ENABLELAW
Medical Negligence & Serious Injury Specialists

A CLIENT GUIDE TO BIRTH INJURY CLAIMS

1. THE PURPOSE OF THIS GUIDE

Making a claim for damages (compensation) for clinical negligence can be a worrying and stressful experience. We recognise that most of our clients have never been involved in anything similar before, and are unclear as to what their role and ours may be. This Guide has been prepared to help you. It deals with clinical negligence claims generally, and with the specific problems which arise in birth injury claims.

It may be that your main concern is not to recover compensation, but to seek an apology, and an assurance that what happened to you will not happen to others. Perhaps you just want to know whether what happened could have been avoided. You must tell us if this is the case, because it may affect our advice as to the best way of proceeding.

When you have suffered injury following medical treatment, your faith in the medical profession can be affected. It can be difficult to put yourself in the hands of doctors, even if they were not involved in your original treatment. If we are to help you, however, we will need to instruct medical experts to advise us, and it may be necessary for them to see you. We will do what we can to make this as easy for you as possible.

Clinical negligence claims are notoriously difficult to pursue. Medical defence organisations tend to defend claims even when they know they are justified. The percentage of claims that succeed is much lower than for other personal injury claims. Clients tell us that the stress of making a claim can be as bad, if not worse, than the original injury. We will do our best to keep the stress to a minimum, but it will help you to be aware that making a claim is not an easy course to take.

The legal system in this country is complicated, and is not user-friendly. It is changing all the time. Some of the principles which the courts apply in considering claims for clinical negligence are confusing and difficult to understand. We will do our best to explain them, but please do not worry if you feel you do not understand all that is happening. The important thing is that you feel confident that we have your best interests at heart. If you lose that confidence, then it will be difficult for us to continue to advise you.

2. THE LEGAL REQUIREMENTS: WHAT WE HAVE TO PROVE

To recover damages for personal injury sustained in a medical accident, you have to show the following:-

- that the treatment or diagnosis about which you are complaining occurred wholly or in part through **negligence** on the part of the hospital or clinician concerned;
- that the negligent treatment has **caused** the injury, loss and damage in respect of which you are seeking compensation;
- that the injury, loss and damage you have sustained was a **reasonably foreseeable consequence** of the negligent treatment.

3. PROVING NEGLIGENCE

In clinical negligence cases it is often difficult to say whether the hospital or clinician were negligent, because there may be many different ways of carrying out a medical procedure, all of which are acceptable. Provided that the hospital or doctor can show that what was done would be regarded as

acceptable practice by a 'responsible body of medical opinion', then it does not matter that other doctors would have acted differently, even if they take the view that the hospital's way of doing things was wrong or harmful. This is the principle laid down by the courts in the case of "Bolam v Friern Hospital Management Committee" in 1957, and is usually referred to by lawyers as the '**Bolam principle**'.

You do not have to prove negligence beyond all doubt, but you have to show that it is more likely than not that your opponent was negligent (this is called proving 'on the **balance of probabilities**').

4. PROVING CAUSATION

The issue of causation (i.e. what actually caused the injury) is often more difficult to deal with than the issue of negligence. In the case of a child with cerebral palsy, for example, the hospital may well accept that the baby should have been delivered sooner, but argue that this would in practice have made no difference to the outcome, perhaps because the injury arose during the earlier stages of labour. The causes of cerebral palsy are not well understood, and there is often disagreement between experts as to when and how the injury was caused.

What you must bear in mind is that:-

- An adverse outcome (i.e. A less than perfect result) does not necessarily mean that the treatment was negligent
- Even where an adverse outcome could have been avoided, this does not necessarily mean that the treatment was negligent
- Even where negligence can be shown, you do not necessarily have a valid claim, because your loss may have been caused by something else, or may have been unforeseeable

5. MAKING A FORMAL COMPLAINT TO THE HOSPITAL

Sometimes it is useful to make a formal **complaint** to the hospital or clinician for investigation under their internal complaints procedures before undertaking any investigation into the claim. The advantage of this is that a full account of the treatment you have received is given, and the hospital will explain why it took the action complained of, or why there was an unsatisfactory outcome. We may decide not to incur the expense of further investigation in the light of this reply.

The Legal Services Commission require a formal complaint to be made and investigated before legal aid is applied for, in cases where the damages are unlikely to exceed £10,000.

6. APPOINTING A LITIGATION FRIEND

In a birth injury claim where the child's condition is thought to be due to negligence on the part of the hospital at the time of birth, the claim is brought on the child's behalf by their Litigation Friend. The Litigation Friend is usually the child's father or mother, and their task is to conduct the claim and comply with the court's requirements.

The Litigation Friend has an important role to play in giving us instructions when decisions have to be made about the claim, particularly in connection with any offers of settlement.

7. WILL YOUR CLAIM SUCCEED?

Before we can tell you whether the claim is likely to succeed, we have to obtain all the relevant **medical records** from the hospital and/or your G.P. These then have to be sorted into chronological order and any gaps in the records identified. If medical records which may be relevant to the claim have not been disclosed by the hospital, then it may be necessary to apply to court for an order requiring that they be disclosed.

Once the medical records are available, we will then instruct an independent **medical expert** or experts to study them, and to advise whether there are sufficient grounds for alleging negligence against the hospital or clinician to justify starting proceedings through the courts. More than one expert will be necessary if there is more than one area of medical expertise involved. In a birth injury case, for example, we may require an opinion from an obstetrician as to the way in which labour was handled, and an opinion from a paediatric neurologist as to the time when the injury occurred and whether earlier delivery could have prevented it.

These experts will be based in a different part of the country from the place where the negligent treatment occurred. They will usually be busy clinicians themselves, with their own patients to look after, and often it can take 6 months for them to complete their reports, particularly if they are well-known in their field of work. The cost of expert reports is heavy. However, the choice of expert is crucial, since the claim is likely to stand or fall depending on the contents of their report. We will tell you why we recommend a particular expert.

When the experts have advised, usually we arrange a **conference** with the experts and with a barrister ('counsel') specialising in clinical negligence claims, so that the precise issues and difficulties in the case can be identified, and a decision reached as to whether proceedings through the courts are justified. It is essential that you attend this conference, because of course the decision involves you as well as the legal and medical experts.

8. TAKING PROCEEDINGS THROUGH THE COURTS

If the expert advice is that there are sufficient grounds to justify bringing proceedings against the hospital or clinician, then we will consider with you the next step to take. Taking **proceedings through the courts** is a long and expensive process, and not a step to take lightly. There may well be other ways of achieving a satisfactory outcome, which do not involve the courts. We will advise you about them.

Once the decision has been made to take proceedings, a typical **sequence of events** is as follows:-

(a) A **letter of claim** is sent to the hospital trust, setting out the nature of the claim, and the grounds for alleging negligence on the part of the hospital. The hospital trust then has 3 months in which to make a formal response, saying whether the claim is admitted, or if not, on what grounds it will be defended.

(b) If the claim is denied, then our barrister will draft **Particulars of Claim** (a formal document specifying the precise allegations made against the Defendant). This has to be approved by our medical experts and yourself before it is filed with the court, because it can only be amended with the court's permission.

(c) Proceedings are **commenced** in the courts by filing the Particulars of Claim and other formal documents, which are then served on the Defendant. The Defendant has a limited time in which to file its Defence, responding in detail to the Particulars of Claim.

(d) **Statements of factual witnesses** are then exchanged; for example, statements of the evidence of the doctors or nurses involved at the time, and of yourself and any other eyewitnesses we decide to call.

(e) Often at this stage a **further conference** with the barrister and experts is held, when the strength of the case is reassessed, and the experts are questioned about any issues which may arise from

the Defendant's evidence.

(f) **Reports of experts** are then exchanged; this is the first time we get to see what the Defendant's medical experts are saying. Usually at this stage we have a fairly good idea as to the chances of the claim succeeding at trial.

(g) Sometimes a **split trial** is ordered, which means that the issues of liability and causation will be determined by the court separately from the issue of quantum (i.e. how much the claim is worth). The object of a split trial is to avoid incurring the cost of assessing the value of the claim, which in a birth injury claim can be substantial.

(h) If a split trial has not been ordered, and expert evidence is needed in order to assess the value of the claim, for example expert advice on care needs, therapy needs, etc., then **quantum experts** will have been instructed to see you and prepare reports, which should be available at this stage. Normally, quantum experts are instructed jointly by us and by the Defendant.

(i) A **Schedule of loss and expense** (sometimes called a Schedule of Special Damage) will be prepared, incorporating all the items of loss and expense to date and in the future which the quantum experts have identified.

(j) We may also need to prepare for you a further witness statement (a **quantum statement**) setting out in detail the medical history, and confirming the items of loss and expense set out in the Schedule.

(k) The Defendant has to serve a **Counterschedule** saying which items in the Schedule are agreed, and why the remaining items are disputed.

(l) By now a trial date will have been set, and the parties will be looking to settle the claim before the substantial cost of trial is incurred. Often at this stage a **round table meeting** takes place, when the parties and their legal representatives try to negotiate a settlement. In a birth injury case, any settlement will be subject to the approval of the court, since a minor or someone who is mentally incapable of managing their own affairs does not have legal capacity to approve a settlement themselves.

(m) If no settlement is reached before the date fixed for trial, then the **trial** takes place. You will be represented by your barrister, and the court will hear evidence from you and the other lay and expert witnesses in order to decide whether the claim should succeed.

9. THE APIL CODE OF PRACTICE

In connection with any court proceedings, we will comply with the Code of Practice recommended by the Association of Personal Injury Lawyers:

CODE OF PRACTICE

We will not commence court proceedings unless and until:-

- **Your claim has been properly investigated**
- **All relevant obtainable material has been assessed**
- **Your claim is supported by appropriate expert medical opinion**
- **The amount likely to be recovered is in proportion to the legal costs likely to be incurred**
- **The pre-action protocol for clinical negligence cases has been complied with**
- **Other ways of resolving the claim or of seeking appropriate redress have been explored**
- **Appropriate funding arrangements are in place between us**
- **You authorise us to start proceedings**

In addition, we will try to ensure that the case is not conducted in a manner which may unfairly harm the practice or reputation of any medical practitioners against whom a claim is made.

10. RESOLVING THE CLAIM

Most claims are resolved by **negotiation** rather than by trial. The advantages of a settlement over a trial are that the claim can be concluded that much more quickly, and the outcome is one which you have had an opportunity to consider and agree. At trial, the evidence does not always go the way one expects it to, and surprising results do occur. The outcome of trial is 'all or nothing', and clinical negligence cases are seldom sufficiently clear-cut to justify taking the risk of ending up with nothing. In acting for you, we will do our best to negotiate a settlement of the claim on the best terms available, while at the same time pursuing it to trial without delay.

11. THE TIME LIMIT FOR TAKING COURT PROCEEDINGS

In birth injury cases where the claim is made on behalf of the child, the time limit for commencing court proceedings against the hospital or clinician does not end until:-

- the child's 21st birthday, except where the child is unlikely ever to be able to manage his or her own affairs, when time does not run; or
- three years after the child's death.

We will monitor the **limitation period** for you to ensure that the relevant period is not overlooked, but you should be aware of the period also.

In practice, court proceedings ought to be started when the matters set out in the APIL Code of Practice [see the previous page] have been completed.

12. THE NEED FOR PATIENCE

Clinical negligence claims can often take a long time to resolve. One factor which delays the resolution of a claim is the time it takes to establish a firm prognosis in respect of the injuries, i.e. how long it is likely to be before the effects of the injury disappear, whether the claimant is likely to be left with any permanent symptoms, etc. The period varies according to the severity of the injury. In birth injury cases, it may take five years for the claim to be concluded, or even longer in certain circumstances.

The other main factor which causes delay is the length of time it takes to obtain all the expert evidence necessary to support the claim. In addition to experts dealing with liability, we may also need to call experts to establish the extent of the injuries, and that they were caused by the negligence alleged.

We will do what we can to resolve your claim in the shortest possible time. It is not, however, in your interests for a claim to be settled too soon. Once a claim has been settled, it is too late to ask your opponent to pay more money if the injury subsequently turns out to be more serious than was thought at the time we settled. You should not agree to settle the claim until the prognosis is clear from the medical evidence which has been obtained.

13. WHAT YOU NEED TO DO

We will keep you informed of our progress in taking all these steps, by sending you copies of our correspondence, by writing to you, and if possible by regular interviews with you. If there is anything you are unsure about at any stage, you should not hesitate to telephone us for advice. We are here to help you, and to make things as easy as possible for you. We recognise that it helps you if you have confidence in what we are doing on your behalf.

There is much you can do to assist us in dealing with your claim. It is important that you keep written records of the following:-

- The circumstances of the original treatment and the names and addresses of the hospitals and doctors involved
- Details of all expense you incur which you wish to claim from your opponent
- Details of the injuries and treatment at various stages (this may be particularly useful when our medical expert does his examination, as he will want you to describe the symptoms and treatment to date)
- Any questions which you may wish to raise with us when we next meet

We will need to prepare a written **statement** of your evidence in relation to both the circumstances of treatment and the sums claimed as a result. It is important that this statement is as accurate and comprehensive as it can be, because increasingly Judges at trial rely on written statements from witnesses rather than oral evidence given in the witness box. This means you may not have a chance to expand on the contents of your statement if the case gets to trial.

You should therefore check the statement carefully, making sure not only that it is accurate and comprehensive, but that you are happy with the words used. Do not let us put words into your mouth!

14. WHAT CAN BE CLAIMED

The claim for compensation ('**damages**') may include the following:-

- Any financial loss or expense you have suffered, for example prescription charges, travelling expenses and telephone calls, and the cost of private medical treatment
- In particular, any lost earnings through having to take time off work following the negligent treatment, or while further treatment is undertaken
- All anticipated future loss and expense, including any loss of earnings which is likely to arise in the future
- Damages to reflect any disadvantage which may be suffered in the future in seeking employment
- Damages to reflect the pain, suffering and restrictions caused by the injuries
- If the claim arises as a result of the death of someone close to you, you may be entitled to damages for bereavement

You should be aware of the **welfare benefits** to which you may be entitled, such as disability working allowance, incapacity benefit and severe disablement allowance. We can advise you on this if you think you may be eligible

15. DEDUCTIONS FROM YOUR COMPENSATION

The following sums have to be deducted from your compensation:-

- Where **welfare benefits** have been received as a result of the injuries, the Compensation Recovery Unit of the Department for Work and Pensions has the right to deduct from the claim the benefits which received up to the date on which the claim is concluded, or up to five years from the date of the injury if earlier. The benefits are recouped from the different heads of loss which we are claiming, on a 'like-for-like' basis. For instance, benefits received because you have not been working (such as Income Support) can only be recouped from any sum you recover for lost earnings
- Any **legal costs** which cannot be recovered from the Defendant for any reason, for example, the cost of obtaining any medical reports which the court does not think the Defendant should have to pay for, and our charges in dealing with the Legal Services Commission about legal aid. The LSC

has the right to claw back these costs from the award under its 'statutory charge'. As legal costs are subject to assessment by the court, we cannot say at this stage what figure may be involved

- Any **interim payments** we have received from the Defendant
- Our charges and expenses in obtaining advice on structuring the award, investing the award generally, and dealing with the Court of Protection (see below). Some or all of these costs may be recoverable from the Defendant

16. DIFFERENT TYPES OF COMPENSATION: LUMP SUM AWARDS

Where a lump sum is awarded, the full amount of the settlement, less any interim payments, benefits, costs etc, is held on the child's behalf until they reach the age of 18. The **advantages** of this are that:-

- The Claimant is not dependent on the Defendant for providing for the Claimant's needs. It is up to the Claimant, or their Receiver or trustees, to decide how to spend or invest the money
- Depending on the way in which the lump sum is invested, there is complete flexibility to provide for the Claimant's needs at any stage. Those needs might be difficult to determine in advance. Flexibility may be of particular importance where the amount of the settlement is less than the full sum needed to meet the Claimant's needs

The **disadvantages** of a lump sum award are that:-

- The award is based on an assumed life expectancy for the Claimant, which is inevitably an inaccurate guide to the actual duration of the Claimant's life
- The award is based on a future rate of return on investments of 2½ % net of tax, which may or may not be accurate, depending upon the chosen investment strategy, the extent to which the cost of care etc. may increase faster than RPI, and the economic conditions prevailing at the time
- Both income and capital are liable to tax
- A large lump sum requires relatively sophisticated financial management, which involves a significant cost
- The Claimant or his trustees may be worried that the fund is insufficient to provide for the Claimant throughout his lifetime, and accordingly may be overcautious in investing or spending the sums on their behalf. Conversely, a Claimant might dissipate the award

17. DIFFERENT TYPES OF COMPENSATION: PERIODICAL PAYMENTS

The courts now require the parties to a settlement to consider whether all or part of the award should be paid by annual payments. Sometimes, a proportion of the award is used to purchase an annuity or annuities based on the Claimant's life expectancy. The annual sum is therefore dependent solely on the amount of money paid to the life insurer, and the assumptions made by the life insurer about future growth etc. The resulting annuity may not cover the anticipated annual requirements of the Claimant.

In other cases, however, the focus is on the Claimant's annual requirements, rather than the actual amount of the award. Provided the arrangement produces sufficient annual income to cover those needs, the Claimant need not be concerned with the cost to the Defendant of providing the money. The **advantages** of this sort of arrangement are that:

- The annual sum or sums are guaranteed for the Claimant's lifetime. Life expectancy is therefore irrelevant
- A self funded periodical payments arrangement such as that which the NHS offers does not involve the purchase of an annuity from a life office, but simply involves periodical payments from the Defendant's own funds. This enables the arrangement to match the Claimant's annual requirements more closely than if the annual payments were restricted by the products available on the annuity market
- The annual payments under a periodical payments arrangement are free of income tax

- Flexibility can be built into the periodical payments arrangement by taking part of the award as a lump sum

The **disadvantages** of a periodical payments arrangement are that:-

- There is a continuing involvement with the Defendant for the Claimant's lifetime
- The annual sum is index-linked, but only to changes in retail prices via the RPI. In practice, the cost of care and of medical equipment tends to rise much faster than the RPI, so over time the real value of the annual payments declines

As you can see, a periodical payments arrangement is effectively an alternative way of investing part of the award. Provided that the annual payments meet the anticipated needs, it is likely to be a cheaper and more effective way of providing for those needs than any other form of investment. The objective is not, of course, to maximise the value of the award, but simply to provide sufficient income over the Claimant's lifetime to cover their needs. It is not appropriate to try to build up a fund of money which could pass to other family members when the Claimant dies, since this would not of course benefit them.

18. FAMILY TRUSTS

Whether we go for a lump sum award or a periodical payments arrangement, there will still be a substantial sum of money which needs to be invested. Broadly, there are two ways of holding that money: either the money can be held in the Court of Protection and applied by a Receiver appointed by the Court, or alternatively the money can be managed by a private trust. The **advantages** of a private or family trust are that:-

- The fund can be looked after by members of the family together with a professional trustee. The member of the family is able to bring to the trust a close personal knowledge of the Claimant's needs etc, and the professional trustee is able to contribute managerial and record keeping skills. It gives a recognised role to the family, and enables the trustees to use the money in the most appropriate way to benefit the Claimant
- The fund is not subject to the supervision of the Court of Protection, nor is it liable to pay annual administration fees to the Court
- The trustees have control of the investments, and can invest the fund in a wider range of investments than a Receiver can

There are, however, **disadvantages** in a family trust:-

- Disputes sometimes arise between the trustees themselves, or between the trustees and the Claimant or other members of the family, about the way in which the trust should be run, and how the money should be used. Sometimes these disputes are difficult to resolve without court proceedings. It is essential therefore that the trust can be revoked, if the relationship between the trustees and the Claimant breaks down
- There is no clear mechanism for external supervision and control of the way in which the trust is run, or how the money is used. Sometimes, trustees may appoint a new trustee who is unsuitable, or may invest the funds inappropriately. This is why the court will insist that there is an independent professional trustee as well as members of the family
- There are tax disadvantages with a family trust which may make a considerable difference to the annual income from the sum invested

Normally the court requires that substantial awards are administered for the child's benefit by the Court of Protection.

19. INVESTING AND ADMINISTERING SUBSTANTIAL AWARDS

Whether the compensation is paid by a lump sum award or a structured settlement, there will still be a substantial sum of money which needs to be invested. Where the Claimant is not capable of administering their own affairs, the money is normally held by the Court of Protection, which appoints a Deputy to manage the fund and deal both with investment decisions and also with payments for the Claimant's benefit. Normally, the Court will appoint a family member as Deputy.

There are a number of things which the Court of Protection insist upon before the Deputy can deal with the fund; we can advise you about these. Once the necessary arrangements are in place, the Deputy has to make annual returns to the Court, but the Court's requirements are not particularly onerous.

20. SOME TERMS USED IN BIRTH INJURY CASES

It will help you to follow the issues in the case if you understand the medical terms used by doctors in discussing events at the time of birth. This glossary may be useful.

Amniotic sac – the 'bag' containing the fetus within the womb.

Anoxia – complete lack of oxygen.

Apgar score – this is a measure of the baby's condition at birth, based on five tests:

Test	**0**	**1**	**2**
Appearance / Colour	Pale or blue	Body pink but extremities blue	Pink
Pulse / heart rate	None	Less than 100 bpm	More than 100 bpm
Grimace / reflex response to stimuli	None	Minimal	Cough or sneeze
Activity / muscle tone	Limp	Some flexion of limbs	Well flexed, active
Respiratory effort	None	Hypo-ventilating; slow, irregular	Good or crying

The 'score' will vary from 10 [well] to 0 [moribund].

Asphyxia – oxygen starvation, causing a deficiency of oxygen in the blood.

Auscultation – listening to the fetal heart rate using a stethoscope.

Baseline heart rate – the average heart rate as seen on a CTG printout. A normal pattern is a baseline rate of between 110 bpm and 150 bpm.

Brachial plexus – the group of nerves at the base of the neck.

Bradycardia – abnormally slow heart rate.

Breech presentation – the commonest form of malpresentation, where the baby's buttocks enter the birth canal first.

Cerebral Palsy – this is a disorder of movement and motor function caused by brain damage. CP can take different forms:-

Paraplegia – this means that the disorder affects only the lower limbs.

Tetraplegia/Quadriplegia – this means that all four limbs (indeed the whole body) are affected by the disorder.

Dystonic/Dyskinetic – these terms indicate that the dominant motor abnormality is that of unwanted and unhelpful fluctuations of muscle tone, which at rest tend to be floppy but become too stiff when voluntary movements are attempted. "Dyskinetic" implies that there are also involuntary movements, e.g. jerking of the upper limbs or head.

Athetoid – where the condition is characterised by involuntary, slow and more or less rhythmical movements of the limbs, especially of the fingers, caused by the brain abnormality.

Cervix – the neck of the uterus.

Cord occlusion – where the cord becomes blocked through compression, causing the circulation of blood to the fetus to be impaired.

Cord presentation – where the cord precedes the presenting part of the emerging fetus, giving rise to a risk of prolapse through the cord being torn away from the membranes.

Cord prolapse – this occurs where the membranes are ruptured, damaging the fetal cord and impairing the circulation of blood to the fetus.

Crowning – where the baby's head distends the cervix and no longer recedes during contractions.

CTG – Cardiotocograph, an electronic monitor used to record contractions and fetal heart rate during labour via electrodes. The machine produces a printout or trace', which gives a chronological display of the progress of labour, and any signs of fetal distress.

Decelerations – slowing of the fetal heart rate during contractions, apparent from the CTG trace. Early or type 1 decelerations are those which start at the onset of a contraction, and where the fetal heart rate reaches its lowest point at the peak of the contraction, returning to the baseline by the end of the contraction. Late or type 2 contractions are where the fetal heart rate reaches its lowest point more than 15 seconds after the contraction has peaked.

Dilatation – the stretching of the uterus as labour progresses. Full dilatation occurs at 9-10 cms.

Episiotomy – a deliberate incision in the perineum to assist the passage of the fetus through the birth canal.

Etonox – a mixture of gas and air used as a form of pain relief.

Febrile – high temperature.

Fundal – relating to the rounded upper part of the uterus.

Gestation – the period of pregnancy, lasting typically 37-42 weeks [nine months].

Hypertension – maternal blood pressure above the normal range [about 140/90 mmHg during labour].

Hypoxia – shortage of oxygen.

Hypoxic ischaemic encephalopathy – where the baby suffers neurological injury as a result of oxygen insufficiency in the womb or during labour.

Induction of labour – artificially encouraging the onset of labour, typically through administering oxytocin [Syntocinon] or prostaglandins.

Intrapartum – during labour.

Ischial spines – slight protuberances which can be felt on either side of the pelvis during vaginal examination, and which are used by midwives to determine how far into the pelvic canal the baby's head has descended.

Labour – the first stage of labour lasts from the onset of contractions until full dilatation of the cervix; the second stage lasts from full dilatation until delivery; the third stage involves delivery of the placenta.

Liquor – [pronounced 'lye-kwor'] the fluid surrounding the amniotic sac.

Lithotomy position – where the mother lies on her back with lower legs raised and supported in stirrups.

Meconium – fluid from the fetal intestinal tract. It is a sign of possible fetal distress if passed during labour.

Membranes – layers of thin tissue forming the amniotic sac containing the fetus, surrounded by liquor.

Multiparous – second or subsequent pregnancy.

Partogram – a record of labour completed by the midwife, showing dilatation of the cervix and fetal heart rate during labour.

Perineum – the area between the vagina, the anal canal and the ischial spines.

pH level – a measure of acidosis in the baby's blood, obtained by blood sample.

Placental insufficiency – where the placenta fails to supply the fetus with the necessary nutrients during preganacy, causing retarded growth or stillbirth.

Post-partum haemorrhage – excessive bleeding of the uterus during the final stage of labour.

Primiparous – first pregnancy.

Show – term used by midwives for the blood-stained discharge from the cervix at the onset of labour.

Suprapubic – above the front of the pelvis.

Tachycardia – abnormally fast heart rate.

Ventouse extraction – delivering the fetus using an instrument attached to the fetal head by suction.

Version – manipulating the fetus in order to correct a malpresentation such as a breech.

Vertex – part of the fetal skull.

21. COMMON ABBREVIATIONS

B/P = blood pressure

BS = Bishop score [suitability for induction of labour]

CDS = central delivery suite [labour ward]

CS = Caesarean section

CTG = cardiotocograph [monitors fetal heart rate and maternal uterine contractions]

Cx = cervix

EDD = estimated date of delivery

EEG = electroencephalogram

FHHR = fetal heart heard regular [via auscultation]

FHR = fetal heart rate

FM = fetal movements

FMF = fetal movement felt

GA = general anaesthetic

IOL = induction of labour

LMP = last menstrual period

LOA = left occiput anterior [fetus presenting with **right** shoulder uppermost]

LW = labour ward

MRI = magnetic resonance imaging

NAD = *nil ad demonstrandum* [nothing abnormal detected]

NBF = Neville Barnes forceps

NICU = Neonatal Intensive Care Unit

O/P = on palpation

OP = oropharyngeal [by throat]

PV = *per vaginam* [by vagina]

ROA = right occiput anterior [fetus presenting with **left** shoulder uppermost]

ROM = rupture of the membranes

S/B = seen by

S/R = specialist/senior Registrar

SRM = spontaneous rupture of membranes [also SROM]

USS = ultrasound scan

VE = vaginal examination

WARNING

The information contained in this guide is for generic use only and cannot be relied upon for any specific purpose. We recommend that specialist professional advice is taken before entering into (or refraining from entering into) a particular transaction.