

JMW remains high in the rankings

In the Legal 500 Directory for 2008/09 JMW is once again ranked highly for Clinical Negligence and the Head of Department, Eddie Jones, is described as “absolutely outstanding”.

Chambers UK 2008 again ranks both Eddie Jones, Olivia Scates and Sally Leonards as leading individuals for Clinical Negligence in the North West. The Directory states; ‘JMW Solicitors has cemented its reputation as one of the finest firms in the region’.

Poor response to complaints

Results from the Health Care Commission’s first ever audit of complaint handling show that the way in which complaints are followed up varies greatly.

The Commission identified the 10% of Trusts most at risk of not meeting the core standards set down by the government, and found that only 2 of these 32 Trusts had adequate arrangements in place across all standards.

The core standards require Trusts to make complaints procedures accessible, to act on concerns and make changes where appropriate and to ensure that complainants are not discriminated against.

The main concern was that few Trusts had systems in place to monitor whether complaining had had a detrimental effect on patients’ subsequent care, although 12 Trusts failed to meet all the core standards. This could affect their rating in the Commission’s annual health checks.

Is Anyone Listening? A report on Complaints
www.healthcarecommission.org.uk



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Neonatal jaundice

Welcome to the Autumn edition of the JMW Clinical Negligence newsletter.

Jaundice is a symptom rather than a disease and is characterised by a yellowish staining of the skin and the whites of the eyes. It is very common in the newborn and is due to an excess of bilirubin, the normal pigment of red cell breakdown. Once the liver is mature it excretes bilirubin as waste but in the neonate the liver is still developing and is therefore less efficient at removal.

So-called normal neonatal jaundice (also known as physiological jaundice) typically develops between the 2nd and 5th day after birth and then gradually clears over the next couple of weeks without any treatment, apart from plenty of fluids.

Occasionally, however, particularly in the premature infant, the bilirubin level does not decrease on its own and treatments such as phototherapy or (rarely) exchange blood transfusion must be given in order to prevent bilirubin crossing the blood-brain barrier. This is a very serious condition known as kernicterus and can result in irreparable brain damage.

Jaundice is most dangerous in small, sick premature babies where the barrier between the blood and the brain may be compromised and kernicterus can occur at levels of bilirubin considerably lower than in large full term babies.

Neonatal jaundice/ kernicterus

R was the second of uniovular twins delivered at 35 weeks gestation. Intrauterine twin-to-twin transfusion had occurred with R being the donor twin. Because of this his haemoglobin was very low and a blood transfusion was commenced soon after birth.

The next day R was noted to be jaundiced with a bilirubin level of 216 micromols/litre (grossly elevated). He was commenced on phototherapy, a standard treatment for neonatal jaundice, but despite this the bilirubin continued to rise and was 240 by that evening.

The next day the bilirubin level had not decreased despite continuing phototherapy, but for some reason it was not recorded again until 24 hours later by which time it was 310. (There was a suggestion that it may well have peaked at an even higher level). By this stage R was very unwell and displaying symptoms of kernicterus; rigidity and arching of the back. Kernicterus occurs when bilirubin crosses into the brain from the blood serum and is deposited in the fatty parts of the brain (often nerve tissue) causing irreversible damage.

It would appear that R's prematurity and generally poor condition was not taken into account when assessing the significance of the rising bilirubin levels. A level above 350 is liable to cause kernicterus in a healthy full-term baby but any level above 250 usually gives some cause for concern. In a sick premature baby, where the blood brain barriers can be compromised, kernicterus can occur at considerably lower bilirubin levels.

With appropriate monitoring of bilirubin levels R would almost certainly have received either double phototherapy or an exchange transfusion which would have avoided bilirubin reaching dangerous levels. R developed mild cerebral palsy, mild learning difficulties, visual problems and severe hearing impairment.

Shortly before the trial the defendant admitted that R's profound hearing loss and other problems were caused by negligence (a failure to adequately monitor bilirubin levels) rather than by any genetic factors, and on the first day of the trial an offer of £5.5 million was made and accepted.

Missed jaundice in African baby

K was the first child of a young Sudanese mother recently arrived in this country. The baby was small and 3 or 4 weeks premature. His Apgar score (which gives an indication of a baby's condition at birth) was 8 at birth and 9 at 5 minutes.

Although the labour and delivery were essentially normal the mother became distressed during the second stage and the baby was delivered by Ventouse extraction. This resulted in a fairly large haematoma under the scalp.

The baby appeared hungry but was not breast feeding well mainly because of the mother's anxiety and inexperience. He required 'topping up' after most feeds.

Because of pressure on beds, mother and baby were discharged the following day and it was arranged that the health visitor would visit frequently to give support.

Although K was almost certainly mildly jaundiced before he was discharged this was not noticed because of his very black skin and therefore his bilirubin level was not checked before he left hospital.

The health visitor called daily, primarily to assist with breast feeding. She was a little concerned about the baby as he did not appear to be thriving, but she put this down to the infected umbilicus he had had since coming home. She did not appreciate the significance of the rather yellow sclera, believing it to be normal in an African baby.

After about a week the baby appeared drowsy and floppy and the health visitor was concerned enough to call the GP. The GP noticed the, by now, quite deep jaundice and the baby's rather plaintive high pitched cry and immediately admitted him to hospital.

Once in hospital the bilirubin level was checked and found to be extremely high although it was felt that it was already beginning to come down from its peak. Although an exchange blood transfusion was considered it was realised that brain damage due to kernicterus had already occurred.

Kernicterus in almost-term babies is less common than in very premature infants, but in K's case his bilirubin rose to dangerous levels for a number of reasons:-

- It was not noticed for more than a week that he had rapidly increasing jaundice.
- He had an insufficient intake of fluid because of feeding difficulties.
- He had a large haematoma/bruise on the scalp (dead red blood cells create bilirubin).
- He had an infection.

K was not as severely brain damaged by kernicterus as some babies but he has some hearing loss, is mildly intellectually impaired and has a degree of athetoid cerebral palsy that becomes apparent when he is tired.