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A brief glimpse into hell

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Jo Murphy-Lawless looks at what lies behind the Irish inquest into Bimbo Onanuga's death

In a corridor of the Rotunda Maternity Hospital a man falls to his knees, shaking with tears, his voice hoarse from screaming for help. His dear wife has collapsed in the room behind him. No staff member, not midwife, nurse, or doctor, nor any other person reaches down to comfort him.

His name is Abiola Adesina. His wife, who has experienced an intrauterine fetal death, is herself dying. Her name is Bimbo Onanuga. She will leave behind her a daughter, Nelly, who is seven, and who sustained devastating injuries at birth in Limerick Regional Hospital resulting in severe cerebral palsy. Bimbo has been the devoted carer of this beloved daughter since her birth.

Why understanding background circumstances matters

The AIMS membership, its hardworking committee, and all those who come to read the AIMS Journal care deeply about best conditions of practice to secure best birthing for women. We know that the care of each pregnant woman should reflect precisely her needs in all their dimensions. Rosemary Mander and I have recently stated the necessity of understanding the politics of maternity at fundamental levels, peeling back the concrete problems we see on a daily basis in our dysfunctional maternity services, to explore the power issues that are at the root of how contemporary governments and state-sanctioned institutions 'see' those same services. We have argued that it is imperative to understand fully what they value and what they choose to override.[1]

Within the British context, and certainly within the rapidly privatising NHS in England in the wake of the Health and Social Care Act,[2] this entails identifying how these inaccessible institutions spin their webs of influence on, create their definitions of, and distribute funding for maternity care. This level of analysis helps us to make sense of the chicanery that lies behind such moves as the 'reconfiguration' of maternal services in the Greater Manchester area that actually deprived vulnerable women of vital support.[3] We can see that after decades of the stated intent by British neoliberals to do so and the resulting starvation of funds for frontline services amidst a nightmare of managerial overload, the NHS now faces the risk of being broken up, taking with it the finest examples of maternity care across the country for which women, midwives and communities have fought so long.[4]

Ireland and its cataclysms

It is harder to track the structural cataclysm of the Irish maternity system because the connections

between it and the political ideology that sustains it are nowhere near clear-cut. In Ireland, maternity care has been available free of charge for all women since 1991. Yet the reasons for poor maternity services and the continuing reliance on an obstetric-consultant-driven system of care, where extensive private practice is intermingled with public provision provided by the same obstetricians, are far less apparent to the general public and far more hidden to the individual woman who becomes pregnant and who needs care.

Sociologists like myself might regularly draw attention to the 'patriarchal dividend' that characterises Irish society, where too few questions are asked about the ease with which men dominate and benefit from our existing institutions.5 People who are meant to be policymakers just as regularly speak about the need for 'transparency' and 'accountability' of these same institutions where maledominant power makes itself felt, and leave it at that, neither expecting nor getting any more than the exchange of fine words.

In the wake of Savita Halappanavar's death in 2012, her inquest was followed by a series of reports of which the final one to be issued by the Health Information and Quality Authority stated at last officially, in print, the unspeakable truth known to all who work with and in these services:

'*In summary, of the care provided there was a*:

- *general lack of provision of basic, fundamental care, for example, not following up on blood tests as identified in the case of Savita Halappanavar*
- *failure to recognise that Savita Halappanavar was at risk of clinical deterioration*
- *failure to act or escalate concerns to an appropriately qualified clinician when Savita Halappanavar was showing the signs of clinical deterioration.*

*'It was ... noted that there were many areas where maternity service needs were not being fully met at the time of the investigation. This finding reinforces the Authority's concerns in relation to the inconsistency in the provision of maternity services in Ireland and the need to ensure that all pregnant women have appropriate access to the right level of care and support at any given time. 'The Authority was concerned at the absence of a national over view and structured assurance arrangements to monitor the safety and quality of maternity services in Ireland.'*6

These findings and recommendations scarcely begin to dig in to the chaos that characterises maternity care. Interestingly, even the Master of the Rotunda Hospital, Sam Coulter-Smith, offers a critical view (via a third party) on this chaos. Dr Coulter-Smith has said he is concerned about the extent to which the Health Information and Quality Authority (HIQA) report into the death of Savita Halappanavar will be acted on, given past failures to implement reports' recommendations.'There isn't accountability or responsibility attached to these recommendations. The HSE is a very big organisation; who is responsible for carrying this out, when will it be done by and where is the accountability? I would have liked to see this in the report,' he said.7

Corruption by another name: the impact of unaccountable obstetric power

Over many years I have written extensively about the workings of obstetric power in the Irish context. However, a raft of recent events has forced me to shift my analysis to a different frame altogether. These events centred on a series of six news items which appeared in the weeks following the conclusion of the inquest for Bimbo Onanuga on 5 November 2013.

The first item had to do with the unwelcome revelation (for them), under a Freedom of Information request, that the masters of Dublin's maternity hospitals are receiving previously undisclosed private top-up payments over and above the officially agreed upon statutory limits on state salaries, and in addition to their private practices.8 According to these reports, since amended with still further details,7 Dr Coulter-Smith is currently receiving a total salary of €346,116 of which €60,000 comes from a 'privately funded allowance'.8,9An earlier Freedom of Information request in March 2013 revealed that the Board of Governors of the Rotunda Hospital had explored the possibility of renting a building in nearby Capel Street and converting it to serve as an outpatients antenatal clinic, badly needed for the over-crowded hospital. However the Board decided to suspend the idea because it was deemed too expensive in light of current financial constraints.10

A second item, in November 2013, reported on a newly published research study, covering 30,000 women using both public and private care in a Dublin maternity hospital between 2008 and 2011. Crucially, the same group of obstetricians led the care for both groups of women. Altogether, 34.4 percent of privately paying mothers had a caesarean compared with 22.5 percent of women in the public system, with the greatest disparity involving pre-planned caesareans, where 11.9 percent of first time mothers who were going privately had an elective caesarean section compared with 4.6 percent of those going publicly. The researchers conclude:

*'Privately funded obstetric care is associated with higher rates of operative deliveries that are not fully accounted for by medical or obstetric risk differences.'*11

The researchers are discreet and do not suggest what is widely acknowledged: these are financially driven outcomes.

A third story concerned an inquest which opened into a maternal death in 2012 in the National Maternity Hospital, Holles Street, in which Nora Hyland, a first-time mother, died after a 40-minute wait for a blood transfusion. According to evidence given to the Coroner, following a drop in the fetal heart rate, an emergency caesarean was carried out and thereafter blood was ordered, as the woman was thought to have lost a litre of blood. 37 minutes passed before the blood arrived in theatre. The woman's basic observations were all reported as normal before she collapsed but it was later estimated that she lost over 3 litres of blood. Consultant obstetrician, Dr Shane Higgins, was reported as testifying that the 'hospital had been unable to establish the cause of death'.12 The inquest may well bear out that sound procedures were in evidence, yet the continuing sense that individuals are right to distrust clinical care

because of poor clinical outcomes is not without reason.

A fourth case in the High Court awarded damages of aruond €800,000 to the family of Dhara Kivlehan who died after developing HELPP syndrome in 2010. Dhara was also a first-time mother who had indications of preeclampsia when she was admitted to Sligo General Hospital. Two days later her baby was delivered by caesarean and she was eventually airlifted to Belfast Royal Victoria Hospital where she died. Her widower is left to bring up their son. There has been no inquest in the Republic despite the family's consistent call for one. Ms Kivlehan did not die in this jurisdiction and thus it is not known if her death will have been listed in the new Maternal Death Enquiry system in the Republic. Belatedly, an inquest will be held in the Northern Ireland. Many of the same lapses of care that the HIQA report pinpointed in relation to Savita Halappanavar were evident in Dhara Kivlehan's death. It is important to note that undiagnosed HELPP syndrome led to the death of Tania McCabe and one of her twin sons in Our Lady of Lourdes Hospital Drogheda in 2007, where, as a result of the subsequent investigation, recommendations for responding to HELPP were meant to be put in place and followed throughout the Irish maternity services.

The HIQA report on Savita Halappanavar noted the similarities between her death and that of Tania McCabe and further commented:

'The HSE [Health Service Executive (Ireland)] reported that these recommendations were implemented at a local HSE level with regional HSE oversight. On enquiry, the Authority noted with concern that only five of the 19 maternity hospitals/units were able to provide a detailed status update on the implementation of recommendations from the Tania McCabe report.'[6]

At the press conference following the publication of the HIQA report, Phelim Quinn, the director of HIQA, drew attention to the 'disturbing resemblance' between Savita Halappanavar's and Tania McCabe's deaths. He stated that it was 'simply unacceptable' that six years after the report about the latter's death, a mere five of the Republic's 19 public maternity hospitals had submitted detailed reports on the implementation of those recommendations.[13] And of course Ireland has no reliable national system of audit.

It should also be noted that in the four cases of maternal death to have come before the courts in 2013, three coronial inquiries and the High Court case for Dhara Kivlehan - all four young, healthy women have been of black minority ethnic (BME) status: two Indian, one Malaysian and one Nigerian. This is no coincidence. The UK national confidential enquiries into maternal deaths have drawn attention to the fact for some years past that BME women have an above odds representation in maternal mortality statistics.

Finally, there were two cases within days of one another centred on catastrophic birth injuries resulting in severe cerebral palsy for a boy and a girl. It took six years and 12 years respectively to bring the two cases to court against the hospitals, the HSE and the State Claims Agency, all of whom variously denied at many points any and all responsibility for the injuries. Apologies were issued to both families at the

conclusion of the court hearings, and damages totalling €11.1 million were awarded.

In summing up the case for Dhara Kivlehan, Justice Mary Irvine noted that 'this was the third case before her within the last two weeks where a defendant [the HSE and associated bodies] had "held out almost to the bitter end" before admitting liability. This was "very regrettable" and caused enormous distress to a family.'14

In the 1980s and 1990s, Irish society endured a complex series of corrupt activities in three separate spheres: flagrant abuse of (then) EEC subsidies to its lucrative beef industry, undisclosed payments to serving politicians, and bribes to influence local authority planning processes for rezoning land for building. Common knowledge amongst many who colluded with these activities or who were on the edge of them, it took some time for the knowledge to come out in such a way that officials were forced to take action. In lieu of prosecuting the perpetrators of these massive frauds and putting all of them in prison, the state established tribunals at vast expense, the three largest ones costing a combined total estimated at €385 million. The perpetrators enjoyed impunity. Diarmaid Ferriter, the historian, has written of this wide-scale destruction of public trust that post-independence Ireland, prizing consensus and stability above all else, established a political culture which 'bred a cynicism and selfishness about how to do business and make money ... and a parallel devotion to a culture of self-advancement'. Ferriter also cites a 'fundamental neglect of civic morality' which ran alongside a snobbish and deeply hierarchical society15

This society unquestioningly awarded high status to its supposed cream, the legal and medical professions, despite appalling levels of accountability and nonadherence to their public duties. During the tribunals, we saw the extent to which many in the legal profession benefited to the tune of millions, receiving fees paid from the state budget, as poachers turned gamekeepers. One of the figures heavily involved in the tirbunal on payments to politicians, Charles Haughey, as Minister for Health had awarded gold-plated contracts to hospital consultants at the beginning of the 1980s. These contracts made them state-salaried employees for the first time with full-time contracts, but with unlimited scope to carry on private practice in public or private hospitals while their public duties could absorb as little as six hours a week.16 For obstetric consultants, this opened up an era of untrammelled and immensely lucrative private practice. It was a dangerous turning point.

In the wake of all we have come to understand in this last year about how our obstetric units and maternity hospitals function, alongside and with the HSE, it is futile to pretend that the official health and obstetric establishments, with rare exceptions, are not built on the same catastrophic dishonesty that led to the tribunals, with the same traits of collusion and secrecy which have resulted in permanent damage and loss of life for women and their babies. Irish midwifery, traditionally subservient to obstetrics in this patriarchal society, bears its own culpabilities despite a stated commitment to formally professionalise over the last 15 years.

What we learned from Bimbo's inquest

It took almost three years for the inquest for Bimbo to be heard. It is not mandatory in the Republic for an

inquest after every maternal death, only that a report is filed with the Coroner's office. That office in Dublin is oversubscribed and has been hard pressed by cutbacks in the wake of the 2008 economic collapse. The Coroner's team may not have been fully alerted to the seriousness of the circumstances surrounding Bimbo's death from the autopsy reports for Bimbo and for the female fetus who had died at 29 weeks. Tragic as the death of any mother is, Bimbo's report appeared to be straightforward, a fundal rupture of the uterus followed by collapse and progressive coagulopathy which led to her death. But what were the circumstances leading up to that moment? An inquest is a precious public resource for a family, perhaps often without funds to engage in other legal processes, whereby they can come to understand the train of events that has led to the death of a loved person in unexpected circumstances.

What was known in outline was that an intrauterine fetal death (IUFD) was confirmed in the Rotunda on 1 March 2010, that Bimbo was prescribed and administered mifepristone prior to a planned readmission on 4 March for a medical induction, that she returned to hospital in pain on the afternoon of 3 March, and that on the morning of 4 March 2010 the first dose of misoprostol was administered. We know that two hours later she was given pethidine to manage pain and that one hour after that a second dose of misoprostol was given. Shortly thereafter Bimbo collapsed. An emergency hysterotomy/caesarean was performed in her room as part of resuscitation efforts and, after a brief spell in theatre, she was transferred to the intensive care unit of the Mater Hospital where she died later that evening.

The first day of the inquest, 18 April 2013, heard important witness statements from the Mater's consultant in intensive care medicine and from the professor of pathology at the Mater Hospital. From the latter, we learned that Bimbo's uterus had ruptured at the site of implantation, which was unusually thinned.

A further three days of witness statements and testimony followed.

The Coroner was furnished initially with depositions from only four clinicians in the Rotunda. Bimbo's full clinical records indicated that many other clinicians were involved in her direct care. Counsel for Abiola, Bimbo's partner, pressed for, and extricated, the names of several other clinicians whose testimony was vital to have a full picture of events prior to and following Bimbo's collapse. The Coroner requested their depositions and presence, despite protestations from the Rotunda's legal team that two key people no longer worked in the hospital and that one of them had gone abroad. The Coroner patiently observed that in an era of Skype, testimony could be taken that way to facilitate the clinician currently in Australia. That was arranged for the second day, 5 July 2013. Yet more names emerged on the second day of the inquest, requiring more depositions to be sought. Under relentless questioning by Abiola's counsel, the hospital's legal team also finally released that day the rather slim critical incident report compiled after Bimbo's death, which for more than three years had been inaccessible to Abiola and to Bimbo's parents in Lagos.

By the conclusion of the inquest, there was a total of 24 depositions, 19 of which were from Rotunda staff.

The very first day of Bimbo's inquest coincided with the penultimate day of Savita Halappanavar's inquest which lasted for a fortnight. By the end of the first week of that latter inquest in Galway, the lack of basic care, let alone the shambles of disorganisation and the absence of clinical leadership had been laid bare.

Participants in the inquest were to become familiar with similar themes in the course of the four days; for example, how it becomes normalised that an off-licence drug, misoprostol, about which there are significant concerns internationally and which requires evidencebased protocols and careful monitoring when being used for an IUFD with a woman who is in the third trimester,[1218] can be administered without even taking basic observations contemporaneously. We learned that pain for a woman in the course of a medical induction with misoprostol, but not diagnosed as associated with established labour, can be viewed as normal. Although there was consistent reassurance from the Rotunda's legal team, and from Dr Coulter-Smith personally in his testimony, that lessons had been learned and recommendations carried out, Dr Coulter-Smith did not say when changes had been made and what they actually were.

Finally, we learned about the two small acts of kindness shown to Bimbo and Abiola on 4 March 2010: the H. Dip. midwifery student who noted late in the morning that Bimbo was warm and brought a fresh jug of water in to her along with an electric fan; and the consultant anaesthetist in the Mater Hospital who responded at once to Abiola's pleas to ring Bimbo's parents in Lagos on Abiola's mobile to tell them personally that their daughter was dying.

The Rotunda learned how the African community in Dublin responded to the death of a woman most of them had never met, but about whose fate they cared very much. The representatives from the hospital had to face a public gallery with many African women in attendance each day of the inquest.

Abiola, unable to attend on the first day because of unresolved visa problems with the British Home Office (to whom the Coroner's Office wrote to ensure that he would be able to attend the inquest thereafter), learned that Bimbo's life and death and his and Nelly's loss mattered to people in Ireland whom he had never met. So serious was her condition, Nelly had not survived her mother by many months and that too mattered to people.

A just verdict amidst many injustices

The small press coverage that the inquest attracted was accurate and fair, but the inquest did not have the dramatic appeal of Savita Halappanavar's death. I would ask questions about the sliding hierarchy of values attached to maternal deaths in Ireland. Unlike say Savita Halappanavar or Tania McCabe, a white Irish woman and a Garda police officer, Bimbo was not a middle-class professional and her death had initially been covered only by the small African press in Dublin. A Nigerian woman with the designation of 'asylum-seeker' comes at the bottom of that hierarchy of values, as shown in Carolyn Tobin's work.19 Nelly never had a court case about her injuries nor did Bimbo receive any additional funds to help her care for her daughter.

However, Bimbo, her death, and the circumstances of Abiola and of Nelly, mattered greatly to a legal team who gave absolute commitment to gaining this inquest and to questioning all witnesses with exacting thoroughness, so that the events of March 2010 could be laid out fully. The generosity of Colm MacGeehin, Laura Horan and Dr Ciaran Craven and all their staff who stinted nothing in pursuit of the truth is exemplary. They stand out as a token of earnestness for a less corrupt Ireland in the future. The same can be stated about the Dublin City Coroner, Dr Brian Farrell, whose courtesy and care towards Abiola never wavered and whose attention to a complex series of hearings was monumental.

I know more than most about maternal deaths in the Rotunda Hospital, seeing with a different eye because of the many hundreds of detailed accounts I have read of women's deaths dating back to the 1770s. So, perhaps, I have a somewhat more historical sense of the utter cataclysm for Bimbo, Abiola, and their families and for Nelly, Bimbo's little girl, which the inquest had explored.

[Note] Author's Note Medical misadventure is defined as an unintended outcome of an intended medical action.20 The work of an inquest is not to apportion blame. However, in the range of verdicts available to a coroner, this is a specific verdict about the cause of death and coroners can enter this on the death certificate for the person. This is distinct from a narrative coronial verdict, for example, which records only the circumstances of a person's death, and does not use established categories to indicate a conclusion as to cause of death. [EndNote]

It grew dark as the afternoon of 5 November lengthened towards 5 pm. The lights had long since been switched on. The summaries were intricate for counsel both on behalf of Bimbo's family and for the Rotunda. Finally the Coroner took up the task of his summary and verdict. As we listened and waited, I found myself gripping the shoulder of a lovely Ghanaian woman sitting just in front of me who had so kindly attended on all four days. The Coroner's verdict of medical misadventure left people in tears. The main door being locked because of the lateness of the hour, we were led out onto the street through a side entrance to begin to absorb all that had taken place.

In the same year, two verdicts of medical misadventure20 have been given. One delivered about Savita Halappanavar in Galway University Hospital and one about Bimbo Onanuga in the Rotunda. There can now be no mistaking the mountain of work that is required to build credible maternity services in Ireland.

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