AIMS For a better birth...

Coroner's inquiry into a breech delivery

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Women who want a normal, midwifery-managed, vaginal breech birth are now faced with a considerable dilemma. The default position of medical personnel is that vaginal breeches are more likely to be born dead or damaged. Beverley Beech reports on a recent case and finds there are still more questions than answers.

As a result of the Hannah trial (AIMS Journal, vol 12 no 4, 2001; pp 12-3), obstetricians now 'offer' women carrying breech babies external cephalic version (ECV; turning the baby to a head-down position) or, if that doesn't work or the woman refuses it, a caesarean operation.

In the past before most women were required to deliver in hospital, midwives regularly assisted women to birth their breech babies. Eventually, however, obstetricians decreed that breech presentations were abnormal (and thus outside the midwives' remit) and within the province of obstetric care.

It became common for a woman with a breech to be delivered by a doctor who required her to be restricted to a bed with continuous electronic fetal monitoring, an epidural and the baby delivered by forceps, manual manipulation or a caesarean section.

Compare this with a midwife-managed birth: the woman is free to move about and adopt whatever position is most comfortable to her, while the midwife listens to the heartbeat regularly with a Pinard stethoscope or a hand-held Doppler fetal monitor.

Many women, when allowed to decide for themselves, adopt a handsand- knees position for the birth and the baby is born by the expulsive efforts of the mother - the midwife does not pull the baby out. This kind of midwife-managed birth is now difficult to obtain on the NHS. The majority of experienced midwives have lost the skills, and most of those who qualified in the last two decades never gained them in the first place.

Women who want a normal vaginal breech birth often have a long and difficult search to find sufficiently skilled midwives to assist them. If they are lucky, they are able to engage the services of an independent midwife. However, if they choose to give birth in hospital, the majority find that the hospital staff refuse to allow an independent midwife to attend. Such women are then forced, by lack of choice, to birth at home. Others choose a home birth because of their previous dreadful birth experiences in NHS hospitals.

Penny Baker wanted a normal midwifery-managed breech birth and wanted her independent midwife to

assist her in hospital, but The Chelsea & Westminster Hospital would not give her midwife a contract.

Penny went into labour and was attended at home. Phoebe, her second child, was born at 00:24 hours, following a short, uncomplicated labour and gentle birth. However, in common with many babies presenting by the breech, she was slow to breathe. The midwives resuscitated her and, after 20 minutes, her Apgar score had climbed from 4 at one minute to 7 at 10 minutes, and then 8 at 20 minutes.

The midwives remained with Penny and the baby for the next four hours to be sure that all was well. Phoebe had some colostrum and appeared to be healthy. Later that day, the midwife made a routine postnatal visit-Phoebe had breastfed well and all appeared to be satisfactory. By 22:00 that evening, however, Penny noticed that Phoebe was becoming less attentive and phoned the midwife to discuss her concerns. Penny had the impression that Phoebe had been shattered by the birth, but was nevertheless feeding well and responding.

At 11:00 the following morning, the midwife arrived for a routine postnatal check to be greeted by a very distressed Penny. She had put Phoebe in her cot and, on her return a short while later, found Phoebe still and not breathing.

An ambulance was called and Penny, Phoebe and the midwife went to hospital. The staff recorded a brief history, but the consultant paediatrician, Michael Markiewicz, did not discuss the birth and subsequent events with the midwife. At 11:35 that morning, Phoebe was pronounced dead.

On 14 August, a coroner's inquiry was held under the direction of Dr Paul Knapman at Westminster Coroner's Court.

The first person to be called to give evidence was Professor Risden, paediatric pathologist at Great Ormond Street Hospital. Professor Risden found that Phoebe was a normal size for her gestational age. Although there was no evidence of hypoxic changes in the brain, he found bilateral adrenal haemorrhage, indicating a lack of oxygen. When asked when the hypoxia might have occurred, he acknowledged that it was difficult to say, but felt that it was most likely during the course of the labour and while Phoebe was emerging.

When Professor Risden received Phoebe for an autopsy, he was told by Dr Markiewicz that Phoebe had died six hours after birth when, in fact, it had been 35 hours after birth. Professor Risden was asked if this discrepancy would have altered his findings and he said no.

Dr Markiewicz gave evidence of Phoebe's condition when he saw her within three minutes of her arrival at Chelsea & Westminster. He stated that symptoms of a bilateral adrenal haemorrhage would include seizures (but, as in Phoebe's case, this does not occur in all cases). He found it surprising that Phoebe's condition had improved after the birth and that she had collapsed, but stated that, had the birth occurred in hospital, a paediatrician would have been called.

It is interesting to note that, when hospital staff refer to a 'paediatrician' being called, the reality is that it

is usually a junior doctor gaining experience who is routinely called. In paediatrics, it is never a senior specialist in the field or a qualified consultant paediatrician.

Dr Markiewicz could not say whether the outcome would have been any different had Phoebe had paediatric attention soon after birth.

During the evidence-giving, the midwives raised the question of Phoebe having a moderate growth of alpha-haemolytic streptococcus that did not show up on subsequent tests, but was found on the tip of the umbilical catheter. This question was waived aside by the coroner even though Dr Markiewicz in his evidence had agreed that Phoebe's condition could have been an indication of overwhelming infection.

Following Phoebe's death, the midwife repeatedly called Dr Markiewicz to arrange for the placenta to be examined at autopsy. He did not respond to her calls. The supervisor of midwives, who also wished a pathologist to examine the placenta, contacted the pathology department at Great Ormond Street Hospital to ensure that it would be available. She was told that it was not required. As a result, the placenta was never examined by the pathologist.

The Confidential Enquiry into Stillbirths and Deaths in Infancy Third Annual Report states: "The pathologist is entitled to expect a report of the circumstances of the baby's death, preferably following a visit to the site by the lead professional, together with the details of the baby's medical, family and social history," Yet, the pathologist neither spoke with the midwives nor read the midwives' notes which, incidentally, the coroner had praised for their quality.

Professor Philip Steer, an opponent of vaginal breech birth, gave evidence of the risks of vaginal breech delivery compared with caesarean section, and quoted the Hannah trial and two subsequent, allegedly supportive, studies. He failed to mention the weakness of the Hannah trial-that it failed to compare midwifery- managed breech births with caesarean sections. Professor Steer informed the court that he had undertaken a 'study' of 21 vaginal breech deliveries at home and in hospital: one baby died and two had brain damage, so the 'study' had been terminated early.

Interestingly, no coroner's inquest has ever been called into the death of the baby in that study. Many babies delivered by the breech die in hospital, yet we know of no coroner's inquiries into those cases. The caesarean operation rate for breech presentations at Chelsea & Westminster is now almost 100 per cent.

The coroner had invited a metropolitan police detective sergeant to be present during the hearing (not a routine occurrence), and the two midwives were the only witnesses to be given a formal legal caution before giving evidence. Throughout the evidence, the coroner frequently looked at Professor Steer, who shook his head or nodded to confirm or reject what was being said-particularly when expert midwifery evidence was given by Mary Cronk.

The coroner focused on the fact that this baby was born at home, no doubt reinforced by Dr Markiewicz's claim that, had the birth taken place in hospital, a paediatrician would have been called. That claim was refuted, however, by the fact that midwife Brenda van der Kooy had done the course in Advanced Life

Support in Obstetrics and had carefully followed its principles "to assess on your observations of the baby and the changes in these, rather than Apgar scores that are not useful indicators". Any paediatrician would have followed this procedure and, one assumes, would have arrived at a similar decision that, as the baby had continued to improve, it was not necessary to take any further action.

Listening to the evidence, I gained the distinct impression that the coroner felt that, had Mrs Baker been fully informed of the risks of breech delivery, she would not have had Phoebe at home. But when Mrs Baker herself gave evidence and was closely questioned about her understanding of the risks, she made it perfectly clear that she was very well informed, had had lengthy discussions with her midwife and had even searched the Net for information as well. She also said: "I chose a home birth because, during my first pregnancy, I had an appalling experience of the NHS."

Nevertheless - and no doubt ignorant of the evidence of the greater risks of birth in hospital - the coroner informed the court that he intended writing to the Nursing and Midwifery Council to urge them to amend the midwives rules to ensure that, in respect of home births, the risks have been explained and recorded in writing, and that the women be encouraged to countersign this. If that becomes a requirement, I for one will be vigorously pressing for a similar requirement to be made of those who intend birthing in hospital - perhaps then women will finally understand just how great are the risks they are taking.

The coroner ruled that Phoebe's death was by misadventure.* At the end of the day, Mr and Mrs Baker still do not know why Phoebe died. While there is no doubt that babies presenting by the breech have a higher mortality than babies presenting head down, we still do not know how many of these deaths are due to obstetric or midwifery management and how many are due to the risk that a baby may be presenting by the breech because there is a problem.

* The coroner's court told me that 'misadventure' is used when something unexpected or unforeseen has occurred. Yet, the coroner's rules suggest that this finding should not be used-an 'open verdict' or 'accident' is preferred.