husband had said that the friend was a close friend of his wife. She later said that her husband had not been to the house before because the other family had recently moved. I should say that this evidence disturbed me in that it seemed to be plainly addressing an inconsistency that she was aware of.

156. Ms Nouri denied that, prior to the birth of the twins, she had never been told that Saba's oesophagus was blocked or narrow. She was told this after the birth.

157. She also denied that Dr Tan, on 15 July 2011, had mentioned the possibility of an AVSD or of a "hole in the heart". It was at this stage of her evidence that Ms Nouri became tearful and stated: "if he said he told us that, he's lying" (T 456.14). He had never said that any cardiac issue might be related to a chromosomal abnormality. Any such abnormality was related to the single umbilical artery. She agreed that Dr Tan said that the heart could not be seen very well at that stage of the pregnancy. He definitely did not mention a short femur or small abdominal circumference.

158. Ms Nouri described the meeting with Dr Robertson on 25 July 2011. It started off with a discussion of the results of the amniocentesis test. As far as the heart was concerned, Dr Robertson said that she would arrange an appointment with a cardiologist in

Sydney. This was when the discussion about an abortion occurred and Dr Robertson said that further discussion would take place after the cardiologist's appointment.

159. Like her husband, Ms Nouri denied ever being shown still images from the ultrasound, either on 25 July 2011 or at any other appointment when ultrasounds were conducted. She agreed that Ms Paoletti was present and said Dr Robertson would sometimes take over the conduct of the ultrasound. She was adamant that Dr Robertson generally chatted with Ms Paoletti during the ultrasounds.

160. Ms Nouri was asked if she trusted Dr Robertson. She said that she did. She was then challenged as to why this trust existed if Dr Robertson was not giving her proper explanations. She said that, as far as she and her husband were concerned, the only matter that was a concern was Twin B's heart, and they had been reassured by Dr Murphy, and also by Dr Robertson, that there was no abnormality besides an insignificant variation. She said that she had not sought explanations of the medical terms being used by the doctors because she and her husband would not have understood them. They preferred to ask questions in "simple terms".

161. During the cross-examination, Ms Nouri became very upset on occasions. She said that Dr Robertson "played that game with my life and my kid's life". She said that she was angry "with the whole system". At one point, I adjourned to enable Ms Nouri to recover from the distress she was obviously feeling. I have no doubt that her distress was genuine.

162. The details of the conversations alleged by the defendant as having occurred with the doctors were put to Ms Nouri. She agreed with some suggestions and not others. In summary, she adhered to her evidence in chief and denied that any detail had ever been given to her or her husband. There had certainly been no explanation of any condition other than that relating to Twin B's heart. The discussion of the fetus' heart was limited. She and her husband were under the impression that the heart condition was an anomaly; it was not an abnormality likely to result in a disabled child.

163. The concentration on matters concerning the heart gives some validity to the plaintiffs' claim, in the sense that their complaint is not that the possibility of a heart condition was not disclosed, rather that all of the other potential risks, like TOF, were not mentioned. Ms Nouri denied that there had ever been mention of a small stomach. She denied she had ever been shown a still picture of an apparently small abdomen and she was certain that no one had told her that a small abdomen might relate to a condition called TOF.

164. Ms Nouri was cross-examined about her attitude to flying to America, notwithstanding that there might have been a risk to her life. She said that, even with such a risk, she would have made the trip. She had been influenced by the experiences in her and her husband's family. Her answers in cross-examination were consistent with those she gave in chief (T 418.36 – T 418.39).

165. Ms Nouri was shown a video of her visiting a supermarket with Saba and, later, visiting a family friend on 6 September 2017 (Exhibit 7). She confirmed that the manner in which Saba is seen is to be walking in the video is the way she normally walks.

166. In relation to the doing up of Saba's seatbelt, Ms Nouri said that if it was cold or Saba was wet due to urine leakage, she would generally place her in the vehicle, close the door and then do the seatbelt from the inside. Although the questioning was sustained

on this point, I do not see it as being a significant issue. I would not accept that she drove off without doing up her daughter's seatbelt.

167. The suggestion that Ms Nouri did not have time to do up Saba's seatbelt was dispelled by close examination of the footage. Although the seatbelt is not done up before the passenger door is closed, there is nothing to suggest that it could not have been done up from inside the vehicle. The vehicle does not depart so soon as to prevent this conclusion.

168. Ms Nouri said she was a practising Muslim. She described herself as following a "liberal" interpretation of the Islamic faith. She said that she adhered to the Turkish approach, according to which terminations of pregnancy were available until 25 weeks' gestation and thereafter if justified.

169. Ms Nouri was asked about the completion of a form in preparation for admission to Calvary Hospital for the birth of her daughter in 2010. The question about depression has been answered in the negative. She said this was because she was not depressed at the time. She said that the answer in respect of smoking was incorrect. When asked what it was that she smoked she refused to answer, stating that there were cultural reasons for her refusal. The cultural reasons were not explained. On one level, it might be said that her refusal to answer was relevant to her credit. On the other hand, I note that she was at the end of a very long cross-examination, during which she had often become upset or visibly distressed. It may be that this was simply 'one question too many'. I think the latter is the case.

170. As will be seen below, I have significant concerns about some of the evidence given by Mr Shaor, especially relating to economic loss and financial matters. Nevertheless, I thought his evidence about the interactions with the FMU was generally sound. I did not have similar reservations in respect of Ms Nouri's evidence. There is obviously a very large financial incentive in their evidence being tailored to achieve a successful result. However, I did not form the impression that this influenced their evidence. They impressed me as parents who had been overwhelmed by the tragedy both as it affected their daughter and the rest of the family.

171. I do accept that some of the parents' evidence may have assumed a subconsciously exaggerated flavour. For example, while Dr Robertson may have on occasion hummed a tune while working, I do not accept that she was constantly singing or discussing social matters with other staff. I also do not accept that Dr Robertson never showed and explained ultrasound images to the plaintiffs. These exaggerations have no doubt been influenced by the tragedy that has befallen this family and the need to attribute blame, in particular to Dr Robertson.

172. As a general observation, I accept the oral evidence of the parents concerning the information supplied by the defendant. For present purposes the most important aspect of this acceptance relates to whether or not the parents were told, before Saba was born, that she might have a TOF.

173. It was submitted by the defendant that this conclusion was contradicted by the plaintiffs in their statement (Exhibit 40) where, on page 3, it is stated:

> Then we got a phone call for the delivery to take place on the 3/11/2011 and we were being asked to come for the final U/S on the 02/11/2011. Before the U/S we saw Dr Ken and he told us it is going to be caesarean and he is going to do it himself, then we went to the other room for the U/S and after the final U/S they told us that baby no2 has got a very

small abdomen. He said this could be due to two reasons one of them could be the oesophagus is blocked somewhere or too narrow.

174. The defendant's reliance on this passage to show the plaintiffs were told about the TOF before the birth is misplaced, for these reasons:

    (a) The conversation occurred the day before delivery, giving the parents no opportunity to act upon it;

    (b) It is contradicted later in the statement, on page 4, where it is explicitly stated that the surgeon gave a detailed description of a TOF and this was the first time the condition had been mentioned.

175. My reasons for rejecting Dr Robertson's evidence on the key issue of the provision of information about a TOF are set out below.

176. Following the evidence given by Ms Nouri, the defendant called the members of the FMU to give oral evidence. The first witness was Ms Paoletti. As her Curriculum Vitae (CV) (Exhibit 13) demonstrates, she is a well-qualified sonographer.

177. She said that, on average, she would see about 10 new patients and five existing patients a day. She has therefore seen some thousands of patients since 2011.

178. Ms Paoletti said that she was nervous in the witness box. This was evident in the manner she gave her testimony. Nevertheless, I think she did her best to be honest, although at times I felt she was concerned not to give answers that might adversely affect the credibility of her FMU colleagues.

179. Ms Paoletti, not surprisingly, had little memory of Ms Nouri. However, she could clearly recall two matters. They both related to the first time she met Ms Nouri, which was on 25 July 2011. She said that she had been briefed to conduct the ultrasound with a view to identifying whether Twin 2 had an AVSD (hole in the heart). On examination, she noticed that the umbilical vein drained directly into the right atrium. This was the first time she had seen this abnormality. That was the reason she remembered it.

180. The second specific memory concerned a conversation she said occurred between Dr Robertson and Ms Nouri. Dr Robertson was explaining an image of the umbilical vein. Dr Robertson asked Mr Nouri if she understood the explanation. She replied that she did understand because she had been a pathologist "in her own country". Ms Paoletti was surprised and immediately felt ashamed because she had made an adverse assumption about Ms Nouri's level of education.

181. Ms Paoletti said that she was sure that Dr Robertson had shown Ms Nouri image 145 in Exhibit 10. Under cross-examination, I think it became apparent that she had chosen this picture because it was the only one that 'fitted the bill' of depicting the heart and being coloured.

182. Ms Paoletti said that, after the ultrasound had been conducted, Dr Robertson spoke to Ms Nouri in a consulting room. She accepted that she could not recall all of the conversation between the doctor and the patient.

183. The consultation on 25 July 2011 was the only consultation of which Ms Paoletti had a specific memory. She was taken to other ultrasound reports in Exhibit 1 indicating her presence but she had no specific memory of these occasions. She said the reports, such as at page 81 of Exhibit 1, were computer-generated. The diagnosis was entered either during the consultation or very soon afterwards.

184. Ms Paoletti said that the charts on the form indicated the bounds of 'normality' from the 5th to the 95th percentile. She agreed that results outside the bounds of normality would be brought to the attention of the doctor. My observation of these forms is that they concern the investigation of Twin B's heart and make little comment (although not none at all) on other abnormalities, such as abdominal circumference and femur length. Ms Paoletti agreed a small abdominal circumference was a "red marker" to be noted and monitored. It was important to look for changes or a lack of changes, as appropriate.

185. Ms Paoletti agreed that, where there were twins, there was a natural comparison between the twins. She also agreed that, in this circumstance, discordant results could be indicative of an abnormality in one twin.

186. Ms Paoletti said that during a consultation there would not normally be much discussion with the patient. There might be some minor chatting between the technician and the doctor but this would not take very long.

187. Dr Robertson was the next witness. Her CV is Exhibit 14. She conducted her initial training in South Africa. She worked for some time in a high risk ultrasound practice in Cape Town (Tygerberg Hospital). She was familiar with requests for terminations. She said the situation in South Africa was similar to that in Australia, namely that a termination beyond 20 weeks' gestation would need to be put before an Ethics Committee. She said that she would act as the patient's advocate and it was necessary to produce evidence to justify the termination.

188. In 2003, Dr Robertson began working in the FMU at Canberra Hospital. She became the Director in 2007. In the course of her work, she developed relationships with two Sydney hospitals: the Royal Women's Hospital and the Royal Prince Alfred Hospital. Her main contacts at these hospitals were Dr Antonia Shand and Dr Jon Hyett respectively.

189. Dr Robertson explained that mothers came to the FMU for one of two reasons: either there was a potential problem with the fetus or there was a maternal concern.

190. Dr Robertson did not recall being introduced to the parents on 25 July 2011 but did recall the ultrasound examination. She also recalled reading Dr Tan's notes and the results of the Fluorescent In Situ Hybridisation (FISH) test prior to the examination. She was not sure if she had read the NCDI report. She said that her intention on the day was to clarify the condition of the fetal heart.

191. Dr Robertson thought she came into the consultation room about halfway through Ms Nouri's examination. She asked the sonographer, Ms Paoletti, to demonstrate the configuration of the blood vessels and the stomach within the fetus' abdomen. She took over the scanning and collected some images. Dr Robertson said that she always started with images of the abdomen because it gave appropriate clues for the condition of the heart.

192. Dr Robertson said that she formed a different view to that of Dr Tan. She did not think there was a hole in the heart. She referred to pages 129, 135 and 141 of Exhibit 10 to explain her view. Exhibits 15, 16, 17, 18, 19 and 20 show markings made by Dr Robertson during her evidence.

193. Dr Robertson said that she spoke to the parents and informed them of the unusual path of the umbilical vein; namely, that it bypassed the ductus venosus and drained directly into the right atrium of the heart. She told them that, because the umbilical vein was not

being regulated by the ductus venosus, this meant that there was increased blood flow into the heart. She told the parents that this was not an abnormality, as such, and would not require surgical correction. Dr Robertson said that she informed the parents that the ductus venosus ceases to function after birth.

194. A ductus venosus is a shunt that regulates blood flow into the heart. If it is bypassed by the umbilical vein there is no control over this blood flow, which can result, as in Twin B, in a larger right atrium.

195. Dr Robertson also recalled telling the parents that the main risk was that the fetus can go into heart failure. This required continuing management.

196. Dr Robertson said that she had seen this condition once before, in a patient she saw at the FMU in 2005. This particular fetus was not a twin. The pregnancy required increased surveillance and the baby was delivered at 37 weeks because of the development of polyhydramnios.

197. Dr Robertson said that she told the parents that an appointment would be made for them to consult a specialist in Sydney. This was done through Dr Shand at the Royal Women's Hospital. An appointment was later made with Dr Murphy.

198. Dr Robertson said that, at the end of her explanation, she asked Ms Nouri if she understood what she had been told. Ms Nouri replied: yes, she understands, she was a pathologist where she came from (T 622.39 – 622.40). This is corroborated by the referral letter that appears at page 91 of Exhibit 1.

199. Although Dr Robertson could not remember having this conversation with the parents, she said that it was her normal practice to say words to this effect:

> It is important that I also remind you that the ultrasound is not definitive. Ultrasound alone cannot detect all problems in a baby, and sometimes things become clearer as time goes on. And sometimes certain problems can only be diagnosed once the baby is born. (T 627.13 – T 627.17)

200. Dr Robertson was adamant that the parents had not mentioned the subject of late termination at the consultation on 25 July 2011.

201. She then gave some general evidence about terminations. She said that they were carried out at the FMU. They were conducted by Professor Ellwood. Dr Robertson noted that an important distinction was made if the pregnancy was a twin or a "singleton". In the former case, an important consideration was the welfare of the healthy twin. Statistically, in the second trimester, there is a 20% chance of complications. This includes a 14% chance of a spontaneous birth at a very premature stage.

202. Dr Robertson said that any late termination – that is, a termination after 20 weeks' gestation – required the approval of an Ethics Committee. It was necessary to prepare a case to be put to the Committee, which involved the parents consulting persons such as social workers. Dr Robertson said that, if she was asked about a termination, she would set out the important considerations. These included the procedure itself, the requirements of the procedure and the possible complications involved in the procedure.

203. Dr Robertson said that, in the case of twins, it was preferable to do the procedure during the third trimester (weeks 29 to 40). This was to increase the chances of survival of the healthy twin. Timing would, however, take into account the wishes of the parents.

204. Dr Robertson said that the chances of a successful application for a termination were greater earlier in the pregnancy. I asked her whether this was inconsistent with her earlier evidence that, in a twin pregnancy, the termination was better carried out in the third trimester. She said that she understood the point but did not concede the inconsistency.

205. A termination in respect of a twin pregnancy is carried out by the insertion of a needle through the mother's abdomen into the fetal heart. With a singleton, the procedure was done by way of a forced induction. If a pregnancy was late term, an injection would also be given. Dr Robertson referred to the injection method as feticide.

206. An inconsistency arose between the evidence of Dr Robertson and Ms Paoletti. Dr Robertson said that she observed and identified the unusual path of the umbilical vein. Ms Paoletti said that she had made the discovery (T 566.5 – T 566.11). Ms Paoletti said that this was one of the reasons that she remembered the consultation.

207. Whether it was Dr Robertson or Ms Paoletti who identified the condition is not relevant. The importance of this point is that it indicates the possible unreliability of the memories of the two respective witnesses. Both witnesses were giving evidence of events that occurred at least six years ago, about an examination that was one amongst the thousands that have occurred since. The paucity and unreliability of the FMU's notes do not assist them.

208. There is an even more important point that arises from the diagnosis made by Dr Robertson when looking at the ultrasound images on 25 July 2011. As already noted, she said the condition was very rare and it was only the second time she had seen it. It prompted her to refer the matter to Dr Shand and Dr Murphy in Sydney.

209. Dr Murphy's report is in Exhibit 1 at pages 133 and 134. It was fundamental to Dr Robertson's diagnosis that the right atrium of Twin B's heart was larger than the left. This is different to the finding made by Dr Murphy. He does not even mention the unusual path of the umbilical vein identified by Dr Robertson. I asked Dr Robertson if she agreed with Dr Murphy and she said she did not. I also asked her if it concerned her that Dr Murphy had not picked up this very rare presentation. She said it did not because he was the specialist. Nevertheless, she continued to believe that her position was correct.

210. It is to be recalled that both plaintiffs alleged that Dr Robertson told them on 5 September 2011 that she had not agreed with Dr Murphy and that was why she was sending them to another cardiac specialist at Westmead. It was put to the plaintiffs that Dr Robertson had never stated that she disagreed with Dr Murphy. It is apparent, however, that Dr Robertson did disagree with Dr Murphy, making the plaintiffs' account of the conversation more credible.

211. I also found evidence that Dr Robertson did not think it unusual that there was a disagreement to be quite unbelievable. She had identified a very rare condition. As a result, she referred the matter to Dr Murphy (via Dr Shand). It is very odd indeed that Dr Murphy, who not only came up with a different diagnosis but also seemed to have not identified the rare condition at all, would not have been contacted by Dr Robertson to discuss the matter. It is entirely consistent, however, that Dr Robertson might have wanted there to be another opinion.

212. It is also significant that, when Professor Ellwood gave evidence, he identified the inconsistency between Dr Murphy's views and those that had been adopted by the FMU. He agreed with the proposition, if only in hindsight, that Dr Murphy had "got it wrong". While in the witness box, Professor Ellwood looked at the images in Exhibit 10 and noted that they depicted an enlarged right atrium both before the referral to Dr Murphy and consistently afterwards.

213. Professor Ellwood was of the view that, if the report found in Exhibit 1 at page 89 had been sent to Dr Murphy, he would have expected Dr Murphy to have recorded his disagreement with the report.

214. Notwithstanding her evidence that she thought Dr Murphy was wrong, Dr Robertson later stated that she had not assumed that Dr Murphy had identified the same abnormality as she had. I think that reference should be made to the following sets of questions and answers:

> HIS HONOUR: Yes. All right. And does this letter from Dr Murphy agree with what you told us this morning about the way the umbilical vein went basically in an unusual path?
>
> DR ROBERTSON: No. He did not agree with that aspect. And that's why I've said the point of difference is it's the basis of disproportion. [T 644.36 – T 644.39]
>
> …
>
> MR HIGGS SC: At the time, do you remember – at the time you got the report back from Dr Murphy, was there anything in there, in your view, that was inconsistent with your diagnosis of the abnormal venous connection between the umbilical vein going into the right atrium?
>
> DR ROBERTSON: Rightly or wrongly, I assumed the absence of comments about my findings – assumed that Dr Murphy agreed with me. [T 680.14 – T 680.18]

215. It is also important to note that, in her evidence-in-chief, Dr Robertson said that she had no relevant contacts at Westmead Hospital (T 596.15 – T 596.16). However, she later said that, if there had been a need for cardiac surgery, she would have referred the matter to Westmead Hospital. In addition, it was pointed out to her in cross-examination that the letter from Dr Murphy was copied to Dr Cooper, who is the cardiac surgeon at Westmead Hospital. When confronted with this evidence, Dr Robertson had no explanation for Dr Cooper being included other than that Dr Murphy, who shared a practice with Dr Cooper, might have thought that Dr Cooper might one day need to see Ms Nouri. I found this explanation quite unconvincing.

216. Returning to the chronology, the next appointment Dr Robertson had with the parents was on 8 August 2011. The record is in Exhibit 1 at page 93. Dr Robertson recalled telling the parents about Dr Murphy's findings and informing them that the second chromosome test was normal.

217. I note that Dr Robertson agreed that, upon receipt of Dr Murphy's report, there were three opinions about Twin B's heart condition: there was her opinion, stemming from the abnormal path taken by the umbilical vein, missing the ductus venosus and producing an enlarged right atrium; there was Dr Tan's opinion, of a hole in the heart; and there was Dr Murphy's opinion, that the heart was normal (with both atriums being the same size) but that the 'connections' followed an abnormal route.

218. There was no evidence to suggest that Dr Robertson ever explained this disagreement to the parents. As far as the notes were concerned, Dr Robertson agreed that it was important to inform parents of significant matters concerning the pregnancy. It was also

important to record that discussion. She agreed that there was no record in the FMU notes of such discussions.

219. This in contrast with the note prepared by Dr Tan on 5 September 2011 (Exhibit 1, page 100), which specifically records a discussion with the parents. The note reads:

> Einas complains of SOB progressively getting worse the last 2 weeks. There is sign of polyhydramnios and the deepest pool measuring 13cm. I will see her again next week to repeat the measurement of the deepest pool for twin 1 and possible aim for amnioreduction on Wednesday next week after steroid covered. I have explained the possibility of preterm delivery with Amnioreduction. She is happy to come back next week for further discussion.

220. Dr Robertson said that the main reason for the matter having been referred to Dr Murphy was to see if the pregnancy could be managed in Canberra or if it needed to be done in Sydney. This was because the facilities in Sydney allowed for cardiac surgery after birth. She said that she told the parents that there was a need for continuing surveillance of the pregnancy and that Ms Nouri could not yet be discharged from the care of the FMU.

221. Dr Robertson agreed that she may not have seen the parents on 22 August 2011 and she had no recollection of seeing them on 5, 12 or 15 September 2011.

222. The doctor was referred to the notes of a High Risk Meeting on 6 September 2011 (Exhibit 1, page 147). She initially said she could not remember if she attended but said that she was probably there. She later said that she was definitely there. She said that a number of persons from the unit and other areas of the hospital would have been present. A geneticist from Sydney attended once a month. At the meeting, the background to the case was discussed, in particular having regard to the increase in amniotic fluid. The possibility of a TOF was raised.

223. There is no evidence that Dr Robertson ever discussed the meeting with the parents.

224. On 22 September 2011, there was another ultrasound-based examination. Dr Robertson said that her intention in conducting the examination was to test her thoughts on the reasons for the increase in amniotic fluid and to establish whether or not there was a TOF. She said that she took the parents through a number of saved images to demonstrate the issue. She referred to images 321 and 322 in Exhibit 10. Dr Robertson pointed out the abdominal circumference of Twin 2 as being small. The image at page 321 is a cross-section taken through the abdomen and liver. Page 322 is a cross-section taken through the chest.

225. Dr Robertson said that, by the end of the consultation, she thought there were two possible reasons for the increase in amniotic fluid. The first was that, consistent with her opinion as to the cause of the cardiac abnormality, the enlarged right atrium and generally bigger heart was exerting pressure on the oesophagus, thereby restricting the passage to the abdomen. The second was that there was a TOF, involving either an abnormal or blocked connection between the food pipe and the stomach.

226. Dr Robertson said she favoured the first of the above possibilities. She said she explained this possibility to the parents in detailed terms. This is an example she gave of the detail she was apparently able to recall:

> In this image, you can again see I have compared the two babies side by side and if I can point out the screen for you, can you seen that twin 2 has got again as we have seen in the past quite a big right atrium and overall the heart looks bigger than it should be. Given these two findings, namely the smaller stomach and this quite large heart, I am wondering

about two possible causes of an increase in fluid in your baby. One would be that this heart exerts pressure on the food pipe and therefore fluid cannot pass through as it should be but the other cause is when there is a defect. It is called a tracheoesophageal fistula. It's sometimes referred to as a TOF where there's an abnormal connection between the air pipe and the food pipe. That abnormal connection can either be completely absent or it can be narrow and therefore fluid cannot pass through in the usual way to the baby's stomach (T 663.12 – 663.23).

227. I found this evidence difficult to accept, for the following reasons:

(a) It seems unlikely that she could have recalled the detail that she related, notwithstanding the passage of time and her lack of memory of many other elements in her dealings with the parents. Dr Robertson said that she saw about 20 patients a day. Ms Paoletti referred to seeing approximately 15 patients a day. Whichever is correct, many thousands of patients had been seen over the six years since Dr Robertson spoke to the plaintiffs.

(b) At T 663.35 – T 663.36, Dr Robertson states that she cannot recall "the specific response" of the parents to the explanation. I find this surprising having regard to the precision and detail of her recollection of what she said. The parents are educated people who quite clearly had an interest in the pregnancy. I have no doubt that faced with an explanation of the type asserted by Dr Robertson the parents would have had a number of questions for the doctor.

(c) There are two versions of the FMU notes for 22 September 2011 (Exhibit 1, pages 111 and 113). Putting aside the unsatisfactory explanation behind there being two versions, neither corroborates the doctor's evidence. In fact, there is nothing in the notes that suggests there was even a discussion with the parents. As will be seen below, there are issues with the accuracy of the notes generally.

228. It is also worth noting that, if Dr Robertson's evidence is accepted, although the 'in house' discussion raising the possibility of a TOF occurred on 6 September 2011, it was not until 22 September 2011 that it was discussed with the parents. When Professor Ellwood gave evidence, he said it was appropriate for the parents to have been told about the possibility of a TOF.

229. In summary on this vital point, I do not accept Dr Robertson's evidence that she told the plaintiffs about a possible TOF on 22 September 2011, or in fact at any other time prior to the birth of Saba.

230. There is another very important element that arises from Dr Robertson's preferred theory about the encroachment of the enlarged right atrium on the oesophagus. When Dr Murphy gave oral evidence he plainly said this had not occurred with Saba. I think it worth quoting from his evidence:

MR CRANITCH SC: Yes. Now, as I understand your evidence, although not contained necessarily within your report, you opined that the right atrium invariably enlarges in foetuses because it's taking all the blood rather than pumping blood through the lungs. Is that correct?

DR MURPHY: Yes.

MR CRANITCH SC: So it's a normal development of any ---?

DR MURPHY: Well, we normally see it a little later in gestations. They would normally be beyond 23 weeks that it becomes more prominent.

MR CRANITCH SC: Of course?

DR MURPHY: It would be more like 26 to 28 weeks' gestation onwards that that would become more prominent ---

MR CRANITCH SC: Thank you?

DR MURPHY: --- and easier to detect.

MR CRANITCH SC: All right, but even though it may become more prominent, the fact of the matter is it happens with every baby, doesn't it?

DR MURPHY: It would in advanced gestation; correct.

MR CRANITCH SC: Thank you. It is most unlikely, is it not, that normal variations cause problems with adjacent structures, such as the oesophagus, because it's just something that happens routinely?

DR MURPHY: No. I don't understand what your question is.

MR CRANITCH SC: It's unlikely that that would interfere with the operation of the oesophagus or compress it or something like that?

DR MURPHY: No. It's normal.

MR CRANITCH SC: It's just a normal development?

DR MURPHY: Correct.

MR CRANITCH SC: And, indeed, it would be very rare, if at all, that an enlarged right atrium would compress an oesophagus. Is that not right?

DR MURPHY: It depends on the actual heart. There are certain other cardiac anomalies where the lung arteries, the pulmonary arteries can be compressed, that other structures could theoretically be compressed, but you would have to have an absolutely enormous right atrium such as an extremely severe Ebstein's anomaly where you get what's called a wall-to-wall heart; in other words, the heart can fill almost the entire chest cavity, it's so stretched, but that would be extremely rare. (T 999.44 – T 1000.34)

231. Lest there be any doubt about the strength of the Dr Murphy's view, he said this in re-examination:

MR HIGGS SC: You said that generally later on in pregnancy you would not expect the large right atrium to press on the oesophagus generally. What are, if any, the circumstances where that can occur, in your opinion?

DR MURPHY: Well in this baby the right atrium was a normal size. In a normal baby the right atrium and right ventricle can be a little bit larger, just a little bit larger than the left as the pregnancy progresses, typically beyond 26 to 28 weeks' gestation, however, it is extremely unlikely or extremely rare that I would ever expect that to cause any problems whatsoever with an oesophagus. There are certain rare heart conditions where, for example, the blood vessels coming from the heart don't follow their general paths and so, for example, either the lung arteries, instead of splitting or what we call bifurcating, one to each lung, with the food pip and the windpipe between the bifurcation, sometimes one of the branches of the lung artery could wrap around the food pipe or the windpipe and cause problems with swallowing or breathing. Similarly, the aorta in a foetus, before eight weeks' gestation when the heart is just forming, in the first eight to nine weeks with the pregnancy you actually start with two aortas; a left aortic arch and a right aortic arch. The right aortic arch in most people dissolves and geos away and we're left with a left-side aortic arch. It's extremely rare but, sometimes, for example, a baby could be born and have both aortic arches which effective wrap around the windpipe and the food pipe. Now, these are very rare heart conditions and this baby had neither of those. (T 1002.21 – T 1002.41)

232. Another interesting point in Dr Murphy's evidence arises from his handwritten note on his copy of the ultrasound report of 15 July 2011 (Exhibit 36). He said this:

> MR HIGGS SC: And by reference to usual practice and with the benefit of that note, that is a discussion that you had with Dr Robertson regarding your agreement with her view in that regard; is that right?
>
> DR MURPHY: Well, yes. I mean there's the note there that says that she's reviewed the study and that she agreed that it was not an AVSD or a TGA and told me that it was a junior sonographer who had looked at that. I don't know who actually typed that original report. (T 993.19 – T 993.24)

233. The "junior sonographer" was Ms Tegan Sullivan. She did not give evidence and there is no other evidence about her seniority. However, there is an air about the discussion between the doctors that suggests Dr Robertson may have been attributing the wrong diagnosis to the sonographer as a response to Dr Murphy's rejection of the finding, a finding incidentally also supported by Dr Tan.

234. Dr Robertson gave an explanation of the record-keeping process. She said that after a Fetal Wellbeing Report was generated by a computer program (Viewpoint 5), additions could be made, such as the comments at the bottom of the page, following which the report would be printed and placed in the patient's file. This file would be sent to the records department when the pregnancy was completed. The documents as printed could be obtained from the records department but, if sought from Viewpoint 5, would be produced in the program's latest format. This might include, as is the case here, a different heading.

235. In relation to the anomalies between the reports at pages 111 and 113 of Exhibit 1, Dr Robertson said that the report had probably been changed after she had completed the consultation and given the matter further thought. Professor Ellwood's evidence on these documents was a little different. He thought that, chronologically, page 113 would have been prepared before page 111. Nevertheless, he had no explanation for the differences in the diagnosis between the two pages and he experienced difficulty in explaining the structural differences to the pages, particularly the inclusion of the barcode.

236. Dr Robertson was taken to task about this evidence under cross-examination. It was put to her that the note which included the possibility of a TOF had been made in October 2011, when it was forwarded to Dr Shand in Sydney. She rejected this suggestion. While I cannot say when the amendment was made, the following points seem to cast some doubt on the doctor's evidence:

    (a) The notes refer to a conversation between Dr Robertson and Dr Carlisle. Dr Robertson, in her oral evidence, said Dr Carlisle spoke to the parents. This is in contrast with Interrogatory 18.

    (b) If the first version (Exhibit 1, page 111) was a draft, then why is it signed?

237. In cross-examination, it was put to Dr Robertson that she had effectively taken over the role of the parents in determining whether or not a termination should be sought. She had done this by not discussing with them the implications of a diagnosis of TOF. Dr Robertson said that "the vast majority of people with TOF will lead a relatively normal life" (T 685.22 – T 685.23). This answer was significant because it was apparent to me that Dr Robertson accepted that a diagnosis of TOF could have major implications and was attempting, somewhat unsuccessfully, to mitigate the failure to properly explain the

ramifications of a TOF to the parents. I have already noted that, although Dr Robertson may have spoken to Dr Carlisle, the interrogatories would suggest that Dr Carlisle did not speak to the parents.

238. Dr Robertson was closely cross-examined about the High Risk Meeting that took place on 6 September 2011. Her evidence-in-chief was, I thought, confusing, particularly as to whether she attended or not. Her evidence in cross-examination was even more confusing, as it seemed to fluctuate between her having been present or not present. Ultimately, I think she could only say that she probably attended, and that Dr Tan or Professor Ellwood could also have been present.

239. What is apparent is that whoever was at the meeting raised the possibility of a TOF, but that it was not discussed with the parents until 22 September 2011 (assuming it was discussed at all). The difference between 6 September and 22 September, in terms of the gestation period, is 28 weeks and 2 days compared to 30 weeks and 4 days. This is a difference which might have been significant in a decision about a selective termination. However, it must be recognised that any decision to perform a termination may have been delayed to 32 weeks' gestation in order to strengthen the prospects of Twin A if the termination generated a pre-term delivery of this twin. More importantly, the plaintiff's case is that the information should have been provided on 22 September 2011.

240. Dr Robertson was asked about Twin B's abdominal circumference measurements. She pointed out that this was not a measure of the size of the stomach which, I gathered, was a more important consideration. In respect of the abdominal circumference and femur length, Dr Robertson said that, notwithstanding the measurements sometimes being in a very low percentile, they were not significant because:

    (a) There was some doubt about the actual date of commencement of gestation;

    (a) Twins can be different sizes; and

    (b) Girls are normally smaller than boys.

241. Dr Robertson said that the most important factor was the continuing growth of Twin B, which seemed to be occurring in a normal fashion. While I have no reason to doubt Dr Robertson's explanation, it does seem odd to me that there is no continuing record of stomach size yet there is a continuing tracking of abdominal circumference and femur length. I also note that Dr Robertson, in her email to Dr Shand on 17 October 2011, referred to a history of a small stomach.

242. Professor Ellwood is now the Dean of Medicine at Griffith University School of Medicine. He established the FMU at Canberra Hospital in 1995 or early 1996. He brought a great deal of experience to that role (see Exhibit 23). In 2011, the FMU was made up of three doctors, two sonographers and a midwife.

243. Although there was no strict hierarchy in the unit, and although Dr Robertson was the Director, I gained the impression that it was the practice that all major decisions would be made by Professor Ellwood. He certainly carried out all terminations and was consulted on major issues.

244. The FMU saw approximately 100 patients a week. Professor Ellwood was rostered to work in the unit two days a week but would often be present on other days to see particular patients. He said that the FMU was busy.

245. Professor Ellwood had a specific recollection of meeting the plaintiffs on two occasions, but thought he may have met them on other occasions as well. He also recalled discussing Dr Robertson's findings with her, including the abnormal path taken by the umbilical vein. He said that he had seen a similar condition once before at Canberra Hospital. This was the same occasion referred to by Dr Robertson.

246. Professor Ellwood originally introduced the High Risk Meetings and gave some background to them. They took place every Tuesday, subject to the main holiday periods. There was no specific agenda.

247. At the meeting, the participants would raise matters of concern. Generally, these matters of concern came from one of three sources. They arose from cases in the FMU, in-patients and babies in the nursery. Generally, the discussion occurred close to delivery or where a neonatologist might have some input.

248. In the case of Ms Nouri, this discussion would have been generated by the findings of polyhydramnios, because this could have led to an early delivery. In that case, a nursery bed would have been necessary. Professor Ellwood could not remember the meeting on 6 September 2011 and could not recall whether he attended. He attended most meetings. The notes were written by a Ms Warwick, a senior genetic counsellor.

249. Professor Ellwood said that excess amniotic fluid is normally caused by one of the following:

    (a) A swallowing problem associated with a brain defect;

    (b) A mechanical problem causing an obstruction in the oesophagus. A TOF is an example of a mechanical problem;

    (c) Increased production of urine; or

    (d) An unidentifiable cause.

250. In this case, Professor Ellwood said that there was no evidence of causes (a) and (c). A TOF was considered unlikely because, although Twin B had a small stomach, it did seem to contain fluid from time to time. This left the unidentifiable cause which, in turn, raised the possibility of the enlarged right atrium being a factor. Professor Ellwood said that, where an abnormality was identified, it was usual practice to look to that abnormality as being the cause of other abnormalities.

251. Professor Ellwood said that he had the strongest recollection of the meeting on 26 October 2011. He may, however, be mistaken that it was at a previous meeting that Dr Latif was present. He said that the purpose of the meeting was to discuss Ms Nouri's birth plan. He thought that he met the plaintiffs in the scanning room. There was a discussion of how the births would occur. He recalled that the plaintiffs sought a caesarean section because of the postpartum bleeding suffered after the birth of Ms Nouri's daughter.

252. Professor Ellwood also thought that Ms Nouri had expressed concerns about a natural birth affecting Twin B. He was not, however, very confident of his recollection in this regard.

253. The timing of the meeting was influenced by the expectation that, due to the excess amniotic fluid, birth was likely to occur in the following week. It was generally thought that it would be better to wait until 37 weeks' gestation, to allow for the maturing of the

babies, but that birth during the 36th week was an acceptable compromise. Although the notes indicate that Professor Ellwood was to consult with Dr Tam, he did not do so because he came to his own conclusion that a caesarean section was appropriate.

254. Professor Ellwood said that he had performed a number of selective terminations. He thought he might have done one or two a year. He said that any termination after 20 weeks required the approval of an Ethics Committee. He said that the possibility of a termination was never raised with him and he could see no cause to justify a referral to a committee. He said that after 24 weeks' gestation, three factors were important:

    (a) Were the parents requesting a termination?

    (b) Would the medical practitioner agree to perform it?

    (c) Would it be approved by the Ethics Committee?

255. Professor Ellwood said that he would not have agreed to perform a termination in this case. In cross-examination, it was put to Professor Ellwood that late-stage elective terminations occur in 10% of cases where a TOF is identified. Professor Ellwood said that he had never performed a termination because it was thought the baby might be born with a TOF. This applied to singleton and twin pregnancies.

256. I note that Professor Ellwood's comment was restricted to cases where a TOF was the only diagnosis (T 691.28). Twin B was different. Not only was there a possibility of TOF but there was an unusual umbilical vein path, a small stomach and the overall smaller size of Twin B.

257. Professor Ellwood said that if, at 28 weeks' gestation, an Ethics Committee had refused a selective termination request and Ms Nouri had asked him for his opinion on travelling overseas, he would have been firmly against the proposition. This was because of the potential risks to both Ms Nouri and the unborn twins. Ms Nouri would face the risk of postpartum bleeding in an emergency labour. The presence of the polyhydramnios made a pre-term birth a real risk. Deep Vein Thrombosis was another risk that the mother would face while travelling.

258. Professor Ellwood was asked about VACTERL Association. While he was not aware that the diagnosis had been made, he did understand that at least one doctor had suggested its presence. He said that VACTERL could not be diagnosed before birth because some of its elements were only observable after birth.

259. Nevertheless, in my view, Twin B had a number of abnormalities or anomalies which might not have suggested VACTERL but which would have raised, if only for discussion, the possibility of disabilities going beyond the cardiac anomaly. Once a TOF was suspected, at even a low level of possibility, the further possibility of other complications would have been evident. As stated in Exhibit Q, the defendant's own information sheet:

> **Can there be other problems that affect my baby?**
>
> TOF may be associated with a number of other problems involving the heart, spine, kidneys, anus, limbs. These other organs and bones will be checked by using ultrasound and x-rays. If other abnormalities are found they will be discussed with you.

260. The overall impression I had from Professor Ellwood's evidence is that both he and Dr Robertson, having formed a conclusion about the right atrium being larger than the left, did not agree with Dr Murphy. I have already noted that Dr Robertson's disagreement

is consistent with the allegation made by the parents that she was seeking another opinion. Based on Professor Ellwood's evidence, this opinion could have been obtained in Canberra because Dr Cooper visited Canberra from time to time. This is specifically raised as an option by Dr Murphy.

261. Dr Tan gave oral evidence. In 2011, he was working at the FMU as a qualified doctor, training in the areas of obstetrics, gynaecology and fetal medicine.

262. Dr Tan first saw the plaintiffs on 15 July 2011. He read the report from NCDI before meeting with them. He said that he spoke to the plaintiffs after the ultrasound and told them that there was a suspected malformation with Twin B. The plaintiffs were informed that one of the possible causes could be a cardiac anomaly. They were also told that there was an approximately 30% chance of Down Syndrome.

263. Dr Tan gave the plaintiffs the option of an amniocentesis to identify any chromosomal abnormalities. This was carried out. After the consultation, he discussed the matter with Dr Robertson, prompting the letter sent to the Royal Hospital for Women (page 91 of Exhibit 1).

264. Dr Tan next met the plaintiffs on 5 September 2011. Ms Nouri was complaining of shortness of breath. An ultrasound was conducted and an excessive amount of fluid was found around Twin 2. Dr Tan was unsure why this was the case, because both babies had good interval growth. He discussed the matter with Professor Ellwood and then spoke to the parents about an amnioreduction. He told them about the risks of a pre-term delivery.

265. Although Dr Tan attended about 90% of the High Risk Meetings, he could not recall if he had attended the meeting on 6 September 2011.

266. The records reflect that Dr Tan saw the parents on 12 September 2011 but he had no recollection of that occasion. On 15 September 2011, he carried out the amnioreduction. The note for this procedure is at page 105 of Exhibit 1. The note contains a fundamental error. It refers to an amnioreduction procedure on Twin 1 involving the use of forceps. Not only was there no amnioreduction performed on Twin 1 but the use of forceps is nonsensical. Dr Tan said that the entire entry for Twin 1 was a mistake.

267. I also asked Dr Tan about the obstetric history recorded in the notes. Firstly, he found it difficult to explain why this history is included in the notes in a form that only later came into existence. In this regard, there were a number of explanations about the different style of the notes, none of which was convincing. Secondly, I referred him to the entries for Gravida and Para. Gravida is the number of pregnancies that a patient has had and Para is the number of births after 20 weeks' gestation. Dr Tan agreed that the entries in respect of Ms Nouri were wrong. As at 2011, Ms Nouri had had three pregnancies and two births.

268. I asked Dr Tan if he had any explanation for the errors in the notes. He did not. I regard the state of the notes as very important in this case. Quite reasonably, the staff at the FMU have a limited recollection of a lot of the detail concerning their consultations with the plaintiffs. They have therefore either relied upon, or been prompted by, the notes. In such a circumstance, notes are an important source of evidence, especially when they have been prepared contemporaneously.

269. In *Fox v Percy* [2003] HCA 22; 214 CLR 118 the High Court said this at [39]:

> Further, in recent years, judges have become more aware of scientific research that has cast doubt on the ability of judges (or anyone else) to tell truth from falsehood accurately on the basis of such appearances. Considerations such as these have encouraged judges, both at trial and on appeal, to limit their reliance on the appearances of witnesses and to reason to their conclusions, as far as possible, on the basis of contemporary materials, objectively established facts and the apparent logic of events. This does not eliminate the established principles about witness credibility; but it tends to reduce the occasions where those principles are seen as critical.

270. In *The Nominal Defendant v Cordin* [2017] NSWCA 6 ('Cordin') the majority in the New South Wales Court of Appeal criticised the trial judge for preferring lay evidence over contemporaneous notes. While I, with respect, prefer the decision of the dissenting judge (McFarlane JA), the important distinction with *Cordin* is that there was no issue about the reliability of the contemporaneous records. In the present case, as has been pointed out, there are obvious and major errors in the notes. It is difficult to see how the notes, where they are contradicted by other apparently reliable evidence, can be treated as more reliable than the other evidence.

271. On 3 November 2011, Dr Tan performed the caesarean procedure by which both twins were born. Prior to the operation, he reviewed the notes and notified the neonatal team. This was because the births were occurring during the 36th week of gestation. He recalled that Dr Latif had also attended.

272. Under cross-examination, Dr Tan said that he now works primarily in private practice. He is the Managing Director of the Canberra Fetal Assessment Centre, a private institution conducting similar work to that of the FMU. Dr Robertson also works at the Canberra Fetal Assessment Centre.

273. Dr Tan agreed that most of his recollections were founded on his usual practice.

274. Dr Tan was asked about his views following the consultation on 15 July 2011. He disagreed with the suggestion that he had come to a conclusion that there was a major cardiac anomaly. However, when taken to the notes for 15 July 2011 (Exhibit 1 page 82), he agreed that he had in fact reached the conclusion of a major cardiac anomaly in Twin 2. Another possibility, having regard to the state of the notes generally, is that the diagnosis in the notes on 15 July 2011 is yet another mistake.

275. Dr Tan was asked why there had not been further investigation after the cardiac anomaly, short femur and small abdominal circumference were identified. He said that he was a junior doctor at the time and would have referred these matters to a more senior staff member. He agreed that, based on his experience up to the present time, they were matters that required investigation.

276. He said that, if he was now confronted with this constellation of anomalies, he would refer the patient to a tertiary hospital.

277. Ms Katheryn Columbine is the coordinator of the Early Learning Centre (the ELC) at Canberra Girls Grammar School. She first met Saba in 2016, when discussions were held about her enrolment at the ELC. There was a trial period of two days during which a parent was required to be nearby.

278. Saba was enrolled to attend in 2017 and did so, but not beyond 9 June 2017. Ms Columbine said that Saba was generally dropped off by her mother at about 9:30 am and picked up before 3:00 pm.

279. Ms Columbine described some of the activities she had witnessed Saba performing. They included playing in a sandpit, painting and drawing and on one occasion climbing an “A-frame”. She had seen Saba walking to the junior school, a distance of about 300 metres, holding a teacher’s hand.

280. Ms Columbine said that she had seen Saba eat about a quarter to a third of a sandwich. She had not seen her drinking. She recently met with Mr Shaor about Saba’s continuing attendance at the ELC. Mr Shaor told her that Saba needed treatment in Sydney which might dictate when she could return. She did not remember a discussion about home-schooling in this regard but thought there had been a discussion about the possibility of home-schooling in another context.

281. The apparent purpose of calling Ms Columbine was for the defendant to establish that Saba’s condition was not ‘as bad’ as reflected in some of the medical reports and certainly not consistent with the assumptions that had been given to Dr Scheinberg and Ms Moylan.

282. If this was the purpose, it came somewhat undone in cross-examination. Ms Columbine agreed that Saba is severely disabled, that her prospects of progress in school are limited and that she would need special assistance if she was to stay at school. Her capacity to walk is compromised and she needs nappy and urine bag changes. Her language is limited, her balance is compromised and her playing skills are parallel rather than being interactive. She needed constant watching.

283. Ms Harrison was Saba’s teacher in 2017. She is a very experienced teacher and has qualifications in respect of the teaching of disabled children. Her CV is Exhibit 26. Ms Harrison gave evidence that Saba has attended 62 of 152 school days over the course of terms 1 and 2.

284. There is no doubt, based on Ms Harrison’s evidence, that Saba is a severely disabled child. Despite this, Saba has “a smile that just lights up a room”, is eager to learn and is happy to be at school. She is persistent and keeps trying.

285. Unfortunately, Saba does not always succeed and the gains made by her are not always retained. Although Ms Harrison had an overall impression of some progress being made, it was limited and Saba’s needs were many.

286. Ms Harrison described the constant assistance that Saba needs. Even if she walks around the classroom, she cannot negotiate an obstacle that she happens to encounter. She can walk for 50 metres or longer but her hand is always held. If she goes up stairs, she has one hand on a railing and the other is held by a teacher.

287. Saba requires her nappy to be changed frequently throughout the day. This exercise involves a teacher closing off the toilet area to all other persons and then carefully changing the nappy. There is not only a concern for Saba but also a concern for the rest of the class, because Saba carries the Methicillin-Resistant Staphylococcus Aureus (MRSA) bug and care must be taken to ensure that it does not spread to any other person.

288. Ms Harrison said that Saba does eat and, with the benefit of medication, only vomits about once a week. However, she only eats small amounts and obviously not enough to sustain her. The impression I had from Ms Harrison’s evidence is that Saba eats to be ‘one of the children’, rather than because she is hungry. She does, of course, receive most of her sustenance through her feeding tube.

289. Ms Harrison said that Saba's language structure was very simple. She can and will make requests but they are not always understandable. She will ask for help if she needs it. She can put on a hat but cannot dress or undress herself. She cannot put her socks on. She can put her feet into shoes and do up the velcro but the shoes must first be placed in front of her feet.

290. In the playground, Saba attempts to climb the "A-frame". She can put her foot on the first rung of three but requires prompting to lift her other foot onto the next rung. When she crosses between two "A-Frames" on a plank, her hand is held for security.

291. Ms Harrison said that, in a conversation with Mr Shaor on 30 March 2017, he described the routine that he follows during the night with Saba and said that he handed over to his wife during the day while he was at work. She was challenged about the reference to Mr Shaor being at work. She accepted that her recollection of the conversation was vague and that Mr Shaor may not have made a reference to work. She relied on the contents of the report she had prepared during the meeting (Exhibit 27).

292. This report is largely consistent with the evidence she gave before me and highlights the severity of Saba's condition.

Medical evidence on liability

293. Before beginning this summary, I make the following point. Some of the doctors deal with the postnatal treatment of Saba. As I understand the case being put on behalf of the plaintiffs, no allegation of negligence is being pursued in relation to this treatment. The negligence alleged is the failure of the defendant, through its staff, to inform and counsel the plaintiffs about Twin B's condition, and prospective condition, so that they could make an informed decision about whether or not to proceed with a selective, or even total, termination of the pregnancy.

294. The consequential issue is then one of causation: had the parents been informed and counselled, could a termination have taken place having particular regard to the requirements of State and Territory laws (and Ethics Committees), the availability of termination in Australia or abroad and the associated costs.

295. Dr Cole is a consultant obstetrician and gynaecologist and a specialist in maternal fetal medicine. His first report is dated 9 July 2012. He was asked to comment on the actions of the defendant and also of NCDI. The first ultrasound, on 8 July 2011, was carried out by NCDI.

296. Dr Cole saw no difficulty with the care provided by NCDI. Dr Cole observed that:

> ...a significant abnormality was detected, and the appropriate course of action was taken – i.e. referral to a tertiary fetal medicine service for detailed evaluation.

297. The service referred to by Dr Cole is the FMU at Canberra Hospital.

298. Dr Cole noted that a good deal of information was missing from the documents provided to him. Nevertheless, he was able to reach some preliminary findings. Dr Cole concentrated on examining which of the conditions evident in Saba at birth could have been detected antenatally.

299. Dr Cole concluded that, on the information available to him, most of the conditions could not have been identified before birth or would have at least been very difficult to identify.

300. Dr Cole was then provided with further information, leading to his supplementary report dated 30 August 2012. The doctor once again noted the absence of medical notes and other documents he thought were important. Based on the assumption that no antenatal counselling was provided, he said that this was an omission which he thought "of itself to be short of the standard reasonably expected of a tertiary fetal medicine service".

301. Dr Cole noted that:

> ...the possibility of oesophageal atresia/tracheo-oesophageal fistula was raised following the ultrasound examinations by Dr Meiri Robertson at 22+1 weeks, and 30+4 weeks gestation... The only question of relevance I believe is whether these concerns were discussed with the parents of Saba Nouri during the course of the pregnancy.

302. This comment highlights the core liability issue in this case: if the defendant's doctors knew of the condition, did they tell the parents? The parents say that, if they had been told, Ms Nouri would have undergone a termination, in Australia or elsewhere, thus preventing the birth of Saba. As already stated, the plaintiffs say this action would have been taken even if it involved the termination of the pregnancy in respect of both twins.

303. In relation to counselling, Dr Cole said that:

> ...it would be normal practice in fetal medicine units to counsel parents regarding the significance and consequences of a detected fetal anomaly. This counselling would usually include a discussion about any potential risk for additional abnormalities, along with consideration regarding the range of possible outcomes (prognosis), from best case to worst case scenario, and where possible some estimate (albeit highly variable) of the likely outcome for a particular fetus, taking into account the specific features of that case.

304. Dr Cole continued:

> Following that counselling regarding the significance and consequences of the fetal abnormality, a discussion re possible courses of action for the pregnancy would usually be considered reasonable. This would commonly include a management plan should the parents wish to continue the pregnancy, and taking into account the legal framework for termination, possibly raising the option of termination of pregnancy. It would then be up to the parents (technically the mother) to indicate how they wished to proceed with the pregnancy.

305. In relation to the significance of the findings, Dr Cole said:

> The combination of a major cardiac abnormality AND oesophageal atresia / tracheo-oesophageal fistula carries a significantly worse prognosis than either condition in isolation. Thus, if the condition was suspected, in my opinion it would be reasonable and proper to discuss this suspicion with the parents, including the information regarding a poorer prognosis if the diagnosis later proved to be correct.

306. In his final report, dated 12 September 2017, Dr Cole was provided with three medical reports and asked to answer two questions. In answering the first question, he was asked to assume that the parents had expressly requested that they be fully informed of any potential problems with the pregnancy. In that case: "what would have been the appropriate advice to give at or about 28 weeks following the scan of 22 September 2011?"

307. On the above assumption, Dr Cole said that the hypothetical counselling that he would have provided to the plaintiffs would have been as follows:

> A number of problems have been identified with Twin 2, including poor growth, a possible heart abnormality, a two-vessel cord, and excessive fluid around the baby. Each of these things has the potential to cause some problems, although the significance of these

> potential problems can vary. For example, the poor growth may lead to a decision to deliver the babies early. The seriousness of this will depend on how early delivery is required. At the moment there are no features which would suggest that delivery will be required soon, but that could change. For this reason I will need to continue with regular ultrasounds to monitor the baby's growth and health. If delivery is term or near term, it is not likely to cause any major problems for the babies, however if earlier delivery is required this could lead to some problems including varying degrees of brain injury, lung problems, etc. Unfortunately it is not possible at this stage to predict if or when preterm delivery will be required...
>
> In addition, you need to be aware that where we see more than one thing wrong with the baby, we often worry about a more serious underlying problem that links the different problems. We have been able to rule out some of the more serious potential problems because you have had an amniocentesis which showed that both the babies had normal chromosomes, however it is important to be aware that there are other conditions which will not be detected by chromosome testing. Sometimes these can be very serious, and can be associated with other physical problems, intellectual disability, etc. Other times there will be no underlying serious problem. Unfortunately we may not be able to know before the babies are born whether there are additional problems that we haven't identified yet.

308. Dr Cole added that "further counselling would be [provided] in response to the parents' questions".

309. The second question asked of Dr Cole was to explain the options available to the plaintiffs if the they had requested a selective termination. After pointing out that selective termination carried a risk for the other twin, Dr Cole explained that late selective termination rules in Australia vary from state to state and even within different institutions in the same state. He said:

> ...where patients request a late (often defined as greater than 23 – 24 weeks' gestation) termination, many hospitals refer such requests to a termination review panel, or committee. In most hospitals, the role of the committee is to review the circumstances of the case, confirm that it satisfies the applicable legal framework, and make a decision as to whether the hospital is prepared to allow the termination to proceed. A panel or committee may elect to refuse a patient request for termination, even if it satisfies the legal requirements.

310. Dr Cole ended his letter in this way:

> In the case of Saba Nouri, had the parents requested a selective termination, their request would have been presented for consideration to the relevant committee at The Canberra Hospital. Given the lack of a specific underlying unifying diagnosis, and on the basis of what was known about the identified abnormalities (and their non-specific nature and the associated lack of specific prognostic information) at 22 September 2011, it is not clear whether such a request would have been granted or refused.

311. I note that the question to Dr Cole, and consequently his answer, was restricted to a selective termination. It does not deal with a termination in respect of both twins.

312. Dr Farrow is a general and paediatric surgeon. Of particular significance is that his role, as at the time of the report, was as Director of Clinical Governance for Sydney Children's Hospital Network. His first report is dated 21 May 2014. In setting out the history of the matter, Dr Farrow notes that the specialist cardiology ultrasound by Dr Murphy at 23 weeks' gestation "did not demonstrate any significant cardiac anomaly". Dr Farrow then continued:

> This is important because in the absence of significant cardiac disease all of Saba's other anomalies are eminently survivable.

313. I have quoted this comment because there is a contrast to be drawn between survivable anomalies and any abnormalities. It was the plaintiffs' wish that they be informed of the latter, not just anomalies which would have affected survivability of Twin B. This distinction seems to be behind Dr Farrow's answer to the first question. He was asked whether or not the plaintiffs should have been referred for genetic counselling at 23 weeks' gestation. He answered "no" because the fetus was genetically normal and "without a serious life limiting cardiac defect and with no other anomalies detected".

314. I observe, however, that the NCDI ultrasound on 8 July 2011 had noted the two-vessel cord and the ultrasound on 15 July 2011 noted an anomaly in femur length.

315. Dr Farrow had a different view following the 30 week ultrasound, "where the possibility of oesophageal atresia was raised". He said that, at this stage, "there was enough information available to justify a consultation with a genetic counsellor". Dr Farrow then went on to say that the referral should have been made as soon as the genetic abnormality was detected.

316. When asked what findings a clinical geneticist might have made, Dr Farrow said:

> Intrauterine growth retardation, two vessel cord, abnormal venous drainage of the heart, small stomach as demonstrated on the ultrasound of 22 September 2011, and query TEF.

317. As I understand the question, Dr Farrow was asked if an Ethics Committee would have agreed to a late termination at 30 weeks' gestation. This was his reply:

> I do not believe an Ethics Committee would have agreed to a late termination based on what was known about Saba antenatally. The cardiac anomaly was thought to be minor and while there was a suspicion of TOF this is a surgically correctable condition.
>
> However, had the full extent of Saba's anomalies being appreciated and revealed to the mother antenatally, late termination may have been considered, especially if continuing the pregnancy of Saba was having a detrimental effect on the mother. Selective termination of one twin is not without risk, with around a 10% rate of losing both foetuses. However, with two amniotic sacs and two cords this risk might have been lower. This is not however my area of expertise and I would defer to other experts in this regard.

318. I think it plain that Dr Farrow had not been asked to assume that the plaintiffs would have preferred a termination of both fetuses over the birth of one 'normal' and one disabled child.

319. In his conclusion, Dr Farrow said this:

> In summary there appears to have been a window of opportunity at around 30 week's [sic] gestation when the ultrasound of 22 September 2011 was performed. The abnormalities detected were not referred to a genetic counsellor or paediatric surgeon but to a neonatologist, and the opportunity to discuss the pros and cons of continuing with the pregnancy of Twin 2 with the parents was lost.

320. Dr Farrow points out that, even if the plaintiffs had been consulted, a decision may have been made to continue the pregnancy of Twin 2. As noted above, on the plaintiffs' case, the anomalies then known would have led to a decision in favour of termination.

321. In his second report, which takes the form of an email dated 14 September 2017, Dr Farrow addresses what ought to have been done following the FMU High Risk meeting of 6 September 2011. As at this date, the gestation term was 28 weeks and 2 days. Dr Farrow said:

> With the identification of multiple abnormalities at that meeting suggestive of VACTERL rather than simply a suspicion of OA, it would [be] very reasonable for the parents to be referred to a paediatric surgeon for antenatal consultation and counselling. The advice regarding the survivability of OA may have been tempered by the presence of other potentially significant abnormalities. Ultimately the parents will make the decision about continuation of the pregnancy based on all the information provided to them...
>
> The counselling ideally would have discussed all the known possible defects at that time, as well as OA. OA alone is treated very successfully. OA with other significant defects is more complex, and the decision on what to do would be more considered with options being put to the parents.
>
> VACTERL can be associated with other genetic conditions, but of itself has no specific genetic cause. A normal karyotype does not exclude VACTERL, but suspicion of cardiac problems, limb problems, polyhydramnios and small gastric bubble does suggest VACTERL. All of these conditions were present or suspected on ultrasound and known to hospital staff.
>
> Given the subjective conditions of the parents as listed, I believe it is likely that the parents, if provided with full information, may have chosen a selective twin termination. That information most likely would be provided in its full context by an antenatal consultation with a paediatric surgeon.

322. I think the above quoted passages show that Dr Farrow's opinion is that, following the High Risk Meeting, the information available to the defendant was such that the plaintiffs should have received the appropriate counselling, including outlining the options available to them. Based on Dr Farrow's first report, I think that he considered a termination was possible at "around 30 weeks gestation". As noted above, the meeting took place a few days before gestation reached 30 weeks.

323. Based on Dr Farrow's opinion, and assuming the appropriate counselling did not take place after the High Risk Meeting, it suggests that the defendant breached its obligations to the plaintiffs sometime after 6 September 2011. Whether this breach of obligations is also a breach of the duty of care owed by the defendant will be discussed below.

324. Dr Hern practices in Boulder, Colorado in the USA. I am not sure of his precise qualifications other than that his practice includes the carrying out of terminations. He was asked whether he would have performed a selective termination on Ms Nouri had she presented to him at 28 or 30 weeks' gestation.

325. He responded, in his report dated 2 April 2017, that he would have accepted her as a candidate for a selective termination. He stated that such terminations are preferably performed at 32 to 34 weeks' gestation, because this allows for the "lung maturation in the healthy fetus".

326. Dr Hern says the procedure would have been carried out in his office and, because Ms Nouri would be travelling from Australia and did not have a local attending physician, she could have been admitted to a local university teaching hospital. Dr Hern then gave this warning:

> In Ms. Nouri's case, returning to her own physician in Australia would mean a long, arduous journey including a flight of 16 hours or more from Los Angeles to Sydney not counting travel time from Colorado to Los Angeles and from Sydney to New South Wales. During this time, she would be at risk of precipitate labour and delivery as well as deep vein thrombosis from restricted movement with the accompanying risk of thromboembolism and death. These are not unmanageable risks, but preventing a major complication or death during this interval would require close coordination with her own physicians and medical resources at points of travel.

> An alternative would be for Ms. Nouri to have an established relationship with medical professionals in the United States where she could await delivery of the healthy twin.

327. Putting aside Dr Hern's geographical error as to the location of Sydney, it is plain that he is giving a stern warning of the dangers that would have been involved in the return trip.

328. There is no evidence before me that these arrangements could have been made or afforded. There is also no evidence about the costs involved or the practicalities of engaging medical professionals in the USA. There is, for example, no evidence about whether any travel or other insurance may have been available. There is also no evidence about the likely cost of remaining in America and the capacity of the plaintiffs to pay for the assorted medical services.

329. Dr Hern gave oral evidence by way of audio-visual link from Colorado. Unfortunately, the visual element of the link did not last for very long. However, his evidence was able to continue. Dr Hern was able to be heard, even if not seen.

330. Dr Hern gave evidence that he had performed selective terminations on a number of occasions. He said that it was essential that the twin that was to be the subject of the termination could be identified. He noted that it is also vital that there is no placental connection.

331. Dr Hern said that, when a patient arrives for a selective termination, he would insist upon being provided with as much information as possible. He would also carry out an ultrasound examination. He agreed that he also needed to have a definitive diagnosis of a problem or problems with the twin.

332. The procedure involved the insertion of a needle into the area around the fetal heart and the injection of Digoxin. Once this had occurred, the twins would be monitored until it was confirmed that the feticide had been successful.

333. Dr Hern said that there were several risks inherent in carrying out the procedure. He would be concerned about the patient's general condition. He said that he had not seen anything in the documents that raised a concern but would have reserved judgment until he had examined the patient.

334. Dr Hern said that the polyhydramnios would present a challenge because it sometimes means that it is more difficult to place the needle in the correct position. He said that the challenging aspects of the procedure probably explained why it was not carried out by many practitioners.

335. Dr Hern said that he would have checked the information with the patient's treating doctors in Australia. Dr Hern was asked about the assumptions upon which he had proceeded in giving his report. He identified these assumptions as those stated in the letter from the plaintiffs' solicitors, dated 2 December 2016 (Exhibit 31).

336. Dr Hern said that he would consult with the patient's treating doctors to ascertain if there was a definitive diagnosis of a serious nature. This question and answer then occurred:

> HIS HONOUR: Can I just ask a question? Doctor, it's the judge here. Can I ask you this question, if you had not been able to talk to the patient's treating doctors for whatever reason, would you have proceeded with a selective termination?

> DR HERN: Only if I had a written document from the doctors saying that they were in agreement with this patient's decision that they were going to help her following this operation and that they were (indistinct) to verify that there were serious abnormalities.

337. The above evidence seems to me to be important in determining the issue of causation.

338. There are three reports from Dr Maclean, a paediatrician and clinical geneticist. The first report is dated 22 August 2013. Although he expressed a concern about a lack of documentation, Dr Maclean sets out an extensive and detailed history. In examining the background, he notes that there had been a previous termination of pregnancy (TOP), which was known to the defendant. He continued:

> A history of termination of pregnancy is relevant in genetic counselling. Practically it might have - if true and known - provided an avenue to raise and discuss with the couple about their experience of TOP in addressing one of the questions raised: that TOP should have been offered or more broadly, that discussion of late termination of pregnancy was an implicit expectation for a fetal medicine specialist and/or geneticist based on the ultrasound findings. The response of the woman/couple may then have guided further discussion i.e. if TOP is something they would or would not countenance.

339. For present purposes, I think Dr Maclean's most relevant comments in his first report relate to his opinion of the position as at 30+ weeks' gestation. He starts off by saying this:

> The combination of the cardiac anomaly, SUA, SGA with discordance as compared to the growth of the co-twin together with polyhydramnios sufficient to lead to amnioreduction at 29 weeks gestation and suspicion of TOF/OA raises the prospect of a multi-system disorder. The findings, in my opinion, were sufficient to alert and counsel the parents as to the potential for a serious underlying disorder. While the additional findings shift the balance of probabilities towards a multi-system disorder, the findings do not allow for an individual diagnosis to be established…
>
> The level of overall certainty that could be conveyed to the parents at 30+ weeks gestation is also directly influenced by limitations on the prenatal diagnosis of TOF/OA, which is discussed in detail later in the report. (Exhibit 2, page 191)

340. Dr Maclean then goes on to discuss the capacity for prenatal diagnosis of the assorted constituents of VACTERL. He says that the condition, or association, cannot be confirmed in a laboratory:

> It is a diagnosis of exclusion, after excluding chromosomal/large-scale genomic disorders and known syndromic associations. The presence of morphological (sonographic) features sufficient to satisfy criteria for the diagnosis [of] VACTERL antenatally is not proof of the diagnosis: antenatal genetics assessment is incomplete in its assessment for alternative diagnoses in this context. (Exhibit 2, page 198)

341. Later in the report, in his conclusions, Dr Maclean says:

> VACTERL association is a diagnosis that might be suspected *in utero*. The diagnosis cannot be definitively established antenatally. Practically, in being the commonest association with a finding of suspected TOF/OA, it is useful to direct further fetal medicine assessments. There was potential for directed assessment of anorectal and spinal malformations. The findings do not suggest that the cloacal and urological disorder was diagnosable antenatally. There were no features to indicate duodenal atresia. (Exhibit 2, page 210)

342. Dr Maclean concluded that the findings as at 22 September 2011 "in being sufficient to involve a neonatologist, were sufficient to refer Ms Nouri to a clinical geneticist". He continued:

> Based on knowledge that over 10% of antenatal diagnosis of TOF/OA result in ETOPFA and in respecting the individual rights of women and couples, acknowledgement of the late termination of pregnancy as an option could be reasonably expected. It does not necessarily follow that an individual institution, such as TCH, would have agreed to offer a late termination of pregnancy for suspected TOF/OA following Ethics Committee review.
>
> It is reasonable in speaking with parents to reinforce the positive outcomes for most infants with TOF/OA without concomitant life-threatening malformations.
>
> It is not possible to state from the documentation provided that Mr and Ms Nouri were adequately informed as to the findings in the third trimester, the implications of the findings, the potential associations and their options, including selective termination.
>
> I do not believe that genetics referral was indicated at 23 weeks gestation, based on the report of Dr Murphy to Dr Robertson, in reporting no significant cardiac anomaly…
>
> I would question the pre-operative consent process - not at the time of delivery, where there was prompt and thorough assessment occurring alongside critical interventions, rather in the missed opportunity for Ms Nouri and Mr Shoab [sic] to be better informed on TOF/OA repair and its complications pre-operatively by means of antenatal paediatric surgical consultation. This might have prompted further review of the antenatal findings, in considering their implications for management and outcome and the potential for complications and ongoing sequelae. (Exhibit 2, pages 210 – 211)

343. Dr Maclean's second report is dated 24 April 2017. By this time, he had been provided with further documentation, including documentation concerning the High Risk Meeting that took place on 6 September 2011.

344. Dr Maclean also deals with a report of Dr Challis, dated 10 April 2015, which is relied upon by the defendant. He does not agree with Dr Challis and makes this observation:

> There is however, a central issue in the case, which is not responded to by Dr Challis, which was the suspicion of TOF/TEF was not raised with the parents prior to delivery, to enable them to understand the expected process for care of an infant with a severe but surgically correctable anomaly such as TOF. Genetic counselling, which might be done by a genetic counsellor experienced in fetal medicine consultations or a clinical geneticist, can be an important step to assist the couple in their understanding and in providing a safe, non-judgemental and non-directive, environment for the couple to raise their questions and concerns and for the clinicians to be able to respond to those concerns, including any putative request for selective feticide for suspected fetal anomalies. (Exhibit 2, page 225)

345. Dr Maclean ends this report in this way:

> The key conclusion is that with the overall clinical picture that was emerging as of 28 weeks and further confirmed at 30 weeks, there was sufficient information to consider TOF as a relevant and indeed, increasingly likely diagnosis; to arrange for various specialist/multidisciplinary inputs (neonatology, surgical and clinical genetics in the subsequent weeks) and, to allow the family time to process this information and based on their reflections, to develop an approach that offered care for the family, the pregnancy and the child following delivery depending on the couple's approach, requests and individual decisions. The surgically-remediable nature of the defect and the stage of pregnancy would mean that were the family to request selective feticide, this would mandate Ethics Committee review. One could not assume assent to this to be readily forthcoming. Accordingly, other options may need to be considered should the family seek to pursue selective feticide. This would require the couple to access private services, sometimes internationally, that gives support to the couple's autonomous decision-making. This is outlined in the correspondence of Dr Hern - with similar pathways accessed by families that I would attest to in my own professional experience. Furthermore, it is likely that many of the selective terminations and late TOPFA are done outside of the public hospital system. I do not have access to data on the respective proportion. The data on TOF and TOP have been discussed in a previous report. (Exhibit 2, page 228)

346. What I think emerges from Dr Maclean's conclusion is that, at 30 weeks' gestation, the plaintiffs should have been counselled, and if they had chosen a selective termination it would have been reasonably available, either upon approval by an Ethics Committee at a public hospital or privately, in Australia or internationally. Dr Maclean certainly does not exclude as a reasonable possibility that a selective termination was available at 30 weeks' gestation.

347. Dr Maclean's last report is dated 26 May 2017. In this report, he was asked further questions. Amongst his answers are the following:

> The diagnosis of TOF/VACTERL constitutes sufficient grounds for a couple to request termination of pregnancy. There are specific concerns regarding the cardiac anomaly and growth restriction that would indicate a risk of early mortality and greater morbidity…
>
> Practically, it is likely that a significant proportion of referrals for ETOPFA for TOF will be made from 20 weeks onwards. TOF/VACTERL is a condition that is typically not apparent until a pregnancy is relatively advanced i.e. from the time of the second trimester ultrasound onwards and for which features that increase the diagnostic likelihood, such as polyhydramnios, do not become apparent until the third trimester…
>
> Given a balance of probabilities favouring a diagnosis of TOF and VACTERL at 28 weeks and two days, it is my opinion that in taking such a case to Ethics Committee on the parent's behalf, there would be opposition to termination of pregnancy by selective feticide in the circumstance of a third trimester termination, where the twin-pregnancy creates a unique circumstance with the potential to affect the survival and well-being of the co-twin. The issues related to TOP in a twin pregnancy, which is outside of my expertise, is discussed by Prof Challis and Dr Hern. It is likely to be material to the view of an Ethics Committee.
>
> I would not envisage there being consensus or for 6 out of 7 health professionals to agree to selective feticide for TOF/VACTERL. The uncertainties in this case, the limitations for a fetal medicine specialist to make a definitive antenatal diagnosis of TOF (i.e. beyond reasonable doubt as opposed to on balance of probabilities) as attested to by the literature, the expectation of a normal neurocognitive outcome and the surgically-remediable nature of TOF would likely sway the opinion of the committee away from the decision to approve termination/selective feticide...
>
> The family's expressed concerns during the pregnancy and their experiences of disability in the family as raised in their affidavit are relevant in coming to an understanding as to how the couple view the diagnostic uncertainties and the risks. There is precedent for couple's [sic] accessing ETOPFA - for non-life threatening conditions - which had been rejected by an Ethics Committee…
>
> Finally, an option that would remain open to the family would be to pursue selective feticide outside of the public hospital system, either locally or internationally, with policies and guidelines differ [sic] from those of NSW and ACT Health. (Exhibit 2, pages 233 to 234)

348. The just quoted passages reinforce the conclusions in Dr Maclean's second report that, even at 30 weeks' gestation, a termination was an available option, either via an Ethics Committee ruling in a public hospital or outside of the public system. Moreover, the public system is not restricted to international options, but might include access to a termination within Australia.

349. Notably, Exhibit C, suggests that links to overseas services were available through the ACT Department of Health website. The defendant conceded that Dr Hern's practice (as described below) was contactable through the internet.

350. Dr Maclean was cross-examined on his reports. He was taken to some of the articles that his reports refer to in order to establish, inter alia, the number of terminations that

have followed a diagnosis of a TOF. The picture became a little confusing, which led me to asking the following question:

> HIS HONOUR: So, is this what you're saying: that as soon as you get the suspicion of TOF, you need to be looking for other things, and if there are other anomalies you need to be suspicious of all sorts of other things?
>
> DR MACLEAN: Yes, it increases one's index of suspicion. Thank, your Honour. (T 787.42 – T 788.1).

351. Dr Maclean agreed that a TOF could only be definitively diagnosed postnatally (T 786.1)

352. Dr Maclean was also cross-examined about the likelihood of there being a TOF:

> MR HIGGS SC: You'd agree, wouldn't you, that a foetal medicine expert that has a long history and experience with interpreting ultrasounds would be the specialist that would be better placed to, on the images, work out whether or not there was an enlargement of the right atrium or heart that would explain this mechanical obstruction?
>
> DR MACLEAN: In this particular instance we have actually divergent opinions between the cardiologist and the foetal medicine specialist as to the right atrial pathology, its nature, its effects. So as an additional specialist in providing interpretation assistance coming to an independent view, it's important to consider a range of different options of various opinions that are present and, in certain instances, even to challenge some of the opinions that have been put forward. So the question of whether this is an impingement leading to obstruction versus an alternative pathology is an entirely relevant consideration.
>
> MR HIGGS SC: Have you proceeded on the basis that Dr Murphy disagreed with the explanation of a mechanical obstruction explaining this polyhydramnios?
>
> DR MACLEAN: Dr Murphy's report appeared in advance of the polyhydramnios developing and there was no subsequent foetal echocardiogram that was undertaken in relation to the later presenting pathologies.
>
> MR HIGGS SC: Are you aware that later on in October that there was correspondence with the Royal Hospital for Women where Dr Murphy was to see whether or not there was anything further that they could add to the findings that had been made by Canberra Hospital?
>
> DR MACLEAN: There was correspondence with Dr Antonia Shand. I'm not aware that there was any correspondence with Dr Murphy.
>
> MR HIGGS SC: I see. You have taken that correspondence into account, have you?
>
> DR MACLEAN: Yes. In considering the pathological implications in excess of that extracardiac major venous abnormality. It is important information for me as a geneticist in thinking about the various possibilities that may be occurring.
>
> MR HIGGS SC: There's just one other matter. Can you go to page 193 of the tender bundle. In the second-last paragraph on that page you refer to a body of literature on selective late termination in twin pregnancies indicates no risk for the co-twin – I'm paraphrasing. I've just read that to you. What's the body of literature? Is that referred to in any of your reports?
>
> DR MACLEAN: No, it's not. I haven't ---
>
> MR HIGGS SC: That's really more of an area for obstetricians to express an opinion upon than you. Would you agree with that?
>
> DR MACLEAN: In answer to your question, yes, I'd be very differential [sic] to the expertise of a foetal medicine specialist in --- (T 796.25 – T 797.20)

353. The difficulty with the cross-examination concerning the likelihood of there being a TOF is that a TOF was suspected as early as 6 September 2011. The issue is, therefore,

not whether there was likely to have been a TOF, but rather whether or not the parents were told about the suspicion at all, and if so, with what detail.

354. My understanding of Dr Maclean's evidence is that he identified the difference of opinion between the FMU specialists and Dr Murphy and the need for the significance of the difference of opinion to be clarified. Again, this is consistent with the plaintiffs' evidence that Dr Robertson was concerned to have a further opinion about the cardiac position.

355. Dr Maclean emphasised the need for further investigation when the polyhydramnios returned:

> HIS HONOUR: Yes. Just carry on doctor – if you hadn't finished?
>
> DR MACLEAN: So the question about whether the impingement and the distortion of the oesophagus is sufficient to cause such severe obstruction as to lead to polyhydramnios that requires drainage not on one but on multiple occasion, we see plenty of children with cardiomegaly with atrial and other enlargements who might have some feeding difficulties but don't necessarily get into such severe oesophageal obstructions. So on first principles, one of the things that I would be considering is the interpretation of the signs in relation to the findings. (T 796.16 – T 796.23)

356. I asked him to explain the role of a geneticist in a pregnancy. He said:

> DR MACLEAN: So where we might come in is if there was a specific diagnosis, such as a chromosomal abnormality. A common one might be Down's syndrome which generally is very well understood by most people in the population – most foetal medicine specialists. But if it was something a little further then we might be asked to come in to assist and to explain to families what that chromosome result meant; what it would mean for a future child; what their options are in the midst of the pregnancy; what other subspecialists, for example, they may wish to discuss it with in helping inform families about the implications of findings in a pregnancy. Other situations in a pregnancy might be a number of findings that are suggestive of an individual genetic diagnosis. So often genetics is about rare conditions. We work very much as part of a team, so work with other subspecialists, and it might be, in trying to pull together threads of pathology that don't necessarily make sense. An example might be – to bring it back to this case – might be considering, "Okay. Well, what are the features that are present and what might they be telling us? Does it come together as an individual diagnosis? What's the certainty and uncertainty around that? Is there a way to be able to add to the certainty during the pregnancy? Are there additional tests that might be done to establish if something is or isn't a given diagnosis?" Then, in dealing with families, we work very much with genetic counsellors. It's a very non-directive approach. So in helping families to understand the information, very often are helping – and in assisting foetal medicine specialists. So a busy foetal medicine specialist might not have the same amount of time that a geneticist is afforded to be able to sit down with families to go through the information. We're very much basing it on discussions with foetal medicine specialists, say, taking us through a series of findings and then talking with the families about what that might mean or how that might link in with, say, in this case, involving neonatologists, so very much a multidisciplinary approach. In certain instances there may be a question, depending on the stage of pregnancy, about termination, as to the likelihood of that question arising, the context of it – sometimes the context that individual families have. So if they've had previous experience that may make it an easier topic to raise and discuss. In pregnancies that are getting into the second and third trimester, obviously the topic becomes much more sensitive and very often it's led by families in certain instances. (T 797.28 – T 798.18)

357. I also asked the doctor whether there was any important distinction between the parents being informed about a possible TOF immediately after the High Risk meeting on 6 September 2011 (at 28 weeks 2 days' gestation) and them being informed on 22 September 2011 (at 30 weeks and 4 days' gestation). His answer was a little different to the opinion he expressed in his report (Exhibit 2, page 226) in that he thought the

parents should have been told at the earlier time but with the caveat that the matter would be reviewed.

358. Dr Schmidt is an obstetrician and gynaecologist. His first report is dated 5 October 2012. He was asked two questions that reflect the primary issues in the case: whether the plaintiffs had been adequately informed, before the birth of the twins, of the degree of abnormality of "the gastrointestinal tract including the oesophagus, duodenum and anus", and "[w]hether a termination of pregnancy could have been offered to Mr and Ms Nouri had they known of the abnormalities antenatally".

359. Dr Schmidt did not give a definitive answer to the first question, essentially because of a lack of certain information. As to the second question, he set out the legislation in New South Wales and the Australian Capital Territory and then said:

> In conclusion, a single ultrasound scan at 30 weeks and 4 days gestation in a twin pregnancy with a suspicion of Tracheo-oesophageal fistula would not be sufficient grounds for termination of pregnancy. At 30 weeks and 4 days gestation if a Radiologist was concerned enough to suggest a neonatal review should be arranged, an [sic] antenatal Geneticist should have been consulted and VACTERL syndrome may well have been diagnosed antenatally.

360. In his second report, dated 23 May 2017, Dr Schmidt was asked if an Ethics Committee in Canberra or New South Wales "would have sufficient grounds for termination of pregnancy at 28 weeks and 2 days if a geneticist had a suspicion that the fetus may be suffering from VACTERL syndrome". He answered:

> After taking into consideration the mental health of the mother and the probability of a severe genetic defect in the fetus a committee should comply with the request of the mother and the treating practitioner for termination of pregnancy.

361. Dr Schmidt also dealt with a second question:

> "[w]hether, if the Ethics Committee in Canberra or New South Wales was advised by the mother that she did not want to risk having an abnormal child, would the guidelines allow sufficient grounds for termination of pregnancy at 28 weeks and 2 days?"

362. Dr Schmidt responded:

> Considering the mental health of the mother, under the circumstances whereby she was aware that she could have a severely affected child, should she wish not to proceed with the pregnancy, termination should be offered.

363. Dr Schmidt's opinion is, I think, generally in accordance with that of Dr Maclean, albeit with the additional consideration of the mental health of the mother. There is no evidence, other than that given by the plaintiffs, of the mother's mental health.

364. Dr Schmidt's final report is dated 12 September 2017. In this report, he is asked to discuss the risks of air travel to America if the mother had decided to seek a termination in that country. He concluded:

> Einas Nouri could be given the green light for travel following amnioreduction. It would be recommended that she should be treated with anticoagulants and compression stockings, that she should mobilise regularly throughout the flight and should drink large quantities of fluid (water).

365. The doctor's opinion canvasses the flight to America but does not deal with the return flight and, in particular, the dangers identified by Dr Hern. It also suggests that a precondition for the flight would be an amnioreduction procedure. It is to be recalled that Ms Nouri asked for the second procedure that she underwent to be stopped due to

her discomfort. This would suggest that Dr Schmidt's precondition would not have been met. Ms Nouri did not give evidence that she would have undergone another amnioreduction if it had been suggested.

366. Dr Schmidt was also asked if the plaintiffs should have been referred to a clinical geneticist, paediatric surgeon and or a neonatologist. Unfortunately, the question does not include the specific point in the gestation term that the question is addressed to. Dr Schmidt answered:

> The combined problems of twin 2 indicate the need for antenatal diagnosis, so that the parents can make an informed choice in regard to their options. Both Mr and Ms Nouri were well educated and should have been given accurate and truthful advice and this advice can only be given by a specialist in the field of genetics. A geneticist may have diagnosed VACTERL with the information presented. Although speculative, the parents would have had a better understanding and less anxiety had all alternatives in regard to diagnosis been excluded…
>
> I have no doubt that a generalist obstetrician confronted with the diagnostic dilemma presented by twin 2 would have sought the advice of a geneticist and referred Einas to a foeto-medicine unit for further care in pregnancy.

367. There is a report from a Dr Sella, who practices in Albuquerque in New Mexico in the USA. It is not apparent whether she has any qualifications beyond those of a general practitioner. Nevertheless, she appears to work in a practice devoted to female issues (called Southwestern Women's Options). She states that she is an "abortion provider" and has provided first, second and third trimester abortions to women from around the world, including Australia.

368. Dr Sella goes on to say that, had Ms Nouri presented at 28 weeks' gestation, she would have been assessed for an abortion, provided there were no obstetric issues and no "contradictions for an outpatient termination of pregnancy". In addition, she would have required the plaintiffs to understand that both twins would be aborted because selective terminations were not performed by the clinic. She would have also needed to have been satisfied that the termination "was absolutely necessary for [the mother's] physical and emotional well-being".

369. I think it implicit from the last quoted passage of Dr Sella's report that she would have wanted to consult with Ms Nouri's treating doctors. I would find it extraordinary that she would, for example, form a conclusion about what was "absolutely necessary" based on a consultation immediately before performing any procedure. This is all the more so when the only procedure available was a termination in respect of both twins.

370. Another difficulty with Dr Sella's report is that her starting point was being contacted at, or shortly after, 28 weeks' gestation. She does not say what would have occurred if the contact was made at around 31 weeks (ie shortly after 22 September 2011). Factoring in the logistics of getting to America it cannot be said that Dr Sella would still necessarily have been prepared to perform a termination, which by this stage, would have involved the termination of a viable and healthy fetus in Twin 1.

371. The limitations and qualifications, both precise and implicit, in Dr Sella's report do not allow me to conclude that Dr Sella would have performed a termination had she been contacted after 22 September 2011.

372. Turning to the defendant's medical evidence, the first report is from Dr Challis an Associate Professor, who is the Executive Medical Adviser in Obstetrics at the Sydney Children's Hospital. For current purposes, he is the head of the FMU at the Children's

Hospital. He was asked a number of questions. He firstly explained what a two vessel cord referred to. It is the same as a single umbilical artery. He said:

> The finding is generally of no clinical significance but should prompt a careful review of fetal anatomy to exclude the presence of any associated abnormalities.

373. The finding led to the referral to the Canberra Hospital FMU and the steps taken at the unit on 15 July 2011. Dr Challis said the steps, including the amniocentesis, reflected the correct approach. He said:

> The steps taken at the Fetal Medicine Unit were appropriate and thorough and were in all respects appropriate for normal practice in a Fetal Medicine Unit in 2011. That is: they carefully repeated the morphology scans for both fetuses, and in doing so became suspicious of a cardiac abnormality and growth problems in twin 2, in addition to the SUA. All other anatomical features in twin 2 were found to be normal at that time, including the head, the brain and spine, face, neck and skin, abdominal wall, gastrointestinal tract, kidneys and bladder, extremities and skeleton.

374. Dr Challis then conducted an examination of the chronology of treatment with a view to identifying what disabilities might have been revealed by the continuing ultrasound examinations. When it came to the consultation with Dr Robertson on 22 September 2011, he said:

> On 22 September Dr Robinson [sic] again and appropriately carefully examined the fetus for a structural cause for the polyhydramnios in sac B as per the list above, and noted the stomach of the twin to be small. She was thus suspicious of a swallowing problem in this twin as the cause for the polyhydramnios. She postulated in her report that this may have been due to pressure in the fetal chest, or possibly a trachea-oesophageal fistula (?TEF).

375. It is important to remember that the negligence alleged in this case is not the medical actions or diagnoses of the doctors at Canberra Hospital. Rather it is directed to what they told, or did not tell, the plaintiffs about Twin B.

376. Dr Challis was asked if VACTERL should have been diagnosed during the pregnancy. He responded:

> It was not possible to make the diagnosis of VACTERL at any stage in the pregnancy. VACTERL syndrome is a diagnosis of exclusion, where the baby is known to exhibit multiple compatible anomalies and when no other syndrome of genetic cause is found. It may be suspected but never confidently diagnosed antenatally. There are no diagnostic karyotypic findings on amniocentesis. In this case, on the available sonographic findings, the diagnosis of VACTERL could not have been made with any confidence antenatally at any stage. The anal malformation was not diagnosable antenatally, Meckel's diverticulum (an abnormal pouch in the intestine) is not diagnosable antenatally, and duodenal atresia cannot be diagnosed in the presence of oesophageal atresia.

377. In a statement suggestive of advocacy, Dr Challis then goes on to commend the staff at Canberra Hospital for even suspecting the pathology. He may well be right but the point at issue is whether having become suspicious, the suspicion should have been communicated to the parents.

378. Dr Challis was asked about the availability of termination after 20 weeks. He said that a selective termination would not have been available in Canberra. It would have been available in Sydney. He had performed a number of these procedures. The next question was to examine the possibility of a termination as the gestation progressed. He said:

> It is my opinion that a request for selective feticide would not have been agreed to at any stage in the pregnancy based on the contemporaneous information that was available at the time. This is principally because there was no stage in the pregnancy where the

> anomalous twin was diagnosed with any anomaly or anomalies which would have been likely to result in a dismal outlook for the baby. I believe that it is unlikely that any of the foetal medicine specialists in my department would have even undertook to take it to a committee. In each of the few cases the committee had agreed to selective feticide, the anomalous twin has had a structural or genetic abnormality which the committee was confident would lead to a dismal outlook and where the risk to the welfare of the co-twin could be justified. I'm not aware of any cases where the presence of SUA, polyhydramnios, and suspected oesophageal atresia has resulted in a request for a late termination. As these findings are non-specific, it would be impossible for a committee to conclude that they were very likely to be compatible with a poor outlook for the baby.

379. When asked to approach the same question but in relation to termination of both pregnancies, Dr Challis said:

> In principle the responses to question 12 (re-selective termination) apply here - but possibly more strongly. Feticide for *both* babies would have been required with subsequent induction of labour. This is because after 24 weeks the babies could have been born alive and survived, but with the complications of extreme prematurity… I can confidently state that no fetal medicine unit in NSW would have undertaken a double feticide at any gestation for the vague and apparently minor abnormalities seen in one twin in this pregnancy.

380. Dr Challis, Dr Schmidt and Dr Cole gave evidence in a conclave. Dr Cole was on the telephone but nevertheless was able to participate helpfully. The conclave was very useful particularly because, despite objections taken by the defendant, it was conducted in a non-adversarial manner in which the opinions of the experts were discussed. In addition, I had the benefit of answers to the same questions, which is generally absent when doctors are cross-examined separately.

381. Dr Schmidt emphasised that he is a "generalist" and his answers were given from that standpoint. Nevertheless, his input was of assistance, in particular from his position as a person who refers patients to a FMU. I think the most convenient way to approach their oral evidence is to summarise what I consider to be the main points arising from it. They are:

    (a) After the amniocentesis tests revealed no chromosomal abnormality, in the normal course the parents would be spoken to about the need for further testing, if appropriate. This might involve no more than ultrasounds at regular intervals, to monitor the fetus.

    (b) Dr Cole added that it would be appropriate to "maintain a high index of suspicion". The parents would be counselled to the effect that there was still a concern although there was still a "possibility of a normal outcome".

    (c) In relation to termination of pregnancy, Dr Challis said the issue was complex. One of the complications in this pregnancy was that the anomalies were not discovered until after 20 weeks' gestation, meaning that in New South Wales an Ethics Committee would need to be convened to approve a termination. Dr Challis ultimately said that termination would be discussed if it was raised by the parents. This was against the background of Dr Murphy's report indicating that there was no structural cardiac abnormality. When the view of Dr Robertson was added, namely that the right atrium was enlarged (contrary to Dr Murphy's opinion), Dr Challis said he would follow up the distinction and "would counsel the parents that there is still concern about the functional status of this baby". I think it plain that this counselling never occurred. Dr Robertson's difference of opinion was also never chased up. Dr Cole said that,

in this circumstance, he would either arrange a second opinion or a repeat echocardiogram with the same cardiologist. Dr Schmidt agreed. It was also observed that a simple phone call to the cardiologist might have been in order.

(d) Dr Challis outlined the risks in carrying out a selective termination at 22 or 23 weeks' gestation. He agreed that it was a viable option to wait until 32 weeks' gestation to protect the second fetus.

(e) Dr Challis said that he had not seen a venous drainage anomaly of the type diagnosed by Dr Robertson. He observed that this gave her an advantage in that she had experienced it once before. I think Dr Challis overstated the position. In my opinion, Dr Robertson having experienced 'something like' the same condition once before did not make her a specialist in that condition. Rather, it emphasised the need to follow up the difference of opinion with Dr Murphy.

(f) Dr Cole agreed with Dr Robertson's diagnosis of the anomaly.

(g) Dr Challis said that a TOF is "a bread and butter condition for fetal medicine specialists". To the extent that Dr Challis was suggesting that it is easily correctable, his opinion is different to that of Dr Robertson. Dr Challis and Dr Cole both agreed that the absence of a fetal stomach was a strong indicator of a TOF. However, the presence of a stomach did not necessarily exclude a TOF, although it made it less likely. None of the doctors saw any significance in the delay in discussing a TOF with the parents between 6 and 22 September 2011.

(h) The doctors were asked to comment on Dr Robertson's opinion that the polyhydramnios was a product of the enlarged right atrium placing pressure on the oesophagus. I think it is fair to say that all of the doctors disagreed with this possibility, although to different degrees. Dr Challis referred to the "likelihood of multiple rare things". He thought the hypothesis was reasonable.

(i) Dr Cole had a very different view. He said: "I think that it's not something that I would have had on my list as an explanation in this situation". Dr Schmidt had an even stronger view, stating that he simply did not see the relationship between an enlarged right atrium and the oesophagus.

(j) Dr Challis gave a detailed statement of what he would have said to the parents following the appearance of polyhydramnios. On the plaintiffs' version, nothing close to Dr Challis' explanation was provided to them. Dr Cole endorsed the type of explanation that Dr Challis had suggested. Dr Schmidt said "there should be a frank conversation to intelligent people as to what is going on and they can then raise their concerns and discussion go from there".

(k) When asked about the sort of counselling that would be given about the possible ramifications of a TOF, Dr Cole and Dr Challis said that the content of the conversation would depend, to a degree, on the parents' responses, which would dictate the amount of detail they would be given. Dr Schmidt had a different view, stating that parents needed to be given a detailed description of all aspects of a TOF, including the risks involved and the nature of any

procedures that would be necessary. Dr Schmidt said that he would defer to the opinion of the fetal medicine specialists on this point.

(l) Dr Schmidt was of the view that a good deal of counselling was called for after the appearance of the polyhydramnios because "at this particular stage a lot is going wrong". He thought that an astute geneticist could have reached a diagnosis of VACTERL, or at least it would have been "high on the list".

(m) Dr Challis and Dr Cole had a different view in relation to VACTERL as a "diagnosis of exclusion" and a "constellation of some or many findings". Dr Challis said there was not enough information available before Saba's birth to have reached a "unifying diagnosis because there was still a range of possibilities". He did not see the need to have involved a clinical geneticist. Although Dr Cole agreed with Dr Challis, he did add that he thought it necessary to provide:

> counselling revolving around uncertainty and explaining to the parents that there is the potential of a unifying condition but that we have no evidence pointing to any particular condition at this point in time.

Even on the defendant's version, no counselling of this type took place.

(n) The doctors were asked about the parents bringing up the issue of termination of pregnancy at 30+ weeks' gestation where there is a suspicion of a TOF. Dr Challis said that he would inform the parents that, absent a definitive diagnosis, it would be unlikely that a termination would be approved. Dr Cole said that, as long as there was uncertainty around the diagnosis and the prognosis, the situation was "more challenging". He noted, however, that if the parents were persistent, a meeting of the hospital's Ethics Committee would be convened. Dr Cole stated that, if he was the parent's advocate before the Ethics Committee in this particular case, it would have been "a very difficult case to sell". Dr Challis said that, if approval had been given, he would have carried out the procedure.

(o) All of the doctors agreed that, if approval had not been given, it was very unlikely that the procedure would have been carried out by any doctor in Australia outside the public hospital system.

(p) The doctors were generally united in their opinion about the risks that would have faced the parents, had they decided to travel outside Australia to have the termination. Dr Schmidt said, however, that there had been a window of opportunity after the first amnioreduction, when the mother had a long cervix of about 3.1 cm.

(q) The doctors referred to the risk of going into labour while in the air, the risks of the healthy baby being born prematurely, and the risk of a procedure being performed by a doctor who was not known to the parents.

(r) There was some minor disagreement between the doctors regarding the medication that might have been taken to guard against the risk of deep vein thrombosis. The relevant medication was Clexane. Dr Schmidt and Dr Cole had no difficulty with its use, while Dr Challis would not have prescribed the drug because the mother had a high risk of postpartum haemorrhage and a history of this condition.

(s) If the parents had insisted on travelling, they would have been provided with a letter of introduction in as much detail as possible to assist the overseas doctor.

(t) I asked the doctors about the state of the notes, in particular the error concerning the amnioreduction procedure on Twin A. This can be found in Exhibit 2 at page 105.

(u) Dr Challis and Dr Cole generally agreed that the mistake was not significant, but was a product of a busy practice. I found this response surprising, particularly having regard to the need for accurate notes. Dr Challis and Dr Cole did significantly disagree on the overall standard of the notes. Dr Challis said that the brief notes were not dissimilar to notes that might be made in his unit. Dr Cole responded:

> I would take a very different view to Dr Challis on this to be honest with you. I would think that the role of clinical notes is several folders [sic], it's obviously a medico-legal document but it has much more important roles in terms of the internal workings of the hospital and recognises that multiple parties are usually involved in the area [sic] of these patients in documenting what the medical issues are, what the thought processes of the care providers are, what the thought processes of the patient is and directions for care that enable others that followed to have insight into all of that I think is extremely important… and I would think that the quality and extent of the documentation of the clinical interactions in this case falls well below what I would consider a personal standard and certainly if any of my junior staff produced a lack of notes like this for a complex case like this I would be extraordinarily disappointed in that behaviour. So I would see this as an important issue in the case to be honest. (T 892.42 – T 893.15)

(v) Dr Challis described the procedure involved in a selective termination. He also referred to the counselling, by social workers and psychiatrists or psychologists, which would be involved. He said the procedures were done "in cases where an outlook for a fetus is dismal and we think that it makes the world a better place". I think the point he was endeavouring to make was to highlight the distinction with the current case, where the prenatal indications were not dismal. This of course is to be contrasted with the very dismal eventualities.

382. Before leaving the conclave, I think it appropriate to express my view on the difference of opinion about the notes. I entirely agree with Dr Cole. I do not think that a busy practice is an excuse for inferior notes. The notes may be important for possible litigation purposes but they are certainly important for the continuing management of a patient. The fact that a doctor does not have time to prepare proper notes is not an excuse; it is more an indication of either the inefficiency of the doctor or of his or her preparedness to see more patients than should be seen. I also accept it could be a product of the doctor being overworked and not having the time or resources to complete the notes. There was a distinct impression that the FMU was very busy.

383. As far as the mistakes are concerned, such as those concerning the obstetric history and the amnioreduction carried out on Twin A, I think that they carry more significance than can be excused as a simple error. The presence in the notes of a discussion of a procedure being carried out which never actually occurred is, in my view, capable of having significant consequences. Doctors may be very busy, and the mistake may be easily made, but it is a mistake that, in my view, bespeaks negligence, although it is not negligence of a type alleged in the present case.

384. The state of the notes, both in regard to their brevity and to the errors, does however assist in defining the overall picture of the workings of the FMU and the degree to which I accept the versions of events that the unit's doctors have advanced. The absence of detailed notes, set against the background of the many thousands of patients seen in the unit since 2011, strongly points in favour of acceptance of the plaintiffs' version of the conversations that did (or did not) occur.

385. Dr Evans is a neonatal specialist. His report commences at page 353 of Exhibit 2. Dr Evans appropriately indicates areas where he does not think that he has the necessary expertise to answer the question posed to him. I have gained the most benefit from his report in the areas in which he is plainly an expert.

386. In discussing conversations with the plaintiffs, Dr Evans makes this comment at [34]:

> Bearing in mind that the diagnosis of TOF was uncertain at this stage [28 to 30 weeks], my counselling about other abnormalities would depend on cues from the parents that they wanted me to go into that detail. Often parents don't want too much detail at this stage. Some do, so it's important to tailor the counselling to the individuals concerned.

387. The impression I had of the plaintiffs was that they were parents who were intelligent, well-educated and would have been interested to know the detail of what was occurring with the condition of Twin B. On this assumption, Dr Evans continued at [35]:

> If they indicated that they wanted more detail, I would discuss other abnormalities including chromosomal abnormalities (which had been excluded in this case) and that about 10% of TOF cases may have the VACTERL association. Highlighting that some of the other abnormalities in this association are difficult to diagnose antenatally but that, again, the outcomes from the VACTERL association were usually good.

388. I find it difficult to imagine that, even if the outcomes were "good", there would not still be a substantial effect on the newborn child. More importantly however, even on Dr Robertson's version, VACTERL association was not discussed with the parents.

389. Dr Currie is a paediatric surgeon. His report commences at page 365 of Exhibit 2. The first question asked of Dr Currie was whether or not it was reasonable for the hospital to have not arranged a prenatal consultation with a paediatric surgeon, after the possibility of a TOF was raised with the parents on 22 September 2011. The question of course assumes that the possibility was raised with the parents.

390. Dr Currie's response seems to cover both sides of the argument:

> I do not believe it was unreasonable not to arrange a prenatal consultation with a paediatric surgeon. The prenatal diagnosis of a TOF is unreliable, it is not made with certainty and an ultrasound has a low specificity and sensitivity for this condition. In other conditions, when a diagnosis is known and where immediate post-delivery treatment is needed, then I believe that a paediatric surgical consult prenatally is vital. In the case of a TOF, given the uncertainty of the diagnosis, then clinically a paediatric surgeon cannot add much to the prenatal treatment, except to insist that the child is born in a unit which can offer specialised paediatric surgical services…
>
> Having said that, such a prenatal consult is often very parent driven as they wish to have all available facts presented to them in case the child does have a TOF.

391. As I understood Dr Currie's report, he does not think that a prenatal consultation between the parents and a paediatric surgeon is necessary when a TOF is suspected, but recognises that parents might wish to be informed of the possible consequences of a TOF and that, in such a case, their wishes should be taken into account. I have already said that the plaintiffs impressed me as parents who would have wished to be

informed. In addition, I note that Dr Maclean gave evidence that there was more than a suspicion of a TOF, because of the existence of a number of other abnormalities.

392. I think that the medical evidence, taken as a whole, unquestionably supports the plaintiffs' contention that they should have been informed not only of the suspicion of a TOF but also of its possible ramifications for the newborn child. As has been observed above, there was an identified heart anomaly, there was an issue between the doctors about the nature of the heart condition or at least its effects, there was evidence of a shortened femur, there was a history of a small stomach and there was a return of the polyhydramnios. As at 22 September 2011, there were enough issues to necessitate a discussion with the parents outlining the meaning of a TOF, the manner in which it could be addressed, and the relevance of Twin B's fetal state to her likely condition after birth.

393. I also draw the following conclusions from the medical evidence, including the reports and the oral evidence of the doctors:

    (a) The note taking and record keeping in the FMU was well below an acceptable standard.

    (b) An ethics committee in any State or Territory in Australia would not have approved a selective or total termination after 22 weeks' gestation.

    (c) A termination would not have been available in Australia outside of the public health system.

    (d) Assuming the parents were informed of the TOF on 22 September 2011, it makes no difference that they were not informed after the High Risk Meeting on 6 September 2011.

    (e) VACTERL Association could not have been conclusively diagnosed before Saba's birth but a suspicion of its presence was available.

    (f) Even without a diagnosis of VACTERL Association there were indications, if not high probabilities, that Saba would be born with disabilities, in particular a TOF which might have a significant effect on her future life and would probably require corrective surgery.

Expert travel evidence

394. Two reports from travel agents, Mr McNamara and Mr Sheikhdin, were tendered by the plaintiffs (Exhibits L and M respectively). Mr Sheikhdin has previously made travel arrangements for the plaintiffs.

395. The reports deal with the rules relating to pregnant women flying in the later stages of pregnancy. Essentially, it is apparent that flights to America can be taken without medical support up to 32 weeks of pregnancy. United Airlines allows travel before 36 weeks of pregnancy and Delta does not seem to have any restriction at all.

396. However, both travel agents were of the view that, notwithstanding the airline that was selected, there was a possibility that upon presentation at the airport, airline staff could potentially seek medical proof that the passenger was fit to fly. This would generally be in the form of a letter from a doctor. In addition, Mr Sheikhdin said that if he was made aware of "complications" in the pregnancy of a passenger seeking a ticket he would first clear the issuing of the ticket with the relevant airline.

397. I think the limit of what I can draw from the evidence from the travel agents is that an airline ticket could have been purchased by Ms Nouri but it may have required production of medical material and was always subject to the right of the airline to refuse to accept her as a passenger.

398. One means of ameliorating the risks involved would have been to take a flight with a stopover in, for example, Hawaii. All of the flights are lengthy, the longest being from Sydney to Dallas which is 17 hours and only operated by Qantas. Mr McNamara was not sure if this flight was in operation in 2011.

The duty of care

399. Although the *Civil Law (Wrongs) Act 2002* (ACT) is always the starting point in an action for negligence, there was no real issue in this case that the defendant could potentially be liable under s 43 or that the standard of care, as defined in s 42, was applicable. The issues in this case were more confined to the content of the duty of care and whether or not there had been a breach of that duty.

400. The defendant conceded that it owed the plaintiffs a duty of care.

401. The general duty in medical negligence matters is that described in *Rogers v Whitaker* [1992] HCA 58; 175 CLR 479 at [5]:

> Neither before the Court of Appeal nor before this Court was there any dispute as to the existence of a duty of care on the part of the appellant to the respondent. The law imposes on a medical practitioner a duty to exercise reasonable care and skill in the provision of professional advice and treatment. That duty is a "single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgment" ((2) Sidaway v. Governors of Bethlem Royal Hospital [1985] UKHL 1; (1985) AC 871, per Lord Diplock at p 893); it extends to the examination, diagnosis and treatment of the patient and the provision of information in an appropriate case ((3) Gover v. South Australia (1985) 39 SASR 543, at p 551.). It is of course necessary to give content to the duty in the given case.

402. I asked the parties for a note on what they respectively submitted was the content of the duty. I note at the outset that, in their different formulations, the parties did not distinguish between the parents. In other words, it was not suggested that a duty of care was owed to the mother but not to the father. It was also not suggested that any distinction could be made about the content of the duty of care between the mother and the father.

403. The defendant's note took the form of a primary position and a backup position. The primary position was as follows:

> With respect to a claim for damages for wrongful birth, putting aside specific enquiry from the parents, there was no duty to provide information to the parents about the unquantifiable risk of other consequential or associated conditions where:
>
> (a) There was only a possibility of TOF and, if present, it could not be diagnosed until after birth.
>
> (b) Any other, consequential or associated condition could not be diagnosed until after birth.
>
> (c) The risk was unquantifiable but small.
>
> (d) It was not reasonably foreseeable that the mother would seek and/or could have obtained a termination of pregnancy at this gestation in a twin pregnancy, if she were properly advised as to the unavailability of a late termination locally and the dangers to herself and the twins if she flew overseas.

(e) In the absence of specific enquiry, a doctor in the position of the defendant would not reasonably regard further information as to a small but unquantifiable risk of other consequential or associated conditions as material to any decision that the mother needed to make, in circumstances where termination of pregnancy would not reasonably have been thought to be available and/or available locally.

404. The defendant's primary position clearly extended beyond the content of the duty to questions of causation and breach.

405. The defendant's secondary submission was:

> In the circumstances of this matter, it is accepted that there was a duty to warn of the possibility of TOF after the small stomach was noted on 22 September 2011, notwithstanding TOF was only a possibility.

406. The plaintiffs' submission was as follows:

> The duty of care is to exercise reasonable care and skill in the provision of professional advice and treatment.
>
> In this instance the Plaintiffs contend that the content of the duty was to inform them about possible disabilities or anomalies with twin 2 (Saba) in a timely manner so that they could make an informed decision about whether or not to continue the pregnancy.

407. In final written submissions, the plaintiffs' position was refined to the following:

> In this instance, the plaintiffs maintain that the content of the duty of care includes an obligation on the part of the defendant through its medical staff to keep the plaintiffs informed of any abnormalities detected in the pregnancy, including providing them with sufficient information to make an informed decision about whether to continue with the pregnancy, and the options, if any, for termination in the event that the plaintiffs should so desire it.

408. Taking some cues from the respective submissions, I have come to the view that the content of the duty of care in this case should be expressed as follows: the defendant was under a duty of care to inform the parents, so as to enable them to make informed decisions about treatment, including termination of pregnancy, of all matters reasonably relevant to the wellbeing of the mother and the fetus, including conditions which might reasonably be expected to materially affect the fetus following birth. This duty to inform arose when the defendant possessed enough reliable information to allow it to reach these conclusions.

409. The plaintiffs submitted that three obligations arose from the duty of care. These were:

(a) To raise with the plaintiffs the anomalies disclosed upon ultrasound testing.

(b) To explain to the plaintiffs the possible significance of those anomalies.

(c) To refer the plaintiffs for appropriate counselling as to the options available so that an informed decision might have been made to continue with the pregnancy or not.

Breach of the duty of care

410. I have already made a number of factual findings above which indicate my acceptance of the plaintiffs' version about what they were told or not told. It follows that I find that there has been a breach of the duty of care. I think my finding is reflected in the observation of Dr Cole, already quoted above that:

> The combination of a major cardiac abnormality AND oesophageal atresia / tracheo-oesophageal fistula carries a significantly worse prognosis than either condition in isolation. Thus, if the condition was suspected, in my opinion it would be reasonable and proper to

discuss this suspicion with the parents, including the information regarding a poorer prognosis if the diagnosis later proved to be correct.

411. I have also taken the following into account in reaching this conclusion:

(a) Although a TOF was only a possibility it was a significant enough condition to be brought to the attention of the parents. The defendant submitted that a diagnosis of a TOF was "bread and butter" for fetal medicine specialists. This was the evidence of Dr Challis. Accepting this to be the case, the condition was not bread and butter to the potential parents. Further the parents would have been entitled to be informed of the possibility of a condition that, while even probably capable of early correction, was likely to require treatment of the newborn baby and possibly continuing treatment as the child grew.

(b) The defendant submitted that:

> With regards the advice to be provided to the parents arising from these various options - there were a number of possible diagnoses but most were surgically correctable, and no-one would know until the baby was born.

This is precisely the point. It must be the case that a parent should be informed of a possible diagnosis which will require surgery.

(c) Even if a TOF was only a possibility, it was nevertheless a possibility of a real condition of a nature parents would be entitled to be informed about. The defendant, in its written submissions, repeated on a number of occasions that the parents were sophisticated. They were clearly able to understand the information. They were not people who needed to be shielded from 'bad news' or complicated information.

(d) It is also relevant that possible cardiac abnormalities had often been discussed. The possibility of a separate condition would have formed part of the overall discussion about the fetus.

412. I have, however, accepted the defendant's submission that the earliest date when a duty to inform might have arisen was 22 September 2011. Although there is the suspicion of a TOF on 6 September 2011 it was reasonable for the matter to be considered and a further scan to be conducted, noting that the last scan had occurred on 5 September 2011. Dr Cole agreed with this proposition (T 870.23).

413. The plaintiffs submitted that the cardiac condition also features in the breach debate. The point made was that a failure to inform the parents about the cardiac issues prior to 22 September 2011 indicated the attitude of the defendant to the provision of information and also delayed any consideration or preparation of a termination before 22 September 2011. I reject this submission for the following reasons:

(a) The case was run on the basis of a failure to inform of a TOF.

(b) While I prefer the plaintiff's evidence about the failure to inform of a TOF, I do not accept that they were not given information about the cardiac issue. This was the reason they were at the FMU, it was the cause of them going to Dr Murphy and was raised frequently by Dr Robinson in relation to another opinion.

(c) Most importantly Dr Maclean said:

> There were sufficient feature at 28 weeks for the FM specialist to have raised diagnosis of TEF in the high-risk meeting. It was one of two differential diagnoses for polyhydramnios in Fetus 2. There were grounds to have established TEF as a provisional working diagnosis. It may have been reasonable to await review following the next ultrasound at 30 weeks before raising the possibility TEF – as well as the difficulties in establishing a definitive diagnosis – with the parents.

(d) Then, in his oral evidence, after confirming his view about a delay of giving information to the parents to about 30 weeks, he emphasised the probable significance of a possible TOF over the cardiac condition.

> So, if I could paraphrase the question from there, it was the re-accumulation of the 15 polyhydramnios, it, whilst not diagnostic of an individual problem, it would heighten the likelihood of an obstructive - it would speak to the severity of the problem, the - and as a non-obstetrician, the potential for earlier delivery, the discomfort and diagnostically it would add greater weight to an obstruction versus a narrowing, or versus a cardiac problem, in my individual opinion (T 801.13; 19 October 2017).

(e) The above oral evidence is well explained in Dr Maclean's report at page 191 of Exhibit 2:

> Re-interpretation of the cardiac anomaly together with other sonographic findings in the context of polyhydramnios, a small stomach and possible TOF/OA identified at 30 weeks gestation becomes more nuanced. It is important in counselling prospective parents to know if there are identified factors that directly impact on predicted outcome. It is equally important to communicate the difference between direct evidence of serious pathology and markers of increased risk (biomarkers, sometimes termed "soft markers" in fetal medicine).

414. I should add at this stage that it is implicit in my finding of a breach of duty that I am satisfied, if it be necessary to so find, that the breach took into account the entitlement of the plaintiffs to certain damages flowing from the negligence of the defendant. This is an area mostly dealt with below under 'Damages' but is mentioned here because of the defendant's submissions concerning breach of duty for purely economic loss.

415. The defendant referred me to a number of English authorities concerning breach of duty and damages. A case not referred to is *Meadows v Khan* [2017] EWHC 2990 (QB) ('Meadows'), a decision of Justice Yip in the High Court of England and Wales. Her Honour conducted a very useful summary of relevant English authorities.

416. In *Meadows* a claim was made for the costs of raising a child who had been born with haemophilia and autism. The negligence in the case was the failure of the defendant to inform the plaintiff of the child's haemophilia. Had she known about the condition she would have undergone a termination of the pregnancy. Although the negligence was admitted her Honour nevertheless examined the authorities concerning the damages that might flow from a breach of duty. It was not contested that damages should be awarded for the costs associated with the haemophilia. It was disputed that there was any entitlement to expenses related to the autism.

417. One of the issues identified by her Honour, after examining authorities referred to by the defendant in the cases of *Parkinson v St James & Seacroft University Hospital NHS Trust* [2000] QB 266 and also *Groom v Selby* [2002] Lloyds Rep Med 1, was whether the autism was a consequence "falling within the responsibility the defendant had assumed". Her Honour said, from [61]:

> The thrust of the defendant's argument (summarised at paragraph 38 of the skeleton argument) was that the additional losses associated with Adejuwon's autism fall outside the scope of the duty owed to the claimant.

> I do not accept that is so. As I have already said, the focus of the defendant's duty and the very purpose of the service the claimant sought was to provide her with the necessary information to allow her to terminate any pregnancy afflicted by haemophilia. The birth of Adejuwon resulted from a pregnancy which was afflicted by haemophilia. His autism was bad luck, in the same way that the meningitis in *Groom* was bad luck. Equally, each condition was the natural consequence of a pregnancy that would not have continued if the doctor's duty had been performed correctly. The scope of the duty in this case extended to preventing the birth of Adejuwon and all the consequences that brought.
>
> For the same reasons, I reject the submission that the losses flowing from Adejuwon's autism fell outside the defendant's assumption of responsibility. It is true that the defendant did not assume any particular responsibility in relation to autism but neither did the doctor in *Parkinson* assume a particular responsibility for learning difficulties or the doctor in *Groom* for meningitis. In all cases, the doctor did assume a responsibility which, if properly fulfilled, would have avoided the birth of the child in question.

418. In my view the defendant had assumed a responsibility to inform the plaintiffs of the possibility that Saba would be born with a TOF "which, if properly fulfilled, would have avoided the birth" of Saba.

419. I have reached this conclusion notwithstanding that the only conversation concerning termination had concerned the suspected cardiac condition. In my view, any condition which required the parents to be informed about it, also carried the inference that if informed, the mother might seek a termination. This is especially the case with a condition such as TOF where, even without ultrasound confirmation, the possibilities of numerous other conditions or disabilities existed (again see Exhibit Q).

Causation

420. Causation is governed by s 45 of the *Civil Law (Wrongs) Act 2002* (ACT) ('the CLW'). It states:

> **45 General Principles**
>
> (1) A decision that negligence caused particular harm comprises the following elements:
>
> (a) that the negligence was a necessary condition of the happening of the harm ('factual causation');
>
> (b) that it is appropriate for the scope of the negligent person's liability to extend to the harm so caused (the ***scope of liability***).
>
> (2) However, if a person (the ***plaintiff***) has been negligently exposed to a similar risk of harm by a number of different people (the ***defendants***) and it is not possible to assign responsibility for causing the harm to 1 or more of them—
>
> (a) the court may continue to apply the established common law principle under which responsibility may be assigned to the defendants for causing the harm; but
>
> (b) the court must consider the position of each defendant individually and state the reasons for bringing the defendant within the scope of liability.
>
> (3) In deciding the scope of liability, the court must consider (among other relevant things) whether or not, and why, responsibility for the harm should be imposed on the negligent party.

421. It is clear from the authorities that s 45(1), like s 5D(1) of the *Civil Liability Act 2002* (NSW) ('the CLA'), establishes a 'but for' test. It is also plain that the onus in respect of causation is always on the plaintiff. Section 46 of the CLW states:

> **46 Burden of Proof**

> In deciding liability for negligence, the plaintiff always bears the burden of proving, on the balance of probabilities, any fact relevant to the issue of causation.

422. I agree with the defendant's formulation of the primary debate concerning causation. The defendant submitted:

> The key issue in relation to causation is whether the first plaintiff would have obtained a termination of pregnancy in relation to twin 2 at something different being done by TCH, which should have been done.

423. The following are the primary problems faced by the plaintiff on causation:

(a) It is important to remember here, as a starting point, that the plaintiffs' case is that the information about a possible TOF should have been given to them on 22 September 2011, but not before that date. This is 30 weeks and four days into the pregnancy. If a termination was to be considered, counselling provided and travel arrangements made, then time would have been short and, in effect, 'everything would have needed to fall into place'.

(b) The plaintiffs say that the duty of care owed to them included the obligation to refer them for counselling. It cannot be said what the effect of counselling would have been. Their pre-determined idea of a termination could well have been affected by considerations explained to them during counselling, for example about the likely effect on Twin A, the dangers to the mother associated both with a termination and with travel and the possibility that, to the extent that Saba's likely condition was then known, that it might have been influenced by post-natal treatment.

(c) The likelihood of travel occurring at all. It does seem likely that one airline or another may have issued tickets to the plaintiffs, but they may nevertheless not even have boarded the plane, in particular if a medical clearance had been required.

(d) Dr Cole (at T 902.28) said about a week of preparation would be necessary before travel. This included the possibility of a second amnioreduction being required and then counselling occurring (but not affecting the parents' intentions). The logistics of travel would need to be factored in. Notably, in their joint statement (Exhibit 40, page 2) the plaintiffs say:

> When my wife was roughly 32 weeks they asked us to go to Sydney which we said we are happy to go back to Sydney to see the cardiologist but my wife is not in a position to travel neither by a car nor a normal passenger plane.

(e) If the plaintiffs thought that Ms Nouri was not well enough to fly from Canberra to Sydney at about 32 weeks' gestation, one wonders how she could have been well enough to fly to America at about the same time or even a week or two earlier. Notably, on 18 October 2011 the Ms Nouri was in so much pain she could not undergo an amnioreduction.

(f) While the parents said that they would have been able to fund the exercise, the evidence about costs and practical accommodation requirements is limited. I also do not know if any immigration difficulties may have arisen. Mr Shaor said he would have made an online application for a visa (known as an ESTA) but there is no evidence from any American immigration authority on this point. I note that Mr Shaor was refused entry to the USA as a refugee because of his military history. I do, however, note that the plaintiffs are

Australian citizens and this may have negated any history that Mr Shaor had in relation to American border authorities.

(g) Perhaps most importantly, the probability that a termination would have been conducted in America at all. It is very clear from Dr Hern's evidence that he would not have performed a selective, or any, termination simply because it was requested. He would have had to satisfy himself that it was an appropriate procedure to take place especially having regard to his assessment of the mother's condition and her history. I do not think the evidence is such that I can make a finding on a balance of probabilities that Dr Hern, or any other 'abortionist', would have been prepared to carry out the termination.

(h) Dr Hern also said he would have wanted to see a definite diagnosis of a serious condition before he proceeded. He did qualify this evidence by suggesting he would have at least needed to see all the relevant documentation. The point however remains, that I cannot be satisfied on a balance of probabilities that Dr Hern would have carried out the procedure. Yet further, it is impossible to know the condition Ms Nouri would have been in on her arrival in America.

(i) The plaintiffs' evidence never rose to the point (as described in the opening) of either plaintiff telling Dr Robertson that a termination would be chosen if they had been told of Twin B having any disability. The evidence went no further than the possibility of a termination being related to a cardiac condition.

(j) I have stated above the limitations that attach to Dr Sella's report.

(k) While I accept that the plaintiffs are now adamant that they would have sought a termination it is important to remember that they are looking back with the benefit of hindsight and in the knowledge of the disabilities that have affected Saba.

424. I do not think the plaintiffs have surmounted the above problems. Ms Nouri was unlikely to have been able to travel absent a second amnioreduction, a procedure she was not able to complete on 18 October 2011. If she would have presented at the airport, obviously very pregnant, and in pain, I could not be satisfied that the relevant airline would have allowed her to board. I am not satisfied that any doctor would have provided her with supporting documentation if she had not had the second amnioreduction and was not in a fit state to fly.

425. Further, I am not satisfied that Dr Hern, or any like doctor, would have been prepared to carry out the abortion. The fact that Dr Hern said he carried out similar procedures does not mean he would have performed any procedure on Ms Nouri. The state of the evidence can be taken no further than to say that he might have carried out a procedure. This is not enough to establish causation.

426. The hindsight point is also important. I have no doubt that the plaintiffs, now living with a severely disabled child and having had their lives and livelihoods severely affected, are convinced they would have found a way to achieve a termination. What is unknown is if counselling, which they say they should have had, would have had an effect on them or if the risks and logistics of travel to America would have either been beyond

them, or been viewed as risks they were not prepared to take. All of the doctors agreed that Ms Nouri faced substantial risks in travelling to America.

427. It follows that the plaintiffs have not established, on a balance of probabilities, that they could or would have obtained a termination had there not been a breach of the duty of care as outlined above. Accordingly, the plaintiffs must fail on liability.

Damages

428. Because of my decision on liability I intend to deal with damages fairly briefly, but hopefully explaining the sums I would have awarded had I found in favour of the plaintiffs.

429. Before looking at the individual heads of damages, it is important to remember that Saba's disabilities are not the product of the alleged negligence. Assuming she was born, she would have had the disabilities. The plaintiff's case is that she should not have been born at all, so that all of the financial effects flowing from her birth should be met by the defendant.

430. The plaintiffs say that if she had not been born they would have been able to carry on working (and therefore earned money), they would not have endured the grief and anguish associated with raising a disabled child, they would not have had the expenses of raising Saba (even as a healthy child) and they would certainly not have had the costs associated with all of her extra needs.

431. The plaintiffs claimed damages into the future for the whole of Saba's life expectancy of 31 years. The defendant said that whatever damages were awarded could not extend beyond Saba reaching 18 years of age because this was when her parents' legal obligation to support her came to an end.

432. Further, the defendant submitted that the plaintiffs could not receive both the costs of commercial care and economic loss. This was because they were going to provide the care for Saba and therefore would not incur any costs of commercial care. If commercial care was awarded it was agreed that the appropriate rate was $43 per hour.

433. The plaintiffs each claimed $200,000 for general damages. The defendant said there should be no award at all. It was conceded that the plaintiffs had not suffered any psychiatric disorder and they were not entitled to any claim for nervous shock.

434. In my view, the plaintiffs are not entitled to damages of the type they claim. I can see no basis in authority for awarding general damages. I can see no support in *Cattanach v Melchior* [2003] HCA 38; 215 CLR 1 ('Cattanach') for the claim. A similar claim received some scrutiny by Beech-Jones J in *Neville v Lam* (No 3) [2014] NSWSC 607. His Honour said this, at [166]:

> [166] A discussion at this level of generality cannot be advanced further partly because *Cattanach* did not directly address it, and partly because it is also conditioned by issues of causation and remoteness. However, at the very least the various judgments in *Cattanach* suggest that once some part of a claim for non-pecuniary loss is pitched in a manner that necessarily involves or requires an assessment of the relative benefits and detriments of rearing a child, then it cannot be entertained.

435. The plaintiffs relied on a Queensland Supreme Court decision of de Jersey J in *Veivers v Connolly* [1995] 2 Qd R 326. In this case, his Honour awarded general damages of $50,000 to compensate the mother of a severely disabled child. The award was for

pain and suffering and loss of amenities and in particular for the "anguish she suffered during the pregnancy and because of the birth of a gravely handicapped child, and through her subsequent care of the child, which will continue". In my view this decision can no longer be supported following *Cattanach*.

436. In respect of the claim for both economic loss and commercial care the defendant pointed to the following concession made by Senior Counsel for the plaintiffs on 27 August 2018. He said:

> MR CRANITCH: To a degree, your Honour. This is the opening that's been exercising my mind because at the end of the day there are two people providing the support, one backing the other up and that's not going to change over the lifetime, particularly from the point of view that this, of course, are damages of Mr Shaor and Ms Nouri, that is not going to change. So really what Ms Moylan says is probably not relevant in the context of their claim for damages because it is an additional matter that they would - we have got no evidence that they would pay for a separate carer out of their own pocket. They just intend to continue to care for their child. So, I mean, once I have put that into the equation, your Honour, I will be able to give your Honour a definitive answer and my learned friend about Ms Moylan.

437. In final submissions, when the plaintiffs' Senior Counsel was not present (due to ill health), Junior Counsel said that the case had always been run on the basis of a claim for commercial care and any concession that had been made by his learned leader was withdrawn. I accept that a claim for commercial care had been pursued through the case and take no account of the concession apparently made. However, that does not imply my acceptance of the claim for commercial care, at least in total, because of the effect of the claim for economic loss. It also does not remove the plain fact that the parents are likely to continue to provide at least the majority of care for Saba.

438. The only basis upon which future economic loss could be claimed is that the plaintiffs would be unable to work because they were providing care for Saba. Accordingly, there would be no commercial care expense. I think there is a caveat to this apparently simple approach.

439. It was agreed that Saba required 24-hour care. This is 168 hours per week. The NDIS provides 15 hours of care per week. This means that the plaintiffs, if unassisted, would be providing 153 hours of care per week.

440. If the plaintiffs were working and also caring for their other children their capacity to continue to provide the 153 hours per week would be severely strained. In my view there is a legitimate scope to award the plaintiffs economic loss together with an amount of commercial care. This could be reflected in, for example, having an overnight carer or perhaps a carer on one or two days per week.

441. In my view, an approach which both compensates the plaintiffs for economic loss and also allows a degree of commercial care is to allow for 14 hours per week of commercial care.

442. In relation to the general entitlement to economic loss, I am satisfied that the parents do have such an entitlement. This I think is made clear by the High Court in *Cattanach*.

443. The next point is whether the economic loss should be allowed beyond Saba's 18th birthday. Her need for care will certainly not end on her 18th birthday and will continue at the same level, if not an increased level, for the balance of her life expectancy. The child in *Cattanach* was born healthy and without disabilities. There was no suggestion that any loss should be provided after the child turned 18.

444. The observations by Gleeson CJ and Heydon J in *Cattanach* suggest that damages might be extended beyond the age of 18. However, both of these judgments were in the minority and both Judges would not have allowed damages at all.

445. The authorities are not clear on this matter. There are English authorities, like *Gaynor N v Warrington Health Authority* [2003] Lloyds Rep Med 365 which suggest the damages could continue as long as the child has a need for the care.

446. In *Waller v James* [2013] NSWSC 497, at first instance, Hislop J, if he had awarded damages, would have restricted them until the child reached 18. His Honour conducted a comprehensive review of the authorities. He said from [277]:

> [277] It was accepted by the defendant that Keeden will need care for the remainder of his life.
>
> [278] The defendant, however, contended that the scope of the defendant's liability is to be identified by reference to the nature of the harm for which compensation is being awarded. The relevant harm is the burden of raising a child, in this case a child with disabilities. It is a harm that the plaintiffs will incur because, as parents, they have a legal responsibility to care for and maintain Keeden — *Family Law Act 1975* (Cth) ss 60B, 61(C)(1), 66C, *Child Support (Assessment) Act 1989* (Cth) s 3 — *Luton v Lessels* (2002) 210 CLR 333 at [6]. Accordingly, the claim should be limited to the period of time in which the plaintiffs have a legal responsibility to care for Keeden. The legal obligation on the plaintiffs will cease when Keeden attains his majority upon his eighteenth birthday.
>
> [279] In *Cattanach* McHugh and Gummow JJ at [68] said "..it is the burden of the legal and moral responsibilities which arise by reason of the birth of the child that is in contention." Kirby J in his judgment also made reference to legal and moral responsibilities. The plaintiffs contended that the reference to "moral" responsibilities in those judgments extended to a responsibility beyond the statutory legal obligation. The plaintiffs submitted they have a moral obligation to care for Keeden for the rest of his life. This may be. However, in context, it is probable that the above comments were referring only to the parents' responsibility to a child up to the age of 18 years as this is what was in contention in *Cattanach*.
>
> [280] Reference was also made to the decision of Kirby J in *Cattanach* where his Honour said the "full damages against the tortfeasor for the cost of rearing the child" must be taken to be the "reasonable costs of rearing an unplanned child to the age when that child might be expected to be economically self-reliant, whether the child is 'healthy' or 'disabled'". The plaintiffs submitted that Keeden would never be in that position but would, in the eyes of the community, become economically self-reliant when he commenced to receive a full pension.
>
> [281] The defendant contended that the conclusion that liability should cease upon Keeden obtaining his majority would impose intelligible limits on the recoverable damages and would keep the law of negligence within the bounds of common sense and practicality — *Cattanach* at [32] per Gleeson CJ (dissenting).
>
> [282] There is no binding authority on this issue. It was not decided in *Cattanach* because the claim there was limited to a claim for care to age 18. The authorities which were referred to were inconsistent. In McDonald v Sydney South West Area Health Service [2005] NSWSC 924 at [88] Harrison AsJ held the responsibility of parents for their children does not always cease at age 18 but may continue during tertiary studies. In *G & M v Armellin* [2008] ACTSC 68 a claim for the cost of continuing to support the additional child during tertiary education was refused, the court noting that it was "not part of the legal responsibility of a parent to support a child through university and many parents do not do so."
>
> [283] In the United Kingdom there are a number of first instance decisions. In *Rand v East Dorset Health Authority* [2000] Lloyds Rep Med 181 the parent of a disabled child was awarded damages reflecting the costs of raising the child until the age of 25. In *Hardman v*

Amin [2001] PNLR 11 the damages extended to the lifespan of the claimant's parent. See also *Gaynor N v Warrington Health Authority* [2003] Lloyds Rep Med 365 at [16].

[284] The authorities to which reference has been made provide little guidance beyond age 18. The issue appears to be an open one. Any entitlement beyond 18 years will depend upon policy considerations. At this stage of the development of the law, if I was awarding damages I would limit them to the period up to Keeden's 18th birthday.

447. With some reluctance I have come to the view that notwithstanding the moral obligation that will continue to motivate the parents after Saba turns 18, they are not entitled to damages after this time. My decision is reinforced by the fact that after Saba reaches 18 there will be a legal obligation on NDIS to support her. I have no doubt this will not be to the same extent as the obviously excellent care she receives from her parents. Nevertheless, she will be entitled to support from this scheme.

448. The next point is the quantum of the economic loss that should be awarded. The plaintiffs have claimed the weekly sum they were earning when working at the Saudi Arabian Embassy. Their claim is for the gross figure of their former wages. I have the following difficulties with this claim:

    (a) In awarding damages for lost income, the purpose is to place the plaintiffs in the position they would have been but for the defendant's negligence.

    (b) The plaintiffs' evidence was that, assuming the twins were born without complication or disability, they would have returned to Sudan where Mr Shaor was involved in a commercial development. There is no evidence to suggest what amount he might have earned in this development. Ms Nouri would no doubt have spent some time concerned with the rearing of the twins. I have no idea whether she would have then sought employment in the Sudan.

    (c) There is a good deal of reason to doubt Mr Shaor's evidence about his economic loss, both generally and as to whether or not he has been working since the birth of Saba. I found his explanations about his reasons for going to the embassy and the receipt of an amount equal to his wages, as being a loan and not in respect of work done, very difficult to accept. In fact, I do not accept that evidence. I also note Mr Shaor's obstructive refusal to provide supporting evidence of his claims. For example, he refused to provide an authority addressed to the Australian Taxation Office ('ATO'), although did apparently change his mind. He also initially agreed to provide an authority for release of Centrelink documents but later refused to do so. His refusal did not extend to documents relevant to the Carer's Pension.

    (d) Ms Nouri needed to look after the healthy twin in any event. She is unlikely to have returned to full-time employment until he reached school age.

    (e) In relation to the claim for gross wages I do not accept that the wages of the plaintiffs were not subject to an assessment for tax. There are ATO interpretive decisions which would suggest to the contrary (for example, Australian Taxation Office, *ATO Interpretative Decision,* 2003/617, 15 July 2003)

449. The doubts I have had about the plaintiffs' claim for economic loss have led me to the conclusion that they have not established an acceptable basis for damages for the past. I am, however, satisfied that they should be awarded damages for the future, until Saba reaches 18, but not in the amounts that they seek. It is very difficult to come to

any logical conclusion about the appropriate amount. I have decided to assess their claim on the basis of average weekly earnings on a net basis.

450. My calculation of net weekly wages for males is currently $1,300 per week and for females is $1,079.

451. There are 11 years until Saba reaches 18. The 3% multiplier is $490. Because of the relatively short period of time I will apply a deduction for vicissitudes of 10%. The calculation for Mr Shaor is $1,300 x $490 x .9 = $573,300. The calculation for Ms Nouri is $1,079 x $490 x .9 = $475,839.

452. Although the parties did not address me on the point, I do not see why the plaintiffs should not be entitled to lost superannuation benefits on their economic loss. I will assess the lost benefits at 13%.

453. As I have said above, I think the plaintiffs do have a joint, but partial claim for care of 14 hours per week. At $43 per hour the calculation is $43 x 14 hours x $490 = $294,980.

454. It was effectively suggested to Mr Shaor that funds paid by the NDIS into Saba's account had been inappropriately used by him and his wife. He rejected the assertion saying that the monies were a reimbursement of expenses that he and his wife had paid and therefore they were free to withdraw their equivalent from the account.

455. The next claim by the plaintiffs is for past out-of-pocket expenses of $186,300. The defendant suggested $20,000. The plaintiffs claim is based on Mr Shaor's oral evidence that he was paying $3,000 per month until the NDIS started to pay medical expenses in November 2016. Thereafter, the claim is for $300 per month.

456. It is almost impossible to assess this claim because of the lack of documentary evidence. However, some guidance can be taken from Exhibit 45. Assuming the core support amount of $72,297.80 includes care at $43 per hour for 15 hours per week, the balance of $38,757.80 over 52 weeks equals $745 per week. This is roughly equivalent to the $3,000 per month claimed. I will include this amount in the damages that would have been awarded, together with the $300 per week from November 2016. In other words I accept the plaintiffs' claim of $186,300.

457. For the future, I would have continued the claim at $300 per week for the next 11 years. On the 3% tables this is $300 x $490 = $147,000.

458. The table below is a summary of the damages I would have awarded:

Future economic loss for Ms Nouri	$475,839
Lost superannuation benefits for Ms Nouri	$61,859
Future economic loss for Mr Shaor	$573,300
Lost superannuation benefits for Mr Shaor	$74,529
Commercial care for both plaintiffs	$294,980
Past out-of-pocket expenses	$186,300
Future out-of-pocket expenses	$147,000
Total	**$1,813,807**

459. I make the following orders:

(a) Judgment for the defendant.

(b) The plaintiffs are to pay the defendant's costs of the proceedings.

460. I will hear the parties if any other costs order is sought. I note there is an outstanding issue of certain costs being paid personally by the plaintiffs' solicitor.

I certify that the preceding four hundred and sixty [460] numbered paragraphs are a true copy of the Reasons for Judgment of his Honour Justice Elkaim.

Associate:

Date: