Neutral Citation [2013] IEHC 383

THE HIGH COURT

JUDICIAL REVIEW

Record No. 2013/470 JR

Between/

AJA TEEHAN

Applicant

-and-

THE HEALTH SERVICE EXECUTIVE

First Named Respondent

-and-

MINISTER FOR HEALTH

Second Named Respondent

Judgment of Ms. Justice Iseult O'Malley delivered the 16th August, 2013

Introduction

1. The applicant is a pregnant woman who is expecting her second child on 13th October, 2013. Her first child was delivered in hospital by way of caesarean section in April, 2007. As a result of concerns arising from that experience the applicant wishes to deliver her second child by way of vaginal birth in a home setting. The first named respondent ("the HSE") has refused to provide her with a home birth service. The issue arises from the fact that, under a Memorandum of Understanding ("the MOU") governing the relationship between the HSE and self employed midwives, clinical indemnity is not available to midwives attending at a home birth if, *inter alia*, the mother has previously had a caesarean section. This policy is based on a view that vaginal birth after caesarean ("VBAC") is not safe in the home setting.

2. The applicant does not seek a mandatory order that midwifery services be made available to her for a home birth. Rather, she claims that the respondent has fettered its discretion and applied a blanket policy without assessment of her individual suitability. She has researched the issues involved and has concluded that the risks associated with home births are, in her case, minute. She considers that if she attends a hospital for the birth she is more likely to undergo a repeat caesarean section, which also carries risks. She is fully aware that, should a home birth not progress or should anything give rise to concern she would have to transfer to hospital immediately.

3. In summary, the reliefs sought are: certiorari of the decision; a declaration that the failure to consider her case on its merits amounts to the application of a "blanket" policy and fetters the discretion of the HSE; a declaration that the second named respondent's policy on home birth services and its implementation by the HSE, precluding the provision of a service to mothers who have had a previous caesarean section (irrespective of their individual circumstances or the evidence) is unlawful; a declaration that the HSE's refusal, along with the threat of criminal sanctions for any medical practitioner who attends such a home birth, violates the applicant's rights under Article 8 of the European Convention on Human Rights and Fundamental Freedoms, and an order of mandamus directing the HSE to consider the applicant's request in accordance with law.

4. The reference to the "threat of criminal sanctions" is a reference to s. 40 of the Nursing and Midwives Act, 2011. This provision is not yet in force.

5. The respondents contest the justiciability of the policy in question and further argue that it is a policy based on sound medical considerations, adopted in order to safeguard the life and health of mothers and babies.

The Memorandum of Understanding

6. The importance of the MOU lies in the fact that professional indemnity insurance in this area of work has become unavailable in the private market.

7. In 2002 the State-backed Clinical Indemnity Scheme was introduced in response to the fact that private insurance companies would no longer offer cover to obstetricians and gynaecologists. The CIS covered all public hospital employees but not the self-employed midwives. The latter were, at the time, members of the Irish Nurses Organisation. INO membership benefits included professional indemnity insurance, and it continued to include coverage for private sector nurses and self-employed midwives until 2008, when it ceased to provide this facility.

8. The State then offered the self-employed midwives participation in the CIS, but only on the basis of adherence to the terms of the MOU drawn up specifically to provide a framework for their relationship with the HSE.

9. The MOU itself has its origins in the report "Delivery on Choice: Homebirth options for women in Ireland" published in 2008 by the National Implementation Committee. This Committee had been set up to implement the 2004 Domiciliary Birth Report, put together by the Chief Executive Officers of the then-extant Health Boards and accepted as a working document by the newly-established HSE. The membership of the Committee and its sub-groups comprised a range of practitioners, officials and consumer representatives.

10. By the time of publication of the report in 2008 the issue of insurance for midwives was a significant problem and the Committee devised the MOU as part of its strategy to fulfil the primary objective of "provision of a safe, evidence based homebirth service for low-risk women".

11. It is perhaps worth noting that in the foreword to the report, the Chairperson of the Committee observed that

> *"Proponents and opponents of a Homebirth option for low risk women are, in equal measure, both passionate and resolute in the pursuit of their respective objectives.*
>
> *The arguments for and against the provision of a homebirth option for women are well documented. Experience both here and in other health care services demonstrates that it is possible to provide for a homebirth option, with an associated but acceptable level of risk, which can be managed to maximise the safety of both mother and child ....*
>
> *... Given that there is no statutory obligation on the HSE to provide for maternity services in settings other than hospital or maternity units, there are many who would say there are too many associated risks for either mother or child, to make it feasible for the HSE to provide such a service ...*
>
> *... The withdrawal of insurance cover for self employed community midwives by the INO could have made it impossible to have the option of homebirths in the Republic of Ireland ... "*

12. The MOU in effect constitutes a contract between the individual self-employed community midwife ("SECM") and the HSE. In it the HSE sets out "guidelines and a clinical governance framework for the provision, control and supervision" of the community midwifery services provided by the SECM. The SECM must be registered in the Midwives Division of the Register of Nurses held by An Bord Altranais and operate within its Code of Conduct and Scope of Practice. The services to be provided are defined as

> *"such services as can appropriately be given by the SECM and which the SECM, having conducted a Risk Assessment, has established that it is safe to provide such services, the provision of which are not contra-indicated".*

13. The Schedules to the MOU cover a range of topics including payment for the service provided by the SECM, professional conduct and practice, performance management and reporting, continuing professional development, complaints and so on.

14. There then follows a series of Tables. Table 1 sets out a list of medical conditions "indicating increased risk suggesting planned birth at an obstetric unit." Table 2, with which this case is concerned, deals with "other factors suggesting planned birth at an obstetric unit". These are grouped into four categories relating to previous pregnancy complications; current pregnancy; fetal indications and previous gynaecological history. Caesarean section comes into the first category.

15. Tables 3 and 4 deal respectively with medical conditions and other factors "indicating individual assessment when planning place of birth". These range from cardiac disease without intrapartum implications to female circumcision.

16. Tables 5 and 6 deal with issues that may arise during or after labour and are not relevant to this case.

17. In summary, a SECM who adheres to the MOU will be paid for his or her services by the HSE in accordance with the schedule of fees set out therein and will be covered for medical malpractice claims. The provision of services where Table 1 applies is "contra-indicated" and will result in loss of cover.

18. Having regard to the history and genesis of the MOU, the second named respondent in these proceedings says that the relief claimed by the applicant in respect of the policy is misconceived insofar as it refers to it as his policy. He does, however, endorse and support it.

Correspondence between the applicant and the HSE

19. When the applicant became pregnant for the second time she carried out her own research as to her options. She was anxious to avoid a hospital delivery because she felt that certain interventions by hospital staff on the previous occasion had led to the caesarean section. Having regard to the risks associated with a repeat caesarean she felt that she would be safest giving birth at home.

20. As the applicant lives in Thomastown, County Kilkenny, she contacted the Designated Officer for home births in the counties of Kilkenny and Carlow, Ms. Eithna Coen, and explained to her that she wished to have a VBAC in a home setting. She was told that HSE policy precluded home birth services for women who have had caesarean births. Ms. Coen suggested that the applicant contact Ms Sarah Philomena Canning in Dublin. Ms. Canning is a very experienced self employed community midwife who has sworn an affidavit in the case, considered below. The applicant proceeded to do so and received a reply from Ms. Canning on the 14th May 2013.

> *"Thanks for getting in touch and you're by no means alone as I regularly get enquiries about homebirth after caesarean but as you're already aware previous c/section excludes you from the HSE homebirth scheme in operation here since 2008. It isn't clear to me why Eithne Coen has given you the application forms and referred you to me as she would be aware the terms of the scheme are applicable nationwide. I'm sorry if your hopes have been raised as I must confirm on behalf of the HSE that your application for homebirth is declined on grounds of your previous c/section and it's important to also understand there's no room whatsoever for negotiation on it.*
>
> *You should also understand that the HSE criteria for homebirth are simultaneously the criteria for clinical indemnity insurance and in the absence of that it wouldn't be at all advisable to proceed with homebirth. In any event it will be a criminal offence that carries the penalty of a 10yr prison sentence for a midwife to practice without insurance whenever the Minister gets around to putting that element of the 2011 Nurses & Midwives Act into operation which may well already be the case by the time your baby is due.*
>
> *The 0.6/0.8% risk of scar rupture as you rightly identify is the reason for excluding previous c/section due to the fatal consequences it can have for the life of the mother and baby and in such circumstances it's logical that the hospital setting is the safer option where help is immediately on hand. Having said that I appreciate that there are inherent risks in all options and the ESRI figures on repeat c-section rates are indeed a valid concern. However, since giving birth in hospital is the only option available to you perhaps you might consider ways of limiting the risks of repeating c/section by discussing it with your obstetrician and perhaps also with the manager of the labour ward to see if you can get assurances of support for physiological birth?"*

21. The applicant formally applied for a home birth on the 23rd May 2013 by way of an email sent to Ms. Coen and copied to Ms. Sheila Sugrue, National Lead Midwife for the HSE. The relevant sections of this email are as follows:

" ...At the start of our conversation Eithne indicated that official policy in the HSE dictated that table 2 and my c-section would mean that a home-birth was not available. I explained to her the circumstances of my previous c-section (which you have now both seen in writing), some initial research I had undertaken regarding the tiny, tiny risk and how very determined I was to at least go through the application process. Subsequently, she gave me voluminous research information (as she has outlined) which I was very grateful for, given that it helped me to make an informed decision regarding my choice. She also gave me the application form so that I could approach a midwife and go through the process - but again stressed that it was very unlikely that this process would end up with me being allowed to attempt a homebirth ...Subsequently, I did contact Philomena.

Unfortunately, it seems from her response that her hands are very much tied by policy, rather than recourse to reason, medical evidence, or anything that takes cognisance of my personal medical history, or the lack of merit of the sweeping generalisations made within Table 2. Her response indicating previous positive outcomes for VBAC at home up until 2008, along with her willingness to at least raise this with you, indicates that if it weren't for these stringent guidelines curtailing her, she would be willing to act for me. This is even more frustrating for me.

Sile, you do say that I have made a good case to be allowed to attempt a home-birth, and suggest that I might discuss this with the consultant in my hospital. I would be willing to discuss this with a consultant who was at least open to recommending a home-birth in certain, merited circumstances. Could I ask if this consultant would have the power to recommend a homebirth for me?

I know that I am asking to be considered individually, but I really do believe, based on the research that I've examined, that a homebirth gives me, my baby, and my family the best possible attempt at a risk-minimised birth. "

22. The applicant received a response from Ms Sheila Sugrue on the 28th May 2013 stating that she did not have the power to change the criteria set down by an expert steering committee on caesarean section.

"Thank you for your email communications outlining your individual situation. I have to let you know that I do not have any authority to change the criteria for eligibility for the home birth service provided by the self employed community midwives on behalf of the HSE.

The criteria were drafted by a group of experts including midwives and obstetricians and set out in Tables with the agreement of the Clinical Indemnity Scheme who provide cover for the Self employed community midwife. You have a right to have the baby wherever you wish but the HSE however would not be in a position to provide the service in this instance or provide indemnity cover for the midwife. "

23. On the 29th May 2013 the applicant received a formal letter of refusal from Ms. Coen.

"As the Designated Officer for Home Births for Carlow/Kilkenny I am writing to you in response to your email dated 23rd May 2013 addressed to both Sheila Sugrue and myself I am accepting your email as an official application request for a homebirth in the Kilkenny area at your home ...

Congratulations on your pregnancy and from your email, it sounds like you are fit and well and your pregnancy is progressing well. You had alerted me to your obstetric history of a previous C-section at St Luke's Hospital, Kilkenny in out telephone conversation and now you are requesting a VBAC at home. I see clearly you have researched the subject of the possibility of a VBAC at home at great length and you have informed yourself From your research and from all the research I have given to you, there can be no doubt that having a VBAC in a hospital setting carries a 'miniscule' risk of a uterine rupture and although it is a miniscule risk, if it occurs its consequences to both the mother and baby can be dire. I could not find research on the risks of having a VBAC in a home setting as it is not a practice that occurs in Ireland or internationally and therefore it is difficult to ascertain what the best evidence is.

A well as the risk of uterine rupture, in recent evidence also, Crowther and colleagues (2012) reported on neonatal outcome following VBAC or planned elective repeat c-section and found 'risks of fetal or infant death or serious adverse infant outcomes were significantly lower in planned elective repeat c section (0.9%) versus the planned VBAC (2.4%).' This has to be considered alongside the risks of repeat C-section, of course. It is because of these risks no matter (uterine rupture and adverse infant outcomes) how small they are, that a woman having a VBAC is given only the option of having her baby in a hospital setting in an obstetric unit, under the dutiful care of a Consultant Obstetrician as per HSE Guidelines for Homebirth. A key factor in assessing the fetal risks and uterine rupture is the availability of trained obstetric, anaesthetic and paediatric staff in the hospital on a 24 hour a day basis and the ability of the unit to implement a decision to proceed to a C-section quickly, if it is necessary. These resources would not be available in a home setting and therefore the risk of adverse maternal and fetal outcomes would be increased.

Medical evidence uses the 'gold standard' of evidence to support decision making and in obstetrics and midwifery the 'gold standard' is considered systematic reviews, viewed in the Cochrane library. Because VBAC practice is relatively new in research terms, we do not have any systematic reviews on the subject of VBACs and indeed no randomised control trials either. It will be some time before medical evidence will be able to provide conclusive evidence on ways on managing VBAC and I imagine this evidence will always be in a hospital setting.

However, what we do know from practice and the limited research carried out is that there can be some risks to both mother (uterine rupture) and baby (fetal or infant death). For now, medical and midwifery practice relies on the evidence presented through expert guidance in the form of clinical guidelines, such as the National Institute for Health and Clinical Excellence Guideline, 132 (UK) and Delivery after previous C-section, Clinical Practice Guideline No 5, Institute of Obstetricians and Gynaecologists, Royal College of Physicians of Ireland to guide decision making and practice.

Taking all of this into account, I have to decline your request for a homebirth at this time. "

24. The applicant's solicitor then sought expert reports from Dr Richard Porter, Consultant Obstetrician and Gynaecologist at the Royal United Hospital Bath and Professor Cecily Begley of the Nursing and Midwifery Department in Trinity College Dublin for the purposes of obtaining expert evidence and data on the safety levels associated with VBAC deliveries. Both reports were duly received and sent to Ms. Coen on the 14th and 19th of June respectively.

25. In the covering letter to Ms. Coen on the 14th June, the applicant's solicitor outlined the applicant's position regarding the

distance of her home from St Luke's Hospital in Kilkenny:

> *" ...our client's home is a 20 to 30 minute drive to St Luke's Hospital in Kilkenny. In the event that there are any complications during the birth of her child, our client instructs us that she is willing to be transferred to a hospital immediately. Furthermore, our client instructs us that she has relatives living in Kilkenny City and would stay with them, if necessary, to be in a home setting which is within a few minutes of St Luke's Hospital."*

26. Ms Coen replied by letter dated the 24th June 2013, once again refusing the applicant's request.

> *"Thank you for the comprehensive details and supporting reports which has been considered carefully.*
>
> *In response, after Ms Teehan's request !formally reviewed the literature and furnished Ms Teehan, with the most up to date medical evidence available on the practice of a VBAC and the concluding risks. Ms Teehan was further informed of the risks to herself and her baby in my letter and from the reading of Professor Begley's presentation of the evidence, there is agreement that there are 'slightly increased risks 'for Ms Teehan's baby and a 26% chance of a repeat caesarean section. The decision to provide a HSE homebirth service for Ms Teehan cannot be supported given those risks.*
>
> *Find enclosed the Health Service Executive (HSE) "Memorandum of Understanding" revised 22/01/10, with attached Tables 1,2,3,4,5 & 6, outlining factors indicating place of birth on which Ms Teehan's application for a homebirth with HSE services was declined, a decision supported by the up to date medical evidence. "*

Expert medical evidence on behalf of the applicant

27. Mr. Richard Porter, who provided a report for the applicant, is a consultant obstetrician and gynaecologist in Bath, England. He was for many years the Director of Maternity Services for Wiltshire Health Care NHS Trust (and successor Trusts) which he describes as one of the largest maternity services in the UK.

28. Mr. Porter reviewed the applicant's obstetric history and concluded that there was nothing to suggest a recurrent need for delivery by caesarean section. He was of the view that by any criteria the applicant should be advised to have a trial of vaginal delivery in her subsequent pregnancy.

29. Notably, Mr. Porter says that

> *"There is little doubt that VBAC should optimally take place in an obstetric unit where there is ready availability of surgical facilities such that a repeat caesarean section can be performed."*

30. The most important risk associated with VBAC, as identified by Mr. Porter, is that of uterine rupture, arising from the scar left by the previous caesarean section. This is described by him as a "*low but important risk*". He refers to the Royal College of Gynaecologists "Green Top Guideline" (Birth after Previous Caesarean Birth, 2007) which points to a risk of 22-74/10,000, compared to virtually no risk for elective repeat caesarean section ("ERCS"). The Guideline notes that, although a rare outcome, uterine rupture is associated with significant maternal and perinatal morbidity and perinatal mortality.

31. Mr. Porter says that there is also an increased risk or perinatal mortality, but only such as equals that of a woman having her first birth (as opposed to the expected decrease in risk for a second birth). The Guideline puts this risk at 2-3/10,000 when compared to ERCS.

32. The main issue giving rise to concern where the mother decides to give birth at home is identified as the delay in transfer to hospital for an emergency caesarean section should the need arise. This could be a clinically important delay and might make a major difference to the outcome for either the mother or the baby, or both. The risk in this regard cannot be quantified.

33. The position adopted in the Guideline is that women should be advised that a planned VBAC should be conducted in a suitably staffed and equipped delivery suite, with continuous intrapartum care and monitoring and available resources for immediate caesarean section and advanced neonatal resuscitation.

34. Having said this, Mr. Porter states that care is needed in applying the above considerations to the applicant, since she is aware of them and knows that if labour does not progress or if she needs intervention she has to transfer to the obstetric unit. He considers therefore that her risk of uterine rupture is at the lowest end of estimates for VBAC, assuming that she would be given appropriate advice as to transfer. He considers that she has researched the issues carefully and will follow such advice.

35. Mr. Porter also notes that the risk of uterine rupture is increased by obstetric interventions such as induction or augmentation of labour, which of course would not arise in a home birth.

36. Mr. Porter then goes on to discuss the policy options available to a maternity service when presented with a request that goes against the advice given on the intended place of birth for a VBAC. These are to, firstly, make it clear to the woman that the service does not recommend the course of action that she is choosing, but will provide services with the intention of maximising safety as far as possible or, secondly, to refuse to provide any assistance. The latter is a course that he feels will set the woman and the service in conflict, may lead to a loss of "satisfaction/fulfilment" for the woman and may at worst result in a situation where the woman chooses to give birth at home without any trained help. He queries the acceptability of, in effect, compelling a mentally competent woman to give birth in a hospital.

37. Professor Cecily Begley is the Professor of Nursing and Midwifery in Trinity College Dublin. She is currently the co-ordinator of a trial, involving 11 partners in 8 European countries, which is testing an intervention designed to increase the rate of vaginal birth following one previous caesarean section in 15 units across Ireland, Italy and Germany. In preparation for conducting the trial, the international literature on VBAC and its risks have been studied.

38. Professor Begley notes that the majority of the research on VBAC is observational, since few women will consent to a randomised trial that denies them the chance of a vaginal birth. She says that the evidence, therefore is not of the highest level but she points out that clinical decisions have to be made based on the best evidence that there is.

39. She puts forward the following statistics from the literature review:

- VBAC rates in Ireland are low (10- 36%) compared with the Netherlands, Sweden and Finland (45- 55%)
- VBAC success rate is high (70- 87%)
- Successive caesarean sections carry risks, and a woman at full term is five times more likely to die having an ERCS than having a planned VBAC
- However, a baby at full term is 2.6 times more likely to die in a planned VBAC than an ERCS (1.3 per 1,000 as opposed to 0.5 per 1,000)
- The risk of uterine rupture with a planned VBAC is 4.7 per 1,000 as opposed to 0.26 per 1,000 with ERCS
- There is a perinatal death rate of 2.8% of term babies associated with uterine rupture

40. Professor Begley concludes that on balance, the evidence demonstrates that VBAC is the safest option for most women with a previous caesarean section. She states that adverse events with VBAC are rare (maternal deaths 0.019 per 1,000; baby deaths 1.3 per 1,000; ruptured uterus < 4.7 per 1,000) in comparison with, for example, one's life-time risk of dying in a car crash, which is put at 10 per 1,000.

41. It appears that there are few studies on VBAC in the home setting. Professor Begley refers to one involving 57 women and another involving 360 VBACs in birth centres which included a small number of home births.

42. In general observations about the safety of home births, Professor Begley noted that low-risk women choosing home birth are more likely to have a normal birth than in hospital. She says that for women having their first birth, there is a higher incidence of adverse events affecting the baby in home birth than in hospital (9.3 per 1,000 as opposed to 5.3 per 1,000) but that these rates are still low. Because her first delivery was a caesarean section the applicant, as noted above, would be categorised as a first-time mother in terms of labour.

43. Professor Begley says that a systematic review of midwife-led care showed a higher incidence of spontaneous vaginal births, particularly in home-like situations and midwife-led units, compared with hospitals. From this she concludes that the applicant has a greater chance of a successful VBAC at home than in hospital.

44. As successful VBACs are safer than repeat elective caesareans, a planned VBAC at home is a reasonable option of care, once the woman is aware of the risks and benefits of all models of care. She therefore considers that for the applicant, choosing to have a VBAC at home is a "fairly safe option", with slightly increased risks for the baby and no known increased risks for the mother.

45. In conclusion, Professor Begley states her belief that coercion of an intelligent, caring mother to act against her wishes is contrary to the basic principles of most healthcare professionals. She believes that the latter do act in the mother's best interests but that they may not always be aware of all the research on every aspect of care.

46. Ms. Sarah Philomena Canning is the self employed community midwife referred to in the correspondence. She is qualified as a midwife for 30 years and has worked in Britain, the Middle East and Australia. She has an M.Sc. in Primary Health Care. For the last 13 years she has worked as an SECM in the Eastern Region, where she has attended 450 women planning home birth with no adverse outcomes for mothers or babies.

47. Ms. Canning refers to the rationale for the exclusion from home birth services of women who have had a previous caesarean section as being the risk of uterine rupture. She describes this risk as "minute". The risk is increased by the active management of labour associated with hospital births, as opposed to the way labour is managed in the home setting. Even in hospital births uterine rupture is rare. She refers to a 1994 study which reviewed the experience of the Coombe Maternity Hospital between 1982 and 1991. There were only 15 cases of uterine rupture in 65,488 deliveries. Thirteen of those cases were associated with the use of an oxytocic agent, which would never be used in the home setting.

48. Ms. Canning says that before the introduction of the MOU she had attended 21 with a history of caesarean section. In each case, the woman had decided after detailed assessment and discussion to proceed with a home birth. According to Ms. Canning this decision was taken, notwithstanding the small statistical risks, in order to avoid the risk of uterine rupture that, in the woman's view, obstetric intervention might cause. Ms. Canning considered the decision in each case to be reasonable, given that VBAC is a safer option than repeat caesarean section and that there was a high likelihood of the latter in hospital. All 21 babies were delivered successfully: 17 by VBAC at home, 4 by caesarean section after transfer to an obstetric unit.

49. Ms. Canning says that were it not for the terms and conditions set out in the MOU she would be willing to attend the applicant. In her opinion, mothers have a fundamental right to choose where they wish to give birth and the applicant should be given the opportunity to exercise that choice.

Expert medical evidence on behalf of the respondents

50. Ms. Sheila Sugrue is the National Lead Midwife in Ireland. Before taking up that position she was the Nursing/Midwife Advisor at the Department of Health and Children, in which capacity she was a member of the National Implementation Committee which was responsible for the MOU (see pargraph 8 above). She avers that the policy embodied in the MOU is based on sound medical evidence and in that regard she refers to the affidavit of Professor Michael Turner.

51. Professor Turner is the Professor of Obstetrics and Gynaecology at University College Dublin Centre for Human Reproduction and the Coombe Woman and Infants University Hospital. He was a member of the HSE Task Force on Home Births from 2010-12 but was not involved in drawing up the table of cases to be excluded from insurance cover. His report in this case is based on a review of the pleadings.

52. In the introductory part of his report Professor Turner says that he is "a keen advocate for VBAC" and thus "strongly supportive of Ms Teehan's desire not to have a repeat caesarean section". He also strongly supports Professor Begley's views in relation to VBAC generally. From the information available to him he can see no reason why the applicant should have a repeat caesarean and no contra indication to her attempting a VBAC. However, this situation might change as the pregnancy evolves. He agrees with Mr. Porter that the applicant should be advised to have a trial of vaginal delivery and that there is every reason to believe that there

would be a high chance of success.

53. The issue in the case as he perceives it is not between planned ERCS or planned VBAC in hospital, but planned VBAC at home versus planned VBAC in hospital.

54. Addressing the issue of the policy and rationale of the guidelines in relation to home birth, Professor Turner states that the safety of home births is a subject of debate among health care professionals. There is very little high quality scientific evidence because of the difficulty in setting up a randomised control trial. He notes that

> *"even amongst enthusiasts for home births, however, there is a general consensus that it should be confined to low risk pregnancies and should occur only in circumstances where the woman and / or her baby can be transferred at short notice to an appropriately staffed maternity hospital. "*

55. Professor Turner advises caution in interpreting the figures in studies relating to the risk of uterine rupture, given the variety of factors relating to the clinical circumstances. In his opinion the absolute risk of occurrence is low, but the reason that risk generates such concern is because of the serious consequences. The deaths of both mother and baby may result. Even if the child survives there is a risk of cerebral palsy.

56. A particular feature of home birth management that is a cause for concern is the monitoring of the fetal heart rate. Professor Turner says that in labour, uterine rupture usually presents with fetal heart rate abnormalities. A previous uterine scar (as where there has been a previous caesarean section) is regarded worldwide as an indication for continuous electronic fetal heart rate monitoring. In home births, the normal practice is to monitor by auscultation every 15 minutes. Professor Turner regards this as inadequate in the case of a previous caesarean section. In a supplemental affidavit Ms. Canning has expressed disagreement with this view. She considers that electronic monitoring as carried out in hospitals is overly restrictive of the mother and tends to give a high rate of false positives.

57. If rupture does occur, a key factor in determining a safe outcome is the length of time between the decision to perform an emergency caesarean and the actual delivery. Under 18 minutes seems to be a safe period. Noting that the applicant lives 20-30 minutes away from St. Luke's and additional time must be added for assessment and transfer to theatre, Professor Turner expresses the view that labour after caesarean section should only take place in a well-staffed maternity hospital where delivery can be expedited quickly.

58. Professor Turner makes the point that the applicant's experts do not address the fact that the applicant has not previously had a vaginal delivery. According to a study published by the Coombe, this reduces her chances of a successful VBAC from 3 out of 4 to 2 out of 4. It also increases her risk of having an instrumental vaginal delivery, which would require transfer to hospital. For the same reason, he is of the view that the two small studies referred to by Professor Begley and the experience of Ms. Canning in relation to the 21 women are not of assistance because there is no information as to how many of them had had a previously successful vaginal delivery. In any event he considers the numbers involved to be too small to draw any conclusions.

59. Professor Turner believes, therefore, that the risk assessment embodied in the MOU is correct and that planned VBAC should not take place at home. On the policy issue, he agrees with Mr. Porter that there is a need for a contingency plan in the event that a woman chooses not to accept professional advice offered, in case anything goes wrong. However, he is of the view that the plan should not include the HSE paying for a service that contravenes national guidelines and, based on the evidence available, is not safe. Likewise, he believes that it is reasonable for the State Claims Agency to choose not to indemnify such a service.

Other evidence

60. Two affidavits in support of the applicant have been sworn by women who have had successful home births after caesarean section.

61. Ms. Marie O'Connor, a research sociologist who has published extensively on the topic of healthcare in Ireland has sworn an affidavit in which she sets out the history of domiciliary midwifery services in the State since the Health Act of 1953 and the policy objectives associated with such services. From her analysis, she concludes that removal of professional discretion from the SECMs and the Designated Officers of the HSE poses an unacceptable risk to the health of mothers and babies. In this regard she refers to a survey she conducted on commission from the Department of Health in the early 1990s, where she found that 11% of home births (out of a total of 138) were unattended by medical professionals.

62. An affidavit on behalf of the second named respondent has been sworn by Michael Smith, Assistant Principal in the Department of Health. Mr. Smith sets out the history of the MOU, summarised above. He says that the policy in the MOU is not to be attributed to the Minister, although the Minister supports it. He refers to the fact that on foot of EU Directive 2011/24, all medical practitioners will have to have professional/clinical insurance from October of this year.

63. Mr. Smith makes the point that the Clinical Indemnity Scheme and the State Claims Agency are both funded by the state. He submits that it is unreasonable to ask these bodies to provide insurance for a particular service when they believe that the service in question increases risk and is contrary to recognised and accepted best practice. He says that since the inception of the State Claims Agency, obstetrics represented 20% of all claims by speciality but 53% of all liability. (It should perhaps be noted here that Ms. Canning makes the point that midwifery is not obstetrics, and that claims against midwifes have been relatively few and generally of a lower order of damages.)

64. According to Mr. Smith, s. 40 of the Nurses and Midwives Act, 2011 (which provides for criminal sanctions for practicing without insurance) will not be commenced until the Nursing and Midwifery Board of Ireland has made rules in relation to the requirement for indemnity insurance for midwives.

Submissions

65. On behalf of the applicant, Mr. Matthias Kelly S.C. makes it clear that he is not asking the court to make a medical decision. He argues instead that this is a situation where the HSE has a discretion but has fettered that discretion and has refused to engage with the evidence presented by the applicant. He submits that the applicant is not attempting to make a martyr of herself for an ideological cause. Rather, she is trying to minimise the danger to herself by avoiding the increased risks associated with hospital births, on the basis that the potential use of oxytocin; or the induction or augmentation of labour all may lead to the likelihood of a repeat caesarean section. The argument is made that, based on her personal health, she is at the lowest end of the risk category. The risk arising from the distance from her home to the hospital is adequately dealt with by her commitment to have the birth in a relative's home in Kilkenny city.

66. Mr. Kelly submits that the issue is the removal of professional judgment from clinical decisions by the adoption of the MOU policy, and not the insurance question. It is to be assumed that the State would revise the indemnity arrangements if the court condemned the policy.

67. Reliance is placed on a number of authorities dealing with the fettering of discretion or the application of a "blanket" policy such as *R. v. Port of London Authority, ex p. Kynock* [1919] 1 KB 176, *British Oxygen Ltd. v. Minister of Technology* (1971] AC 610, *Mishra v. Minister for Justice* [1996] 1 I.R. 189 and *McDonagh v. Clare County Council* [2002] IEHC 78.

68. Mr. Kelly also submits that the applicant's rights under Article 8 of the European Convention on Human Rights are engaged and he relies upon *Ternovzsky v Hungary* 67545/09 as establishing a right on the part of the mother to choose the setting of birth

69. On behalf of the HSE Mr. Paul A. McDermott says that the MOU is a medical based policy, and that the HSE is entitled to say that in certain circumstances a particular procedure will only be provided in a particular way. It is submitted that the authorities dealing with the application of a blanket policy apply only to cases involving an identifiable statutory right, such as the licence cases. Here, it is submitted, the decision of the Supreme Court in *O'Brien v. South Western Health Board* [2003] IESC 56 makes it clear that there is no statutory right to a home birth. That being so, the HSE is entitled to say that home births will only be provided for in certain circumstances. Whether one agrees with the medical evidence or not, this is clearly a lawful policy. In this case, the HSE did not respond with a simple refusal - it explained its policy to the applicant and offered a variety of options.

70. Mr. McDermott further submits that this is not the type of decision that attracts the rules of natural justice. It is the outcome of a non-justiciable medical policy. The policy is, in any event, not irrational having regard to the evidence. It seeks to identify and implement best practice. The applicant is not entitled to ask the HSE to breach its own guidelines and provide a service which, in the view of the HSE, does not meet that standard.

71. Mr. Eoin McCullough S.C. on behalf of the Minister submits, firstly, that the policy is not the Minister's but that of the HSE. However, he states that the Minister supports the policy. It is argued that the policy was drawn up, not by officials, but by experts in the field. It is based on data and accords with the Guideline issued by the Royal College of Gynaecologists.

72. Dealing with the insurance issue, Mr. McCullough submits that the fact that there is difficulty getting insurance on the open market does not mean that the State must be obliged to step in as the insurer of a risk of which it disapproves. The risk exists, no matter which figures are accepted, and the results if things go wrong can be catastrophic. The real question is - who is to provide the insurance?

73. Mr. McCullough submits that the court should not order the HSE to re-consider the case in the light of the individual circumstances of the applicant's case. The HSE has said that it will provide the service only in the circumstances set out in the MOU. If the applicant were to be entitled to individual consideration outside the terms of that document, the same principle would have to apply to every medical protocol and the courts would end up micro-managing medical decisions.

74. Both respondents submit that the relief sought in respect of the Convention cannot be granted, in the light of the Supreme Court decision in *MD.(A Minor) v. Ireland* [2012] 1 IR 697. The court cannot treat the Convention as if it had direct effect.

The law

75. Section 62 of the Health Act, 1970 provides as follows:

> *62.-(1) A health board shall make available without charge medical, surgical and midwifery services for attendance to the health, in respect of motherhood, of women who are persons with full eligibility or persons with limited eligibility.*
>
> *(2) A woman entitled to receive medical services under this section may choose to receive them from any registered medical practitioner who has entered into an agreement with the health board for the provision of those services and who is willing to accept her as a patient.*
>
> *(3) When a woman avails herself of services under this section for a confinement taking place otherwise than in a hospital or maternity home, the health board shall provide without charge obstetrical requisites to such extent as may be specified by regulations made by the Minister.*

76. The first authority dealing with the section appears to the judgment of the Supreme Court in *Spruyt v. Southern Health Board* (Unrep., 14th October, 1988). In that case the application was for an order of mandamus directing the respondent Board to provide the services of a midwife for the birth of the applicant's child. The Board had made arrangements with a registered medical practitioner, rather than a midwife. Giving the *ex tempore* decision of the court, Finlay C.J. said at p. 2 of the judgment

> *"There is no dispute that the Section applies whether a person with such eligibility is anxious to have their child born in a hospital or maternity home or at home, and that there is no difference in the extent of the obligation, though there may be differences in the method of providing it between those two situations. The Health Authority has under subsection (3) an obligation where a confinement is to take place otherwise than in a hospital or maternity home to provide without charge obstetrical requisites and that obligation has been carried out in this case.*
>
> *The issue which arises in this case [isJ whether the midwifery service mentioned in the subsection can be provided by a registered medical practitioner or whether they must be provided by a midwife registered under the Nurses Act. I am satisfied that the conclusion reached by the learned High Court Judge that midwifery services can be provided by a registered medical practitioner is the correct conclusion and the proper interpretation of the section."*

77. In his concluding remarks the Chief Justice said:

> *"The only other point which arises in the case is that I am satisfied that the statutory obligation which is contained in section 62(1) can only be provided by a Health Board if it enters into arrangements with a registered medical practitioner or a registered midwife to provide the attendance to the health in respect of motherhood of any particular woman having a child at home. It could not under any circumstances be discharged merely by an offer to indemnify such a person with eligibility against the cost of their own choice and arrangement with a private practitioner, either consisting of a midwife or a registered medical practitioner ...[The Board's] offer to indemnify the applicants against the cost of taking the services of a registered midwife who is prepared to act in relation to this birth, but not to provide personal insurance for any midwife prepared to enter into a contract with the applicants is not a purported discharge of*

their obligation under the section, but rather an ex gratia arrangement. "

78. There were a number of cases raising issues as to the extent of a health authority's obligations under the section in the early 2000s, most of which appear to have become moot before reaching a full hearing in the High Court. The only one with a considered judgment on the matter is *O'Brien v South Western Area Health Board*, which actually deals with four separate cases. Each of the applicants sought an order of mandamus directing the respondent Board to provide them with a domiciliary midwife service, whether by way of a midwife or a registered medical practitioner. The respondent contested the proceedings on the basis that it was not obliged to make available a domiciliary midwife service and that its policy was to provide maternity services through general practitioners and maternity hospitals. On the facts, it pointed to the consideration that each of the applicants lived more than 30 minutes away from a hospital.

79. In the High Court, O Caoimh J. held that sub-section (3) could not be read as requiring the provision of services in any particular place that was not a hospital or maternity home and in particular could not be construed as requiring the provision of midwifery services to any woman who chose to have a home birth. He was satisfied that the Supreme Court in *Spruyt* was not concerned with this issue and was limited to the fact that the respondent in that case was not required to provide the services of a midwife where it was providing midwifery services by way of a registered medical practitioner. His conclusion was that the statutory obligations of the Board were met by the provisions of the service in a maternity hospital and that a rational basis had been advanced as to why this was the position adopted.

80. The decision of O Caoimh J. was upheld in the Supreme Court. Giving the judgment of the court, Geoghegan J. accepted that the terms of the section did make it clear that the Oireachtas had in mind the possibility at least that the midwifery services provided by a health board might include home midwifery services. That, however, was a far remove from a statutory obligation to provide such services and there was nothing in the section to justify interpreting it so as to create such an obligation. It would, the court said, be reasonable to interpret sub section (1) as requiring a health board to make available appropriate medical, surgical and midwifery services, but that obligation would be fully complied with by the provision of such services within the confines of a hospital.

81. One of the four cases being dealt with by the court in *O'Brien* raised an additional issue arising out of the fact that different health boards had at the time different policies in relation to home births. Geoghegan J. said that he could find no justification for raising a complaint of discrimination in this regard.

> *"Section 62 does not lay down a national prescription as to how these services are to be provided. It leaves it to the individual health board. That must mean that each health board is entitled to consider the matter itself and there may obviously be different policies in different boards. Unless a health board was to adopt a wholly unreasonable policy, its decisions in this regard cannot be impugned. Apart from what is contained in the papers before the court it is common knowledge that there is widespread difference of opinion within medical circles as to the desirability of home births. "*

82. Geoghegan J. then referred to the affidavit filed by the general manager of the respondent board, which explained the view of his board that consultant-staffed maternity units were deemed to be the safest environment for deliveries, especially in the event of the many complications that could arise. The view of the Court was that there was nothing unreasonable about this policy.

83. *Ternovszky v. Hungary* was concerned with legislative provisions regarding the activities of medical practitioners which were ambiguous as to whether or not assistance at home births was lawful. In finding that there had been an interference with the applicant's right to respect for her private life, the European Court of Human Rights said (in paragraphs 22 to 26):

> *"The next matter to be decided is whether the contested legislation constitutes an interference with the exercise of the rights guaranteed to the applicants under Article 8 § 1. "Private life" is a broad term encompassing, inter alia, aspects of an individual's physical and social identity including the right to personal autonomy, personal development and to establish and develop relationships with other human beings and the outside world (see Pretty v. the United Kingdom, no. 2346/02, § 62, ECHR 2002-III), and it incorporates the right to respect for both the decisions to become and not to become a parent (Evans v. the United Kingdom [GCJ, no. 6339/05, § 71, ECHR 2007-IV). The notion of a freedom implies some measure of choice as to its exercise. The notion of personal autonomy is a fundamental principle underlying the interpretation of the guarantees of Article 8 (cf Pretty, loc. cit.). Therefore the right concerning the decision to become a parent includes the right of choosing the circumstances of becoming a parent. The Court is satisfied that the circumstances of giving birth incontestably form part of one's private life for the purposes of this provision; and the Government did not contest this issue. The Court notes that the applicant was not prevented as such from giving birth at home. However, the choice of giving birth in one's home would normally entail the involvement of health professionals, an assumption not disputed by the parties. For the Court, legislation which arguably dissuades such professionals who might otherwise be willing from providing the requisite assistance constitutes an interference with the exercise of the right to respect for private life by prospective mothers such as the applicant.*
>
> *In order for the "interference" established above not to infringe Article 8, it must first of all have been "in accordance with the law". The Court considers that the term "in accordance with the law" alludes to the very same concept of lawfulness as that to which the Convention refers elsewhere when using the same or similar expressions, notably the expressions "lawful" and "prescribed by law" found in the second paragraphs of Articles 9 to 11. The concept of lawfulness in the Convention, apart from positing conformity with domestic law, also implies qualitative requirements in the domestic law such as foreseeability and, generally, an absence of arbitrariness (Rekvenyi v. Hungary [GC], no. 25390/94, §59, ECHR 1999-III). The Court notes that it has found that the law itself constitutes the interference with the applicant's right to respect for private life (see paragraph 22 above) but considers that this conclusion does not preclude an examination of whether the quality of the law meets the requirements of the notion of "in accordance with the law" in paragraph 2 of Article 8.*
>
> *The Court considers that, where choices related to the exercise of a right to respect for private life occur in a legally regulated area, the State should provide adequate legal protection to the right in the regulatory scheme, notably by ensuring that the law is accessible and foreseeable, enabling individuals to regulate their conduct accordingly. It is true that, in this regard, the State has a wide margin of appreciation; however, the regulation should ensure a proper balance between societal interests and the right at stake. In the context of home birth, regarded as a matter of personal choice of the mother, this implies that the mother is entitled to a legal and institutional environment that enables her choice, except where other rights render necessary the restriction thereof For the Court, the right to choice in matters of child delivery includes the legal certainty that the choice is lawful and not subject to sanctions, directly or indirectly. At the same time, the Court is aware that, for want of conclusive evidence, it is debated in medical science whether, in statistical terms, homebirth as such carries significantly higher risks than giving birth in*

hospital..

In the present case, the Court observes that child delivery is regulated not only as a matter of public health but also as one falling within the ambit of social security. According to the Constitution, public health and social security is provided by institutional services (see paragraph 7 above). For the Court, a constitutional obligation of this kind warrants regulation which should take into proper consideration the right of choice of the mother.

The Court observes that sections 15 and 20 of the Health Care Act 1997 recognise patients' right to self-determination in the context of medical treatment, including the right to reject certain interventions (see paragraph 8 above). At the same time, section 101(2) of Government Decree no. 21811999 sanctions health professionals who carry out activities within their qualifications in a manner which is incompatible with the law or their licence (see paragraph 9 above). For the Court, these legal provisions may reasonably be seen as contradictory in the context of assisting home births, an issue otherwise unregulated under Hungarian law. The Court notes in this connection that the Government admitted that in at least one case proceedings were instituted against a health professional for having assisted home birth. It also takes cognisance of the task given by Act no. CLIV of 2009 to the Government to regulate the matter in a decree (see paragraph 10 above). However, the parties agree that such regulations have not been enacted to date, although the Government accepted their necessity (see paragraph 18 above). These considerations enable the Court to conclude that the matter of health professionals assisting home births is surrounded by legal uncertainty prone to arbitrariness. Prospective mothers cannot therefore be considered as freely benefiting from such assistance, since a permanent threat is being posed to health professionals inclined to assist home births by virtue of Government Decree no. 218/1999 as well as the absence of specific, comprehensive legislation on the matter. The lack of legal certainty and the threat to health professionals has limited the choices of the applicant considering home delivery. For the Court, this situation is incompatible with the notion of "foreseeability" and hence with that of "lawfulness". "

Discussion and conclusions

84. The starting point for the decision of this court has to be the decision of the Supreme Court in *O'Brien v. South Western Area Health Board*, by which I am of course bound. It is therefore established that there is no statutory obligation on the HSE to provide for a home birth service. It does have an obligation to provide maternity services and it may, in the exercise of its discretion, provide for home births if it considers it appropriate so to do. Further, if it does so decide (as it has) it is entitled to adopt such policy guidelines as it sees fit provided they are not "wholly unreasonable".

85. The applicant has not in these proceedings taken issue with this statement of principle. It has been submitted on her behalf that the guidelines are unreasonable in that they are inflexible. What she asks is that the HSE should consider her case on its merits rather than stick to a rigid application of the guidelines. Mr. Kelly, in stressing to the court that it was not being asked to make a medical decision, submitted that all that was required was an alteration to the MOU.

86. In my view the court could not undertake that exercise without a finding that the policy adopted by the HSE is unreasonable and I do not consider that such a finding is possible.

87. The guidelines set out in the MOU are the outcome of a careful, prolonged process carried out with the participation of representatives of all the stakeholders in this area. They are based on, and justified by, extensive statistical evidence. The policy is not in fact rigid, as it provides for a long list of conditions or factors which are subject to individual assessment in Tables 3 and 4. What the applicant seeks, in reality, is a direction that the category of women who have had a previous caesarean section should be moved into one of those Tables. That would be a clinical decision, based on assessment of the risk involved, which the court is not entitled to make. The categories to be included in the various Tables cannot be interfered with in the absence of manifest irrationality.

88. The expert witnesses who have presented evidence on behalf of the applicant have all, in one way or another, conceded that delivery in a hospital setting would be safer for the applicant than a home birth although they consider that a home birth would be feasible in her case. Where they take issue with the HSE is really in their belief that she is entitled, nonetheless, to make the choice.

89. It is true that there is room for disagreement on the evidence and that there are many who hold firmly opposed beliefs. It is also true that statistics can be looked at in different ways. For example, one side may say that the risk is "only 0.5% " that uterine rupture will occur" while the other side says "as many as as 50 women in 10,000 may suffer uterine rupture". However, it is not my task to decide who is right in this argument. The question is whether it is reasonable to arrive at the position embodied in the MOU and I consider that it is. The HSE is entitled, having regard to the potential consequences of uterine rupture, to provide maternity services in such a way as to minimise the risk of its occurrence, even if that risk is small.

90. As I see it, the issue of insurance is at the heart of the problem. In the modern era it simply is not possible for medical practitioners dealing with the field of childbirth, whether midwives or obstetricians, to practice without insurance. No party in the case has suggested otherwise, although insurance is not yet compulsory. Once that is accepted as a factor, it follows that if a particular service is to be provided, someone must be prepared to bear the potential liability. I have no doubt but that all medical practitioners are aware that if something does go wrong in childbirth, the consequences may be, not only immensely tragic in human terms, but also extremely expensive in financial terms.

91. The applicant has argued that the risk in her case is minute and that she is prepared to accept it for herself. However, there has been no suggestion that she might waive liability in respect of any injury resulting from a decision to engage a midwife's services for a home birth. Even if a mother did make such a waiver, it would probably not bind a child born with injuries as a result of a childbirth mishap attributable to negligence. It is also clear that Ms. Canning, who also believes the risk to be very small, is not prepared to act without insurance.

92. The effect, therefore, of the claim made by the applicant in this case would be to compel the HSE to accept, or rather, to consider in good faith whether it should accept, liability for a risk that it does not believe is justifiable. As a matter of law I do not consider that she is entitled to that. In my view, this is what distinguishes this case from the authorities cited relating to "blanket" policies- the applicant is not just asking for her case to be considered on the merits, she is asking that the HSE assume the burden of liability relating to a risk that it considers, on reasonable grounds, is better avoided.

93. Pleading issues aside, I do not consider that the decision of the European Court of Human Rights in *Ternovszky* assists the applicant. While it makes it clear that childbirth is part of the protected area of a woman's private life (with which I fully agree) it is

careful to acknowledge the disagreements that exist in relation to home births and does not suggest that there is an unqualified right to be provided with a home birth service. The factual basis for the case - the lack of clarity as to the legality of providing home birth assistance - has no relationship with the facts of this case.

94. I do not feel that I should express any view on s. 40 of the Nurses and Midwives Act, 2011 since it has not been brought into force and is not, therefore, applicable to this case.

95. I do consider that there is a potential problem with the HSE's policy arising from the issue identified by Mr. Porter - that is, the need for a contingency plan in the event that a woman decides not to take the professional advice given to her and ends up giving birth unattended by anyone with the requisite expertise. I note that it was part of the terms of reference for one of the sub-groups in the National Implementation Committee to draft a policy for this, and that it was unable to reach agreement on a recommendation. However, there is no reason to suppose that this issue will arise in this case.

96. In the circumstances I refuse the reliefs sought.