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Shared Insights

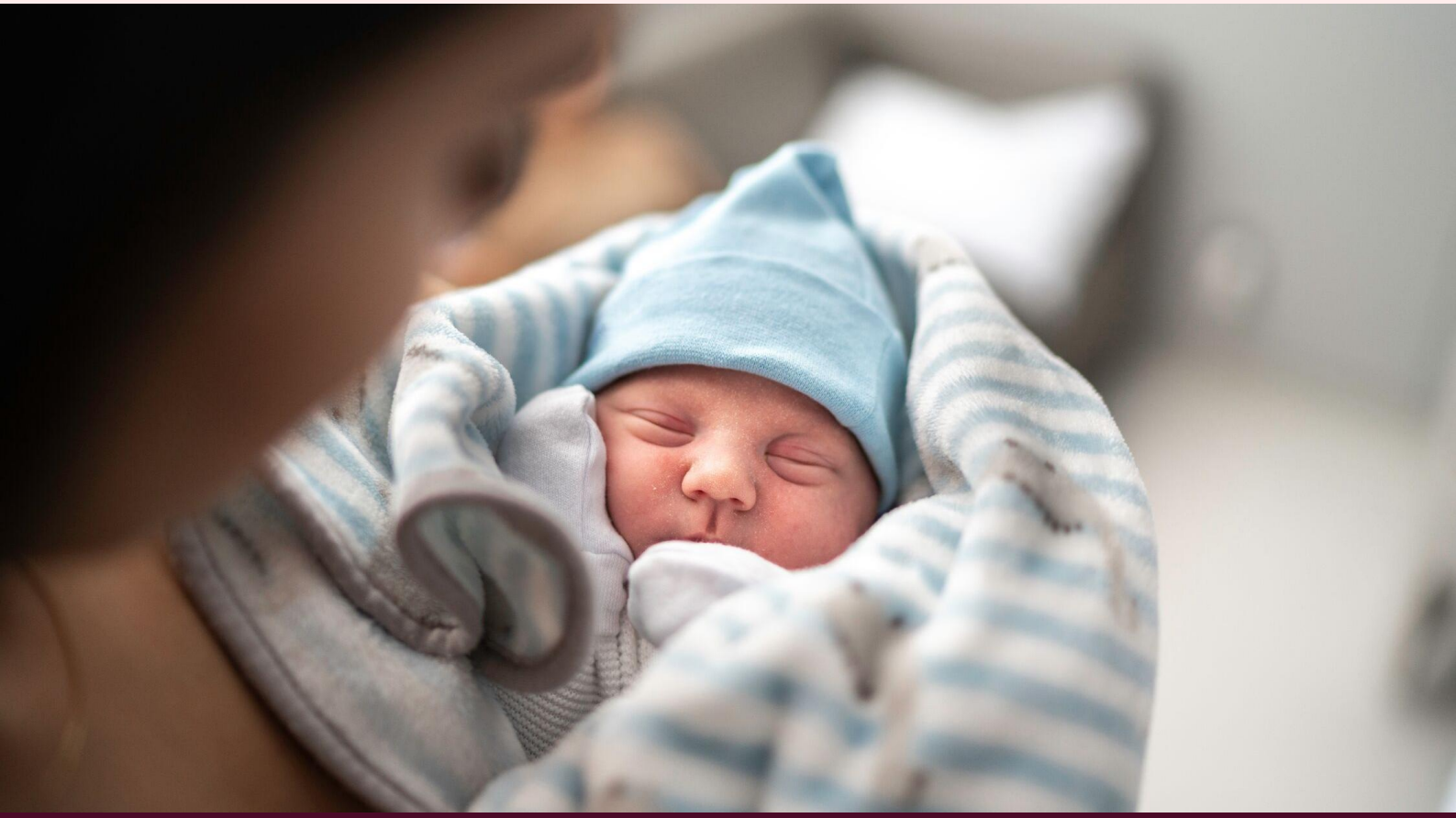
Maternity Forum: Birthing outside of guidance

Panel of Speakers

Kelly Buckley – Partner, Browne Jacobson (Chair)
Rachael Bose – Senior Associate, Browne Jacobson
Heather Simmonds-Copete – Research Officer and Peer Supporter, Birth Trauma Association
Floretta Cox – Consultant Midwife, University Hospital of Leicester NHS Trust
Elizabeth Swift – Consultant Obstetrician, University Hospital of Leicester NHS Trust

BIRTH TRAUMA ASSOCIATION

NHS University Hospitals of Leicester NHS Trust



Browne Jacobson

Introduction

This session focused on how to support staff to provide safe clinical care to birthing people who choose 'birthing outside of guidance', (sometimes also described as birthing off pathway' or 'birthing choices'), meaning that they opt for a birth that falls outside of the current recommendations or clinical guidelines. This includes 'free birthing'.

We appreciate that however described, 'birthing outside of guidance' can be a highly emotive topic for both birthing individuals and healthcare providers. We know birthing people may have strong preferences for how they want to give birth, sometimes diverging from recommended guidelines or care pathways. We acknowledge the challenges, which can lead to tension between the desire for patient autonomy and healthcare professionals' responsibilities to ensure safety according to established protocols.

Contents

In this session, we heard legal, patient and clinician perspectives and discussed a range of issues including:

- The legal risks associated with 'birthing outside of guidance'.
- Common pitfalls.
- Best practices during planning and supported decision-making processes.

The session was chaired by Browne Jacobson's Kelly Buckley. Rachael Bose of Browne Jacobson covered the legal framework and potential issues arising from decisions to 'birth outside guidance'.

We were delighted to be joined by Heather Simmonds-Copete, who shared her powerful personal story of birth trauma and the work she now does to support others through the Birth Trauma Association and Floretta Cox and Elizabeth Swift of University Hospitals of Leicester NHS Trust who gave an account of their tailored support for patients in these circumstances. They shared their practical experience of providing a dedicated service for these patients and how to keep communication open to support achieving the best outcome for all.

Given the time limitations, our session did not deal with emergency situations when 'birthing outside of guidance' or the issue of capacity.

We would like to thank our speakers for enriching our understanding with their diverse experiences and knowledge.

How we can help

This session highlighted the importance of clear communication and facilitating supported decision making through informed consent.

We provide practical training to support organisations and clinicians to improve consent and supported decision-making processes and have developed a virtual training bundle, delivered by Browne Jacobson's risk management and maternity experts, to empower healthcare organisations and clinicians with the knowledge to handle consent more effectively, reducing legal risks and improving patient care.

This paid for on-demand webinar includes insights, lectures and case studies. If you would like more information about the training package you can find it here

Alternatively, please contact:

Rebecca Coe or Amelia Newbold.

The legal perspective

Rachael Bose – Senior Associate,
Browne Jacobson

Overview

From a claim's perspective, nationally, obstetric claims made up 12.8% of the number of new claims received in 2023/2024, but this accounted for 57% of the total estimated value of claims against NHS Trusts in 2023/2024 (approximately £6.6 billion). Annual report and accounts 2023/24.

Whilst every case is different, the following clinical themes are often present:

- Failures/delays in escalating concerns leading to delays in delivery.
- Errors in fetal heart monitoring (CTG).
- Documented plans for review not being actioned.
- Lack of situational awareness.
- Shortcomings in the process to obtain consent.
- Shortcomings in communication and record keeping.

The issues most likely to arise in 'birthing outside of guidance' and the main focus for today relate to consent, communication and record keeping.

'Birthing outside of guidance'

The phrase 'birthing outside of guidance' typically refers to situations where a birthing person opts for treatment that falls outside standard medical recommendations or clinical guidelines. This covers a broad range of circumstances from reducing the amount of fetal monitoring to maternal requests for Caesarean section to planning for a VBAC delivery at home.

The most common themes identified by the recent MNSI Briefing: Birthing outside of guidance are refusing an induction of labour and requests for VBAC at home.

Asking 'why?'

It is important to understand why the birthing person chooses to 'birth outside of guidance' and how healthcare professionals can support them to improve outcomes and the experience of birthing persons and babies.

There are many reasons why people choose to 'birth outside of guidance'. This includes a desire for autonomy, tokophobia (extreme fear of childbirth), a previous traumatic birth experience, perceived control / safety concerns, personal or cultural preferences or mistrust of the medical system.

'Birthing outside of guidance' can also encompass a wide range of situations from free birthing without the assistance of any registered health professional to maternal requests for a caesarean section when one is not 'medically indicated'.

Current themes in 'birthing outside of guidance' include reducing the amount of fetal monitoring, declining examinations during the intrapartum period, opting not to have an induction of labour against advice, maternal requests for caesarean section and the use of a Doula or other traditional / non-licenced birth attendant in place of a licenced midwife or obstetrician.

The legal framework

Of particular relevance to these scenarios is the law around informed consent. Rachael discussed the case of Montgomery v Lanarkshire which aligned the law with guidance towards a patient-centred standard.

This is also covered in detail in our recent Shared Insights session on Consent click here to read that note.

In Montgomery, the Supreme Court held that doctors must disclose all "material risks" defined by reference to what a reasonable patient in that person's position would find significant. In particular:

It highlights the importance of patient autonomy: A Clinicians' duty is to *inform and respect* the competent birthing person's decisions. Under Montgomery, they should be told of reasonable alternative treatment options and the material risks. The consent process must centre on what matters to the patient.

There is a duty to share information: GMC guidance on Decision making and consent states clinicians must "find out what matters to patients so they can share relevant information" about benefits/harms of options and reasonable alternatives". Discussions should be patient-tailored, explaining recognised risks and how individual factors affect ***them***.

It defined legal responsibilities: A competent birthing person has the right to accept or refuse treatment including their mode and location of delivery. Practitioners must respect these rights and must not coerce. If harm occurs, focus may turn to what information had been provided that prompted them to come to their decision.

It leaves us with the need to balance safeguarding against autonomy: Both UK law and professional codes distinguish between lawful refusal and situations warranting safeguarding. In general, an adult's informed choice to birth outside of guidance, including free birthing, does not itself trigger mandatory safeguarding action, unless there are signs of incapacity or risk to the child after birth. There should not be any threats of legal action solely arising out of the birthing person's choice nor should a Trust refuse all aspects of care.

Emphasis is on supporting women: Even when a decision such as free birthing is made, clinicians should maintain engagement. Midwives and doctors should "unravel the complex reasons" behind that choice and offer continued antenatal and postnatal care. The NMC Code requires treating women with kindness, respect and dignity, even if their choices differ from staff preferences. The RCOG and NMC acknowledge birthing choices such as free birth occur and must be responded to respectfully.

Clinical guidance

All authoritative guidelines recognise maternal autonomy. NICE Caesarean Section Guidelines (NG192) recommend clinicians should discuss the request in detail including the birthing person's reasons for the request, benefits/risks, alternative options and importantly – to document these discussions fully.

If, after informed discussion, the birthing person still makes their request to birth outside of guidance, that choice should be respected and supported.

If the request is driven by severe fear (tokophobia) or other severe anxiety, then offering a referral to the perinatal mental health team is advised.

There is already specific guidance for circumstances that fall outside the standard guidelines such as the RCOG's Planned Caesarean Birth (Consent Advice No. 14) | on what to do should a birthing person request a Caesarean section even when not medically indicated.

These guidelines have a focus on shared decision making with the birthing person ensuring discussions are tailored to that individual and the importance of recording the consent process.

Practitioner and Trust responsibilities

It is important to actively listen to women's concerns and essential to understand their fears, preferences, and past experiences to provide tailored support. This should be followed up with unbiased, comprehensive information on all birth options. This includes detailed explanations of the benefits and risks associated with each, ensuring women can make informed decisions.

Respecting Autonomy: Respecting each birthing person's right to choose their mode of birth is fundamental. Whether it's supporting a request for a Caesarean section or facilitating a freebirth, the guidance is clear that the approach should be without judgement, legal threats, or denial of care.

Supporting Women: Engagement doesn't end with the decision. There must be an offer of continuous care and support throughout all stages—antenatal, perinatal, and postnatal."

Treating all women with kindness and respect, regardless of their birth choices, is essential. This approach fosters trust and supports a positive birthing experience which might mitigate the risks of a complaint or litigation.

Risk Awareness: Trusts should educate staff to ensure they understand the legal position: no policy may unlawfully deny a request without medical justification. However, Trusts also have a duty to ensure safe practice. This means offering timely Caesarean to those who request it, and conversely, making clear the risks of a delayed induction or unassisted birth.

Clinicians must balance respect for choice with their responsibility to patient safety.

Team Roles: One way to do this is by involving senior staff early in the process when a complex birth choice is made, as advised by NICE guidelines. This ensures that adequate resources and expertise are available.

Documentation and risk management requirements

In some scenarios competing clinical demands can make detailed record keeping difficult, but thorough record-keeping and following guidance can mitigate both clinical and litigation risk.

When faced with scenarios such as these, it is vital to document every discussion in detail – why choices were offered or declined, information given, and the patient's questions and decisions. Include that the birthing person was informed of the material risks of their choice and alternatives. The GMC explicitly requires accurate recording of the information exchange and decisions.

Use of leaflets and other resources: It is often useful to have information provided in leaflet form to take away and consider which may prompt questions enabling more informed discussion at any follow-up appointments. There are also other resources available to ensure understanding such as translation apps. There is little to be gained by having a detailed and complex discussion with a patient in a language that they might not understand.

Consent Forms: You can use consent/refusal forms where appropriate as an aide-memoire, but do not rely on them alone. A signed form is not a substitute for meaningful dialogue. Ensure the record makes clear that consent was informed (or refusal documented) and include time, date, names of staff present.

Incident Reporting: If a birthing person departs from Trust plans (e.g. stops attending appointments or explicitly plans a freebirth), consider whether to flag this through internal risk registers so senior staff can review. Any adverse outcome should be promptly reported via Trust incident processes.

E**scalation Logs:** Document referrals to mental health or safeguarding services, even if not pursued. Note any signposts to support services and objections raised by the patient.

Communication and consent strategies

Patient-Centred Discussion: Adopt an empathetic, non-judgemental approach, encouraging the patient to share their fears and values. Listen actively and validate feelings, regardless of personal views.

Tailored Information: Use clear language and visual aids (e.g., risk charts, procedure diagrams) to aid understanding. Verify understanding by asking the patient to repeat the information; correct any misunderstandings. Use translation services and apps to tailor not just the contents of the information provided but the way in which it is communicated.

Balanced Explanation: Outline both maternal and fetal risks for vaginal vs. Caesarean delivery, tailored to their specific situation. Discuss both common and rare but serious risks and explain emergency procedures for freebirth. Information is intended to inform, not scare or coerce. Explain rarer but serious risks such as uterine rupture in VBAC and how management in a home setting will differ from that in a hospital. Explain scenarios when an emergency could occur and how it would be handled (ambulance, hospital transfer).

Offer Alternatives. Studies show that a lot of decisions outside guidance stem from a place of anxiety or a drive for autonomy. Discuss anxiety-reducing options such as psychological support or alternative birthing locations if safe. Highlight that choosing support options does not compromise overall decision-making autonomy.

Reinforce Autonomy: Remind them of their ultimate decision-making power and that there is no universally "right" medical decision. Ensure they are aware of the support available for any chosen option. Emphasise that accepting some support or having alternative arrangements in place should things not go to plan does not negate their overall choice. Most importantly, emphasis should be placed on respect and understanding with the goal of shared decision-making and safer outcomes.

Final Confirmation: Confirm the final decision in writing using a consent form and make detailed notes to document informed choice. Communicate any plan changes to all relevant team members (obstetric, anaesthetic, paediatrics).

Rachael Bose
Senior Associate
+44 (0)330 045 2436
rachael.bose@brownejacobson.com

The patient perspective

Heather Simmonds-Copete –
Research Officer and Peer Supporter,
Birth Trauma Association

Heather bravely shared her own traumatic birthing experience and how this has shaped her journey. She became a peer supporter then a research officer for the Birth Trauma Association, a charity providing free empathy-based peer support to birthing people (and partners) who have suffered birth trauma.

Heather reflected that 'birthing outside of guidance' might conjure up images of free birthing with no medical assistance, but in her experience, it is much wider than that, including refusal of vaginal examinations (VEs) and fetal monitoring. Critically, she highlights that birthing people often decide to 'birth outside of guidance' because they are scared and confused and/or have suffered birth trauma in the past. Maternity services across the country are in crisis and the negative press coverage also affects birthing peoples' decisions and choices. It is not only a physical choice to 'birth outside of guidance' but a psychological and emotional one too.

There are a multitude of reasons why women choose to decline certain procedures which may include that they would trigger memories of traumatic personal experiences such as sexual assault, previous traumatic birth, fear of hospitals and a fear or labour itself (tokophobia).

It is so important that clinical staff supporting birthing people explore the 'why' and offer an opportunity to discuss the available options.

Heather gave some real-life examples of the effects of support (or lack of) for birthing people who ask about 'birthing outside of guidance' both of which highlight the importance of finding ways to achieve supporting women in having safe and better births.

The first example related to a woman who wanted to birth at home because of a previous avoidable traumatic experience in labour. The hospital concerned stood firm on the decision that a home birth was not safe because of risk factors such as a raised BMI. The woman ended up giving birth in hospital which was re-traumatising.

The second is a positive example of a woman who was anxious about having vaginal examinations (VEs). The hospital worked with the woman to make a supportive and effective care plan which enabled her to undertake her own VEs to determine dilation; and also made a plan as to what to do if labour did not progress. The woman felt listened to and cared for and had a good outcome, with the baby delivered safely.

In Heather's experience, taking the time to explore with empathy the underlying reasons for decisions to 'birth outside of guidance' will help women make the best informed decisions for them and help staff find safe ways of respecting those decisions.

Discussion

Is there is anything staff can do to protect themselves from litigation if things go wrong?

Kelly confirmed that from a legal perspective, each case will need to be taken on its merits. There is no specific pathway to follow in terms of communication with patients. If staff have concerns, we advise clinicians to seek advice from colleagues and/or a Trust's legal team at an early stage.

Good, clear, contemporaneous documentation of the discussions throughout the planning stages is key to evidence informed consent throughout. In particular:

- Try and keep dialogue open between clinicians and patients choosing to 'birth outside guidance'.
- Discuss and document all material risks.
- Follow up by sending the patient detailed individualised care plans and/or, where appropriate, a record of discussions in writing.

Is it necessary to have a signature section on the birth plan to acknowledge the information and agreement or is it sufficient to say birth plan agreed and sent

Ideally, it would be good to have the patient's signature on the birth plan, but the notes should also document the ongoing discussions about material risks and reasonable alternatives, and these should be re-visited and discussed at all the antenatal clinic appointments, again documenting these discussions.

Language barriers can sometimes present challenges. Some birthing people who do not speak English prefer using partners/ family members instead of language line whereas local policy recommends using language line. Any advice to address this?

There are a number of antenatal Apps and information leaflets which are available in a variety of different languages and can be very useful when caring for birthing people who do not speak English. When having discussions with someone whose first language is not English, use of an interpreter is the gold standard.

Using family members to translate is not recommended. Medical terminology may not be easily translatable on an ad hoc basis.

What do you do if a home birth cannot be safely accommodated because there are not enough staff?

There is not an absolute duty to provide care at home for all women who request a home birth. The legal duty is for the Secretary of State to provide a reasonable system of provision of NHS services, i.e. there is no absolute right of any individual patient to demand a particular service is provided to them in a particular way on a particular day, provided the overall system of NHS care made available to them is reasonable. Practically, however, communication is again key. Birthing people need to be aware in advance of the possibility that if the home birth team is not available, safe care will need to be provided at the hospital. If this is refused, this needs to be documented in detail and the option for the birthing person to change their mind and access care in hospital at any time reinforced.

Can you recommend any training we can go on to help guide us on how to have these sensitive discussions.

The informed decision making training through the Personalised Care Institute is really good and only takes about 30 minutes.

Birthrights offer training to Trusts/MDT.

The Birth Trauma Association has some videos on its website and also provides training to teams – please email Heather if you would like to discuss what is available: heather@birthtraumaassociation.org

Contact us

Lorna Hardman
Partner

+44 (0)115 976 6228
lorna.hardman
@brownejacobson.com

Nicola Evans
Partner

+44 (0)330 045 2962
nicola.evans
@brownejacobson.com

Kelly Buckley
Partner

+44 (0)115 908 4867
kelly.buckley
@brownejacobson.com

Rachael Bose
Senior Associate

+44 (0)330 045 2436
rachael.bose
@brownejacobson.com

Amelia Newbold
Risk Management lead

+44 (0)115 908 4856
amelia.newbold
@brownejacobson.com

Rebecca Coe
Partner

+44 (0)115 948 5606
rebecca.coe
@brownejacobson.com

For further information about any of our services, please visit
brownejacobson.com