AIMS For a better birth...

Sally Rowlette's inquest

AIMS Journal 2015 Vol 27 No 2

Jo Murphy Lawless asks what it tells us about the context of maternal deaths in Ireland

This is the eighth verdict of medical misadventure in a maternal death since 2007. The MBRRACE Report follows another inquest verdict On 9 December 2014, the MBRRACE Saving Lives, Improving Mothers' Care UK report was published with the principal finding that maternal death rates have declined from 11 per 100,000, in the period 2006-8, to 10 per 100,000 for the current reporting period of 2009-2012.1 Ireland, through the Maternal Death Enquiry (MDE), has been part of this confidential enquiry process since 2009 when, we are told, 'formal prospective collection of data concerning Irish maternal deaths2 commenced.

On 3 December 2014, the inquest into the death of Sally Rowlette in the maternity unit in Sligo Regional Hospital on 5 February 2013, returned a verdict of medical misadventure. This is the eighth such inquest and verdict since the death of Tania McCabe and her son Zach in Our Lady of Lourdes Hospital Drogheda in 2007. Five of these maternal deaths which went to inquest occurred since 2009, four of them between 2010 and 2012, while the fifth, Ms Rowlette's death in 2013, is outside the reporting period for the current MBRRACE/MDE summary.

Fundamental problems with the official internal hospital Health Service Executive (HSE) sanctioned review and investigation into Ms Rowlette's death were raised in the course of her inquest, with that hospital review scant on detail and seriously at odds with the clinical detail which emerged in the course of the inquest.3'4'5

These discrepancies raise very serious questions, sitting uncomfortably as they do alongside similar revelations from the seven other inquests since 2007. A number of these inquests were hard-fought for by the women's widowers, most notably, the inquest for Bimbo Onanuga who died in March 2010 in the Rotunda Hospital and Dhara Kivlehan, who died in September 2010, in the Royal Victoria Hospital, Belfast having been airlifted there from Sligo Regional Hospital. All these inquests and the surrounding efforts by families and legal teams to get at the core detail for the reasons eight young women died have featured delaying and obstructionist tactics on the part of the individual hospitals and the HSE itself.

The HSE, in full operation as the overall management body for the Irish health services since 2005 under the Department of Health, is not directly accountable to Irish citizens through parliamentary process, but is a so-called 'arms-length body'. The HSE promotes itself and its hospitals with the accepted language of good governance, accountability, best clinical standards, putting the person at the centre of its

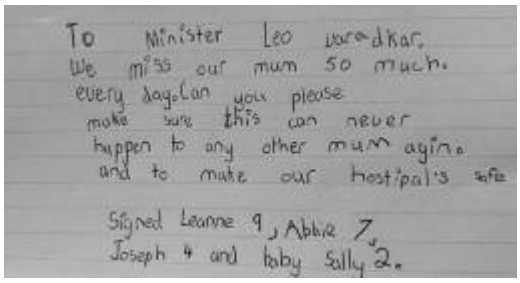
endeavours and so on, yet this proves meaningless when serious lapses of care occur.

Individuals and families can register complaints with the HSE but in reality, individuals have no immediate chance of redress save through initiating a legal process. Ireland's formal health and social care institutions have a vicious history in the 20th century of secrecy, suppression and denial of the truth of women's needs and circumstances as mothers: the older scandal of the Magdalene homes and the current scandal of the treatment of women who experienced symphisiotomy are testament to this culture of which the HSE has also become a willing participant.[6,7] Under the circumstances, we need to ask two questions: how secure and reliable is the current process of data collection and collation on maternal deaths in Ireland as part of the MBRRACE confidential review, and how is better, safer care to be secured for women coming out of these tragedies.

Securing accurate accounts of why women die Nine months after Sally Rowlette's death, upon its becoming a focus of discussion in the press, the HSE issued a statement, saying that patient safety in Sligo Regional Hospital was paramount. It stated that 'we take all action necessary to ensure the safety and welfare of all pregnant women and all other patients attending the hospital'. It also said that 'risk management' and 'clinical governance' procedures ensure 'safe practice within the Obstetrical Service', with every 'adverse incident' reviewed and 'appropriate action taken'.[8]

That might sound reassuring had it not emerged during the recent inquest that the HSE's internal review of Sally's death from HELLP syndrome (a life threatening condition described as a variant, complication or severe form of pre-eclampsia which affects - women in every 1000 during pregnancy or after birth) failed completely to identify, let alone examine in detail, the disastrous failures in her clinical care. Astonishingly, this slim report contained a single recommendation, that women who developed HELLP syndrome be informed of same so they could reach decisions about family planning in respect of future pregnancies. There were no recommendations whatsoever about changing or improving the clinical management of HELLP syndrome.9 The expert witness, a prominent Dublin consultant obstetrician, Dr Peter Boylan, brought in by the Sligo Coroner to review the HSE document, stated in his testimony that the lapses in care for Sally Rowlette began as early as 35 weeks but that her care on admission in labour was non-existent for what was by then a 'medical emergency'.[9]

More astonishingly and worse still, Ms. Rowlette's inquest followed that for Dhara Kivlehan which concluded in September 2014. That inquest, long-sought by Ms Kivlehan's widower and ultimately requiring an order from the Attorney General to hold the inquest,[10] took place a full four years after Ms Kivlehan's death in 2010, also from HELLP syndrome which was left untreated and undealt with in Sligo Regional Hospital after her baby was born by caesarean.


To Minister Leo Varadkar.
We miss our mum so much.
every day can you please
make sure this can never
happen to any other mum agine
and to make our hostipals safe
Signed Leanne 9, Abbie 7,
Joseph 4 and baby Sally 2.

A letter from Sally Rowlette's children to the Minister for Health

If the widowers of Dhara Kivlehan and Sally Rowlette and their dedicated legal teams had not pressed so hard for an inquest, none of the critical details in lapses of clinical care would be available to be provided to the Maternal Death Enquiry at any point.9 The same is true for Bimbo Onanuga who died following treatment for an intrauterine fetal death in the Rotunda Hospital in March 2010. This was yet another prolonged struggle to gain an inquest, with her widower being left with no answers at all as to the reason Ms Onanuga died, until November 2013. Again the so-called internal HSE hospital review completely failed to disclose the circumstances surrounding Ms Onanuga's death, although the public was reassured of an HSE 'review' of her death in 2011, following questions being raised in the DÃ¡il (Irish Parliament) about why no inquest had been held. At that point the HSE issued a very belated press release, extending their 'sympathies' to the family of Ms Onanuga for whom they claimed to have no contact details (although the inquest revealed that they did) and claiming as well to have submitted a report to the MDE. 12 Yet that report would have been woefully incomplete. Another slim review document comprising the HSE 'investigation' into Ms Onanuga's death was finally produced to her widower under challenge from his legal team during the prolonged inquest in 2013. The 'findings' in this review in no way matched the circumstances revealed in the course of the inquest, at the end of which Ms Onangua's death certificate, originally reading 'natural causes', was changed by order of the Coroner at the inquest's conclusion to 'death by medical misadventure'.

We can hope that this revised account of events about Ms Onanuga's death found its way into the analysis of the just published 2009-2012 MBRRACE/MDE (which does accept coroners' reports). However, the full details of Dhara Kivlehan's case did not. The reporting period had closed and the MBRRACE report itself was being finalised before her inquest was held at the end of September 2014. We will need to hope that the next MBRRACE/MDE report will fully reflect the details from Sally Rowlette's inquest.

What we also need to understand is that if these courageous, bereaved men had not succeeded in securing inquests, the Irish data for the MBRRACE/MDE report would be even more incomplete. The very instrument lauded as a way of improving maternal safety has been shown by the inquests themselves to be critically undermined as a result of the culture of secrecy and failure to disclose which has been shown to lie at the heart of the HSE.

Securing better practice in the wake of maternal deaths There has been a consistent and long-running

disregard by the obstetric community in Ireland and by the HSE throughout its managerial layers as to the necessary work to incorporate lessons from experience and best practice evidence.

Tania McCabe' s death and that of her son Zach in 2007 gave rise to a 2008 HSE report with the issuing of recommendations and directions to the country's 19 maternity units.[13] This report drew attention to:

- Delays in care
- Failure to diagnose signs of impending collapse
- Gaps in communication
- Failure to respond clinically at the highest levels of skill

These are the same issues pertinent to all eight maternal deaths which have gone to inquest since 2007. The HIQA (Health Information and Quality Authority) 2013 report on the death of Savita Halappanavar noted many of the same outstanding failures as the HSE 2008 report. It also noted that following on from that 2008 report, only five of the 19 units could even issue a 'status update' on HSE recommendations about critical care and directions from the HSE on developing a safer evidencebased system of monitoring and care for women with the potential to develop sepsis and, by extension, other serious conditions.[14]

In the UK, both NICE (National Institute for Health and Care Excellence) and the RCOG (Royal College of Obstetrics and Gynaecology) have published and updated specific evidence and protocols for identifying, dealing with and responding to HELLP, and other serious syndromes since 2000[15'16] long before Sally Rowlette and Dhara Kivlehan's deaths.

National clinical guidelines for obstetric care in Ireland did not even begin to be produced until 2010 by the Institute of Obstetricians and Gynaecologists (IOG). The IOG was set up in the 1990s, but had not worked on developing guidelines in the way that its UK counterparts the RCOG had.

However the IOG guideline dealing with preeclampsia, eclampsia and HELLP syndrome was produced in 2011 and revised and updated in 2014.[17] Dhara Kivlehan died in 2011. If this IOG guideline had been adhered to, or indeed any lessons learned from Dhara Kivlehan's death, Sally Rowlette might not have died.

The indications from the inquests to date are that there are multiple failures by clinicians, local hospital environments and our national overseeing institutions in relation to their deaths and the deaths of the other women who have died since the 2008 HSE report on Tania McCabe: Bimbo Onanuga, Nora Hyland, and Savita Halappanavar.

Not only were the broad general lessons from the 2008 HSE report not applied to maternity units at local hospital level, the HSE itself failed to apply proper and continuing scrutiny to ensure that standards were exacting and that units were complying with the evidence in the wake of these maternal deaths. Even if this country's senior clinicians and administrators did not want to rely on the long-running standards set in the UK by NICE and the RCOG, they did have, albeit belatedly, several years after Tania McCabe's

death, the beginnings of IOG guidelines.

Why did the HSE deliver merely status updates after issuing the 2008 Report on Tania McCabe, apparently requesting these only after Savita Halappanavar's death in 2012?

Why did the HSE not insist on each unit validating that it was up to date in fulfilling the 2011 IOG guideline for preeclampsia, eclampsia and HELLP?

Why, after Dhara Kivehan's death, was there not a similarly rigorous inspection of the facts and actions taken at Sligo Regional Hospital, as happened in Galway University Hospital after the death of Savita Halappanavar?

In the wake of Ms Kivlehan's death, where were the senior clinicians and administrators in HSE West who should have ensured that better procedures were put in place?

Did it take the international outrage over Savita Halappanavar's death, because of the complicating factor of abortion, to provoke any action in Ireland? HSE managers, hospital administrators and senior clinicians are receiving and have received significant remuneration (their salaries plus allowances and top-ups), despite six years of austerity which have wreaked havoc on the pay levels for ordinary workers in the health services.18 Indeed the number of senior hospital administrators has risen by 11 percent since 2011.19

The just released figures from the Rotunda's 2013 clinical report revealed three maternal deaths for that year : pulmonary embolism was cited as an issue for two of those three.20 All we have from the Rotunda Hospital (which has yet to complete its 'business plan' for the HSE in order to justify the extent of top-up payments enjoyed by the Master and senior administrators)21 is the assurance from the current Master, Dr Sam Coulter-Smith, that the hospital 'is looking at improving systems to tackle the difficult-to-predict but often fatal risk of embolism in some pregnant women'.22 Are consultant obstetricians and senior managers unable to access the RCOG Greentop 37A, on reducing the risk of thrombosis and embolism, first published in 2004?23 The issue of 'insufficient staff ', which the current Master asserts as an excuse, cannot cover the fact that senior staff have not done their jobs at hospital or at HSE levels in introducing guidelines about women in need of urgent attention.

Between 2009 and 2013 there have been 13 maternal deaths in the Rotunda.20 For the sake of comparison, when there were 10 maternal deaths in Northwick Park Hospital in London between 2002 and 2005, the hospital was put under special measures, an external team was sent in to safeguard women while far-reaching independent investigations were carried out and changes demanded before the special measures were lifted.24'25

The eight women who have lost their lives in Ireland's maternity services through medical misadventure, 2007-2013

Tania McCabe

died 9 March 2007, Our Lady of Lourdes Hospital

Evelyn Flanagan
died 19 October 2007, Mayo General Hospital

Jennifer Crean
died 10 February 2009, St. Vincent's Hospital after being transferred in a coma from National Maternity Hospital, July, 2008

Bimbo Onanuga
died 4 March 2010, after being transferred from the Rotunda Hospital to the Mater Hospital Dublin where she died later that evening

Dhara Kivlehan
died 28 September 2010, Belfast Royal Victoria Hospital, after being transferred from Sligo Regional Hospital on 24 September 2010

Nora Hyland
died 13 February 2012, National Maternity Hospital

Savita Halappanavar
died 28 October 2012, Galway University Hospital

Sally Rowlette
died 5 February 2013, Sligo Regional Hospital

The inquest for a ninth woman who died in Ballinasloe, having been discharged from Portiuncula Hospital, is due to begin shortly.

Why do the HSE and the senior obstetric establishment in this country consistently choose to ignore the application and follow-through on good guidance to prevent and reduce the numbers of maternal deaths?

An inquest for every maternal death The extent of the lack of secure clinical governance at local hospital, regional and national levels is laid bare by the series of inquests families have endured since Tania McCabe's death. Given the consistent patterns of poor to non-existent care which have been revealed, along with the institutional obfuscation, dissembling, and denial which have characterised all eight inquests, we can also conclude that these same patterns are likely to be found in many of the additional deaths which escaped the scrutiny of an inquest process because, under current law, maternal deaths are not automatically subject to inquests.[26]

We can now see how the assumed comprehensive nature of the Maternal Death Enquiry report has been jeopardised; unless the MDE team was enabled to draw on inquest findings, its understandings of why individual deaths have occurred is woefully incomplete. By extension, this also means that any maternal

death which did not get to inquest is unlikely to have the full facts recorded for the MDE team in Cork, as hospitals and the HSE scrabble to withhold and deny. As part of MBRRACE, the MDE report seeks to lay claim to be part of a trusted instrument, the UK national confidential death enquiry which has been rightly accorded massive prestige internationally for over six decades. Instead, we can see that in the Irish context, it is massively misleading.

On its website, the Institute of Obstetricians and Gynaecologists states that it 'aims to pursue excellence in the delivery of healthcare to women and maintain high standards of practice.'27

We would like to see that happen in reality throughout the HSE maternity units whose clinical directors are members of the IOG. And yet it appears that Ireland's vicious institutional history of suppression of the needs and lives of pregnant women and women giving birth is set to continue.

Jo Murphy Lawless Jo is a sociologist in the School of Nursing and Midwifery, Trinity College Dublin

References and Notes

1. Knight M et al (2014) Saving Lives, Improving Mothers' Care: Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-2012 MBRRACE.
   Although this report includes data on maternal deaths dating back to 2009, the work of the national confidential enquiry was re-commissioned in 2010, following the 2006-2008 CEMACE report, and then suspended for a period of some months early in 2011 while a review committee developed new terms of reference (See Yentis (2011) From CEMD to CEMACH to ...? Where now for the Confidential Enquiries into Maternal Deaths, Anaesthesia, 2011, 66, 859-860). It is thought that reporting forms in UK hospitals ran out during this hiatus, amongst other problems.
2. Murphy-Lawless J (2013) Harsh Myths, Harsher Realities: Maternal Deaths in Ireland and the Crises of Our Maternity Services. AIMS Journal Vol. 25, No. 2.
   On the MDE's statements on incomplete compliance by the 19 Irish maternity units with data collection for the MDE.
3. McDonagh M (2014) Husband of woman who died after birth told to go home before she had stroke. Irish Times, 1 December 2014. www.irishtimes.com/news/crime-and-law/courts/husband-of-womanwho- died-after-birth-told-to-go-home-before-she-had-stroke-1.2021405.
4. Harkin G (2014) Death of mother a day after giving birth was 'medical misadventure' - inquest rules. Irish Independent, 3 December 2014. www.independent.ie/irish-news/courts/death-of-mother-a-dayafter- giving-birth-was-medical-misadventure-inquest-rules-30796744.htm
5. McDonagh M (2014) Sally Rowlette inquest returns medical misadventure verdict. Irish Times 3 December 2014. www.irishtimes.com/news/crime-and-law/courts/coroner-s-court/sallyrowlette- inquest-returns-medical-misadventure-verdict-1.2024305.
6. Smith J (2008) Ireland's Magdalen laundries and the nation's architecture of containment. Manchester : Manchester University Press.
7. ICCL (2014) Proposed symphysiotomy redress scheme strongly criticised by rights watchdog.

Press release 6 November 2014. www.iccl.ie/news/2014/11/06/proposed-symphysiotomy-redress-schemestrongly- criticised-by-rights-watchdog.html.

8. Sligo Today (2013) Second woman dies following childbirth in Sligo. 18 December 2013. www.sligotoday.ie/details.php?id=29000.
9. Burke S (2014) Hospitals need to learn from the cases of Sally and Dhara to prevent future deaths. Irish Independent 12 December 2014. www.independent.ie/opinion/comment/hospitals-need-to-learn-fromthe- cases-of-sally-and-dhara-to-prevent-future-deaths-30811833.html.
10. Henderson L (2014) Inquest into death of woman after giving birth in Sligo hospital. Sligo Weekender, 16 January 2014. sligoweekender.ie/2014/01/16/inquest-death-woman-giving-birth-sligohospital/.
11. Harkin G (2014) Dhara Kivlehan died as result of medical misadventure, inquest finds. Irish Independent, 29 September 2014. www.independent.ie/irish-news/courts/dhara-kivlehan-died-as-result-ofmedical- misadventure-inquest-finds-30623766.html.
    At the conclusion of Dhara Kivlehan's case, the HSE's legal team not only endeavoured to have a verdict of death by natural causes returned, but also sought to prevent their last ditch argument to escape a medical misadventure verdict from being reported in the media.
12. Hunter N (2011) Safety flaws highlighted in maternal death probe. Irishhealth.com, 26 May 2011. www.irishhealth.com/article.html?id=19216
13. HSE (2008) Report into the circumstances pertaining to the death of Mrs Tania McCabe and her infant son Zach at Our Lady of Lourdes Hospital, Drogheda on Friday 9 March 2007. www.hse.ie/eng/services/publications/Hospitals/Report_into_maternal_and_child_death_at_Our_Lady_of_Lourdes_Hospital.pdf
14. HIQA (2013) Investigation into the safety, quality and standards of services provided by the Health Service Executive to patients, including pregnant women, at risk of clinical deterioration, including those provided in University Hospital Galway, and as reflected in the care and treatment provided to Savita Halappanavar. www.hiqa.ie/node/5421
15. NICE (2010) Hypertension in pregnancy: The management of hypertensive disorders during pregnancy.
16. RCOG (2006) Severe Pre-eclampsia/Eclampsia, Management (Green-top Guideline No. 10A).
17. Institute of Obstetricians and Gynaecologists/Clinical Strategy and Programmes Directorate, HSE (2011) The Diagnosis and Management of Pre-eclampsia and Eclampsia, Clinical Practice Guideline. HSE.
18. McConnell D (2013) Revealed: the true extent of salary top-ups and allowances enjoyed by HSE's senior executives. Irish Independent, 24 November 2013. www.independent.ie/irish-news/revealed-the-trueextent- of-salary-topups-and-allowances-enjoyed-by-hses-senior-executiv es-29779368.html.
19. Irish Times (2014) Too Many Managers: HSE Staffing. Irish Times, 1 December 2014. www.irishtimes.com/news/health/too-many-managers- 1.2021282.
20. Hunter, N. (2014) 3 maternal deaths at Rotunda last year. Irishhealth.com, 2 December 2014. www.irishhealth.com/article.html?id=24233

21. HSE (2014) Written reply to Parliamentary Question 19053/14. Clare Daly T.D. 13 November 2014.
22. Hunter N (2014) Rotunda to tackle embolism risk. Irishhealth.com, 2 December 2014. www.irishhealth.com/article.html?id=24237
23. RCOG (2009) Greentop Guideline 37A, Reducing the Risk of Thrombosis and Embolism during Pregnancy and the Puerperium (2004, revised 2009). www.rcog.org.uk/globalassets/documents/guidelines/gtg37areducingriskth rombosis.pdf
24. Health Care Commission (2006) Investigation into 10 maternal deaths at, or following delivery at, Northwick Park Hospital, North West London Hospitals NHS Trust, between April 2002 and April 2005. Comission for Healthcare Audit and Inspection.
25. Davies S (2007) Where next for the maternity services? A midwifery perspective. Healthcare Risk Report 13 (2):14-15.
26. McDonagh M (2014) HSE apologises to Sally Rowlette's family for her 'tragic death'. Irish Times, 16 December 2014. www.irishtimes.com/news/health/hse-apologises-to-sally-rowlette-sfamily-for-her-tragic-death-1.2040175.
    The HSE proffers 'apologies' to families left behind though it should be noted that such apologies have generally been released after the fact of the maternal deaths being investigated through legal processes; to add to families' sense of loss, these have been released through the HSE media arm and PR consultants, as with the latest 'apology' to Ms Rowlette's family.
27. IOG (2015) About us. www.rcpi.ie/landing.php?locID=1.5.71