JP v HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST (2024)

Out of Court Settlement (approved) 26/04/2024

SUMMARY

The claimant, a twenty-year-old woman, received £250,000 total damages for the left-sided Erb's Palsy sustained during her birth at the defendant's hospital in May 2003.

MOST SIGNIFICANT INJURY

Left-sided obstetric brachial plexus injury which was predominantly a Narakas Grade I injury and primarily affected C5 and C6 with minimal injury elsewhere in the brachial plexus.

OTHER INJURIES

Pain and stiffness in left shoulder, reduced strength, dexterity, grip and range of movement, cosmetic abnormality to left arm, breast and hand, scarring and psychological issues.

EXTENT OF INJURY

Permanent left-sided Erb's Palsy with associated pain and stiffness. Permanent cosmetic abnormalities to left arm, breast and hand. Ongoing psychological symptoms.

TOTAL INJURY DURATION

Permanent

HELD

Clinical Negligence: C, female, newborn at the date of the incident and 20 at the date of the settlement, sustained left-sided Erb's Palsy during her birth at a hospital of the defendant trust (D) on 8th May 2003.

C's mother (M) fell pregnant with C, her second child, in 2002. The pregnancy was managed by D. There were no specific risk factors for pregnancy complications, and M was allocated to midwifery-led care. The antenatal period was unremarkable, and all maternal observations were within normal limits.

On 6 May 2003, at 08:00, M was admitted after a possible spontaneous rupture of the membranes. Induction of labour was arranged for 11 days beyond her due date.

On 8 May 2003, at 08:40, M was admitted for the induction. At 08:40, the position of the foetus was noted as “ROA” or right occipito-anterior. In other words, the left shoulder was uppermost at that time. At 09:55, a 3mg tablet of Prostin was inserted. At 13:00, a VE was done, and M was found to be 3-4cm dilated. At around 13:50, she was fully dilated. The vertex was “just visible”. At 14:00, C’s head was delivered. At 14:01, shoulder dystocia was diagnosed.

It was likely that, at that stage, the anterior shoulder was the left shoulder. However, D did not make any note as to which shoulder was the anterior one, and its record-keeping was substandard. The emergency buzzer was activated.

A midwife evaluated the need for an episiotomy but that was not required as there was already a second-degree tear. M’s legs were placed in the McRoberts position, and suprapubic pressure was applied. Nothing else was written in the medical records regarding the difficulty in delivering C’s shoulders (or, as above, which shoulder was uppermost).

C was delivered at 14:02. She was delivered in a shocked condition but rallied rapidly. Her Apgar scores were calculated at 3, 10 and 10 at one, five and ten minutes respectively. Her birth weight was 4,270g. Given that C was delivered only a minute after the shoulder dystocia had been diagnosed it was unlikely that, within that minute, D was able to undertake each of the following steps: (i) re-positioning M into the McRoberts position; (ii) after allowing time for the change in position to take effect, tentatively checking the effectiveness of the change by means of standard traction; (iii) applying suprapubic pressure; (iv) after allowing time for that step to take effect, tentatively checking the effectiveness of that measure by means of standard traction; (v) having ascertained that the obstruction had been overcome, delivering the baby by means of standard traction.

It was more likely that, in re-positioning M and in applying suprapubic pressure, D’s midwife did not allow time for those steps to take effect and/or, rather than tentatively checking the effectiveness of the steps taken by means of standard traction after each manoeuvre in an axial line, used excessive force to overcome the shoulder dystocia.

Following delivery, C was found to have sustained bruising to her face. Such bruising was unlikely to occur where standard traction had been applied and was relied upon as evidence of the fact that excessive force was used. It was likely that, during the final stages of delivery, C sustained a permanent obstetric brachial plexus injury (OBPI). Immediately after delivery, C was diagnosed with a left-sided OBPI or, as it was noted, “mild Erb’s palsy”. It was predominantly a Narakas Grade I injury and primarily affected C5 and C6 with minimal injury elsewhere in the brachial plexus.

Liability

C claimed that D was negligent and/or in breach of its duty of care in the management of her shoulder dystocia. C claimed that D: (i) used excessive force during the final stages of delivery and/or applying inappropriate traction against resistance; (ii) used excessive force in moving M into the McRoberts position and then applying suprapubic pressure; and (iii) failed to allow time for those steps to take effect and/or pulled too hard too fast rather than applying standard traction over a period of a few tens of seconds. Had standard traction been applied it was likely that C would have rotated and delivered, assuming that the dystocia had been overcome.

Liability was disputed. D relied on the midwives' experience, arguing that it was highly unlikely that they would not have caried out the McRoberts steps correctly.

In January 2006, C underwent an operation: a subcapsularis release and a latissimus dorsi transfer. She had a Botox injection (which brought a few months of relief) in August 2015. On 17 November 2017, she underwent an anterior shoulder release operation, with the application of a shoulder spica. It was envisaged that she might need a further operation: an anterior release to her elbow. Currently, C had pain and stiffness in the left shoulder, together with reduced strength, dexterity, grip and range of movement. She could not carry as well as she might have done, and she was occasionally woken by the stiffness in her shoulder. There was also a significant cosmetic abnormality, a droop and underdevelopment of the left arm, her left breast and her left hand. Her left arm was thinner and shorter than the right, and her left hand and left breast were smaller than the right. She also had three scars, including a 25cm surgical scar. C reported some psychological issues. She was aware of the limitations and cosmetic abnormalities in her left upper limb. She was given some antidepressants and had been referred to the children and adolescent mental health services locally by her GP in the past.

With regard to her activities of daily living, C had various limitations: difficulties with swimming, riding a bicycle, gymnastics and other skilled bimanual sporting activities. She also had difficulty with some aspects of dressing, washing and drying her hair. Looking forward, she would struggle with heavier tasks around her home and garden and might require assistance with DIY. C would have mild limitations with employability. The weakness and stiffness would prevent adequate function in the heaviest of tasks and in very rapid medium manual tasks.

Out of Court Settlement: £250,000 total damages

The case was settled on a global basis with no particular breakdown of damages. However, the following breakdown was estimated by the claimant's solicitors.

Breakdown of General Damages: Pain, suffering and loss of amenity: £39,600.

Breakdown of past losses: Travel: £1,650; Care: £4,671.

Breakdown of future losses: Professional assistance: £47,343; Loss of earnings: £143,178; Therapies: £4,500; Aids and appliances: £900; Miscellaneous: £6,212.

BODY PART

Body Part: SHOULDER - ARM - SHOULDER, LEFT - LEFT SHOULDER - LIMB - UPPER LIMB - BRACHIUM - ARM - LIMB - UPPER LIMB - ARM, LEFT - LEFT ARM - ARMS

CONDITION

Condition: LEFT-SIDED ERB's PALSY - SHOULDER DYSTOCIA - LEFT SIDED OBSTETRIC BRACHIAL PLEXUS INJURY – PAIN AND STIFFNESS IN LEFT SHOULDER – REDUCED STRENGTH, DEXTERITY, GRIP AND MOVEMENT – COSMETIC ABNORMALITY – SCARRING – PSYCHOLOGICAL ISSUES

APPEARANCES

Dutton Gregory LLP for the claimant.
DAC Beachcroft for the defendant.

ACKNOWLEDGMENTS

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PERSONAL INJURY – CLINICAL NEGLIGENCE