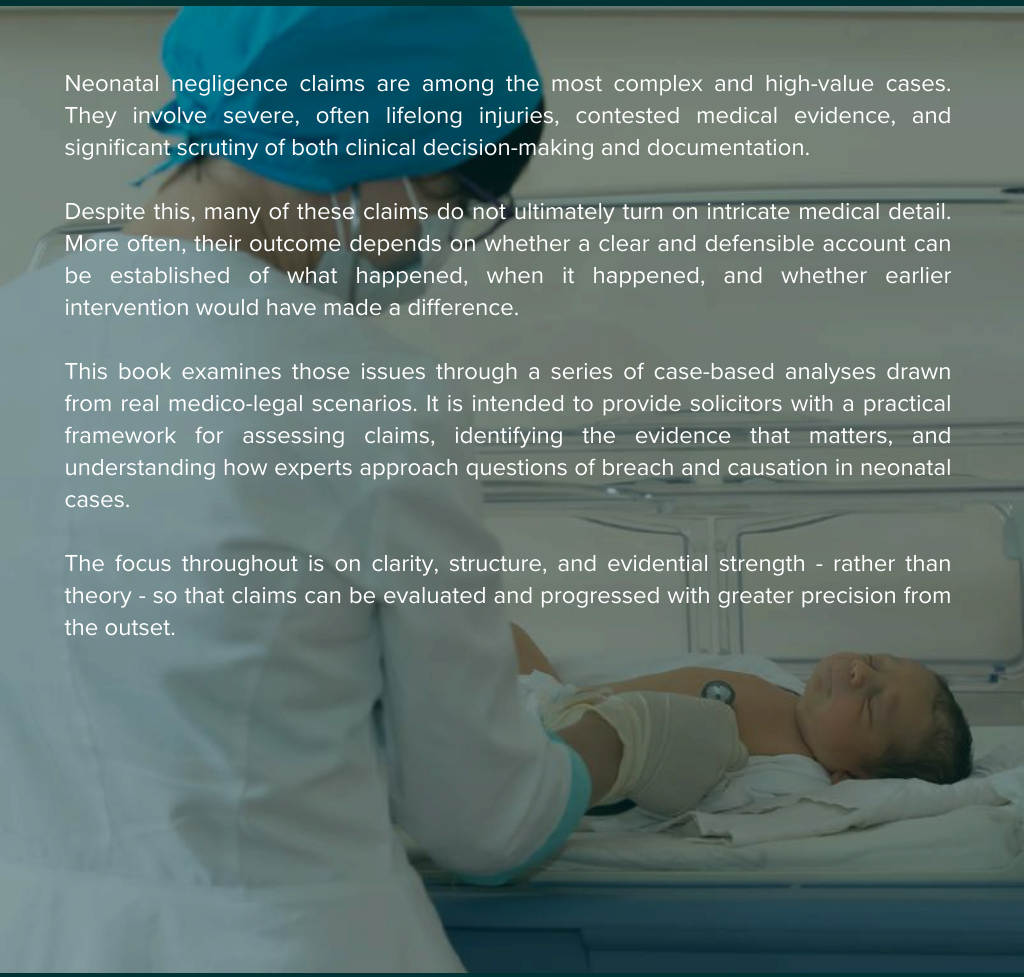
Neonatal Negligence: Case-Based Insights for Solicitors



Neonatal negligence claims are among the most complex and high-value cases. They involve severe, often lifelong injuries, contested medical evidence, and significant scrutiny of both clinical decision-making and documentation.

Despite this, many of these claims do not ultimately turn on intricate medical detail. More often, their outcome depends on whether a clear and defensible account can be established of what happened, when it happened, and whether earlier intervention would have made a difference.

This book examines those issues through a series of case-based analyses drawn from real medico-legal scenarios. It is intended to provide solicitors with a practical framework for assessing claims, identifying the evidence that matters, and understanding how experts approach questions of breach and causation in neonatal cases.

The focus throughout is on clarity, structure, and evidential strength - rather than theory - so that claims can be evaluated and progressed with greater precision from the outset.

Produced by INNEG based on key clinical and medico-legal insights shared during our webinar on Neonatal Failures & Birth Injury Risks led by Dr Ujwal Karoholu, Consultant Neonatologist

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Introduction

Neonatal negligence claims are often assumed to hinge on complex medical issues. In practice, they rarely do. More frequently, the outcome of a claim turns on failures in process, delays in decision-making, and the strength (or absence) of contemporaneous evidence.

For solicitors, the difficulty lies not simply in understanding what happened clinically, but in identifying when a departure from acceptable care occurred, whether that departure made a material difference, and how reliably this can be demonstrated through the available records. These cases demand a structured, evidence-led approach rather than a purely medical one.

This guide takes a case-based perspective, using real scenarios to illustrate how neonatal claims are analysed in practice.

It focuses on the points at which claims succeed or fail, the types of evidence that genuinely influence expert opinion, and the situations in which expert input is either decisive or of limited value. The aim is not to provide a broad overview of neonatology, but to ground legal analysis in the realities of clinical decision-making and documentation.

Each case is examined in a consistent framework, beginning with the factual timeline and moving through the key legal issues, including breach and causation. This is followed by a detailed consideration of the evidence, an explanation of how experts are likely to approach the case, and, finally, the practical implications for those progressing or defending a claim.

The intention is to provide a clear, pragmatic structure that can be applied to similar cases, enabling solicitors to assess viability earlier, instruct experts more effectively, and focus on the issues that are most likely to determine the outcome.

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Case Study 1: Delayed Response to Reduced Fetal Movements

This case concerns a mother who presented in the later stages of pregnancy with a reported history of reduced foetal movements. She was initially assessed by a midwife shortly after admission; however, the concerns raised at that stage did not result in escalation to medical review.

Following this initial assessment, there was a prolonged period, approximately 4 hours, during which no meaningful reassessment or intervention took place. During this time, a CTG trace was recorded and noted to be suspicious, with documentation indicating that escalation or transfer was required. Despite this, no effective action was taken.

The mother was eventually reviewed and proceeded to an emergency caesarean section at approximately 5:30am. By this stage, there were clear concerns regarding fetal wellbeing.

The baby was born in a compromised condition and subsequently diagnosed with hypoxic ischaemic encephalopathy (HIE), classified as Grade 3, indicating a severe injury. The child later developed cerebral palsy, consistent with significant hypoxic insult.

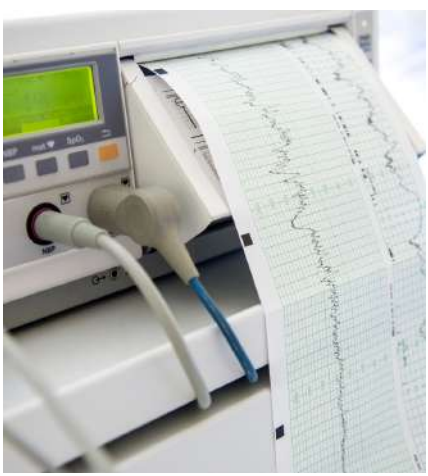
Legal Issues

The primary legal issues in this case centre on breach of duty and causation.

In relation to breach, the focus is on whether the care provided fell below an acceptable standard in the circumstances. The key concerns arise from the failure to escalate a presentation of reduced foetal movements, the lack of appropriate response to a suspicious CTG trace, and the delay of approximately three and a half to four hours before meaningful intervention occurred. Each of these points requires consideration against established obstetric practice and relevant guidelines at the time.

Causation presents the more complex issue. The central question is whether, on the balance of probabilities, earlier intervention (most notably earlier delivery) would have avoided the hypoxic insult or materially reduced its severity. While the presence of delay may support an argument for breach, it does not in itself establish liability. The outcome of the claim will depend on whether a clear causal link can be demonstrated between the identified failures and the development of hypoxic ischaemic encephalopathy.

In practical terms, this is often the point at which such claims succeed or fail.



Key Evidence

In cases of this nature, the evidential focus must begin with the period prior to delivery. Although the neonatal outcome is central to the claim, an effective analysis depends on understanding the events leading up to birth, rather than starting with the neonatal records in isolation.

The most significant pre-delivery evidence will typically include the CTG traces and, critically, how they were interpreted at the time, alongside the midwifery records documenting observations, concerns, and any decisions regarding escalation. The timing of key events - particularly the interval between the identification of concerns and the decision to proceed to delivery - is often pivotal. Any contemporaneous documentation indicating concern, uncertainty, or planned action is likely to carry substantial weight.

Evidence from the point of delivery and the immediate neonatal period then assists in assessing the extent and likely timing of the injury. APGAR scores, recorded at defined intervals, provide an indication of the baby's condition at birth and response to initial management. The duration and intensity of resuscitation are also highly relevant, as they may reflect the severity of compromise.

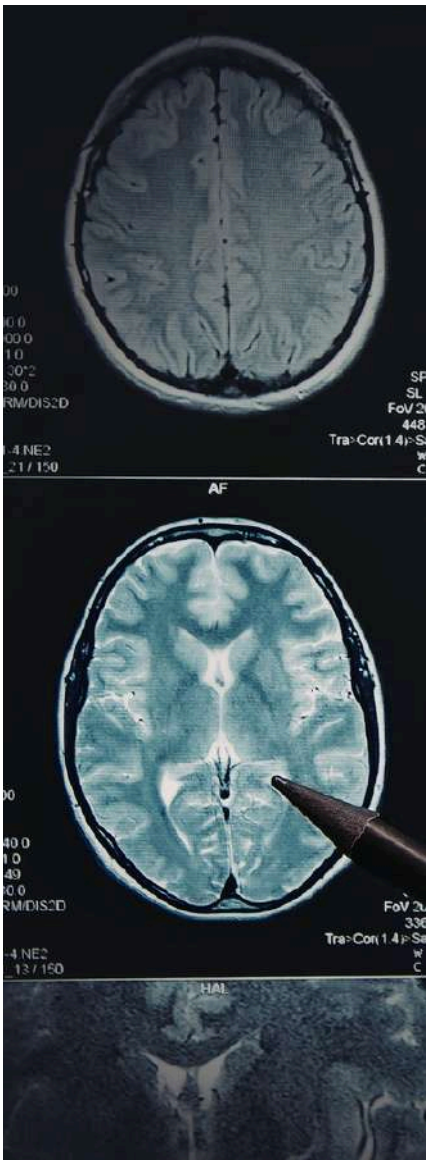
Cord blood gas analysis, particularly where both arterial and venous samples are available, is of particular importance. These results can assist in distinguishing between acute and more prolonged hypoxic events.

Where such data is incomplete or absent, the ability to draw firm

conclusions regarding timing is significantly reduced. Similarly, placental histology may provide insight into antenatal factors that could have contributed to the presentation.

Postnatal evidence, including MRI findings, neurological development, and longer-term outcomes, serves to confirm the nature and extent of the injury, but is generally less informative when determining when and how the injury occurred.

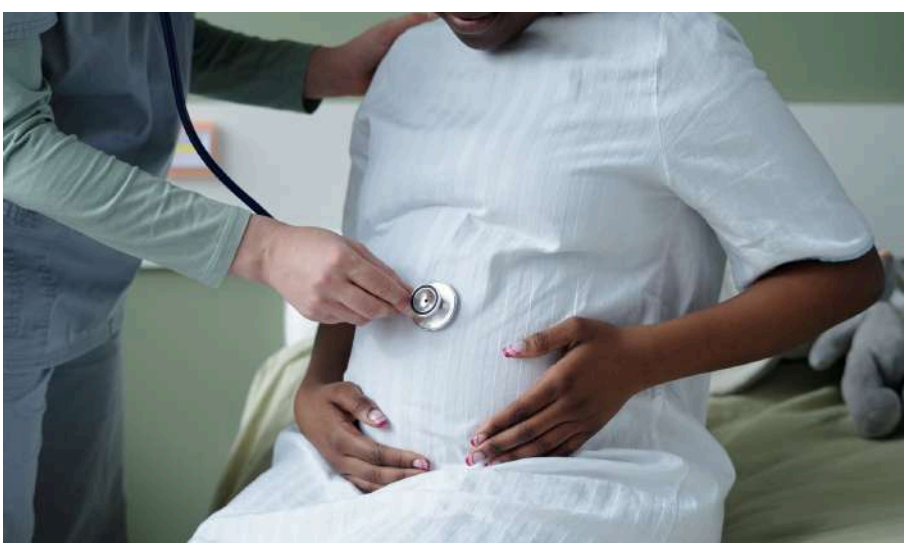
Taken together, the strength of a claim will often depend not on the volume of evidence, but on the quality and completeness of these key records, particularly those relating to the period immediately prior to delivery.



Expert Analysis

In cases involving alleged birth asphyxia, a neonatologist's role is necessarily limited to the period from birth onwards. They do not assess the standard of care provided during labour in isolation and will typically rely on obstetric and midwifery experts to address issues of breach occurring prior to delivery.

The neonatal expert instead focuses on the baby's clinical condition at birth and the immediate postnatal course. This includes a detailed review of the initial presentation, the extent and duration of any resuscitation required, and the baby's subsequent neurological progression. Particular attention is given to how the infant responded to intervention, as this can provide indirect but important insight into the severity and likely timing of the hypoxic insult.



The pattern of injury is also central to the analysis. This is informed by clinical observations, imaging - particularly MRI findings - and the overall trajectory of the child's development. The expert will consider whether the presentation is consistent with an acute, profound hypoxic event, a more prolonged period of compromise, or an alternative non-hypoxic cause.

Certain clinical indicators are often used as part of this reasoning. A baby who responds quickly to minimal resuscitation is unlikely to have experienced a significant or prolonged hypoxic episode. In contrast, the need for sustained and intensive resuscitation, particularly where recovery is delayed, is more suggestive of a substantial insult. These features are not determinative in isolation, but they form part of the broader evidential picture considered when addressing causation.

Strategic Takeaways for Solicitors

Several practical points emerge from this case which are directly relevant when assessing and progressing similar claims.

First, the analysis should begin with obstetric care rather than neonatal outcome. While the injury becomes apparent after birth, questions of breach will usually arise from the management of labour and the response to emerging concerns. Focusing prematurely on neonatal records risks overlooking the critical period in which the alleged failure occurred and may weaken any subsequent argument on causation.

Secondly, timing is often central to both breach and causation. . The intervals between the identification of risk, escalation, and delivery must be examined closely.

Even relatively short delays can be significant in the context of evolving foetal compromise, but their importance will always depend on the clinical picture at the time rather than the passage of time alone.

A further difficulty arises where key evidence is incomplete or missing. In particular, the absence of cord blood gas results or placental histology can materially limit the ability of experts to determine the timing and mechanism of injury. In such cases:

- the evidential position may be weakened for both parties; and
- it may not be possible to reach definitive conclusions on causation

Finally, it is important not to place undue weight on outcome alone. The presence of cerebral palsy or another significant injury does not, in itself, establish negligence. A successful claim will still require:

- a clearly identifiable breach of duty; and
- a demonstrable causal link between that breach and the injury sustained

Maintaining this structure in analysis helps ensure that cases are assessed on evidential merit rather than outcome-driven assumptions.

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Case Study 2: Consent, Medication, and Misinterpretation

This case concerns a baby born in a compromised clinical condition who required admission to the neonatal unit shortly after delivery. Prior to birth, the parents had signed a document indicating that they did not consent to certain interventions, specifically vaccinations and the administration of vitamin K.

Following delivery, the baby required medical treatment, including the administration of gentamicin, an antibiotic commonly used in neonatal care where there is a risk of infection. This treatment was given in the context of the baby's clinical presentation and in accordance with standard neonatal practice.

In the longer term, the child developed significant disabilities, including developmental delay, non-verbal communication, and reduced mobility requiring ongoing support.

The parents subsequently brought a claim alleging that treatment had been administered without their consent. Their position was that their earlier refusal extended beyond vaccines and vitamin K to encompass all medications. In addition, it was alleged that the administration of gentamicin had caused or contributed to

the child's condition.

A central issue in the case, therefore, was the interpretation of the consent documentation and whether it could reasonably be understood as a refusal of all medical treatment, as opposed to specific interventions.

Legal Issues

The legal issues in this case centre on the scope of consent and the question of causation.

In relation to consent, the key issue is whether the treatment provided fell outside the scope of what the parents had agreed to. The parents' position was that they had refused all forms of medical treatment for their child. However, the contemporaneous documentation recorded a refusal limited to specific interventions, namely vaccination and the administration of vitamin K. The distinction between a generalised belief and what was actually documented is critical. The court's assessment will focus on the written record and whether it clearly supports a broader refusal of treatment. In the absence of such evidence, it is unlikely that the administration of antibiotics would be

considered a breach of consent.

Causation presents a separate and equally important issue. While gentamicin is known to carry a risk of ototoxicity, including potential hearing loss, this risk is well recognised and carefully managed within neonatal practice through controlled dosing and monitoring of drug levels. Establishing that gentamicin caused or materially contributed to the child's condition would require clear supporting evidence.

In many cases, alternative explanations for the child's disabilities - particularly those related to the baby's condition at birth or underlying clinical factors - may be more probable. As such, even if concerns are raised about treatment, a successful claim will depend on demonstrating a credible causal link between the administration of the drug and the outcome, rather than relying on the mere possibility of harm.

Key Evidence

The evidential assessment in this case is centred on three core areas: the scope of consent, the clinical justification for treatment, and the manner in which the medication was administered.

The starting point is the consent documentation itself. The precise wording of any written record is critical, as the court will place far greater weight on what was explicitly documented at the time than on any subsequent interpretation. The key question is whether the refusal was clearly limited to specific interventions - such as vaccination and vitamin K - or whether it can reasonably be read as extending to all forms of treatment. Any ambiguity in the documentation will be scrutinised closely, but in the absence of clear wording supporting a blanket refusal, broader interpretations are unlikely to carry significant weight.

The clinical context at the time of treatment is equally important. Evidence relating to the baby's condition at birth, including signs of compromise or risk of infection, will inform whether the administration of antibiotics was necessary and appropriate. Where treatment is given in response to a clinically justified concern, this will significantly undermine any argument that it was administered improperly.

Finally, the details of drug administration must be examined. This includes the dosage given, whether appropriate monitoring of drug levels took place, and how clinicians responded to any abnormal results. In the case of gentamicin, adherence to established protocols - particularly in relation to dosing and monitoring - will be central to assessing whether the treatment was delivered safely.

Taken together, these strands of evidence determine both whether the treatment fell within the scope of lawful consent and whether it was capable of causing the harm alleged.

Expert Analysis

From an expert perspective, the analysis in this case is likely to be relatively straightforward. The central issue is not what the parents later believed they had refused, but what was actually recorded in the contemporaneous documentation and whether the treatment given was clinically indicated at the time.

A neonatal expert would first consider the scope of the documented refusal. If the records show that the parents declined vaccination and vitamin K, that does not, without more, amount to a refusal of antibiotics. Gentamicin is a

therapeutic drug used in the management of suspected neonatal infection; it is not comparable in purpose or function to either a vaccine or prophylactic vitamin K. The distinction is clinically and legally significant.

The expert would then assess the baby's condition at birth and the circumstances in which treatment was administered. If the infant was born unwell and required neonatal support, the use of antibiotics may be readily justifiable as part of standard management, particularly where there was a perceived risk of sepsis or other infection. In that context, the administration of gentamicin would be evaluated not as an isolated act, but as part of an urgent clinical response to the baby's presentation.

On that analysis, the expert is likely to conclude that the treatment was both clinically justified and consistent with the documented position on consent. The real weakness in the claim lies in the gap between the parents' later understanding of what they intended to refuse and the narrower refusal actually recorded in the notes.

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Strategic Takeaways for Solicitors

This case highlights several practical considerations when dealing with claims involving consent and alleged treatment-related harm.

First, contemporaneous documentation will almost always carry greater weight than retrospective accounts. The court will focus on what was recorded at the time, rather than what a party later believes or recalls. Where consent is documented as applying to specific interventions only, it will be difficult to extend that refusal to other forms of treatment without clear supporting evidence.

Secondly, allegations of lack of consent require careful framing. A refusal of particular treatments does not amount to a blanket refusal of all medical intervention. The distinction between specific and general refusal is critical, and claims that rely on broad interpretation without documentary support are unlikely to succeed.

In relation to causation, it is important not to overstate the risks associated with commonly used medications. While aminoglycosides such as gentamicin are known to carry potential side effects, including ototoxicity, these risks are well understood and managed within standard clinical practice. Establishing a causal link between the drug and the alleged injury will require robust and specific evidence,

particularly where appropriate monitoring and dosing protocols have been followed.

Finally, these cases often involve a divergence between the parents' perception of events and the clinical record. While that perception is relevant to the background of the claim, it must be distinguished from the legal test. The strength of the case will ultimately depend on whether the evidence supports a breach of duty and a causal connection to the injury, rather than the presence of a sincere but unsupported belief.

Cross-Case Lessons

When considered together, these cases highlight several recurring themes that are central to the assessment of neonatal negligence claims.

A consistent pattern is that many claims arise not from complex or controversial medical decisions, but from failures in process. Delays in recognising deterioration, failures to escalate concerns, and breakdowns in communication are far more commonly at issue than technical errors in treatment. These are often easier to identify but not always straightforward to link to outcome.

The relative weight of different types of evidence is also critical. Certain records carry significantly more evidential value than others.

In particular:

- contemporaneous timelines of events;
- CTG traces and their interpretation; and
- cord blood gas analysis

are often central to determining both breach and causation. By contrast, retrospective opinions that are not grounded in the underlying clinical data are unlikely to carry the same weight, particularly where key records are incomplete or missing.

Another important feature of these cases is the interdependence of expert evidence. Neonatal claims frequently span multiple disciplines, and it is rarely sufficient to rely on a single expert.

Depending on the issues in dispute, input may be required from:

- an obstetrician, to address care during labour;
- a neonatologist, to assess postnatal management and condition at birth; and
- a radiologist or other specialist, to interpret imaging and long-term impact

Without this combined approach, gaps in the analysis are likely to remain.

Finally, while breach of duty is often identifiable - particularly in cases involving delay or failure to act - the decisive issue is usually causation. Establishing that a different course of action would have altered the outcome, on the balance of probabilities, is frequently the most challenging aspect of the claim.

It is at this stage that cases are most likely to succeed or fail, and where the quality of both the evidence and expert analysis becomes critical.

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Key Takeaways for Solicitors

These cases illustrate the importance of adopting a structured and disciplined approach from the outset of any neonatal negligence claim.

At the pre-instruction stage, the priority should be to establish a clear and accurate timeline of events. This involves mapping the sequence of care from the initial presentation through to delivery and postnatal management, identifying precisely when key decisions were made and acted upon. At the same time, any gaps or inconsistencies in the records should be noted early, as these may later limit the ability to establish breach or causation.

When instructing experts, the focus should be on asking targeted and case-specific questions rather than seeking broad or general opinions. In particular, it is important to address the likely timing of the

injury, whether earlier intervention would have been expected to alter the outcome, and whether there are plausible alternative explanations for the clinical presentation. Clear and focused instructions are more likely to produce useful and defensible expert evidence.

As the case progresses, it is essential to challenge assumptions, particularly those driven by outcome. A poor clinical outcome does not, in itself, establish negligence, and cases should not be advanced on that basis alone. Instead, attention should remain on the key decision points within the clinical timeline and whether opportunities for intervention were missed.

Maintaining this level of discipline throughout the life of the claim helps ensure that it is built on a coherent evidential foundation, rather than retrospective interpretation or assumption.

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