



# Obstetric Negligence Conference

## Common Negligent Errors in Obstetric Cases: A Claimants' Lawyer's Perspective

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# 1. Introduction

Injuries resulting from Obstetric Negligence Cases are:-

- The NHS's most expensive cases.
- Coveted by lawyers (on both sides).
- “Feared” by obstetricians, midwives, ultrasonographers and their employers (and insurers).
- Criticised by victims as unjust.
- Applauded by the lucky “winners” who can overcome the “Grand National” type hurdles of:
  - Breach of duty of care.
  - Causation of injury.
  - Quantum of damages
- In Britain, the 2 horse race (causation and quantum) offered by “no fault compensation” has never been a starter (too expensive).



My purpose today is to consider in a practical way a number of FFW cases which are relatively current and which highlight the complexity and diversity of obstetric negligence cases.



## 2. Mis-reading Ultrasound Scans

Two cases:

- A v B NHS Trust
- P v EG NHS Trust



# A v B NHS Trust

- The central allegation was that the Hospital ultrasonographer carried out an anomaly scan negligently in that she failed to detect that the right upper limb was abnormal and then incorrectly advised the parents “that all was well”.
- At the time, the Hospital 20 week anomaly scan was governed by the “**Obstetric Scanning Protocol**” published in 1996. *The Protocol* included a requirement to check the limbs to ensure that there were “**four limbs of normal length**”.
- It was accepted at the time when the ultrasound scan was carried out on 8/6/2000 that:
  - The right radius was absent;
  - The right ulna was shortened.
  - The hand by reference to the shortened ulna would, as a result of absence of the radius, have been in a fixed flexed or club position. That is in a position 90° or less to the ulna;
  - There were only 4 digits in the left hand.



## A v B NHS Trust Cont'd

- FFW argued that the radial club hand would and should have been detected during the anomaly scan; a scan which required the sonographer to ensure that all 4 limbs were of normal length, and which the sonographer carried out by scanning along the humerus to the elbow then down the forearm to the hand and then checking the hand itself.



# A v B NHS Trust Cont'd

Expert View:

*“Ultrasound scans of fetal limbs at 18-21 weeks of pregnancy*

*By*

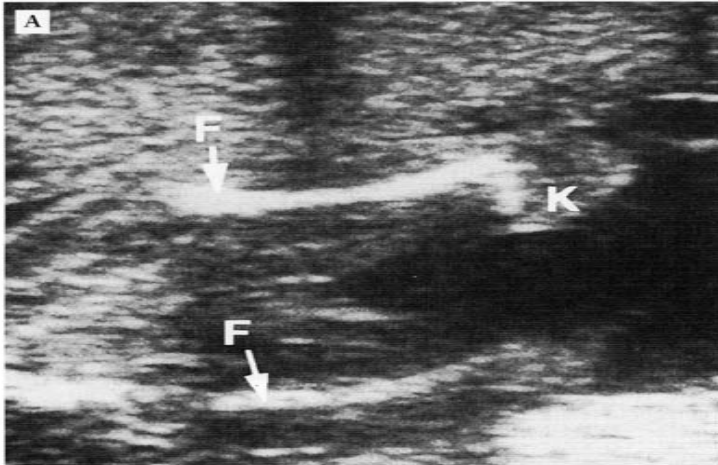
*Hylton B Meire*

*Fetal limb bones can be very clearly seen on ultrasound scans from early on in pregnancy. By 18-20 weeks they can be seen with great clarity.”*

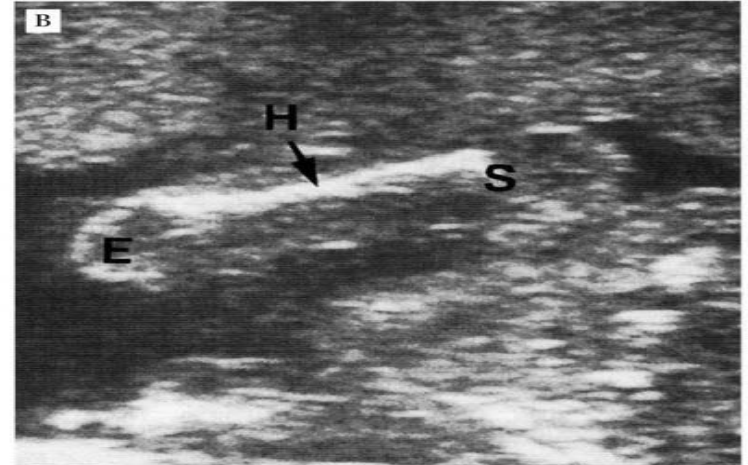


*Clinical Ultrasound Volume 3*

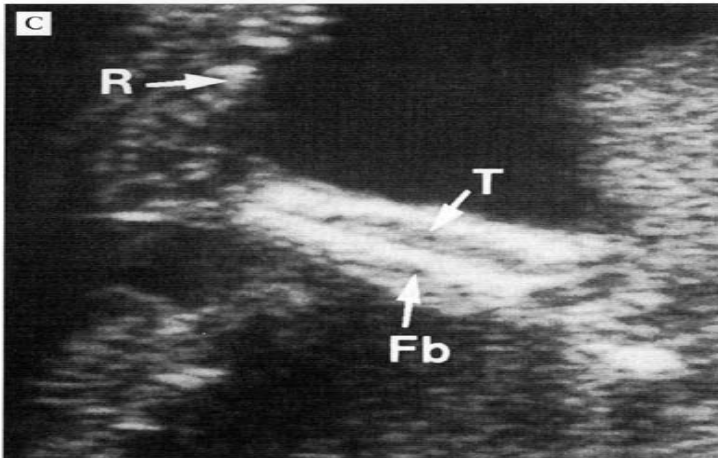
**A = FEMUR**



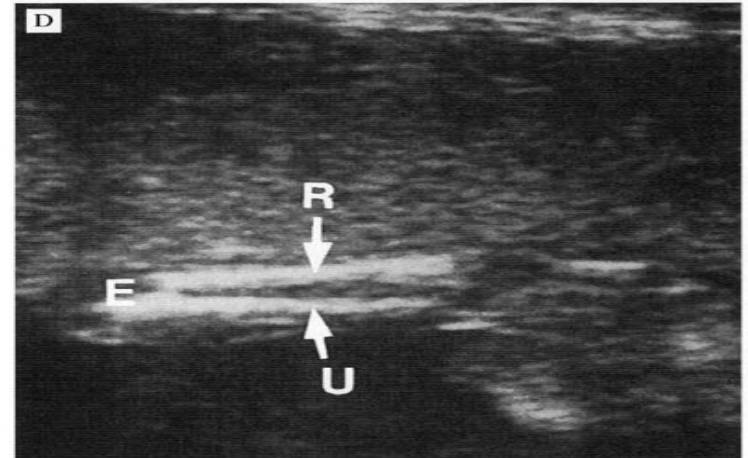
**B = HUMERUS**



**C = TIBIA & FIBULA**



**D = RADIUS & ULNA**



**Fig. 8.47 Measurements of the long bones in a fetus of 18 weeks.** Note the soft tissue extremities beyond the diaphysis at each articulation. **A:** Femur (F). Only the proximal femur is fully visualised. Note the expansion of the diaphysis at the femoral condyles and the knee (K) beyond. **B:** Humerus (H). S – shoulder, E – elbow. **C:** Tibia (T) and fibula (Fb). The heel and toes can be seen on the foot. **D:** Radius (R) and ulna (U). The ulna is longer because of the olecranon. E – elbow.

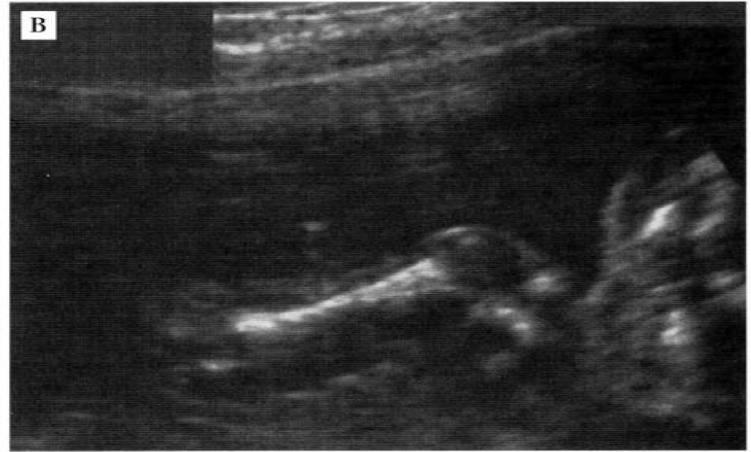




**A = FEMUR**



**B = HUMERUS**



**C = TIBIA & FIBULA**



**D = RADIUS**

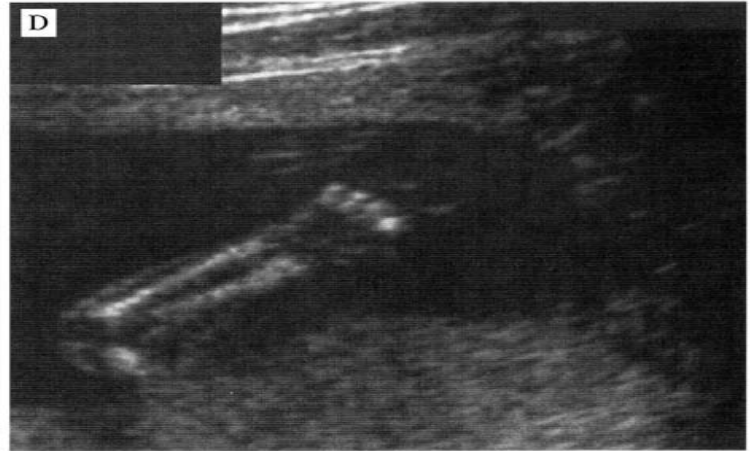


Fig. 19.1 Scans of normal fetal limb bones. A: Femur, B: humerus; C: tibia and fibula and D: radius and ulna at 18 weeks.



## Normal fetal hand at 17 weeks

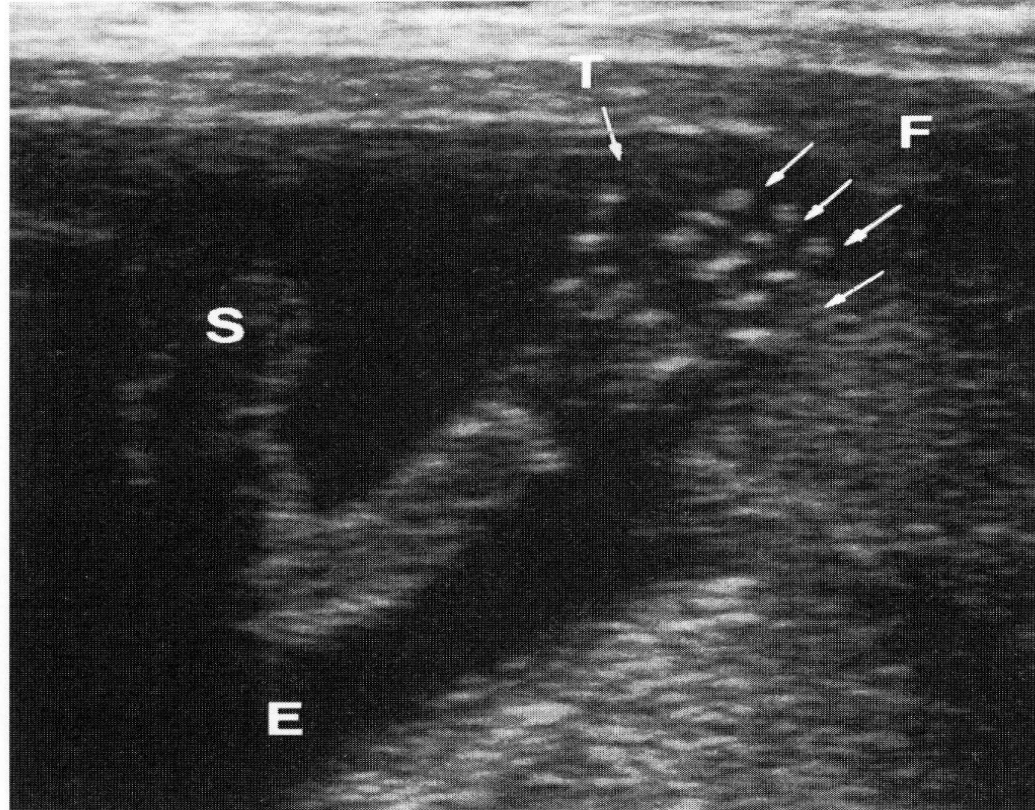


Fig. 8.53 Scan of the forearm and fanned hand (17 weeks). Contours of the shoulder (S), elbow (E), thumb (T) and fingers (F) can be seen. The fifth finger is partly obscured.



# A v B NHS Trust Cont'd

Outcome:

Had the anomaly been detected the parents would have been referred to a tertiary fetal medicine unit for further investigations which would have revealed the presence of a large hole in the fetal heart in addition to the abnormalities of the fetal limbs. The existence of two serious anomalies would have resulted in the pregnancy being terminated.



# A v B NHS Trust Cont'd

## “Wrongful Birth”:

The child was born with complex severe and varied disabilities including:-

- ▶▶ Facial hemiplasia and right sided palsy.
- ▶▶ Right ear deformity and right sided deafness.
- ▶▶ Serious spinal abnormalities.
- ▶▶ Severe right upper limb abnormality.
- ▶▶ Serious cardiac condition.
- ▶▶ Ventricular septal defect.
- ▶▶ Significant gait problem and poor coordination.
- ▶▶ Developmental delay consequent upon physical disabilities.
- ▶▶ Gastrostomy tube-fed.



# A v B NHS Trust Cont'd

Outcome:

Case settled for £1.35 million in March 2006



# P v EG NHS Trust

- The central allegation concerned the failure of the ultrasonographer to identify abnormalities of the spine present on the “*routine anomaly scan*” in November 1998.
- Specifically:-
  - Failing to visualise the whole of the spine;
  - Failing to visualise the skin covering the spine in sagittal section and/or the spine in transverse and/or coronal section.
  - Failing to visualise the image of the cerebellum so as to ascertain its normality in terms of position, size and appearance.
  - Advising the parents that “*all was well*”.



# P v EG NHS Trust Cont'd

## Outcome

- Had the abnormalities been detected, the parents would have elected to terminate the pregnancy.
- The child was born normal Apgar scores although a low pH. The Obstetric Registrar noted the presence of myelomeningocele at delivery.
- The two Paediatricians at birth noted as follows:-  
*“C/O myelomeningocele and feet abnormality – **NOT** diagnosed antenatally.”*
- P was transferred for surgery for closure of the myelomeningocele on 27 April 1999.



# P v EG NHS Trust Cont'd

“Wrongful Birth”:

The child was born with severe injuries including:-

- ▶▶ Spina bifida.
- ▶▶ Neuropathic bladder and incontinence.
- ▶▶ Bowel function – had no control over his bowels.





# P v EG NHS Trust Cont'd

## Ultrasound Dept. Hospital Sept 1996

- *Second Trimester anomaly scan.*
- *To be performed at 19 weeks approximately.*
- *CHECK*
- *presentation*
- *placental site*
- *liquor volume*
- *fetal heartbeat – presence of*
- *fetal number*
- *fetal bladder*
- *fetal stomach*
- *fetal kidneys*
- *spine*
- *umbilicus*
- *fetal heart for number of chambers/beat*
- *Measurements to be taken*
- *BPD*
- *femur length*
- *cerebellum*
- *nuchal thickness*
- *anterior cerebral ventricle*
- *IMAGE*
- *Midline lower uterus*
- *BPD*
- *femur length*
- *cerebellum*
- *nuchal thickness*
- *Any other images as required”.*



# P v EG NHS Trust Cont'd

Outcome:

Case settled for £750,000 in December 2003.



### 3. Effectively Diagnosing and Treating Co-existing Illnesses

Co-existing Illnesses e.g.:

- Diabetes.
- Haematological conditions.



# M v L & D NHS Trust

Mrs M suffered from a haematological disease called Primary Anti-phospholipid Syndrome (PAPS). The syndrome is associated with obstetric complications such as miscarriage, fetal death, clot formation in the placenta resulting in placental failure, pre-eclampsia and intra-uterine growth restriction [IUGR].



# M v L & D NHS Trust Cont'd

The central allegations are:-

- The failure to treat the pregnancy as a “high risk” pregnancy.
- The failure to advise, establish and enforce a suitable management plan for the pregnancy to include:
  - ultrasound biometry at 26 weeks of gestation and at weekly intervals thereafter;
  - instruction that if ultrasound biometry showed IUGR, the Claimant’s mother and the fetus undergo close, obstetric surveillance;



# M v L & D NHS Trust Cont'd

- close surveillance, if required, should comprise of:
  - serial Doppler measurements of the umbilical artery; and
  - serial cardiotocograph (CTG) monitoring;  
both on a weekly basis.
- if either of the Doppler or CTG were abnormal then even closer surveillance was required, and should have comprised:
  - serial Doppler measurements of the umbilical artery on a 2 x weekly basis;
  - daily cardiotocographic monitoring;
  - regular biophysical profiling - that is profiling of the fetal size, fetal movement, fetal heart rate and amniotic fluid volume.



# M v L & D NHS Trust Cont'd

## Outcome:

- In fact, J was born on 14 August 1996 at 34 weeks gestation by Caesarean section for fetal distress.
- Had the obstetricians followed the management plan for a high risk pregnancy, IUGR would have been diagnosed before 30 weeks gestation. On the balance of probabilities, close surveillance of the pregnancy would have resulted in an abnormal Doppler study and would have resulted in delivery to J before he suffered any damage to his brain.



# M v L & D NHS Trust Cont'd

Outcome:

J suffered very severe disabilities arising from spastic quadraplegic cerebral palsy with mixed athetoid features and learning disabilities. He has a life expectancy to the age of 60.





# M v L & D NHS Trust Cont'd

Outcome:

Case ongoing: Trial fixed for 24 November 2008.

The Defence admits:-

***“...the Defendants failed to devise and institute an adequate plan in relation to M’s thrombocitopenia. It is denied that such breach of duty caused the Claimant to suffer from intra-uterine growth restriction or caused M to suffer from pre-eclampsia.”***



## 4. Mis-interpretation of CTGs

Now the gold standard is:-

The Guidelines produced by the National Institute for Clinical Excellence see “*The Use of Electronic Fetal Monitoring*” published in May 2001 and, in particular, section 2.4 entitled “*Interpretation of EFM*”.



## 4. Mis-interpretation of CTGs Cont'd

The Guidelines contain the following definitions to categorisation of fetal heart traces:

<b>Category</b>	<b>Definition</b>
Normal	A cardiotocograph where all four features fall into the reassuring category
Suspicious	A cardiotocograph whose features fall into one of the non-reassuring categories and the remainder of the features are reassuring
Pathological	A cardiotocograph whose features fall into two or more non-reassuring categories or one or more abnormal categories

The Guidelines also specify the following categorisations of fetal heart rate function:

# 4. Mis-interpretation of CTGs

## Cont'd

Feature	Baseline (bpm)	Variability (bpm)	Deceleration	Accelerations
Reassuring	110-160	$\geq 5$	None	Present
Non-reassuring	100-109	<p><math>&lt; 5</math> for</p> <p><math>\geq 40</math> but less than 90 minutes</p>	<p>Early deceleration</p> <p>Variable deceleration</p> <p>Single prolonged deceleration up to 3 minutes</p>	The absence of accelerations with an otherwise normal cardiocotograph is of uncertain significance.
Abnormal	<p><math>&lt; 100</math></p> <p><math>&gt; 180</math></p> <p>Sinusoidal pattern</p> <p><math>\geq 10</math> minutes</p>	<p><math>&lt; 5</math> for</p> <p><math>\geq 90</math> minutes</p>	<p>Atypical variable decelerations</p> <p>Late decelerations</p> <p>Single prolonged deceleration <math>&gt; 3</math> minutes</p>	



## 4. Mis-interpretation of CTGs Cont'd

The Guidelines also stipulate that:-

*“In cases where the CTG falls into the suspicious category conservative measures should be used.”*



# A v ERHC NHS Trust

A was born on the 29 December 2003. She suffers from severe disabilities arising from spastic quadraplegic cerebral palsy, microcephaly and epilepsy.

# A v ERHC NHS Trust Cont'd

## Evidence of Normal CTG

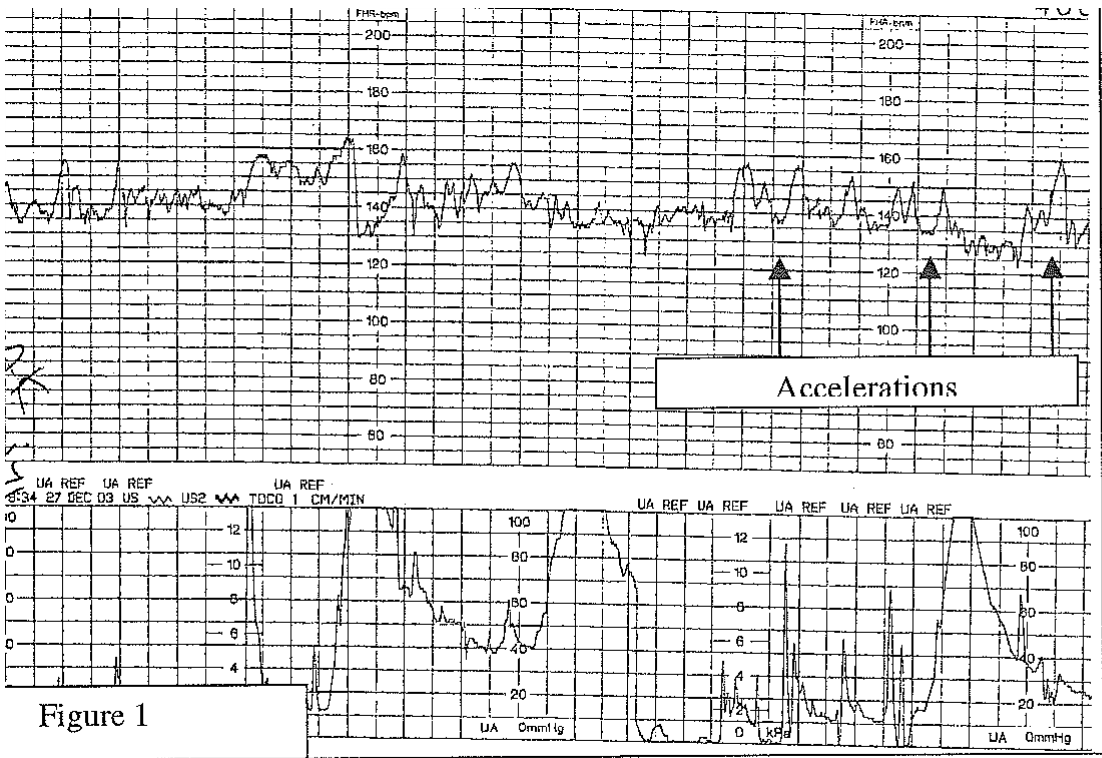
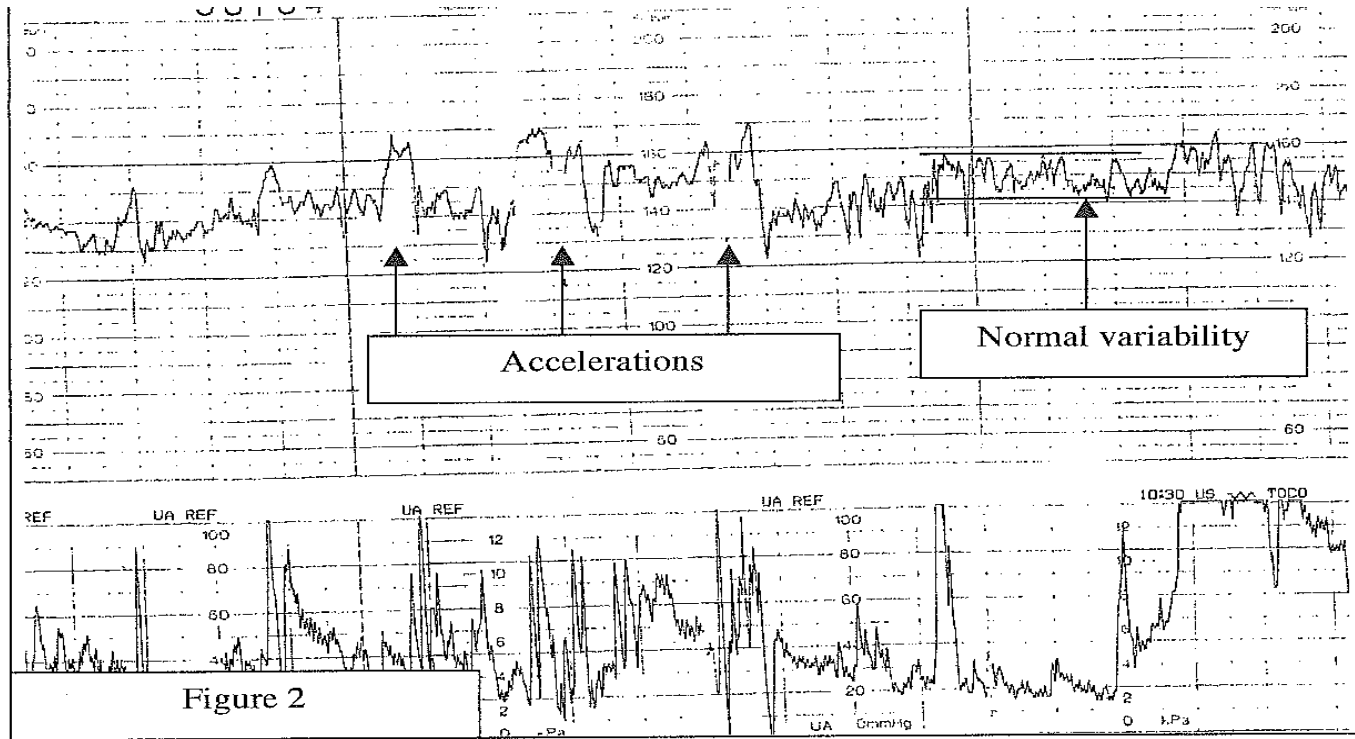


Figure 1

# A v ERHC NHS Trust Cont'd

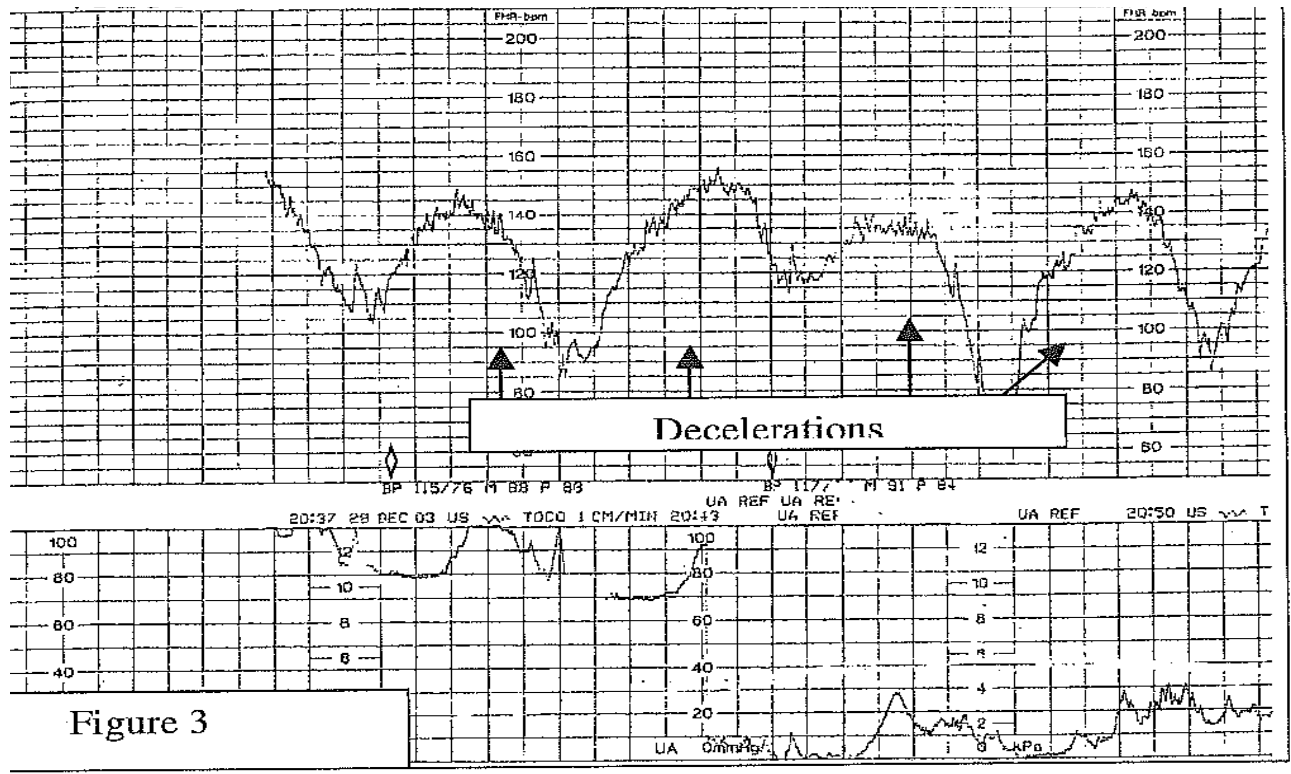
## Evidence of Normal CTG





# A v ERHC NHS Trust Cont'd

## Evidence of Abnormal CTG



# A v ERHC NHS Trust Cont'd

## Evidence of Abnormal CTG

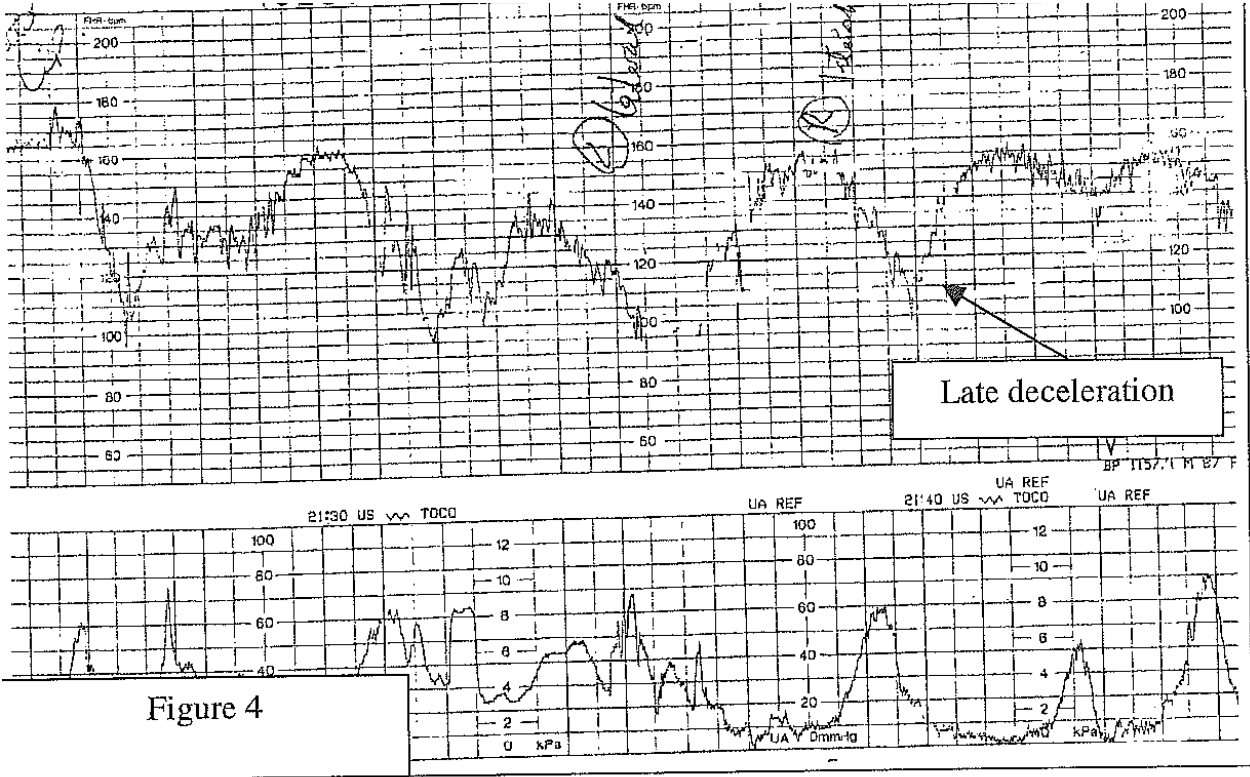
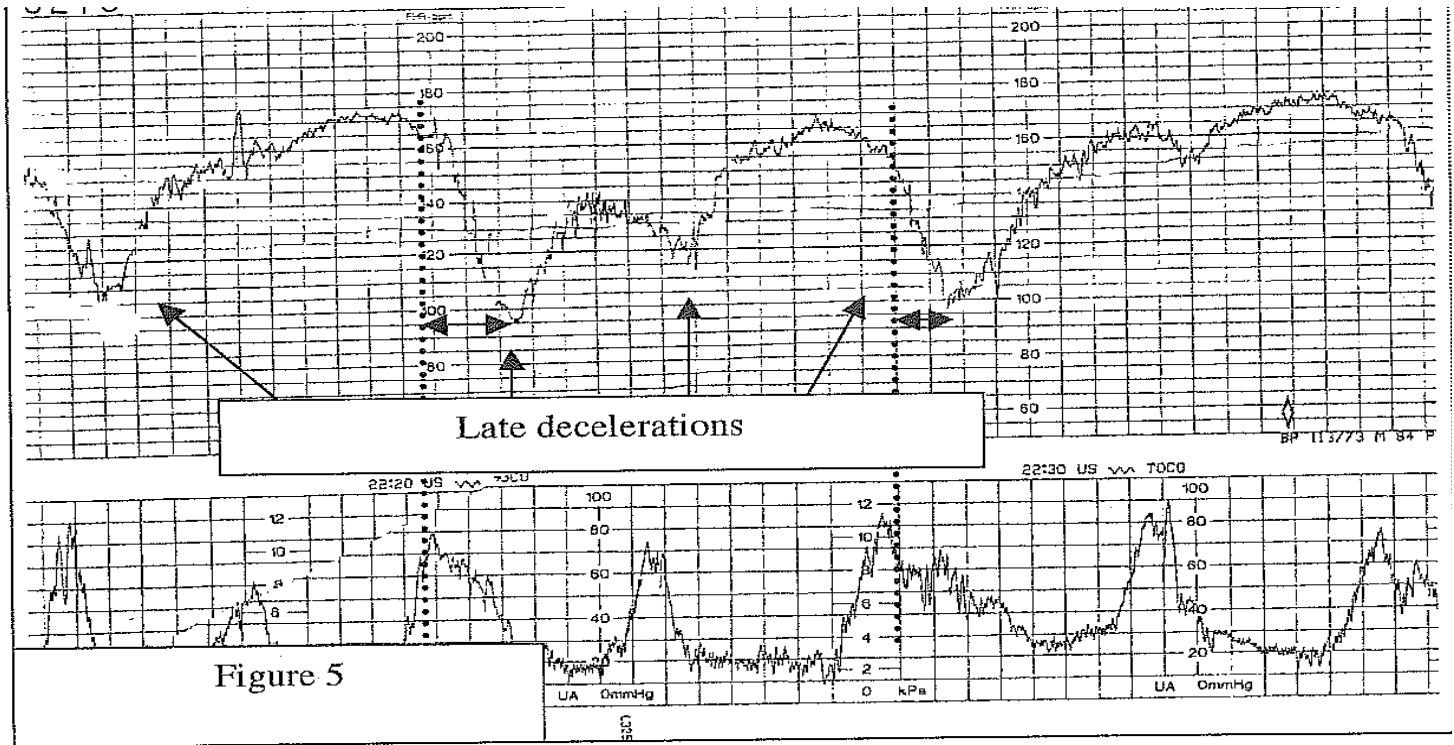


Figure 4

# A v ERHC NHS Trust Cont'd

## Evidence of Abnormal CTG



# A v ERHC NHS Trust Cont'd

## Evidence of Abnormal CTG

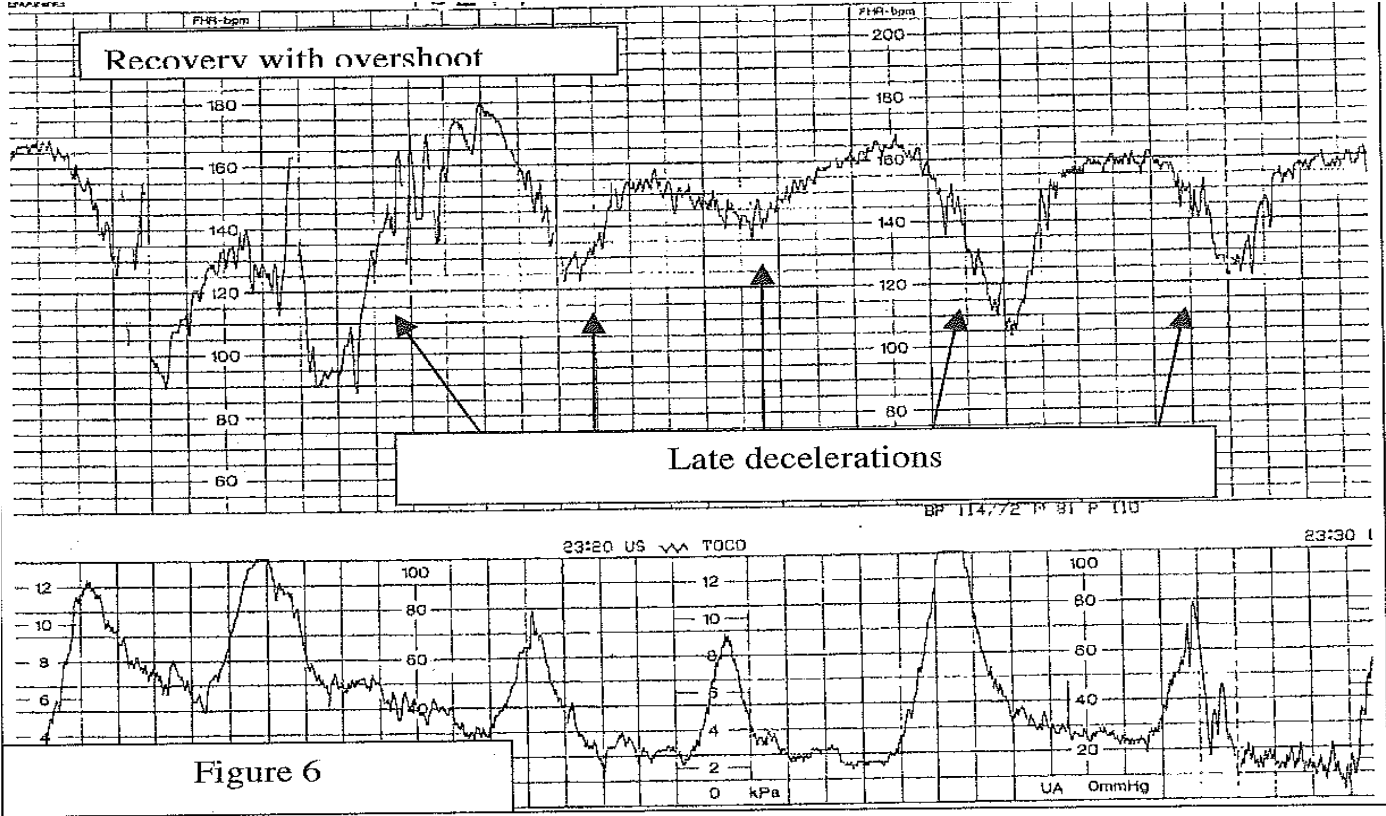


Figure 6

# A v ERHC NHS Trust Cont'd

## Evidence of Abnormal CTG

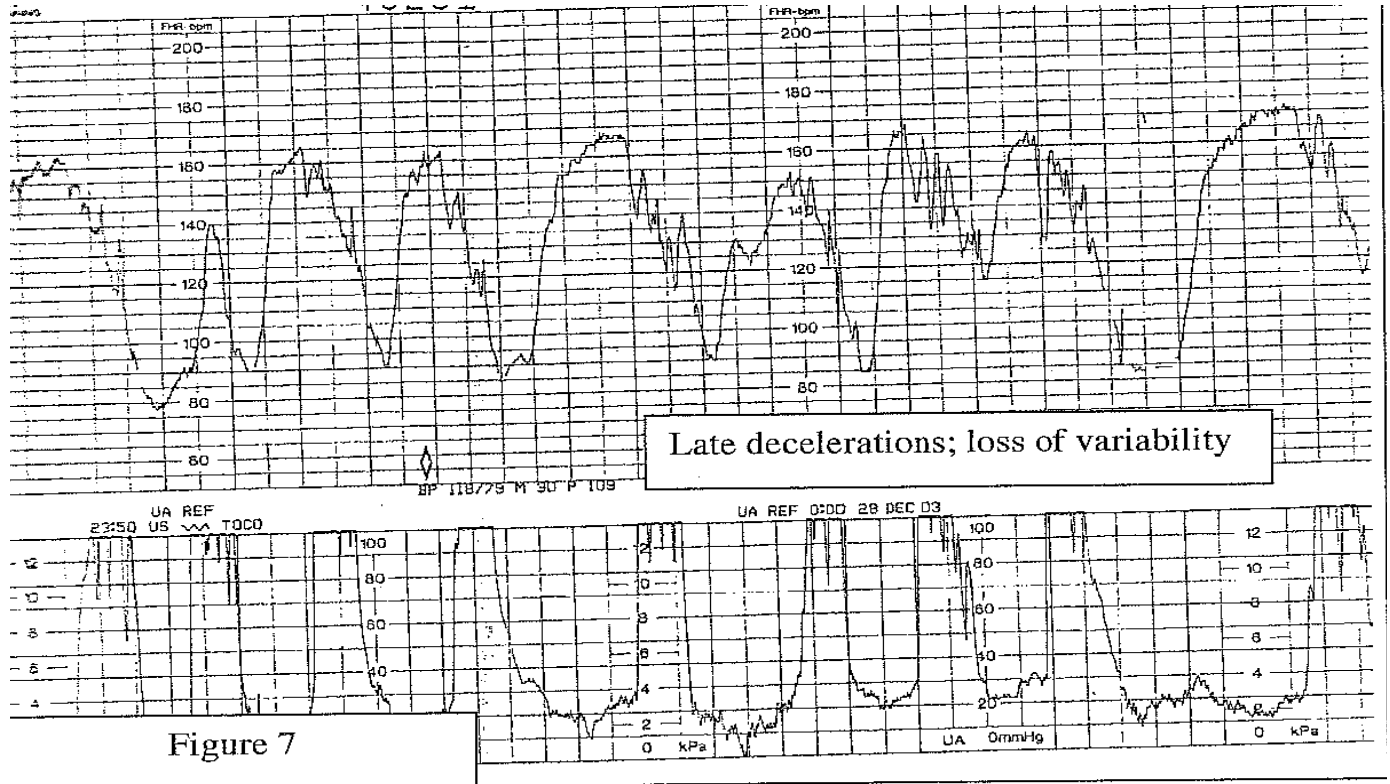


Figure 7



# A v ERHC NHS Trust Cont'd

## Midwives' Notes:

At 22.00:

*"Discussed plans for birth, happy for syntometrine IM, consent for IM konakion for baby. Happy for skin-to-skin, wishes to cut the cord. M wishes to breast feed. FHR 156bpm. Temp 36.5°C."*

At 2230:

*"M and R comfortable. CTG, baseline 160bpm, Variability 5-15bpm, accelerations present, declarations variable, ↓ 100bpm with recovery over 80 seconds to baseline. Dr K (Reg) aware and happy to continue."*

At 2300:

*"M feeling rectal pressure with contractions. CTG continues with variable decelerations ↓ 90-1—pmb. Recovery to baseline over 60-80 seconds."*

At 2330:

*"VE to assess with consent, fully dilated, ceph +1 below ischial spines. DOA. Clear liquor. Draining. No caput or moulding. FHR 156 bpm. M commenced pushing and descent felt on examining fingers."*

*Variable decelerations continue, ↓ 90-100bpm, recovery over 60 seconds to baseline."*



# A v ERHC NHS Trust Cont'd

Outcome:

After an internal enquiry, the parents received the following apology:

***“We were able to review the fetal monitoring from 2040 hours onwards and noted that this CTG appeared different from the earlier traces. Decelerations of the fetal heart were clearly visible and it was recognised that the CTG had been misinterpreted and of poor quality (from 2040 hours). We formally wish to apologise for the fact that the CTG was misinterpreted.”***

[Consultant Obstetrician]



# A v ERHC NHS Trust Cont'd

Outcome:

Judgement entered on liability for damages to be assessed. Interim payments made to enable the family to purchase care and accommodation.

Trial set for June 2009.





## 5. The Improper Use of Syntocinon during Labour

The Gold Standard is now the Royal College of Gynaecologists “*Induction of Labour Guidelines*” published in June 2001 which include recommendations to:-

- Discontinue Syntocinon if the CTG is suspicious.
- Increase the Syntocinon infusion to a maximum level of 32milliunits per minute over minimum period of 4½ hours.
- Set a maximum period of time in which to continue Syntocinon subject to regular reviews and so as to achieve progress and dilatation of approximately 1cm per hour.



# K v ORH NHS Trust

K was born on the 4 October 2001. He suffers from cerebral palsy which is predominantly an asymmetric 4 limb spastic condition and affects his upper limbs more than his lower limbs. K's intelligence and intellectual capability is preserved.



# K v ORH NHS Trust Cont'd

The central allegations were:

- From 1100 on 04.10.01 the Defendant failed to establish and implement any management plan in respect of the administration of Syntocinon during the mother's labour. Syntocinon was commenced at 0900.
- A competent management plan should have been in accordance with the R.C.O.G's Induction of Labour Guidelines published in June 2001.
- By 11.00 on 04.10.01 the CTG was suspicious because it showed:
  - Poor baseline variability.
  - Absence of accelerations.
  - Presence of decelerations, both early and late.
- The Defendant negligently increased the dose of Syntocinon to 32 mls/hour at 1100.



## K v ORH NHS Trust Cont'd

- The Syntocinon dose should have been decreased to no more than 8mls/hour.
- The use of Syntocinon at the proper rate would have been unlikely to result in full dilatation being achieved given:
  - That it was not in fact achieved for over 6 ½ further hours and only achieved with prolonged and increasing negligently administered doses of Syntocinon.
  - The occipito-posterior position of the fetus.
  - The in co-ordinate nature of the uterine activity.
- The labour, with proper care, would have been unlikely to progress so as to enable vaginal delivery.
- K would and should have been delivered by caesarean section by 1500 which would not have exposed him to stress caused by uterine contractions or instrumental delivery.



# K v ORH NHS Trust Cont'd

Outcome:

Proceedings were issued in January 2005. The case settled for £3.5 million in February 2006 close to the date fixed for Trial



## 6. The Use of Fetal Blood Samples during Labour

K v ORH NHS Trust

The Defendant accepted that there were decelerations present on the CTG early in the labour. It contended that the appropriate management was fetal blood sampling (FBS) in accordance with the hospital protocol.

The Defendant stated that had FBS taken place, it would have demonstrated a reassuring pH and labour would have been permitted to continue with Syntocinon augmentation.

We responded on behalf of the Claimant as follows:-

***“The Defendant was not entitled to rely upon the hypothetical outcome of a procedure which it negligently failed to carry out.”***



# K v ORH NHS Trust

In any event, the proper procedure would have been:-

- To turn off the Syntocinon.
- To call a senior obstetrician.
- Not to start the Syntocinon unless there was a reassuring FBS and/or the CTG returned to normal.

If the result of the FBS had been normal and shown a pH in excess of **7.25**, then the Syntocinon could have been restarted at a low dose.

The labour would then have required hourly review by a senior obstetrician including hourly performance of FBS (particularly as the presence of Meconium would have been noted).



# K v ORH NHS Trust

The CTG would have been abnormal when the Syntocinon was increased and the labour would have been unlikely to progress to vaginal delivery.

Further, after 3 repeat FBS samples, and little progress in labour, a decision would have been taken to deliver K by caesarean section.





## 7. The Use of Forceps

X was born on the 1 March 1997. He was the first delivered of twins and he suffered significant injuries, it is alleged by the injudicious use of forceps.



# X v RVI NHS Trust

The Central Allegations of Negligence are:-

The Defendant failed to elect to deliver the Claimant by Caesarean section once during the course of the vaginal examination:

- he had confirmed that the Claimant was in the left occipito-transverse position; and
- he had discovered that:
  - the Claimant's right hand was positioned next to the Claimant's head,
  - a loop of umbilical cord was positioned next to the Claimant's head.

Further, the obstetrician chose to attempt to rotate the Claimant's head manually without recognising, either adequately or at all, that by doing so there was a substantial risk that the umbilical cord would prolapse during the course of the attempt or that the manual rotation would not be successful and require delivery by Kielland's forceps.



# X v RVI NHS Trust

Having decided to carry out a rotational, Kielland's forceps delivery the obstetrician used them in such a manner as to cause the following injury:

- A wide irregular right inferior parietal skull fracture.
- A right cephalohaematoma, that is haemorrhaging beneath the periosteum of the parietal bone.
- A subaponeurotic or subgaleal haemorrhage, that is haemorrhaging beneath the tissue connecting the frontal and occipital components of the occipito-frontalis muscle, of the scalp
- A tear to the dura underlying the skull at the site where it was fractured as a consequence of contusion and/or infarction.

It is the Claimant's case that either the blades of the forceps were misapplied at the outset or during the course of their use and that they were used with excessive force. The Claimant relies upon the injury and damage the Claimant suffered as evidence of these matters.

# X v RVI NHS Trust

## Outcome

X suffered the following injuries:-

A serious cosmetic disability in the form of a flattened right occiput.

- A traumatic brain injury which has resulted in low head growth.
- Visual difficulties comprising:
  - left visual field defect.
  - An inferior oblique overaction, that is when the eyes are turned they also move upwards.
- Left-sided hemiplegia which has resulted in:
  - A left arm and hand with dystonia with an overtly abnormal left arm and hand posturing.
  - Left lower limb spasticity.
- Learning difficulties.



# X v RVI NHS Trust

Outcome:

Liability denied in pre-action protocol. Proceedings just issued.



## 8. Shoulder Dystocia

### N v RB & B NHS Trust

- Macrosomia is the single most important determinant of difficult shoulder delivery (shoulder dystocia).
- N suffered an injury to her right brachial plexus and her left arm because her macrosomia caused her shoulders to become obstructed in the birth canal.
- It was **traction on her head and neck** whilst her right shoulder was arrested behind her mother's symphysis pubis that caused the brachial plexus injuries to the right side.
- A caesarean section would on the balance of probabilities have prevented the shoulder dystocia. Ante-natally the doctors were aware that she was likely to be a large baby. Her abdominal circumference had been above the 97<sup>th</sup> centile according to the ultrasound scans.



## N v RB & B NHS Trust Cont'd

- However, in 1998 (as now) the accuracy of ultrasound estimation of birth weight was poor. Investigation would have suggested a baby of about 4 kilos. There is no consensus at present as to when birth weight indicates the need for caesarean section. This is due to the fact that most babies weighing over 4 kilos are delivered safely. In any event, half of all shoulder dystocia occurs in babies below 4 kilos.
- Since there were no indications for caesarean section during labour, the allegations centred on the management of the shoulder dystocia during labour once it was discovered.



# N v RB & B NHS Trust Cont'd

## Obstetric Department Shoulder Dystocia Protocol

### Procedures

- *alternative positions*: **Try lateral or squatting positions** and cut generous medio-lateral episiotomy to reduce resistance of hard/soft tissues. Apply **firm traction** in an attempt to dislodge anterior fetal shoulder. If unsuccessful after 2 contractions:
  - *summon obstetric, anaesthetic and neo-natal paediatric assistance.*
  - *suprapubic pressure* and traction: **position mother in lithotomy** Instruct assistant to apply firm suprapubic pressure to displace anterior shoulder, flex fetal neck towards rectum and pull hard.
  - *Woods screw manoeuvre*: digitally identify fetal posterior shoulder and apply pressure to rotate towards fetal back. Deliver posterior shoulder by traction and rotate it anteriorly bringing the other shoulder into the posterior vagina and available for similar treatment. (Equivalent intention of Lovsetts).

NB. Fracturing a fetal shoulder during one of these procedures may be unavoidable and should be considered as an option if all the above are successful.





# N v RB & B NHS Trust Cont'd

The central allegations of negligence concerned differences in the **internal** hospital protocol from the **standard advice** in 3 ways:-

- The hospital protocol recommends “***firm traction to the head***”.
- The hospital protocol does not recommend the most favourable positions for delivery i.e. MacRoberts or on all fours.
- Instead the protocol recommends “***lateral or squatting positions***” and “***position mother in lithotomy***”.



# N v RB & B NHS Trust Cont'd

- The hospital's protocol was probably the reason for the mismanagement of shoulder dystocia by the obstetrician in attendance.
- Textbooks had warned for some time before 1998 of the dangers of pulling on the neck whilst the shoulder is still obstructed.
- The one manoeuvre to be avoided at all costs in dealing with shoulder dystocia is **firm** (see the protocol) or **strong** (see the statement of the attending doctor) traction. It was this traction which caused N's brachial plexus injury and it could have been avoided.
- No responsible doctor would have repeatedly applied strong traction to the baby's head and neck whilst the shoulder was still impacted by the symphysis pubis.



# N v RB & B NHS Trust Cont'd

Outcome:

N suffered severe brachial plexus injury.

Liability admitted. Damages to be assessed.



## 9. Caesarean Sections

### T v NHS Trust

- On 24.10.2005 T was admitted to hospital for the birth of her first child. At about 0240hrs on the next day a decision was made to proceed to delivery by Caesarean section. The surgery took place uneventfully and the child was born without difficulty and in good condition.
- Following the caesarean section, T did not receive any medical surveillance for the first two days. By the 28.10.2005 the caesarean section wound was causing severe pain.
- On the 29.10.2005 there was swelling and bruising particularly on the right side of the wound.
- That day the Claimant was preparing to leave hospital but because her pain was persistent, she asked a midwife to check the wound. After this examination she felt a pulling sensation and asked the midwife to check her wound again. The wound had dehised and the bowel was visible.



# T v NHS Trust

- T was taken to theatre and the wound was repaired under general anaesthetic. The operation note recorded that:-
  - “*Suture tied [left] edge of sheath but rest of sheath completely open.*
  - *only x 4 fat sutures intact.*”
- This note indicates that the suture was **tied at the left edge** but by implication there was no suture on the right edge.
- We allege that the Registrar who performed the Caesarean Section failed to adequately secure the suture at the right edge of the wound. The probability is that the suture at the right hand end of the rectus sheath had become undone shortly after the operation because it was anchored improperly.
- We do not accept that the wound dehiscence is simply a rare but recognised complication of caesarean section. Wound dehiscence in a transverse lower abdominal incision is extremely uncommon, especially in a young patient who has not had previous surgery in that area. These incisions are inherently very strong and usually heal without complication.



## T v NHS Trust Cont'd

T suffered a dehiscence of her wound, experienced considerable distress and had to undergo surgery under general anaesthetic to repair the wound. Her wound became infected and as a result of the dehiscence she has developed neuropathetic pain and suffers from complex regional pain syndrome. T also developed PTSD and depression. As a result of the pain, T has been unable to care for her son as she would have wished, has been unable to resume work and has had to move closer to her parents who provide care and assistance.

Outcome:

Liability has been denied in the pre-action protocol and proceedings are about to be issued.



# 10. Implications of Hypoglycaemia Post Partum

K v E of E S Health Authority

K was born on the 2 June 1990.

He suffers from asymmetrical cerebral palsy of the spastic quadrapelgic type. He has severe learning difficulties. He has a squint and permanent neurological deficiency both in terms of motor and intellect. He is wholly dependent upon his family to provide care and assistance.

The case was tried before His Honour Judge D C Mitchell (sitting as a Deputy Judge of the High Court) between the 3 and 18 December 2007.



# K v E of E S Health Authority

The midwifery issues were as follows:

- The failure to monitor K's blood sugar after birth with sufficient accuracy.
- The failure to manage K's "**hypoglycaemia**" between the time of birth (23.55hrs) and 10.00hrs on the 3 June 1990 when he was admitted to the Special Care Baby Unit.





# K v E of E S Health Authority

## Cont'd

K's mother had become diabetic when she was about 13 years of age. The diabetes had been severe and difficult to control and she required a number of admissions to hospital during her pregnancy to try and maintain glucose control.

As an infant of a diabetic mother, K was at high risk of death or brain damage prior to and after birth. All the expert witnesses confirmed that in the immediate post partum period, K would require careful monitoring. This was especially so since K was hyperinsulinaemic. This had the predictable effect of developing low levels of blood sugar, hypoglycaemia and brain damage.

By the standards of 1990, **the target level for blood sugar was 2.0mmol/l**. The Judge found:

*“Although there may be disagreements between the experts as to the precise number, it is clearly the case that a responsible body of paediatricians in 1990 thought **2.0 was a reasonable target** and so I find.”*



# K v E of E S Health Authority

K was fed after birth but at 0410hrs his BM stix was 0. The midwife informed the paediatrician, gave a 20ml feed and ordered 2 hourly BM stix.

There was a dispute on the factual evidence as to whether this regime was reasonable and whether it was followed. The Judge accepted the evidence of the midwives that there had not been a further reading of 0 and that:-

*“K was fed at 0600hrs and BM stix were taken.”*

(There had been no note to this effect).

The Judge concluded that:-

*“In my Judgement, whilst there may be certain reservations about some of the decisions made before K went to SCBU, the specific allegations referring to that period set out in ... the amended Particulars of Claim do not establish that the hospital or its staff were negligent with respect to this aspect of the claim.”*



# K v E of E S Health Authority

Outcome:

Judgement for the Defendants



# Clinical Negligence Team



Paul McNeil



Samantha Critchley



Mark Bowman



Richard Earle



Peter Flory



# Conclusion

*“If pregnancy were a book, they would cut the last two chapters”*

Nora Ephron