

MALPRACTICE 2026

International Conference on Medical Malpractice

Obstetrics & Gynecology

8 - 11 OCTOBER 2026

Istanbul, Türkiye & Online

Sismanoglu Megaro

ABSTRACT BOOK

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Clinical Practice

Legal Responsibility

Patient Safety

MALPRACTICE 2026

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PROGRAMME AT A GLANCE

The full scientific programme, with all presentation times, chairs and speakers, is published separately and on the conference website. All times are Istanbul time (UTC+3).

THURSDAY 8 October	FRIDAY 9 October	SATURDAY 10 October	SUNDAY 11 October
08:00 Registration & Welcome Coffee	10:00 Keynote 3 · Schiffrin	10:00 Keynote 6 · Giannubilo	10:00 Keynote 9 · Mozayani
10:00 Opening Ceremony	10:30 Keynote 4 · Vanezis	10:30 Keynote 7 · Vieira	10:30 Session VI · Systems of Care
11:00 Keynote 1 · Madazli	11:00 Coffee Break	11:00 Coffee Break	12:10 Lunch & Poster Viewing
11:30 Keynote 2 · De La Luz- Martínez	11:30 Session II · Forensic Expertise	11:20 Session IV · Surgical and Procedural Complications	13:00 Workshop · AI-Based Cardiotocogram Assessment
12:00 Lunch & Poster Viewing	13:10 Lunch & Poster Viewing	13:00 Lunch & Poster Viewing	14:30 Closing Ceremony
13:30 Panel · Sexual Therapy and Genital Esthetics	14:20 Keynote 5 · Freeman	14:00 Keynote 8 · Yenisey	
14:45 Coffee Break	14:50 Session III · Prenatal Diagnosis and Wrongful Birth	14:30 Session V · Medical Law and AI	
15:15 Session I · Injury and Death Around Birth			
17:00 Welcome Reception			

INVITED LECTURES

KEYNOTE LECTURES

Nine keynote lectures are delivered across the four days.

- 1 Rıza Madazlı**
Professor of Obstetrics & Gynecology · Türkiye
Physician's nightmare: malpractice claims
- 2 Ixchel De La Luz-Martínez**
Expert Witness in Forensic Genetics & Laboratory Medicine · Mexico
Trapped in the transnational void: four DNA tests, institutional revictimization, reproductive malpractice, and the human cost of cross-border surrogacy
- 3 Barry Schiffrin**
Maternal-Fetal Medicine Specialist · United States
The voice of the fetus before and after birth
- 4 Peter Vanezis**
Professor of Forensic Medical Sciences · United Kingdom
Women's health — a forensic pathologist's perspective
- 5 Michael Freeman**
Forensic Medicine & Epidemiology · United States
Causal analysis in birth and neonatal injury malpractice claims utilizing epidemiologic data and methods
- 6 Stefano Raffaele Giannubilo**
Professor of Obstetrics & Gynecology · Italy
Behind the CTG trace: intrapartum fetal monitoring, timing of delivery and medico-legal causation
- 7 Duarte Nuno Vieira**
Professor of Forensic Medicine & Medical Law · Portugal
Navigating medical malpractice: the European guidelines for evidence-based and equitable assessment
- 8 Feridun Yenisey**
Emeritus Professor of Criminal Law & Criminal Procedure · Türkiye
From clinical decisions to legal responsibility
- 9 Ashraf Mozayani**
Professor of Forensic Toxicology · United States
When the laboratory fails the patient: specimen misidentification, reporting errors, and the laboratory director's role in patient safety and malpractice prevention

ORAL ABSTRACTS

SCIENTIFIC SESSION I

*Maternal, Fetal and Neonatal Injury and Death: Forensic Reconstruction of Causation***O-01** MAL2026/ABS/029**The causal architecture of perinatal death: a forensic case series of fetal and neonatal fatalities****Matteo Scopetti**¹, Martina Padovano^{2,3}, Anna Claudia Caruso², Damiano Marchesini², Federico Battipaglia⁴, Carmen Sementa⁵, Alessandro Santurro⁴, Vittorio Fineschi²¹ Department of Medical Surgical Sciences and Translational Medicine, Sapienza University of Rome, Rome, Italy² Department of Anatomical, Histological, Forensic and Orthopaedic Sciences, Sapienza University of Rome, Rome, Italy³ Forensic Science Police Service, Directorate for the Forensic Science Police and the Cyber Security, Department of Public Security, Rome, Italy⁴ Department of Medicine, Surgery and Dentistry, University of Salerno, Baronissi, Italy⁵ Forensic Medicine Unit, AORN San Giuseppe Moscati Hospital, Avellino, Italy

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Background and aims: Perinatal death is frequently described in terms of its terminal hypoxic-ischemic mechanism, whereas forensic assessment requires reconstruction of the upstream biological event and evaluation of whether healthcare management materially contributed to the fatal outcome. The present study aimed to characterize the causal architecture of perinatal death and assess how integrated post-mortem analysis informs judgments of causation, preventability, and professional responsibility.

Methods: A retrospective review was conducted on 30 fetal and neonatal fatalities subjected to forensic or medico-legal investigation. Maternal, obstetric and neonatal records, cardiotocographic and imaging data, autopsy findings, placental and umbilical-cord pathology, histology, timing of death, and final medico-legal conclusions were comparatively analyzed. Mother and fetus were considered a single causal unit when both outcomes resulted from the same catastrophic maternal event. Cases were classified according to the predominant upstream pathophysiological mechanism rather than the terminal mode of death.

Results: Despite substantial clinical heterogeneity, most fatalities converged on hypoxic-ischemic compromise through distinct causal pathways. Recurrent patterns included placental insufficiency and vascular pathology, placental or umbilical-cord thrombosis, mechanical cord abnormalities, acute placental abruption, maternal hemodynamic or cardiorespiratory collapse, and inflammatory/infectious disease. A distinctive mother-fetus event demonstrated sequential causation from fatal maternal intracranial hemorrhage due to vertebral artery aneurysm rupture to maternal cardiorespiratory arrest and secondary fetal hypoxia. Neonatal fatalities additionally disclosed traumatic and hemorrhagic mechanisms superimposed on intrapartum compromise. Comparable terminal hypoxic phenotypes were associated with markedly different medico-legal interpretations, ranging from sudden, substantially unavoidable biological events to potentially preventable outcomes related to healthcare management.

Conclusion: Perinatal hypoxia represents a final common pathway rather than a sufficient causal diagnosis. Integrated analysis of maternal events, clinical chronology, placenta, umbilical cord, and fetal or neonatal autopsy permits reconstruction of the causal architecture underlying death and provides a more robust basis for distinguishing biological inevitability, preventability, and professional responsibility.

Keywords: *perinatal death; stillbirth; forensic pathology; obstetric malpractice; causation*

O-02 MAL2026/ABS/019

The case of a missed diagnosis of congenital malformation of the right lower limb, fibular agenesis and foot anomalies, during repeated ultrasound examination

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Background and aims: Fibular agenesis is a rare birth defect where a baby is born with a partially or completely missing fibula. The case is a newborn delivered by caesarean section and only after birth it was noticed that the child has deformed right leg several centimeters shorter. It was determined that the 4th and 5th toes of the foot are missing, there is a lack of stability, an absence of 7 bones in the right foot/leg, and a shortening of it; the diagnosis is fibular hemimelia.

Methods: During her pregnancy the mother has undergone 9 ultrasound examinations and biochemical analysis of blood and urine by the obstetrician resulted in normal parameters. A caesarean section was performed at 38 weeks and 5 days of pregnancy and the baby was delivered. An examination X rays was performed to the newborn and sent to an orthopedic specialist that confirmed the diagnosis of fibular agenesis of the right foot.

Results: The result was a confirmed diagnosis of fibular agenesis, congenital malformation of the right lower limb and foot anomaly. This diagnosis was never mentioned to the parents and never written to any of the 9 ultrasound examination performed by the obstetrician.

Discussion / conclusions: The physical anomaly present in the child's body is clearly detectable through ultrasound examinations. Evidence of medical negligence is apparent regarding the failure to perform necessary diagnostic procedures that had a direct and decisive impact on the failure to detect the child's physical anomaly in a timely manner.

Keywords: *medical neglect; fibular agenesis; ultrasound examination; congenital malformation*

O-03 MAL2026/ABS/057

Forensic analysis of fatal neonatal sepsis: a case of untreated maternal infection and Apgar score discrepancy

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Background: The case originates from a commission-based examination, comprising specific questions requested to investigate circumstances surrounding a neonatal death following alleged improper medical care (Criminal Code of Ukraine, Art. 140, Part 2). This comprehensive review was undertaken to clarify whether medical management during pregnancy, delivery, and the early neonatal period directly contributed to the infant's fatal outcome.

Methods: A complete forensic analysis of all medical records – including antenatal consultation charts, seven hospitalization records for threatened preterm labor, delivery notes, neonatal intensive care logs, autopsy findings, and histological reports – was performed to address the queries. Specific focus was placed on maternal infectious status, antibiotic administration, labor management, the immediate postnatal assessment, and the neonatal resuscitation timeline.

Results: The investigation revealed recurrent maternal infectious morbidity across multiple third-trimester hospitalizations, without any targeted antimicrobial therapy. The infant was born at 36 weeks and 6 days with Apgar scores of 8/8 and initially roomed-in with the mother. Within 41 hours, fulminant *E. coli* sepsis developed. Placental examination noted "flabby, yellow tissue with a putrid odor." Postmortem histology confirmed diffuse bilateral pneumonia, serofibrinous meningitis, interstitial myocarditis, hepatitis, nephritis, adrenal hemorrhages, and cerebral edema with intraventricular hemorrhage. A critical discrepancy was identified: the Apgar score of 8/8 was physiologically incompatible with the extensive multiorgan infectious pathology documented at autopsy, suggesting delayed recognition of severity.

Conclusion: The forensic review indicates that the neonatal death was potentially preventable through appropriate antenatal infectious screening and antibiotic therapy during repeated hospitalizations. The 33point forensic inquiry successfully identified a missed window for intervention. The case underscores that failure to investigate and treat ascending maternal infection in recurrent preterm labor can lead to fatal fetal sepsis, and highlights the need for objective neonatal assessment protocols to prevent similar adverse outcomes.

Keywords: *medical malpractice; neonatal sepsis; maternal-fetal infection; Apgar score discrepancy; preterm labor*

O-04 MAL2026/ABS/020**Neglection case of a medical mistreating pregnancy resulting in the premature infant death**

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Background and aims: A 39-year-old woman, 27 weeks and 2 days pregnant by IVF, is admitted to the hospital with a suspected diagnosis of preterm labor. Upon presentation, the patient reports severe abdominal pain in the suprapubic region. She is administered Buscopan and ibuprofen. Ultrasound imaging shows normal measurements and no evidence of strong contractions. Three hours after admission, the patient appears calm and stable. Six hours post-admission, she reports severe pain, gastric vomiting, weakness, and nausea; the abdomen shows increased tenderness, and there is bowel dysfunction. A surgical consultation is requested, and the patient is subsequently taken to the operating room. The diagnosis is acute abdomen, hemoperitoneum, and fetal distress. Following a laparotomy, a deceased female fetus is delivered.

Methods: After the delivery the mother pressed charges to the hospital for neglect and medical mistreatment that led to deceased fetus in utero. A full autopsy of the infant and histological examination was performed to find the cause of death of the infant. Also, the whole documentation regarding the treatment in the hospital was sent by the Prosecution to the Institute for evaluation.

Results: The autopsy and the histological examination revealed *feto morto*, uterine rupture and hemoperitoneum. The cause of death of the infant was hypoxia as result of the decrease in circulating blood volume due to uterine rupture.

Discussion / conclusions: Based on the review of the medical documents and the autopsy of the fetus in utero, it results that in this case, elements of medical negligence are found, related to the delay in making the correct diagnosis, which consisted of a uterine rupture with the presence of free blood in the abdominal cavity, resulting in the death of the fetus and endangering the patient's life.

Keywords: *medical neglect; uterine rupture; fetus autopsy*

O-05 MAL2026/ABS/056

Atraumatic rupture of a hepatic hemangioma as a rare cause of sudden death of a pregnant woman in the third trimester of pregnancy

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Background: Hepatic hemangiomas are benign liver tumors that are usually asymptomatic but may cause serious complications, including spontaneous rupture and life-threatening hemorrhage. Pregnancy may increase the risk of complications due to hormonal influences. We present a case of spontaneous rupture of a giant hepatic hemangioma resulting in maternal death.

Case presentation: A 29-year-old G1P1 woman at 38 weeks of gestation developed chest pain and hemodynamic instability, after complaining of generalized weakness, she presented to the health center's emergency department for medical attention. Upon objective examination, she was assessed as having a lipotomic state (fainting/near-fainting) due to pregnancy, with a blood pressure of 100/70 mmHg. After receiving IV infusions, she chose to leave for home. The next morning, she was found lifeless by her family members in her bedroom. The fetus died in utero. The autopsy findings were the rupture of hemangioma, the dimensions of the hemangioma are 15x12 cm, located on the posterior surface of the liver, with a blood collection in the peritoneum of approximately 2000 ml. Upon histological examination, the hemangioma was of the cavernous type. Cavernous hemangiomas consist of very wide, cavity-like expanded vascular spaces (blood vessel channels) lined with endothelial cells. It is precisely these types of benign tumors that carry a high risk of rupture (particularly during pregnancy due to hormonal changes and increased intra-abdominal pressure), causing massive hemorrhage into the peritoneum (hemoperitoneum).

Discussion and conclusions: Atraumatic rupture of a hepatic hemangioma during pregnancy is rare but potentially fatal. Although this case represents a rare cause of death, elements of malpractice can be identified because the complaints were not properly evaluated initially, resulting in a diagnosis that does not match the autopsy findings. In forensic medicine and medical liability, this breach or error can be analyzed through two main aspects: 1. Diagnostic Error and 2. Breach of the Standard of Care and Observation. In forensic and legal terminology, this is defined as medical negligence or professional error resulting in death, due to the failure to fulfill the duty of care and the absence of careful differential diagnosis.

Keywords: *hepatic hemangioma; spontaneous rupture; pregnancy; hemoperitoneum; hemorrhagic shock; maternal mortality*

ORAL ABSTRACTS

SCIENTIFIC SESSION II

Forensic Expertise: Method, Standard of Care and the Limits of Proof

O-06 MAL2026/ABS/030

Disentangling complication, error, and causation: a forensic case series in obstetrics and gynecology**Alessandro Santurro**¹, Matteo Scopetti², Anna Claudia Caruso³, Damiano Marchesini³, Roberto Raimo¹, Carmen Sementa⁴, Martina Padovano^{3,5}, Vittorio Fineschi³¹ Department of Medicine, Surgery and Dentistry, University of Salerno, Baronissi, Italy² Department of Medical Surgical Sciences and Translational Medicine, Sapienza University of Rome, Rome, Italy³ Department of Anatomical, Histological, Forensic and Orthopaedic Sciences, Sapienza University of Rome, Rome, Italy⁴ Forensic Medicine Unit, AORN San Giuseppe Moscati Hospital, Avellino, Italy⁵ Forensic Science Police Service, Directorate for the Forensic Science Police and the Cyber Security, Department of Public Security, Rome, Italy

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Background and aims: Obstetric and gynecological adverse events frequently prompt medico-legal investigation, but adverse outcomes, breach of duty, causation, and liability are distinct concepts. This study aimed to identify recurrent patterns in obstetric and gynecological malpractice investigations and to assess which analytical steps best distinguish unavoidable complications from professionally attributable harm.

Methods: A retrospective review of 28 medico-legal expert reports concerning obstetric and gynecological care was performed. Cases were assessed according to clinical area, index event, adverse outcome, alleged error, deviation from the standard of care, causal relevance, final medico-legal attribution, and multidisciplinary involvement.

Results: Sixteen cases (57.1%) concerned obstetrics and 12 (42.9%) gynecology; five cases (17.9%) involved substantial multidisciplinary care. Maternal death occurred in 15 cases (53.6%), while one additional case involved neonatal death without maternal death. Recurrent scenarios included postpartum hemorrhage and other obstetric emergencies, visceral injury during pelvic surgery, retained surgical items, diagnostic or therapeutic delay, sepsis, and failure to recognize postoperative complications. Three recurring medico-legal configurations were identified: severe adverse events occurring despite appropriate care; deviations from accepted practice with uncertain or insufficient causal relevance; and substandard conduct associated with a medically supported causal nexus to the adverse outcome. Retained surgical items represented the clearest attribution pattern, whereas hemorrhagic, septic, and diagnostic-delay cases required more complex assessment of preventability and causal contribution.

Conclusion: Obstetric and gynecological malpractice investigations are clinically heterogeneous but show reproducible medico-legal patterns. A structured separation of adverse events, error, causation, and final attribution may reduce outcome-driven reasoning, improve consistency in expert assessment, and facilitate translation of forensic findings into targeted patient-safety strategies.

Keywords: *medical malpractice; obstetrics and gynecology; forensic medicine; causation; patient safety*

O-07 MAL2026/ABS/027

Clinical practice guidelines in obstetric and gynecologic malpractice expertise: a proposed methodology for their selection

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Background and aims: Clinical practice guidelines are frequently used to reconstruct the standard of care in medical malpractice expertise. However, guidelines differ in development methodology, transparency, evidence quality and strength of recommendations. Importantly, clinical management should be assessed against the guideline applicable at the time of the medical act, rather than against subsequently published recommendations. We propose an objective methodology for selecting guidelines applicable to obstetric and gynecologic malpractice expertise.

Methods: A two-level selection algorithm was developed. First, methodological reliability is assessed according to the issuing organization's recognition, document type, development methodology, evidence grading, published AGREE II assessments and updating status. This appraisal is performed centrally rather than repeatedly in each case. Second, case-specific applicability is assessed by the expert, including the version in force at the relevant time, clinical question, patient eligibility, scope and applicability of the recommendation to the circumstances of the case. The methodology was informed by systematic reviews evaluating guidelines in obstetrics and gynecology.

Results: Published evaluations indicate generally high methodological quality among guidelines issued by recognized organizations: 13 of 17 guidelines concerning preterm prelabor rupture of membranes and 87.5% of guidelines addressing preeclampsia received high methodological assessments. However, methodological quality does not eliminate differences between recommendations; for example, recommended aspirin doses have varied by more than threefold between guidelines. These findings support a proportionate methodology combining temporal validity, methodological quality and case-specific applicability.

Conclusions: The reference guideline should be selected from those applicable at the time of the medical act and developed by organizations using rigorous and transparent methodologies. AGREE II and GRADE should be considered methodological appraisal tools, not absolute prerequisites for guideline use. This approach may improve the objectivity, reproducibility and credibility of medico-legal malpractice expertise.

Keywords: *medical malpractice; medico-legal expertise; obstetrics and gynecology; clinical practice guidelines; AGREE II; GRADE*

O-08 MAL2026/ABS/023

Amniotic fluid embolism or medical negligence? Divergent causal reasoning in Greek obstetric malpractice litigation

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Background and aims: Amniotic fluid embolism (AFE) is a rare obstetric emergency whose overlap with hemorrhage, disseminated intravascular coagulation (DIC), and cardiopulmonary collapse complicates retrospective causal attribution. This study examines how Greek courts distinguish AFE from preventable medical error.

Methods: A targeted Qualex review identified eight (8) published Greek judicial decisions arising from six (6) obstetric incidents across criminal, civil, and administrative proceedings. Two (2) incidents each generated a pair of judgments: one criminal/civil pair and one trial/cassation pair. One single-decision incident was excluded because AFE was mentioned only generically, leaving seven (7) judgments grouped into five (5) case clusters. One retained case concerned an anesthesiologist and was included because AFE was expressly raised and rejected as an alternative cause. The clusters were analyzed for causal mechanism, alleged breach, expert evidence, and outcome.

Results: AFE was accepted as probable or sole cause in three (3) incidents, and medical liability was rejected. In one, AFE was rejected in favor of an iatrogenic anesthetic mechanism, resulting in criminal liability. In the remaining cluster, delayed cesarean delivery caused neonatal death, while maternal complications were not attributed to negligence. Three (3) clusters involved postmortem forensic assessment: two (2) maternal autopsies with pulmonary histology supporting AFE, and one neonatal examination supporting perinatal asphyxia. The other two (2) involved surviving mothers with neurological injury, and so causation rested on clinical records and expert opinions. Forensic pathologists were pivotal in these fatal cases, integrating chronology, hemorrhage, DIC, pulmonary histology, and fetal squamous cells, despite the latter's non-pathognomonic nature.

Discussion / conclusions: AFE is neither malpractice per se nor an automatic defense. Its histological findings are equivocal and non-pathognomonic; forensic pathologists must interpret them alongside the complete medical record, chronology, treatment response, and coagulation data. An integrated assessment is essential to distinguish unavoidable complications from preventable errors and to establish causation for each maternal or neonatal outcome.

Keywords: *amniotic fluid embolism; obstetric malpractice; medical liability; causation; Greek jurisprudence*

O-09 MAL2026/ABS/013

Medical malpractice — the chain of causation

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Context: Examining the chain of causation regarding the evidence: findings in expert reports contradicted by the opinions of practicing professors—emphasized by the emphatic "NO" (not out of fear). E.g., a Professor (MD, PhD) stating: "The pre- and post-operative data did NOT—did NOT suggest! —the existence of a retroperitoneal hemorrhage prior to 19:30" [NO, there is absolutely no doubt; it is clear, elucidated, and plainly visible].

Method: Examining the causal link requires investigating all antecedents leading to the outcome: 1. existence of pre-operative antecedents that trigger hemorrhages; 2. hemorrhage of non-surgical origin (transient circumstance); 3. death.

Results: In managing the surgical procedure, the physicians were aware of and strictly adhered to professional standards and precautionary measures required for the operation. When lawful actions intervene between the actual cause and the outcome, the chain of causation is not broken.

Conclusions: As long as there is a link between the antecedents of an outcome, they are subject to criminal sanctions to the extent that they are imputable. The scope of criminal law ends when it reaches actions that result from lawful conduct (performed in compliance with professional standards).

Keywords: *adverb; causal link; transient circumstances*

ORAL ABSTRACTS

SCIENTIFIC SESSION III

*Prenatal Diagnosis and Wrongful Birth: Fetal Death, Viability and Liability***O-10** MAL2026/ABS/053**Prenatal control, wrongful birth and medical liability: the emerging Greek jurisprudence****Maria-Effraimia Gerasopoulou***School of Law, Democritus University of Thrace, Greece**Papageorgiou General Hospital of Thessaloniki, Greece**mg@lex-lawfirm.gr**Greece*

Background: The rapid development of prenatal screening and diagnostic technologies has significantly increased the capacity to detect fetal abnormalities during pregnancy, while simultaneously raising complex questions of medical liability and ethics. In Greece, claims arising from failures in prenatal diagnosis and counselling have become increasingly visible in judicial practice, particularly where parents allege that negligent medical care deprived them of the possibility of making an informed decision concerning the continuation or termination of pregnancy. This paper examines the evolution of wrongful birth claims in Greek jurisprudence and explores their implications for contemporary obstetric practice.

Methods: The study undertakes a black-letter analysis of Greek case law concerning prenatal diagnosis, and wrongful birth, emphasizing on the courts' approach to the duties of obstetricians, causation, informed parental decision-making, and the assessment of recoverable damage. Relevant statutory provisions and theoretical approaches are considered alongside the jurisprudence.

Evaluation: Greek jurisprudence is viewing prenatal control as a medical matter that raises critical legal concerns, with particular impact on reproductive autonomy and informed parental choice. The cases also raise fundamental questions concerning the scope of physicians' diagnostic and informational duties, the standard of prenatal care, and the legal characterisation and quantification of the resulting harm. The increasing number of disputes in this field reflects both technological developments and heightened expectations concerning prenatal care.

Conclusion: The evolution of Greek wrongful birth jurisprudence demonstrates the emergence of a distinct and increasingly significant area of obstetric medical liability. Its development raises broader questions concerning the balance between reproductive autonomy, professional responsibility and the limits of medical negligence law, making the Greek experience particularly relevant to the international medico-legal debate.

Keywords: *prenatal control; wrongful birth; fetal medicine*

O-11 MAL2026/ABS/043**No malpractice, but disability: forensic medicine perspective on diagnosed Down syndrome cases****İrem Türkkan¹**, Ceren Hawva Sümer¹, Mustafa Bilal Ceylan¹, Ebubekir Çetin¹, Yusuf Atan^{1,2}¹ Council of Forensic Medicine, Istanbul, Türkiye² Bilecik Şeyh Edebali University, Faculty of Medicine, Bilecik, Türkiye

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Background and aims: Prenatal Down syndrome is a common cause of medical malpractice claims in obstetric practice. However, although physician management may be consistent with accepted medical standards and no malpractice identified, disability evaluation may still be requested by courts. This reflects the distinction between malpractice assessment and disability evaluation, which serve different medico-legal purposes. This study aims to retrospectively evaluate such cases referred to the Council of Forensic Medicine and discuss them within the framework of strict liability under the Turkish Code of Obligations, the constitutional principle of the social state, and the physician's obligation to obtain informed consent.

Methods: This retrospective descriptive study included 28 cases evaluated between January 2018 and June 2026 in which the 7th Specialized Board concluded that no medical malpractice had occurred, while the 2nd, 3rd or 9th Specialized Boards were requested to determine disability status, disability rate or permanent care requirement. Maternal age, prenatal follow-up, screening tests, invasive diagnostic procedures, postnatal diagnosis, associated congenital anomalies, disability status, permanent care requirement and board opinions were reviewed.

Results: Disability evaluation was requested despite the absence of medical malpractice and was performed independently of physician liability. Of 28 cases, 20 (71.4%) were male and 8 (28.6%) female, with a mean age of 7 years. An impairment rate was determined exclusively in 5 cases, current-regulation disability rate in 4, both rates in 1, former- and current-regulation disability rates in 3, and all three rates in 4. No rate assessment was performed in 11 cases because no fault was attributed.

Discussion / conclusions: Malpractice assessment and disability evaluation are separate medico-legal processes. While malpractice depends on physician fault, disability evaluation serves different legal purposes based on social protection mechanisms and the constitutional principle of the social state. These findings emphasize comprehensive informed consent regarding prenatal screening limitations and proper documentation to protect patient rights and physicians.

Keywords: Down syndrome; medical malpractice; disability; informed consent; forensic medicine

O-12 MAL2026/ABS/049

Ethical challenges in obstetric practice when abortion is permitted at or beyond potential viability

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Background: Abortion laws vary considerably between jurisdictions, including provisions permitting termination at or around potential fetal viability. In such circumstances, obstetricians may encounter competing ethical obligations involving reproductive autonomy, fetal interests, beneficence, non-maleficence, professional integrity and obligations towards a potentially viable neonate. Viability itself is a probabilistic clinical concept influenced by gestational age, fetal condition and available neonatal care. Objective: To examine the ethical challenges faced by obstetricians when providing or considering legally permissible abortion at or around potential viability, and to develop an ethically defensible framework for clinical decision-making.

Methods: A focused narrative review of ethical, medico-legal and professional literature concerning later abortion, fetal viability and obstetric decision-making was undertaken. The World Health Organization (WHO) Abortion Care Guideline was used as the principal ethical framework, with analysis based on respect for autonomy, dignity, non-discrimination, informed decision-making, quality of care and accountability.

Results: Major ethical challenges include balancing maternal reproductive autonomy with perceived fetal interests; providing accurate, non-directive counselling regarding prognosis and available options; and addressing termination sought for severe fetal anomaly or maternal indications. Conscientious objection presents an additional conflict between the clinician's moral integrity and the patient's right to legally available care, raising questions regarding disclosure of objection, timely referral, continuity of care and obligations in emergencies. Further challenges arise where fetal survival after delivery is possible but prognosis remains uncertain or severe morbidity is anticipated. Ethical and professional obligations towards a live-born neonate must remain distinct from the ethical justification for termination of pregnancy.

Conclusion: Abortion at or around potential viability presents complex ethical dilemmas that cannot be resolved by gestational age alone. Respect for reproductive autonomy must be balanced with professional integrity and appropriate consideration of fetal and neonatal interests. Clear legal frameworks, non-directive counselling, multidisciplinary deliberation, safeguards for conscientious objection, continuity of care and clearly defined obligations following delivery are essential for ethically and professionally defensible obstetric practice.

Keywords: *abortion; ethics; conscientious objection; medical law; obstetrics*

O-13 MAL2026/ABS/047**Cardiotocography documentation, autopsy yield, and the limits of expert determination in 174 stillbirth malpractice cases**

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Background and aims: In stillbirth malpractice claims the Board must establish the documented interval of fetal death, its cause, and the conformity of care with the accepted standard, each resting on different evidence. We examined the availability of cardiotocography documentation, the diagnostic yield of autopsy, and whether gaps in these streams limited the Board's ability to reach a determination.

Methods: We retrospectively analysed 174 autopsied stillbirth malpractice claims (≥ 22 completed weeks) assessed between 01.01.2018-30.06.2026 by the specialist boards of the Council of Forensic Medicine (the Board). Clinical, cardiotocographic, postmortem and decision variables were coded from expert reports. Autopsy diagnostic yield was a Board-accepted specific aetiology, rather than a nonspecific hypoxic mechanism or no cause. Fisher's exact test with Benjamini-Hochberg correction was used.

Results: Inadequate follow-up (99; 56.9%) and delayed delivery (90; 51.7%) were the commonest allegations, yet malpractice was established in only 16/161 assessable cases (9.9%). Medical error could not be determined in 13 (7.5%), nine for missing records or CTG traces. Cardiotocography had been performed in 145 cases (83.3%) but was not itself associated with malpractice. Among 129 interpretable final traces, a non-reassuring trace was the only retained association of ten comparisons: 9/45 (20.0%) versus 3/84 (3.6%) (OR 6.75, 95% CI 1.72–26.41; $q=0.037$). Autopsy supported stillbirth in all cases but yielded a specific aetiology in only 63 (36.2%): 13/69 with maceration (18.8%) versus 46/96 without (47.9%; $p<0.001$). Placental findings were unavailable or unreported in 102 (58.6%).

Discussion / conclusions: Board determinations tracked evidence availability and interpretability rather than allegation content. This specific-aetiology rate falls well below that expected from complete investigation. Missing records explained most indeterminate determinations, maceration the reduced aetiological resolution. Systematic CTG archiving and standardised placental examination are actionable priorities. An indeterminate medical-error determination should not be interpreted as evidence that care met accepted standards.

Keywords: stillbirth; medical malpractice; cardiotocography; maceration; forensic pathology

O-14 MAL2026/ABS/041

Estimating the time of intrauterine fetal death: a systematic review

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Background and aims: In medico-legal investigations where negligence is alleged after intrauterine fetal death, the decisive question is when death occurred. Romania's Criminal Procedure Code requires the forensic autopsy of a newborn to establish the time of death, but not that of a fetus. Expert opinions rely on maceration criteria never tested against the interval they estimate. The aim was to identify the methods used, the interval each measures, and how precisely the reference time of death was known.

Methods: PubMed, Scopus and Web of Science were searched from inception to May 2026 for studies estimating the time of intrauterine fetal death by macroscopic, histological, imaging or molecular methods; reference lists were also screened. Animal studies, intrapartum deaths, early pregnancy loss, case reports and reviews were excluded; language limits applied. Records were classified by the interval measured and by reference precision. Risk of bias will be assessed using tools appropriate to each study design. The review was not registered.

Results: Of 33 full-text records (1964–2026), 17 studies covering 1775 fetuses were included. Only 14 (42%) measured the death-to-delivery interval; 6 the delivery-to-examination interval, 3 a maceration grade as surrogate, 2 a single interval spanning both, and 8 none. One molecular study related DNA integrity to the interval without estimating it. The time of death was known exactly in 4 studies. Correct classification into a time category reached 86% and 90% for fetal and placental histology and 69% and 79% for external examination, three figures from one cohort.

Conclusions: Most studies underpinning forensic estimation of intrauterine fetal death do not measure the retention interval, and few validate their findings against an exactly known time of death. Reported accuracies therefore reflect agreement with reference intervals of unstated width. Validation against exactly timed deaths is required before such estimates can support medico-legal conclusions.

Keywords: *intrauterine fetal death; postmortem interval; maceration; forensic pathology; malpractice*

ORAL ABSTRACTS

SCIENTIFIC SESSION IV

*Surgical and Procedural Complications: Operative Harm and Accountability***O-15** MAL2026/ABS/008**Chasing beauty, confronting death: vaginal filler-related fatalities through the lens of patient safety and medicolegal accountability in South Korea****Sohyung Park¹**, Seongho Kim², Min-joo Lee², Minjung Kim², Junmo Kim³, Seon Jung Jang⁴¹ Division of Forensic Medical Examination, National Forensic Service, Wonju, Republic of Korea² Division of Forensic Medicine, National Forensic Service Seoul Institute, Seoul, Republic of Korea³ Division of Forensic Medicine, National Forensic Service Daegu Institute, Daegu, Republic of Korea⁴ National Forensic Service Busan Institute, Busan, Republic of Korea

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Background and aims: Vaginal filler injection is increasingly marketed as a minimally invasive and simple procedure for vaginal rejuvenation, which may facilitate administration even by unqualified providers outside medical settings. However, serious and fatal complications remain poorly characterized in both clinical and forensic practice, that have been also insufficiently recognized by manufacturer vigilance and regulatory post-market surveillance systems for medical devices. We reviewed postmortem cases of vaginal filler-related fatalities identified in South Korea to characterize the postmortem findings and to explore patient-safety and medicolegal implications.

Methods: We retrieved seven postmortem cases of unexpected death after vaginal filler injection, and reviewed demographic information, clinical course and death circumstance, postmortem findings, filler materials, and procedural documentation, based on their investigation reports and medical records.

Results: All of seven cases were fatal non-thrombotic pulmonary embolism by filler material, which was determined to be the cause of death. Through postmortem examination, vaginal filler injection in the vaginal wall and surrounding tissue, and pulmonary embolism by filler materials were identified. For filler materials, hyaluronic acid was injected in three cases, collagen in three cases, and both of them in one case. Six cases occurred in woman's clinics or gynecology clinics. However, in one case, vaginal filler injection was done as unlicensed medical practice and investigation discovered illegal distribution of filler materials.

Discussion / conclusions: Vaginal filler injection remains insufficiently standardized and expert consensus is still limited. Although their incidence is unknown, fatal complication of pulmonary embolism following the procedure justify the need for comprehensive pre-procedural counseling, an appropriate cooling-off period to support informed consent, and more consistent clinical and regulatory governance.

Keywords: vaginal filler; non-thrombotic pulmonary embolism; forensic pathology; patient safety; medical malpractice

O-16 MAL2026/ABS/011**Severe hyperchloremic metabolic acidosis and respiratory failure following excessive normal saline absorption during diagnostic hysteroscopy**Nurşen Tanrıkulu¹, Uğur Özbek¹, Ali Haspolat¹, Ali Şefik Köprülü², **Ersi Kalfoglou**³¹ Kolan International Hospital, Department of Anesthesiology & Reanimation, Istanbul, Türkiye² Istanbul Yeni Yüzyıl Medicine Faculty, Department of Anesthesiology & Reanimation, Istanbul, Türkiye³ Department of Legal Medicine at Ankara Medipol University, Türkiye

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Background and aims: Diagnostic hysteroscopy requires uterine irrigation for visualization. Although 0.9% normal saline is considered a safe isotonic distension medium, excessive systemic absorption may rarely cause hyperchloremic metabolic acidosis and respiratory insufficiency. Because hysteroscopic fluid absorption syndrome is associated with electrolyte-free distension media, severe hyperchloremic metabolic acidosis due to normal saline absorption may be underrecognized. We report a rare case of severe hyperchloremic metabolic acidosis with postoperative respiratory failure following diagnostic hysteroscopy using large-volume normal saline irrigation.

Case description: A 35-year-old woman (ASA I) underwent diagnostic hysteroscopy for abnormal uterine bleeding under general anesthesia. The procedure lasted 140 minutes and required approximately 12 L of 0.9% normal saline for uterine irrigation and 900 mL of intravenous normal saline. Postoperatively, she developed dyspnea, tachypnea, hypoxemia (SaO₂-75%), and oxygen requirements. Arterial blood gas analysis revealed severe hyperchloremic metabolic acidosis (pH-7.21, HCO₃⁻-13 mmol/L, base excess--10.6 mmol/L, pCO₂-43.6 mmHg, Cl⁻-123 mmol/L). Lactate, hemoglobin, renal function, and hemodynamic parameters were normal, excluding other causes of metabolic acidosis. The patient was admitted to the intensive care unit and treated with supplemental oxygen, intravenous sodium bicarbonate (80 mEq), and serial blood gas and electrolyte monitoring.

Results / evaluation: Biochemical improvement occurred within six hours. Oxygen saturation increased from 75% to 99%, and repeat arterial blood gas analysis showed normalization of acid-base status (pH-7.41, HCO₃⁻-22.6 mmol/L, base excess--2.8 mmol/L, pCO₂-34.8 mmHg, Cl⁻-113 mmol/L). The patient required neither invasive mechanical ventilation nor renal replacement therapy and was discharged without sequelae after intensive care stay.

Discussion / conclusions: Normal saline should not be considered entirely risk-free as a hysteroscopic distension medium. Excessive absorption during prolonged procedures may cause severe hyperchloremic metabolic acidosis and postoperative respiratory failure despite its isotonic nature. Careful monitoring of irrigation fluid deficit and early arterial blood gas and electrolyte analysis are essential for prompt diagnosis, timely supportive treatment, and prevention of serious morbidity.

Keywords: *diagnostic hysteroscopy; hyperchloremic metabolic acidosis; normal saline irrigation; irrigation fluid absorption; respiratory failure*

O-17 MAL2026/ABS/018

Gossypiboma following cesarean section: a forensic case report

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Background: Gossypiboma refers to a retained surgical textile material and represents a rare but potentially serious adverse event. Although retained surgical items are generally considered preventable, attribution of responsibility may be challenging in team-based surgical practice, particularly when perioperative safety procedures have been documented as appropriately completed. This case highlights the forensic significance of distinguishing individual professional negligence from organizational failure.

Case description: A woman underwent cesarean section. During surgery, increased bleeding necessitated the use of an increased number of surgical textiles. Operative records documented that surgical material counting was performed by operating-room nursing staff, with 40 items recorded as used and all reported as accounted for. The surgeon reportedly confirmed the count and inspected the operative field before closure. The signed surgical safety checklist also documented completion of instrument, sponge, and needle counts. Subsequently, the patient developed postoperative complaints, and imaging raised suspicion of an intra-abdominal foreign body. Reoperation after two months revealed a retained surgical compress associated with intra-abdominal infection and dense adhesions.

Evaluation: Forensic evaluation demonstrated a discrepancy between the documented correct count and the subsequent identification of a retained surgical compress. Medical records indicated that the counting and verification procedures had been performed and documented. Therefore, the adverse outcome alone was considered insufficient to establish an individualized breach of the surgeon's duty of care. Potential mechanisms included an erroneous count, documentation error, or failure within the institutional safety process.

Conclusion: Gossypiboma requires a detailed analysis of the entire perioperative safety process rather than automatic attribution of negligence to the operating surgeon. When a retained surgical item occurs despite a documented complete count, forensic evaluation should determine whether the event resulted from individual negligence or a failure in the organizational safety process.

Keywords: gossypiboma; retained surgical item; medical malpractice; forensic medicine

O-18 MAL2026/ABS/062

Cytotec in obstetrics: fatal consequences of its use

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The off-label use of Cytotec® (misoprostol 200 µg) in obstetrics has long been a controversial practice in Germany. Although Cytotec is approved solely for the treatment of gastric ulcers, it was for many years widely used for induction of labour. This abstract highlights why this practice is not merely a regulatory issue but a serious patient safety concern with potentially harrowing consequences for both mothers and children.

Cytotec contains a high dose of misoprostol and has not been approved by the European Medicines Agency for obstetric use. In contrast, Angusta®, containing 25 µg misoprostol, has been specifically approved by the EMA for labour induction, reflecting established safety and dosing standards. Despite this, Cytotec continued to be used off-label, even after warnings about application errors and severe adverse effects.

A forensic case from before 2020 illustrates the risks associated with Cytotec. We report the case of a 39-year-old pregnant woman who received a cumulative overdose of misoprostol during labour induction, resulting in uterine hyperstimulation, severe fetal hypoxia and an emergency caesarean section. The mother subsequently died from atonic uterine haemorrhage. Criminal allegations included malpractice due to overdose, insufficient monitoring and inadequate patient information regarding off-label drug use.

This case demonstrates that the use of Cytotec in obstetrics is not a theoretical risk but a documented cause of severe harm, including maternal death and life-threatening neonatal injury. From a forensic medical perspective, the case underlines the necessity of critically reassessing off-label practices. Given the availability of an EMA-approved low-dose alternative, the continued use of Cytotec in obstetrics cannot be justified and should be prohibited in order to prevent avoidable fatalities and medico-legal consequences.

Keywords: Cytotec; off-label use; obstetrics; maternal death; forensic medicine

ORAL ABSTRACTS

SCIENTIFIC SESSION V

*Medical Law: Jurisprudence, Rights and Artificial Intelligence***O-19** MAL2026/ABS/016**CTG and emergency caesarean section in recent case law: Türkiye, Germany, France and England compared****Kazım Furkan Ağkuş***Law Faculty, Turkish-German University, Istanbul, Türkiye**agkus@tau.edu.tr**Türkiye*

Background and aims: Cardiotocography (CTG) interpretation and emergency caesarean section are recurrent sources of obstetric malpractice litigation. Responsibility becomes particularly complex where fetal injury results from successive acts of midwives, obstetricians and hospital organisations. This study compares judicial approaches in Türkiye, Germany, France and England, focusing on responsibility and the legal significance of delay.

Methods: A comparative case-law analysis was conducted using Turkish Court of Cassation decisions together with BGH, 6 December 2022, VI ZR 284/19; Cour de cassation, 23 November 2022, no. 21-16.392; and CDE v Surrey and Sussex Healthcare NHS Trust [2023] EWCA Civ 1330. The cases were compared according to the duty breached, responsible professional, organisational factors, decision-to-delivery timing and causation.

Results: German case law recognises concurrent professional responsibility: even where the obstetrician commits the principal error, a midwife may retain an independent duty to react to an evidently pathological CTG. French case law similarly attributes responsibility for delayed escalation and separately recognises failures in organising continuous obstetric care. English case law places particular emphasis on counterfactual causation and shows that even a short delay may be legally relevant where earlier delivery would probably have reduced hypoxic injury. Turkish criminal case law remains predominantly physician-centred and frequently refers to the decision-to-incision interval, including the thirty-minute benchmark, although recent decisions increasingly acknowledge systemic constraints.

Discussion / conclusions: The comparison shows that elapsed time should not operate as an autonomous threshold of liability. The decisive question is which professional owed which duty at each stage between the first pathological CTG finding and delivery, when escalation became necessary, and whether the breach can be causally attributed to the outcome. A duty-based and temporally structured analysis may enable a more accurate individualisation of criminal responsibility in Turkish obstetric practice.

Keywords: CTG; caesarean section; obstetric malpractice; criminal liability; midwifery

O-20 MAL2026/ABS/012

Juridical responsibility for off label use of drugs in Romanian obstetrics and gynecology

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Background and aims: Based on Article 704 of Law No. 95/2006 no medicinal product may be placed on the market in Romania without a marketing authorization and authorization holder is responsible for placing the medicinal product on the market. This regulation does not apply to physicians because physicians do not place medicines on the market (on the contrary, Romanian law expressly prohibits them from selling medicines), but merely use medicines in the provision of medical services. The issue arises when a physician uses a drug off-label—that is, in a manner or for a purpose other than those for which the drug was authorized for marketing—because in such cases, the marketing authorization holder is not liable.

Methods: The purpose of this study is to identify, within Romanian case law, situations in which gynecologists may be held liable for the off-label use of medications and, by analyzing these situations, to identify the conditions under which such liability arises.

Results: In Criminal Decision No. 917/A/2015, the Cluj Court of Appeal convicted a gynecologist of the crime of abuse of office against the interests of individuals under Article 246 of the 1969 Penal Code, as well as of malpractice (civil medical liability), for administering misoprostol to a pregnant woman — Cytotec (a gastric ulcer medication not authorized at that time in Romania and brought from the United States)—to induce labor, but failed to inform the patient of the risks to the pregnant woman or the fetus that the off-label use of this drug might pose, as required by Article 649 of Law 95/2006 and Article 6 of Law 46/2003.

Discussion / conclusions: Romanian law regulates the authorization of drugs for marketing by pharmaceutical manufacturers and distributors, but does not prohibit the off-label use of drugs by physicians. However, in such a situation, legal liability (criminal and civil) rests with the physician (not the pharmacist)—not for the off-label use of the medication itself, but for the manner in which it was administered.

Keywords: *medical liability; off label; patient consent*

O-21 MAL2026/ABS/026

Bodily integrity after loss of reproductive capacity: medical liability and the right to private life

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The loss of reproductive capacity as a consequence of medical intervention represents one of the most profound forms of interference with bodily integrity. Procedures such as hysterectomy, bilateral oophorectomy, salpingectomy, sterilisation, or other interventions resulting in permanent or substantially impaired fertility affect not only the physical integrity of the patient but also reproductive autonomy, personal identity, family life, and the ability to make fundamental decisions concerning parenthood.

This paper examines the legal implications of medically induced loss of reproductive capacity through the interconnected concepts of bodily integrity, informed consent, medical liability, and the right to private and family life. Particular attention is given to cases in which infertility or loss of reproductive function results from an intervention that was not adequately explained, was performed beyond the scope of the patient's consent, or became necessary following an avoidable complication or an alleged departure from the applicable standard of care.

The analysis distinguishes between two separate but frequently overlapping grounds of liability: negligent impairment of reproductive capacity and lawful or medically indicated treatment performed without sufficiently specific informed consent. It argues that the absence of technical malpractice does not necessarily exclude legal responsibility where the patient was deprived of a genuine opportunity to decide whether to accept an intervention carrying a foreseeable risk of permanent infertility.

Drawing upon the principles developed under Article 8 of the European Convention on Human Rights, the Oviedo Convention, European human-rights jurisprudence, and the broader doctrine of patient autonomy, the paper considers reproductive capacity as an essential dimension of both physical integrity and private life. It further explores the heightened disclosure obligations associated with irreversible interventions, including the duty to discuss fertility consequences, organ-preserving alternatives, the possibility of fertility preservation, and the consequences of extending the initially planned surgical procedure.

The paper concludes that reproductive harm cannot be assessed exclusively through the traditional framework of physical injury. The irreversible loss of fertility may constitute a distinct interference with bodily integrity and personal autonomy, requiring legal assessment of both the medical justification for the intervention and the quality and scope of the patient's consent. Effective protection of bodily integrity therefore requires recognition that preserving reproductive choice, whenever medically possible, forms an integral part of contemporary patient-centred care and of the legal protection of private life.

Keywords: *bodily integrity; reproductive autonomy; infertility; informed consent; medical malpractice; medical liability; hysterectomy; reproductive capacity; patient autonomy; right to private life; Article 8 ECHR*

O-22 MAL2026/ABS/048

Artificial intelligence in obstetrics: emerging challenges in medical liability

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Background: Artificial intelligence (AI) is increasingly being incorporated into obstetric care for risk prediction and clinical decision support, including prediction of pre-eclampsia, postpartum haemorrhage, preterm birth and fetal compromise. While AI may facilitate earlier recognition of high-risk pregnancies, its integration into clinical decision-making creates novel questions of medical liability when algorithm-assisted care is followed by adverse maternal or fetal outcomes. Objective: To examine the emerging medico-legal implications of AI-assisted obstetric risk assessment, that has emphasis on attribution of liability, standard of care and causation following algorithmic error or inappropriate clinical reliance.

Methods: A structured narrative review of literature concerning AI-based obstetric risk prediction, algorithmic errors, clinical decision support and medical liability was undertaken. The World Health Organization (WHO) framework on ethics and governance of AI for health was used as a conceptual framework, that emphasis on responsibility, accountability, human oversight and redress. A medico-legal methodology for AI-related liability, incorporating dataset validation, error identification and causal-chain reconstruction, was additionally considered.

Results: AI-related obstetric liability may arise from misclassification, inadequate validation, limited generalisability, algorithmic or automation bias, and inappropriate reliance on recommendations. Responsibility lies on clinicians, institutions, or developers. Forensic assessment should examine data integrity, validation, errors, clinician interpretation, and causation. As AI becomes standard practice, appropriate use may influence the standard of care.

Conclusion: AI-assisted obstetric care may reshape medical malpractice by creating distributed responsibility and complicating breach and causation. A robust medico-legal framework addressing validation, human oversight, documentation, monitoring, causal reconstruction, and redress is essential to prevent innovation from diluting accountability.

Keywords: artificial intelligence; liability; obstetrics

O-23 MAL2026/ABS/039

Can generative artificial intelligence (GenAI) transform pre-action conduct within medical negligence claims? A comparative analysis of the regulatory frameworks of the UK and EU

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Aim: The overall aim of this project is to critically compare the UK and EU regulatory frameworks' impact on the impact of GenAI on pre-action conduct in Medical Negligence claim.

Methodology: Utilising a comparative and doctrinal legal analysis, the study identifies and compares key legislative reforms, specifically the prescriptive EU AI Act versus the UK's principles-led, context-specific model. It further assesses the transformative potential of GenAI within the context of Pre-action conduct for medical negligence claims.

Findings: Medical negligence claims are experiencing protracted and litigious courses with some claims, for example in the UK complex infant brain injury claims are averaging 11 to 12 years before settlement. GenAI provides a disruptive opportunity to tackle this through its superior technological capabilities, potentially enabling earlier data-driven settlement offers. However the lack of evolution of traditional doctrinal principles for medical negligence practice in the age of GenAI and formal opportunities for solicitors to take up GenAI literacy training remains underdeveloped. This has created a "legal practice transfer gap", and has legal professionals feeling underprepared to confidently use GenAI tools for fear of misconduct and practice violations. In order to mitigate this risk, solicitors will need embrace AI literacy skills, in order to practice epistemic vigilance. As AI does not yet have a legal personality, solicitors are seemingly evolving into strategic auditor of AI-generated insight to preserve the epistemic integrity of the justice system and ensure any integrated technology serves the pursuit of justice.

Conclusion: The research concludes that medical negligence law is shifting from reactive litigation to proactive data-driven dispute resolution. While GenAI offers great potential the blind implementation and reliance on GenAI tools also has potential to undermine some of the foundations of legal practice: Duty to act with honesty, accountability, confidentiality. To facilitate this, the study proposes the MOG framework to ensure institutions can safely implement GenAI tools within clinical negligence workflows.

Keywords: generative artificial intelligence; EU AI Act; alternative dispute resolution; medical negligence; obstetric malpractice

O-24 MAL2026/ABS/059

Who is the victim? Shifting media frames in a high-profile obstetric malpractice case in Türkiye

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Background: Medical malpractice is developed not only through clinical evidence and judicial decisions but also through media narratives that shape blame, victimhood and public perceptions of medical error. A high-profile Turkish case concerning prenatal screening, the birth of a child with Down syndrome, and an approximately TRY 77 million enforcement amount (about €1.37 million/US\$1.59 million) provides a distinctive example.

Methods / case description: A qualitative comparative framing analysis was conducted on 16 unique publicly accessible Turkish online news reports: eight published during the January 2026 first-judgment wave and eight during the July 2026 appellate/reversal wave. Headlines and article narratives were coded for principal actor/victim, attribution of responsibility, informed consent and prenatal screening, expert evidence, legal certainty, physician vulnerability, and disability-related framing. Only public material was analysed; no non-public personal data were collected, and names were excluded from coding and reporting.

Results / evaluation: January reporting showed competing frames: 5/8 headlines (62.5%) were physician-centered, while 3/8 centered the family and compensation. By July, all 8/8 selected headlines (100%) centered the physician, emphasizing seizure of assets, personal vulnerability, or appellate reversal. Representative framing shifted from "family to receive 77 million TL" to a physician-focused narrative of a "77-million-lira seizure" and appellate reversal. Across both periods, the compensation figure functioned as a dominant narrative anchor, while distinctions between disability, adverse outcome, informed choice and legally attributable harm were often compressed.

Conclusion: The case illustrates how the social meaning of malpractice may change while the underlying clinical event remains unchanged. Responsible reporting should distinguish allegation from established fault, adverse outcome from negligence, compensation from punishment, and disability from legally cognizable harm.

Keywords: *medical malpractice; obstetrics; media framing; informed consent; social forensic sciences*

ORAL ABSTRACTS

SCIENTIFIC SESSION VI

*Systems of Care: Organisational Risk, Prevention and Patient Safety***O-25** MAL2026/ABS/032**Beyond the adverse event: medico-legal risk, patient harm and economic exposure in obstetric and gynaecological malpractice**

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Background and aims: In obstetric and gynecological malpractice, the occurrence of an adverse event does not necessarily imply professional liability. Medico-legal assessment requires the integration of clinical events, resulting in harm, causal relevance and potential economic consequences. The aim of the study was to investigate the relationship between clinical outcomes, medico-legal risk and estimated economic exposure in obstetric and gynecological malpractice cases evaluated at Policlinico Umberto I, Rome, Italy.

Methods: A retrospective analysis was performed on 62 obstetric and gynecological malpractice cases selected from 1,896 medico-legal files. Event type, patient outcome, severity of harm, estimated risk of adverse judgment and technical financial estimates were evaluated. Cases were stratified into low versus medium/high medico-legal risk. Associations between categorical variables were assessed using Fisher's exact test.

Results: Medico-legal risk assessment was available in 49 cases: 21 (42.9%) were classified as low, 12 (24.5%) as medium and 16 (32.7%) as high risk. Among the 34 cases with both risk assessment and documented clinical outcome, absence of patient harm occurred exclusively in low-risk cases (5/13 vs 0/21 medium/high-risk cases; $p=0.0046$). A numerical technical financial estimate was available in 39 risk-assessed cases. Zero economic exposure was assigned in 8/18 low-risk cases but in none of the 21 medium/high-risk cases ($p=0.0007$). Median estimated exposure was € 1,750 in low-risk cases and € 30,000 in medium/high-risk cases ($p=0.009$). Event category alone was not significantly associated with medium/high medico-legal risk.

Conclusion: The medico-legal relevance of obstetric and gynecological malpractice cases appeared to depend less on the category of the adverse event than on its demonstrable consequences and their medico-legal appraisal. Documented patient harm was associated with higher risk of adverse judgment, while attribution of economic exposure closely paralleled medico-legal risk stratification. Joint assessment of harm, liability risk and economic consequences may provide a more comprehensive forensic framework for malpractice evaluation.

Keywords: *medical malpractice; forensic medicine; obstetrics and gynecology; medico-legal risk; economic exposure*

O-26 MAL2026/ABS/007**An interdisciplinary national model for the first response to gender-based violence: an Italian Ministry of Health-funded project**

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Background: Gender-based violence (GBV) represents a major public health issue and a significant challenge for obstetric and gynecological practice, with important implications for patient safety, medico-legal risk and professional accountability. Although national guidelines and regional care pathways are available in Italy, considerable variability still exists in the early recognition of victims, multidisciplinary clinical management, preservation of forensic evidence, criminalistic management of biological and material traces, and compliance with legal obligations by healthcare professionals. To address these challenges, the Italian Ministry of Health funded the national project "Management and Coordination of First Response Activities in Gender-Based Violence Cases", aimed at developing first Italian interdisciplinary model integrating obstetrics and gynecology, forensic medicine, psychology, legal sciences and criminalistics to support national guidance for healthcare professionals involved in the first response to GBV.

Methods: The project adopts a multidisciplinary, competency-based approach. Obstetricians, gynecologists, forensic physicians, psychologists, legal scholars and criminalistics experts collaborate through structured working groups, simulation-based training, educational programmes and comparative analysis of existing healthcare pathways. The project focuses on early recognition of violence, clinical management, forensic evidence preservation, criminalistic procedures for evidence handling, legal responsibilities of healthcare professionals and coordination with judicial authorities.

Results: The methodological phase has been completed. A multidisciplinary educational framework, a structured national training programme and a survey assessing healthcare professionals' knowledge and training needs have been developed. These outputs constitute the basis for the first Italian interdisciplinary national guidance currently under development.

Conclusions: The project promotes a shift from malpractice management after adverse events to prevention through multidisciplinary education, standardised clinical pathways and shared medico-legal and criminalistic procedures. The resulting national guidance is expected to improve patient safety, strengthen legal compliance, preserve forensic evidence, reduce medico-legal risks and provide a transferable interdisciplinary model for healthcare systems managing gender-based violence.

Keywords: gender-based violence; criminalistics; forensic medicine; patient safety; guidelines

O-27 MAL2026/ABS/024

Maternal adiposity as a vulnerable clinical substrate: a medico-legal analysis of four perinatal and neonatal deaths

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Background and aims: Maternal obesity increases the risk of stillbirth and may reduce the reliability of clinical examination, ultrasound, and external fetal monitoring. We investigated whether maternal adiposity acted as a vulnerable clinical substrate in which failures of risk recognition, surveillance, or escalation converged to produce adverse outcomes.

Methods: We conducted a structured medico-legal review of 20 fetuses and neonates referred to our department between 2020 and 2026. Four cases (20%) involved maternal obesity and were selected for detailed analysis. Maternal and obstetric records, available cardiotocographic tracings and their interpretations, signal continuity, uterine activity, imaging, placental findings, intervals from deterioration to delivery, and expert reports were assessed across risk classification, surveillance, and clinical response.

Results: Three pregnancies ended in stillbirth and one in neonatal death following severe hypoxic-ischaemic encephalopathy. Obesity was formally incorporated into antenatal risk assessment in only one case. Among the three fetuses alive at hospital assessment or during labour, no intrapartum risk reclassification was documented despite new warning signs. Surveillance failures were heterogeneous: a 3-hour-20-minute absence of monitoring after an initially reassuring tracing; class III obesity with uninterpretable external uterine activity monitoring during oxytocin administration and an 80-minute interval from the first documented non-reassuring fetal heart rate to birth; a 22-minute monitoring interruption and a 122-minute interval from the initial non-reassuring assessment to delivery; and, in the antepartum death, intermittent outpatient surveillance, with the last recorded fetal heart activity approximately 36 hours before the estimated time of death.

Discussion / conclusions: Maternal adiposity emerged not as an isolated cause of death, but as a vulnerable clinical substrate that exposed weaknesses in measurement, risk recognition, signal acquisition, and escalation. Safe care requires repeated integration of BMI and gestational weight gain into risk assessment, predefined alternatives when monitoring is technically limited, and prompt multidisciplinary action when fetal status changes.

Keywords: *maternal obesity; stillbirth; fetal monitoring; clinical risk; medico-legal analysis*

O-28 MAL2026/ABS/006**Home birth in the Western Balkan area: regulatory gaps, midwifery liability, and the need for a harmonised feto-neonatal autopsy protocol**

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Planned out-of-hospital birth is an issue of growing medico-legal relevance, situated at the intersection between a woman's right to self-determination regarding the place and manner of childbirth and the duty of the State and healthcare professionals to ensure maternal and fetal safety. The leading international scientific societies (NICE, ACOG, RCOG, FIGO, ICM) agree that home birth should be considered a viable option only in low-risk pregnancies, with the assistance of a qualified midwife (ideally integrated within the healthcare system), a clear plan for rapid transfer to a hospital facility, and adequate informed consent explicitly addressing the increased risk of adverse neonatal outcomes compared with hospital birth, set against the lower degree of medicalisation experienced by the mother. The Authors present a case series drawn from the medico-legal and forensic autopsy practice of professionals operating between Trieste and the western Balkan area, concerning cases of feto-neonatal death and medico-legal litigation arising from planned home births. The cases were analysed in light of the regulatory and deontological frameworks currently in force in different countries. Analysis of the cases allows the identification of the principal recurring profiles of professional liability: the adequacy of low-risk pregnancy selection (eligibility criteria), the completeness and traceability of informed consent, adherence to recognised clinical guidelines, the timeliness of hospital transfer in the presence of warning signs, and the integrity of clinical documentation. The discussion also addresses the issue of liability "for organisational omission" on the part of national health systems which, while not prohibiting home birth, fail to regulate its practice, thereby effectively shifting a disproportionate professional risk onto the midwife. The regulatory fragmentation observed across the Julian and Balkan countries calls for a comparative approach to the medico-legal assessment of adverse outcomes associated with home birth. Finally, the Authors emphasise the need — already a statutory objective of the Balkan Network for Quality Improvement in Forensic Medicine — to promote the harmonisation of a shared autopsy protocol for feto-neonatal investigations across the Balkan countries, in order to reduce diagnostic discrepancies and technical errors that currently undermine the comparability of epidemiological data and the assessment of causal links in professional liability proceedings.

Keywords: *planned home birth; midwifery; autopsy; best practice*

O-29 MAL2026/ABS/061

An unusual factor in medical malpractice: inability to challenge authority figures and seniors

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Diagnostic and therapeutic errors in clinical practice do not stem solely from individual carelessness, lack of medical knowledge, or technical limitations. Human factors, specifically steep authority gradients, hierarchical pressure, and an institutional culture of silence frequently compromise patient safety. This paper presents historical and clinical case studies illustrating how an inability to challenge senior medical figures leads to severe surgical malpractice. It contextualizes these observations through interdisciplinary literature spanning Crew Resource Management (CRM), Psychological Safety, power distance paradigms, and systemic institutional reform. Mitigating medical errors caused by an inability to challenge authority requires structural protections, mandatory safety communication protocols, and psychological safety training. However, these clinical interventions cannot succeed in a vacuum. A broader democratic mindset within medical institutions and society is essential to dismantle autocratic practices and ensure patient safety remains paramount.

Keywords: *extraperitoneal cesarean section; authority gradient; hierarchical pressure; culture of silence; passive compliance*

POSTER ABSTRACTS

E-POSTERS

Shown on the e-poster screens at the venue and published on the conference website

P-01 MAL2026/ABS/005

Abnormal fetal abdominal circumference and intrauterine fetal death in a term pregnancy complicated by diabetes: a case report

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Background: Intrauterine fetal death (IUFD) in term pregnancy is a rare but one of the most severe adverse perinatal outcomes. Pregnancies complicated by pre-existing diabetes mellitus require intensified fetal surveillance due to increased risk of placental insufficiency, fetal growth restriction (FGR), and IUFD. Current guidelines state that abnormalities in fetal biometry, especially reduced abdominal circumference (AC) or discordance between AC and other parameters, should indicate further evaluation and closer monitoring.

Case description: We present a case of a 37-year-old primigravida with pre-existing type 1 diabetes mellitus and suboptimal glycaemic control. At 37 weeks of gestation, ultrasound showed discrepancy between gestational age and fetal biometry. Abdominal circumference corresponded to 34 weeks and 3 days, while other parameters were consistent with approximately 36 weeks. Estimated fetal weight was 2694 g, and HC/AC ratio was increased. According to medical records, no Doppler assessment of fetal or uteroplacental circulation, cardiotocography, or biophysical profile was performed after this finding, and surveillance was not intensified. Ten days later, intrauterine fetal death was diagnosed. A stillborn female infant without anomalies was delivered vaginally. Postpartum, severe uterine atony with massive hemorrhage required subtotal hysterectomy.

Evaluation: Autopsy showed a mature female fetus without malformations, with grade II maceration and autolysis, without ability to determine exact cause of death. Findings suggested possible late placental dysfunction and asymmetric fetal growth restriction. According to current guidelines, fetal biometry discordance would have required further assessment, including Doppler studies and intensified surveillance. From medico-legal point, documentation does not show that recommended diagnostic steps were performed after abnormal ultrasound finding. This raises concern regarding adequacy of clinical decision-making and adherence to standard antenatal care protocols in high-risk pregnancy.

Conclusion: This case highlights importance of correct interpretation of fetal abdominal circumference in pregnancies with pre-existing diabetes and adherence to surveillance protocols. Although causality cannot be proven, the case suggests a possible missed opportunity for timely fetal risk assessment and emphasizes importance of guideline-based clinical decisions and proper documentation in high-risk obstetric care.

Keywords: *intrauterine fetal death (IUFD); fetal abdominal circumference; type 1 diabetes mellitus in pregnancy; fetal growth assessment*

P-02 MAL2026/ABS/021

Health impairment in victims of sexual violence: medico-legal classification and documentation in a nationwide study in Lithuania, 2014–2023

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Background and aims: Sexual violence is a major public health and medico-legal concern and may involve physical violence and health impairment. Identifying patterns and factors associated with more severe outcomes may improve recognition, forensic assessment, and prevention. This study assessed health impairment documentation completeness and severity patterns by victim and offence characteristics.

Methods: A retrospective analysis included 3,046 victims of sexual offences recorded in the Departmental Register of Criminal Offences (Information Technology and Communications Department, Ministry of the Interior, Lithuania) during 2014–2023. Outcomes were classified under the Lithuanian Criminal Code as no impairment, physical pain, negligible, non-severe or severe health impairment, or death. Associations were assessed using chi-square or Fisher's exact tests and multivariable logistic regression.

Results: Health impairment status was documented in 1,035 cases (34.0%), with significant annual variation ($p < 0.001$). Among documented cases: 51.2% no impairment, 24.8% physical pain, 14.9% negligible, 7.1% non-severe, and 1.1% severe impairment; death occurred in 1.0%. Health impairment differed by age ($p < 0.001$): at least negligible impairment or death was recorded in 17.0% of children, 16.0% of adolescents and 42.6% of adults. More severe outcomes occurred in 7.0%, 7.1% and 14.1%, respectively. Adjusted for age and year, sex was not associated with either outcome. During the COVID-19 period (2020–2021), non-severe or severe impairment or death occurred in 16.7% of documented cases, versus 3.8% in 2018–2019 and 7.5% in 2022–2023 ($p < 0.001$). Rape remained associated with at least negligible impairment or death (OR 2.51, 95% CI 1.63–3.86) and more severe outcomes (OR 3.84, 95% CI 2.02–7.29), although model fit was limited.

Conclusions: Health impairment severity varied by age, time period, and legal classification. Lower documented physical impairment among minors may reflect age-related differences in assault dynamics. More consistent health impairment documentation could improve comparability and interpretation of medico-legal assessments.

Keywords: *sexual violence; forensic medicine; health impairment; injury severity; medico-legal assessment*

P-03 MAL2026/ABS/022

Positive stain is not proof: postmortem AFE biomarkers and malpractice claims, a literature review

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Background and aims: Amniotic fluid embolism (AFE) is a rare, heterogeneous obstetric syndrome with insufficiently understood pathophysiology and no definitive confirmatory method. Although it has been described as the anaphylactoid syndrome of pregnancy, the latest literature implicates interacting immune-inflammatory, complement, coagulation, and vascular pathways rather than simple mechanical obstruction. In medicolegal evaluation, postmortem biomarkers may support diagnosis but risk being interpreted beyond their validated evidentiary value.

Methods: A focused narrative review of PubMed and Scopus literature through 6 August 2026 examined postmortem and comparator studies of proposed markers, including fetal/amniotic components (squames, mucin, cytokeratins, STN/TKH-2, ZnCP-I, IGFBP-1), immune/mast-cell activation (C3/C4, C5a-CD88, tryptase, chymase), and thrombo-inflammatory pathways (CD61/GPIIb/IIIa, fibrin, neutrophil elastase, citrullinated histone H3), emphasizing specificity and postmortem interpretation.

Results: Evidence does not support any single marker as sufficient for diagnosing AFE or determining death causation. Fetal material may be present in maternal circulation without clinical AFE, while TKH-2 detects sialyl-Tn-bearing mucin but remains an unvalidated supportive, rather than confirmatory, marker of AFE. Tryptase may indicate mast-cell activation but lacks specificity and cannot confirm or exclude AFE. Platelet-rich GPIIb/IIIa-positive pulmonary microthrombi support thrombo-inflammatory activation but are not validated as specific diagnostic markers of AFE. Serum reflects circulating markers, whereas tissue demonstrates localized changes. Without validated postmortem thresholds, biomarkers should only corroborate clinical and autopsy findings.

Discussion / conclusions: Current evidence does not support the utilization of any postmortem biomarker alone to establish AFE, fatal causation, or malpractice. Expert assessment must distinguish biomarker detection from clinicopathological diagnosis, causal contribution, and breach of care. Biomarkers remain supportive, not determinative.

Keywords: *amniotic fluid embolism; anaphylactoid syndrome of pregnancy; forensic pathology; postmortem biomarkers; medical malpractice*

P-04 MAL2026/ABS/025

Right to bodily integrity: medical malpractice in cases of extended surgical procedures in gynecology

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The right to bodily integrity constitutes a fundamental human right, safeguarding the inviolability of the human body and patient autonomy in decisions concerning medical interventions. In gynecological surgery, situations may arise in which unexpected intraoperative findings prompt the surgeon to modify or extend the initially planned scope of the procedure. Such circumstances raise complex medical, ethical, and legal questions concerning the boundaries of professional discretion and the requirements of valid informed consent.

This paper examines the relationship between the right to bodily integrity, informed consent, and the professional standard of care in cases involving an extension of the initially agreed scope of gynecological surgery. Particular attention is paid to situations involving a transition from organ-preserving to radical surgery, the performance of hysterectomy instead of a previously planned limited intervention, and the removal of ovaries or fallopian tubes without the patient's explicit prior consent.

Drawing on the case law of the European Court of Human Rights, the Convention on Human Rights and Biomedicine (Oviedo Convention), national legislation, and relevant judicial practice, the paper explores the criteria under which an intraoperative extension of a surgical procedure may be justified by an immediate and unforeseen threat to the patient's life or health. Conversely, it examines circumstances in which such an intervention may constitute an unjustified interference with bodily integrity and give rise to medical liability.

The paper argues that, except in cases of an immediate and unforeseeable threat requiring urgent intervention, any substantial departure from the previously agreed scope of surgery should be addressed in advance through an adequate and procedure-specific informed consent process. The mere existence of a medical indication does not automatically substitute for the patient's autonomous decision. Failure to respect these boundaries may undermine patient autonomy and, depending on the circumstances, result in civil, disciplinary, or criminal liability.

Keywords: *bodily integrity; informed consent; medical malpractice; medical liability; gynecological surgery; extended surgical procedure; patient autonomy; professional standard of care*

P-05 MAL2026/ABS/033**Risk analysis of obstetric vacuum extractor use: from autopsy findings of caput succedaneum and cephalohematoma to adverse clinical outcome profiles**

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Background and aims: Vacuum-assisted vaginal delivery is an established obstetric intervention, but distinguishing physiological birth-related lesions from clinically significant trauma remains a major medico-legal challenge. In particular, differentiating caput succedaneum from cephalohematoma is crucial when evaluating the severity and forensic implications of vacuum-related scalp injuries. This study presents a case of obstetric vacuum extractor use to demonstrate the essential role of clinicopathological correlation in establishing legal causation and assessing potential medical liability.

Case and problem presentation: A retrospective forensic investigation was conducted on a male term neonate (40+5 weeks; birth weight: 3298 g) who died following vacuum-assisted delivery. A comprehensive medico-legal autopsy—incorporating targeted cranial dissection, systematic histopathological sampling, and placental examination—focused on determining the anatomical distribution and depth of extracranial hemorrhage. External examination revealed altered cranial morphology and a prominent caput succedaneum. Cranial dissection identified marked bilateral parieto-temporo-occipital hemorrhagic infiltration within the soft tissues, occurring in the complete absence of skull fractures, dural tears, or intracranial hemorrhage. The anatomical distribution and morphological features reflected soft-tissue birth trauma rather than the subperiosteal, suture-bound pattern characteristic of a classic cephalohematoma. Histological sampling further identified focal subepicardial hemorrhages alongside visceral hemorrhagic extravasations in the kidneys and right adrenal gland. Placental and umbilical cord examinations demonstrated no significant pathological abnormalities.

Discussion / conclusions: In forensic pathology, the differential diagnosis between caput succedaneum and cephalohematoma extends beyond descriptive classification to carry profound medico-legal weight. In this case, extensive extracranial hemorrhagic infiltration occurred without underlying skull fracture or intracranial hemorrhage, demonstrating that the presence of conspicuous birth trauma does not, per se, establish a fatal preventable mechanism. Differentiating an expected, recognized procedure-related complication from a potentially preventable adverse outcome requires a rigorous, integrated synthesis of lesion morphology, anatomical distribution, delivery dynamics, clinical evolution, and postmortem findings. Ultimately, this multi-parameter diagnostic approach is essential to deliver a scientifically robust assessment of causation and verify profiles of obstetric and neonatological liability.

Keywords: vacuum-assisted delivery; caput succedaneum; cephalohematoma; neonatal trauma; medico-legal assessment

P-06 MAL2026/ABS/034**The synergistic role of clinical evidence and autopsy findings in the diagnosis of intrauterine fetal death (IFD) due to abruptio placentae**

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Background and aims: Evaluating the precise etiology and medico-legal implications of sudden intrauterine fetal death (IFD) necessitates a comprehensive, integrated diagnostic framework. This study illustrates the synergistic role of clinical evidence and postmortem findings in analyzing a fatal case of abruptio placentae at 36 weeks of gestation in a fifth-pregnancy (G5) patient with a history of chronic smoking and prior unrevealing emergency department (ED) visits. The primary aim is to demonstrate how combining antepartum clinical records with fetal-placental pathology allows for an accurate reconstruction of event timing and objective assessment of professional liability.

Case and problem presentation: A retrospective forensic medico-legal investigation was conducted, integrating sequential ED clinical documentation, maternal risk profiles, and timeline reconstruction with a complete fetal autopsy and placental histopathology. In the present case, the patient had made multiple ED visits for non-specific complaints; in each instance, clinical and ultrasonographic evaluations were unrevealing. At 36 weeks, emergency admission led to the diagnosis of acute placental abruption and IFD of a female fetus. Gross and histological examination of the placenta revealed normovascularized chorionic villi with mature stromal axes featuring chorangiosis, vascular engorgement, and hypercellularity of the vasculosyncytial membranes. Furthermore, intervillous fibrinoid necrosis, extensive hemorrhagic infarction with scattered microcalcifications, severe vascular congestion, subchorionic and intervillous extravasation, and a retroplacental hematoma with erythrocyte-rich fibrin-hematic clots were observed, alongside normal umbilical cord membranes. Overall, macroscopic and microscopic examination of the various fetal organs revealed no congenital malformations or structural anomalies, demonstrating only non-specific alterations attributable to the hyperacute fatal event. The convergence of unrevealing antecedent clinical assessments and acute postmortem findings indicated that the catastrophic detachment occurred abruptly.

Discussion / conclusions: In complex forensic evaluations, establishing the etiology of IFD secondary to abruptio placentae relies on correlating clinical history with postmortem evidence. While chronic smoking and multiparity represent established risk factors, the absence of objective clinical or ultrasonographic indicators during prior ED presentations, combined with histopathological signs of placental insufficiency and autptic evidence of a hyperacute event in the absence of malformations, demonstrates the sudden and unpredictable nature of the event. This integrated approach, based on the synergy between clinical and postmortem evidence, is essential to provide robust grounds for establishing legal causation and assessing obstetric liability.

Keywords: *placental abruption; intrauterine fetal death (IFD); medical litigation; obstetric and gynecological liability*

P-07 MAL2026/ABS/035**Medico-legal aspects in the differential diagnosis of concurrent outcomes of perinatal cerebral sinovenous thrombosis (CSVT) and intrapartum hypoxic-ischemic events**

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Background and aim: Differentiating perinatal cerebral sinovenous thrombosis (CSVT) from the sequelae of intrapartum hypoxic-ischemic events is one of the most complex challenges in medical litigation. Because both conditions can present with overlapping neurological signs in the immediate postpartum period, establishing the exact etiology is crucial for determining legal causation and medical liability. In these cases, it is mandatory to outline a rigorous, evidence-based medico-legal framework that integrates clinical and neuroimaging profiles alongside long-term outcomes to clearly differentiate a localized vascular event from a systemic intrapartum hypoxic-ischemic insult.

Case and problem presentation: A retrospective forensic and clinical analysis of a malpractice case was conducted, focusing on delivery dynamics, neonatal clinical timeline, Apgar scores, and sequential brain MRI/MRV findings. In the presented case, in the presence of disputed Category II/III cardiotocography (CTG) during a term pregnancy (40+2 weeks), a vacuum extractor was applied to a deeply engaged fetus (birth weight: 3.2 kg; Apgar: 7 at 1 min, 9 at 5 min). Mild respiratory depression required brief ventilation. Focal seizures emerged at 6 hours and progressive EEG anomalies developed by approximately 40 hours, prompting a brain MRI/MRV. Imaging revealed diffuse ischemic suffering prominently localized in the left hemisphere due to superior sagittal sinus thrombosis (CSVT). Follow-up MRI showed malacic evolution in left-hemispheric with temporo-parieto-occipital extension. At 2 years, forensic examination confirmed a normal physical growth and complete absence of focal neurological deficits, alongside an overall neuromotor delay currently managed with rehabilitation therapy.

Discussion / conclusion: In complex forensic evaluations, a definitive differential diagnosis in case of concurrent outcomes of perinatal cerebral sinovenous thrombosis (CSVT) and intrapartum hypoxic-ischemic events relies on a strictly integrated approach combining clinical review and neuroimaging analysis. On one hand, the clinical presentation—specifically the obstetric and ante-partum data, the precise post-partum onset, temporal succession, and characterization of neurological signs and symptoms—can provide critical chronological context. On the other hand, radiological findings can offer essential objective data regarding the type, territorial distribution, and spatial extent of brain lesions.

However, in medico-legal analyses, differential diagnosis remains intrinsically bound to judgments based on the available evidence. Even when grounded in a meticulous weighing of available scientific evidence, such assessments carry inherent limitations. To provide robust grounds and reach a decisive verdict in court, these evaluations must harness every available supportive element to verify the different profiles of obstetric and gynecological liability.

Keywords: *intrapartum hypoxic-ischemic events; perinatal cerebral sinovenous thrombosis; differential diagnosis; medical litigation; obstetric and gynecological liability*

P-08 MAL2026/ABS/036

Challenges in the forensic evaluation of obstetric malpractice: the impact of conflicting expert opinions

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Background and aims: Medical malpractice is a legal term referring to when a health worker makes a mistake or fails to do their job properly, causing physical injury, harm, or death to a patient. The medical equivalent for it is clinical error. In Romania, references to medical malpractice can be found in two laws, but there is no dedicated legal framework for it. When a malpractice claim reaches a Court of Law a forensic medical expertise is requested to establish the authenticity of the claim.

Methods – case presentation: The case we are referring required a forensic expertise to establish if a pregnancy was correctly monitored by the physician and if the diagnostic and treatment applied during the labor period was adequate. As per Romanian legislation, a committee of three forensic doctors was constituted which decided that the opinion of an obstetrics-gynecology specialist was required. Based on the available medical information, literature data and the specialist's opinion, a report was submitted. Subsequently, the law enforcement authorities asked for clarifications regarding the conclusions of the initial report and the help of the specialist was requested again. The subsequent reports received from the specialist partially contradicted the initial one.

Results: One of the main pitfalls encountered in malpractice forensic expertise in Romania is the absence of officially appointed clinical specialists for the forensic malpractice committees, being up to the committee to find specialists willing to participate and, in many cases, without prior contact with them. Thus, a close collaboration allowing clear and concise case-oriented discussions is difficult. In the current case, given the limited timeframe, the committee was forced to interpret the available data without taking into account the specialist's report.

Discussion / conclusions: This case highlights the importance of clear communication and methodological consistency between forensic and clinical experts, essential elements for producing reliable malpractice forensic expertise.

Keywords: *malpractice; forensic expertise; clinical specialist opinion*

P-09 MAL2026/ABS/037

Delayed response to cardiotocographic deterioration in a fatal umbilical cord prolapse: a forensic case evaluation

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Background and aims: Umbilical cord prolapse is a rare and unpredictable obstetric emergency associated with acute fetal hypoxia. This case illustrates the forensic challenges of distinguishing an unforeseeable obstetric complication from potentially modifiable deficiencies in intrapartum management and of assessing their causal contribution to an adverse fetal outcome.

Methods: A medico-legal evaluation was performed in the case of a 33-year old pregnant women, with a term pregnancy complicated by prolonged rupture of membranes and meconium-stained amniotic fluid. Medical records, serial cardiotocographic recordings, obstetric documentation and postmortem findings were reviewed to assess fetal evolution, timing of deterioration, clinical response and the potential causal relationship between medical management and fetal death.

Results: Initial assessment did not demonstrate clear evidence of fetal distress requiring immediate caesarean delivery. During labour, cardiotocographic monitoring subsequently showed repeated decelerations and changes in fetal heart rate variability, with progressive deterioration beginning between approximately 03:15 and 04:37. At 05:55, a prolapsed pulsatile umbilical cord was identified and emergency caesarean section was subsequently performed. The fetus was delivered without possibility of successful resuscitation. Postmortem examination demonstrated findings consistent with acute intrauterine hypoxia, including meconium aspiration, bilateral pulmonary haemorrhage, shock kidneys and hepatic stasis. The forensic evaluation considered the umbilical cord prolapse an unpredictable major determinant of death, while identifying deficiencies in fetal monitoring and delayed response to cardiotocographic deterioration.

Conclusions: An indirect causal relationship was considered to exist between the medical management and fetal death. Although the triggering event—umbilical cord prolapse—was unpredictable, the adverse outcome might have been influenced by earlier recognition of fetal deterioration and more prompt obstetric intervention, which could have increased the probability of fetal survival. This case highlights the medico-legal distinction between an unforeseeable complication and potentially modifiable deficiencies contributing to its fatal outcome.

Keywords: *obstetric malpractice; cardiotocography; umbilical cord prolapse; fetal hypoxia; causality*

P-10 MAL2026/ABS/046**Umbilical cord abnormalities in intrauterine fetal death (IFD): forensic evaluation between predictability and preventability**

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Background and aims: Sudden intrauterine fetal death (IFD) associated with umbilical cord abnormalities presents complex medico-legal challenges. Establishing liability requires a strict conceptual distinction between ex-ante clinical detectability (the feasibility of identifying anomalies during antenatal exams), preventability, and causation. The present case highlights how standardized autptic and histopathological investigation serves as the objective baseline to separate these distinct medico-legal dimensions in cases of sudden IFD caused by umbilical cord abnormalities.

Case and problem presentation: A retrospective forensic medico-legal investigation was conducted, integrating serial obstetric records, cardiotocography (CTG), and ultrasonography with a complete fetal autopsy and placental-cord histopathology. In the present case, at 36+1 weeks, a pregnancy that was clinically uneventful—supported by reassuring CTG, normal biometry, and adequate amniotic fluid 24 hours prior—presented with sudden cessation of fetal movements and confirmed IFD. Gross and histological post-mortem examination documented a moderately tightened true knot paired with a severe focal cord diameter reduction (0.7 cm) and a hypercoiled segment. Forensic histopathology verified localized vascular compression, acute umbilical vein thrombosis, intervillous ischemic alterations, and multiorgan hypoxic distress (visceral petechiae and acute congestion) in a normally developed male fetus without congenital malformations. The convergence of reassuring antecedent clinical evaluations and hyperacute autptic findings indicated an abrupt mechanical circulatory occlusion.

Discussion / conclusions: In complex forensic evaluations, establishing the etiology of IFD secondary to umbilical cord abnormalities relies on correlating clinical history with post-mortem evidence derived by systematic autptic and histological documentation. Because umbilical cord abnormalities (true knot, false knot, cord length alterations, stenosis and umbilical arterial abnormalities) frequently lack ex-ante clinical detectability, post-mortem evidence is crucial in the evaluation of predictability or preventability (realistic possibility of timely intervention) of the event. This integrated approach, based on the synergy between clinical and post-mortem evidence, is essential to delineate diagnostic limits from professional liability in obstetric litigation.

Keywords: *intrauterine fetal death; umbilical cord abnormalities; fetal asphyxia; medico-legal investigation; obstetric litigation*

P-11 MAL2026/ABS/050**Recurring methodological problems in expert assessments of obstetric malpractice claims: a 12-case series****Tuğçe Koca Yavuz¹**, Laçin Lal Çakır², Fatime Gül², Erdal Mehmet Aksoy^{2,3}, Abdullah Coşkun Yorulmaz²¹ Council of Forensic Medicine, Istanbul, Türkiye² Department of Forensic Medicine, Koç University School of Medicine, Istanbul, Türkiye³ Institute of Forensic Medicine and Forensic Sciences, Istanbul University-Cerrahpaşa, Istanbul, Türkiye

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Background and aim: Obstetrics is among the specialties frequently subject to malpractice claims, given severe adverse outcomes such as maternal death, perinatal loss, hypoxic-ischemic encephalopathy (HIE), and cerebral palsy (CP). In such cases, expert assessment should rest on scientific methodology, causation analysis, and the contemporaneous standard of care. This study aimed to identify recurring methodological problems in previous expert assessments and how scientific expert opinions help reveal them.

Materials and methods: Twelve obstetric malpractice cases for which scientific expert opinions were prepared at the Department of Forensic Medicine, Koç University Hospital, between 2020 and 2026 were retrospectively reviewed. Cases were evaluated for report year, defendant and specialty concerned, gestational age, clinical and peripartum characteristics, maternal and neonatal outcomes, nature of the allegation, informed consent, previous expert reports, concordance between reports, and methodological problems identified during assessment.

Results: Adverse outcomes included two maternal deaths, one intrauterine fetal death, one maternal morbidity, seven permanent disabilities (CP/HIE), and one congenital anomaly. The most frequent methodological problems were attribution of CP etiology to intrapartum events without adequate causation analysis (n=6), hindsight bias (n=5), assessment of disability and actuarial loss before causation was established (n=5), excessive evidentiary weight assigned to cardiotocographic findings (n=4), application of standards not in force at the time of the event (n=3), and opinions formulated on incomplete records (n=3). Previous reports were discordant in seven cases and partially discordant in three. In three cases, additional documentation or findings not previously submitted were incorporated.

Conclusion: Recurring methodological problems were identified concerning causation, contemporaneous standard of care, interpretation of cardiotocographic findings, and completeness of medical documentation. Scientific expert opinions may contribute not only to the conclusion reached but also to systematic evaluation of the methodology, scientific reasoning, and causal chain underlying it. A structured, case-specific approach based on contemporaneous standards is important for the reliability and consistency of expert opinions.

Keywords: causation; cerebral palsy; expert testimony; hindsight bias; medical malpractice

P-12 MAL2026/ABS/052

Venous thromboembolism in postpartum period. A case report

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Background and aims: It is well known that pregnancy and the postpartum period in women constitute a high-risk state for the development of venous thromboembolism. This is due to elevated levels of fibrinogen and other coagulation factors, alongside reduced levels of biological anticoagulants in the organism. This process increases significantly if there are risk factors originating from the individual himself.

Methods: We present the case of a 27-year-old woman admitted for a scheduled cesarean section due to pelvic fetal disproportion, precluding normal vaginal delivery. No intraoperative or early postoperative complications occurred. During the 4-day hospital stay, the patient received anticoagulant prophylaxis with Fraxiparine (nadroparin calcium, which belongs to the low-molecular-weight heparin family) in dosage 0.4 mL once daily. She was discharged from the hospital without recommendation to continue anticoagulant therapy at home. Four days later, the patient was found at home collapsed and unresponsive. The emergency medical team confirmed death.

Results: Forensic autopsy revealed that the cause of death was acute pulmonary thromboembolism originating from deep vein thrombosis of both lower extremities. The forensic medical expertise concluded that, given the existing risk factors – recent cesarean section, obesity, smoking, metabolic syndrome, and immobilization with reduced physical activity, the patient should have received a higher dose of low-molecular-weight heparin during her hospital stay. Based on her body weight, the appropriate daily dosage would have been 2 x 0.6 mL per 24 hours, with continuation of anticoagulant therapy after discharge.

Discussion / conclusions: Risk factors should never be ignored, and every woman post labor should be consulted with a cardiologist to specify the necessary medication dose.

Keywords: *forensic medicine; forensic sciences; obstetrics & gynecology; malpractice; thromboembolism*

P-13 MAL2026/ABS/055**Areas of contribution of a medicolegal consultation system to patient safety in a foundation university hospital: a preliminary study based on institutional experience****Tuğçe Koca Yavuz¹**, Laçın Lal Çakır², Fatime Gül², Erdal Mehmet Aksoy^{2,3}, Abdullah Coşkun Yorulmaz²¹ Council of Forensic Medicine, Istanbul, Türkiye² Department of Forensic Medicine, Koç University School of Medicine, Istanbul, Türkiye³ Institute of Forensic Medicine and Forensic Sciences, Istanbul University-Cerrahpaşa, Istanbul, Türkiye

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Background and aims: Forensic medicine services are most often associated with the evaluation and reporting of forensic cases and the investigation of medical malpractice claims. However, a structured medicolegal consultation embedded within clinical practice may contribute more broadly to patient safety, risk management, and institutional learning. This preliminary study aims to describe the medicolegal consultation and advisory activities conducted by the Department of Forensic Medicine within a foundation university and to identify their principal areas of contribution to patient safety.

Materials and methods: The medicolegal activities carried out at the university hospital by the Department of Forensic Medicine, Koç University School of Medicine, since its establishment in 2019 were evaluated within the framework of a descriptive preliminary study. The activities were classified under the following headings: consultation and advisory services provided to clinicians and administrators, education; participation in mortality and morbidity assessments, forensic reporting, support for death certification, and involvement in patient safety and risk management processes. The study aimed to identify the domains addressed and the institutional functions, rather than to measure service volume.

Results: The activities constituted a multifaceted advisory model extending beyond the classical evaluation of forensic cases. Clinicians and administrators were provided with consultation on patient rights, informed consent, malpractice risk management, medical documentation, forensic case management, and health law. Medicolegal training was provided to medical students, residents, specialist physicians, and academic staff. Participation in mortality and morbidity meetings was undertaken. Forensic evaluation was performed in disability, trauma, and suspected sexual abuse cases. Clinicians were supported in cases of a forensic nature or in which death certification was uncertain and problematic. Contributions were made to open disclosure and "safe apology" processes. Five principal areas of contribution emerged: clinical decision support, accurate and timely documentation, education, risk communication, and institutional learning.

Conclusion: A structured medicolegal consultation system is not limited to the evaluation of forensic cases or the investigation of disputes. Beyond a reactive field of expert opinion, it may assume a proactive role in the early recognition of clinical risks and the support of institutional learning. Quantitative process and outcome indicators are needed to establish the position of the model within patient safety systems more objectively.

Keywords: forensic medicine; patient safety; medicolegal consultation; clinical risk management; health law

P-14 MAL2026/ABS/058**When medical malpractice is suspected but not confirmed: a multidisciplinary forensic analysis of maternal and fetal death following fulminant influenza A(H1N1) infection**

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Background: Maternal death is among the most challenging situations encountered in forensic practice, particularly when accompanied by allegations of medical malpractice. Distinguishing an unavoidable fatal outcome from substandard medical care requires comprehensive evaluation integrating clinical, pathological, and medico-legal evidence. We present a multidisciplinary forensic investigation of a maternal and fetal death following fulminant influenza A(H1N1) infection during late pregnancy.

Methods / case description: A complete medico-legal review was performed using hospital records, prehospital documentation, autopsy findings, histopathological examinations, toxicological and virological analyses, and an independent obstetric expert opinion. The patient, a 31-year-old woman at 36 weeks of gestation, developed fever and respiratory symptoms. Hospital admission was recommended during an outpatient obstetric consultation but was declined by the patient. Four days later, she was admitted with severe respiratory failure, rapidly progressing to fetal demise, emergency cesarean delivery, acute respiratory distress syndrome, and maternal death despite intensive multidisciplinary management.

Results / evaluation: Virological testing confirmed influenza A(H1N1) infection. Autopsy and histopathology demonstrated diffuse alveolar damage with hyaline membranes, bilateral bronchopneumonia, and acute respiratory distress syndrome as the cause of maternal death. Fetal examination revealed generalized hypoxic injury consistent with severe maternal respiratory failure. The forensic commission concluded that the clinical management complied with accepted medical standards. The recommendation for hospitalization had been appropriately made, emergency cesarean section was medically justified, and no objective evidence of medical malpractice was identified. The fatal outcome resulted from the exceptionally aggressive evolution of the maternal disease rather than deficiencies in medical care.

Conclusion: This case illustrates the crucial role of multidisciplinary forensic investigation in objectively evaluating alleged medical malpractice. By integrating clinical documentation with autopsy, histopathology, virology, and specialist consultation, forensic experts were able to reconstruct the sequence of events, determine the mechanisms of maternal and fetal death, and distinguish an unavoidable fatal disease from negligence. Such comprehensive evaluations are essential for ensuring scientifically grounded medico-legal conclusions in complex obstetric deaths.

Keywords: *forensic medicine; maternal death; medical malpractice; influenza A(H1N1); pregnancy*

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