Irish Inquests

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Jo Murphy-Lawless looks at the inquest into Savita Halappanavar's death and its aftermath

The full inquest on the death of Savita Halappanavar opened on 8 April 2013 and concluded on 17 April, with the jury returning a unanimous verdict of medical misadventure. The jury also endorsed nine recommendations for fundamental change. Two of the recommendations alone reveal the utter clinical impoverishment of Irish maternity services:

- that protocols on the management of sepsis along with 'proper training and guidelines for all medical and nursing personnel' should be instituted;
- that a protocol for sepsis be written for each individual hospital by its microbiology department and be applied nationally.[1]

University Hospital Galway is a third level hospital meant to provide comprehensive acute services for the western region of Ireland. It is beyond the bounds of understanding that a third level hospital had insufficiently clear protocols in place for the management of sepsis, including training, that were reliable, evidence-based, and above all, with all staff up to date on their use. It is beyond belief that the many clinicians involved in Savita's care from Sunday 21 October 2012 to Wednesday 24 October were so hapless as to be unable to try to discern warning signs in her condition during that period and take swift action; or even to ask themselves what substantive risks there might be for a woman in the process of an inevitable miscarriage and proactively look for warning signs.

We know that obstetric clinicians, driven by interventionist imperatives, are quick enough to imagine the worst of outcomes for pregnant and labouring women in ordinary circumstances and react accordingly, very often to the detriment of women's well-being. Why,mwhen this woman's condition did point to genuine risks, was she not strictly monitored? The inquest revealed that the confusion arising from the 1992 constitutional ruling on the X case, that a woman whose life is at risk can be given a termination, formed only one strand, if a significant one, in the appalling lapses of care Savita endured.

It is even more distressing to read a recommendation that calls for 'proper and effective communication between staff on-call and a team coming on duty'.[1] Surely this is what comprises basic clinical care that people expect as a matter of course when entering hospital, that clinicians communicate effectively with one another?

The inquest explored a terrible catalogue of errors: the blood sample taken on the Sunday evening which was never followed up or noted again, which would have shown an elevated white blood cell count; an examination by the obstetric consultant on Monday morning, over eight hours after the membranes had ruptured fully,showing 'no infection', but a full blood screen and c reactive protein test were not ordered to confirm that; instead, a clinical decision to 'await events' was taken; readings showing an elevated pulse which were taken on Tuesday evening by an alert student midwife were not picked up by senior clinical staff; then a large gap of time when vital signs were not taken; Savita's shaking with cold in the early hours of Wednesday morning was attributed to a cold room, with an extra blanket brought in for her, while paracetamol was given for her raised temperature, her pulse and blood pressure not recorded, and no alarm bells sounded; the note made by a junior doctor about a foul-smelling discharge from a vaginal swab taken some hours later at 6.30am, which was not picked up by the consultant obstetrician at 8.30am; bloods taken at 7am that Wednesday morning did not reach the laboratory until three hours later.[2] In his summing up, the Galway Coroner, Dr Ciarán MacLoughlin, said that by 1pm, when the consultant obstetrician was contacted again, Savita 'was in peril of her life'.[3]

A microbiologist called in as an expert witness by the Coroner noted that on the Sunday she was admitted, Savita was not given a vaginal examination nor was she checked for leaking amniotic fluid. This consultant also took issue with the type of antibiotics finally prescribed on the Wednesday, the wrong drug for the extent of the sepsis and the E. Coli ESBL, and the lack of 'prompt attention' to deliver the fetus.[4]

What was perhaps even more unbearable to hear was how Savita, in tears, was subjected to an ultrasound on several occasions to determine if there was still a fetal heartbeat. This surveillance related to a possible decision about a medical termination by Dr Katherine Astbury, the consultant obstetrician in charge of Savita's case, in accordance with that consultant's interpretation of what constituted a risk to the life of the woman.

In February 2013, there was a series of hearings before the Oireachtas Health Committee, a joint parliamentary committee, in which obstetric consultants from the Dublin maternity hospitals stated that six terminations had taken place in the Rotunda Hospital and three in the National Maternity Hospital in 2012. They were taking their lead from guidelines published by the Irish Institute of Obstetricians and Gynaecologists which is all consultants have to rely on, given the current legislative vacuum. They estimated that the numbers of terminations nationally to save women's lives 'could be as low as 10 or as high as 30' in any given year.[5] Is it really conceivable that these same obstetricians wait on allsimilar occasions to perform a medical termination when there is no fetal heartbeat, until severe chorioamnionitis has set in, until the delay most certainly puts a woman's life in the balance?

The barrister for the hospital and the Health Services Executive maintained an aggressive presence throughout the inquest. In respect of the nine hours between Tuesday night and Wednesday morning when there was no regular recording of vital signs, this barrister argued that it would be incorrect to say that no vital signs had been taken as Savita's temperature had been taken on two occasions. If that passes for good-quality clinical care, women in Ireland should feel a sense of dread in having to enter a maternity unit at all.

In the wake of the inquest, those who carry the principal responsibility for the poor quality of our maternity services, namely the community of consultant obstetricians who stand at the apex of this system, continue to dodge that responsibility. They appear to prefer splitting hairs and defending their own positions with their considerable egos. Peter Boylan, former Master of the National Maternity Hospital, who was an expert witness at the inquest at the Coroner's request, tried toargue that given the current legal vacuum, Savita was not ill enough and therefore not enough at risk of losing her life on Monday or Tuesday to justify a termination, whereas by Wednesday morning she was, but it was too late to carry it out in order to save her. His focus was not the clinical care and he effectively exonerated the consultant obstetrician in charge of Savita's case about that dimension. Boylan is determined to get legislation in place on the X case so that clinicians will have some legal safety in the decisions they must take on medical terminations. Yet he gave no indication at the Oireachtas hearings in February that women were literally at death's door before he intervened in the National Maternity Hospital. On the other hand, in a recent letter to the Irish Times, some of his obstetric colleagues including two consultants from Galway, one the professor emeritus of University Hospital Galway, objected to Boylan's position about termination. They argued variously and confusingly, that maternal mortality is on the rise in developed countries, that this was one of the worst cases of sepsis ever seen, that E. Coli ESBL is extraordinarily virulent, and that hospitals must reflect on the lessons from the inquest.[6]

The battle lines now dividing Irish obstetricians on the need for legislation for the X case do not get us to the heart of the matter. Despite their speeches and positions about how they care for women, what neither side is doing is stepping forward to say that our ser vices are in need of urgent reform from the top down, starting with the consultants themselves. Many of the 125 consultants in Ireland are very wealthy indeed as a result of their generously paid public contracts which historically have left considerable scope for a lucrative private practice. Yet it is as if the standards of care have little or nothing to do with them, even though it is their interests and their decision-making which most determine our services. This is the same professional group which has consistently blocked any wide-ranging initiative to establish midwifery-led care.

At the conclusion of the inquest, Praveen Halappanavar, Savita's husband said:*'She was just left there to die. We were always kept in the dark…It's horrendous and barbaricand inhuman the way Savita was treated in that hospital.'*[7]

We are now in the midst of the inquest for Bimbo Onanuga, an impoverished Nigerian woman who died in the Rotunda in 2010 from a ruptured uterus leading to DIC and cardiac arrest, after she had come into the hospital for treatment for a late intrauterine fetal death. An inquest has been urgently sought about Dhara Kivlehan, an Indian woman married to an Irish man, who developed pre-eclampsia and died from HELLP syndrome after a caesarean in Sligo General Hospital in 2010.

What may be the lessons from the deaths of thesethree young, healthy women? That fragmented care on top of unaccountable obstetric practice kills. Our overriding problem continues to be how to make the Irish obstetric community truly accountable for its work.

Jo Murphy-Lawless

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