7 Decision Points That Make or Break Birth Injury Claims

This guide was produced by INNEG and is based on key clinical insights shared during our October 2025 webinar on birth injury claims, featuring Dr Lorna Phelan, Consultant Obstetrician & Gynaecologist.

It is intended to support solicitors in understanding common medico-legal decision points in birth injury litigation and does not constitute clinical guidance or expert opinion on any individual case.

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Introduction

Birth injury litigation sits at the intersection of high clinical risk, emotive outcomes, and complex medico-legal analysis. While cases are often framed around individual events - a CTG trace, a delayed caesarean section, or an instrumental delivery - adverse outcomes rarely result from a single isolated act.

Instead, birth injury claims are shaped by a sequence of decisions made over hours, sometimes minutes, during labour.

These decisions are influenced by evolving clinical context, staffing pressures, maternal preference, and the ability of clinicians to recognise when a previously normal labour has become pathological.

This ebook examines seven decision points that repeatedly appear in claims involving cerebral palsy, hypoxic injury, stillbirth, and neonatal death - and explains why they matter legally, not just clinically.

01

Place of Delivery as Labour Evolves

Decisions around place of delivery are usually made antenatally, when pregnancy is uncomplicated and labour is expected to progress normally. Home birth or birth-centre delivery may be entirely appropriate at the outset.

However, many claims arise where labour ceases to be low-risk, but the original plan is not revisited with sufficient urgency. Labour is a dynamic process: a woman who begins labour physiologically can deteriorate rapidly, particularly where infection, prolonged rupture of membranes, fetal compromise, or failure to progress emerges.

From a legal perspective, the issue is rarely that a home or birth-centre delivery was chosen, but that the point at which continued delivery outside an obstetric unit became unsafe was missed or delayed. Courts focus on whether clinicians recognised that transition and acted decisively.

Solicitors should scrutinise how often risk was reassessed, whether emerging concerns were escalated, and how clearly transfer decisions were documented. Delay at this stage can have profound downstream consequences.

02

Declining Intervention in Pathological Labour

Maternal choice is fundamental to maternity care, but it becomes legally fraught when labour becomes pathological. Increasingly, women decline intervention because of fear, mistrust, or negative narratives around medicalised birth.

In litigation, the question is not whether a woman declined intervention - but whether clinicians adequately contextualised the risks once pathology emerged. Respecting choice does not remove the duty to challenge decisions that materially increase fetal or maternal risk.

Claims frequently arise where declining intervention is documented, but without evidence that clinicians explained the evolving danger, involved senior staff, or revisited the discussion as circumstances worsened.

For solicitors, this decision point often marks the beginning of defensibility issues. A failure to contextualise risk - particularly where harm later occurs - can undermine an otherwise reasonable defence.

03

CTG Interpretation in Clinical Context

CTG interpretation is central to birth injury litigation, yet it is also one of the most misunderstood aspects of obstetric evidence.

Pathological CTGs are rarely missed outright. Instead, disputes arise where traces are classified as "suspicious" or borderline, and clinicians elect to observe rather than escalate. CTGs are inherently subjective, have a high false-positive rate, and are not reliable diagnostic tools in isolation.

What matters legally is not simply how a CTG was classified, but whether it was interpreted in the context of the wider clinical picture. A trace that might be tolerated early in labour may become unacceptable when combined with oxytocin use, infection, reduced variability, or maternal exhaustion.

In many claims, multiple experts interpret the same CTG differently. Solicitors should therefore focus on whether contextual risk factors were present - and whether they should have lowered the threshold for intervention.

04

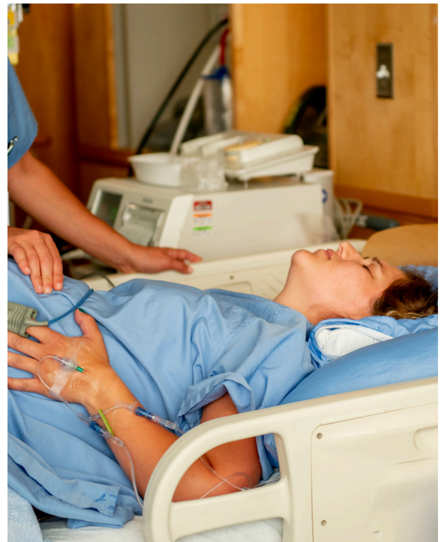
Oxytocin Use and Escalating Risk

Oxytocin is widely used to augment labour, yet it carries significant risk. Excessive uterine activity reduces placental blood flow, increasing the likelihood of fetal hypoxia.

Claims often arise where oxytocin is continued or escalated despite warning signs such as abnormal CTG features, meconium-stained liquor, or uterine hyperstimulation. The combination of oxytocin and compromised fetal reserve is particularly difficult to defend.

From a medico-legal standpoint, the key question is whether oxytocin use was actively reassessed as labour evolved, rather than treated as a static part of the management plan.

Solicitors should examine contraction patterns, dose adjustments, and whether clinicians responded appropriately to signs of fetal distress. Failure to stop or reduce oxytocin can significantly strengthen breach arguments.



05

Timing of Escalation and Delivery

Guidelines often cite a 30-minute decision-to-delivery interval for pathological CTGs, but this metric can be misleading in litigation.

Many claims turn on what happened before escalation formally occurred. Delays in recognising deterioration, reluctance to involve senior clinicians, or systemic pressures such as theatre availability can all contribute to avoidable harm.

Importantly, meeting a numerical target does not automatically negate breach or causation. A delivery performed “within 30 minutes” may still be too late if earlier recognition would have led to a materially different outcome.

For solicitors, causation analysis often hinges on whether earlier escalation, not just faster delivery, would have altered the baby’s neurological outcome.

06

Instrumental Delivery Versus Late Caesarean Section Requests

Requests for caesarean section late in labour feature heavily in litigation. While clinicians rarely refuse caesarean section outright, there are circumstances where proceeding carries greater risk than instrumental delivery.

Once the fetal head is deeply engaged, caesarean section can be technically difficult and dangerous. Claims often arise where women later allege they were denied a caesarean, despite clinicians believing instrumental delivery was safer.

The legal focus is on whether the relative risks were clearly explained and appropriately documented, particularly under emergency conditions. Poor documentation or rushed consent discussions can undermine defensibility, even where the clinical decision was sound.

07

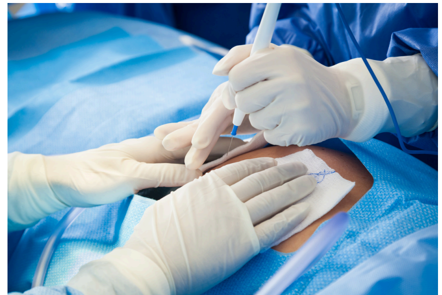
Consent Under Pressure and the Limits of Documentation

Consent is one of the most contested issues in birth injury claims. In emergency obstetrics, consent is often verbal, rapid, and poorly recalled by patients afterwards.

Many women involved in Cat 1 caesarean sections or urgent instrumental deliveries later recall little or nothing of the consent process. This creates fertile ground for dispute, particularly where documentation is sparse.

Solicitors should consider whether antenatal consent discussions occurred, whether risks were revisited as labour evolved, and whether documentation reflects the urgency of the situation rather than an absence of discussion.

Consent disputes rarely turn on perfection, but on whether clinicians acted reasonably in the circumstances - and whether that can be demonstrated on the evidence.



Conclusion

Birth injury claims are not won or lost on isolated errors. They turn on how clinicians made decisions as labour evolved, how risk was contextualised, and whether escalation occurred at the right time.

Understanding these seven decision points allows solicitors to assess cases more effectively, identify where breach and causation are strongest, and instruct experts with greater precision.

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