CHILD INJURY SIG

16th July 2003

Co-ordinator:	Ms Amanda Stevens, Charles Russell
Secretary:	Ms Andrea Johnson, Stewarts
Speakers:	Mr Anthony Johnson, Consultant Obstetrician & Gynaecologist Ms Caroline Hallissey, Counsel Ms Debbie Clarke, Chairperson Erb's Palsy Group

Apil Practice Focus

Amanda gave out the most recent Practice Focus re increasing Fast Track Limit to £25,000. Given the time needed for the speakers tonight a short time was allowed to discuss this with a view to taking the forms away and completing them.

Mr Anthony Johnson

See attached slides for full details of Mr Johnson's presentation.

Mr Johnson considered the appropriate medical management for babies at risk of developing shoulder dystocia and the medico-legal aspects of bringing a claim.

There are 2 groups of people who suffer brachial plexus injuries - motorcyclists following accidents, and newborn babies whose anterior shoulder gets caught under the pubic bone during delivery.

The severity of injury can vary considerably, where a rupture occurs there is no treatment available that would allow full recovery of function (bruising of the nerve usually allows complete recovery).

Mr Johnson noted that there were 2 stages to consider the prevention/reduce the risk of shoulder dystocia:

- Antenatally
- Intrapartum

In any case have to consider whether a shoulder dystocia could have been predicted, if yes then an elective Caesarean Section should be done or considered. The risk factors include:

- Previous history of shoulder dystocia
- Previous macrosomic baby (>4.5kgs)
- Diabetic mother (who tend to have big babies)
- Multiparity

- Obesity
- Ultrasound scan that suggests a baby bigger than 4.5kgs

Risk factors during the intrapartum stage include:

- Epidural
- Delay in cervical dilation
- Protracted descent
- mid cavity forceps/ventouse

Every midwife/obstetrician should be prepared for shoulder dystocia during delivery. Units should have an emergency drill for such events and regular training with a doll and pelvis model to understand the procedure.

When a baby's head is pulled (diagnostic traction) if the body doesn't follow then the correct procedure for shoulder dystocia should be followed:

- Don't pull again and call for help
- Put mother in McRoberts (after 1992/93)
- Apply supra pubic pressure
- Episiotomy (large enough to get arm in)
- Rotate shoulders
- If all of the above fails pull (baby has to be delivered within 10 minutes to prevent brain damage)

A study in Canada found that if McRoberts position and supra pubic pressure were applied no baby in their study suffered a brachial plexus (all deliveries made by an obstetrician).

Traction:
How hard should you pull? American and French research. In France they found that 40lbs was required before the brachial plexus ruptured (NB this research on still born babies, ie no muscle tone). In the US diagnostic traction equated to 84 Newtons, a difficult delivery resulted in 122Newtons and shoulder dystocia occurred at 700 Newtons

Medico-legal considerations:
Date specific as to standard of care (eg McRoberts was not standard practice until about 1992/93)

Relevant case law:

- Gaughan -v- Bedfordshire Health Authority - shouldn't pull for more than 4-6 seconds
- Catnach -v- North Tees HA - pulled too long, should not persist when meet resistence
- Oladipupa -v- East London & City HA - disputed propulsion theory
- Frazer -v- Mayday NHS Trust - disputed the argument of posterior shoulder injury

- Jackson -v- Bro Taf HA - see Caroline Hallissey's notes - diagnostic traction can cause the injury

With regard to litigation the pendulum initially swung in the Defendants' favour, then in the Claimants' and has again swung in the Defendants' favour. Over the last 5-6 years a number of theories have come forward from America:

- Propulsion
- Positional
- Posterior shoulder injury

Propulsion theory - whereby the pressure exerted by the mother in labour causes the injury. Mr Johnson did not think this was feasible given that there is no pressure on the head if pressure is applied from below.

Positional theory - whereby the baby is in an awkward position during the pregnancy, putting pressure on one or more of the nerves. Mr Johnson felt that this was possible, however, the presentation of the baby would be different to that of a baby born due a birthing injury, in that there would be obvious muscle wasting and reduced muscle tone as well as bruising. Mr Johnson had never seen one of these injuries.

Posterior shoulder theory - again Mr Johnson felt this was a feasible argument, however, in 35 years he has never seen one and nor have any of his colleagues.

Ms Caroline Hallissey

See power point presentation for full details of talk

Ms Hallissey advised that the allegations of negligence tended to be:

- Excess traction must have been applied
- Didn't put into the McRoberts position
- Didn't apply supra pubic pressure

Rarely was a claim brought on the basis of antenatal issues.

Case of Jackson -v- Bro Taf HA:

- No antenatal concerns (although 4.71kgs when born)
- Labour straightforward
- Term baby
- 10.45 head born
- 10.53 born
- Both parties agreed that injury caused by traction during delivery
- Mum said pulled forcibly
- Midwife said pulled firmly but not excessive, skin folds didn't disappear (Mr Johnson noted that in almost all deliveries the skin folds would disappear as traction was applied)
- Records were not detailed (but 1987 delivery)
- Defendant's expert argued that the amount of traction required for a diagnostic traction could cause the injury

Judge accepted Defendant's argument on traction. Case undermines Oladipupo. Further as some discretion is given for the traction given during the first pull (as very much a subjective thing) it could cause problems for Claimants.

Mr Johnson said this judgment flies in the face of common sense and research. He also noted that the use internal rotation was not mentioned (if not done then could be criticised).

Ms Hallissey noted that she had spoken to the Claimant's solicitors in this case and they were not appealing to the Court of Appeal as it was felt that given that the judge had found, as fact, that supra pubic pressure had been applied that it would be very difficult to find anything to appeal.

Ms Debbie Clark

see power point presentation attached

Ms Clark noted that the literature available suggested that somewhere between 13 and 80% of Erb's Palsy cases fully recover. Unfortunately, no one keeps records or is required to keep records in such cases. The Erb's Palsy Group is looking to look at long term problems for children born with this injury.

When the Group was first set up the aim was to get the appropriate treatment for the children. Ms Clark noted that there are only 5 experts in the UK who have the appropriate expertise to deal with children with Erb's Palsy:

- Mr Birch, London
- Mr Carstead, London
- Mr Bainbridge, Derby
- Mr Giddins, Bristol
- Mr Kay, Leeds

The view is that if full recovery has not been achieved by 1 month of age then a referral to a specialist is required.

The next aim of the group was to provide support for the children and families affected. Childminders/nurseries often will not consider caring for children with Erb's Palsy as they will not give them the necessary physiotherapy. As a result a parent often has to stay at home to look after the child and give the therapy.

The Erb's Palsy group is able to provide help and support to these families by providing practical information and giving them details of their options.

The third aim of the group is to provide facilitation for training of midwives and arranges annual training conferences.

Damages for Erb's Palsy cases range from £30,000 to £200,000. However, it is not felt this covers the problems that the children go on to suffer (physically and psychologically). This is one of the reasons why the group want to study the long term effects of the disability.

Ms Clark gave examples of how her son had been affected by his disability (Daniel is 12 years old):

- Can't wash his hair
- Can't do up his trousers
- Can't cut up his food
- Doesn't get picked for sports teams
- Unable to play most musical instruments

Some children have problems with toiletting (unable to wipe bottom, etc)

It can be embarrassing to Daniel now, however, Ms Clark was concerned that the practical problems will be worse when he is an adult - who will wash his hair for him? What impact will it have on his career opportunities.

Both Mr Johnson and Ms Hallissey confirmed that without the pressure applied by the group the hospital protocols would not have developed as they have.

Ms Clark provided a number of leaflets:

- Obstetrical Erb's Palsy
- Brachial Plexus Paralysis
- Slide handouts from recent Midwifery Training Day
    - Shoulder Dystocia - improving practice to reduce risk - Sharyn McKenna (clinical risk manager)
    - Obstetric Brachial Plexopathy - Mr L C Bainbridge (Hand and peripheral nerve surgeon)
    - Picking up the pieces - gently putting them back together again - Dr Karen Dodd (clinical psychologist)
    - Preventable or Fact of Life? - Terry Coates

NB if you require copies of any of the above leaflets please contact Andrea Johnson, Stewarts

She also recommended the following book:

Obstetric Brachial Plexus Palsy: a guide to physiotherapy management by the Association of Paediatric Chartered Physiotherapists

Newsround

Members were referred to the recent APIL newsletter article on deduction of CFA costs from a child settlement (APIL vol 13 issue 3 page 28).