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Clinical Negligence Seminar 2026

Birth Injuries

Ampersand Advocates
22nd October 2026

Welcome from the Chair

Una Doherty KC

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01 **Abigail Holmes** – Director of Midwifery and Neonatal Services, University Hospital Wales: "Induction of Labour"

02 **Dr Tara Fairley** – Consultant Obstetrician and Associate Medical Director NHS Grampian: "(1) Suspected Macrosomia – Consent and Shoulder Dystocia; and (2) Key Points of CTG Interpretation"

03 **Dr Julie-Claire Becher** – Consultant Neonatologist: "Time is brain: Attributing causation and contribution in intrapartum and neonatal care"

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INDUCTION OF LABOUR

Consent, competence and defensible care

An expert witness perspective

Abigail Holmes | Director of Midwifery and Neonatal Services
Midwifery Expert Witness



What this session will do

A practical framework for analysing breach, consent and causation

1	**Separate the legal tests**	Montgomery addresses disclosure and choice; competent clinical care requires a distinct professional analysis.
2	**Define competent practice**	Apply professional standards, guidance, local policy and the circumstances at the material time.
3	**Follow the whole pathway**	Counselling, method selection, monitoring, escalation, discontinuation and operative birth.
4	**Test the record**	Ask whether information, reasoning, decision and response can be reconstructed.

A signature is evidence of a form. The defensible standard is evidence of a dialogue.

The expert witness lens

Disciplined reconstruction, not advocacy

1	**Material time**	Identify guidance, policy, clinical information and context then available.
2	**Decision pathway**	Reconstruct what was offered, explained, understood, chosen, reviewed and recorded.
3	**Correct standard**	Keep consent, clinical skill, monitoring, escalation and record-keeping analytically distinct.
4	**Breach and causation**	A deficient process does not itself prove the alleged injury was caused by it.

Avoid hindsight bias.

The legal map

Two questions that should not be collapsed into one

DISCLOSURE AND CHOICE

Montgomery

Was the woman aware of material risks and reasonable alternatives, including delay or no intervention?

Patient-centred materiality and individual significance.

CLINICAL PRACTICE

Bolam / Bolitho

Did the clinical acts and omissions accord with responsible professional practice capable of logical analysis?

Role-specific competence in the circumstances at the time.

Do not ask Bolam to answer the Montgomery question.

Montgomery in one slide

Autonomy changes the direction of the conversation

Take reasonable care to ensure the patient is aware of:

- ✓ Material risks of the recommended option
- ✓ Reasonable alternatives or variants
- ✓ Information this individual is likely to regard as significant

Small numerical risks may still be material because of consequence or personal significance.



The ordinarily competent midwife

A role-specific, context-sensitive standard

1	**NMC Code**	Prioritise people, practise effectively, preserve safety, promote professionalism and trust.
2	**National guidance**	Apply NICE recommendations alongside individual needs, preferences and values.
3	**Local policy**	Follow relevant pathways, medicines protocols, fetal monitoring and escalation standards.
4	**Professional judgement**	Recognise limits, seek advice, escalate and respond when the situation changes.
5	**Documentation**	Make assessments, advice, decisions, monitoring and response attributable and timed.

The standard is reasonable competence, not the best imaginable practice.

Consent is a process, not an event

The quality of the dialogue matters more than the paperwork

1	**Listen**	Identify what matters to this woman and what experience or outcome may be particularly significant.
2	**Inform**	Explain benefits, harms, uncertainty and reasonable alternatives in understandable terms.
3	**Check**	Address capacity, language, literacy, communication and support needs.
4	**Choose**	Support a voluntary decision without coercive language or false urgency.
5	**Revisit**	Renew consent when the method, risk, urgency or proposed intervention changes.

A generic form cannot demonstrate an individualised dialogue.

Good counselling before induction

A minimum defensible conversation

1	**Why now?**	Clinical indication, strength of recommendation, expected benefit and uncertainty of waiting.
2	**What will happen?**	Likely sequence, examinations, methods, monitoring, pain relief, duration and possible delay.
3	**What are the choices?**	Expectant management, another reasonable method, delay, decline, stop, or planned caesarean where reasonable.
4	**What could follow?**	Hyperstimulation, fetal heart rate concern, oxytocin, assisted birth, unsuccessful induction and further intervention.
5	**What matters to her?**	Previous experience, fears, place of birth, mobility, support, trauma and priorities.

Leaflets support dialogue. They do not replace it.

Material risk is personal

Do not reduce disclosure to a standard list

1	**Magnitude**	How likely is the outcome?
2	**Consequence**	How serious would it be?
3	**Patient context**	Why might it matter particularly to this individual?
4	**Alternatives**	Would another reasonable option avoid or alter the risk?
5	**Changing circumstances**	Has the risk profile altered since the earlier discussion?

The expert should identify which risks were material in the actual clinical context.

What should the record show?

Documentation is the audit trail of reasoning and choice

1	**Indication**	Clinical basis, urgency and uncertainty.
2	**Options**	Recommended approach, reasonable alternatives, delay and no intervention.
3	**Individualised risks**	What was material for the woman and why.
4	**Dialogue**	Questions, concerns, preferences, communication needs and who participated.
5	**Decision and plan**	What was chosen, any limits, method, monitoring, review, escalation and safety-netting.

Weak: “risks discussed”, “leaflet given”, “happy to proceed”, “consent obtained”.

Good care during induction

Consent remains live throughout a changing clinical process



Before each intervention

Explain purpose, effect, alternatives and immediate risks; obtain consent.

Monitor proportionately

Maternal observations, fetal wellbeing, contractions, pain and response.

Respond to change

Stop, treat and escalate hyperstimulation, abnormal findings or deterioration.

Manage delay safely

Reassess priority, communicate, document and set review.

Preserve dignity

Privacy, analgesia, hydration, rest, support and communication.

Delay, decline and discontinuation

Respect for autonomy does not remove the duty of care

1	**Delay**	Reassess maternal and fetal wellbeing, reprioritise clinically and explain the revised plan.
2	**Decline**	Explore reasons without judgement, check understanding and describe consequences and uncertainty.
3	**Discontinue**	Stop the intervention if consent is withdrawn, while addressing any immediate safety concern.
4	**Alternatives**	Offer reasonable options and senior review; preserve the therapeutic relationship.
5	**Record**	Document advice, questions, choices, safety-netting, review arrangements and escalation.

Avoid "you must". Explain the recommendation, its strength and consequences.

Common breach allegations

What the expert should test against the records

1	**Inadequate counselling**	Was dialogue timely, tailored and inclusive of material risks and reasonable alternatives?
2	**Consent treated as one-off**	Was each new intervention or material change explained and agreed?
3	**Failure to monitor or act**	Did monitoring match risk and did concern prompt timely review and response?
4	**Unsafe delay**	Was delay clinically managed, reassessed, escalated and safety-netted?
5	**Poor records**	Can the reasoning, communication and care still be reliably reconstructed?

An allegation is an analytical question, not a conclusion.

Worked case: post-dates induction

A sparse record requires disciplined analysis

1	**Standard**	What should have been discussed and recorded in this individual case?
2	**Breach**	Does “IOL discussed, leaflet given” prove no dialogue, or leave the issue unresolved?
3	**Delay**	Was wellbeing reassessed and the changed balance of risk explained?
4	**Monitoring**	Were CTG and uterine activity interpreted and acted upon?
5	**Causation**	What would probably have been chosen with adequate information, and would it have altered the course?

Do not fill evidential gaps with assumptions. Identify them.

A service-level standard of good practice

Safe consent requires reliable systems, not heroic individuals

People	Competence, supervision, communication skills and protected time
Pathway	Clear criteria, methods, monitoring, escalation and failure plan
Information	Accessible decision aids consistent with current guidance
Capacity	Demand planning, clinical prioritisation and response to delay
Assurance	Audit of counselling, outcomes, delays, incidents and experience



Methods of induction

Each method creates a fresh consent and monitoring decision

1	**Membrane sweep**	Explain examination, discomfort, bleeding, uncertainty of benefit and the right to decline.
2	**Mechanical ripening**	Balloon catheter or osmotic dilator: insertion, discomfort, expulsion, infection and next step.
3	**Pharmacological ripening**	Prostaglandin: hyperstimulation, fetal heart rate change, repeat dosing and removal where possible.
4	**Amniotomy**	Explain examination, cord prolapse risk, infection over time and the altered pathway.
5	**Oxytocin infusion**	Explain continuous CTG, restricted mobility, tachysystole and reduction or stopping of infusion.

Agreement to "induction" is not blanket authority for every later intervention.

Informed consent before each stage

The Montgomery question is individual, not procedural

1	**Recommendation**	Why this method now, and how strong is the recommendation?
2	**Material information**	Expected benefit, uncertainty, risks, impact on experience and likely next steps.
3	**Alternatives**	Another method, expectant management, delay, decline or caesarean where reasonable.
4	**Voluntary choice**	Time, questions, support and freedom to withdraw consent.
5	**Record**	Patient priorities, information discussed, decision, limits and agreed review points.

The legal vulnerability is failure to discover what this person would regard as significant.

When should induction be paused or stopped?

Stopping a method is not the same as abandoning the plan of care

1	**Hyperstimulation or tachysystole**	Stop or reduce the causative agent, remove a retrievable pessary where applicable, assess, treat and escalate.
2	**Non-reassuring fetal heart rate**	Do not continue routine dosing or escalation. Start appropriate measures and obtain urgent senior review.
3	**Maternal deterioration**	Pause, reassess the diagnosis and risk, and agree a revised plan.
4	**Withdrawal of consent**	Stop the proposed intervention, address immediate safety and offer alternatives.
5	**Unsuccessful induction**	Reassess the clinical situation and discuss safe options rather than defaulting automatically to caesarean.

Record what was stopped, why, who reviewed, the options discussed and the renewed consent.

When should caesarean birth be offered?

A new recommendation requires a new Montgomery-compliant discussion

1	**Urgent clinical indication**	Maternal or fetal condition means birth cannot safely await vaginal delivery.
2	**Unsuccessful induction**	After reassessment, caesarean is a reasonable option alongside any safe alternative.
3	**Changed risk profile**	A new development alters the balance of benefit, risk and urgency.
4	**Patient request**	Discuss caesarean where requested using balanced, individualised information.
5	**Consent and record**	Explain indication, urgency, material risks, alternatives and likely consequences of delay.

Caesarean is not an automatic consequence of "failed induction".

CTG monitoring during induction

The legal issue is interpretation, response and traceability, not merely attachment of a trace

BEFORE STARTING

1

Confirm fetal wellbeing and uterine activity; ensure the chosen method remains appropriate.

AFTER A METHOD

2

Follow method-specific monitoring and do not discontinue until relevant criteria are met.

DURING OXYTOCIN

3

Continuous CTG plus direct assessment of contraction frequency, duration and resting tone.

IF CONCERN ARISES

4

Classify, review, stop or reduce uterotonics where indicated, treat, escalate and expedite if required.

Interpretation

Classification and features

Escalation

Reviewer, time and action

Continuity

Gaps, signal, clocks and authorship

A normal-looking endpoint does not cure an earlier failure to recognise, escalate or act.

Where clinicians become legally exposed

Common points at which reasonable care becomes difficult to demonstrate

1	**Generic consent**	‘IOL discussed’ does not show material risks, alternatives or patient priorities.
2	**Method drift**	The pathway advances without renewed explanation and agreement.
3	**Normalisation of delay**	Capacity pressure replaces reassessment, reprioritisation and safety-netting.
4	**CTG without action**	Classification, peer review, escalation or response is absent or late.
5	**Fragmented accountability**	Midwifery, obstetric and ward responsibilities are assumed rather than handed over.

A defensible record connects information → decision → intervention → monitoring → response.

Five conclusions for legal teams

The short version

1	**Use the right test**	Montgomery governs material risk and alternatives; professional standards govern clinical acts and omissions.
2	**Interrogate individualisation**	What mattered to this woman, and how was that discovered?
3	**Follow the whole pathway**	Consent at booking does not cover every later intervention or material change.
4	**Read records critically**	Specific contemporaneous reasoning is strong evidence; templates and signatures have limits.
5	**Separate breach from causation**	Ask what probably would have happened with non-negligent counselling and care.

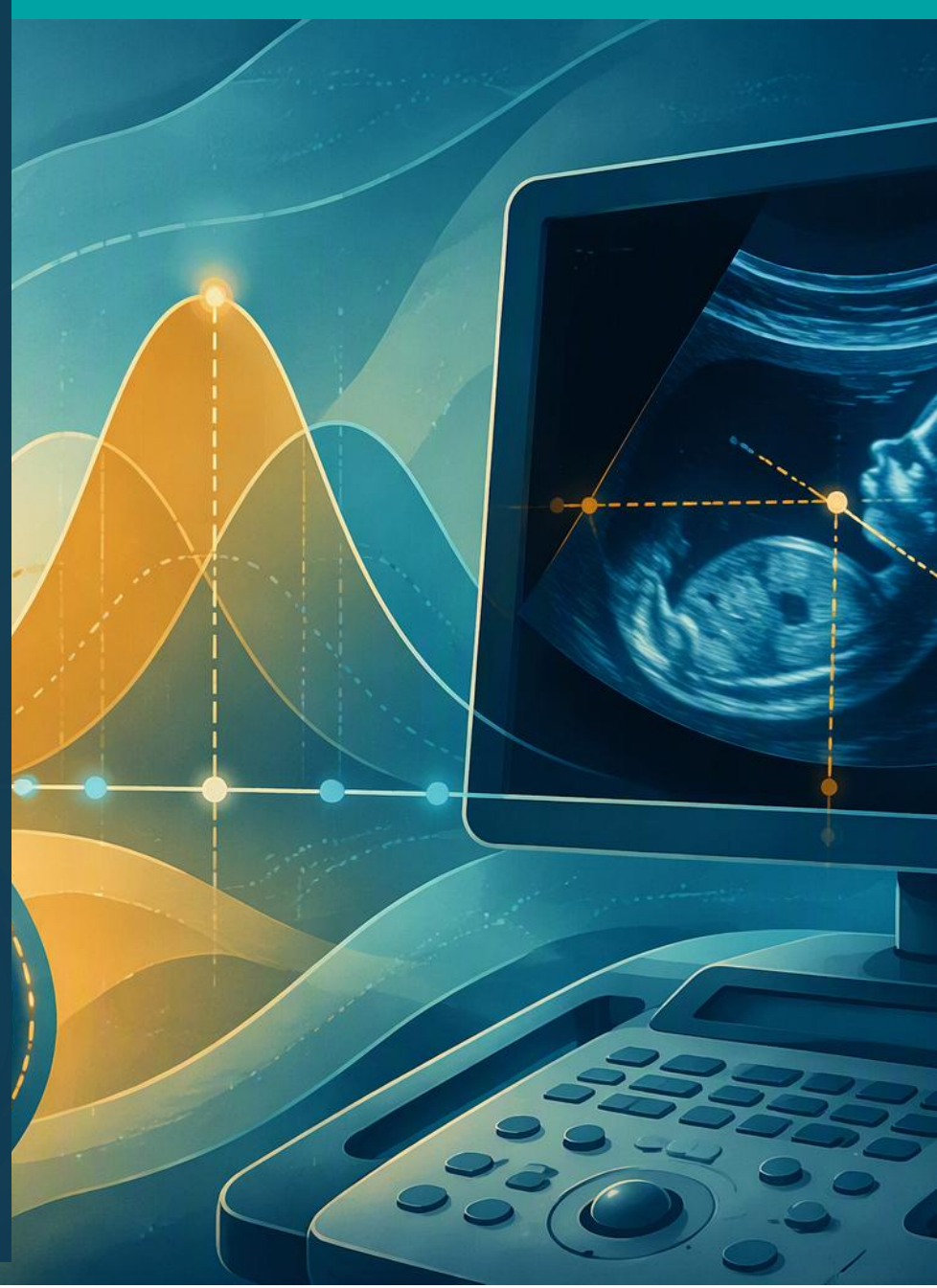
Respectful dialogue, competent care, responsive systems and a record that makes each visible.

THE ‘BIG BABY’ DILEMA

Counselling and consent

A clinical perspective for solicitors

Tara Fairley Consultant Obstetrician NHS Grampian



What to take away

A structured way to consider counselling

1 Clinical uncertainty

“Big on scan” is a probability, not a diagnosis. Think about the quality, timing and interpretation of the estimate.

2 Consent as a conversation

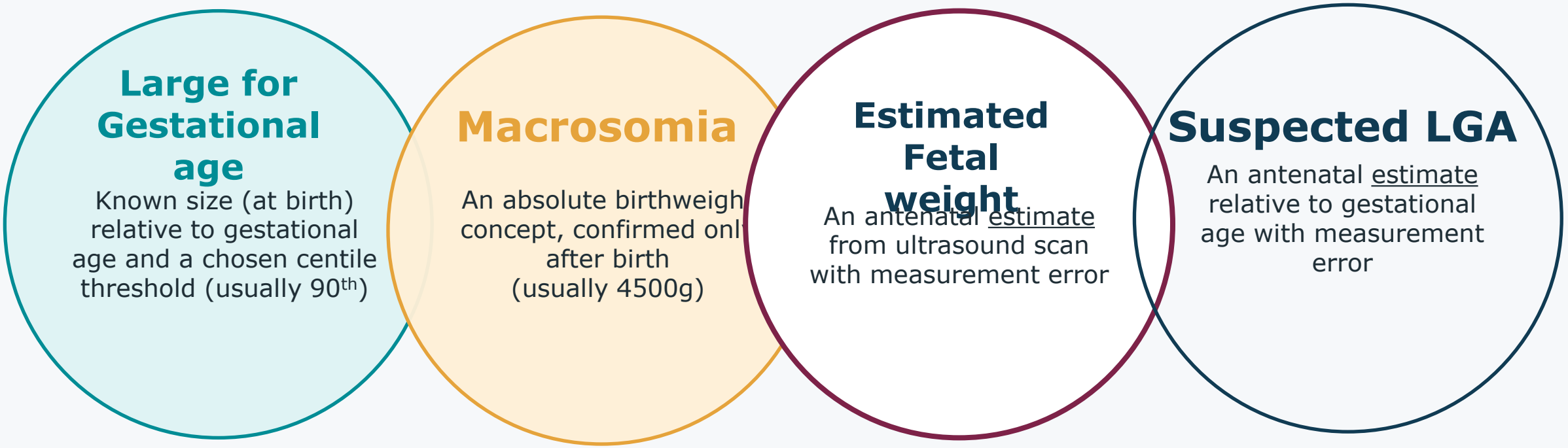
What options, benefits, harms and uncertainties were discussed, and what mattered to this particular woman.

3 Breach = Causation?

A deficient consent discussion and a woman’s decision are separate questions.

The language

Different labels answer different questions



Legal relevance: identify the definition and threshold used at the time, not one selected after the outcome.

Why does having a big baby matter?

Key Elements of counselling – Statistics are based on ACTUAL birthweight not EFW

Increased chance of caesarean in labour

Fetal weight less than 4kg 30 in 100
Fetal weight more than 4.5kg 45 in 100

Other maternal risks

Obstetric anal sphincter injury
Fetal weight less than 4kg 1in 100
Fetal weight more than 4.5kg 3 in 100

Post partum haemorrhage
Fetal weight less than 4kg 2 in 100
Fetal weight more than 4.5kg 6 in 100

Shoulder Dystocia

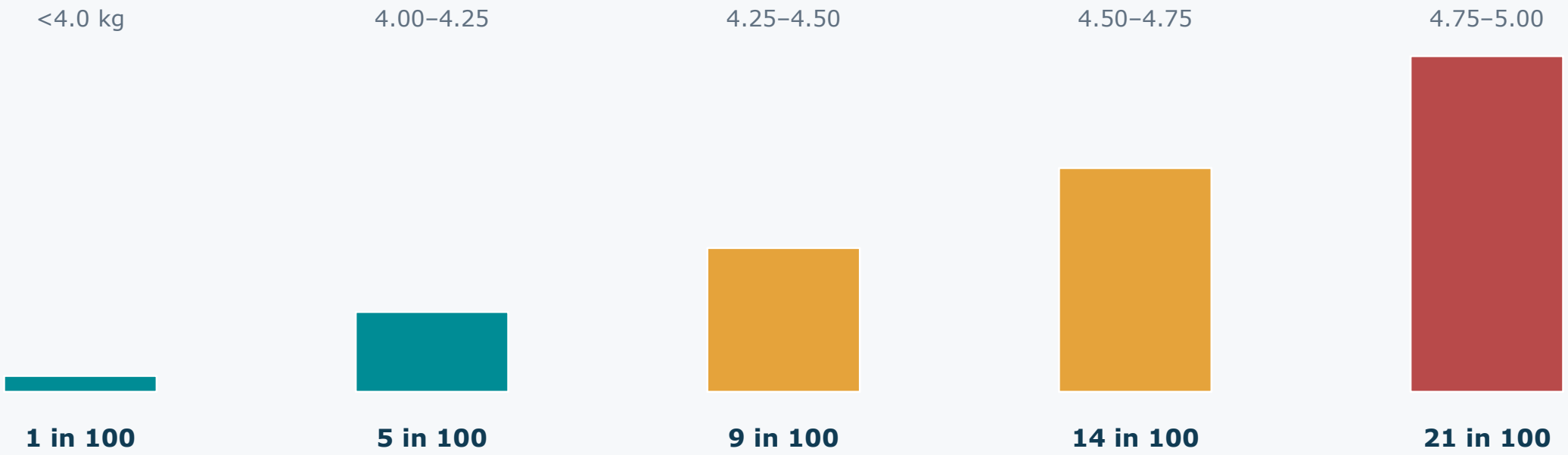
Overall risk 1 in 100
Fetal weight less than 4-4.25kg 5 in 100
Fetal weight more than 4.25-4.5kg 9 in 100
Fetal weight less than 4.5-4.75kg 14 in 100
Fetal weight more than 4.75-5kg 21 in 100

9 in 10 babies suffer no permanent injury

Risk communication: absolute, balanced, contextual

Numbers help only when their denominator and limitations are clear

Shoulder dystocia overall 1 in 100; risk rises across actual birthweight bands.



Use actual birthweight data carefully: antenatal counselling is based on an estimate, not the future confirmed weight.

The first counselling task: explain uncertainty

A scan result should open a decision, not close one



Four questions for the record

1. What exactly was measured and when?
2. What threshold or centile triggered concern?
3. Was the inherent imprecision explained?
4. How did history, diabetes, prior births and preferences modify the discussion?

NIHR decision aid `only 4 in 10 babies predicted to be big were actually big at birth

The decision is usually between 3 options

Reasonable options should be presented comparatively, not sequentially

Expectant management

Potential for spontaneous labour
Ongoing fetal growth and later reassessment
Risks attach to the eventual mode of birth

WAIT AND SEE

Induction of labour

Earlier birth may reduce birthweight
Intervention changes the birth experience
Benefits and harms remain linked to the eventual mode of birth

OFFER / DISCUSS

Planned caesarean birth

Avoids shoulder dystocia in that birth
Introduces surgical and recovery risks
May affect later pregnancies and births

OFFER / DISCUSS

The question is not "Which option was best?" but "Were reasonable alternatives and material trade-offs explored for this patient?"

Documents that matter to expert witnesses

Triangulate what was known, said, understood and decided

Ultrasound report

Biometry, EFW, centile, date, limitations

Antenatal notes

Options, numbers, questions, preferences, plan

Decision aid / leaflet

Version, evidence date, language and accessibility

Local guideline

Thresholds, referral route, expected counselling

Later records

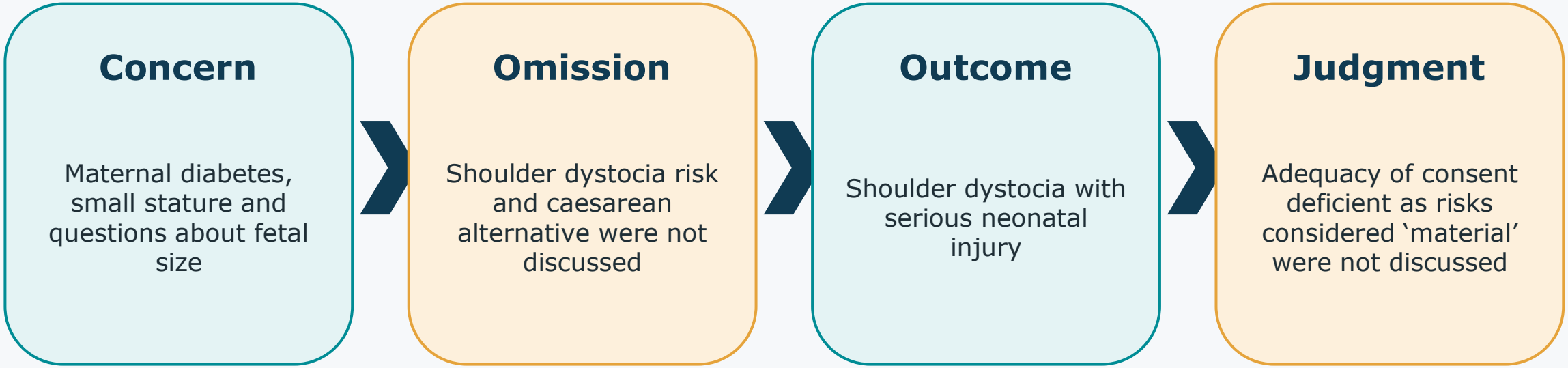
Change of preference, escalation, intrapartum events

Witness evidence

Recall tested against contemporaneous documents

Montgomery

The case itself arose from a woman with diabetes, anticipated fetal size and shoulder dystocia



Obstetricians must resist turning Montgomery into a rule that caesarean birth must be recommended whenever a fetus may be large. The duty is to support an informed, individual decision among reasonable options.

What is “material” after Montgomery?

A patient-centred test, not a clinician-centred checklist

A risk is material if:

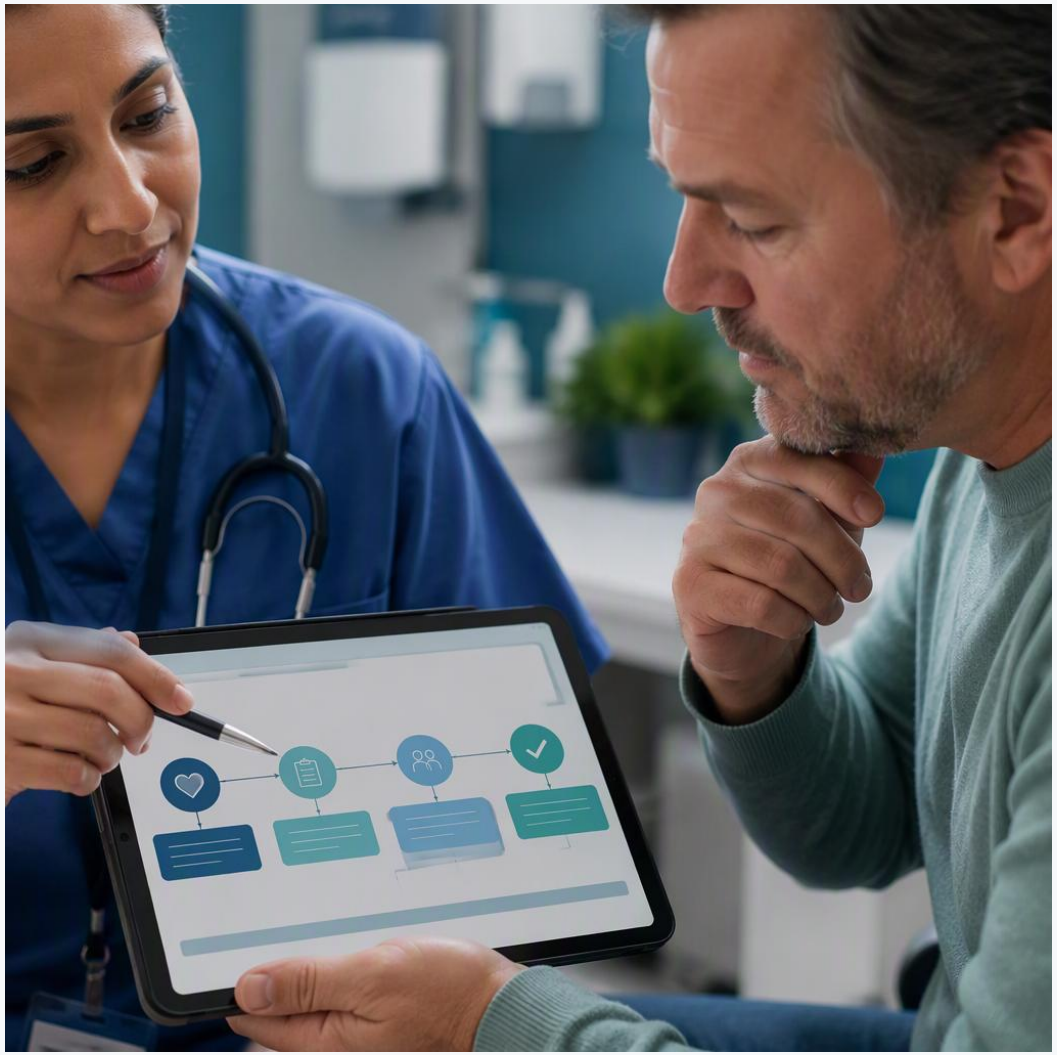
Reasonable person

A reasonable person in this patient’s position would likely attach significance to it.

Individual patient

The clinician knew or should reasonably have known that this patient would attach significance to it.

So the consultation must explore values, fears, prior experiences and preferred trade-offs.



Consent is a process of meaningful dialogue. A signed form or generic leaflet is evidence, but not the whole answer.

An appropriate counselling record

The note should make the reasoning auditable, not merely assert “risks discussed”

- ✓ **Clinical trigger and uncertainty**
- ✓ **Questions asked and answered**
- ✓ **Individual modifiers and patient priorities**
- ✓ **Decision aid / interpreter / accessibility support**
- ✓ **Options actually available**
- ✓ **Preference, decision and rationale**
- ✓ **Balanced benefits, harms and uncertainties**
- ✓ **Contingency and review plan**

Not: “LGA discussed. Patient happy for induction.”

Liability analysis: I keep three questions separate

1. Duty / scope — Was this a decision requiring informed consent?

2. Breach — Were material risks and reasonable alternatives discussed with adequate support?

3. Causation — What would this patient probably have chosen after a proper discussion?

If that is different to what happened in reality, would that alternative pathway probably have avoided or altered the injury?

Expert evidence can inform clinical reasonableness and pathways.

Five key thoughts

1. **Antenatal "size" is an estimate with uncertainty.**
2. **Counselling should compare reasonable options and trade-offs.**
3. **Materiality depends on this patient, not only population risk.**
4. **Documentation should show dialogue, understanding and preference.**
5. **My favourite question: "What evidence shows the patient was enabled to make this decision?"**

SHOULDER DYSTOCIA

Risk, management and outcomes

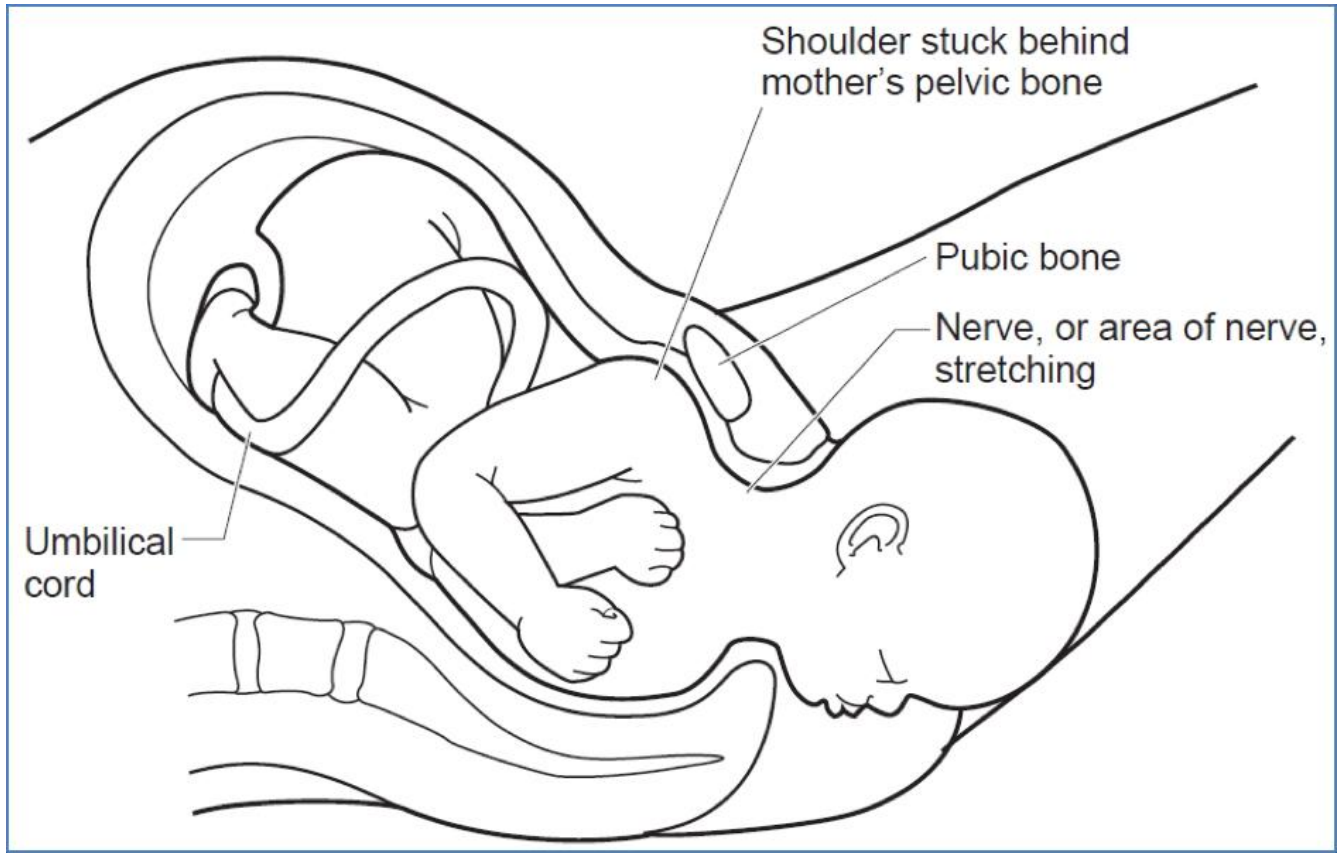
A clinical framework for solicitors

CLINICAL MECHANISM | BREACH | CAUSATION

Dr Tara Fairley | Consultant Obstetrician | NHS Grampian



What is shoulder dystocia?



Clinical definition

Vaginal cephalic birth requiring additional manoeuvres after the head is born because routine axial traction has not released the shoulders.

Typical mechanism

The anterior shoulder impacts behind the maternal symphysis pubis. Less commonly, the posterior shoulder impacts on the sacral promontory.

The challenge

The diagnosis, or even harm, does not prove preventability, delay or negligent traction. Management and causation require separate analysis.

Risk factors change probability, not predictability

Shoulder dystocia cannot be reliably predicted or prevented.

A risk factor supports vigilance and counselling. It does not establish the outcome was foreseeable in the individual labour.

Antenatal

Increased Maternal BMI
Large for gestational age
Diabetes (2-4 x risk)
Previous shoulder dystocia

Intrapartum

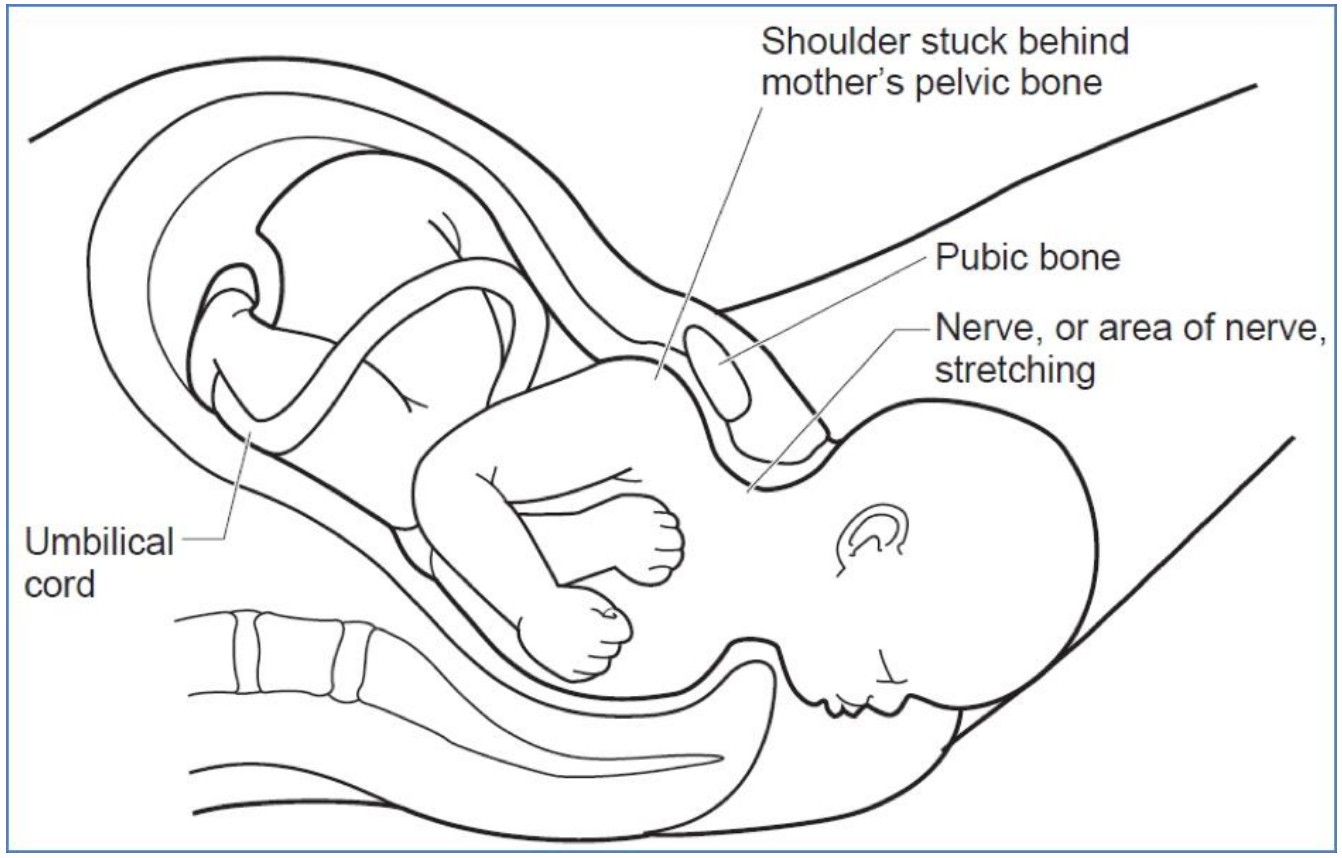
Induction of labour
Operative vaginal birth
Prolonged labour
Oxytocin augmentation

Medicolegal implication

I ask what was reasonably knowable and adequately discussed with the woman at the relevant time?
Avoid converting a known association into an expectation that the clinician should have been able to predict the event would occur.

MECHANISM

Shoulder Dystocia is a bony problem



Impaction

Head is born but the bisacromial diameter is not traversing the pelvis.
Baby's anterior shoulder is wedged against the maternal symphysis pubis

Why is it an emergency?
Umbilical cord is usually occluded
Baby cannot yet breathe
Oxygen supply to baby is absent/reduced

Presuming good fetal condition prior to this we have about 7 minutes to deliver the baby before hypoxic injury begins to occur

What we do and the mistakes we make!



1. Change geometry

Positioning and suprapubic pressure aim to alter pelvic dimensions or shoulder orientation.

2. Reduce the diameter

Internal rotation or posterior arm delivery reduces or reorients the shoulder diameter.

Management is systematic, not forceful

1. ***Anticipate*, declare and call for help**
2. **Stop routine pushing; flatten the bed**
3. **McRoberts positioning**
4. **Suprapubic pressure**
5 or 6. **Deliver posterior arm or internal manoeuvre**
5 or 6. **All-fours or repeat sequence**

Avoid the 4 P's, Panic, pulling, pushing or pivoting.

Outcomes

Maternal

11%

postpartum haemorrhage

3.8%

obstetric anal sphincter injury

Neonatal

2.3–16%

Brachial plexus injury in births complicated by shoulder dystocia
90% resolved spontaneously or with physiotherapy

Other recognised outcomes

Clavicular or humeral fracture
Hypoxic injury
Perinatal death

Key causation distinction

An adverse neonatal outcome may occur despite appropriate management. Outcome alone is not a proxy for breach.

Prognosis and permanence of fetal injuries are out with scope of expertise for obstetric experts

EVIDENCE

The contemporaneous record is the reconstruction



1. Exact time of head birth and body birth
2. Who declared the emergency and when
3. Sequence and operator for each manoeuvre
4. Direction of traction and response
5. Neonatal condition, cord gases and injuries
6. Debrief, neonatal review and follow-up

A breach analysis

STANDARD

What did guidance and competent practice require at that time?

Guideline version
Training evidence

FACT

What does the contemporaneous record show actually happened?

Timings
Notes
Statements

DEVIATION

Was any departure material, or merely imperfect documentation?

Manoeuvres
Traction
Communication

CONTEXT

Was the response proportionate to a time-critical emergency?

Urgency
Resources
Anatomy

Causation

Four questions

01 **What injury occurred?**

02 **What mechanisms can cause it?**

03 **What alternative management is alleged?**

04 **Would that alternative probably have changed the outcome?**

Brachial plexus injury

May be associated with shoulder dystocia, but the injury does not, by itself, confirm a breach of duty.

Hypoxic-ischaemic injury

Requires analysis of duration, fetal reserve, CTG context, gases, resuscitation and neonatal evidence.

Fracture

May occur during resolution of an emergency and is not automatically evidence of unreasonable care.

APPLICATION

Worked file review: build the timeline before the opinion

Scenario

Head delivered at 22:40. Body delivered at 22:44. Brachial plexus injury recorded. Notes list McRoberts, suprapubic pressure and posterior arm.

TIMING

Are times contemporaneous, estimated or retrospectively reconstructed?

SEQUENCE

Who performed each manoeuvre, and was the order clinically coherent?

TRACTION

What evidence supports axial, non-axial or excessive traction?

COUNTERFACTUAL

Which earlier action is alleged should have occurred? Would it probably have changed the injury?

Three points to take home

01 Unpredictable does not mean unmanageable.

02 Systematic timely manoeuvres matter more than force.

03 Outcome, breach and causation are separate clinical questions.

CTG INTERPRETATION

Clinical reasoning and analysis

A practical briefing for solicitors

Dr Tara Fairley | Consultant Obstetrician

Based on NICE NG229, RCOG/RCM consensus material, NHS Resolution learning and NHS Grampian guidance

Interpretation is complex

1 Read the trace

Review the technical elements and features baseline, variability, accelerations, decelerations, contractions and signal quality and reach a conclusion about classification.

2 Reconstruct decisions

Link each CTG segment to the clinical picture, contemporaneous actions and review times.

3 Analyse breach

Distinguish a poor outcome from a potentially unreasonable interpretation, escalation or response.

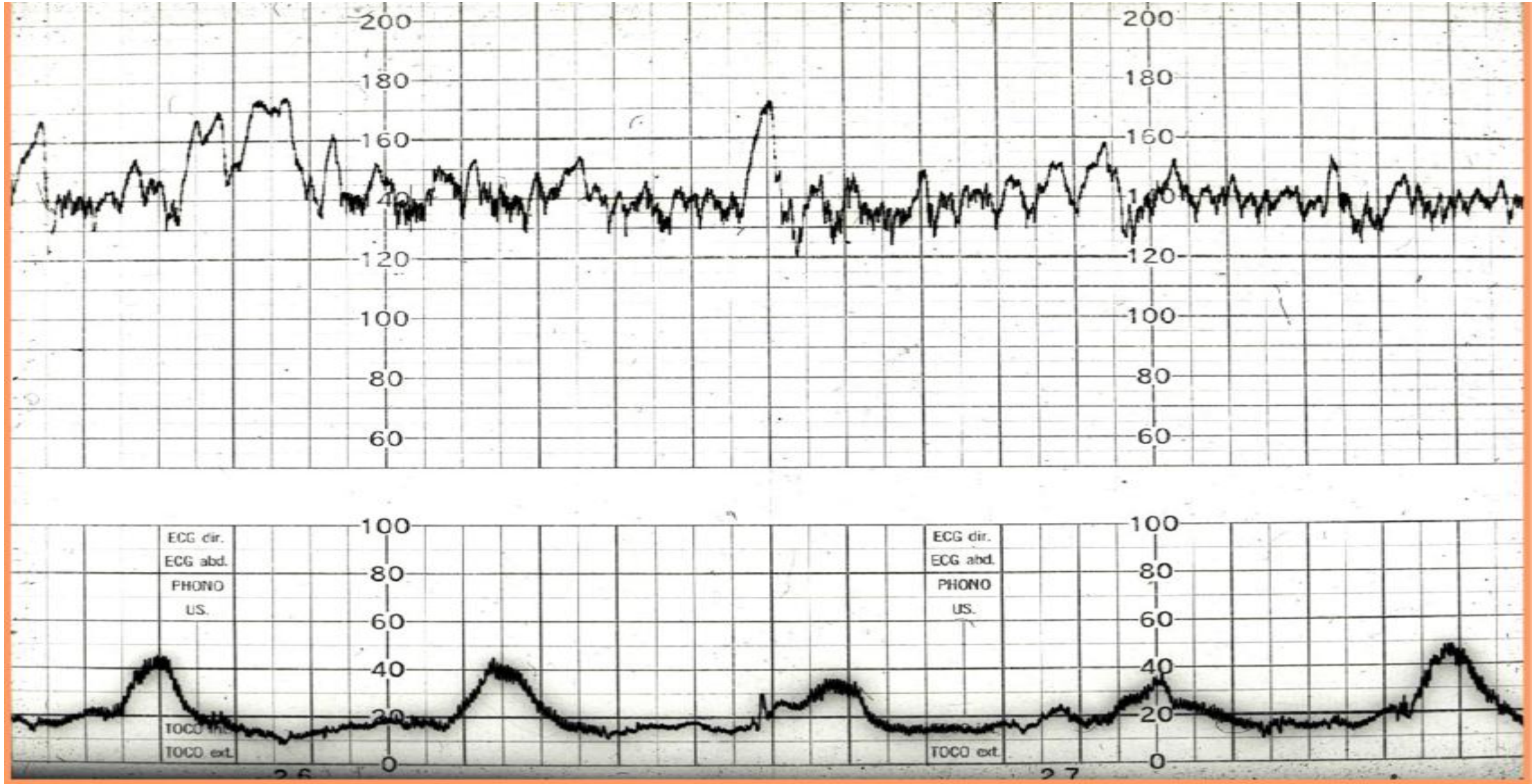
4 Test causation

Identify the counterfactual: what action should have occurred, when, and whether earlier birth probably changes outcome.

5 Can this help you ask better questions of experts?

Separate fact, interpretation, standard of care and causal opinion. Preserve uncertainty.

Normal CTG


200
180
160
120
100
80
60
ECG dir.
ECG abd.
PHONO
US.
TOCO int.
TOCO ext.
100
80
60
40
20
0
26
27

A disciplined reading sequence

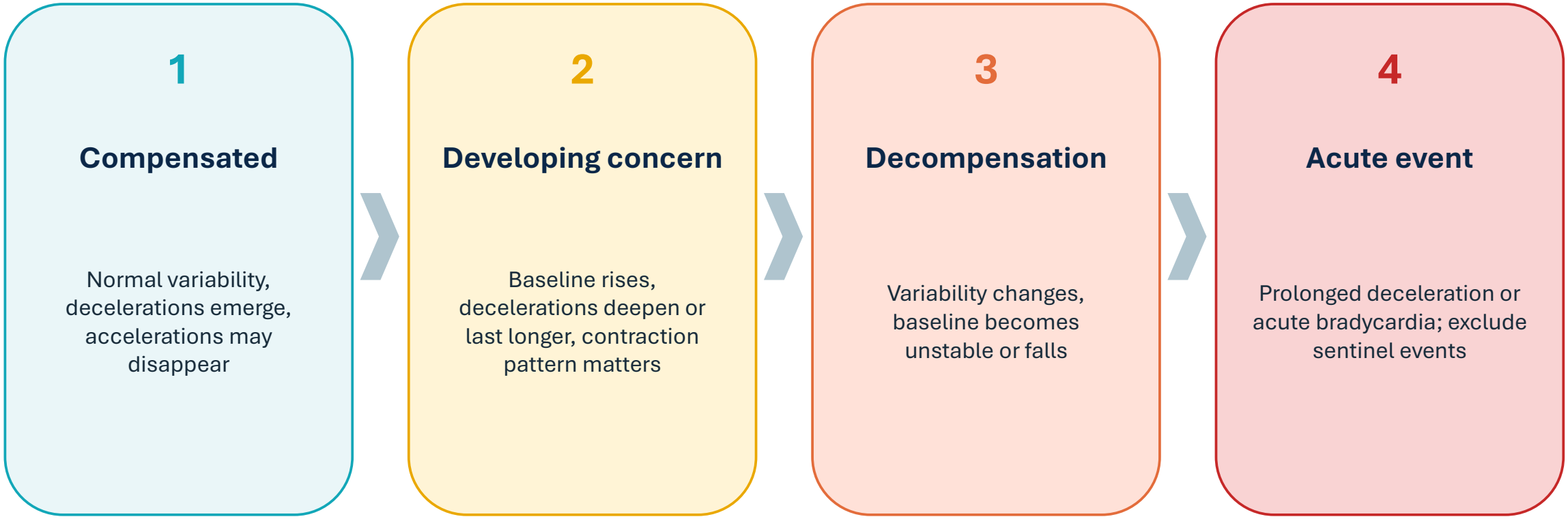
Try to prevent hindsight bias by separating observation from interpretation

1. **Confirm identity & signal quality and source**
2. **Contractions – frequency, no comment on strength**
3. **Baseline**
4. **Variability**
5. **Decelerations**
6. **Accelerations**
7. **Overall category**
8. **Clinical context & plan**

Document the feature, duration, trend, context, action and review plan.

The trace is a film, not a photograph

Trend-analysis often matters more than a single ‘label’



When was the last clearly normal segment? What changed? What was done? Did it work?

What CTG can and cannot tell you

The question is whether the interpretation and response were reasonable at the time, using the information available.

What it contributes

- Continuous record of fetal heart-rate pattern and uterine activity
- Trends over time
- Warning features compatible with evolving hypoxia
- A prompt to reassess, correct reversible causes, escalate or expedite birth
- A contemporaneous record of clinical reasoning

What it does not prove

- Acidosis at a particular moment
- Mechanism of injury
- That an adverse neonatal outcome was avoidable
- That every abnormal feature mandates immediate caesarean birth
- Breach or causation without the full clinical and evidential context

From abnormality to action

An appropriate response is causal, timed and reviewed

Identify likely cause	Maternal position, hypotension, tachysystole/hypertonus, oxytocin, acute event
Act on reversible causes	Change position; treat hypotension; reduce or stop oxytocin; consider tocolysis where indicated
Escalate	Senior midwife and obstetric review according to category and trajectory
Reassess response	State review interval and whether the trace improves, remains abnormal or deteriorates
Decide on birth	Balance urgency, stage of labour, feasibility, maternal safety and the woman's preferences

Key Escalation Triggers

Reduced or absent variability	Duration and severity are important as well as any potential benign explanation
Repetitive late decelerations	Always significant and warrant timely senior review
Bradycardia/Prolonged deceleration	FHR <100bpm for >3 minutes. Depth is relevant but should be actively planning birth by 9 minutes
Meconium with abnormal CTG	Hypoxia is associated with intrauterine gasping and meconium aspiration
Maternal Sepsis with abnormal CTG	Cumulative risk of fetal sepsis and hypoxia in the development of Cerebral Palsy

The contemporaneous record is the bridge

A conclusion without the underlying reasoning is fragile

Record the data

- Person reviewing and time
- Maternal pulse and observations
- Contraction frequency
- Baseline, variability, accelerations and decelerations
- Signal quality or loss of contact
- Stage and progress of labour
- Risk factors and relevant events

Record the reasoning

- Overall category
- Trend and last normal segment
- Likely cause
- Whether acute events were excluded
- Why continuing labour was considered safe or unsafe
- Discussion with the woman
- Review interval and contingency

Record the action

- Position change or other measure
- Oxytocin adjustment
- Tocolysis or fluid treatment
- Escalation and who was contacted
- Decision and time to expedite birth
- Response to intervention
- Handover and outcome

Medico-legal analysis: three separate questions I ask myself

Experts should avoid collapsing outcome, breach and causation into one judgment

FACT

What did the trace and record actually show?

BREACH

Was interpretation, escalation, monitoring or management such that no doctor of ordinary skill acting with ordinary care would have taken the same course?

CAUSATION

On the balance of probabilities, would compliant care have altered the outcome?

A pathological CTG may support concern. It does not, by itself, establish negligence or causation.

Common medico-legal ‘failures’

Patterns for investigation, not assumptions of breach

Failure to recognise evolution

Repeated “normal” labels despite worsening trend

Failure to ensure signal quality

Maternal pulse not checked; prolonged dropout accepted

Failure to reassess risk

New meconium, pyrexia, bleeding or hyperstimulation not integrated

Failure to act or review

Corrective measure undertaken without documented response or review time

Failure to escalate

Concern identified but senior review delayed or absent

Failure to expedite

Decision-making delay after persistent abnormality or acute event

Five take-home messages

- CTG is a trend-based surveillance tool interpreted within the whole clinical picture.
- Signal quality comes before classification. Always distinguish fetal from maternal heart rate.
- A reasoned response links abnormality to cause, action, escalation and timed reassessment.
- The record should make reasoning auditable, not merely state “CTG reviewed”.
- Breach and causation remain distinct from an abnormal trace and an adverse outcome.

Key sources

- NICE NG229 Fetal monitoring in labour, updated 25 March 2026
- RCOG/RCM consensus statement on electronic fetal monitoring
- NHS Grampian IP036 Intrapartum Fetal Surveillance
- NHS Resolution CTG learning case stories

Interpret systematically. Act proportionately. Document contemporaneously.

Time is brain: Attributing causation and contribution in intrapartum and neonatal care

Dr Julie-Clare Becher

Consultant Neonatologist
Royal Infirmary of Edinburgh











Outline

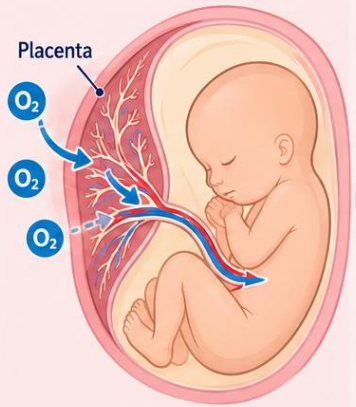
- Asphyxia and the fetal response
- Acute profound asphyxia vs chronic partial asphyxia
- The role of neonatal care
- Attributing causation and material contribution

Definitions

Hypoxia	Lack of oxygen
Ischaemia	Lack of blood supply
Hypoxia-ischaemia	Hypoxia and ischaemia together = ‘asphyxia’
Encephalopathy	Constellation of behavioural abnormalities including change in conscious level, abnormal tone +/- seizures. Many causes.
HIE	Encephalopathy resulting from hypoxia-ischaemia ‘Brain stress’

How a baby responds when oxygen is low

1 Less oxygen reaches the baby



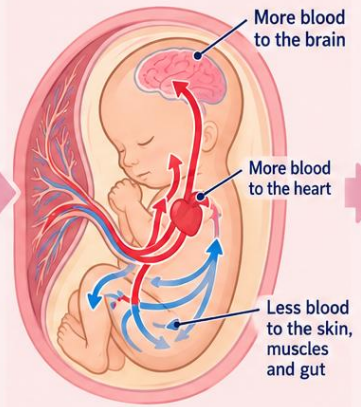
Less oxygen passes from the placenta to the baby, so their blood oxygen levels start to fall.

2 The baby's body goes into alarm mode



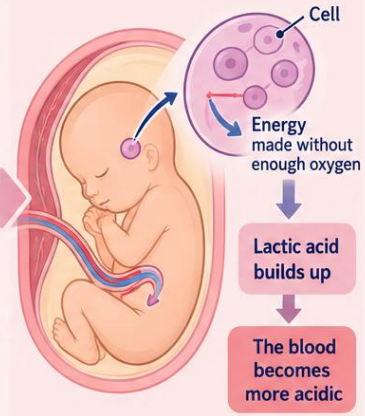
The baby senses the low oxygen and releases stress hormones (such as adrenaline and cortisol) to help them cope.

3 Blood is redirected to vital organs



Blood flow is preferentially sent to the brain and heart to protect these vital organs. Less blood goes to the skin, muscles and gut.

4 If low oxygen continues



The baby's cells start to make energy without enough oxygen. This produces lactic acid, which builds up in the blood and makes it more acidic.



After birth, cord blood tests (pH and base excess) can help show how much acid built up.

pH and base excess are measurements from a sample of blood taken from the umbilical cord after birth. They show how acidic the baby's blood is and can help indicate how much lactic acid has built up.





Asphyxia

- 3-5/1000 births
- Lactic acidosis
  - Fetal, cord or baby blood sample
  - Low pH and low BE (base excess)
- Depressed condition of baby at birth (low Apgar scores)

Caused by any factor which disrupts oxygen and blood flow to fetus

HIE

- 1-3/1000 births
- Brain stress: transient neurological abnormalities from birth and evolves over 3-5d, largely resolving before discharge
- Sarnat classification:
  - Mild
  - Moderate
  - Severe

Permanent brain injury or death

- ~45% moderate/ severe HIE →
- Death
- Cerebral palsy
- Seizures
- Blindness/deafness
- Long term educational difficulties

Risk can be reduced with timely therapeutic hypothermia (<6h)

- 25% of mild HIE- motor, behavioural, cognitive deficit.

Onset and nature of asphyxial insult

- Intrapartum (during labour)
- Antepartum (before labour starts)
- Postnatal (after birth)

- Acute profound/total asphyxia (minutes)
- Chronic partial asphyxia (hours)

→Different implications for outcome

→Different timeframes so opportunity to salvage fetus may or may not be possible

- Mixed, multiple, consecutive and atypical insults

Establishing mechanism of asphyxia

Neonatology
Neurology
Neuroradiology
Educational Psychology
Obstetrics



Clinical history



Umbilical cord/baby blood gases



MRI pattern of injury

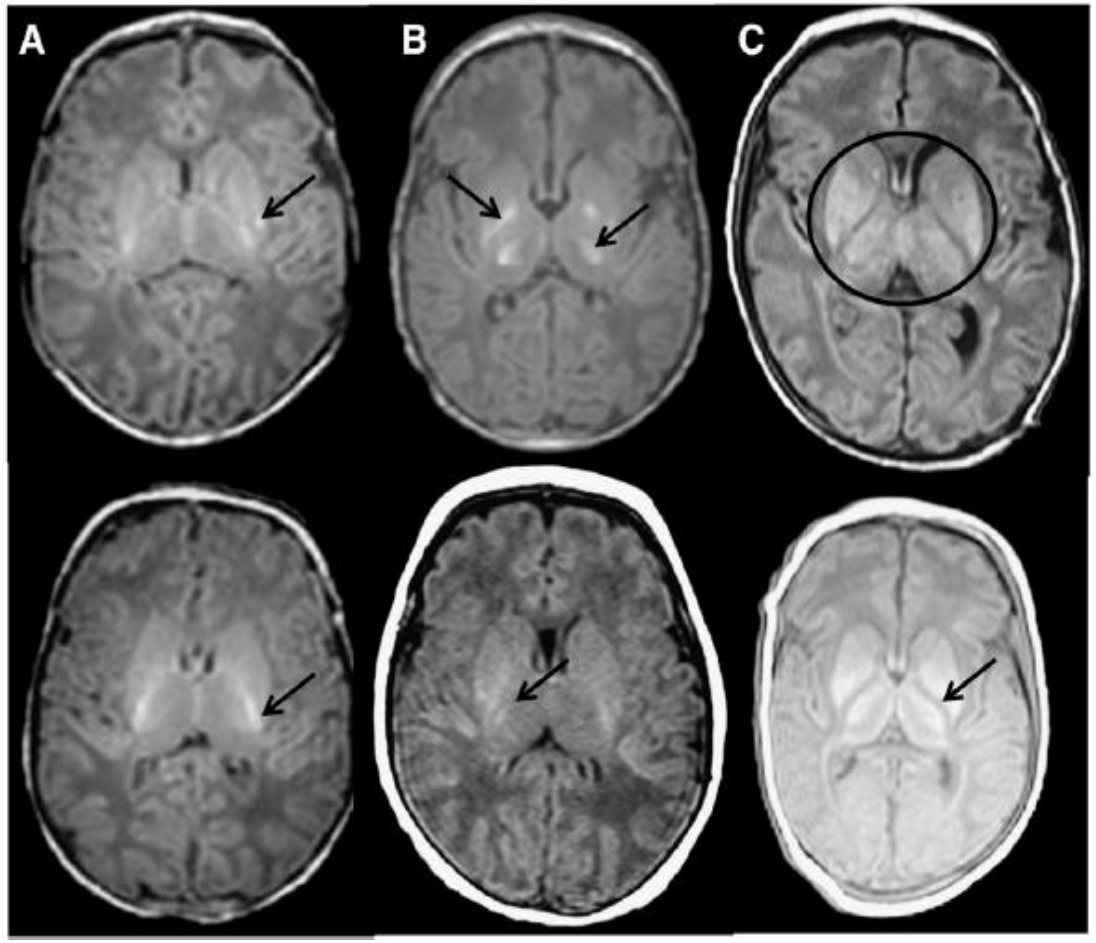


Functional outcome

Acute profound asphyxia

- Total or near total cessation of fetal blood supply eg cord occlusion, abruption, other sentinel event
  - Fetal bradycardia starts immediately
  - Rapid accumulation of acidosis
  - No time for fetus to compensate by redistributing blood flow
  - Damage to the powerhouses of the brain that control tone, involuntary movement, breathing

- Brain injury after 10 minutes
- Fetal death at 25-30 minutes



Basal ganglia and thalamic damage
'deep grey matter injury'

Longterm Outcomes



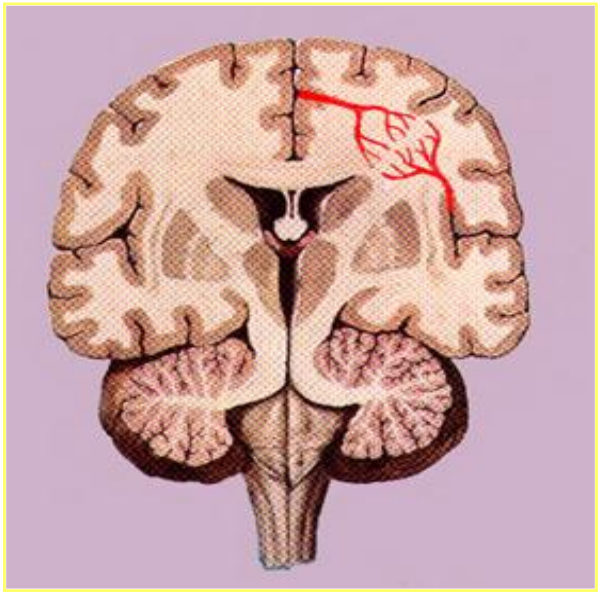
- Dyskinetic cerebral palsy
  - Choreoathetoid/dystonic types
- Difficulty speaking, swallowing
- Preservation of intellect (usually)
- Reduction in lifespan

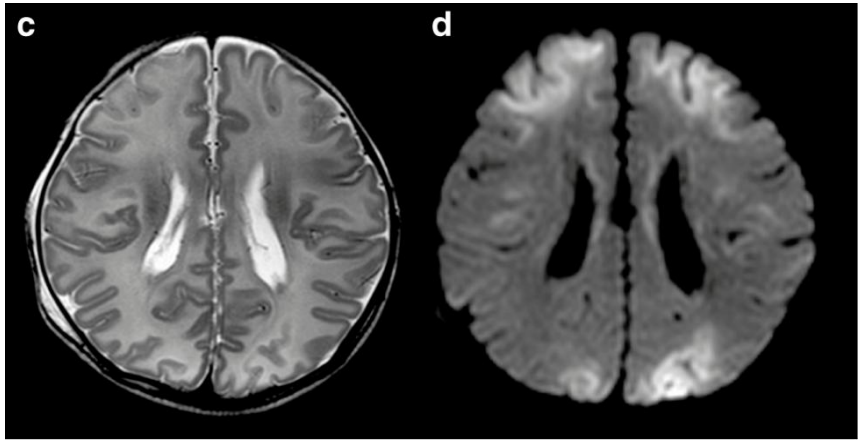


Chronic partial asphyxia

- Partial or intermittent reduction of fetal blood supply eg uterine hyperstimulation, infection
  - High fetal heart rate, decelerations, lack of variabilit
  - Gradual failure of circulation, increasing acidosis
  - Fetal compensation: redistributes blood flow to protect powerhouses, but damage to peripheral vascular watershed areas
  - Ultimately fetal collapse and death

- Brain injury after ~ 60 minutes
- Fetal death after hours





Ischaemic damage to peripheral areas
'watershed injury'

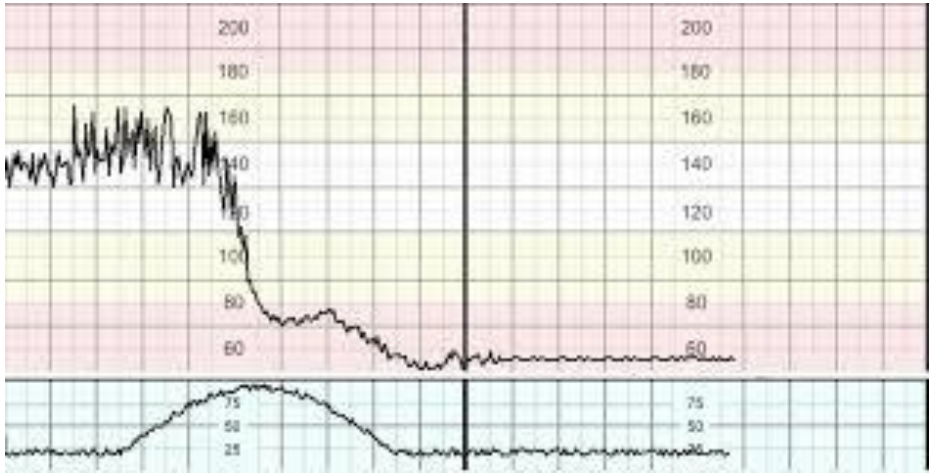


Functional outcome

- Spastic quadriplegia (cerebral palsy)
- Learning impairment
- Epilepsy
- Blindness
- Deafness
- Breathing difficulties
- Microcephaly (failure of brain growth)

- Markedly reduced lifespan

Causation: is brain damage due to asphyxia?



All criteria must be fulfilled:

- Severe metabolic acidosis
- Moderate or severe encephalopathy
- Spastic quadriplegic or dyskinetic cerebral palsy
- Exclusion of other causes eg trauma, infection, structural or genetic disorder

Additional criteria can be used along with above:

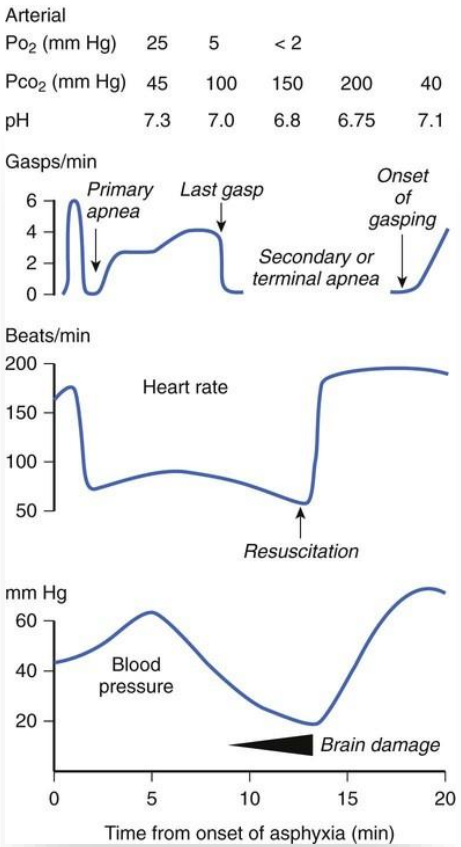
- Sustained deterioration of the fetal heart rate
- Sustained low Apgar scores
- Early imaging study showing acute diffuse injury
- Evidence of multiorgan injury (kidney, liver, heart)

Apgar Scoring System

Indicator		0 Points	1 Point	2 Points
A	Activity (muscle tone)	Absent	Flexed arms and legs	Active
P	Pulse	Absent	Below 100 bpm	Over 100 bpm
G	Grimace (reflex irritability)	Floppy	Minimal response to stimulation	Prompt response to stimulation
A	Appearance (skin color)	Blue; pale	Pink body, Blue extremities	Pink
R	Respiration	Absent	Slow and irregular	Vigorous cry

Maclennan A. BMJ 1999;319:1054-9

Hankins G. Obstet Gynecol. 2003;102:628-36





If breach of duty accepted, would different management result in a different outcome?

1. Mechanism of asphyxia

2. Duration of injury:

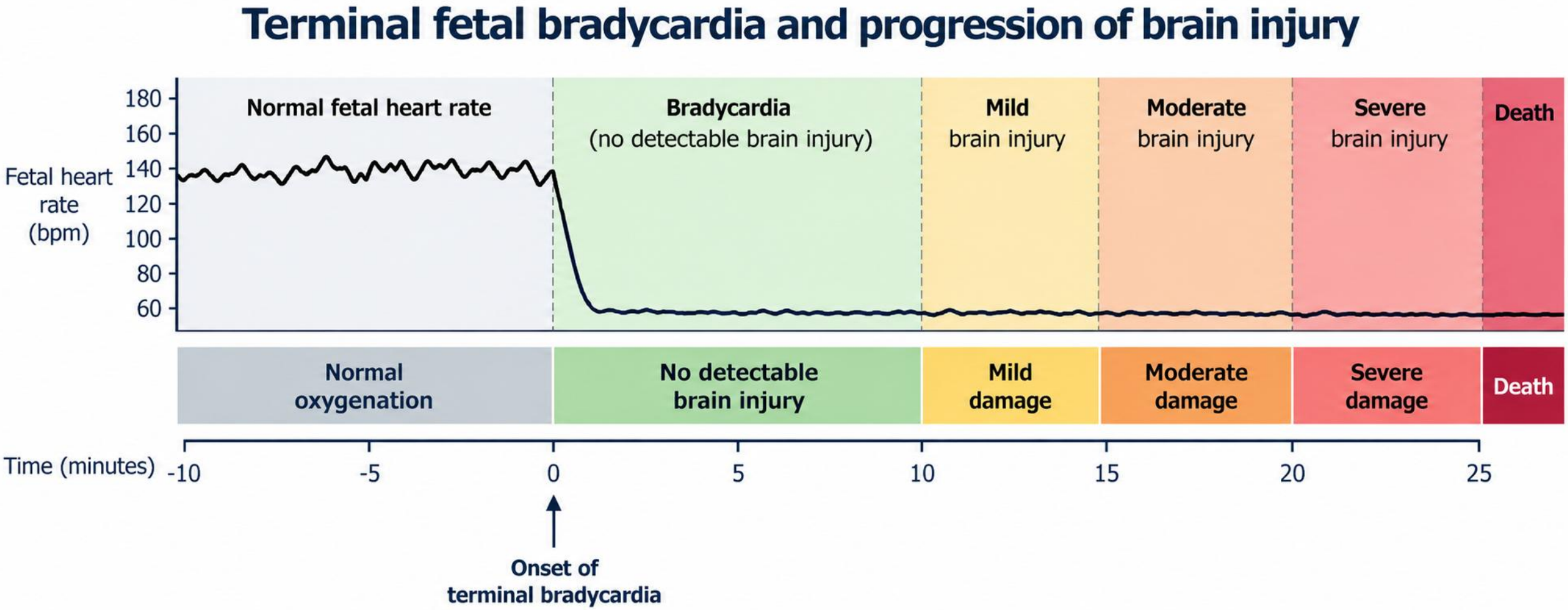
- Specifically, at what precise time did injury start?
  - Not the same time as asphyxia starts….

- When did it end?

3. If breach had not occurred would this have spared any or all of the brain injury?

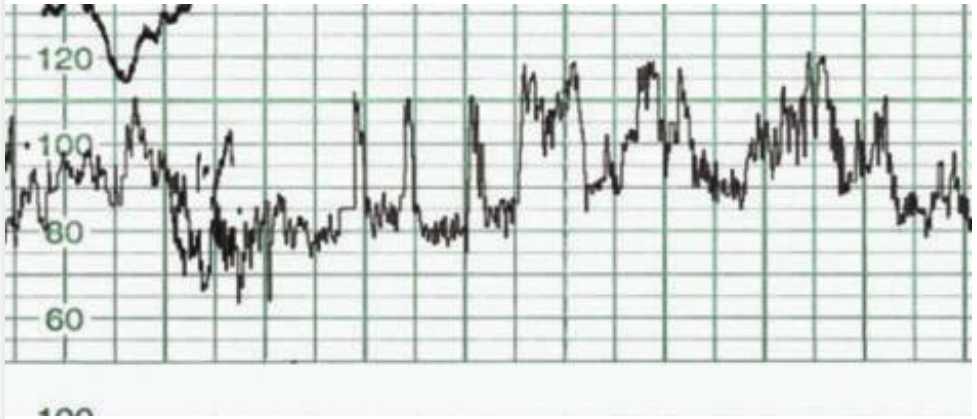
Most of what we know about timing of asphyxial injury is based on non-human primate models from the 1950s….

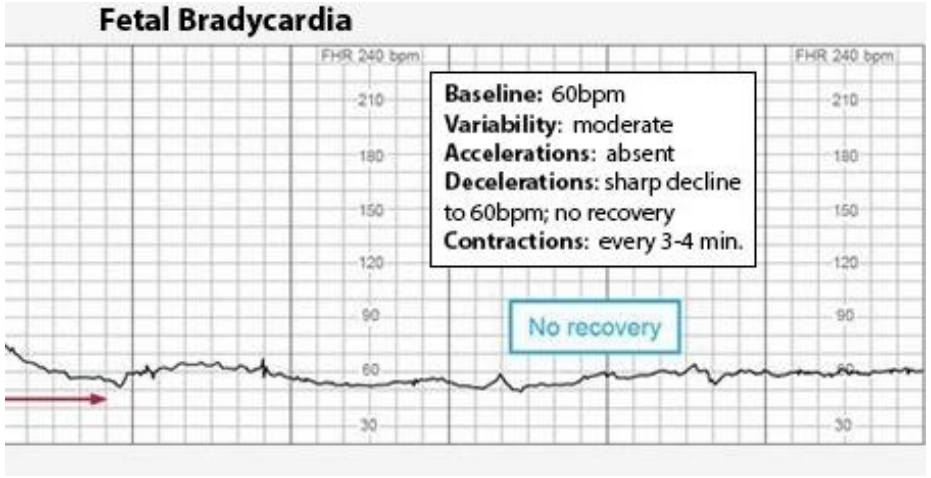
The acute profound model



Assumptions in the acute profound asphyxial model

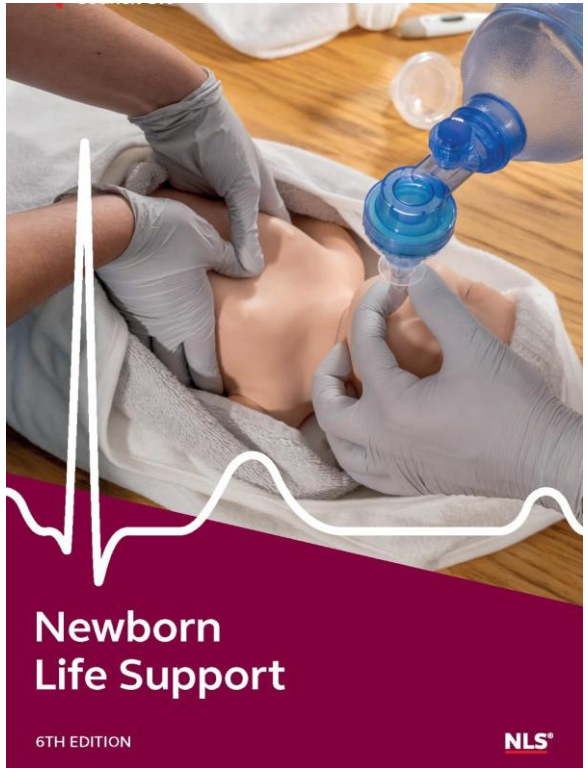
- That the human fetus responds in the same way to asphyxia as other primates
  - Examples of human fetal survival after an hour and with a good outcome
- That the asphyxial insult is constant, total and damage occurs linearly
  - Degree of cord occlusion may vary in severity and constancy
  - Bradycardias of different rates may not produce same degree of injury

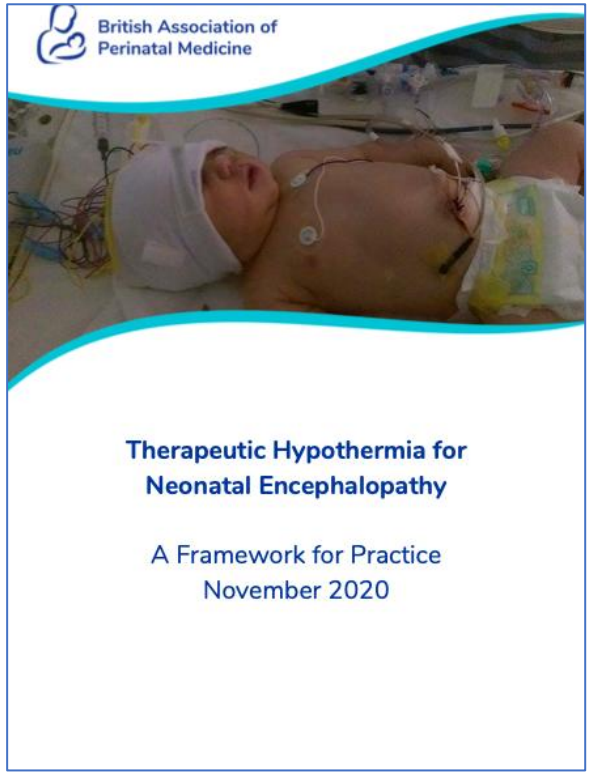


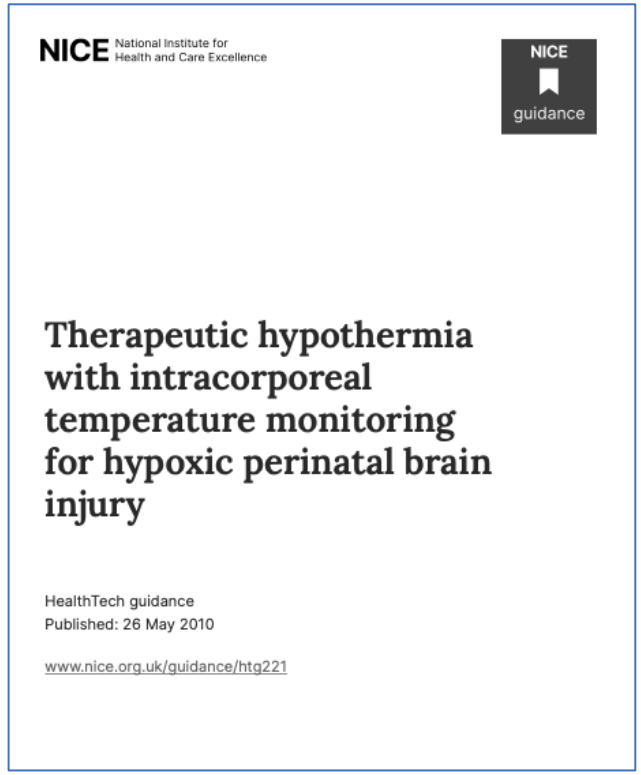


Assumptions in the acute profound asphyxial model

- That modern resuscitation and neuroprotective care do not change these outcomes







Assumptions in the acute profound asphyxial model

- That there are no other factors which modify tolerance of the fetus to the insult

Vulnerability factors

- Growth restriction
- Infection
- Congenital abnormality
- Unknown genetic factors

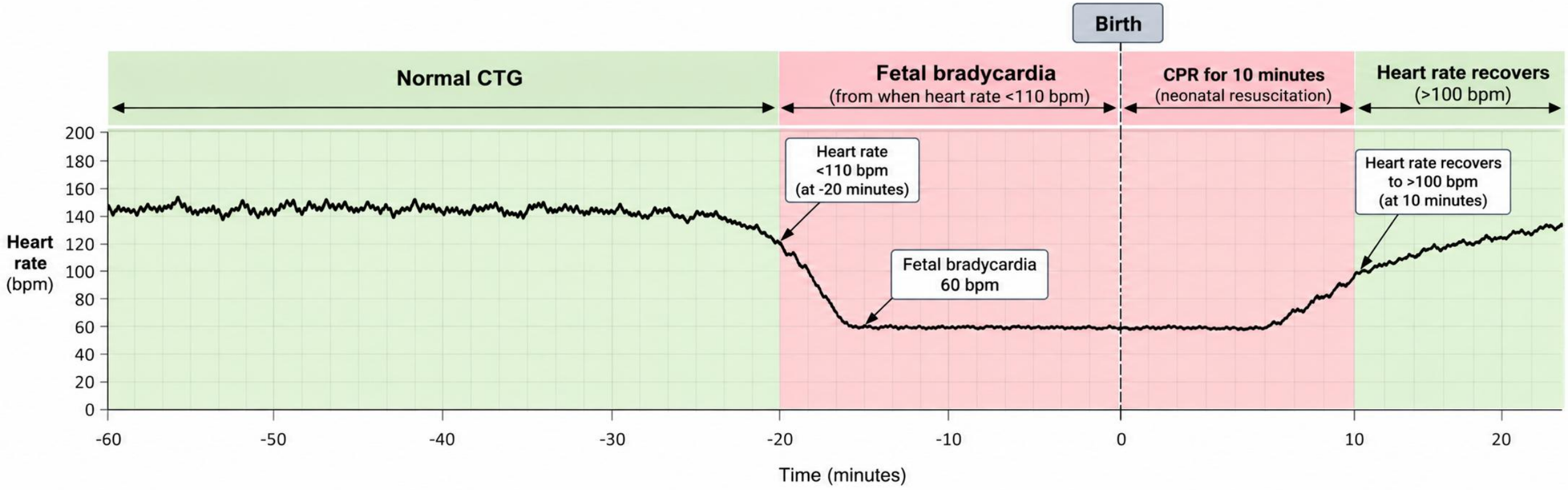
Resilience factors

- Therapeutic hypothermia
- Unknown genetic factors





Acute profound asphyxia due to cord compression

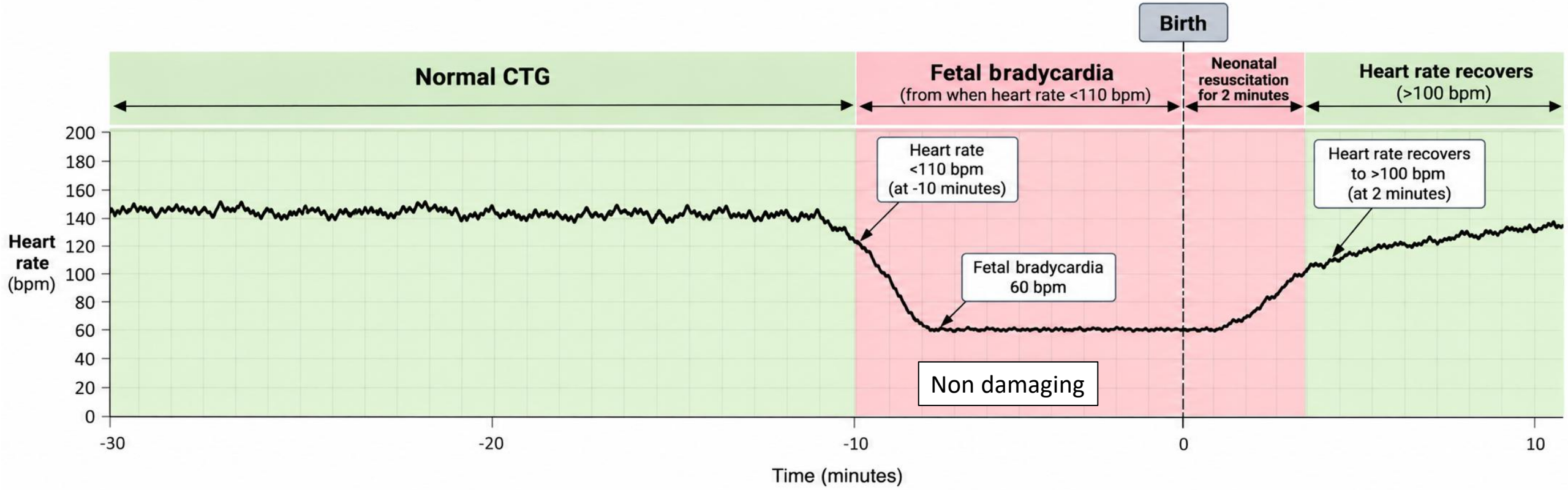


20 minutes intrapartum asphyxia and 10 minutes postnatal asphyxia (usually considered to be of a lesser degree)

Obstetric breach of 10 minutes identified

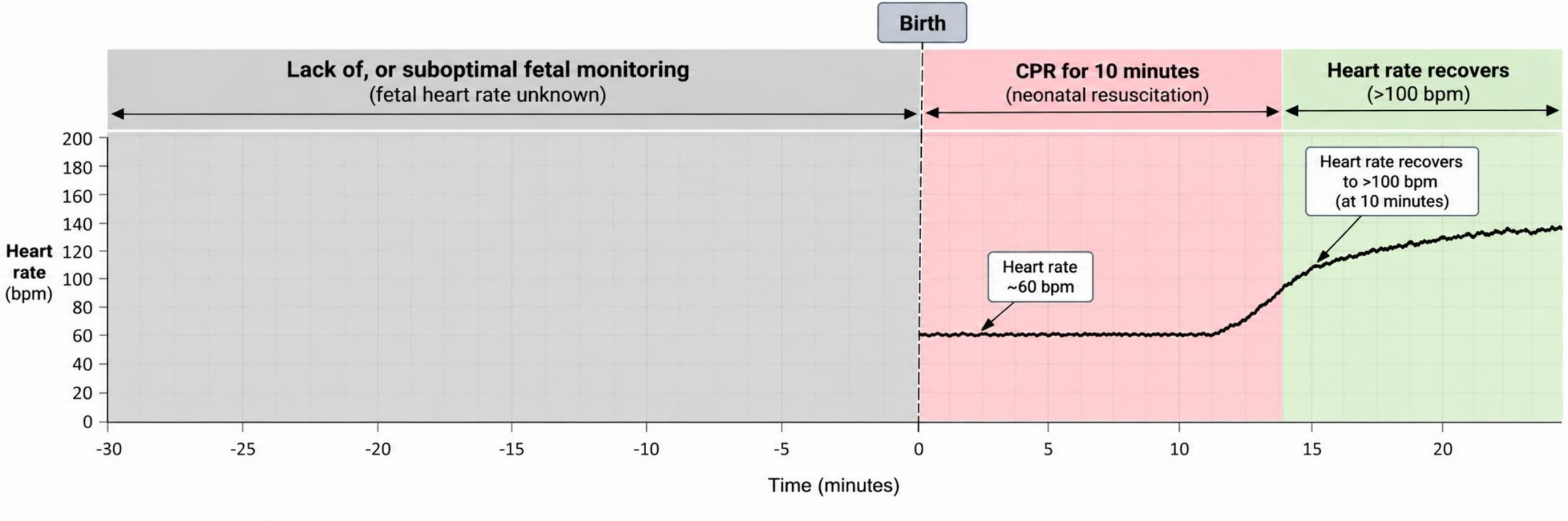
Both start and end of bradycardia known

If delivered 10 mins after bradycardia started→ only 10 mins of acute profound insult→ intact



If only it was so simple….!

Often preceding heart rate not known



Expert evidence

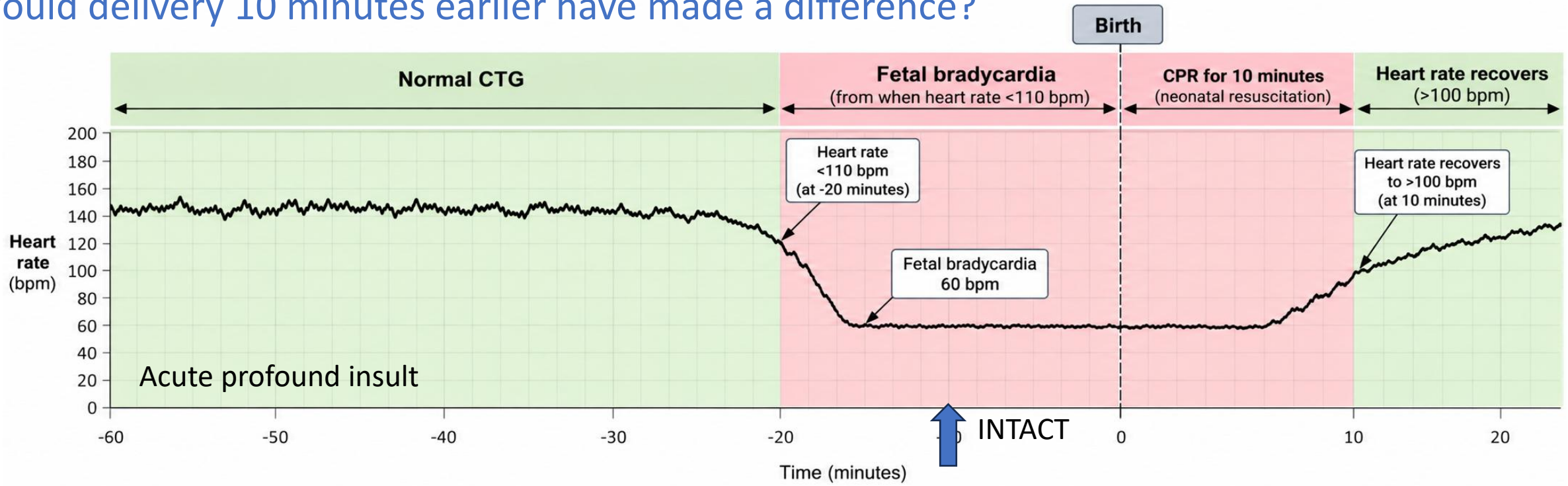
Acute profound

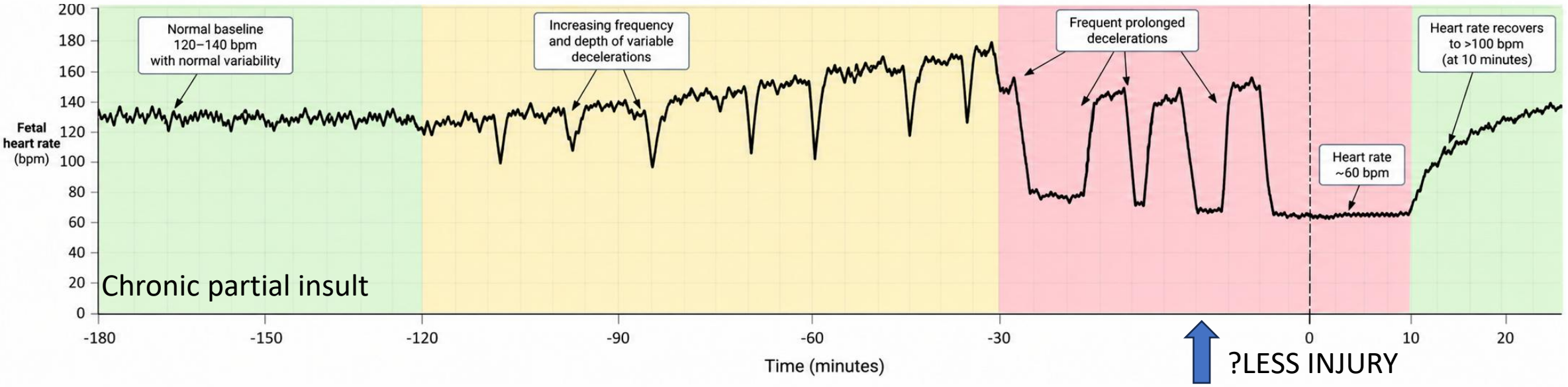
- Sentinel event
- Cord gas: venous pH may be normal, large discrepancy between venous and arterial
- MRI: deep grey matter injury
- Outcome: dyskinetic CP with normal intellect

Chronic partial

- Infection, growth restriction, hyperstimulation
- Venous pH: very acidotic
- MRI: watershed injury
- Outcome: spastic quadriplegia, microcephaly

Would delivery 10 minutes earlier have made a difference?

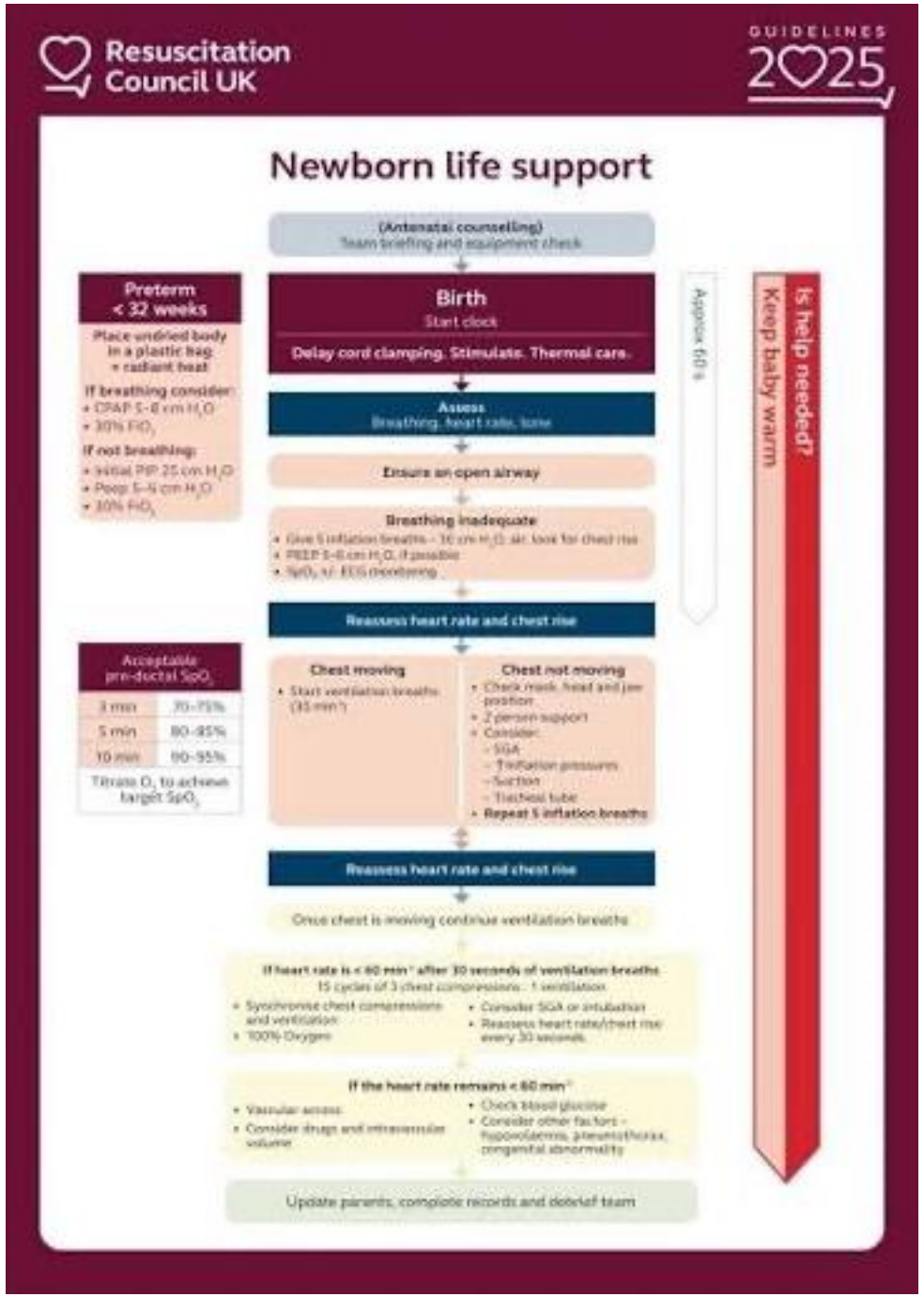




Material Contribution
and
Neonatal Breach of Duty

Material contribution in birth injury

- A number of factors caused the baby's injury cumulatively, either concurrently or consecutively
- One or more of the contributing factors was caused by the defender's negligence
- The injury suffered before and after birth is indivisible
- The contribution of the defender's negligence to the injury was more than negligible
- The pursuer cannot establish that 'but for' the defender's negligence the injury would probably not have occurred as a result of uncertainty in medical science



Resuscitation

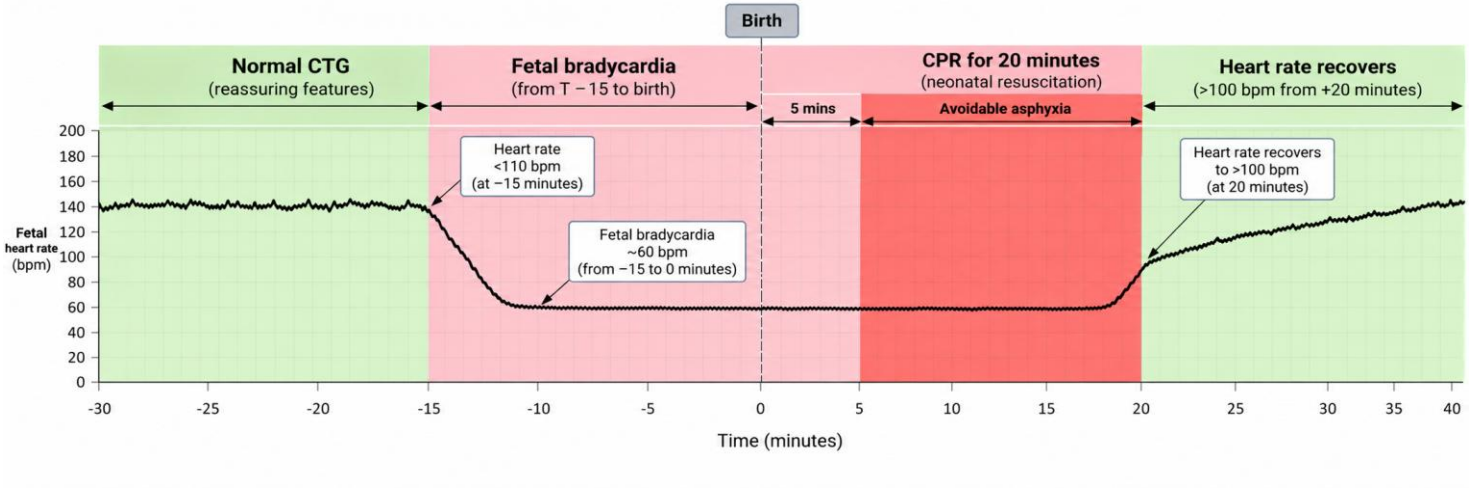
→ Asphyxia may have intrapartum and postnatal components

Resuscitation: aim is to terminate asphyxial episode promptly (defined by when heart rate recovers >100bpm)

Breach of duty issues

- Delay:
  - In calling neonatal team to attend birth
  - In escalating to senior doctors
  - In siting tubes and lines
- Failure to follow standard national guidance (NLS)
  - Starting compressions before aerating the lungs
- Incorrectly performed manoeuvres: intubating the oesophagus rather than windpipe; using incorrect pressures to give breaths

Resuscitation breach

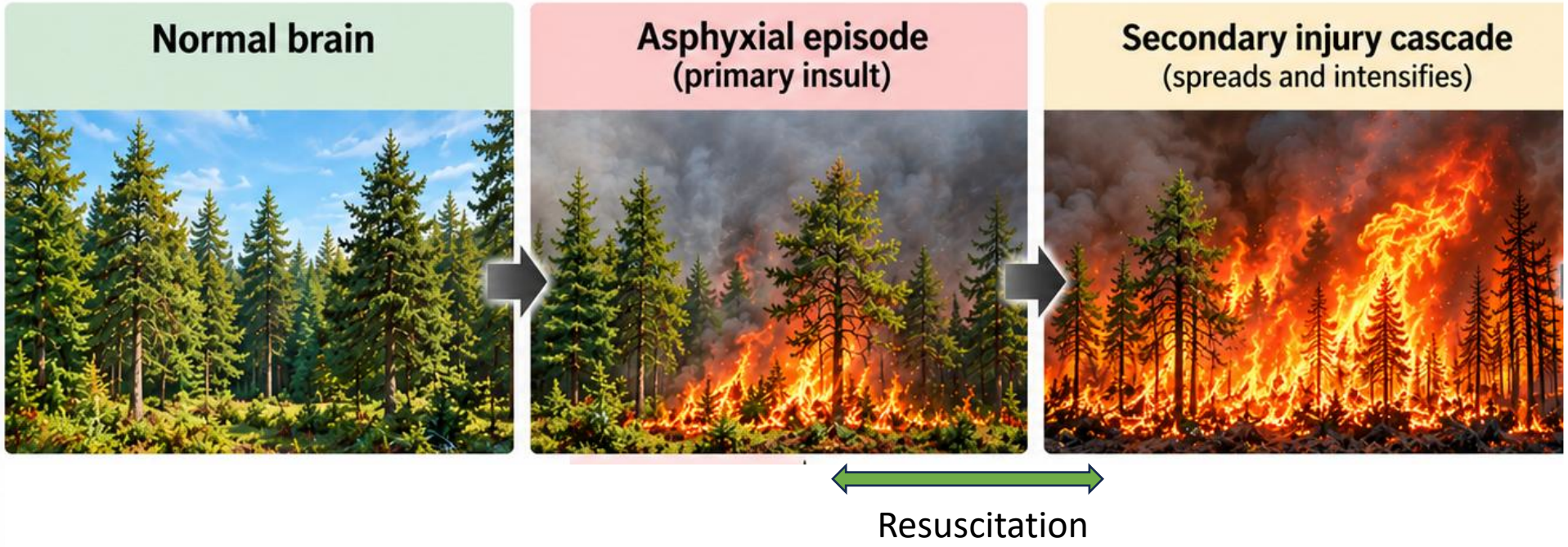


15 minute delay in establishing an airway

- The postnatal asphyxia contributed to the injury suffered before birth
- The injury suffered is indivisible from that occurring prior to birth
- More than negligible contribution



Neonatal care: mitigating harm



Therapeutic Hypothermia



- Core temperature reduction to 33.5C for 72hours
  - babies selected using structured assessment
  - started < 6h to target secondary brain injury

- Standard of care since 2010 (BAPM, NICE) for *moderate or severe* HIE
- Reduces risk of death or disability:
  - From 60% (likely) → 45% (unlikely)

Differing benefit of TH in different severity of HIE:

- Moderate HIE: 54% (likely)→ 37% (unlikely)
- Severe HIE: 86% (likely) → 70% (still likely)

Current trial (COMET) investigating the benefit in mild HIE

Neonatal care: material contribution

- Avoidance of *hypoxia*-
  - causes further brain energy failure- BAPM TH FfP
- Avoidance of *low blood pressure*
  - causes further ischaemia- BAPM TH FfP
- Avoidance of *low carbon dioxide levels*
  - causes further ischaemia- BAPM TH FfP
- Avoidance of *hypoglycaemia*-
  - causes further brain energy failure- NICE guidance
- Avoidance of *hyperthermia*-
  - associated with worse damage - BAPM TH FfP
- Treat *sepsis*-
  - treatment with antibiotics within 1h - NICE standard





julie-clare.becher@scot.nhs.uk

Key points

- The fetus is resilient and brain injury does not begin when hypoxia begins
  - Injury develops late in both acute and chronic asphyxia
- Knowledge of injury patterns informs mechanism and duration of asphyxia
- Neuroprotective care after birth is multifaceted and may be important in material contribution arguments

UK

NHS resolution guidelines and BAPM/NICE guidance establishes the standard of care:

- immediate assessment for cooling required if there is metabolic acidosis or a low Apgar score:
- no dispute of fact so no High Court rulings or Case Law
- most case settlements and are not reported

Nottingham Ockenden Report (June 2026):

- The independent review board formally identified recurring cases where the hospital possessed adequate national therapeutic hypothermia guidance, yet clinicians repeatedly made **"delays and deviations in cooling practice"**
- Successful prior litigation in some cases- Letting the 6-hour neuroprotective window lapse has been cited as an independent omission that materially contributed to the children's ultimate diagnoses of cerebral palsy

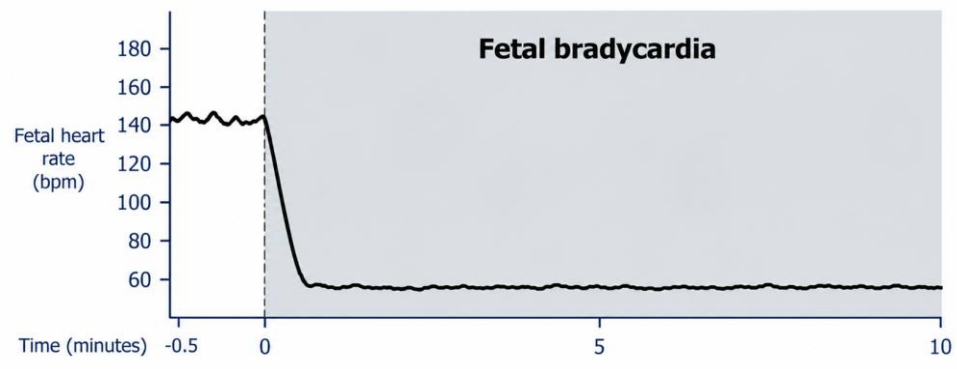
USA

Beam Legal Team Record Verdict (Detroit, Michigan)

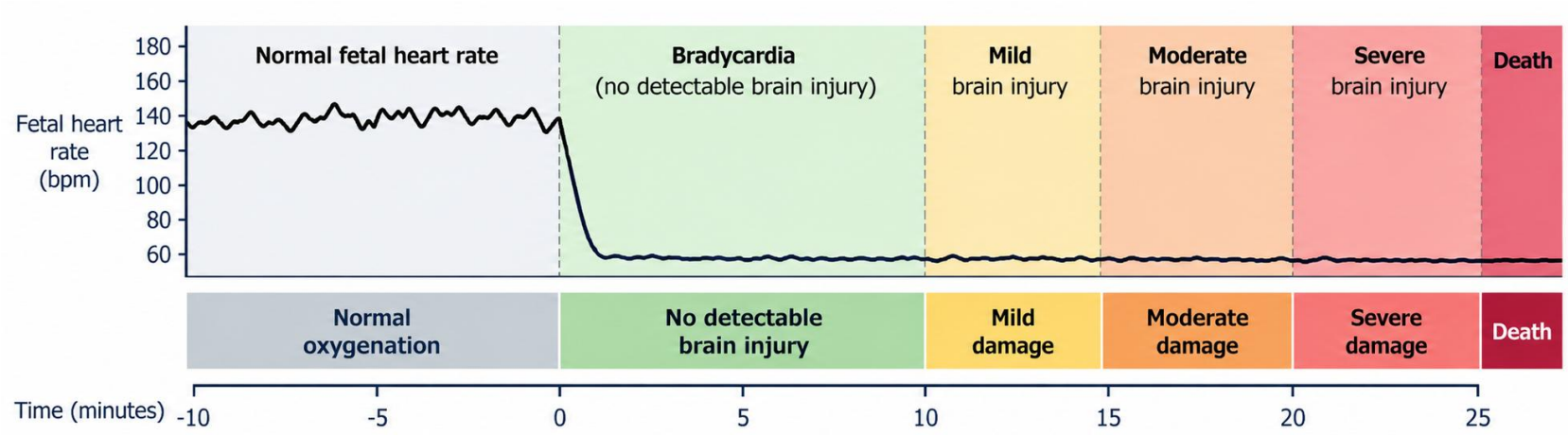
- www.beamlegalteam.com/verdicts-settlements
- Neurological exam performed by a medical resident at 1 hour of life incorrectly ruled out therapeutic hypothermia. By the time the infant began seizing at 7 hours of life, the neonatal team stated it was "too late" to treat because the 6-hour neuroprotective window had closed

The Mercy Hospital Birth Injury Trial (St. Louis, Missouri)

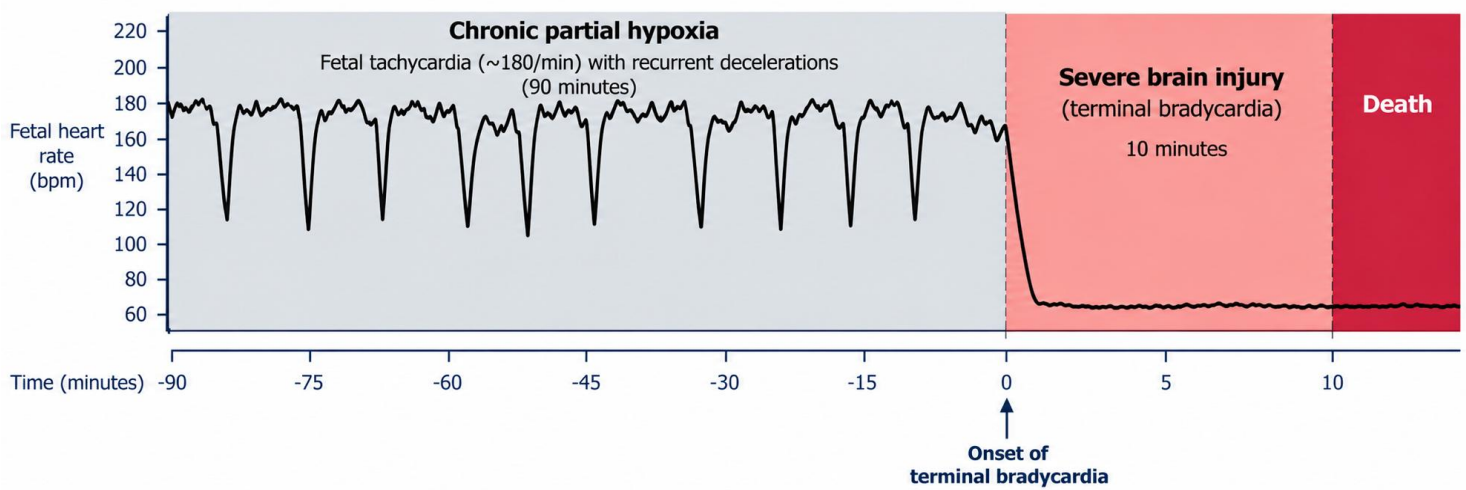
- *R.A., a minor, v. Mercy Hospital East Communities, et al.* (Case No. 21SL-CC03944)
- The failure to execute the brain-cooling protocol deprived the baby of a vital neuroprotective window which would have lessened the child's brain injury by 20% to 30%.



Born at 10 minutes→ intact



Born at 10 minutes→ severe brain injury



Credentials

- Neonatal Consultant in NHS Lothian (since 2007)
- Preclinical and clinical brain injury research (since 1995)
- Co-author of three Frameworks for Therapeutic Hypothermia, British Association of Perinatal Medicine (2010- 2026)
- Quality Lead for the British Association of Perinatal Medicine (2015-2020)
- Chair of the Scottish Cooling Group (since 2010)
- Newborn Life Support Instructor (since 2008)
- NHS Lothian Lead Reviewer for Adverse Events (since 2023)
- Neonatal expert witness (since 2010)

Litigating Birth Injuries Cases

Fiona Drysdale KC

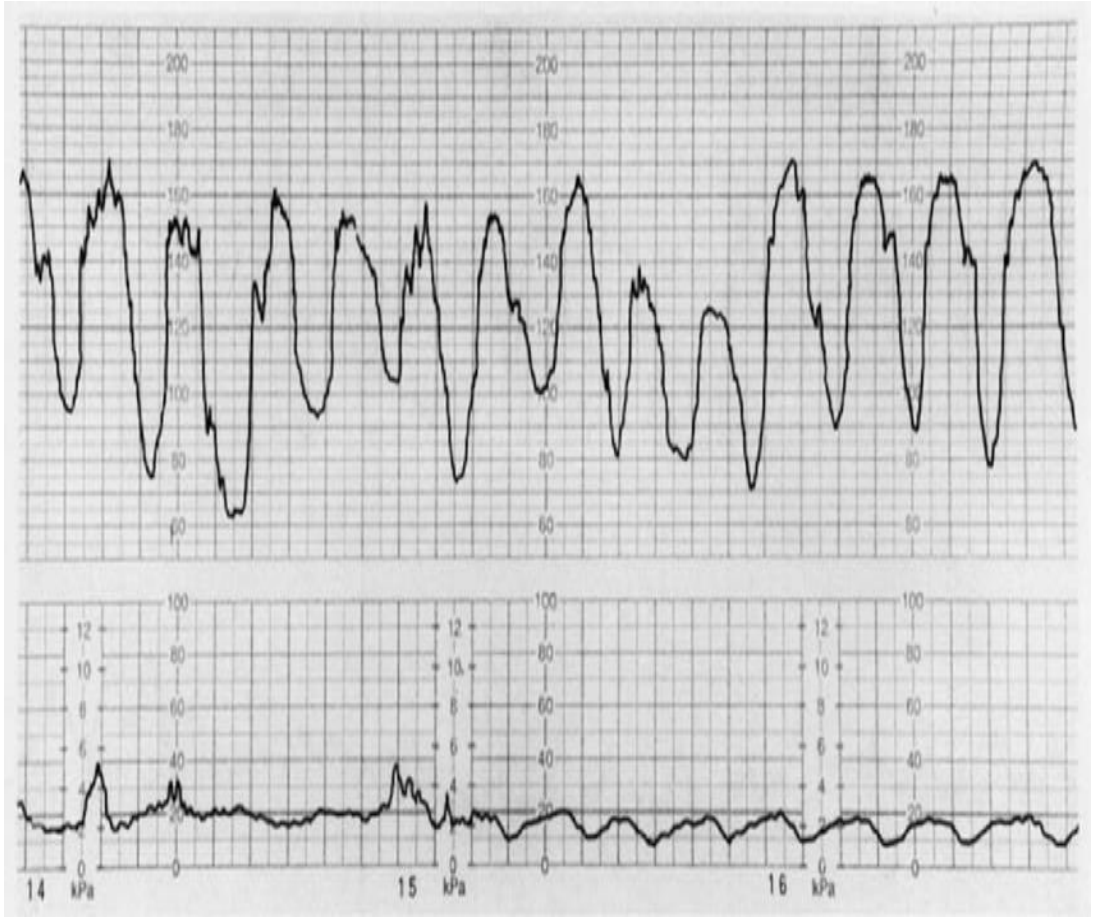


“The most critical and most dangerous day of anyone’s life, is the day you are born”

Prof Sir Chris Whitty, evidence to the House of Commons Public Accounts Committee, 13 March 2025

Preliminary Investigations

- The Culture of Chapter 42A
- Instructing counsel
- Witness Statements - *AM v Lothian Health Board 2026 CSOH 42*
- Medical Records
- Expert Report on Breach of Duty
- Cardiotocography (CTG) – *AM*



Investigation of Possible Defences

- Antenatal course
- Events during the pregnancy
- Progress of labour
- Delivery
- Growth problems



"Her husband? No, I'm her lawyer."

CartoonStock.com

How to defend obstetricians

- MEWS charts = Maternity Early Warning Score
- SBAR- D = Situation, Background, Assessment, Recommendation and Decisions
- Local, SIGN and NICE Guidelines
- Hospital and midwifery records of BP and urine
- Prompt reporting of incidents

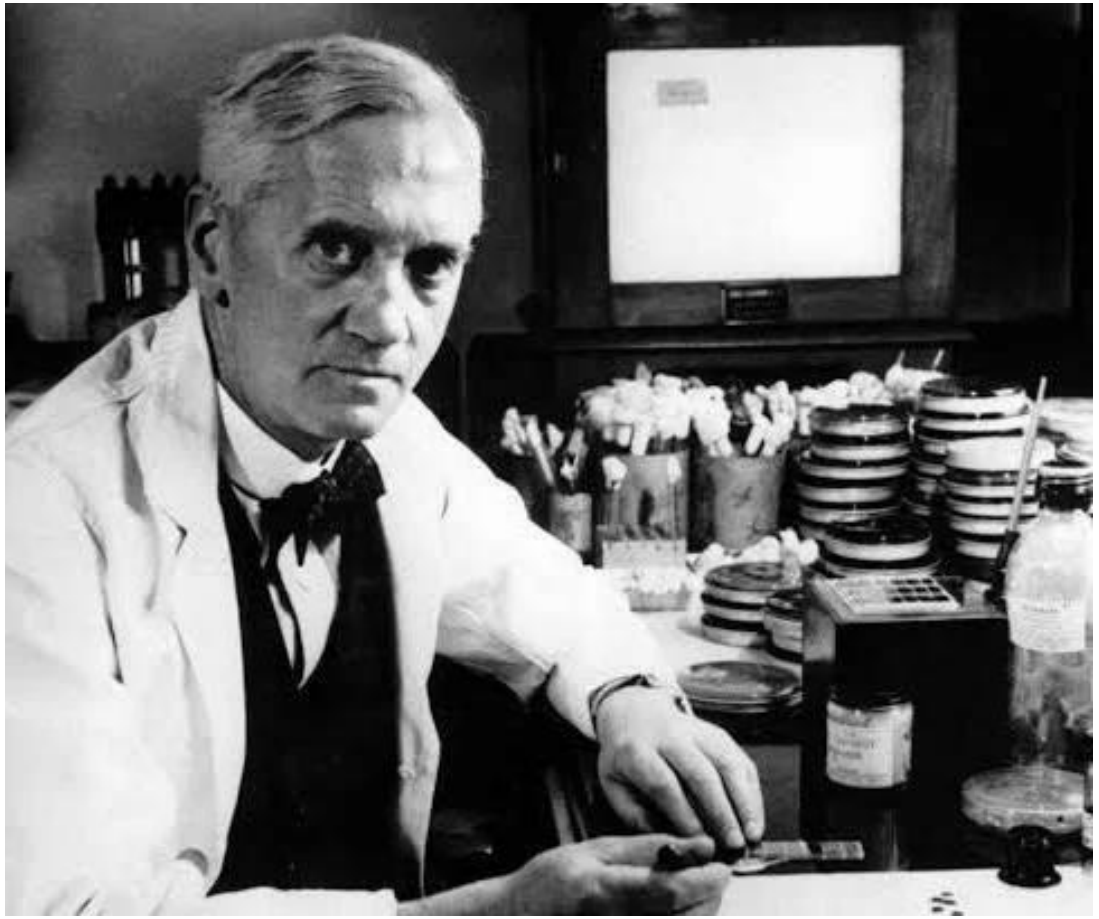


Further defences

- Differential outcome
- More than one cause of damage
- Pathology
- Life expectancy
- *D's Parent and Guardian v Greater Glasgow Health Board [2011] CSOH 99*



Sir Alexander Fleming and the discovery of Penicillin



- Fleming's discovery of Penicillin in 1928 changed the world of modern medicine.
- Penicillin was called a "miracle drug" because it could suddenly cure deadly bacterial infections.
- It was not mass-produced until it was used in WWII for troops in the D-Day landings.
- First became available for public use in the UK in 1946.

Hunter v Hanley 1955 SC 200

The “professional practice test”

1. There is a usual and normal practice
2. The defender has not adopted that practice
3. The course the doctor adopted is one which no professional man of ordinary skill would have taken if he had been acting with ordinary care



Bolitho v City and Hackney Health Authority [1998] AC 232

- The court had to satisfy itself that the medical experts could point to a logical basis for the opinion.

- Where cases concerned the balancing of risks against benefits, the medical experts had to consider the comparative risks and benefits.

- It would only be in rare cases that the court would reject the medical experts' view



Claire Wilkie v Tayside Health Board [2025] CSOH

- First instance - Lord Young
- Appeal to Inner House - Lord Ericht, Lord Malcolm, Lady Carmichael
- Now at avizandum following an appeal by the defender
- Hypoxic brain injury during labour resulting in severe and profound disabilities
- Midwifery Led Unit at Perth Royal Infirmary
- Protocol gave criteria for referral for ultrasound
- The ultrasound referral case
- Usual practice defence
- *Hunter v Hanley* not used by Lord Young



Caesarean Sections

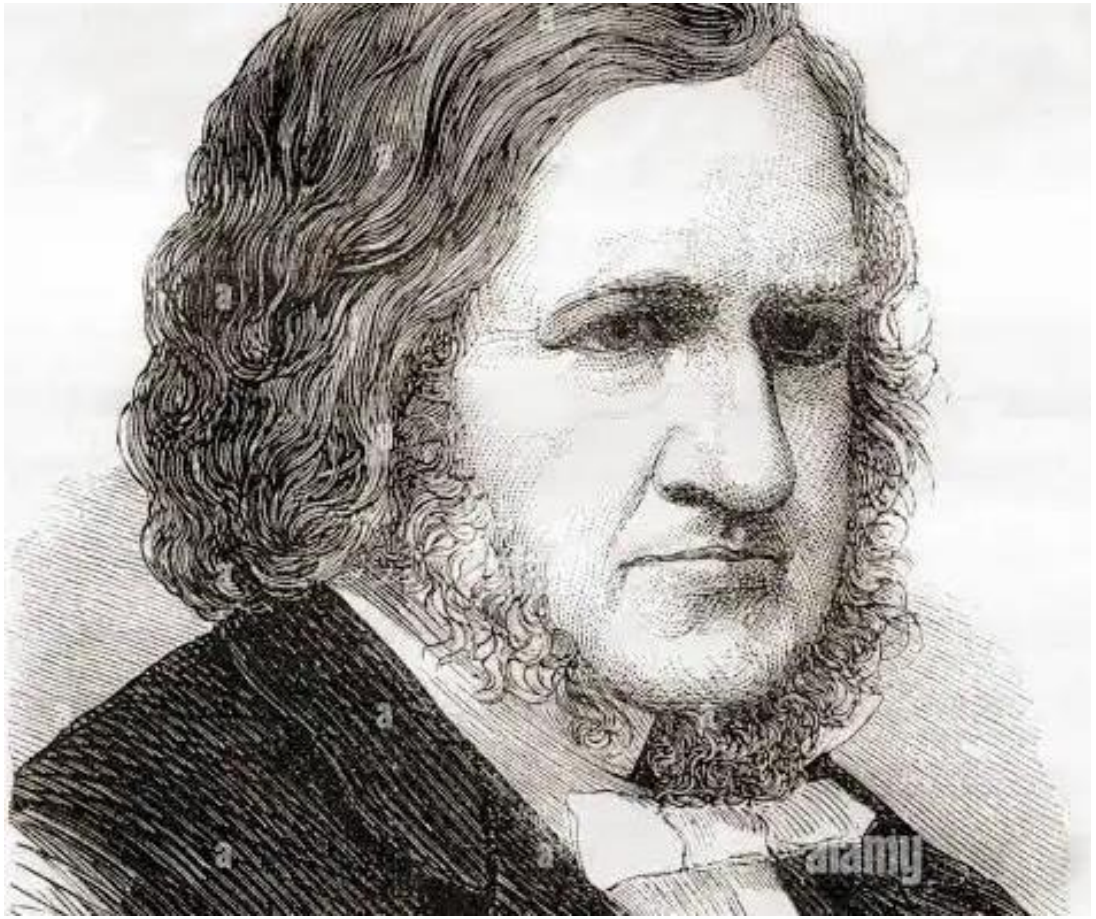


"Despair thy charm, and let the angel whom thou still hast served tell thee, Macduff was from his mother's womb untimely ripped."

William Shakespeare MacBeth Act 5, Sc 8

Sir James Young Simpson pioneered the use of chloroform

- Without anaesthesia, modern surgery would be nearly impossible, and medical care would be restricted to external treatments due to unbearable pain and dangerous physical shock.
- Discovered the anesthetic properties of chloroform
- Revolutionised pain relief in childbirth.
- This made instrumental deliveries possible.



Informed Consent

- *Montgomery v Lanarkshire Health Board [2015] UKSC 11*
- *Hunter v Hanley* does not apply to consent
- Patients can decide on form of treatment
- Consent before treatment
- Duty to take reasonable care to ensure patient aware of material risks and any reasonable alternative treatments



McCulloch v Forth Valley Health Board [2023] UKSC 26

- Hunter v Hanley = the professional practice test
- Use this to determine the reasonable treatment options
- If RTOs not discussed, Montgomery applies



AW v Greater Glasgow Health Board 2017 CSIH 58

What a court requires to do in matters of causation, is to look critically at the various explanations advanced by the experts, evaluating them against standards of logic and practical likelihood, and decide which, if any, is a probable explanation for the sequence of events.

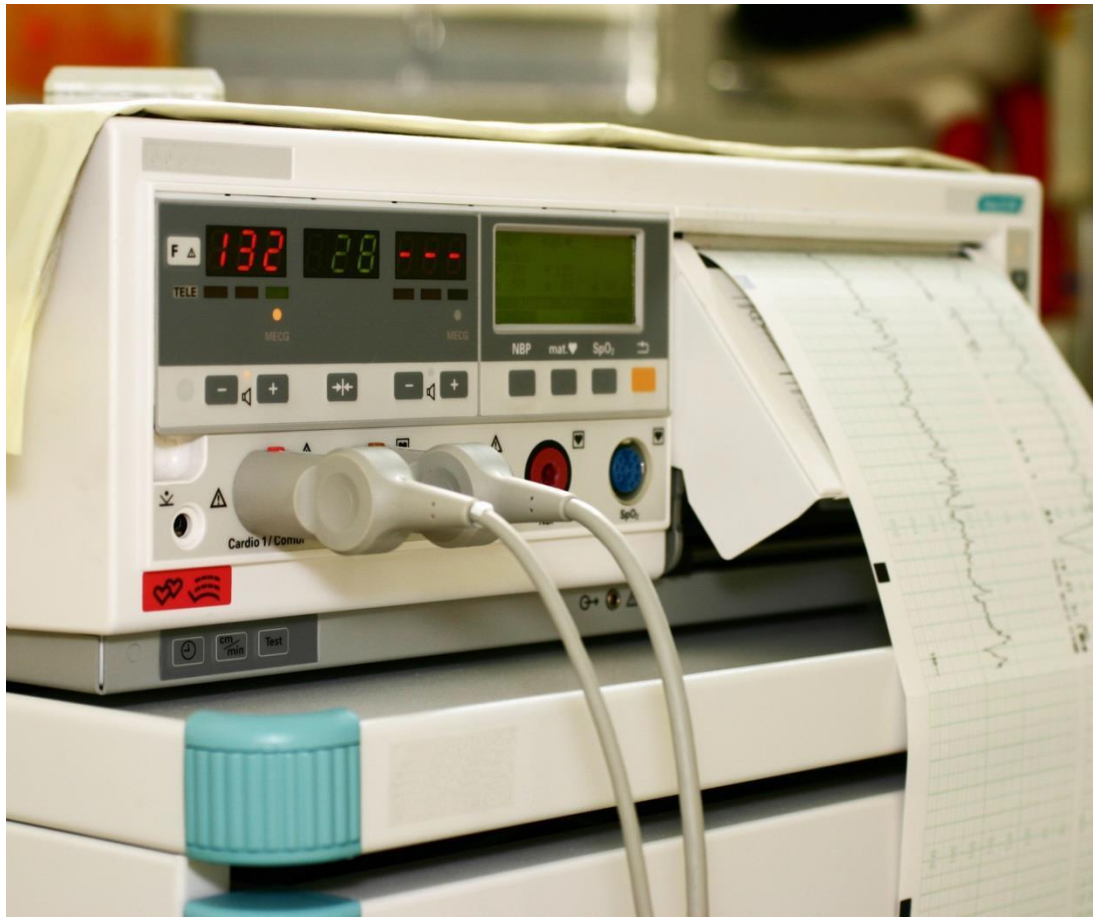
Specialties of Chapter 42A

- How to prepare for a smooth case management hearing
- How to face the challenges of expert reports
- How to prepare for a successful joint meeting of experts



Period Payment Agreements

- *D's Parent and Guardian v Greater Glasgow Health Board [2011] CSOH 99*
- Fairness
- Less risk of collapse of care regime
- Appropriate for children
- Tax free unlike lump sum



Disadvantages of PPAs for defenders

- No flexibility
- No clean break
- Final cost unknown
- No tender possible
- Care-cost indexation ASHE





“The good news is that we know what is needed to make childbirth safer”

Dr Atul Gwande and Dr Katherine Semrau, How to Save Women and Newborns During Childbirth, 2018

Clinical Negligence Conference 2026: Case Law Update

Louise Jardine
Ampersand Advocates

22nd October 2026

Scottish cases

Gasper v Partners of Tain & Fearn Area Medical Practice [2025] CSOH 96	Disapplication of QOCS in a fatal case where there was unreasonable delay in accepting a tender.
Taylor v Forth Valley Health Board [2025] CSOH 103	Admitted failure to take informed consent. Proof on causation of Somatic Symptom Disorder and quantum. Pursuer successful. Pursuer awarded £904,000. Reclaiming motion heard and at avizandum.
*Wilkie v Tayside Health Board [2025] CSOH 111	Birth injury case regarding various midwifery breaches in late-stage antenatal care. Pursuer successful. Reclaiming motion at avizandum.
*AM v Lothian Health Board [2026] CSOH 42	Birth injury case regarding alleged obstetric and midwifery failures. HvH test not met. Defender successful.

Scottish cases

Downie v NHS Fife Health Board [2026] SAC (Civ) 61	Appeal of Sheriff's judgement in a proof concerning alleged negligence in psychiatric care. Appeal refused.
*PO and OO v Lothian Health Board [2026] CSOH 55	Debate in wrongful birth case. LO held that father is a primary victim and owed duty of care in relation to fetal testing and damages should not be assessed with reference to pursuers' means. Reclaiming motion to be heard in March 2027.
CD v Grampian NHS Board [2026] CSOH 92	Fatal case. Quantum awards of £150,000 to father and £75,000 to step-mother – inclusive of interest. Time-bar point being reclaimed.
Lever v Ayrshire and Arran Health Board [2026] CSOH 89	Debate in fatal case regarding interpretation of s3 of Damages (Scotland) Act 2011.

Claire Bayne or Wilkie v Tayside Health Board [2025] CSOH 111

Overview

- Lord Young
- PBA restricted to negligence and causation
- Counsel: Lauren Sutherland KC and Hugh Masters (P); Neil Mackenzie KC and Shane Dundas (D)
- Obstetric experts: Dr Philip Owen (P) and Dr Evelyn Ferguson (D)
- Midwifery experts: Jean McConville (P) and Professor Julia Sanders (D)
- Neonatologist: Dr Andrew Lyon (P)

Facts

- Pursuer had the option of birthing at Ninewells hospital but opted for the midwifery led unit in Perth
- SFH measurement at 40 weeks had discrepancy of 3cm - no growth scan arranged
- Maisie suffered a hypoxic brain injury during labour resulting in profound disability
- Was there was any breach of duty in the antenatal period which resulted in Maisie being delivered in the midwifery led unit in Perth as opposed to Ninewells?

Claire Bayne or Wilkie v Tayside Health Board [2025] CSOH 111

Decision

Transfer time

- One of defender's objections repelled: *"while it is unfortunate that the defenders' own records do not disclose who carried out the tour, that is not something the pursuer bears responsibility for… as much specification as to this ground of fault as could reasonably be expected"*
- Pursuer's evidence regarding transfer time was not accepted

Ultrasound referral – Midwife's decision

- Medical records silent on the midwife's consideration of the SFH discrepancy
- Evidence of midwife's usual practice in comparable situations unclear
- LO was unable to accept that the midwife took a conscious decision not to refer the pursuer for a growth scan.

Claire Bayne or Wilkie v Tayside Health Board [2025] CSOH 111

Decision

Ultrasound referral – Policy interpretation

- Factual background of policy of greater assistance, as opposed to how individual construed it
- *"Use own clinical judgement"* does not qualify need to refer for scan if SFH discrepancy of 3cm or more
- Ultrasound ought to have been arranged

Ultrasound referral – Clinical judgement

- Not decisive given earlier conclusions
- No evidence of usual and normal practice within midwifery profession on the approach to SFH discrepancies
- If the midwife did apply clinical judgement, no evidence that *not* referring for a scan would be outwith usual and normal practice

Reclaiming motion was heard in September 2026 and case is currently at Avizandum

AM v Lothian Health Board [2026] CSOH 42

Overview

- Lady Hood
- Concerned labour and birth from September 2010
- PBA restricted to breach of duty
- Counsel: Astrid Smart KC and David Swanney (P); Una Doherty KC and Ewen Campbell KC (D)
- Obstetric experts: Dr Philip Owen (P) and Professor Deirdre Murphy (D)
- Midwifery experts: Jean McConville (P) and Professor Julia Sanders (D)

Facts

- The pursuer contacted midwifery triage, and then attended, reporting her waters had broken
- Meconium was noted upon examination, around 2.5 hours later – ought this to have been identified earlier and CTG commenced?
- Was the CTG interpreted correctly by the obstetricians?
- Child L born by caesarean section following concerns of fetal distress.

AM v Lothian Health Board [2026] CSOH 42

Decision

Midwifery care

- No breach of duty.
- Largely due to finding that the pursuer did not report meconium to the midwives during second of two triage calls.

Obstetric care

- No breach of duty
- Divergence of opinion between the two experts. Both withstand rational analysis.
- Not a case where the evidence of an expert (Prof Murphy) falls to be rejected.
- *HvH* test not met.

PO and OO v Lothian Health Board [2026] CSOH 55

Overview

- Lord Braid
- Wrongful birth claim concerning antenatal care and birth in May 2020
- Debate re: 1) whether a duty of care owed to the father; and 2) whether damages should be measured with reference to the pursuers' income.
- Counsel: Euan Mackenzie KC and David Swanney (P); Paul Reid KC and Louise Jardine

Facts

- Child A born with Down's Syndrome following negligent care in antenatal period
- Claim advanced for both mother and father in respect of solatium, financial loss and the care costs for Child A
- Defender argued that father is a second victim and duty of care does not extend to him
- Defender also argued damages should be measured with consideration of the pursuers' means – to do otherwise is to substitute wrongful life claim

PO and OO v Lothian Health Board [2026] CSOH 55

Decision

Duty owed to father

- Father is a primary victim
- A duty of care is owed to the father to take reasonable care in the provision of fetal testing

Proper measure of damages

- The pursuers' means is not a relevant consideration for the quantification of loss
- Reasonable heads of claim which are likely to be incurred are recoverable
- Needs of the child and pursuers might overlap – but not identical

Reclaiming motion due to be heard in March 2027

English cases

- **CCC v Sheffield Teaching Hospitals NHS Foundations Trust [2026] UKSC 5**
  - ”Lost years” damages can be recovered where the claimant is a young child – provided normal principles and practice on proof of loss are adhered to

- **JBX v Frimley Health NHS Foundation Trust [2026] EWHC 2294**
  - Proof of quantum in catastrophic brain injury case
  - Damages agreed in seven different scenarios depending on how the case was decided



AMPERSAND

ADVOCATES

Closing remarks and thank you

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