



# ***G v NHS Commissioning Board*** **Case note focussing on (i) Erb's palsy with potentially posterior shoulder dystocia and (ii) NHS resolution approach to settlement** **Justin Valentine, Barrister, St John's Chambers**

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Shoulder dystocia is a serious complication of delivery where one of the baby's shoulders gets impeded usually behind the mother's symphysis pubis. It is an obstetric emergency which must be resolved quickly. It is associated with brachial plexus injury but there is a school of thought that such injury is entirely avoidable. In this case note Justin Valentine, clinical negligence barrister, discusses the issues raised in a recent case of probable posterior shoulder dystocia which, in the event, was compromised.



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The Claimant's birth in 1994 was complicated by shoulder dystocia. According to the Royal College of Obstetricians & Gynaecologists:

*Shoulder dystocia is when the baby's head has been born but one of the shoulders becomes stuck behind the mother's pubic bone, delaying the birth of the baby's body. If this happens, extra help is usually needed to release the baby's shoulder.*

Shoulder dystocia occurs in about one in 150 vaginal births and is associated, inter alia, with a large baby, a high maternal BMI and a long or induced labour. Shoulder dystocia must be resolved swiftly so that the baby can be born and he or she can start breathing.

A recognised complication of resolving shoulder dystocia is Erb's palsy, or brachial plexus injury, which is a paralysis of the arm caused by stretching of the upper group of the arm's main nerves. It is caused by a widening of the angle between the head and affected shoulder (imagine tilting the head to the left or the right, the damage thereby being sustained to the opposite shoulder) as the midwife or obstetrician pulls too hard on the baby's head in a lateral direction trying to free the baby's shoulder.

The McRoberts' procedure is now recognised as the standard procedure to resolve shoulder dystocia. This involves, inter alia, hyperflexing the mother's legs to her abdomen and the application of pressure on the lower abdomen (suprapubic pressure) so that the shoulder is pushed under the symphysis pubis.

In G's case it was noted that there had been shoulder dystocia but otherwise record-keeping was poor. At the date of G's birth, the McRoberts' procedure was well-known but the midwifery experts agreed that they would not have expected all units or all midwives and obstetricians to have used it. However, the trust had its own protocol which was not dissimilar to the McRoberts' procedure. There was evidence to demonstrate prima facie breach of the trust's own protocol in that there was no evidence of the application of suprapubic pressure.

G's Erb's palsy was assessed on the Mallet score as grade IV out of V (V being normal, I indicating no function). She was not able to elevate her shoulder fully or use the arm properly. She had surgery as a child but the symptoms were permanent and she was deemed by her orthopaedic expert to be disabled.

The two primary competing theories for Erb's palsy are excessive traction or injury sustained spontaneously by maternal forces. The matter has been dealt with a number of times by the High Court in recent years. For example, in *Sardar v NHS Commissioning Board* [2014] EWHC 38 (QB) the claimant suffered a right-sided brachial plexus injury. The experts were agreed in that case that if the right shoulder was posterior at birth then the injury was either due to maternal propulsive forces or non-negligent traction the reason being, according to this theory, that brachial plexus injuries are caused by the anterior shoulder impacting the symphysis pubic. In that scenario, the injury is caused by downward traction stretching the nerves of the shoulder impacting upon the symphysis pubis.

In *Sardar*, the issue was which shoulder was posterior and which anterior. Haddon-Cave J found that at birth the baby's injured right shoulder would have been the posterior shoulder and, therefore, the injury was caused by strong cervical contractions and/or impact with the sacral promontory (which is far less prominent than the symphysis pubis) and/or the sheer size of the baby.

A similar conclusion was reached in *Watts v Secretary of State for Health* [2016] EWHC 2835(QB). In that case the claimant sought to argue that his right injured shoulder was in the anterior position and that the injury was caused by excessive traction. However, the judge found that the right injured shoulder was in the posterior position and as in *Sardar* the injury was therefore more likely caused by maternal propulsion rather than excessive traction.

The judges in both *Sardar* and in *Watts* cited a passage from a 2008 paper by Draycott, Sanders, Crofts and Lloyd "A template for revising the strength of evidence for obstetric brachial plexus injury in clinical negligence claims" (Clinical Risk, 2008; 14: 96-100) in which the authors conclude:

*Causation of obstetric brachial plexus injury is multifactorial; evidence suggests that while some cases are traction mediated, others may not be. There is growing acceptance in both the medical literature and case law that the propulsive forces of uterine contraction may play a part.*

*The assumption that the presence of an injury is evidence that traction must have been applied is no longer valid. Injury may occur regardless of best efforts of the accoucheur. Diagnostic traction is acceptable and Claimants now need to demonstrate factual*

*evidence of the use of excessive force or other inappropriate management to succeed in arguing negligent management.*

As noted, in G's case record-keeping was poor. However, the obstetric experts agreed that on the balance of probabilities the left, injured shoulder was in the posterior position at the beginning of labour. G's obstetric expert opined that it could not be assumed that the shoulder would still be posterior as the delivery progressed especially in a pelvis with a degree of cephalo-pelvic disproportion whereas the Defendant's expert was of the view that at birth her injured left shoulder would have remained posterior.

G's orthopaedic expert, however, was firmly of the view that maternal propulsive forces could not explain permanent injury to the brachial plexus. He observed that maternal propulsive forces would help expel the shoulder being held up and could not do anything to the head and neck interface once the head is delivered. He cited an article to support that view; Mechanism of Neonatal Brachial Plexus Injuries: Leslie Iffy, Journal of Women's Health Care 2014 3:2.

Further, it appeared that insufficient attention had been given to more recent evidence of avoidance of brachial plexus injury: "Prevention of brachial plexus injury – 12 years of shoulder dystocia training: an interrupted time-series study" Crofts et al BJOG, 2016. 123(1): p. 111-8. None of the 17,039 babies in the last cohort studied suffered permanent brachial plexus which suggests that if shoulder dystocia is properly managed permanent injury is entirely avoidable. This throws into question the maternal forces theory in relation to permanent brachial plexus injuries such as that suffered by G.

G's mother's evidence as to the use of excessive traction was ambivalent. She recalled being told to push and the midwife saying "Right, let's go for it" but was unable to confirm excessive traction or whether G's injured shoulder was posterior or anterior at birth.

G's claim was presented in the region of £1 million, the bulk of which (over £700,000) being loss of earnings presented as a Ogden 7 style handicap on the labour market award; G achieved a 1<sup>st</sup> class degree and her earnings expectation was high. The Defendant's Counter Schedule totalled approximately £23,000. Nothing was allowed for loss of earnings on the basis that a professional woman would be unlikely to suffer the sort of losses associated with disability pursuant to the deduction for contingencies other than mortality approach.

A joint settlement meeting was held in November 2017. The Defendant sought to persuade G to drop her case citing the case law referred to above. Towards the end of the day an offer was made by the Defendant in the region of £40,000 plus costs and finally £120,000 costs and damages (costs were in the region of £200,000 to trial). No settlement was reached. The trial was listed for April 2018.

In the interim a schedule of issues was prepared for the orthopaedic experts to prepare their joint report. This included addressing the issue raised by G's orthopaedic expert that the maternal propulsive theory could not explain brachial plexus injuries which issue the Defendant's expert had not previously dealt with.

In the event, the joint orthopaedic report was put on hold pending a solicitor and client-only mediation in January 2018. Settlement was achieved in the sum of £135,000 plus costs.

## Practice Points:

1. Cases where the evidence points to posterior brachial plexus injury are likely to be robustly defended. The obstetric literature appears to be in a state of flux. Orthopaedic evidence can be utilised to bolster the contention that the maternal propulsive theory is unsustainable.
2. It appears that the NHS were seeking to avoid setting a precedent where there was sufficient evidence for the trial judge to reject the maternal propulsive forces' theory on the basis of the orthopaedic evidence. In that context the robust stance taken at the JSM was, in retrospect, tactical.

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