**CLINICAL NEGLIGENCE**

**Lessons for all healthcare experts from a case of alleged obstetric negligence**

*OAJ v Dorset County Hospitals NHS Foundation Trust* [2025] EWHC 3345 (KB)

**OAJ v Dorset County Hospitals NHS Foundation Trust [2025] EWHC 3345 (KB) (18 December 2025)**

ChatGPT has identified in it no less than 74 lessons for experts reporting in clinical negligence cases. Not all seem to arise entirely from the judge's criticisms or comments but they constitute a useful *aide memoire* to read if you have not prepared a clinical negligence report for a while,

The case concerned a clinical negligence claim arising from severe brain injury sustained by a child before or around his birth. The preliminary issues were breach of duty and causation. It was alleged that the midwives had failed to refer the mother for obstetric assessment and provide appropriate foetal monitoring following bleeding associated with spontaneous rupture of membranes. It was further alleged that the consultant obstetrician had failed to recognise the significance of subsequent fresh bleeding and an abnormal cardiotocography trace, and had delayed arranging delivery by caesarean section. The defendant maintained that the care provided was reasonable and that, in any event, the injury had occurred before any alleged negligence.

The judge found no breach of duty by the midwives but concluded that the consultant obstetrician had been negligent in failing to recognise the significance of the recent bleeding and arrange sufficiently prompt delivery. However, the expert evidence persuaded the court that the claimant had suffered an acute profound hypoxic-ischaemic event lasting approximately 20–25 minutes, probably between 5.15 am and 7.50 am, before the relevant daytime CTG monitoring. The judge considered that the injury was probably caused by cord compression and that the damage had already occurred, or its course had been set, before the identified breaches.

Accordingly, although breaches of duty were established against the consultant obstetrician, they had not caused or contributed to the claimant's brain injury. The claim was dismissed.

**A. Independence, expertise and professional responsibilities**

1. Maintain independence from the pleadings. Identify the relevant clinical or technical issues, applicable standards and reasoned conclusions independently. The expert's task is not to validate each pleaded allegation, but to provide an objective opinion on the evidence and the applicable standard of care.

2. Remain within the limits of your expertise. Do not offer definitive opinions on another discipline's professional standards without an adequate basis. Distinguish matters within your expertise from those requiring evidence from another specialist and identify and qualify any opinion that crosses professional boundaries.

3. Distinguish professional standards from personal preference. Explain whether an opinion reflects an applicable professional standard, authoritative guidance, accepted practice or personal clinical experience. Where personal practice is relied upon, explain why it represents the relevant standard at the material time.

4. Do not allow the seriousness of the outcome to determine the assessment of care. Assess the conduct against the information reasonably available at the time, rather than through hindsight. A catastrophic outcome does not, by itself, establish that the care was negligent or that the most urgent intervention was required.

**B. Guidance, textbooks and scientific literature**

5. Apply professional guidance accurately to the facts. Quote professional rules and guidance faithfully, explain their scope and purpose, and identify the circumstances in which recommendations apply. Do not substitute a simplified formulation that changes a rule's meaning or assume that guidance concerning one clinical situation applies automatically to another.

6. Identify the status and relevance of guidance. Distinguish national guidance, local protocols, professional rules, textbooks, research papers and personal experience. Explain which source informs the relevant standard and why it applies to the circumstances at the material time.

7. Do not treat general warnings as universal requirements. A textbook's warning about a serious condition does not necessarily establish that a particular intervention is mandatory in every presentation. Explain how the recommendation applies to the specific facts, including the severity of symptoms, examination findings and other relevant circumstances.

8. Ensure that the evidence supports the opinion. Cite authoritative literature accurately and provide complete, contextual extracts where reliance is placed on particular passages. Verify that the source supports the proposition advanced rather than relying on a partial quotation or a general statement that does not address the circumstances in question.

9. Describe research findings accurately. Explain what published studies actually demonstrate, distinguish the authors' conclusions from your own interpretation, and avoid overstating the results. If the evidence is uncertain or the study does not directly address the issue, make that limitation clear.

10. Explain the limits of extrapolation. Animal experiments and laboratory studies may provide useful physiological evidence, but experts should acknowledge limitations such as sample size, experimental conditions, differences between species and the applicability of the findings to the individual case.

11. Use scientific literature proportionately. Do not present an experimental finding as definitive proof of what occurred in a particular patient. Explain how the research informs the opinion, what assumptions are needed to apply it and whether alternative interpretations remain consistent with the evidence.

12. Check the underlying data rather than relying solely on summaries. Where a conclusion depends on the interpretation of a graph, table, study or reported recovery rate, examine the original material where available. Confirm that the figures, timescales and conclusions have been accurately understood and represented.

13. Distinguish the existence of evidence from its evidential strength. A study may be relevant without being conclusive. Explain whether it supports a possibility, makes a mechanism physiologically plausible or provides stronger evidence for a particular conclusion.

**C. Factual accuracy, records and assumptions**

14. Distinguish evidence from inference. Separate contemporaneous records, witness recollection, agreed facts, disputed evidence and retrospective clinical hypotheses. Explain which facts are assumed, why particular evidence is preferred and how the conclusion would change if a disputed fact were not accepted.

15. Read and cross-check the primary records carefully. Reconcile the chronology with the clinical notes, witness evidence, investigation results and other experts' opinions. An overlooked entry can materially undermine an opinion on breach, urgency or causation.

16. Do not repeat an erroneous factual premise simply because it appeared in an earlier report. Check the underlying record independently, particularly where a disputed event affects the alleged breach, the timing of intervention or the proposed cause of injury.

17. Be scrupulously accurate in reports. Do not describe a history as having been taken, an examination as having occurred or a finding as having been recorded unless the evidence supports that statement. Distinguish express documentation from an inference based on usual practice or other records.

18. Identify assumptions expressly. If an opinion depends on the amount of blood lost, the duration of an event, the timing of an injury, the interpretation of a test or a particular clinical action, state the assumption and explain its significance.

19. Distinguish a patient's reported history from objectively observed findings. Neither should automatically displace the other. Explain how the two sources of evidence fit together, whether they conflict and what significance that conflict has for the opinion.

20. Explain how disputed facts affect the conclusion. Where different factual findings would produce different professional or causal conclusions, identify those alternatives expressly. Avoid presenting a conclusion as unconditional when it depends on the court accepting a particular version of events.

21. Correct inaccuracies expressly and assess their consequences. Acknowledging a factual error is important, but the expert must also consider whether it undermines other parts of the report. If a conclusion depended on the inaccurate statement, explain whether that conclusion remains justified.

22. Distinguish usual practice from what actually happened. An expert may infer that a clinician probably asked a question or performed an examination because it would ordinarily form part of practice. The expert must nevertheless identify that as an inference, not as an established fact, unless the evidence supports it.

**D. Investigations, findings and competing interpretations**

23. Distinguish what an investigation directly demonstrates from what must be inferred. Imaging, physiological monitoring, laboratory results and clinical observations may establish particular findings without necessarily establishing their cause, timing or significance.

24. Explain the limitations of each investigation. Identify what the test can and cannot establish, whether its findings are specific to a particular diagnosis, and whether more than one interpretation remains possible.

25. Do not confuse a finding with its interpretation. For example, identifying a particular pattern of brain injury on MRI does not necessarily establish whether it arose from one hypoxic event or multiple events, precisely when it occurred or the mechanism that produced it.

26. Distinguish agreement on one issue from agreement on another. Agreement that an injury exists does not establish agreement on its cause, duration, timing, severity or consequences.

27. Explain the significance and limitations of negative findings. Normal observations, reassuring monitoring or the absence of a particular pathological finding may support one conclusion without

excluding every alternative diagnosis. Explain both the evidential value and the limits of such findings.

28. Avoid treating the absence of evidence as invariably proving the absence of a condition. Consider whether the investigation was capable of detecting the condition, whether the relevant signs would necessarily have been present and whether the timing of the investigation affects its significance.

29. Integrate investigations with the full clinical or factual picture. Interpret individual results alongside the history, contemporaneous observations, subsequent events and other available evidence. Do not allow one result to dominate the analysis without considering its relationship to the rest of the evidence.

30. Distinguish the timing of an event from its mechanism. The evidence may establish a probable timeframe without establishing precisely how the injury occurred. State separately what can be concluded about timing, cause and mechanism.

31. Recognise the limits of retrospective reconstruction. Later investigations may permit a reasoned conclusion about what probably happened, but the passage of time and absence of contemporaneous evidence may prevent certainty. Explain where the evidence supports a conclusion and where uncertainty remains.

**E. Reasoning, hypotheses and uncertainty**

32. Set out the complete reasoning in the report. Important physiological, scientific or clinical explanations and assumptions should not first emerge during cross-examination. The reader should be able to understand how the expert reached the conclusion from the report itself.

33. Make the reasoning from physiology explicit. If an opinion on the timing or mechanism of an event depends on a proposed physiological process or recovery period, explain the underlying assumptions and how the available evidence supports them.

34. Distinguish possibility from probability. Showing that a mechanism could occur does not establish that it probably occurred in the particular case. Explain why the proposed mechanism is more persuasive than the alternatives, or acknowledge that the evidence cannot distinguish between them.

35. Test competing theories against the complete chronology. Ensure that the proposed timing, duration and consequences of an event are compatible with the clinical records, physiological evidence and practical circumstances.

36. Explain why one hypothesis is preferred. It is not enough to identify weaknesses in a competing theory. Demonstrate why the preferred explanation fits the evidence better, and address the principal difficulties with that explanation.

37. Do not allow another expert's opinion to become an untested premise. Examine the underlying evidence and relevant contrary opinions rather than simply adopting a conclusion from another discipline. Where your conclusion depends on another expert's analysis, identify that dependency and consider whether the underlying reasoning is sound.

38. Distinguish clinical experience from medico-legal experience. An expert should explain the evidential basis for a proposed mechanism, particularly where it is unfamiliar in clinical practice or has been encountered only in medico-legal cases. The fact that a theory is familiar from litigation does not establish its clinical probability.

39. Acknowledge uncertainty without abandoning reasoned conclusions. An expert may reasonably conclude that one explanation is more probable while accepting that alternatives cannot be excluded. The important requirement is to distinguish the preferred conclusion from what remains uncertain.

40. Do not claim greater precision than the evidence permits. Estimates of timing, duration, physiological recovery or the relative contribution of different mechanisms should reflect the quality of the evidence and the limits of the available methods.

41. Separate established conclusions from possible explanations. An expert should state what the evidence establishes, what is inferred, what remains hypothetical and why. A plausible explanation should not be presented as a proven mechanism.

42. Explain the consequences of uncertainty. If it is not possible to determine precisely when an event occurred or what caused it, explain whether that uncertainty affects the opinion on breach, causation, prognosis or another material issue.

**F. Evidence from other experts and multidisciplinary working**

43. Respect the boundaries between specialist disciplines. Radiological evidence may inform the proposed mechanism of injury, but should not automatically determine a neonatologist's conclusion if alternative interpretations remain possible. Similarly, a specialist should not determine another profession's standard of care without an adequate basis.

44. Engage with the underlying reasoning of other experts. Do not simply adopt another expert's conclusions because they fall within that expert's specialty. Understand the material findings, assumptions and limitations on which the conclusion rests, and explain how they affect your own opinion.

45. Ensure all relevant reports are exchanged before joint discussions. Experts cannot properly engage with competing evidence if material reports from the other side have not been made available. The parties and experts should ensure that the material needed for an informed discussion is available in good time.

46. Ensure that joint reports genuinely engage with opposing evidence. Identify agreements and disagreements clearly, resolve material factual discrepancies where possible and explain any remaining differences. A joint report should not simply reproduce earlier opinions or perpetuate an error that the other expert has expressly identified.

47. Address material inconsistencies between experts. If experts disagree on a factual premise, scientific finding, clinical interpretation or causal mechanism, explain the nature of the disagreement and its significance. Do not disguise a substantive difference through vague or ambiguous language.

48. Reconsider conclusions when new evidence emerges. If cross-examination, a joint discussion or another expert's report reveals that an earlier assumption was wrong, revisit the conclusions that depended on it. Acknowledging an error is not enough if the overall opinion remains unchanged without justification.

49. Avoid allowing agreement on a limited issue to create false consensus. Experts may agree on the existence of an injury while disagreeing about its mechanism, timing or cause. Record the scope of agreement accurately and identify the questions that remain unresolved.

50. Explain the limits of reliance on other specialists. Where an expert defers to another discipline on an issue, make clear what is being deferred, why it lies outside the expert's expertise and whether the conclusion depends on the other specialist's opinion.

**G. Professional standards, breach and changing circumstances**

51. Separate the factual question from the professional judgment. Whether a patient reported a particular symptom is distinct from whether the subsequent assessment made referral or intervention necessary. Establish the factual basis before applying the relevant professional standard.

52. Explain the alleged breach precisely. Identify what should have been done, by whom, when and why the applicable standard required it. Avoid general assertions that care was inadequate without identifying the act or omission and its clinical significance.

53. Distinguish clinical risk from the threshold for intervention. The existence of a risk does not automatically establish that referral, continuous monitoring or immediate delivery was mandatory. Explain how the degree of risk, the available findings and the relevant guidance informed the required response.

54. Assess the clinical position at each relevant time. An assessment that was reasonable on admission may cease to be sufficient when new symptoms or signs, abnormal monitoring or other significant changes arise. Identify what information was available at each stage and what action was then required.

55. Explain the significance of changing evidence. Do not allow an initially reassuring assessment to determine the analysis of subsequent events. Reassess the professional obligations when the clinical or factual picture changes materially.

56. Differentiate the need for intervention from its urgency. The fact that an intervention is indicated does not necessarily establish that it must be undertaken immediately or at the highest level of urgency. Explain the relevant definitions and apply them to the circumstances at the material time.

57. Avoid retrospective reasoning from the eventual outcome. A poor outcome does not establish that earlier escalation was required; equally, a reassuring outcome at an earlier stage does not prove that the assessment was adequate. Evaluate the decision against the information reasonably available when it was made.

58. Apply guidance to the circumstances it actually addresses. Identify the relevant recommendation, its purpose and the conditions to which it applies. Explain why it is applicable to the particular patient and clinical situation, rather than relying on its wording in isolation.

**H. Causation and counterfactual analysis**

59. Separate breach from causation. A decision may have been required because of a significant risk even if that risk did not ultimately cause the injury. Conversely, a plausible explanation for the injury does not establish that a particular breach caused it.

60. Analyse causation as a complete chain. Address not only what should have been done, but what would probably have happened if it had been done, when the relevant intervention would have occurred and whether it would probably have prevented the injury.

61. Consider the likely consequences of referral or intervention. Do not assume that referral would automatically have resulted in some particular course of action. Explain what the clinician would probably have done under the applicable standard and circumstances.

62. Assess alleged failures of monitoring by reference to the likely sequence of events. Consider what monitoring would probably have shown, when abnormalities would have become apparent, what action would have followed and whether some other intervention could realistically have occurred before the injury.

63. Explain the causal significance of timing. If the injury is thought to have occurred before a particular investigation or clinical decision, explain how that affects the allegation that the later event caused it. Conversely, if the timing is uncertain, identify how that uncertainty affects the causal conclusion.

64. Test the proposed mechanism against the clinical outcome. Consider whether the proposed event, its duration and the recovery period are consistent with the investigation findings, physiological results and condition at the relevant time. Where the evidence cannot distinguish reliably between mechanisms, say so.

65. Reassess causation when an assumption changes. If cross-examination establishes that an intervention would have occurred later than originally assumed, that monitoring would not have been continuous, or that the proposed mechanism is less certain, reconsider whether the alleged breach would probably have made a difference.

66. Distinguish the cause of the original injury from subsequent injury. Where a process may have several stages, explain which injury is attributed to the initial event and whether later physiological processes may have caused additional damage. Do not assume that the full extent of an eventual disability arose at the moment of the initial insult.

67. Avoid unsupported apportionment. If the evidence cannot reliably distinguish the contribution made by different mechanisms or stages of injury, do not assign precise proportions without an evidential basis. Explain the limits of what can be determined.

**I. Reports, oral evidence and cross-examination**

68. Ensure that the report contains the essential reasoning. Reports should set out the factual basis, applicable standards, supporting evidence, contrary evidence, assumptions and reasoning leading to the conclusions. They should not depend on explanations that are supplied only when challenged in court.

69. Answer questions directly. Keep oral evidence focused on the question asked, distinguish established conclusions from possibilities and avoid digressions that obscure the reasoning. Additional explanation should clarify the answer rather than evade the question.

70. Make appropriate concessions. Experts should accept propositions that are justified by the evidence, including the limits of their expertise, the significance of contrary findings and weaknesses in their original reasoning. Fair concessions strengthen the credibility of the remaining opinions.

71. Explain the effect of concessions on the overall opinion. If a concession undermines a factual assumption or a proposed causal chain, explain whether and how the final conclusion changes. Do not acknowledge a weakness while retaining an unchanged conclusion without reasoned justification.

72. Maintain consistency between evidence and conclusions. If an expert considers that a serious injury occurred during a period when monitoring was absent, the expert should explain whether monitoring during that period could have identified compromise and changed the outcome. Apparently contradictory propositions must be reconciled.

73. Be clear about the degree of confidence in each conclusion. Distinguish firm conclusions, opinions expressed on the balance of probabilities, plausible possibilities and matters that cannot be determined. Do not use confident language that exceeds the strength of the supporting evidence.

74. Correct the record when an earlier statement is inaccurate. If an expert discovers that a report misstated a fact, research finding or another expert's opinion, the error should be corrected clearly and promptly, with an explanation of any consequential changes to the reasoning.

***Overarching lesson***

The central lesson across all disciplines is that the value of expert evidence lies in the quality of its reasoning, not the confidence with which its conclusions are expressed. A defensible opinion should be independently formed, grounded in verified facts and accurately interpreted evidence, transparent about assumptions and uncertainty, and tested against competing explanations.

Experts must distinguish what the evidence establishes from what it merely suggests; explain why their preferred conclusion is more probable than the alternatives; respect the limits of their expertise; and reconsider their conclusions when the factual or scientific basis changes. Where the evidence cannot establish the precise mechanism, timing or causal contribution, that limitation should be stated openly rather than concealed behind an apparently definitive opinion.