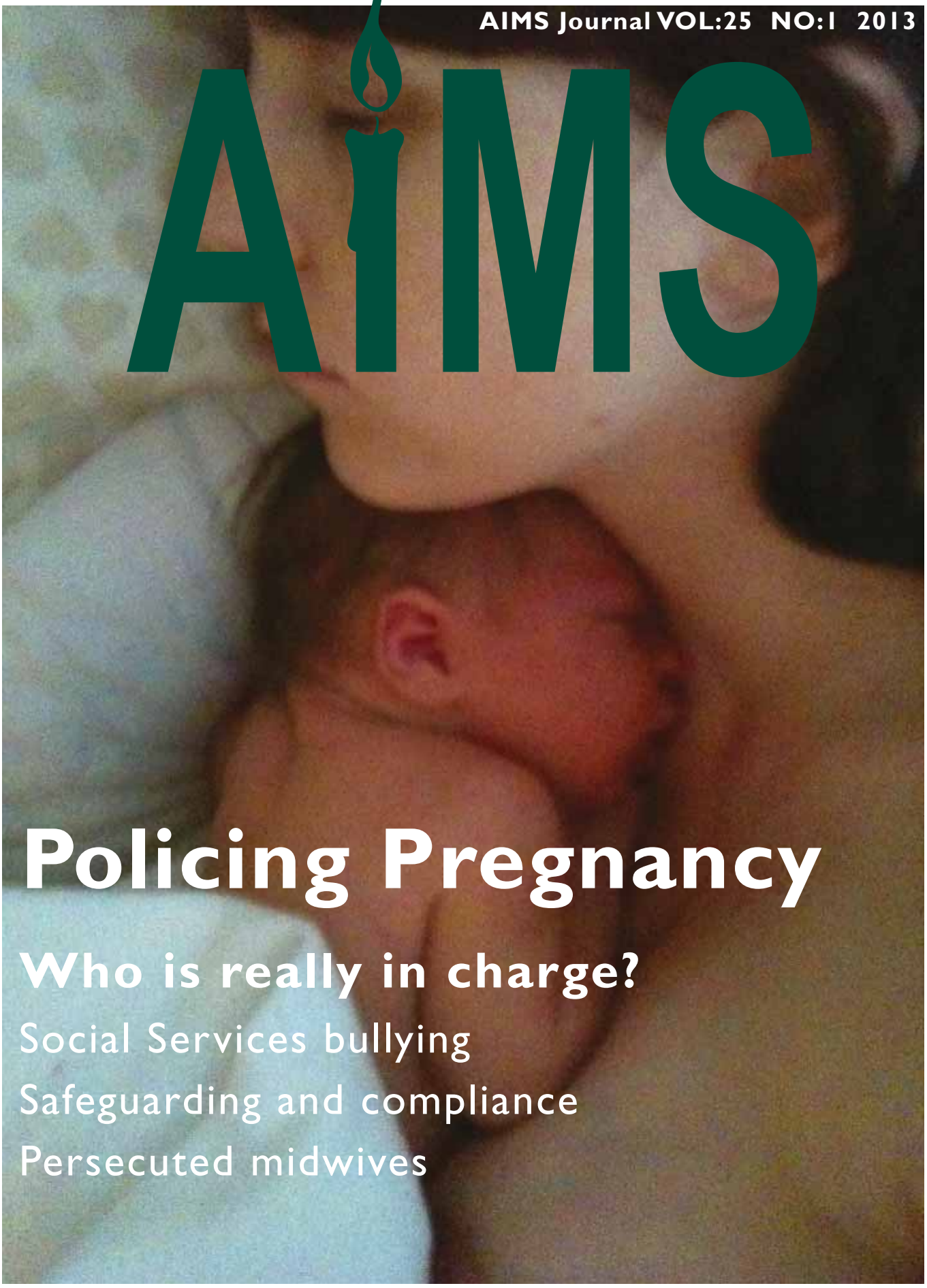
Association for Improvements in the Maternity Services

AIMS Journal VOL:25 NO:1 2013

AIMS



Policing Pregnancy

Who is really in charge?

Social Services bullying

Safeguarding and compliance

Persecuted midwives

www.aims.org.uk

Follow us on Twitter @AIMS_online • Find us on Facebook www.facebook.com/AIMSUK

Diary

AIMS Meetings

Friday 10 May – Wakefield
Friday 21 June – Oxford
AGM – Saturday 6 July – York
All AIMS members are warmly invited to join us. For further details, to let us know you are attending or to send apologies please email secretary@aims.org.uk

Old Bailey Protest

Justice for Becky Reed
Monday 11 March 2013 to
Friday 22 March 2013
See www.facebook.com/JusticeForBeckyReed for details

Hearing Postponed

International Conference on Transitional Care
Cutting the Cord
19 April 2013
University of Birmingham
Speakers:
Amanda Burleigh, RM
Dr David Hutchon
Professor Judith Mercer

0121 414 8606 / 8608
email: med-cpdbookings@contacts.bham.ac.uk
www.birmingham.ac.uk/facilities/mds-cpd/conferences/obstetric-conference/index.aspx

AIMS Workshop

Who's Afraid of the Big Bad Birth?
Kathryn Gutteridge
Thursday 25 April 2013
7:00 – 9.30pm
Birmingham
www.aims.org.uk/bigBadBirth.htm

Birth 4 Life
Family Health and Preventing Barriers to Attachment
22 April 2013

Embassy Centre, Skegness, Lincolnshire

Key Speakers
Kate Simpson, John Armitage, Jayne Grimshaw, Jane Donegan, Caroline Lee

£10 booked in advance
£15 on the day
www.birth4life.co.uk

MaMa Conference
Biology, Psychology, Politics and Practice of Maternity Care
26 & 27 April 2013
Assembly Rooms, Edinburgh

Confirmed Speakers:
Sheila Kitzinger, Soo Downe, Sheena Byrom, Joy Horner, Michel Odent, Amali Lokugamage, Mary Steen, Kathryn Gutteridge, Kerstin Uvnäs-Moberg, Margaret McCartney, Clare Willocks, Ina May Gaskin

www.mamaconference.co.uk

Association for Improvements in the Maternity Services
founded in 1960
by
Sally Willington 1931 – 2008

AIMS

campaigning for better maternity services for over 50 years

AIMS

Hon Chair
Beverley Lawrence Beech
5 Ann's Court, Grove Road, Surbiton, Surrey, KT6 4BE
email: chair@aims.org.uk

Hon Vice Chair
Nadine Edwards
40 Leamington Terrace, Edinburgh, EH10 4JL
email: nadine.edwards@aims.org.uk

Hon Vice Chair
Debbie Chippington Derrick
1 Carlton Close, Camberley, Surrey, GU15 1DS
email: debbie.chippingtonderrick@aims.org.uk

Hon Secretary
Vacant
email: secretary@aims.org.uk

Hon Treasurer
Stuart Lund
email: treasurer@aims.org.uk

Bookkeeper
Jackie Boden
email: treasurer@aims.org.uk

Publications Secretary
Shane Ridley
Flat 56 Charmouth Court, Fairfield Park, Lyme Regis, DT7 3DS
email: publications@aims.org.uk
Note: Orders by post or website only

Membership Secretary
Glenys Rowlands
8 Cradoc Road, Brecon, Powys, LD3 9LG
Tel: 01874 622705
email: membership@aims.org.uk

Website Maintenance
webmistress@aims.org.uk
Chippington Derrick Consultants Ltd

Scottish Network: Nadine Edwards
Tel: 0131 229 6259
email: nadine.edwards@aims.org.uk

Wales Network: Gill Boden
Tel: 02920 220478
email: gill.boden@aims.org.uk

Hon President
Jean Robinson

AIMS Research Group
A group has been established to review research for the Journal. If you are interested in joining the team, please email research@aims.org.uk

VOL:25 NO:1
ISSN 0265 5004

Journal Editor
Vicki Williams
email: editor@aims.org.uk

Editorial Assistant
Lori Fitzgerald

Journal Production Team
Beverley Beech
Gill Boden
Debbie Chippington Derrick
Nadine Edwards

Printed by
QP Printing, London
Tel: 020 3332 0102

©AIMS 2013

Association for Improvements in the Maternity Services. All rights reserved. Please credit AIMS Journal on all material reproduced from this issue.

Submissions to this Journal are the work of individual contributors and may not always reflect the opinions of AIMS.

Submissions to the AIMS Journal may also appear on our website www.aims.org.uk

Cover Picture:
© Melissa Thomas
Melissa and her baby, enjoying a peaceful moment between her unassisted birth and the intrusive involvement of Social Services. Melissa's story will be covered in a future issue of the Journal.

Contents

Editorial
Policing Pregnant Women 4
Vicki Williams

Campaigning
AIMS Campaign Network 5
Vicky Garner

Articles
Child Protection Guidelines 6
Samantha Davey

Safeguarding Compliance 8
Beverley Beech

Perinatal Mental Illness 12
Angeline Brunel Dickson

Bullying by Court Action 14
Jo Murphy-Lawless & Elizabeth Prochaska

Together Against Bullying 16
Lucia Ramirez-Montesinos

Reports
Birthrights 11

GAIN 21

One to One under Attack 25

Readers' forum
Colchester General Hospital 19
Lana Bartholomew

Humanity in Duty? 22
Zoë Foster

The Curate's Egg Service 24
Laura Robinson

Reviews
Bad Pharma 26
Gill Boden

News
The case against Becky Reed 27

Publications 28

Policing Pregnant Women

Vicki Williams shines a light at commonly accepted compliance strategies

Welcome to your 2013 new look AIMS Journal. It is now 53 years since Sally Willington wrote her first letters and began the avalanche of comment, campaigning and complaint that has put AIMS at the forefront of the quest for improved maternity care ever since. Many things have improved immeasurably for childbearing women since 1960, but it often seems that for every success another hurdle appears ahead.

One of the current major issues facing pregnant women is the insistence of health care professionals that they follow a prescribed and frequently rigid path of care: a path of care that often forgets that women have the right to decide what happens to their body, and a path of care that is all too often paying only scant or even no regard to currently available best evidence.

So entrenched is the belief of many health professionals in the guidance or protocol that fear often leads them to insist that a woman does what makes them feel most comfortable, most in control or, sadly, more powerful. This recurring theme was discussed by Johanne Dagustun in her article Beware the Dead Baby Card (AIMS Journal Vol 24 No 3) where she described how health professionals are understanding and using the power of passing fear on to the women they are caring for.

Taking this a step further into the realms of power and control brings us to the theme of this issue, where women are not persuaded to comply out of fear of something happening to them or their baby, but are threatened with the fear-inducing spectre of 'Child Protection', with the implication that there are agencies with the power to force compliance against parents' wishes, even implying that to not comply may result in court-ordered treatment or even the loss of their children to the care of the State.

The previous issue of the AIMS Journal (Vol 24 No 4) looked at the legal and moral rights of women (and parents in general) to accept or decline treatment as they see fit. This issue takes a look at just how pressures and practices aimed at ensuring compliance work, and how they affect those who are subjected to such blatant bullying, denying them their basic human rights.

The stories have a recurrent theme, and the message is clear: there are health professionals who believe they are better placed to know what is right for these parents and their children than are the parents. This imposition of someone else's choices upon others just because they are in a position of power is unacceptable. The use of the threat of taking children away from a parent is a clear abuse of human rights and an extreme form of coercion. Parents who are left feeling this threat is real will then comply with almost any requirement in order to avoid Social Services intervention.

All the women's stories in this Journal are of attempts by health professionals to bully them into compliance or seek revenge when they have made their own decisions to decline care. The case of Sarah Beverton on page 8 is one where not only was the woman threatened, but professionals decided to use her husband's employer to force him to force her (note the chain of coercion) to accept medical attendance at the birth of any future children.

On page 5 you will find a plea for you to get involved to help campaign for maternity services that are commissioned in a way that works for women. If we don't work hard for positive changes we will see many, many more women receiving fragmented care and being pulled to pieces by a system that fails to meet their needs on every level.

Equally worrying is the flip side of the professional bullying of parents; those situations where health care professionals who are advocating for women and supporting their choices are subjected to institutional bullying, investigation and even criminal proceedings simply for standing up for the rights and choices of those they care for. This is illustrated by the story of Lucia Ramirez-Montesinos on page 16 and of the cases taken against One to One Midwives (page 25) and Becky Reed (page 27). Bullied midwives need women's support. We all need to stand together to say this is wrong.

The Nursing and Midwifery Council (NMC) declares that its main role is to *'safeguard the health and wellbeing of the public'* (see www.nmc-uk.org). Its code sets out the standards of conduct expected of nurses and midwives:

- *'Make the care of people your first concern, treating them as individuals and respecting their dignity,*
- *'Work with others to protect and promote the health and wellbeing of those in your care, their families and carers, and the wider community,*
- *'Provide a high standard of practice and care at all times,*
- *'Be open and honest, act with integrity and uphold the reputation of your profession.'*

AIMS is at a loss to see how threatening women, making overzealous and damaging referrals to Social Services and bullying their colleagues, as seen in this Journal, fits that statement. We call on the NMC to stand behind its pledge and start supporting women and those midwives who put women at the centre of the care they give.

A bright light on the horizon is the launch of Birthrights (see page 11). A group of human rights legal experts have come together to provide support and information to women on their rights in childbirth and parenting, and have produced a range of fact sheets covering a variety of topics including rights around consent and treatment and on making complaints and facing criticism and threats under the guise of child protection.

AIMS is offering support to all those trying to exert their own rights, and those who are supporting or acting for them.

Vicki Williams

AIMS Campaign Network

Vicky Garner calls out on behalf of all mothers in the UK – a midwife for me and my baby!

In New Zealand in the 1990s there was a revolution in birth. Women and midwives came together to challenge what birth had become – a medicalised process, with little, if any, alternative. What emerged from this powerful union was a radical shift in maternity care to a system where the woman and her relationship with her midwife was at the core. It required some clever thinking, some bright minds, a great deal of noise and some hard work on the ground, but today New Zealand's maternity system is far from where it would have been if those events had not taken place. It is very possible that we in the UK could be about to have our *New Zealand Moment*, and we've got to seize it.

This year brings two major changes in maternity care – the overhaul of the commissioning process in England and the requirement for independent midwives to be insured. As the UK faces the threat of the loss of independent midwifery as we know it, it may seem strange to say that we are also being presented with an opportunity; one that is unlikely to come round again. This opportunity, if handled well, could help move us away from a system where women's control over their births is being increasingly eroded, towards one where women and their babies are respected, cared for and supported by midwives they know and trust.

AIMS, along with others, is taking the opportunity to examine how we can maximise the chances of our collective voice being heard. This is clearly not going to be given to us on a plate. We are going to have to fight for it, and we can't do it without **you**.

'No decision about me, without me' is the motto of the new Clinical Commissioning Groups (CCGs). This suggestion of upcoming potential to influence, coupled with recent government pledges to make maternity care more woman-centred, gives us hope.

The government has pledged to:

- invest in 5,000 more midwives so that continuity of care both before and after birth can be delivered;
- fund one-to-one care in labour and birth;
- ensure access to a full range of services so that women have a genuine choice about how and where they give birth.

These are promises that many of us have long campaigned for. We've heard them come from Ministers' mouths, yet it is hard to believe. Haven't we heard similar promises in the past? We need actions, not words. Coupled with these bold promises and memorable catchphrases are mixed messages. The move into the new world of clinical commissioning, where we, the users, get to shape the service, is accompanied by the threat to independent midwifery, which may remove any real alternative to NHS care. We are being handed the power to choose with one hand, while our choices are removed with the other.

As our government acknowledges the benefits of one-to-one care and giving every mother-to-be access to a full range of services, it also promotes the move towards increased centralisation of services. It is hard to see how herding women into huge obstetric units, or 'baby factories', can provide the personal, supportive relationship women want with their midwife; the care that has been shown to be best for mothers and babies. In short, the system is working against itself: it is confusing, destructive and is hampering improvement in maternal and infant health.

If you were to ask yourself how midwifery services should look in the future, what would you want? Surely you would want what is good for women, their babies and their families, and what makes financial sense. Perhaps something along the lines of:

'For any woman to be able to choose a midwife whom she can get to know and trust, who can support her through her pregnancy, birth and beyond, regardless of her circumstances or where her baby is to be born.'

The resounding message coming from women and their families is that this is what is good for them and their babies. This is a message that is wholeheartedly supported by the research evidence.

In response to the needs of women themselves, a group with representatives from AIMS, NCT, WI, IMUK, ARM, The Birth I Want and Birthrights have identified this as key to the government fulfilling its promises to deliver woman-centred maternity care. We also know that many midwives want this, but that they need to be enabled to work in a woman-centred way without sacrificing their personal lives.

April 2013 will see CCGs in England take responsibility for commissioning health services, including maternity. The government has laid out its stall. It has issued direction to CCGs that suggests woman-centred care is the way we should be heading. We've been told that maternity services will be informed by the user. Now it's up to us to make that happen. We need to be sure that in every part of the UK, women's voices are heard – championing services that work for women by providing continuity of care and delivering it within the community setting through free-standing MLUs and home birth provision. There are many ways to influence the shape of services, both from within and from without, locally and nationally, but it's all about speaking up for what we want.

AIMS intends to build a network of contacts ready to take action at both local and national level at this crucial time. Please go to www.aims.org.uk/?campaigns.htm to find out more and to register as part of the AIMS campaign network. Please join us, however small a contribution you feel you can make.

Vicky Garner

Child Protection Guidelines

Samantha Davey asks if they are Good Practice or a case of Guilty Until Proven Innocent

There is no doubt that protecting children is a role which hospitals must now accept. Tragedies such as Victoria Climbié[1] and Baby P[2] highlight the need for inter-agency communication and coordination throughout the child protection process. Hospitals are at the heart of this approach so as to ensure that concerns about babies and children at risk of significant harm or 'in need' are identified as early as possible. Once concerns have been raised, Working Together 2000 and Southend, Essex & Thurrock Guidelines suggest that there should be appropriate intervention ranging from provision of support for parents to a 'partnership' between parents and Social Services.

Recently, AIMS requested a copy of the *Good Practice Guidelines for Staff in the North East Essex Health Trusts.* Close scrutiny of the Guidelines reveals that an unnecessarily interventionist approach towards child protection appears to be encouraged in this region. This article explains the troubling aspects of the Guidelines and the implications not only for new parents but for future inter-agency cooperation between North Essex hospitals and Social Services.

The mantra that *'Child protection is everybody's business'*[3] makes it clear that any professional who has child protection concerns has a duty to act. However, the Guidelines indicate that parents are under hospital scrutiny from the moment of their child's birth. The Guidelines inform health professionals that: *'All staff coming into contact with children therefore needs to keep the possibility of abuse in mind and ensure they are adequately trained in its recognition.'*[4]

At birth, and on every subsequent hospital visit, health care professionals such as doctors and nurses are empowered to assess *'parenting capacity.'*[5] It is unclear what this involves and which parents will have sufficient parenting capacity and which will not. It is suggested that this could be wide in scope and may encompass any number of features of parenting, including rejection of aspects of orthodox medicine such as routine vaccinations. It therefore provides medical professionals with the ability to strongly influence parental choices about medical treatment.

Although looking out for obvious examples of parental inadequacy is common sense, the emphasis placed on assessing the ability to parent is unwarranted. If health care professionals think that a mother has insufficient skills to look after her baby, the next step could be a professional assessment from safeguarding nurses that the baby is at *'significant risk of harm.'*[6] The consequences of this are likely to be a referral to Social Services. Once Social Services become involved, actions could range from 'support' to removal of the baby from its mother.

The approach taken towards subsequent visits to hospital facilities after birth demonstrates a reversal of the burden of proof. Although health care professionals must not close their eyes to the possibility of neglect or abuse, they should not be actively looking for it. The Guidelines refer to the duty of 'screening'[7] all children attending Emergency Departments and Drop-In Centres. It is unclear what is meant by *'screening'* but it does seem to suggest that any visit should be considered to give rise to the possibility of neglect/abuse. This means that health care professionals could be actively on the lookout for abuse and may adopt a defensive approach in respect of care. If a doctor or nurse is of the opinion that a child has been abused, significant weight will be attached to such an assessment, despite the fact that there may be no evidence to support it. Parents will then find themselves in the position where they have to prove a negative; that they have not abused their child.

It is more troubling if a baby needs to be taken to hospital. The Guidelines indicate that the younger the child is, the greater the need to be on the lookout for possible signs of abuse. Although health care professionals must be vigilant in ensuring that infants and young children are protected, the Guidelines appear to assume that certain injuries must be caused by abuse and it is for the parent to prove otherwise. They provide a thorough explanation of different fractures a young child may receive and the likelihood that such fractures are caused by abuse. It states that: *'The presence of a fracture in an infant frequently indicates more severe abuse'*[8] and also that: *'The younger the child the greater the likelihood of abuse. One or more fractures in a child less than 1 year is highly suggestive of abuse.'*[9]

This means that should a baby sustain one accidental fracture, it is likely to be assumed that the parents have abused the child rather than presumed innocent unless there are other warning signs. As a consequence, parents may find it difficult to take their baby home unless they can provide an explanation which satisfies health care professionals. Guidelines like this increase the likelihood of parents being treated as guilty until proven innocent, with possible Social Services involvement placing strain on the whole family.

The Guidelines about fractures are based solely on two studies from 1984 and 1999. The Guidelines suggest that spiral fractures are 'unusual' and raise concerns about abuse.[10] Cage and Salus (2010), for example, suggest that spiral fractures can be caused by accidents, for example babies getting their feet caught in crib slats, and do not always suggest that abuse has taken place.[11 12 13] It is crucial that more recent academic literature should be used for support considering the likelihood of Social Services involvement under the circumstances.

It might also be wise for the Guidelines to place a greater emphasis on observation of other features

coupled with a fracture which might be suggestive of abuse, e.g. the demeanour of the child, the nature of the bruising in conjunction with the fracture or the provision of a version of events which is inconsistent with the nature of the injuries. This and a consideration of possibilities other than abuse, such as bone disorders, would make the Guidelines much more effective.

The most alarming feature of these Guidelines is that once Social Services have decided not to accept a referral from the hospital, one might be forgiven for thinking that beyond passing on concerns to the family GP, that would be the end of the matter. This is not the case. The Guidelines state: *'DO NOT GIVE UP if your referral was not accepted, you are free to raise your concerns again.'*[14] This means that even if Social Services are satisfied that a child is not being neglected or abused, further action is encouraged in spite of it.

So not only may parents be treated as guilty until proven innocent but once they believe that their innocence has been 'proven,' health care professionals have carte blanche to continue to pursue parents. This aspect of the Guidelines does not reasonably strike a balance between protecting babies and children versus protecting the interests of the family as a whole. If anything, in this author's opinion, these Guidelines may encourage some health care professionals to engage in their own abuse of parents.

Furthermore, the Guidelines fail to emphasise the notion of 'partnership' in the child protection process. Health care professionals should attempt, to the extent that it is possible, to work with parents. This means that they should explain their concerns and try to resolve matters without conflict, rather than place families under unnecessary stress and put parents on the defensive. The Guidelines may indirectly encourage health care professionals to threaten involvement of Social Services if parents fail to comply with their suggested treatment plans.

The lack of 'partnership' between parents and health professionals and the injustice that can be caused by these Guidelines are apparent. It is necessary to strike a balance so that children are protected without, in the case of blameless parents, harm being caused to the well-being of families as a whole. The danger of unnecessary intervention of health care professionals is demonstrated acutely by the Cleveland Crisis,[15] where a number of families were torn apart because of the work of Marietta Higgs, which was later discredited.

As Jean Robinson has pointed out, even short-term unnecessary intervention can be extremely harmful to families.[16] This is of particular importance when considering a newborn baby, as the more vulnerable the child is, the greater the perceived need for intervention. Unfortunately, unnecessary and excessive state involvement can be especially harmful to new mothers who may lose important opportunities for bonding, breastfeeding and happy memories of a special time.[16]

New parents who have had an unpleasant brush with health care professionals and Social Services may fear 'punitive' measures in the future. Therefore, as Jean Robinson has suggested, women may conceal mental health problems, postnatal depression, rape or any other traumatic life event in case their children are taken away. Parents might even avoid orthodox medicine altogether to avoid even the slightest possibility that they might be parted from their children.[16]

The Guidelines may also have implications for the working relationship that the NHS has with Social Services. If a hospital makes a large number of referrals despite concerns being dismissed by Social Services, it could become apathetic towards genuine concerns. The little boy who cried wolf comes to mind here; if a hospital makes numerous groundless referrals, Social Services may be less inclined to take referrals from specific health care professionals seriously. The last review of these Guidelines apparently took place in February 2007. In this writer's opinion, these Child Protection Guidelines are cause for 'concern' which should be addressed and amended as soon as possible, for the Guidelines introduce much more potential for abuse than they are likely to prevent.

Samantha Davey

References

1. www.victoria-climbie-inquiry.org.uk/
2. www.bbc.co.uk/news/education-11621391
3. NHS (2010) Good Practice Guidelines for Staff in the North East Essex Health Trusts. p.5
4 Ibid p.10
5 Ibid p.6
6 Ibid p.13
7 Ibid p.6
8 Ibid p.10
9 Ibid p.10
10 Ibid p.10
11. Cage R and Salus M (2010) The Role of First Responders in Child Maltreatment Cases: Disaster and Nondisaster Situations. Available at www.childwelfare.gov/pubs/usermanuals/first_responders/appende.cfm
12. Hobbs C (1984) Skull fracture and the diagnosis of child abuse. Arch Dis Child 59:246–252
13. Hobbs C, Hanks H and Wynne J (1999) Child Abuse and Neglect: A Clinician's Handbook, Volume 682. Elsevier. London
14. NHS (2010) Good Practice Guidelines for Staff in the North East Essex Health Trusts p.20
15. Forster M (2008) Cleveland Child Abuse Crisis – Twenty years on. Available at www.bbc.co.uk/tees/content/articles/2007/05/21/child_abuse_feature.shtml
16. Robinson, J (2008) Child Protection. AIMS Journal Vol 20 No 1

AIMS moves one stop closer to charitable status

You may be surprised to know that AIMS is not a charity; at the moment we are a voluntary organisation, but are planning to change. At an EGM (Extraordinary General Meeting) in Bristol in January we took the following vote to take the next step. We will become an Incorporated Company and apply for charitable status.

The advantages of charitable status include:

- exemption from the payment of tax on most of our income;
- eligibility to apply for grants;
- eligibility to receive gifts made under tax effective schemes such as Gift Aid and Give As You Earn;
- raising the profile of AIMS to gain public support.

We will keep members informed via the Members' Yahoo Group and the Journal.

Safeguarding Compliance

Beverley Beech reports on a situation of extreme retaliation against parents who disengage

In March 2006 Sarah Beverton gave birth to her first baby at home. She was not happy with the care she received from the midwives in York, as she felt pressurised during the labour; so when she became pregnant the second time, after moving to South Tees, she decided that, this time, she would give birth and not call the midwives as she felt similarly about the midwives at the two antenatal clinics she did attend.

Sarah's second baby, Rosa, was born on 16 March 2010 (7lbs 12oz) without any complications. On Friday 19 March Sarah and her husband, Kieron Beverton, phoned the midwives to tell them about the birth. The midwife arrived and made it quite clear that she did not approve of their decision, despite this being a decision that the mother has an absolute right to make. In the notes she recorded *'Sarah had a planned home birth on Tuesday without any medical attendance. This was Sarah's own decision and had not been pre discussed with staff.... discussion regarding concerns of not informing staff of delivery, aware Social Services and Child Protection have been informed. No concerns found today at visit, honest and open as to why didnt [sic] want anyone to be present.'*

According to South Tees Local Safeguarding Children Board (LSCB), Midwife Jayne Graham followed the Safeguarding Children Procedures and *'correctly identified that failure to access appropriate medical care and treatment for Rosa, both antenatal, and for three days following her birth, constituted a potential child protection concern... Therefore, Midwife Graham sought advice from Mrs Helen Smithies, Named Nurse for Safeguarding Children, and it was agreed to submit a child protection referral to the Social Services Department.'* In a subsequent letter to AIMS Mrs Tricia Hart (Director of Nursing and Patient Safety) wrote: *'It was established that, should the Trust become aware in future that appropriate medical care was not being sought for Rosa, a further child protection referral should be submitted.'* [Note: Safeguarding Teams have no Safeguarding Midwife: maternity is covered by the Safeguarding Nurse, and we have seen many cases where their ignorance of midwifery has led to errors.]

The assumption was made that the kind of parents who reject orthodox birth care, because of their past experience of it, had behaved unacceptably and they had therefore endangered the fetus, and, furthermore, were the kind who might not seek medical care if their child needed it in future. We are in touch with many parents who have made similar choices, and the evidence we have is that they are particularly caring and thoughtful parents and have in the past always sought medical care for their children when necessary. The assumption is unjustified and not based on any evidence. What it does show, is that health care professionals are unhappy with parents they feel they cannot control, and that they must be taught a lesson. That is exactly what South Tees midwives involved with Sarah's 'care' then proceeded to do.

What gives Midwife Graham and the Safeguarding Children Team the right to say that Sarah had endangered her fetus? A fetus has no status in law and a mother has an absolute right to take the action Sarah did. This is yet another example of health professionals acting where they have no right to do so. Once the baby was born she was healthy and well cared for, so there was no neglect. She did not need medical attention, and if she had, doubtless it would have been sought. Since when did it become a crime not to seek assistance for a healthy child?

repeatedly visited by the midwives

Over the next week Sarah and Kieron were repeatedly visited by the midwives (on three occasions with the excuse that they had forgotten their oxygen saturation equipment – if the baby really needed this equipment she would have required immediate transfer to hospital – clearly she had no need for it and this was just an excuse for repeated visits) and by 26 March the Bevertons had had enough and called the community midwife team to cancel all further appointments, but were told that the midwives had to come again to discharge them officially. *'We weren't willing to let them come again, having had so many visits already and an appointment planned with the health visitor on Monday, but we were told that in that case they would refuse to do the notification so that we wouldn't be able to register Rosa or claim tax credits or child benefit. The woman that we spoke to was the team manager [Sue Smethurst] who also said they would have to "re-inform" social services.'*

When, some months later, Mrs Beverton asked for her records and the minutes of the meeting that decided to inform Social Services, she received a letter which stated: *'You assume that a strategy meeting was undertaken in relation to the birth of your daughter Rosa. Feedback from our Enquiry and Assessment Team indicates that there was no such meeting. Computer records are limited to two contact entries where no further action was taken and the information was recorded for information only.'* (letter, 26 October 2010). So, it would appear that although the Bevertons were constantly threatened with Social Services, no such action had been taken.

Concerned that time was passing and their baby was still not registered, Sarah and Kieron went to register the birth but the Registrar informed them that he could not register the birth as he did not have an NHS number, and the NHS number could only be obtained by making a 'notification' of the birth to the Primary Care Trust's Child Health Department.

The 1907 Notification of Birth Act states that: *'When a baby is born at home with a midwife in attendance the midwife will make the notification'.* It also states: *'In the case of every child born it shall be the duty of the father of the child, if he is actually residing in the house where the birth takes place at the time of its occurrence, and of any person in attendance upon the mother at the time of, or within six hours after, the birth, to give notice in writing of the birth to the Chief Administrative Medical Officer of the Health Board [now the Child Health Department at your local Primary Care Trust] for the area in which the child is born, in manner provided by this section.'*

As these notifications are invariably done by the midwives, very few parents know of this Act's existence. Although the couple repeatedly asked the midwives to do the notification this was not done. On a Child Protection Referral Form written by Claire Allen (Specialist Nurse Safeguarding Children) she noted: *'As Rosa's birth cannot be registered she will not be allocated an NHS number. Our organisation has sought legal advice and this could be achieved by her being registered with "parents unknown". Mr and Mrs Beverton will then have to apply to have their names put on the birth certificate. This could require DNA tests to ascertain they are the parents. Until this is achieved the parents do not legally have Parental Responsibility. Our organisations* [sic] *legal advisor believes it is Children's Social Care's responsibility to ensure this process is carried out. The concern remains that Rosa's health needs are not being met. The circumstances surrounding her birth and the patient's refusal to have any medical assessment need further investigating.'*

no evidence at all that Rosa's health needs were not being met

Fortunately, the Bevertons were unaware of this at the time, although the midwives had informed the Bevertons that a DNA test might be required, and the Bevertons' attempts to find out precisely where this 'notification' was required to be made got nowhere. Furthermore, there was no evidence at all that Rosa's health needs were not being met. So, AIMS wrote a letter of complaint to the Trust about the way this couple had been treated and appealed for the registration to be expedited. Little happened, so AIMS tracked down the relevant department, rang the clerk concerned, and established that, to date, no one had registered the birth. AIMS advised the Bevertons to go to the department themselves and notify their baby's birth. This they did, and they then visited the Registrar (on 27 April aged exactly 42 days, the last day of the time limit for registering births) and registered their baby. Although many families have told us that the mother has given birth without professional attendance after unacceptable previous care, and some have been reported to Social Services, South Tees staff's reaction, in our experience, is extreme retaliation.

However, the saga did not end there. Kieron Beverton works as a care assistant at another Trust. A month after the letter of complaint had been sent, and after the family believed that all had been resolved, Jane Sonnen (the Local Authority Designated Officer (LADO) for Middlesbrough's Review and Development Unit) committed a gross breach of Mrs Beverton's confidentiality. She wrote to Alison Woodhouse at York Primary Care Trust (Kieron's line manager) informing her that Mrs Beverton had given birth:

'with no medical intervention to a baby girl name [sic] *Rosa. When challenged about the possible risks of such a pregnancy and birth Mr Beverton replied "we are not stupid and had done lots of research on the internet." The couple also indicated they would consider another child by using the same pregnancy/birth plan.*

'Mr Beverton I understand is in a position of power and trust in his full time role at York. The individuals in his care are often the most vulnerable in society, therefore given the above information it was felt appropriate at this time to make you aware of the circumstances as highlighted above.

'From a LADO perspective, it remains the responsibility of York to consider if the issues raised constitute a referral and risk assessment. Middlesbrough Borough Council act in the role of ensuring all relevant information is shared.

'I am sure you will appreciate safeguarding is all person's [sic] *responsibility and therefore communication regarding the protection of children and vulnerable adults should be clearly evidenced.'* (Mr Beverton works for the mental health service, as a care assistant for working-age adults.)

Firstly, this was a gross breach of Sarah Beverton's confidentiality. Secondly, Jane Sonnen seems ignorant of the fact that the decision as to how and where to give birth was the mother's, and hers alone. The legal position is that Mr Beverton committed no offence by being present and supporting his wife. His offence in the eyes of Jane Sonnen, apparently, was that he supported his wife and did not disagree with her. Does the man who supports and cares for his wife become a less responsible person, and therefore less able to care for others at work? Or is their sole criterion for carers 'obedience to authority'?

As a result of this letter Mr Beverton was called to a meeting with Julia Lidster (Service Manager – Recovery) and after that meeting he wrote the following to her:

'I was more than slightly surprised to be called into your office following my return from paternity leave to discover that you had been contacted by Middlesbrough Child Protection Team who, I understand from you, has informed you that my wife gave birth at home illegally and that I too was breaking the law by being there. I also understand that the team informed you that the police have interviewed me and so too have social workers. This is untrue, neither the police nor social workers have approached me or my wife.

'As I said at the meeting it is not illegal to give birth at home without a midwife and I am surprised that Middlesbrough Child Protection Team has contacted you. I would be grateful if you would give me a copy of the letter that alerted you to this and I would also like to know who it was who contacted you.

'I note that you insisted that I should agree that there should be no repetition of this in the future because if it happens again you would have to arrange an investigation.'

On 16 May Julia Lidster replied: *'I hope from our meeting you have taken note of the seriousness of this issue as I said the PCT has a responsibility under the safeguarding children legislation and as an employee for the PCT you have a significant role in upholding this.'* Clearly, she had not taken the slightest notice of what he had said and appears not to understand the gross breach of confidentiality that had occurred. Nor did she understand that the decision of how and where to birth was his wife's and not his.

So a complaint went to the South Tees Hospitals NHS Foundation Trust and the Trust's response to AIMS' complaint followed a standard many page account of the 'care' provided and an assurance that had the midwives known of Mrs Beverton's intentions *'the Midwifery Service at STHFT would have supported them and acted as their advocate in their wish for a home birth.'* (This Trust has a 0.6% home birth rate, clearly **not** supportive of home birth.) It contained a number of apologies, some 'sincere', and claims that the staff were very sorry for any distress that may have been caused.

far beyond her social care responsibilities

A complaint was also made to the Information Commissioner on the grounds that Jane Sonnen breached confidentiality and went far beyond her social care responsibilities. Reporting Mr Beverton (who works with vulnerable adults) to his manager on the grounds of 'Safeguarding Children' was stretching the requirements to the limit. The Information Commissioner agreed: *'We wrote to the Council about this matter and have now received its response. On the basis of all the information provided by you and the organisation, we have decided that it is unlikely that the Council has complied with the requirements of the DPA [Data Protection Act].*

'The Council has explained that they have statutory social care obligations, and this disclosure was in support of their duty to safeguard children. The Council is therefore relying on section 35(1) of the DPA, which allows an organisation to disclose information where the disclosure is required by or under any enactment, by any rule of law or by order of a court.

'However, any disclosure made should still be relevant to the circumstances. In this case, it is not clear why this disclosure was considered necessary or what such a disclosure could aim to achieve. It is for this reason that we take the view that it is unfair.'

The Information Commissioner decided not to take action against Middlesbrough Council at this time and has asked it to *'take steps to prevent the situation happening again'*; and he will be keeping a record of this complaint and take it into account should he receive further complaints about Middlesbrough Council.

There is no law that states that a woman must call a midwife or a doctor when she goes into labour, and any woman is free to decide whether or not to avail herself of antenatal care and to birth without a professional attendant. In this case, Mrs Beverton made her decision as a direct result of the treatment she had received before from midwives, in another Trust, and concluded that she was better off birthing alone.

The experiences of this couple highlight the knee-jerk reactions we are increasingly seeing when women make decisions that are outside the standard care provided (or not, as in so many cases). This couple was threatened with being reported to Social Services and this was justified in the Trust's response on the grounds that *'the STHFT Safeguarding Children Policy requires that, where staff identify an actual or potential child protection concern during the course of their work, they should consult the Local Safeguarding Children's Board Procedures and, if considered appropriate, submit a referral to the Social Services Department.'* One has to ask 'what was the actual or potential child protection concern?' Mr and Mrs Beverton were already successfully raising their eldest child, who was a fit and healthy four year old, and Rosa too was fit and healthy. It was acknowledged in the case notes that there were *'no concerns expressed about care of the children'*. One can only presume that this was either a case of the midwives covering their backs, and ticking the appropriate box, or a means of bullying the parents in the futile hope of preventing them taking similar action in the future.

Indeed, when tracking down the paperwork Middlesbrough Council's Children's Complaints Manager acknowledged that *'It appears that there was never a Strategy Meeting held by this Department in relation to concerns for Rosa's well being. This is because there has never been sufficient concern to warrant such action.'*

This statement is supported by the Trust's record of the telephone discussion between Sue Smethurst and Helen Smithies (the Named Nurse Safeguarding Children) which states that *'she* [Sue Smethurst] *does not intend to take any further action at this time'* but then the record goes on to threaten that *'If we become aware that antenatal care is not being sought for future pregnancies a referral will be made to children's social care.'*

Clearly, Sue Smethurst and Helen Smithies are unaware that antenatal care is not mandatory and if Mr and Mrs Beverton choose not to avail themselves of it that is their decision.

It is a principle in AIMS that we support a client to take whatever action they consider to be necessary. Mr and Mrs Beverton wanted to make a formal complaint to the Information Commissioner about Jane Sonnen's breach of confidentiality, but they had been so traumatised and upset by the constant intrusion into their lives, and the threats, they did not feel able to continue with a complaint, but asked AIMS to do so on their behalf. This was duly done.

The experience of this couple highlights the current state of 'monitoring' and 'surveillance' that has developed in maternity care in recent years. The requirement for midwives to report any 'concerns' to Child Protection was brought in without any ethical discussion within the midwifery profession. Midwives have simply rolled over and agreed to these requirements.

Gone are the days when a woman could trust her midwife, indeed midwives portrayed themselves as 'the woman's advocate', something, ironically, that was mentioned in the Trust's letter. What we now have is midwifery as another extension of the State's surveillance and monitoring of every aspect of our lives. If we do not comply, then Social Services will be involved. It is an outrage that not only was this couple threatened with being reported to Social Services but that they have been informed that their behaviour in the future will be monitored should they have the audacity to repeat their decision. These threats are hardly likely to encourage them to go anywhere near anyone in authority, particularly midwives.

In 2001 the Nursing and Midwifery Council disbanded its Ethics Panel with barely a whimper. In the light of this case, and far too many other similar cases, it is time that an Ethics Committee was reinstated and midwives seriously consider their role as the mother's advocate and how that can be achieved in the face of the demands of the State monitoring and reporting system, and the temptation for individuals to use the system as a method of control when they do not approve of the parents' decisions.

Beverley Lawrence Beech

Birthrights

Protecting human rights in childbirth

On the evening of Thursday 24 January several member of the AIMS Committee were pleased to be able to attend the launch of a new charity, and were absolutely delighted to see such widespread support from many other organisations, both lay and professional, for the launch of this important and groundbreaking organisation.

Birthrights is the brainchild of Elizabeth Prochaska, a practising barrister. She has been ably supported by Louisa Noël, a non-practising solicitor, and Rebecca Schiller, a doula who has charity and NGO experience, most recently at Human Rights Watch, both of whom have taken on Trustee and other roles, to make this charity possible.

Elizabeth gave an inspiring speech explaining her journey to launching this charity, which can be read here: www.birthrights.org.uk/wordpress/wp-content/uploads/2013/01/Birthrights-Launch-Speech.pdf

Elizabeth, Louisa and Rebecca are also mothers with a range of birth experiences; they have a deep understanding of the importance of a good birth experience for mothers, babies and their families. They have established good connections with lay organisations, including AIMS, which will enable them to appreciate more fully the issues that women are encountering and to support these organisations in supporting women more effectively. They are providing support and information to midwives who have found themselves persecuted for providing the care that women have requested of them when this has contravened guidelines and policies.

They summarise what they do as:

- Provide free, accurate and accessible legal information and advice on human rights and the law relating to childbearing women.
- Campaign on respect for women's rights in childbirth as fundamental human rights that maternity-service providers are legally obliged to respect and fulfil.
- Offer advice, assistance and training to caregivers, professional or otherwise.

Please take the time to look at the Birthright website (www.birthrights.org.uk) which already offers a range of invaluable resources including factsheets covering issues such as Consenting to Treatment, Choice of Place of Birth, Making a Complaint and Unassisted Birth.

Perinatal Mental Illness

Angeline Brunel Dickson writes about her experience with postnatal depression and how this led to a group of women making a film about their experiences

I had been writing about my own experience for approximately six months when I was approached by the Mental Health Network to meet and discuss how we could try to raise awareness and to help make positive changes to services being provided to women in Glasgow and the surrounding areas.

This was the beginning of something really great and we continued to meet each week. We were then advised that the NHS and the Anti Stigma Partnership would be awarding us a sum of money to help us raise awareness in any way that we thought would be effective and beneficial. One member of our small group came up with the idea of making a film about our experiences, an honest account of our feelings about our own individual recovery process. As we had all had different experiences of PND, prenatal depression and support within the Mother and Baby Unit, located at Glasgow Southern General, we felt that it was an account which spoke for a wide range of women and also understood that other cultures and men also experience perinatal mental illnesses.

Once it was decided that we were going to go ahead with the film, we then had to interview production companies, to make sure that our story would be told in a true and honest way and to make sure that our experiences would be felt by those who would be watching, so that they could feel how far we had come in our recovery and also gain insight into the depths of darkness that is felt when going through this illness. We wanted our stories told in a way that could be understood, not for sympathy but for empathy, in order to help others. It is also important to note that we were supported by Elaine Clark and Roch Cantwell from the Mother and baby unit to produce this film.

After going through many different applications from many different companies, and also the interview process, we decided to go with a company called 'Urban Croft', based in Film City in Glasgow. Martyn Robertson and Emma Hagen were able to work with us, gain our trust and take us back to 'that place' safely, and then bring us back again using techniques such as psycho drama – Emma is a qualified psychotherapist. They were understanding, professional and amazing to work with and we couldn't have produced such an amazing piece of work had it not been for them. They captured the feelings and emotions felt by us, supported and understood what we had gone through and why it was so important to deliver the message that we wanted to get across to those watching, whether it be a consultant, GP, midwife, survivor or someone experiencing perinatal mental health issues.

Once we finished the filming, we went through the editing process until we were happy with the final piece of work. We waited for the Scottish Perinatal Mental Health Conference where I was able to present the film on behalf of the group. It was a very nerve-wracking experience but one which I felt proud to do, in order for the audience to see how empowering the experience can be. The film was well received by most and although the odd comment was raised over child protection and other issues, we were not prepared for the amazing amount of support and positivity which came our way. We were inundated with requests to use the DVD in other areas of Glasgow as a teaching aid and also for showing to people who were going through perinatal mental health issues. It also led to the formation of Maws (meaning mothers), a group which were looking at ways to stand alone, to raise awareness and to be the voice of those who were suffering in silence. Unfortunately some members are no longer in the group but we are still working away and the DVD is available on the Mindreel site.

It is important at this point for me to discuss my own journey with perinatal mental health. Some of the questions that I am asked by people currently on their own journeys will give an understanding of what some women go through and how they deal with emotions.

I wanted someone to give me the answer, to give me hope

A question that I asked so many times was, 'When will I feel better?' I wanted someone to give me the answer, to give me hope and to tell me when the fuzzy head and feelings of hatred and resentment towards my daughter would stop, but because it is very much an individual thing, no one can answer that. However, some things can certainly help in recovery, and for me those things were exercise, counselling, talking to people about it and also attending groups. What works for one person doesn't always work for someone else but trying different things and accepting help until you find your own way is the key. You can also talk to understanding health professionals, tell them how you are feeling so that they can try to arrange some options, try not to be scared or ashamed to speak out. Your feelings are valid, they are real and they are justified. Each person recovers in different ways but you will get through this and you will be a survivor.

I also asked myself on many occasions, 'Why am I like this and why is it happening to me?' There are many theories on why we are affected by perinatal mental

health issues, from hormones to experiences during pregnancy, to previous depression. I'm not a health professional myself, I can only give an opinion on my own experience, and I don't know why.

Every day I tried to rationalise and come to some sort of conclusion but I couldn't. What I was able to do, though, was accept that it had happened, deal with the emotions ranging from anger to sadness and channel them into getting better. It's like a mourning period of sorts. Mourning for who I was before, dealing with the anger that I wasn't her anymore (or so I thought), coming to terms with the fact that I wouldn't have the same amount of time that I had before and that my body had changed. These were things that gave me guilt, feelings that I was selfish for not appreciating that I had a beautiful child. I realise now that I was taking the messages, primarily from the media, about how life was meant to be after a child was born and how it was meant to be a happy experience.

we are expected to get on and deal with our bodies and minds changing with very little support

In reality it isn't always like that. Women are expected to jump back, lose weight, feel normal but in reality our bodies have been through trauma and our hormones have gone through many different stages and phases in nine months. In some cultures a woman is looked after by her community for 40 days, made food, given massage and looked after, but here it is very different and we are expected to get on and deal with our bodies and minds changing with very little support.

Am I a bad parent? PND/PPD/perinatal mental illness chooses you, you do not choose it. I feel that someone who is trying to gain a better understanding in order to help themselves is also a parent who wants to get better in order to be the parent that they want to be. Does that make someone a bad parent then? We are told what is a good parent and what is a bad parent by society, but surely one who loves (which can take a while to come, but that is the illness and not the parent) their child and is looking for help should be the definition of good-enough parenting. We are influenced and pressured by other parents, by the media and by peers as to what a parent should be. Shouldn't love and basic necessities being met be the definition of parent whilst removing the words 'Good' and 'Bad'? I feel personally that those two words carry many other connotations that our minds interpret our own version and we end up adding guilt which is not helpful but harmful.

I am now in my second pregnancy, and I am experiencing hyperemesis for the second time. I do believe that there is a link to PND. I think that there needs to be more research done to explore the links between physical and emotional illnesses in pregnancy and postnatally. I know that I am certainly experiencing signs of both, but due to past experience and being quite proactive, I went to my doctor and told him that I needed to be monitored in this pregnancy and it helps, especially on those days when I am feeling particularly low, to know that I am getting the support that I need. I can't predict the future, but I can access the services and monitor my moods, and I know that because I have got through this once before, I can do it again. It wasn't an ideal time in my life but it has certainly made me really very strong and motivated. I have met some great people, some strong people and some amazing women through this.

Angeline Brunel Dickson

Maws – Our Journey can be viewed at www.mindreel.org.uk/video/maws-our-journey

This film has been made as an educational resource for those experiencing perinatal mental health issues and for health care professionals. It follow the Maws journey through their own experiences of perinatal mental health. Exploring personal accounts of perinatal mental ill health, the aim is to encourage shared experiences and better health care support for new mums.

Bullying by Court Application

Jo Murphy-Lawless talks about the application for a court-ordered caesarean in Ireland

On 9 March 2013, there was an emergency sitting of the High Court in Dublin to consider the application of Waterford Regional Hospital for an order to compel a woman to have a caesarean.

The court heard that the woman, identified only as A, was refusing the caesarean. The barrister acting for the hospital made the following points:

- 'A' was 13 days 'overdue' but could be even 'further along' than they estimated,
- she had previously had a caesarean in 2010 for her first baby, weight 3.6 kgs,
- similar to the first pregnancy, the fetus was said to be 'high and not engaged',
- the results of a CTG trace, carried out on the morning of 9 March were said to be 'non-reassuring'.

The barrister for the hospital said of 'A' (who appears not to have been represented in court at all) that she contested the due date given by the hospital, arguing:

- she was eight days over 40 weeks, not 13,
- that she had wanted to give birth vaginally,
- that while now agreeing in principle to the caesarean section, she wanted to defer it until Monday 11 March, when her partner, who was abroad, would be returning and could be present for the birth of their child.

The expert witness for the hospital, consultant obstetrician Dr John Birmingham, stated by telephone link to the court that; *'I have told her she doesn't have 24 hours ... I cannot be sure of the fetal well-being in 24 hours.'* He also declared that in Ireland, a caesarean is *'almost risk-free'* as an intervention.

In the affidavit submitted to the court by the locum obstetrician whose care 'A' was under in the hospital, it was further argued that:

- the uterine scar from the first caesarean presented 'a grave risk' to the woman and her baby,
- the baby could die or sustain serious brain damage,
- at 13 days 'overdue' the placenta was aging, with diminishing blood supply increasing 'the risk of uterine death',
- the woman could haemorrhage.

Judge Hedigan was on the point of delivering his decision when word came through that the woman had consented to the caesarean, received a spinal anaesthetic and the surgery was about to be performed. The woman and her baby were later reported to be 'doing well'.[1]

At present, we must rely on the press reports alone in assessing the circumstances that ended with a courtroom hearing and the woman's compliance under pressure. There is much that we do not know, for instance whether in A's previous labour she was induced before having a caesarean and whether her uterine scar was a horizontal lower segment one. However, even as reported, there are multiple concerns about the court action. As set out above, it points to a serious breakdown in communication with the woman, if not a classic case of shroud-waving. The ease with which the expert consultant obstetrician states as a matter of fact that a caesarean is virtually 'risk-free' is especially disturbing. The latest data on maternal mortality suggests that the risk of death is increased with elective repeat caesarean delivery (ERCD) compared with planned VBAC.[2] Current data on uterine rupture with planned VBAC is estimated at 0.21 percent compared with 0.03 percent with planned ERCD.[3]

Dr Birmingham's view flies in the face of current concerns about the rates of caesarean in Ireland and internationally, and the concomitant efforts to increase the rates of VBAC. While as yet, there are no published national rates of VBAC here, the caesarean rate ranges from 22 percent to 43 percent in Irish maternity units, indicating that there is no common agreement on what constitutes best practice, or even good practice. In 2010 the Irish Institute of Obstetricians and Gynaecologists, began, very belatedly as it was established in 1976, to produce a series of guidelines for clinical management. In its guideline entitled 'Delivery after Previous Caesarean Section' the Institute quotes VBAC rates with a trial of labour of 74 percent and 65 percent respectively (figures are taken from the 2002 annual clinical reports of two major maternity hospitals in Dublin, the Coombe and the National Maternity Hospital) but points out that this may have involved only a small number of low risk women selected to attempt a trial of labour.[4]

A current Irish-led EU research project, Optibirth, seeks to increase the levels of VBAC by 20 percent in selected centres in Ireland, Germany and Italy, and perhaps in time such research might sway Irish clinicians to think differently. On the other hand, the dominance of obstetric-led care with accompanying high rates of intervention may not be easily dislodged, especially in a context where there remain very high rates of private obstetric practice and very little space and support for publicly available midwifery-led care.

There is one further disturbing layer to the recent court application. The hospital's barrister referred to the eighth amendment to the Constitution, Article 40.3.3, the 1983 pro-life amendment. This controversial amendment says that the state 'acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right.' Quoting this article, the hospital's barrister argued that the court must balance the wishes of 'A' with the right to life of the unborn.

This casts quite a different light on the issue of the decisions and needs of women in beleaguered circumstances. It is true that the Institute guideline states that the decision about a VBAC must be a joint one: *'Such decision-making is best made in partnership with the woman following a full discussion which also takes into account a woman's plans for future pregnancies. The decision may be influenced by the healthcare setting and ideally, in larger maternity units should be informed by the hospital's own rates of UR and VBAC.'*[4]

Yet with Article 40.3.3 as the overarching legal context, a clinical decision can be made without that partnership. Moreover, if that decision reflects poor clinical understanding, in this instance of VBAC, and, notwithstanding a woman's opposition, the logic is that the court can be used to compel women to accept a caesarean. This arose in a case in 2010, where a woman with HIV did not wish her baby, when born, to receive anti-retroviral drugs. The HSE, the national health authority, contested this in court and requested an order for the administration of drugs, but also 'suggested' to the woman that she have a caesarean to which she agreed.[5] While the judge had already stated that the woman could not be forced to undergo the caesarean, when she then agreed there was no legal ruling from him as such. The legal scholar, Katherine Wade, commenting on this earlier case and on the Waterford case, argues that at this juncture, we simply do not know what the scope of Article 40.3.3. is in relation to a woman's autonomy and decision-making in refusing a caesarean.[6]

Unfortunately, we are bound to know sooner rather than later, and in fraught circumstances. The HSE has issued a Draft National Consent Policy, which states in section 7.8.1 'Refusal of Treatment in Pregnancy': *'The consent of a pregnant woman is required for all health and social care interventions. However, because of the constitutional provisions on the right to life of the 'unborn', there is legal uncertainty regarding whether a pregnant woman's right to refuse treatment extends to the refusal of treatment which puts the life of the fetus at serious risk. This matter can ultimately only be decided by the Courts. Thus, where a pregnant woman refuses treatment and this refusal may impact on the life of the fetus, it is essential that the consequences of the refusal are fully and clearly explained to the woman, and legal advice should be sought if she persists in the refusal.'*[7]

Court-ordered caesareans are an issue that birth activists and feminists have been confronting for over three decades in various jurisdictions internationally and our work is clearly far from done. It is worth returning to what Susan Irwin and Brigitte Jordan wrote in 1987: *'A court-ordered caesarean section not only determines the authority of a particular doctor over a particular woman, it confirms medical authority in birthing'*.[8] In the Waterford case, have we seen yet another instance of clinicians seeking court sanction to further authorise their poor clinical skills?

Jo Murphy-Lawless

References

1. MacCormaic R (2013) Woman agrees to caesarean after hospital goes to court. Irish Times, Saturday 9 March, 2013. www.irishtimes.com/news/crime-and-law/woman-agrees-to-caesarean-after-hospital-goes-to-court-1.1320732
2. Signore C. (2012) VBAC: What Does the Evidence Show? Clinical Obstetrics and Gynecology 55, 4, pp. 961-968.
3. Fitzpatrick KE, Kurinczuk JJ, Alfirevic Z, Spark P, Brocklehurst P, et al. (2012) Uterine Rupture by Intended Mode of Delivery in the UK: A National Case-Control Study. PLoS Med 9(3): e1001184. doi:10.1371/journal.pmed.1001184
4. Institute of Obstetricians and Gynaecologists and Clinical Strategy and Health Service Executive (2011) Delivery after Previous Caesarean Section: Clinical Practice Guideline. www.rcpi.ie/content/docs/000001/652_5_media.pdf
5. Irish Independent (2010) Newborn to get HIV drugs after court examines risks at mother's request. 21 November 2010. www.independent.ie/irish-news/in-brief-newborn-to-get-hiv-drugs-after-court-examines-risks-at-mothers-request-26701455.html
6. Wade, K. (2013) Caesarean section refusal in Ireland. humanrights.ie/gender-sexuality-and-the-law/caesarean-section-refusal-in-ireland/
7. HSE (2012) National Consent Advisory Group, National Consent Policy, Part Two – Children and Adolescents www.hse.ie/eng/about/Who/qualityandpatientsafety/Patient_Safety/National_Consent_Advisory_Group/ncag.pdf
8. Irwin S and Jordan B (1987) Knowledge, Practice, and Power: Court-Ordered Cesarean Sections. Medical Anthropology Quarterly, Vol. 1, No. 3, pp. 319-334.

AIMS Comment

Women in England and Wales are not in danger of court-authorised caesarean section thanks to an important decision of the Court of Appeal in S v St George's Healthcare Trust [1998] 2 FCR 685. The Court held that:

'In our judgment while pregnancy increases the personal responsibilities of a woman it does not diminish her entitlement to decide whether or not to undergo medical treatment. Although human, and protected by the law in a number of different ways set out in the judgment in Re MB, an unborn child is not a separate person from its mother. Its need for medical assistance does not prevail over her rights. She is entitled not to be forced to submit to an invasion of her body against her will, whether her own life or that of her unborn child depends on it. Her right is not reduced or diminished merely because her decision to exercise it may appear morally repugnant. In our judgment while pregnancy increases the personal responsibilities of a woman it does not diminish her entitlement to decide whether or not to undergo medical treatment. Although human, and protected by the law in a number of different ways … an unborn child is not a separate person from its mother. Its need for medical assistance does not prevail over her rights.'

As long as a woman has mental capacity to make decisions for herself, she cannot be compelled to accept medical treatment said to be in her child's interest. There is no UK law for 'fetal supremacy', even if the baby is at risk. The expectant mother calls the shots, not the doctors caring for her fetus. As far as AIMS is aware, there have not been any cases on forced caesarean in Scotland or Northern Ireland, which operate their own legal systems, but they could be expected to follow the approach of the Court of Appeal. The Guardian reported a case where the Scottish Public Services Ombudsman ruled that coercion was not acceptable (www.guardian.co.uk/lifeandstyle/2012/dec/16/mothers-fighting-against-birth-intervention).

The position in Ireland may be different (we cannot say for sure because the woman consented to the procedure before judgment was given in the Waterford case) thanks to the constitutional guarantee of the fetus' right to life in Article 40.3.3 which obliges the Irish state, and its courts, to 'defend and vindicate' the right of the unborn. Whether forcible treatment of a mother for the sake of the fetus is compatible with the mother's right to private life under Article 8 of the European Convention on Human Rights is a question that urgently needs to be addressed by the European Court of Human Rights in light of the worrying developments in Ireland.

Elizabeth Prochaska

Together Against Bullying

Lucia Montesinos asks midwives to come together and support each other to change culture

I am a caseloading home birth midwife within an NHS trust in London who has faced bullying in the form of Investigations during my first year after qualifying. I know I am not alone, and I hope my story can offer support, hope and inspiration to other midwives who might be experiencing similar circumstances when working 'with-woman'. When midwives are bullied it affects the care they are able to offer to women and may make them practise defensively instead of in the women-centred way they wish to work.

There is a wealth of evidence[1] that midwives who go against policy in order to practise autonomously and promote normality, the core values of our profession, suffer from unreasonable investigations made by managers or their professional body. This is causing stress and fear amongst midwives, and as a result stops them from being autonomous. I believe the way forward is to work together and support each other for the benefit of women and babies.

The process of any investigation is always stressful and it can make one question one's own practice. Sometimes these investigations are appropriate and necessary to explore and reflect on a case that had a poor outcome or to answer to a complaint in order to get more information from all the parties involved, ultimately to learn and improve practice. However, the growing dominance of managerial and obstetric control and the enforcement of standard and fragmented care can lead to unreasonable professional investigations.[1] Sometimes midwives who work autonomously in the system with a philosophy of working 'with woman' may feel that the rationale behind these investigations is far away from a practice issue and has more to do with wanting to control midwives and to impose the obstetric protocols and hospital policies.

The process of inquiry about midwives' actions and decisions is formally done by an investigation. This is formalised by the midwives' professional body. The NMC has this written into the Code of Conduct:

'As a professional, you are personally accountable for actions and omissions in your practice and must always be able to justify your decisions'[2]

In accordance with the NMC Rules and Standards: *'A practising midwife who is responsible for providing care or advice to woman or care to a baby during childbirth must do so in accordance with standards established and reviewed by the Council in accordance with article 21(1)(a) of the Order.*[3]

Mavis Kirkham explains that newly qualified midwives, return to practice midwives and those who don't fit in are vulnerable groups for bullying within the NHS culture.[4] Let me give you a personal example:

My first encounter with an investigation during my first year as a midwife was after being reported by a colleague for sleeping during the night at a home birth, while taking on the role of the second midwife, during the first stage of labour. That night I was called out in the middle of the night to bring some entonox to a home birth. On arrival the woman, who was having her third baby, was well looked after by the first midwife and her cervix was about 4cm dilated. I decided to stay as she could potentially progress very quickly and give birth very soon and the midwife could call me promptly. The family was happy with this decision.

The woman kindly offered me a spare room to rest, I decided to take up the offer as I thought she must feel safe to have two midwives at her home and I knew that if I went into another room I wouldn't disturb her privacy to labour freely. She knew I was there and that nobody else needed to come in. Unfortunately my managers were not thinking the same and thought that my behaviour was very unprofessional; they told me that they would have preferred that I went back to my house and potentially miss that birth.

This was taken further into an investigation with the allegations that my behaviour breached the NMC Code of Conduct and the hospital policies. My whole world collapsed during the first investigatory meeting, as then I could clearly see how the system takes care of itself and not so much of the woman, putting the needs of the hospital above the woman's. This conflict of interests is explored further by Mavis Kirkham where she examines the culture of the NHS and raises this long standing conflict of interest between the institution, the profession and the client. She goes on to explain that since the Midwives Act of 1902, midwives have been controlled and inspected by the inspectors of midwives.[5] Today the inspector's role is taken by the majority of supervisors of midwives (SOM) who help to ensure that the midwife's primary loyalty is to the institution and her profession rather than to her clients, even though the NMC says that she is in place to protect the public. In my case the managers were more concerned about the reputation of the hospital than about the safety of that mother and child.

Midwives have the right to choose their own supervisor, and this is something very important and I highly recommend midwives exercise this right more often. As a midwife you should find someone supportive and that you can trust – even if this means finding someone outside your hospital.

This was also my first encounter with the union representative for midwives and I must admit it wasn't a positive experience either, as it made me realise how little support midwives have. Midwives under investigation can face inadequate support and representation from trade unions and other professional

bodies. I didn't feel the union was supporting midwives and it was not interested in empowering us either. It seemed to me that it was working for the system instead of for us. I was pressurised to comply with the system and told that I should agree that what I had done was very wrong and therefore I should apologise.

When you have to write your statement, as part of the process of the investigation, you are advised to get it checked by the union representative before you submit it. The representative is supposed to read it, and offer you advice and information about the process, so you feel supported and well informed to make your own decisions. To my surprise that wasn't the case; the representative read my statement and told me what I must and what I must not write. I wasn't allowed to disagree with the representative's opinion and direction. I was pressured to write what I was told and be compliant with the system or otherwise the agreement with the union would finish and I could see myself with no support at all. You can imagine that this situation adds more stress to the mix. I decided that in this case I was still an autonomous practitioner and therefore also accountable for what I wrote and it needed to feel right to me; thus I took the advice that I felt was appropriate. We discussed the need for informed choice, what it meant for me and for her, and that, at the end of the day, it was my responsibility if what I wrote didn't work. That took courage and trust in myself. In the end it turned out that I had to go to a second investigatory meeting by myself because the representative wasn't available and the hospital gave me only three days' notice, as per protocol.

witnessing a footling breech birth with no problems at all

A few weeks later our home birth team supported a woman who was discovered to have a breech baby at term and didn't want to have a caesarean section. I had recently finished a course on moxibustion. Moxibustion is a safe procedure to turn breech babies.[6] One of my colleagues put this woman in touch with me to see if I could help her. I taught the woman the self-application of moxibustion as per my training.

She went into labour, and the baby was still breech. It was agreed that two midwives would be present, along with a Supervisor of Midwives (SoM), for her home birth. So, when the woman went into labour, she rang the first midwife who then rang me and the supervisor. Once I got there, the baby was born very quickly. As Mary Cronk advocates,[7] we kept our hands off the breech and had the honour of witnessing a footling breech birth with no problems at all. It was an amazing and breath taking birth. The woman was very happy and the SoM arrived after the baby and the placenta were born to have a cup of tea with us.

The SoM discovered that night that I practised moxibustion without asking for explicit permission from the managers, and decided to commence a formal investigation about it. The reason for that investigation wasn't a practice issue, nor a poor outcome, because the moxibustion didn't cause any problem and the woman was very happy with using it. This made me realise that the system doesn't want autonomous practitioners, what the system wants is handmaidens. As part of the process of that investigation, I had to stop my clinical practice and do auditing in the office while the investigatory process was taking place.

write everything verbatim, otherwise the agreement to help me would terminate

When I rang the union again asking for support, the officer that helped me with the previous case told me that this time I had to write everything verbatim, otherwise the agreement to help me would terminate. I realised I had to make a decision then, as I wasn't happy to have the same experience as before. I found this person more stressful than helpful. I emailed the manager and told her that I needed to change the representative as I was having difficulties with this person. The manager and I exchanged a few emails and she insisted that the representatives have caseloads of midwives and these can't be changed. She suggested that if I wasn't happy an investigation would need to take place to find out why I was unhappy with my representative. I insisted that I didn't have time for another investigation at that time and that I needed someone to support me now. I couldn't believe what this woman was offering me – another investigation when I was in the middle of one already. It was all nonsense and very ridiculous.

That night I went to an Association of Radical Midwives (ARM) meeting and met a new midwife who had been through the process of investigation and had a similar experience with her hospital and the union. Finding someone who had gone through this was very special, helpful and made me feel better. She also felt that her case was very unfair and she had a similar experience with the union where she didn't feel supported. It inspired me to find again more courage and trust within myself. At that point, I decided to let the union representative go: it was very clear that she was not helpful. I knew I needed help to fight this fight, so I started to find help and support amongst my colleagues and friends. I knew I would still need help with the statement so a very wise and very well-informed colleague helped me with it and another colleague came with me to the investigatory meeting.

Unfortunately, as Margaret Jowitt explains: *'midwives must be managed by protocols and guidelines and the most effective way to enforce these is by peer pressure and, if this fails, by making an example of midwives who step out of line.'*[8] Management can work on the principle of 'divide and rule', reinforcing the behaviour of midwives who comply with the system and making an example of those whose practice deviates from it. If management make an example of a particular midwife, they know it will have an impact on the rest.

I believe the investigations into my practice were also meant to provide an example to frighten other home birth midwives. Will the other midwives stand up and support the midwife? In my case, at the time of these investigations, we were seven midwives working in the home birth team, and most of us worked for the women. These investigations unfortunately had a negative impact on the team: four exceptional midwives left the team, horrified by what was going on. Ultimately, the women are the ones who lose out from these political issues: local women lost four experienced, woman-centred home birth midwives.

I realised then how important it is to have a good support network and that every midwife should take responsibility to build up her own. Perhaps one of the first priorities as a newly qualified midwife is to build up your support network. Choose a supportive SoM, someone who is there for you and for the women and colleagues that you can trust. It is important to build up meaningful and trusting professional relationships with like-minded people so we can help each other and work together for the highest good. I found informal support networks such as the ARM meetings very supportive as you always find people who think like you and share similar ideas and vision about midwifery. This also made me realise that we cannot carry on working as isolated individuals because it won't change the status quo – we must work together if we want to make a change for women and their babies.

Both investigations ended up well. In the first one, the woman who offered the bed was also interviewed. She was very happy with her home birth, with the care she received and to have two midwives in her house. In the second investigation, after the first investigatory meeting the managers decided to drop the case. After these events, I must admit that for the few weeks after the investigation, work was very stressful. When I returned to practice I didn't feel safe – I was double-checking everything and making sure I was documenting perfectly. I felt that I could be investigated again for any stupid reason any minute. It took a few weeks to regain my confidence and to let go of that fear. A good three weeks travelling around the USA and a visit to The Farm, in Summertown, Tennessee, helped that process of coming back to myself and my own peace – I did what needed to be done. I decided to carry on in my job because I love what I do, I love having the opportunity to offer continuity of care to women and be part of those amazing births that only happen at home.

Lucia Montesinos

References

1. Edwards N, Murphy-Lawless J, Kirkham M and Davies S (2011) Attacks on Midwives, Attacks on Women's Choices. AIMS Journal, Vol 23 No 3.
2. Nursing and Midwifery Council (2008) The Code: Standards of conduct, performance and ethics for nurses and midwives. Available at www.nmc-uk.org/Publications/Standards/The-code/Introduction/
3. Nursing and Midwifery Council (2012) Midwives rules and standards. Available at www.nmc-uk.org/Publications/Standards/
4. Kirkham M (2007) Traumatised Midwives. AIMS Journal. Vol 19 No 1
5. Kirkham M (1999) The Culture of Midwifery in the National Health Service in England. Journal of Advanced Nursing, 30(3), 732-739.
6. Grabowska C, Manyande A (2008). Management of breech presentation with the use of moxibustion in women in the UK: a preliminary study. The European Journal of Oriental Medicine 6(1):38–43.
7. Cronk M (1998) Keep your hands off the breech. AIMS Journal, Vol 10 No 3.
8. Jowitt M (2008) Bystanding Behaviour in Midwifery: Machiavellian Plot or Unintended Consequence of Hospital Birth? Midwifery Matters, Issue 118, Autumn 2008.

Further reading

Deery R and Kirkham M (2006) Supporting Midwives to Support Women. In Page L and McCandlish R (eds) The New Midwifery. Churchill Livingstone.

Kirkham M (2000) Midwives support needs as childbirth changes. Journal of Advanced Nursing, 32(2):465–472.

Solon M (2011) The fitness to practice hearing 2. Keep calm and carry on: appearing at a hearing. The Practising Midwife, 14(7):26–27.

Nursing and midwifery Council (2011) Supervision, Support and Safety: Analysis of the 2008–2009 local supervising authorities' annual reports to the Nursing & Midwifery Council. Available at www.nmc-uk.org/Documents/Midwifery-booklets/NMC-Supervision-support-and-safety-analysis-2008-2009.pdf

The Birth I Want campaign was set up by mum of three and campaigner, Vicky Garner, with the aim of 'making constructive noise' about women's experiences of maternity services in the UK.

Knowing and trusting her midwife and having genuine choice over where and how she has her baby are fundamental to a woman having a positive birth experience – this message has come through loud and clear from women sharing their experiences with The Birth I Want.

The campaign looks to articulate and illustrate what women want and need, and indeed what delivers the best outcomes for women and their babies, at a time when maternity services are ripe for change. The Birth I Want has recently launched a video with women talking about their experiences and the issue around supporting women properly during birth.

Please take the five minutes required to watch at www.thebirthiwant.org.uk. Comments and support can be added via the website and their Facebook page www.facebook.com/thebirthiwant.

Colchester General Hospital

Lana Bartholomew shares her experience of labour, birth and a complete lack of support

When I gave birth to my daughter in 2010, it should have been the happiest day of my life. However, it turned out to be a day filled with fear, panic and drugs and it led to a series of events which changed my life and outlook for ever.

Unfortunately, I went into premature labour at 37 weeks. I was very scared by the pain. My family and I explained the situation to the midwife who saw me upon admission. She was very kind and understanding and gave me entonox to alleviate pain. A couple of hours later, another midwife, aided by a student, took over my 'care'. I asked to be given pethidine as I had heard that it was the usual drug offered and she obliged. The pain became unbearable despite the pethidine.

Statistically, pethidine adversely affects one in three women who take it and I was one of them. I felt dizzy and disorientated but I could still feel the pain and it was getting worse. I was very frightened and sought an epidural. I asked the midwife about this but she ignored my concerns. As an experienced midwife, she should have realised how advanced my labour was and asked to examine me. Aside from occasionally appearing to inform me of yet another 'emergency' which prevented an epidural, she was always busy.

The pain became worse and I begged for an epidural and reassurance about my baby. The medical notes suggest that my baby was monitored and doing well until the last half an hour, but I was not informed of this. I felt alone, despite the fact that my family was present in the room. I knew that these midwives were in control, not me. When I felt as though I needed to go to the toilet, and my mother informed midwives of this, they realised what was happening. The senior midwife flew into the room in a panic.

In desperation, I asked my grandmother for a knife so that I could cut my throat and end the pain. A few minutes later I remember saying that my baby could be cut out of me. I repeatedly stated that they needed to hurry because of the safety of my baby. I remember the senior midwife's response was to tell me how 'concerned' she was that I had threatened to self-harm. There was no attempt to reassure me and say: 'Your baby is fine and you're going to be fine.' My daughter was born in the evening and by the time I was cleaned up it made sense to stay overnight. The midwife arranged for me to see a nurse counsellor the next day. I believed that it was because of the negative birth experience. She gave her apologies for the lack of effective pain relief and I was perfectly pleasant, delighted at the prospect of never seeing her again.

I was anxious about the fact that my daughter did not seem to be taking her milk during the night. I felt as though midwives thought it was because I wasn't doing it properly as an inexperienced mother. However, when they had no success either, they began to realise that something was wrong. Her blood glucose level was monitored and as it dropped, my daughter was admitted to SCBU. I don't think I managed to get any sleep that night.

The next morning, a midwife came and told me that there were 'concerns' about the comments that I had made during labour. When the nurse counsellor came to see me, I was non-committal and stated that I was tired, in pain and didn't feel like talking. I didn't want to say anything that could be written in my notes and used against me.

In the afternoon a young midwife told me that, because of the concerns, a Social Services referral might be made. I almost broke down. The young midwife seemed distressed and reassured me that it was for 'support', not to take my baby away from me. After looking at my medical notes it seems as though she argued my case and said that my behaviour was normal. Apparently, there were also concerns because during a painful monthly period I've been known to say 'I want to die.' The safeguarding nurses took this to mean that I had suicidal tendencies! Every day, I had one midwife in particular outlining 'concerns' about me and about the possibility of Social Services involvement in my life. Another midwife repeatedly stated that I was a high risk for postnatal depression.

I was in the hospital for five days, initially because of my daughter's hypoglycaemia and then due to my urinary retention problems. Once my daughter was well, I went to SCBU and spoke to a doctor and nurse who said that she was well. I was asked about Vitamin K which I had initially refused, because as I was not breastfeeding, she would be receiving Vitamin K from formula milk. I accepted it, knowing that the atmosphere was such that I would not be able to take my daughter from the hospital if I refused. However, once I consented, the patronising doctor told me that I might be able to take her home in a few days or so once 'support' was put in place for me. I walked off, angered, distressed and attached to a cathete,r saying that I would contact my family. This incident was used as further evidence of my mental instability!

Afterwards, a midwife spoke to Social Services on the telephone and explained what I had said during labour. She explained that I have no history of mental illness, that I had behaved appropriately since the birth and that 10 days of visits from midwives upon discharge would suffice.

The social worker she spoke to conferred with her own manager and agreed. No further action was to be taken. My daughter and I were to be discharged the following day. I was happy. I was even happier that my daughter was discharged from SCBU and lay in an incubator by my side.

The next day I had my catheter removed and was still unable to urinate. I asked the midwives for a catheter but they told me to keep drinking and to try to pass water. It was suggested that I listen to running water, run a bath, and such, so as to trick my bladder back into action. It didn't work. After spending the whole day without a catheter, drinking water, I was in agony. I begged the midwives for a catheter. My grandmother kept going to the reception desk and stating that I needed help. Other patients on the ward were disgusted by the midwives.

The ward consultant came to see me and suggested that I be shown how to use 'in-out' catheters and would be discharged the following day. She stated that one of the midwives would assist me. The midwife in question told me that she needed to discharge six patients before she could spend two minutes to relieve my pain. I broke down. Just as had been the case in labour, I was being left to suffer. It was only due to my grandmother's persistence that a catheter was finally supplied.

At 8am the next day, a midwife told me that a pre-discharge meeting would be taking place at 11am with the safeguarding nurse, Social Services and other parties present. My understanding had been that the pre-discharge meeting was cancelled and that Social Services were not involved. I had no family present at the hospital and three hours to organise myself to face a situation I had thought was resolved. I complained at the lack of notice and she claimed that the meeting had been arranged late the previous night and that it had not been possible to inform me earlier. My medical notes reveal that this was a lie and that the meeting had actually been arranged the previous afternoon.

The meeting was attended by the safeguarding nurse and a few midwives. There was no social worker present. The midwives themselves were in control of the hospital child protection process. This was confirmed when I was later in possession of my medical records, which showed that a second Social Services referral had been made that morning which they had politely declined to investigate. During the meeting I was subjected to embarrassing questions. I answered them as honestly as I could, knowing that if I refused to answer I wouldn't be going home with my daughter. Once the midwives were satisfied that I had 'support' in place, we were discharged.

At home, I was subjected to daily visits from midwives. The visits were impromptu and sometimes late in the day. Finally, one of the midwives who had provided the care during my pregnancy could see that the visits were needless and discharged me earlier than planned. I was relieved to be free but I could not seem to bond with my daughter. I got in touch with AIMS and Beverley Beech was wonderful. Her support and advice, as well as that of my family, helped me get through the aftermath and the complaint process, which is still ongoing one year later.

First, I wrote a letter requesting to see my medical records. I agreed to pay a fee and sent my birth certificate as proof of identity, as the hospital requested. The hospital claimed not to have received it and I had to send additional proof of identity. The hospital waived the fee for the photocopies of my notes. I then received a letter stating that the notes were enclosed but they were not so I had to get in touch again. It took months to obtain the notes.

Upon examination of them, I was certain that pages were missing, so I wrote back and the hospital sent pages of blank notes. I insisted that there was more and was sent a photocopy of an entry in a ward diary. I wrote a letter of complaint which took several months to process. The hospital admitted that its own psychiatric nurse had not felt that there were concerns to proceed against me but that the matron had sanctioned a second Social Services referral anyway.

I found no evidence in my notes of any consultation with a psychiatric nurse, so I queried this. The hospital admitted that there were notes which it had withheld from me because they would 'distress' me. I could view them at a meeting. I wrote back stating that I wanted to see the notes in the privacy of my own home before I would attend a resolution meeting.

pages of the notes had been falsified

The hospital agreed and the notes raised more issues. Several pages of the notes had been falsified by the midwives in the delivery suite. The midwives claimed that I had repeatedly threatened to kill myself several hours before the birth of my daughter. This did not happen. One of the midwives also claimed that my grandmother had been 'aggressive' and 'confrontational' towards her. Considering that my grandmother is in her seventies, with several health problems and is reliant on a walking stick, the claim sounds ludicrous. However, the timings in the original notes make it clear that the midwife was not even in the room at the time the events took place! I believe that those notes were written retrospectively as protection in the event of a complaint being made.

My grandmother and I attended a resolution meeting. We were led into a meeting room upstairs by a gentleman from PALS [Patient Advice and Liaison Services]. There was a woman in her thirties already in the room who was introduced as the Information Officer. Two other ladies, one of whom was the matron, entered the room shortly afterwards. The other lady left it to me to discuss my concerns. I stated my first concern and wished that it be discussed but she stated that I should outline all of them. I briefly stated my main concerns and returned to the first concern to discuss it in depth. I was very conscious of the fact that although they were trying to make it seem as though they were letting me take charge of the meeting, they wanted to show me who was really in charge. These meetings take place because a woman has not felt empowered in the childbirth process and, again, members of staff attempted to make me feel powerless.

The Information Officer agreed to add amendments to my notes and supplied some information on relevant statutes and government guidance. She was sympathetic and understood that the negative comments might affect my treatment in the future and wanted to allay my concerns. I also discovered that a clinician responsible for my treatment would have decided to withhold some of the notes. She promised that she would find out who it was and add amendments. However, she refused to delete notes that I could prove were factually inaccurate.

A number of issues were discussed including the administration of pethidine two hours before the birth of my daughter, without a prior vaginal examination. The matron asked the time it had been administered and looked in the notes only to be dismayed to discover that I was correct. She admitted that normal procedure had not been followed and did not deny that the pethidine had caused my daughter to suffer from infant hypoglycaemia. I managed to demonstrate that the notes were untrue because of the inconsistencies and witness statements to the contrary. Despite this, the ladies maintained that the notes were accurate. As for the midwife's comments about my grandmother, despite the fact that the midwife's own notes show she was not in the room, the matron maintained that the student midwife was stating what she felt at the time! In terms of the child protection measures taken against me, Baby P was quoted at me as justification for damaging the chances of bonding with my daughter. I had 'won' because I was allowed to take my baby home without Social Services involvement. The hospital had a duty of care towards my daughter, which it had fulfilled. I pointed out that it had a duty of care towards both of us which it had not fulfilled because of the difficulties in bonding.

They would not accept that it was ludicrous to act as they did based on a single comment made during labour. Although the hospital was sorry that I had not been happy with my treatment, the staff will not be giving personal apologies as it is 'not the usual practice' of the hospital, and the staff will not be disciplined as, looking at their conduct as a whole, they are perceived to be good midwives. However, there have been some positive outcomes. The doctor who made me feel as though I had to consent to Vitamin K is no longer on the GMC Register. One of the midwives wrote me a personal apology. The Information Officer has composed a letter to put at the front of my medical record to say that the midwives' comments are inaccurate and must be disregarded. At the moment, the Health Ombudsman and Information Commissioner are investigating the way I was treated and the manner in which my medical notes were compiled and subsequently withheld from me.

Despite this, my negative birth experience has left me reluctant to have children in the future. If members of staff make mistakes, unless it results in the death of mother or child it seems as though they are not made to account for their actions, and I don't suppose Colchester is unusual in this respect.

Lana Bartholomew

GAIN

Industry's Trojan Horse fails to enter WHO's policy setting process

The failure of GAIN (the Global Alliance for Improved Nutrition) to obtain official relations status with the World Health Organisation (WHO) as a non-governmental organisation (NGO) has been warmly welcomed by health campaigners and the International Baby Food Action Network (IBFAN), the global network working to protect infant health.

GAIN is a new type of public-private entity which claims to work to tackle malnutrition – but its work seems to focus on opening up markets for its 600 partner companies (including Danone, the world's second largest baby food company, Mars, Pepsi and Coca Cola).

On the final day of deliberations of its 132nd meeting, in a briefly worded Resolution, WHO's Executive Board called for answers regarding GAIN's links with food corporations and its lobbying tactics.

WHO's Executive Board decided to:
'… postpone consideration of the application for admission into official relations from The Global Alliance for Improved Nutrition to the Executive Board's 134th session, and requested that the following information be provided to the Board through its Standing Committee on Nongovernmental Organizations: information concerning the nature and extent of the Alliance's links with the global food industry, and the position of the Alliance with regard to its support and advocacy of WHO's nutrition policies, including infant feeding and marketing of complementary foods.'

The decision implies that IBFAN's concerns about the lack of transparency in the application process, about GAIN's true nature and purpose in the application process, and its attempts to undermine implementation of key World Health Assembly Resolutions on infant and young child feeding, were taken up by members of the Standing Committee on Non Governmental Organisations.

GAIN's application for official relations status with WHO came just as WHO is to start work on the guidelines for the marketing of complementary foods – a key policy issue that GAIN is keen to influence. Indeed, as the Standing Committee on NGOs Report showed and expressed concern, GAIN has already channelled funds to WHO for its micronutrient work.

For the full press release please visit info.babymilkaction.org/pressrelease/pressrelease31jan13.

Patti Rundall
Co-Chair, IBFAN/Baby Milk Action

Humanity in Duty?

Zoë Foster discusses her experiences of Section 47 and the 'Duty of Care' in NHS midwifery

It is often said in midwifery circles that the most important skill a midwife can master is to 'drink tea intelligently'; in other words, to sit by the labouring woman, conveying confidence in her ability to give birth without unnecessary assistance, but using their intelligence and skill to judge if and when there is a need to intervene.

The same can be said for antenatal care – the best midwives will take their time with you, gradually building up a rapport and learning by osmosis about the family unit, including any issues, fears or possible risks. The NHS midwives who attended my first birth were beautiful women who respected our birth plan without comment and attended to our needs without interfering.

Having said this, pre-birth we were not without our issues with the NHS model of care, and had it not been for our own nous, backed up by the invaluable advice (freely given) from an independent midwife, it's likely I would have felt pushed into a managed birth due to some minor complications throughout my pregnancy.

And for both our home births under the NHS, we have had to endure an 11th-hour wrangle over our circumstances and wishes – both cases then being referred to Social Services under Section 47 (Child Protection Enquiries).

Appearances can be deceptive. When visiting our camper van to assess the space for our first home birth, our midwife's exclamation was, 'But this is a hippy van and you're not hippies!' Without going into the necessary attributes of hippy-dom, I do tend to pride myself on not falling into any particular stereotype. But then, most people don't if you only care to look closely enough. There should be no place within a system of care such as the NHS for out-and-out prejudice, whatever the first impressions may be. At the end of the day we are the vulnerable patients, putting our faith and trust in them to do the right thing, to look after us and our children, our health and overall well-being.

Whilst I must admit our circumstances and outlook could be considered unusual compared with the majority of births taking place every day in the UK, I would have hoped from a model so bent on 'care' that some of their procedures would include a streak of humanity along with a good dose of common sense. Most of the problems we faced boiled down to a lack of or very poor communication between departments, as well as a select number of quite disgustingly ignorant, arrogant and bigoted individuals who unfortunately used their sway to poison the waters for us.

In actual fact, I believe our crime was the most heinous possible. For not only were we perceived as 'different', but we were also extremely well-researched, had friends and contacts who were even more birth-wise than us, and above all we wished to be active leaders in the pregnancy and birth, rather than confused passengers.

I know several women who have sailed through their pregnancies and births under the NHS with few issues and apparent ease and relief. So part of me wonders whether it is not the system that is at fault but myself. Am I the one who doesn't fit into their model and harbours an inherent dislike for 'systems' and therefore is the root cause of all the problems? Even if this is so, there plainly remains a systemic failure.

The result of our mishandling by these unsound midwives was an immense lack of trust in the system as a whole and much upset and stress. Just hours after the birth of my first baby, an unknown-to-us midwife from another unit came out to assess us. She naturally found us all asleep together and as yet unshowered, and despite my apologies, she felt it necessary to report us. We heard about it via our own midwives some days later. To their credit, they took it upon themselves to sort it out directly and discreetly with Social Services, so we never even heard from them. Sadly, this did not prevent the weeks of worry and uncertainty which followed us around, marring and tainting the joy of our wonderful occasion.

During my second pregnancy, all went well until my 36 week appointment, when very suddenly it became apparent that our midwifery team was not altogether on board with either our wishes or our circumstances. Miscommunication between departments together with the unmitigated sly prejudice of a few select midwives – including the Supervisor of Midwives – caused immeasurable damage to our confidence in their care for us and our unborn baby. Despite our lack of funds, it took us only a few hours to seek out the services of an independent midwife (IM). At $38^{1}/_{2}$ weeks we received a call from Social Services. The concerns included in the referral by our NHS midwifery team would have been laughable if it had not been so very traumatic at the time. Many of them were downright lies, maliciously fabricated. One appeared to be in plain breach of the Data Protection Act. The rest were simply petty. Fortunately for us, we had plenty of good people on our side to help put things right. Our original midwifery-led unit (MLU)

Section 47 of the Childrens Act

Section 47 of the Act places a duty on Local Authorities to make enquiries, or cause enquiries to be made, where it has reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm.

(and the self-same midwives who had spoken up for us after our first birth) had only good things to say about us. Our own IM was positively vehement in her defence of us and made short work of the concerns raised. Even the Senior Midwife at our present unit praised our character. Through it all, the Social Services representatives were kind, empathetic, accommodating and humane. Despite all this, the ordeal could not be erased for us and it tolled upon our nerves, ultimately delaying the birth of our second child due to sustained stress and fear of the unknown.

As much as it is of the utmost importance to protect the life and welfare of a child, I am appalled at how easy it is for families to be referred under the Child Protection Act, and to have that on their record – whatever the outcome – for the rest of their lives. There is no thought, no care, as to how this may affect them in both the short and long terms. For us, it has instilled a great and lasting distrust in the NHS system as a whole – so much so that I would not seek help when I was suffering from postnatal illness, to the detriment of my own health and sanity, and that of our family unit.

I am dismayed at how little worth is attributed to the mother during her confinement under the NHS model. At every hurdle, I was told that their primary responsibility and concern was for the health of the baby. It seemed my health was of little importance, unless it was deemed by them to directly affect my unborn child. Their 'duty of care', in essence, is to the child, and in accordance with this, to the physical health of the mother. There is little room within the system for considering the impact of the mother's treatment upon her mental well-being.

What would make the difference is not much: a little common sense, a lot more humanity, a good deal more (accurate) communication and record taking, and, unquestionably, a holistic approach to the health and well-being of the mother. Many of these could be achieved simply through greater continuity of care – speaking to our independent midwife, many clients quoted this as one of the primary reasons for booking with her.

Ultimately, going private made our second birth something to look forward to rather than fear. Our appointments were just like having a good friend round – we drank tea, chit-chatted and gossiped, laughed and confided, and took our time. Somewhere in amidst all this, the salient checks were done and notes made. I knew that from this interaction she could glean so much more information than from pointed and impersonal questioning; this rounded, holistic approach bolstered both my confidence and trust in her as my midwife and my own ability to birth naturally. Our birth plan was discussed, not challenged; our viewpoints were taken into consideration, not wrangled over; personal preferences such as avoidance of internal exams were respected, not pitted against a rulebook. If any of our requests were unusual, our IM advised us that she was legally obliged to document the discussion, but she always worked with us to realise our wishes. Above all, she was an absolute rock of support and an incredible fount of knowledge, expertise and experience, and that gave me the confidence to put my family's welfare in her capable hands.

I am saddened (though not sorry) that we were forced to turn our backs on our otherwise excellent NHS midwifery care due to our experiences. I truly do not believe that there should be a need for a private service, but I am greatly relieved that the choice existed for us in our time of need. I do, however, believe that the independent services that exist can and should inform our NHS-led midwifery practices: for long-lasting systemic and societal success, take care of the mother, the baby and the family as a whole.

Zoë Foster

They said what?

A woman was told she *'could not have a home birth because she has a spiral staircase.'* She is planning to have a pool in an upstairs room, but ...

Midwife to woman planning a water birth: *'We will have to get you out of the pool to deliver the baby as he may drown.'*

Women are frequently told that they will have to leave the pool to birth their placenta despite it being crucial not to unduly disturb mother and baby when supporting physiological third stage. One woman was told she would have to leave the pool: *'because of the risk of air embolism.'* Would this be more or less likely after a birth in water?

Midwife to woman planning to birth in a hospital pool: *'We fully support water birth. Most women want to get out for the actual birth so they can birth on dry land, so we will encourage you to do that.'*

Midwife to woman discussing her home birth plans: *'You cannot have candles at your birth because of the increased risk of fire. Taking risks like that indicates a child protection issue.'*

Midwife discussing a woman's choice: *'You can't choose that; it is against the NICE guidelines.'*

Midwife at a home birth: *'It is OK, we are here, we are in charge now.'* Said whilst noisily setting up her equipment and completely disturbing the woman's peaceful birthing environment.

Doctor to dad who had been helpfully recording times of everything (his labouring wife was clearly unaware of time): *'I'm not talking to you, I am asking your wife for that information, she needs to give me the answers.'*

The Curate's Egg Service

Laura Robinson describes her experience of overzealous health visiting

In December 2004, I gave birth to a beautiful healthy baby girl after a pleasant and satisfying birth. Everything went as planned. I had a very good birth, a gorgeous perfect baby, and a wonderful loving husband. Following discharge from the birthing centre, we drove back to our home. I remember the day well; my husband prepared some lightly cooked scrambled eggs, with toast and smoked salmon for lunch – one of my favourite meals, but alas, not one recommended during pregnancy!

Both my husband and I have had happy and rather uneventful childhoods. My husband had a settled and contented childhood. He went to school, obtained his GCSEs and A-Levels, entered university and, following graduation with an MEng, went straight into employment. I had a somewhat more chequered childhood, moving countries and changing schools, and suffering from depression as a result of bullying when I was 14 years old, which resulted in me having to change schools again (and hence exam boards) halfway through my GCSEs. Even so, I still managed to obtain my good GCSEs, A-Levels and graduate from a red-brick university with a BSc(Hons) and MSc. Following my graduation, I entered the workforce.

Neither my husband nor I smoke, we don't take drugs, we drink very little alcohol and we are law abiding. We don't have criminal records. We are just a typical run-of-the-mill, average couple, making their way in life. Following the birth of our little girl, a friend said about the health visitor, 'You'll see her once for the initial home visit and never again.' The reality is I was seen by the health visitor on 20 occasions within nine months, and it took a further six months to change to another health visitor, which also involved having to change GP surgery. As I look back and ask myself what went wrong, the more important question is why?

My previous health visitor had categorised my family as vulnerable and in need of additional help and support because of the risk factors she thought we possessed. At this point, I could write up a separate essay as to the definitions of 'help' and 'support' as it is clear that different people and services have differing definitions. All I can say is the service I received was anything but helpful and supportive. What I did receive was a series of belittling remarks, patronising (and incorrect) advice, condescending comments, and a level of incompetence coupled with a judgemental and prejudiced service that would be comical were this not such a serious matter with grave consequences. During the 13 months following the birth, what should have been a joyous time, filled with fun and happiness, was marred by the stress of being undermined, looked down upon, criticised and more sinisterly, having my parenting abilities placed under intense scrutiny.

During those 13 months, I was being set up to fail. Not once was it pointed out to me that I was being assessed. Much of what I said in confidence was twisted and later used against me. Much of the time, I was in a tails-I-lose-heads-I-don't-win situation. I have so many examples to cite, but the following more benign incidents serve as examples. Following the initial meeting at my home, my former health visitor requested that I attended clinics on at least a fortnightly basis, otherwise she would come to my home instead. As a result, I followed her instructions and attended the clinics on a weekly basis until my daughter was 12 weeks old and then fortnightly until she was six months old. Yet, when I filed a complaint against my former health visitor the following year, the fact that I had attended the clinics so often was used as proof that I required the level of intervention that I received! Then there was the time when I explicitly informed my previous health visitor that I would be away visiting relatives during two specific weeks in August, only to find out when I eventually obtained my case notes that she had phoned our home several times during one particular week when she knew we were away. She did not leave a message on the answerphone so we never knew she had tried to contact us. However, she did put a non-maternal contact on my notes, the implication being that we were purposely avoiding her.

risk factor for poor/bad parenting or attachment and postnatal depression

I freely admit that I suffered from depression when I was 14 years old. The NHS treated my depression, for which I am forever grateful, as without the counselling I received I would not have had such a successful life. Nevertheless, I could have never foreseen that this episode of teenage depression, which lasted no more than a year, and required only counselling, would be considered a quarter of a century later as a risk factor for poor/bad parenting or attachment and postnatal depression.

I should perhaps mention how my former health visitor's rampages came to a halt. She made a medical diagnosis that she was not qualified to make and then lied by omission to a GP in order to bypass his examination and have my daughter fast-tracked for an unnecessary X-ray at 13 months old – with all the risks that possesses. That is when my father's friend (who is a GP in London)

and a relative (who also used to work for the NHS but then retired) volunteered to give a second opinion. At that point, there was a stark change of attitude towards our family and our daughter no longer needed an X-ray. On the advice of my father's GP friend, we insisted on our daughter being examined by a local paediatrician. The paediatrician examined our daughter, said that she was one of the healthiest specimens he had seen walk through the door and signed her off. We did not hear from that health visitor again, although by then we had already filed a formal complaint against her. Eventually, the Primary Care Trust (PCT) agreed to our request to change health visitor and we had to change GP surgery as well.

Six years on, the experience has had a profound effect on me – anyone who has experienced such character assassination as I have will know what I mean. To summarise the short-term effects, I have had to suffer the stress of a possible investigation into whether my husband and I are fit to be parents, the sense of injustice, the increased anxiety, the constant worrying that other people will believe the character assassination and, ultimately, the possible impact on our daughter. That first year, I was like the proverbial cat on a hot tin roof – nervous of doing anything 'wrong'.

I am a very strong person. However, the long-term effects although not problematic, are certainly regrettable – such as the inability to trust certain people and the inability to confide in people. I used to be an extroverted, bubbly, loud girl with an equally big mouth! Now, I am very much more introvert and I am less open and more withdrawn. I am more cautious of people and of what I say to them. I am suspicious when people ask me about our children and I do not divulge or volunteer any information. I avoid telling people which school our children attend, their ages, their likes or dislike, unless I know the person very well.

The side effects have not only affected me, but also my extended family. For example, following this health visitor nightmare, my parents – after almost 40 years of marriage – filed for divorce. And yes, I do hold my previous health visitor partially responsible for the breakdown of their marriage. My parents suffered as well. I have not lived with my parents for a long time but I can imagine the conversations and possibly the disputes brought on by my case.

The following advice will no doubt be scorned by the 'professionals', but if I knew back in 2004 what I know now, I would have given the health visiting service the widest of berths and ensured that I gave only the minimum amount of information possible to the health visitor. I learnt that, however nice the health visitor may initially appear, such information could be twisted and used against me at a later point. Furthermore, 'clearing' my name was an arduous and lengthy process – it took me over three years, but that is another tale. As far as the health visitor is concerned, she was seen last year selling ice creams and is no longer listed on the Nurses Register.

Laura Robinson

One to One under Attack

One to One midwives in the Wirral have been reported to the CQC (Care Quality Commission), so already these services are under attack. However, they have come out with flying colours.

CQC is the independent regulator of all health and social care services in England and the body responsible for checking whether hospitals, care homes and care services are meeting national standards.

The CQC report said:

'Concerns were raised with CQC that pregnant women who used One to One were not being provided with a safe and quality service. As part of this inspection we looked at these issues.

'The five women we spoke with told us they were given meaningful information by the service prior to and following accepting a service from them. We looked at records that showed a range of information was offered to pregnant women who were considering using One to One. There were signed consent forms for the sharing of information. Women told us they felt the information and advice provided allowed them to make informed decisions about their care and support.

'Care records showed detailed assessments of pregnant women's medical and social histories were carried out. Any identified risk was documented in risk assessments. A birth plan was then produced to reflect their wishes. Women told us they were happy with the service and felt confident in the care and advice provided.

'Training records showed all midwives employed by the service had received training in the protection of children and vulnerable adults. They also showed that each midwife had a designated Supervisor of Midwives for supervision and support.

'Women who used the service all told us they felt listened to and valued. There were effective systems in place to monitor the quality and safety of the services provided by One to One.

More information on the CQC report can be found here: www.cqc.org.uk/directory/1-197591160

More information about the One to One team and the care they offer is available on their website www.onetoonemidwives.org/

Reviews

Bad Pharma: How drug companies mislead doctors and harm patients.
By Ben Goldacre
Fourth Estate 2012
publishers recommended price £13.99

Ben Goldacre is well known for his trenchant views on the importance of science and using it properly. In this book he is not writing about childbirth, he doesn't mention maternity and barely mentions obstetrics. What he offers is a very detailed exposé of the global pharmaceutical industry, a $600 billion business *'rife with corruption and greed'*: he describes how drug companies distort the research into effectiveness of drugs; how government regulators fail to regulate and withhold information; how diseases are invented for profit; and, vitally and shockingly, how much of medical education is now managed by the drugs industry. His conclusion is the stark one that *'medicine is broken'*.

So why should AIMS members get hold of this book? It seems to me that this is important knowledge not just for us but for our children: there are some frightening passages about the lack of research on the effects of drugs on small bodies, sometimes alongside massive marketing for use with children. But I also feel that all of this is relevant to childbirth. One example that springs to mind concerns the most common intervention in childbirth globally; that is the use of the artificial hormone, Oxytocin, now given routinely in developed countries probably to a majority of women in labour, followed by prophylactic Oxytocin immediately after birth to almost every woman. This intervention is not evidence based and a recent study concluded that, 'Oxytocin during labour appears to be an independent factor for severe PPH', the most common form of morbidity for women in childbirth.[1] Goldacre doesn't use this example himself but shows how such a thing can arise and continue.

The relevance to childbirth, however, is more than just an awareness of how research into new drugs is distorted by the pharmaceutical industry: it is much broader than that. We need to understand how health professionals can't get objective information about drugs; how they are under enormous pressure to conduct research themselves and publish frequently; and how sometimes the temptation to fabricate is too strong. Goldacre, in one of his few references to maternity, quotes the example of Malcolm Pearce, a British obstetric surgeon who published a case report claiming that he had reimplanted an ectopic pregnancy resulting in the successful birth of a healthy baby; an anaesthetist and a theatre technician in his hospital thought this was unlikely as they'd have heard of it so they searched the records and found nothing. In the same issue of the same journal Pearce had also published a paper reporting a trial of 200 women with polycystic ovary syndrome who he treated for recurrent miscarriage; the trial never happened and not only had Pearce invented the patients and the results, he had even concocted a fictitious name for the sponsoring drug company, (Wells F. 2008, cited in Goldacre, pg 174). But plain fraud like this is usually not the problem; it is far more likely that findings are wrong not because of avarice, but because of ambition, excitement at discovery, ignorance of statistical analysis and sometimes chance.

The danger is that flawed, wrong or fraudulent research results are used and give rise to a 'spurious overcertainty' within the relationship between women and obstetricians. This leads Goldacre to discuss the role of the doctor in a way that, I think, will appeal to AIMS readers: he uses the concept of doctor as 'personal shopper', that is someone who knows how to find evidence, can communicate risk clearly but who can also understand in discussion with women their interests and priorities. AIMS has long argued for this kind of role. Another serious side effect of the distortions caused by the vested interests of the drugs manufacturers is that people studying social factors, or lifestyle changes, are edged out in favour of academics working in more commercial areas, and that is very detrimental to our understanding of what is important in maternity.

I recommend this book as a detailed and thorough account of how medical knowledge is developed and what can be done to improve it.

Gill Boden

References

1. Belghiti et al. (2011) Oxytocin during labour and risk of severe post-partum haemorrhage: a population based, cohort-nested case-control study. BMJ Dec 2011

Justice for Midwife Becky Reed

Witch hunt of one of the UK's most respected midwives

In late September 2009, King's Healthcare Trust stopped all Albany Practice home births the day after a baby was born at home in poor condition. The baby died in hospital soon after birth. A few days later, on a Friday evening, Becky was suspended from duty with no support, and with nothing in writing. Sixteen months later, at the baby's inquest, the coroner stated that she *'found Ms Reed to be an honest and credible witness',* and that there was no evidence to support a finding of neglect on the part of the midwives.

In December 2009, King's abruptly terminated the contract of the Practice without consultation, citing safety reasons. Its argument was based on a 31-month collection of inaccurate data and statistics that have been challenged by two professional statisticians, including Alison MacFarlane, Professor of Perinatal Health at City University London. Senior managers at King's, including the Head of Midwifery who had already referred Becky to the NMC, subsequently told local councillors at the Lambeth Health Scrutiny Committee that they had *'no concerns in relation to individual midwives'* and that King's had offered jobs to all of them, including Becky, following the termination of the Albany Practice. The unexpected closure of the Practice prompted a range of protests, including a large march and rally in London in March 2010. The 'Reclaiming Birth' march was called by the Albany Mums Group both to protest the closure of their valued local midwifery practice and to push for more woman-centred approaches to childbirth.

Becky Reed was the only midwife to have been with the Albany Practice since its inception. A very experienced and internationally respected midwife, she has written extensively about the Albany model of care and is currently co-editor of the well-respected academic journal, MIDIRS Midwifery Digest.

In January 2010 Becky was referred, without her knowledge, to the Nursing and Midwifery Council (NMC) by the Head of Midwifery at King's, Katie Yiannouzis. The referral cited seven cases, spanning a period of over three years, dating back to July 2006. Becky was primary midwife in only two of the cases. Katie Yiannouzis had been Becky's midwifery supervisor until February 2009 and had raised no concerns with Becky about her practice.

In September 2010, following an Interim Order hearing, Becky was given a Conditions of Practice order by the NMC, requiring her to undertake 450 hours of unpaid supervised practice (the maximum). She successfully completed this at Barnet and Chase Farm Hospitals, and, in April 2011, an Interim Order Review hearing took place where, on the basis of reports from her supervised practice and many testimonials from women and practitioners, the Conditions of Practice were revoked in their entirety and she was deemed fit to practise.

Unbelievably, the NMC investigation continues.

In March 2012, Becky was sent draft charges by the NMC relating to five cases out of the original seven (two of the cases had been mysteriously dropped). In three of the remaining five cases, Becky was the second midwife. The primary midwives have not been referred to the NMC. It is important to note that in the two cases for which Becky was primary midwife, she has successfully completed supervised practice (and been deemed fit to practise by the NMC itself).

On 20 December 2012 Becky was given notice of an NMC hearing which is scheduled to commence at 9am on Monday 11 March 2013 and continue until Friday 22 March. For each of the cases the charges are introduced as follows: *'When providing care for Mother XX and baby you: failed to comply with or practice within the Kings College Hospital Clinical protocols in labour and/or nationally recognised clinical guidance from the Royal College of Obstetricians and Gynaecologists and/or National Institute for Clinical Excellence.'*

The Midwives Rules (Rule 5) direct the midwife to *'work in partnership with the woman and her family, providing safe, responsive, compassionate care'.* Clinical guidelines, therefore, should be considered an important aid to clinical decision-making, but not as rules to be followed in every case.

There is no question that the public needs protection should there be midwives who are dangerous and negligent. This investigation, however, is nothing to do with protection of the public, but symptomatic of an entrenched medicalised and rule-bound culture at the NMC. Becky is certainly not the first woman-centred, skilled and dedicated midwife to undergo bullying and victimisation. For Becky, one of the UK's most respected midwives, to be treated in this way constitutes an attack on midwifery autonomy. If she is ultimately sanctioned, it will make it more difficult in the future for midwives to confidently support women's birth choices.

It will be obvious on reading this that the NMC, which was described last July as *'failing at every level'* by its own regulator, has completely mishandled this case. For Becky, this process has lasted for well over three years – she and her family have suffered both financially and emotionally. We, Becky's support group, will be asking (if you live in the UK) whether you could spare some time to come along to a session of the hearing during the two weeks commencing 11 March. Visible support will indicate the strength of feeling women and midwives have about Becky's mistreatment, as well as highlight the wider issues raised by Becky's case.

If you are able to come along, you will need to book your place online at www.nmc-uk.org/Hearings/Attending-a-hearing/#emailbooking. We would be grateful if you could also email Vicky at thebirthiwant@gmail.com with details of the day/time you book so we can ensure every session is covered.

We also plan to hold a peaceful protest gathering outside the NMC offices at the Old Bailey during the two weeks, probably on the first day. Further details of this protest will be published on our Facebbok page nearer the time.

Please post messages of support at the Facebook site Justice for Midwife Becky Reed www.facebook.com/JusticeForBeckyReed or email to thebirthiwant@gmail.com.

If you would like further information please email Vicky at thebirthiwant@gmail.com, or Sarah at sd889759@gmail.com

Sarah Davies, Vicky Garner,
Nadine Edwards (Vice Chair of AIMS),
Beverley Beech (Chair of AIMS)
and members of the Justice for Becky Reed group.

Publications

AIMS Journal: A quarterly publication spearheading discussions on change and development in the maternity services, and a source of information and support for parents and workers in maternity care. Back issues are available on a variety of topics, including miscarriage, labour pain, antenatal testing, caesarean safety and the normal birthing process. £3.00

Am I Allowed? by Beverley Beech: Your rights and options through pregnancy and birth. £8.00

Birth after Caesarean by Jenny Lesley: Information regarding choices, suggestions for ways to make VBAC more likely, and where to go to find support; includes real experiences of women. £8.00

Birthing Autonomy: Women's Experiences of Planning Home Births by Nadine Pilley Edwards, AIMS Vice Chair: Is home birth dangerous for women and babies? Shouldn't women decide where to have their babies? This book brings some balance to difficult arguments about home birth by focusing on women's views and their experiences of planning to birth at home. Invaluable for expectant mothers and professionals alike. £22.99

Birthing Your Baby: The Second Stage by Nadine Edwards and Beverley Beech: Physiology of second stage of labour; advantages of a more relaxed approach to birth. £5.00

Birthing Your Placenta: The Third Stage by Nadine Edwards and Sara Wickham: Fully updated (2011) evidence-based guide to birthing your placenta. £8.00

Breech Birth – What Are My Options? by Jane Evans: One of the most experienced midwives in breech birth offers advice and information for women deciding upon their options. £8.00

The Father's Home Birth Handbook by Leah Hazard: A fantastic source of evidence-based information, risks and responsibilities, and the challenges of home birth. It gives many reassuring stories from other fathers. A must for fathers-to-be or birth partners. £8.99

Home Birth – A Practical Guide (4th Edition) by Nicky Wesson: The fully revised and updated edition. It is relevant to everyone who is pregnant, even if they are not planning a home birth. £8.99

Induction: Do I Really Need It? by Sara Wickham: An in-depth look into the options for women whose babies are 'overdue', as well as those who may or may not have gestational diabetes, or whose waters have broken but have not gone into labour. £5.00

Making a Complaint about Maternity Care by Beverley Lawrence Beech: The complaints system can appear to many as an impenetrable maze. For anyone thinking of making a complaint about their maternity care this guide gives information about the procedures, the pitfalls and the regulations. £3.00
pdf available for free download

Safety in Childbirth by Marjorie Tew: Updated and extended edition of the research into the safety of home and hospital birth. £5.00

Ultrasound? Unsound! by Beverley Beech and Jean Robinson: A review of ultrasound research, including AIMS' concerns over its expanding routine use in pregnancy. £5.00

Vitamin K and the Newborn by Sara Wickham: A thoughtful and fully referenced exploration of the issues surrounding the practice of giving vitamin K as a just-in-case treatment. £5.00

What's Right for Me? by Sara Wickham: Making the right choice of maternity care. £5.00

Your Birth Rights by Pat Thomas: A practical guide to women's rights, and choices in pregnancy and childbirth. £11.50

A Charter for Ethical Research in Maternity Care: Written by AIMS and the NCT. Professional guidelines to help women make informed choices about participating in medical research. £1.00

AIMS Envelope Labels: Sticky labels for reusing envelopes
100 for £2.00

My Baby's Ultrasound Record: A form to be attached to your case notes as a record of your baby's exposure to ultrasound £1.00

AIMS Leaflet: available FREE
from publications@aims.org.uk

10 Book Bundle £50.00
This book bundle contains 10 AIMS publications at a discounted price, useful for antenatal teachers, doulas and midwives.

- Am I Allowed?
- Birth after Caesarean
- Birthing Your Baby: The Second Stage
- Birthing Your Placenta: The Third Stage
- Breech Birth: What Are My Options?
- Induction: Do I Really Need It?
- Safety in Childbirth
- Ultrasound? Unsound!
- Vitamin K and the Newborn
- What's Right for Me?

First–Time Mothers' 7 Book Bundle £30.00
This book bundle contains 7 AIMS publications at a discounted price, an excellent gift for a newly pregnant friend or relative.

- Am I Allowed?
- Birthing your Baby: The Second Stage
- Induction: Do I Really Need It?
- Safety in Childbirth
- Ultrasound? Unsound!
- Vitamin K and the Newborn
- What's Right for Me?

To join AIMS or place an order visit www.aims.org.uk

AIMS Members Yahoo Group

Stay in touch and have more of a say in what AIMS is doing. Join the Members Yahoo Group where you will receive updates from committee meetings and notice of events, as well as being able to contribute to discussions of current issues. Join at health.groups.yahoo.com/group/aimsukmembers or email egroup@aims.org.uk

health.groups.yahoo.com/group/aimsukmembers