The inquest verdict of medical misadventure for Nayyab Tariq

Last week was a terrible week for maternity services in Ireland, for pregnant women, for new mothers, and for their families:

- The discovery following a number of perinatal deaths, of the CUMH incineration of baby organ parts with no notification to or permission from parents, despite clear HSE guidelines that were drawn up after the organ retention scandal of the early 2000s
- Delays yet again to the inquests for Marie Downey and her baby Darragh who died in CUMH in 2019
- The outright refusal by the HSE to release the independent review on their deaths
- The inquest ending in a verdict of medical misadventure into the stillbirth of baby Willow Clarke in Our Lady of Lourdes Drogheda in 2018

And finally

- Nayyab Tariq's inquest concluding last Wednesday also with a verdict of medical misadventure

Nayyab's death in Mayo University Hospital on 22 March 2020 is the first maternal death that falls fully within the scope of the Coroners (Amendment) 2019 legislation when the law was changed to make all maternal deaths subject to mandatory inquest. The new law which was commenced at the beginning of 2020 was hard fought for by then TD Clare Daly, now MEP, and the Elephant Collective – educators, midwives, students, families directly affected and birth activists who worked tirelessly for six years to gain mandatory inquests for all maternal deaths.

This just concluded inquest for Nayyab, a beautiful young woman giving birth to her first baby, illustrates precisely why our concerns ran so deep. It is beyond credibility that another perfectly healthy young woman who gave birth in a high-tech well-equipped western hospital has died as a consequence of poor and poorly coordinated care, in this instance following post-partum haemorrhage and ensuing shock.

The inquest in Swinford revealed in precise detail that as soon as Nayyab birthed her daughter, there was:

- Failure to monitor and record observations
- Time wearing on with no effective intervention
- Tachycardia
- Nausea and vomiting
- Miscommunication between staff themselves in the labour ward and between them and theatre staff

Over three days in Swinford, we heard a confusion of testimony from senior clinical staff and midwifery staff, attempting to account for their actions about this chaotic timeline from the point when after Nayyab gave birth, a PPH ensued. This was an obstetric emergency. Every single maternity unit in this country is meant to carry out periodic obstetric emergency drills. Every single midwife, junior doctor, registrar and obstetric consultant is meant to regularly refresh training in obstetric emergencies like PPH.

Postpartum haemorrhage is one of the principal killers of childbearing women in poor world countries where access to emergency services is simply absent.

It beggars belief that Nayyab lost her life from PPH in a fully-equipped up to date hospital in Ireland, a rich western country which is meant not just to be up to date with protocols and guidance on the management of PPH but is meant to practice and retrain and re-certify its staff at regular intervals in emergency obstetric drills.

These are professionals who are meant to calmly and comprehensively assess and respond at once to an emergency. They failed.

Following Savita Halappanavar's death in 2012, HIQA produced a lengthy report condemning our maternity services, both the specific catastrophic failures of care of Savita - in addition to the refusal of a termination, and the general structures of our services which fail in the most fundamental way possible when women lose their lives. Following such tragedies, the obstetric system, buttressed by the HSE, resorts to institutional subterfuge to prevent grief-stricken families, their lives irrevocably changed by the death of a new mother, from ever discovering the truth. A succession of hard-fought for inquests, before the law was changed, reveal the extent of the subterfuge.

These failures of care have been repeated again and again and without mandatory inquests, the wearying succession of coverups would never be exposed. In 2012, the year that Savita died, there were six maternal deaths in a two-month period, only two of which ever came to inquest.

Last week, on the final day of the inquest in Swinford, a report was presented from the consulting pathologist, Dr Bennani (who as it happens was the same pathologist who presented his findings at a 2008 inquest for a woman who died in then Mayo General Hospital in 2007, also a death which began with a PPH – see Review of post-mortem ordered (mayonews.ie)). The pathologist gave considerable weight to evidence of a concealed haemorrhage on the uterine wall and displayed to the court hand-drawn diagrams of the uterus with the decidua/deciduosis which had led to this 'concealed' haemorrhage. Ayaz Ul Hassan's solicitor, Johan Verbruggen, had to insist that there be an addendum to the pathology report detailing the blood loss Nayyab sustained from the point when her baby was born.

Our obstetric and maternity services continue to fail catastrophically and they have continued to dissemble: the inquest for Tracey Campbell-Fitzpatrick's death in 2016 saw the same confusions and absences of care, the same attempt to blame the mother herself rather than to come clean about all the professionals missed. And oh can they hide: the cases of Marie Downey and her baby and of Karen McEvoy, who died on Christmas Day 2018 and still their families are fighting to have independent reviews which were commissioned by the HSE made public. The Campbell-Fitzpatrick family, like Sally Rowlette's family, like Tania McCabe's family, like so many other families, had to go to the High Court as private citizens to fight the untruths of these public institutions.

As Ayaz UlHassan has now had to fight.

Do we really want to have women giving birth in services which cover themselves in an avalanche of lies? Between 2007 and 2015, 96 million euro were paid out by the State Claims Agency for legal fees alone for maternity cases (PQ Number 6417/16 Deputy Clare Daly). Think how different it might be if the maternity services and the obstetric consultants who head them up had been honest to begin with, if there had been a duty of candour, if the HSE Legal Services had been honest, when women and babies died.

This country is just emerging from the 18 months of Covid which at its height found our emergency services and our intensive care units working flat out with an extraordinary level of dedication, bringing their skills to bear to save as many lives as they could from an unknown, utterly dangerous virus, posing a risk to the health and life of the entire country.

Imagine how frightened we might have been without that truly professional care at such a point of crisis. Imagine how terrible it would have been had we been relying on services which conduct themselves like our maternity units.

When are these crumbling, archaic, outmoded, arrogant, unaccountable maternity services going to come clean, own up, drop their contempt towards us and show Irish women the level of care and respect we require? There are individual midwives and clinicians within these services who desperately want to see change. Long promised, always deferred.

These failing services cannot be left room to hide any longer.

This is why mandatory inquests are critically important.

We want to thank the Mayo Coroner Mr Patrick O'Connor for his scrupulous and robust conduct of Nayyab's inquest.

Dr Jo Murphy-Lawless on behalf of The Elephant Collective