The Legal Aspects of the HSE National Home Birth Service:

A review of legislation and case law

Report prepared by

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on behalf of the Health Service Executive

This review was prepared as part of a project to support the development of a governance infrastructure for the HSE National Home Birth Service. The project was conducted by a team of researchers at the **UCD School of Nursing, Midwifery and Health Systems**. The project team members were: Gerard Fealy (Principal Investigator), Paul Ward (Legal Report Supervisor), Maria Healy, Mary Curtin, Caroline Keegan.

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1. INTRODUCTION

1.1 Background to the Report

The purpose of this Report is to inform the stakeholders involved in the governance and delivery of the Health Service Executive's National Home Birth Service of the legal aspects of the service and to inform the development of an audit tool.

Scope

The Report deals with the legal issues as to:

i. the legal basis of home birth in this jurisdiction;
ii. the education, training and the continuous professional development of midwives;
iii. the procedures for establishing practice as a self employed community midwife;
iv. governance of the self employed community midwives and the impact of the Nursing and Midwives Act 2011;
v. the legal relationship between the Health Service Executive, the self employed community midwife and the woman availing of the service;
vi. the employment relationship between the Health Service Executive and the self employed community midwife;
vii. the vicarious liability of the Health Service Executive;
viii. safety, health and welfare at work, encompassing the civil and criminal liability of the Health Service Executive and the self employed community midwife; duties and responsibilities pursuant to the Safety, Health and Welfare at Work Act 2005, as amended, the Regulations made thereunder, EU Regulations and Directives; the Protected Disclosures Act 2014; the protection of children and vulnerable persons and road traffic;
ix. clinical indemnity cover;
x. public liability cover;
xi. employer liability cover;
xii. occupiers' liability;
xiii. record keeping;
xiv. the duty of confidentiality to the woman availing of the service; access to medical records and freedom of information, including the provisions of the Data Protection Act 1988 and the amending Act of 2003 and the Freedom of Information Act 2014;
xv. the requirement for informed consent;
xvi. negligence;
xvii. the rights of the unborn child, the new-born child and parental rights, and
xviii. the requirements for notification of births.

The identification of the aforementioned areas was achieved by reference to literature, including the Code of Professional Conduct and Ethics and the Scope of Midwifery Practice published by the Nursing and Midwifery Board of Ireland and from discussion with Ms Sheila Sugrue, National Maternity Lead, Health Service Executive; and Ms Rosemary Ryan, Manager, Client Risk Management Services, Irish Public Bodies Insurance.

The review of legal aspects of home birth uncovered vast body of law in respect of each of areas listed above. Within the scope of this Report, it has not been possible to examine and

discuss in detail all aspects of each legal document or reported case; however but the Report highlights the most salient aspects and provides a comprehensive summary.

The research conducted for this Report has highlighted complicated legal issues pertaining to the legal relationship between the Health Service Executive, the self-employed community midwife and the woman, and the employment relationship between the Health Service Executive and the self-employed community midwife. The nature of the relationship has implications as regards vicarious liability and with whom various duties and responsibilities lie pursuant to legislation and the common law. In so far as it has been possible to do so, the Report covers the legal analysis of both scenarios of the self-employed community midwife being an independent contractor and being an employee of the Health Service Executive.

This Report should be considered a 'living' document and should therefore be subject to regular review, in order to ensure that recent changes in either statute or case law are included. This work should be conducted by a legal expert, such as a Barrister at Law with reading rights at the King's Inns Library.

2. THE LEGAL BASIS OF HOME BIRTH IN IRELAND

2.1 Home birth

The current position is that there is not any statutory right to a home birth. The Health Service Executive (HSE) is obligated by statute to provide maternity services free of charge to women and this may, at its discretion, include a home birth service. The Health Act 1970 (as amended):

> Section 62(1)[1] provides for a health board to make available medical, surgical and midwifery services for attendance to the health of women in respect of motherhood.
>
> Section 62(1A) provides that the services referred to in sub-section 1 shall be provided otherwise than as in-patient services.
>
> Section 62(1B) provides that the health board shall not charge for the services provided under sub-section 1.
>
> Section 62(2)[2] provides that a woman who is entitled to receive these services may choose to receive them from any medical practitioner who has entered an agreement with the health board for the provision of those services and who is willing to take her on as a patient.
>
> Section 62(3) provides that 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 an extent as may be prescribed by regulations made by the Minister.

In *Christie Tarrade and Ors v Northern Area Health Board*[3] four Applicants sought Orders of Mandamus (injunctions) compelling the Health Board to provide domiciliary midwife services to each of them. The applications were made under Section 62 of the Health Act 1970. In addition, each of them argued that they were entitled to damages to compensate them for privately procuring the services of a domiciliary midwife in circumstances where the Health Board did not have such a service.

Leave to apply for Judicial Review was granted between April and May 2000. Three of the Applicants had taken the step of contacting Ms. Philomena Canning, a midwife, who had concluded that each of them was a suitable candidate for a home birth and that she would be willing to take them on as clients. The fourth Applicant had contacted Ann O'Ceallaigh, a midwife, who had proclaimed her suitable for a home birth.

By the time of the hearing of the Judicial Review, each of the four Applicants had given birth. The Applicants had been constrained to hiring the services of private midwives. The net issues were whether the health board had a legally enforceable obligation to provide domiciliary midwife services to the Applicants and whether, where no such service existed,

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[1] Section 62(1) as substituted by Section 18 of the Health (Amendment) Act 2013

[2] Section 108(1) Medical Practitioners Act 2007 provides that every reference to a registered medical practitioner contained in any enactment or statutory instrument shall be construed as a reference to a registered practitioner within the meaning of Section 2. In Section 2 "medical practitioner" means a person who holds a basic medical qualification.

[3] [2000/184 JR] unreported Judgement delivered by Roderick Murphy J on 15th May, 2002

did the health board have an obligation to compensate the Applicants for the reasonable costs and expenses of hiring independent midwives.

As each of the babies had been born prior to the hearing the first issue was deemed moot. On the issue of damages to compensate for the costs of hiring an independent midwife, the question before the court was whether a right to damages could exist in the absence of a positive determination of the substantive claim and whether damages could be awarded for breach of public law.

Murphy J refused the application. He had regard to Section 62(2) of the 1970 Act stating that it expressly stated for the maternity services to be provided by a medical practitioner. He went on to say that midwives are not medical practitioners even though they may be more experienced in child birth than medical practitioners. He therefore held that the Applicants could not rely on Section 62.

In *O'Brien and Ors v South Western Area Health Board*[4] the Applicants sought, by way of Judicial Review, an Order of Mandamus (injunction) compelling the Health Board to provide to them a home birth service. The Health Board did provide a domiciliary homebirth service subject to certain criteria of which one was that it would be possible to get the woman to a consultant staffed maternity hospital by ambulance within a specific time period. None of the Applicants met this criterion.

The Applicants relied on the provisions of Sections 62(1) and 62(3) of the Health Act 1970. The Respondents argued that Section 62 did not impose a duty on the Health Board to provide a homebirth service to eligible persons but rather required it to put in place general categories of services which were to be determined in accordance with the prevailing appropriate medical, nursing and midwifery practice, having regard to resources and priorities.

O'Caoimh J refused the applications. He held that the Health Board satisfied the requirement under Section 62(1) Health Act 1970 regarding the provision of medical, surgical and midwifery services to eligible persons by making such services available to the Applicants within a maternity hospital. He was satisfied that a rational basis had been advanced by the Health Board as to why the provision of the services in question would take place in a maternity hospital.

The Judge held that Section 62(3) could not be construed as requiring the provision of the services in the section to any particular place that was not a hospital or a maternity home. The sub-section merely indicated that if a health board chose to make available midwifery services to a woman's home that it was required to provide without charge obstetrical requisites to the extent specified by the regulations made under the section. The section cannot be read as creating a statutory right to a homebirth but leaves discretion to the individual health boards. The decision was upheld by the Supreme Court.

2.2 The impact of the European Convention on Human Rights and Fundamental Freedoms

The Articles of the Convention are set out in Schedule 1 to the European Convention on Human Rights Act 2003.

[4] [IESC] and [2003] 7 ICLMO 34 (High Court decision upheld by the Supreme Court)

Article 8: Right to respect for private and family life:

1. Everyone has the right to respect for his private and family life, his home and his correspondence.
2. There shall be no interference by a public authority with the exercise of this right except such as in accordance with the law and is necessary in democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the prevention of health or morals, or for the protection of rights and freedoms of others.

The European Court of Human Rights has developed a three-fold test, known as the foreseeability test, to determine whether the interference is in accordance with the law.[5] In order to not constitute a violation of Article 8, the interference must have some basis in national law; the law must be accessible; the law must be formulated in such a way that a person can foresee, to a degree that is reasonable in the circumstances, the consequences which a given action will entail. The foreseeability test is premised on the notion that citizens should be given a good indication as to the circumstances in which an authority may interfere with their private lives.

The State has a wide margin of appreciation in legislating on grounds set out in Article 8(2) (national security etc). However it must ensure a proper balance is struck between societal interests and the individual's right to privacy.

In *Ternovszky v Hungary*[6] **t**he Applicant alleged that her Article 8 rights had been violated by a law that created a regulatory offence pursuant to Section 101(2) Government Decree No.218/1999 that put health workers at risk of prosecution if they assisted in a home birth. She argued that this dissuaded health workers from assisting in home births. She further argued that the current law did not regulate home births but that the Section 101(2) provision represented an unjustifiable threat to professionals inclined to assist.

Hungary pointed to several cases in recent years that had resulted in death or serious injury to babies. It had legislation in progress to regulate the area, but it had not been enacted. Hungary argued that there was professional consensus to the effect that home births were less safe than birth in a health care institution. Nevertheless, since 1997, home birth was no longer prohibited and regard had to be had to the mother's right to self-determination. Home birth was not encouraged or supported because of the perceived inherent risks. Health workers who encouraged home births overstepped their licences. There was no statistical evidence that the law dissuaded mothers from having a home birth, nor had it dissuaded health workers from assisting at them.

The European Court of Human Rights held that private life encompasses, *inter alia*,

> "*aspects of a person'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 ….*
> *"[Article 8] incorporates the right to respect for both the decisions to become and not become a parent …… The right concerning the decision to become a parent includes*

[5] [5] The test was originally laid down in the *Sunday Times v. The United Kingdom*, Judgment of the 26 April 1979, (1980) 2 EHRR 245, at para. 48-50 and has become established jurisprudence.
[6] EHCR application 67545/09, 14th December 2010

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. ……. The Applicant was not prevented from giving birth at home. However, the choice of giving birth at home would normally entail the involvement of a health care professional. ……. 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 the private life of prospective mothers".[7]

The Court went on to state that other rights might necessarily restrict the exercise of Article 8 rights. The Court referred to the medical debate as to whether it had been proved that home birth carried significantly higher risks than giving birth in hospital. The Court further held that the law regarding homebirth had failed the test of foreseeability in that it was surrounded by legal uncertainty and prone to arbitrariness. Accordingly, the status of the law, as it stood, meant that potential mothers were limited in their choices regarding the birth of their children.

In *Dubská and Krejzová v Czech Republic*[8] following the decision in *Ternovszky v Hungary***,** the European Court of Human Rights again looked at the issue of Article 8 rights in relation to home births. Domestic law prohibited midwives, under threat of sanction, from assisting in home births unless they held the appropriate licence and the appropriate technical equipment as specified by the Ministry of Health was available on the premises. The penalty for breaking the law was a heavy fine. While the law did not expressly prohibit home births, the provisions of the legislation made it clear that private homes were unable to meet the necessary requirements for the provision of medical services. The Applicants had argued that the law disproportionately restricted their right to respect of private life. The Court held by six votes to one that the prohibition of midwives assisting a home birth under threat of sanction was not a violation of Article 8.

The Court did find that having regard to the broad concept of private life within the meaning of Article 8(1), including the right to personal autonomy and to physical and psychological integrity, that the impossibility for the Applicants to be assisted by midwives when giving birth at home amounted to an interference with their right to respect for their private lives. However, in respect of the provisions of Article 8(2), a majority of the Court found that the interference was in accordance with the law and that the interference pursued a legitimate aim which, it had been argued by the State, was to protect the health, rights and freedoms of others, in particular the health and life of the mother and child during and after the birth. It held that having regard to all of the circumstances of the case and bearing in mind that there was no European consensus in the matter, the authorities, having adopted and applied the then policy relating to home births, did not exceed the wide margin of appreciation afforded to them or upset the fair balance which is required to be struck between competing interests. Accordingly, there was no violation of Article 8.

Consideration was given by the Court to, *inter alia*, domestic law which was clear in stating that women could only be assisted by a medical practitioner if they gave birth in a hospital[9], domestic guidelines and policy, international law and guidelines, data on perinatal mortality,

[7] Paragraphs 22 to 26
[8] (2015) 51 EHRR 22
[9] Cf Ternovszky v Hungary which involved a lack of legal certainty concerning midwives for home births.

cases taken against midwives[10] and conditions in Czech hospitals. In weighing up the factors capable of increasing the risks to the life and health of the new born and its mother, regard was had to:[11]

- the evidence of a leading obstetrician in Czech Republic who had informed the Court that the country had one of (if not the lowest) mortality rates of new born babies in Europe due, *inter alia*, to the legislation which ensured that all babies were born in hospitals;

- to research studies that did not suggest that there was an increased risk for home births provided a number of preconditions had been met which included a low risk pregnancy, the presence of a midwife and transfer to a hospital within a short time period;

- that in the case of the Applicants, midwives were not authorised to be present for home births, specialist emergency aid was not available and it was always possible for unexpected complications to arise during delivery requiring specialised immediate medical intervention which could be provided in hospital but would be delayed in the case of a home birth;

- the serious impact of the domestic law on the freedom of choice of women and the potentially greater risk it placed them and their unborn children in if they chose to give birth at home without the assistance of a medical practitioners. [Paradoxically, this was not prohibited by Czech law].

Judge Villiger, who concurred with the majority, specifically referred to the Court being asked to examine health issues in contracting state, namely the dangers of home births for new born babies. The Judge noted that with such an argument being advanced, it was

[10] Paragraphs 33-36: as of the date of hearing, no midwives had been prosecuted in the Czech Republic for attending home births *per se.* Several had been prosecuted for alleged malpractice in connection with delivery at home. The Applicants referred to the cases of Ms. Ŝ and Ms. K, who were well known promotors of natural deliveries without unnecessary medical intervention. Ms. Ŝ was found guilty of negligently causing the death of a stillborn baby. She was sentenced to two years imprisonment, suspended for five, and prohibited from practising for five years. Her culpability was that she had not strongly enough advised the mother to contact a medical facility when consulted by telephone during a labour that was ongoing at the mother's home. This was regarded as flawed advice as she had not examined the mother. The conviction was upheld on appeal but the sentence was reduced. At the time of the EHCR Judgement a further appeal was pending on a point of law. In the case of Ms. K, she was found guilty of negligently causing bodily harm to a baby whose home birth she attended and who stopped breathing during delivery. The baby died seven days later. Her culpability was the fact that she had not followed standard procedures for deliveries as laid down by the Czech Medical Chamber. The complaint against her was lodged by the hospital and not by the parents. She was given a custodial sentenced and ordered to pay the equivalent of €105,000 by way of reimbursement of the cost incurred by the insurance company in treating the child until its death. Her conviction was successfully appealed on the ground of the violation of her right to a fair trial and violation of her presumption of innocence. The Court had relied on expert opinion which had not been subjected to thorough scrutiny. It had not been established that she could have prevented the death; she had tried to help the baby and had called an ambulance immediately after establishing that it had hypoxia. The Constitutional Court held that to foresee every possible complication during delivery and to be able to react to it immediately, as was required of Ms. K, would ultimately lead *de facto* to an absolute prohibition on home births. Interestingly, the Constitutional Court invoked Article 8 and held that "*the right of parents to a free choice of the place and mode of delivery is limited only by the interest in the safe delivery and health of the child; that interest cannot however, be interpreted as an unambiguous preference for deliveries in hospitals*"

[11] Paragraphs 93-98

difficult for the Court to act as the highest supervisory medical body in Europe, called to approve upon, or not to approve, the health system of a particular country.

2.3 The Irish Court's application of Article 8 Rights in respect of the right to a home birth

In Ireland, the High Court in the case of *AJA Teehan v The Health Service Executive and The Minister for Health*[12], O'Malley J was asked to consider, *inter alia*, whether the Applicant's Article 8 rights had been violated by the failure of the HSE to consider her application for a home birth on the merits of her particular case rather than apply a "blanket" policy governed by the conditions attached to the Memorandum of Understanding that governs the relationship between the HSE and self-employed community midwives and which state that clinical indemnity is not available to midwives attending at a homebirth if, *inter alia*, the mother has previously had a caesarean section (based on the view that a vaginal birth after caesarean (VBAC) is not safe in a home setting). The Applicant claimed that the HSE had fettered its discretion by adopting such a policy without assessing her individual suitability. She had previously given birth to her first child in hospital by caesarean section and felt that if she were to attend hospital for the second birth she would more likely undergo a repeat section. In the event of being approved for a homebirth, she was fully prepared to transfer to hospital immediately should anything give rise for concern and she was also prepared to relocate to relatives living nearer to the hospital for the purpose of the homebirth.
The Applicant sought the following reliefs,

certiorari of the decision;

- a declaration that the failure to consider her case on its merits amounted to the application of a "blanket" policy and fettered the discretion of the HSE;

- a declaration that the Ministers policy on homebirth services and its implementation by the HSE, precluding services to women who had previously had caesarean sections was unlawful;

- a declaration that the HSE's refusal, along with the threat of criminal sanctions for any medical practitioner who attended such a home birth[13], violated her rights under Article 8 of the European Convention on Human Rights and Fundamental Freedoms, and

- an order of mandamus directing the HSE to consider her request in accordance with law.

The Judge refused the reliefs sought by the Applicant. The grounds for refusal were as follows:[14] *O'Brien v South Western Area Health Board*[15] was an established authority that there was no statutory obligation on the HSE to provide a home birth service. It had an obligation to provide maternity services and had discretion to provide for home births if it considered it appropriate to do so. If it so considered, it was entitled to adopt such policy guidelines as it saw fit provided they were not "wholly unreasonable":

[12] [2013] IEHC 383, unreported, 16th August, 2013
[1313] Section 40 of the Nurses and Midwives Act 2011 is not yet in force
[14] Paragraphs 84 - 92
[15] [IESC] and [2003] 7 ICLMO 34

- the guidelines set out in the MOU were the outcome of careful, prolonged process carried out with the participation of all stakeholders and were based on and justified by statistical evidence;
- in reality the Applicant had sought a direction that the category of women who have had a previous caesarean section should be moved into the lists of factors requiring individual assessment. That involved the Court making a clinical decision, based on an assessment of the risk involved, which the Court was not entitled to make. The categories to be included in the various Tables could not be interfered with in the absence of manifest irrationality;
- each of the Applicant's expert witnesses had conceded that delivery in a hospital setting would be safer for the Applicant than a home delivery although they considered that a home birth would be feasible in her case. Their issue with the HSE was really in their belief that she was entitled, nonetheless, to make the choice;
- on the evidence presented regarding the possibility of uterine rupture, the HSE was entitled, having regard to the potential consequences, to provide maternity services in such a way as to minimise the risk of its occurrence, even though the risk may be small;
- although insurance is not yet compulsory, it is not possible for medical practitioners dealing in the field of childbirth to practice without it. The consequences may be not only immensely tragic in human terms but also extremely expensive in financial terms[16];
- there was no suggestion that the Applicant might waive liability in respect of injury resulting to her from a decision to engage a midwife's services for a home birth. Even if she had made such a waiver, it would probably not bind a child born injured as a result of the negligence of the midwife; and
- as a matter of law, the Applicant was not entitled to compel the HSE to accept or to consider in good faith liability for a risk that it did not believe was justifiable. In that regard, the Judge considered the decision of the European Court of Human Rights in *Ternovszky* and held that it did not assist the Applicant. While she agreed childbirth was part of the protected area of a woman's private life, she stated that the European Court had been careful to acknowledge the disagreements that exist in relation to home births and did not suggest that there was an unqualified right to be provided with a home birth service. In *Ternovszky* the issue had been the lack of clarity as to the legality of providing home birth assistance which had no relationship to the facts of the current case.

[16] Pending the commencement of Section 40 of the 2011 Act it is not unlawful for a registered midwife to attend a woman in childbirth without clinical indemnity insurance.

3. REGULATION OF SELF-EMPLOYED COMMUNITY MIDWIVES

3.1 Regulation of self-employed community midwives: Education and training of midwives

Article 42 of EC Directive 2005/36/EC on the Scope of Midwifery imposes a duty on member states to ensure that midwives are able to gain access and pursue at least the following activities:

i. the provision of sound family planning information and advice;
ii. diagnosis of pregnancies and monitoring normal pregnancies; carrying out the examinations necessary for the monitoring of the development of normal pregnancies;
iii. prescribing or advising on the examinations necessary for the earliest possible diagnosis of pregnancies at risk;
iv. provision of programmes of parenthood preparation and complete preparation of childbirth including advice on hygiene and nutrition;
v. caring for and assisting the mother during labour and monitoring the condition of the foetus in utero by the appropriate clinical and technical means;
vi. conducting spontaneous deliveries including where required episiotomies and in urgent cases breech deliveries;
vii. recognising the warning signs of abnormality in the mother or infant which necessitate referral to a doctor and assisting the latter where appropriate; taking the necessary emergency measures in the doctor's absence, in particular the removal of the placenta, possibly followed by manual examination of the uterus;
viii. examining and caring for the new-born infant; taking all initiative which are necessary in case of need and carrying out where necessary immediate resuscitation;
ix. caring for and monitoring the progress of the mother in the post-natal period and giving all necessary advice to the mother on infant care to enable her to ensure the optimum progress of the new-born infant;
x. carrying out the treatment prescribed by doctors; and
xi. drawing up the necessary written reports.

In relation to training and education of midwives, HSE is mandated by Section 7(4)(b) of the Health Act 2004 to manage and deliver, or arrange to have delivered on its behalf, health and personal social services. In pursuance of this object it is responsible to facilitate the education and training of students training to be registered medical practitioners, nurses and other health professionals and its employees and the employees of service providers. When Section 84 of the Nurses and Midwives Act 2011 is commenced, in addition to having responsibility for the basic education and training of nurses and midwives, the HSE shall also have express statutory responsibilities with respect to specialist nursing and midwifery education.[17] It shall promote the development of such specialist education and training in co-operation with the Nursing and Midwifery Board of Ireland and training bodies approved by the Board, and it shall co-operate with the training bodies in work force planning for the purpose of meeting specialist nursing and midwifery staffing and training needs of the public health service on an ongoing basis.

[17] Section 84(2)(a-c)

Section 85[18] of the 2011 Act deals with the duties of the Nursing and Midwifery Board of Ireland in relation to the education and training of midwives. The provisions deal with the setting and maintaining of standards, the approval (and removal of approval) of programmes of pre first time registration, post-registration leading to registration or annotation and specialist nursing midwifery education and training.

When Part 11 of the 2011 Act is commenced there will be a statutory duty on registered nurses and midwives to maintain their professional competence on an ongoing basis.[19] It is expressly provided that a nurse or midwife shall co-operate with any requirements imposed by the rules.[20] A nurse or midwife may be called upon by the Board to demonstrate to its satisfaction their competence in accordance with a professional competence scheme at any time or pursuant to censure by the Fitness to Practice Committee. If the nurse or midwife fails to demonstrate the required level of competence, the Board may direct that he or she attend a course(s) of further education or training or do anything which, in its opinion, is necessary for him/her to achieve the required standard of competence.[21] A nurse or midwife may be complained by the Board to the Preliminary Proceedings Committee if he or she were to refuse to co-operate with the rules; were to fail to comply with a notice to demonstrate their competence pursuant to a direction of the Fitness to Practice Committee; were to be deemed to impose a serious risk of harm to the public or were to have committed a serious breach of the Board's guidance on ethical standards and behaviour.[22]

Under Part 11 of the 2011 Act, there will also be a duty on employers to facilitate their staff in the maintenance of their professional competence.[23] This may be done by providing learning opportunities for them in the workplace.[24]

The self employed community midwives who wish to contract with the HSE to provide its home birth service do so pursuant to a Memorandum of Understanding that sets out the principles and governance structure which supports the home birth service. (Hereinafter, self-employed community midwives that have entered into a contract for the provision of home birth services are referred to as SECMs).

In Schedule 1 to the Memorandum of Understanding, entitled, "Qualifications, Experience and Continuing Education and Training/Professional Development", there is, *inter alia*, a contractual duty on the SECM to ensure that he/she has completed specified requisite programmes and to supply evidence of such to the HSE upon request. The SECM is required to:

a) undertake maternal and neonatal resuscitation programmes for all registered midwives involved in providing midwifery care to women and their families on a minimum of a two yearly basis (CESDI[25] 2001, Neonatal Resuscitation Programme 2006);

[18] Commenced (Nurses and Midwives Act 2011 (Commencement) (No.2) Order 2012. SI 385 of 2012 (Article 2(1))
[19] Section 87(1)
[20] Section 87(3)
[21] Section 87(2)
[22] Section 88(3) (Maintenance of professional competence is also referred to under the heading of "Negligence"
[23] Section 90(1)
[24] Section 90(2) (Further discussion on the duty of the HSE as regards education and training is referred to under the headings of "Safety, Health and Welfare at Work" and "Negligence"
[25] Confidential Enquiry into Stillbirths and Deaths in Infancy Report

b) attend at emergency drills as required to maintain competence including: antepartum haemorrhage; postpartum haemorrhage; shoulder dystocia; management of cord accidents; breech birth; eclampsia
c) undertake education and training on the cardiotocograph (CTG) interpretation on a regular basis where self employed community midwives use this mode of foetal monitoring (RCOG 2001);
d) moving and handling.[26]

The same contractual duties appear in the Second Schedule to the Agreement entered into between the HSE and the SECMs providing services on its behalf which must be signed annually by the SECM.

3.2 Regulation of self-employed community midwives: Procedure to establish practice

Section 58(1) of the Nurses Act 1985 provides a prohibition on persons attending childbirth unless they come within the specified category of persons which includes midwives. Under Section 2 of the 1985 Act, a midwife is defined as a person whose name is entered in the midwives division of the register maintained by the Board. Section 58(2) makes it an offence for an unregistered midwife to practice midwifery and provides for a fine not exceeding IEP£1,000 on summary conviction.

Section 57 of the Nurses Act 1985 places an obligation on midwives to inform the health board (now HSE) in whose functional area he is or intends to practice of the fact of practising or his intention[27]. Midwifery covers the full scope of ante/birth/postnatal care. There is a mandatory obligation on the HSE to exercise general supervision and control over the midwife in accordance with ministerial regulations.[28]Accordingly, in order to practice as a SECM, he/she must be registered and must have notified the HSE in accordance with the aforementioned statutory provisions.

When Sections 39 to 41 of the 2011 Act are commenced, a midwife will only be able to practice as a midwife or advertise his/her service if he or she is registered on the Register of Midwives[29] unless he/she provides the service in a case of sudden or urgent necessity where neither a registered midwife nor a registered practitioner is immediately available[30]; if the

[26] Note that in Draft 7 of Memorandum of Understanding dated 12/10/2015 the list required programmes has been significantly extended to include children's first training; moving and handling training; hand hygiene training; medication management certificate; breast feeding education; new born bloodspot screening certification; perineal suturing competence; cannulation and venepuncture competence; medical gases certification; familiarisation with guidelines issued by various professional bodies.
[27] Section 57(1)
[28] Section 57(2). To date, no ministerial guidelines have been issued by the Minister for Health. Those SECMs who have contracted with the HSE to provide a home birth service do so under the terms of the Agreement and Memorandum of Understanding which provides that the HSE, in facilitating choice for women in relation to home birth, will endeavour to carry out its responsibilities within defined parameters, including, *inter alia*, the development of appropriate guidance and governance framework (inclusive of clinical governance) for the control and supervision of midwives who are operating as self employed community midwives[28]. However, in the case of other SECMs who are providing a home birth service other than through the HSE, there is not any mechanism or framework currently in place for the HSE to exercise general supervision and control. Given the wording of Section 57 this lack may expose the HSE to liability for negligence in failing to provide a safe system of work (*in fra).*
[29] Section 39
[30] Section 40(2)

practice is only in the course of providing first aid to a person[31] or he/she is a foreign qualified midwife who is in the State for humanitarian purposes for no longer than 30 days and has been issued by the Board with a permit to practice midwifery in accordance with the terms and conditions of that permit. Section 44 makes it a criminal offence to practice as a midwife in any other circumstances.

Currently, there is no legal obligation on self-employed community midwives to have clinical indemnity insurance. However, upon commencement of Section 40 of the 2011 Act there will be a further prohibition on midwives from attending a woman in childbirth, for reward, unless the he/she is a registered midwife and has adequate clinical indemnity insurance in accordance with the rules made by the Board.[32] An exception, pursuant to Section 40(2), will apply to those who provide attention in a case of sudden or urgent necessity where neither a registered midwife [with adequate clinical indemnity cover] nor a registered medical practitioner is available. Criminal sanctions are provided in Section 40(3).

Midwives that contravene Section 40 will be liable on summary conviction (at the lower end of the criminal justice system, administered in the District Court) to a class A fine and/or imprisonment for a term not exceeding six months. Those convicted on indictment for a first offence will be liable to a fine not exceeding €65,000 and/or imprisonment for a term not exceeding five years, and on subsequent conviction to a fine not exceeding €160,000 and/or a term of imprisonment not exceeding ten years or both.

In addition to the risk of criminal sanction, the Act makes clear in Section 45 that where professional services are rendered by a nurse or midwife that was unregistered at the time of the provision of the service he/she will not be able to charge a fee for the service, unless the service was provided in the circumstances set out in Section 41 (see above: first aid or foreign qualified here for less than 30 days on humanitarian grounds and issued with a permit by the Board).

Currently, self-employed community midwives may acquire clinical indemnity insurance either privately or vicariously through the HSE from the Clinical Indemnity Scheme of the State Claims Agency on strict conditions that the care and treatment provided by him or her to the mother and baby is within the time frame of the signed Agreement between the HSE and the SECM (from first consultation regarding a homebirth until 14 days after the birth of the baby) and that the care and the treatment provided is consistent with the pathway of care prescribed in the Agreement and Memorandum of Understanding[33]. Accordingly, in order to enforce the contractual right to clinical indemnity cover, the SECM must adhere to the terms of the Agreement.

3.3 Regulation of self-employed community midwives: The governing body

All nurses and midwives are governed by the Nursing and Midwifery Board of Ireland. This is a statutory body regulated by legislation contained in the Nurses Act 1985 and the Nurses and Midwives Act 2011[34]. The 2011 Act has yet to be commenced in full.

[31] Section 41(1)
[32] Pursuant to Section 13 of the Act
[33] HSE, 1st March 2014.
[34] Section 4(1) repeals parts of the 1985 Act. The SI effecting Section 4(1) has repealed Part II (An Bord Altranais), Part III (Registration), Part IV (Education and Training), Section 48 (arrangement with persons to assist the Board), Sections 50 – 56 inclusive (Report by the Board; General Advisory Functions of the Board;

The object of the Board is to protect the public in its dealing with nurses and midwives and to protect the integrity of the practice of nursing and midwifery through the promotion of high standards of professional education, training and practice and professional conduct among nurses and midwives.[35]

The 2011 Act introduces an open and accountable governance framework for nurses and midwives, which aims to protect the public. The Act provides for the registration, regulation and control of nurses and midwives; it aims to enhance the high standards of professional education, training and competence, to investigate complaints against nurses and midwives and to increase the public accountability of the Board. The Act introduces a Preliminary Proceedings Committee which investigates complaints. The Act introduces new grounds of complaint. The Act dissolves the National Council for the Professional Development of Nursing and Midwifery.

Part 6 of the 2011 Act pertains to the Registration and Practice

Section 42 is an enabling provision whereby the Minister may, following or acting upon consultation with the Board, make regulations to designate titles which may be used by registered nurses and midwives or by designated classes of nurses or midwives.
Of relevance to midwives and accordingly to SECM's, Section 43 states that a designated title may only be used if permitted by the regulations made under Section 42.
The Act, in Section 44, imposes criminal sanctions for persons who use a designated title without being entitled to do so. However, Section 44 has not yet been commenced.
Sections 39, 40, 41, 44 and 45 which refer to circumstances in which a midwife may practice have been referred to above.

Sections 46 to 54 inclusive relate to registers; registration in general; applications to have registration removed; conditions attached to registration; refusal of registration and the appeal to Court against the Board's decision; the correction of registers, and the publication of registers. In so far as these sections pertain to SECMs:

- Section 48 provides that a nurse or midwife may make an application to the Board, accompanied by the appropriate fee or fees, to be registered in one or more divisions of the register of nurses and midwives. If the Board is satisfied that the applicant meets the relevant criteria, he/she will be registered in one or both of the divisions.
- Section 46(6)(b) requires that a person whose name has entered the register make a declaration that he/she has met the requirements, as prescribed by the Board in the immediately preceding period.
- Section 51(1) places an onus on the nurse or midwife making an application for registration to declare in the application whether he/she has any relevant medical disability that may impair his or her ability to practice. The term, "relevant medical disability" is defined in Section 2(1) of the Act as meaning,

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Functions in relation to European Directives; Assignment of Board to Additional Functions); References to An Bord Altranais; Regulations and Regulations Regarding Adaptations) and the Second Schedule of the Nurses Act 1985. Therefore, those sections pertaining to Part V (Fitness to Practice), Part VI – Section 49 (Improper use of title by Nurse/Midwife), Section 57 (Notice to be given to health board by midwife); Section 58 (Prohibition on Attending Childbirth) and Section 59 (Prosecution of Offences) remain in force.

[35] Section 8

"a physical or mental disability of the nurse or midwife (including addiction to alcohol or drugs) which may impair his or her ability to practice nursing or midwifery or a particular aspect thereof"

- If the Board were to deem it to be in the interest of public safety, it may then impose relevant conditions to the registration, which, if agreed by the applicant, would then enable registration. Pursuant to Section 46(8) details of the relevant conditions will be detailed on the Register.

- Sections 51(4) to 51(7) provides for the situation where a relevant medical disability arises after registration. An onus is placed on the nurse/midwife to inform the Board within 30 days after the disability becomes a relevant disability within the meaning of the Act or, in cases where that is not practical due to the nature of the disability, to notify the Board as soon as practical in the circumstances. The same mechanisms are applied by the Board as described above. Pursuant to Section 51(7), if the person refuses in writing to agree to the attachment of the proposed conditions, or does not respond within 30 days after receiving the decision from the Board, the Board is obliged to make a complaint under Section 55(1)(d) (see below).

- Section 52 sets out the right of the Board to refuse registration or restoration to the register, etc, and the right of appeal of the applicant to the Court against the Board's decision.
- Section 53 deals with the correction of registers by the Board.

Part 7: Complaints to Preliminary Proceedings Committee Concerning Registered Nurses and Midwives

Pursuant to Section 9(2)(i) the Board may establish committees to inquire into complaints. Two committees, namely the Preliminary Proceedings Committee (hereinafter referred to as the PPC) and the Fitness to Practice Committee (hereinafter referred to as the FPC), have been established.

Part 7 of the Act has been commenced save for Section 55(b) which is one of the nine grounds of complaint to the PPC relating to poor professional performance which has not yet been commenced in so far as it relates to the Board's referral of the complaint to a professional competence scheme. It should be noted that the term "poor professional performance" is defined in Section 2(1) as meaning,

"failure by a nurse or midwife to meet the standards of competence (whether in knowledge or skill or the application of knowledge or skill or both) that can reasonably be expected of a registered nurse or registered midwife, as the case may be, carrying out similar work".

Of relevance to the SECM, Section 55(1) sets out nine grounds upon which a person and the Board may make a complaint to the PPC. These are:

i. professional misconduct;
ii. poor professional performance (not yet commenced)
iii. non-compliance with a code of professional conduct;
iv. a relevant medical disability;
v. a failure to comply with a relevant condition;

vi. a failure to comply with an undertaking or to take any action specified in a consent given in response to a request under Section 65(1);
vii. a contravention of a provision of this Act (including a provision of any regulations or rules made under this Act);
viii. an irregularity in relation to the custody, prescription or supply of a controlled drug under the Misuse of Drugs Acts 1977 and 1984 or another drug that is likely to be abused, or
ix. a conviction in the State for an offence triable on indictment or a conviction outside the State for an offence consisting of acts or omissions, that, if done or made in the State, would constitute an offence triable on indictment. (Where a complaint is made under this ground, the PPC is obliged to refer to refer the complaint to the Board, pursuant to Section 55(5) and, in accordance with Section 55(6) if the Board is of the opinion that the nature of the offence or the circumstances in which it was committed renders the person permanently unfit to practice and that it is in the public interest that the Board take immediate action, the Board can decide to cancel registration pursuant to Section 69(1). In other cases, the Board must refer the complaint back to the PPC).

Section 55(2) goes on to state that the complaint may be made on the grounds of professional misconduct or poor professional performance notwithstanding that the matter to which the complaint relates occurred outside of the State.

Sections 56 and 57 deal with the practice and procedures of the PPC. Section 56(9) places a mandatory obligation on the nurse/midwife to comply with any notice under Section 56(8) requiring him/her to supply to the PPC within the time specified such information relating to the complaint as is specified in the notice.

Section 58 enables the Board to apply *ex parte* (without prior notice to the other side) to the High Court for an order suspending the registration of the registered nurse/midwife, whether or not he/she is the subject of a complaint, if the Board considers that the suspension is necessary to protect the public until steps or further steps are taken under this Part, and, if applicable, by the Fitness to Practice Committee (FPC).

Section 59 directs the PCC to inform the Board if it considers that no further action is required or that the complaint should be referred to another body or authority or to a professional competence scheme, or that it is of such a nature that it may be resolved by mediation or other informal means.

Section 60 refers to resolution of complaints by mediation or other informal means and Section 61 pertains to referral of complaints to the Fitness to Practice Committee.

Part 8: Complaints referred to the Fitness to Practice Committee (FPC)
This Part of the Act deals with the practice, procedure and exercise of powers by the FPC. Under Section 65(1) a nurse or midwife may consent to censure or remedial action imposed by the FPC and may be requested to do one or more of the following:

(a) Undertake not to repeat the conduct which is the subject of the complaint;
(b) Demonstrate his/her relevant competencies to the satisfaction of the Board (not commenced);
(c) Take such steps as may be specified by the Board, which may include taking a course of education or training or gaining clinical practice experience for the express purpose

of updating his or her skills and knowledge;
(d) Consent to undergo medical treatment;
(e) Consent to being censured by the Board.

Section 65(2) states that where the nurse or midwife gives and undertaking or his/her consent to the requests of the FPC, pursuant to Section 65, the inquiry into the complaint shall be considered to be completed. Under Section 65(3), if the nurse or midwife refuses to provide such an undertaking or consent, the FPC may proceed as if such a request had not been made. The FPC must report to the Board. Section 66 covers situations where the complaint is withdrawn after the FPC has commenced its inquiry. The Committee may either, with the agreement of the Board, decide that no further action should be taken or proceed as if the complaint had not been withdrawn. In all other cases, pursuant to Section 67, the FPC must submit a report to the Board in accordance with the specifications set out in sub-section 2. Section 68 contains the steps that must be taken by the Board on receipt of the report of the FPC. The Board may in cases where the person has given an undertaking or consented to a request made by the FPC pursuant to Section 65 (see above), impose the measures that must be taken pursuant to Section 69(2) (see below), or in any other case, if the FPC has found that the allegation has not been proved, dismiss the complaint (Section 68(b)(i), or if the FPC has found that the allegation is proved, the Board must decide on the appropriate measure pursuant to Section 69.

Part 9: Measures taken with regard to Registered Nurses and Registered Midwives following Reports of the Fitness to Practice Committee (FPC)

The measures that may be imposed by the Board are contained in Section 69(1)(a)-(g) and the Court may impose one or more of the measures:

(a) an advice or admonishment, or a censure, in writing;
(b) a censure in writing and a fine not exceeding €2,000;
(c) the attachment of conditions to the nurse's or midwife's registration, including restrictions on the practice of nursing or midwifery that may be engaged in by the nurse or midwife;
(d) the transfer of the nurse's or the midwife's registration to another division;
(e) the suspension of the nurse's or midwife's registration for a specified period;
(f) the cancellation of the nurse's or midwife's registration from the register of nurses and midwives or a division of that register;
(g) a prohibition from applying for a specified period for the restoration of the nurse's or midwife's registration in the register of nurses and midwives or a division.

Pursuant to Section 69(3), where the person has been convicted on indictment of an offence and the Board has resolved that the person is permanently unfit to practice, it may cancel that person's registration without first received a report of the FPC.

In situations where the measure(s) imposed are contained in (b)–(g) above, the sanction does not take effect unless confirmed by the High Court. The nurse or midwife has a right to appeal to the High Court against the Court's decision (Section 73).

Section 77 states that a nurse or midwife may also be removed from the register for failing to pay an appropriate fee notwithstanding that he/she was issued with a reminder sent to him/her at their registered address. The Board must wait at least 28 days after the sending of the said reminder before removing their name from the register. Section 78 provides that where within six months of the date on which the fee became due the nurse/midwife applies for

registration to be restored and pays the appropriate fee, the CEO of the Board shall restore his/her name to the register.

Section 79 provides for the restoration of registration which has been cancelled by the Board once the circumstances prescribed in Section 79(2) have been met. Rules setting out the criteria to be considered by the Board when deciding on the restoration of registration of a nurse or midwife were brought in by statutory instrument in 2014[36]. Section 79(3) enables the Board to attach conditions to the restored registration. Pursuant to Section 80, the Board is enabled to remove the conditions in the circumstances set out in Section 80(1)(a)-(d). Under Section 79 and Section 80 respectively, the Board may also refuse an application for restoration to the register or the removal of conditions attached to registration. Under Section 81, the nurse/midwife may appeal to the High Court any decision of the Board pursuant to Sections 79 and 80.

Section 82 places an obligation on the Board to inform the Minister, the HSE, the nurse/midwife's employer (where that employer is not the HSE) of the cancellation; restoration; removal; suspension of a nurse/midwife's registration; and of the termination of the suspension period; the transfer of that person's name to another division of the register; the attachment of conditions to registration; the removal of conditions; the prohibition from applying for a specified period for restoration of registration; the censuring and/or fining of a nurse/midwife. The Board is also obliged to inform the relevant bodies in other jurisdictions where it believes the nurse/midwife may be registered.

Part 10: Education and Training (referred to above) deals with the duties of the HSE in relation to education and training (including specialist training) of nurses and midwives (Section 84, which has not commenced) and also deals with the duties of the Board in relation to education and training of midwives (Section 85, which has been commenced)

Part 11: Maintenance of Professional Competence (not commenced)
Referred to above.

The Code of Professional Conduct and Ethics and the Practice Standards for Midwives, issued by the Board, are relevant to the governance of the SECM. In addition to breaches leading to disciplinary hearings, the contents of these documents may also be used in negligence actions as a benchmark against which to measure the standard of care exercised by the SECM.

3.4 The legal relationship between the HSE, the SECM and the woman

Pursuant to the Health Act 1970[37], the State must provide maternity services free of charge to women. The State has discretion as to how it fulfils its function in this regard and the provision of a home birth service is entirely at its discretion. Currently, the home birth service is provided by the HSE through self-employed community midwives (SECM) who contract with the HSE for the provision of home birth services

[36] Nursing and Midwifery Board of Ireland Rules Specifying Criteria To Be Considered for Applications for Restoration to the Register, made pursuant to Section 79(2)(d)
[37] Section 62, as amended

The governance arrangements to provide the home birth service through SECMs is set out in the Memorandum of Understanding (MoU) and the Agreement, prepared by the HSE[38], and entered into by the HSE and the SECM.

The MoU sets out the principles and governance arrangements; it contains details of the clinical governance structure, the qualifications, experience and continuing education and training/professional development requirements of the SECM and clarifies the clinical circumstances regarding a woman's eligibility for home birth and the indications requiring intrapartum and postpartum transfer.

The Agreement provides a contractual framework within which the HSE and the SECM meet the service needs of the woman and baby in line with the governance structure including HSE policy, standards and criteria in relation to best clinical practice. The Agreement also sets out the SECM's remuneration details.

The Agreement defines the respective roles of the HSE and the SECM. The role of the HSE includes the development of appropriate guidance and a governance framework (inclusive of clinical governance) for the control and supervision of midwives who are operating as self employed community midwives; the development of guidelines and information packs to assist women making an informed choice regarding a home birth; the provision of birth packs and information to women; the development of quality assurance and clinical audit and the extension of the clinical indemnity scheme to the SECMs.

The role of the SECM is set out as:

> *"every self employed community midwife, in providing a home birth service to expectant women, will carry out his/her responsibilities under the home birth service agreement with due care and skill to the highest professional standards and within the following parameters:"*

These parameters include provision to the HSE of evidence of current registration with the Irish Nursing and Midwifery Board of Ireland; a statement confirming that they comply with the current Code of Conduct and Scope of Practice produced by the Board; provision of evidence confirming that they satisfy the minimum qualification, training and continuous training education required by the HSE; their agreement to comply with the requirements of the HSE as regards the care pathway from the initial assessment of the woman's eligibility to indications for intrapartum and postpartum care, which are set out in detail in Schedule 3; that they have notified the Designated Midwifery Officer in whose functional area he/she intends to practice[39] and that they have entered into a contract with the HSE in respect of the provision of a home birth service.

In effect, by signing the Agreement, the SECM accepts that he/she will form part of an organisation that provides the home birth service. This involves the acceptance of general supervision and control by the HSE. In defining the management of the service, the Agreement provides that the HSE's Designated Midwifery Officer, by means of the individual birth contract, be responsible for the general supervision and control of the SECM; will link with the expectant woman as required and will provide reports to the HSE's Clinical Governance Group. The Agreement provides for biannual meetings between the SECM and

[38] Effective since 1st March, 2014 (currently under revision)
[39] As per the requirement of section 57 Nurses Act 1985

the HSE's managers of the service (the "management group"). The management group is tasked with monitoring the provision of the agreed work programme and the implementation of the Agreement. The SECM is required to work within the risk management/incident reporting structures, set out in Schedule 6 of the Agreement. Schedule 6 sets out the requirements of the HSE, the Clinical Indemnity Scheme and the HSE's insurers in relation to risk management, adverse incident reporting etc. This provides that the SECM shall, *inter alia*, co-operate with the HSE Risk Management Process and provide such information as is requested for the HSE Risk Management Register and where appropriate provide timely reports to the Clinical Indemnifiers STARSWEB system and that the SECM will address clinical risk issues identified, in accordance with the HSE Risk Management Policy (such policies to be brought to the attention of the SECM by the HSE). The Schedule also provides that the HSE and the SECM will work together in enhancing the safety of the service. There is an individual responsibility on the SECM to identify areas of concern, or serious untoward incidents arising in connection with the service or any related matter, to the Designated Midwifery Officer, and to provide details of the issue and setting out the steps that he/she will take in eliminating the risks identified. The SECM also agrees to participate in peer review and clinical audit, as outlined in Schedule 10.

The HSE, provides the SECM with documentation and information in its possession as may be reasonably required to enable the SECM to fulfil his/her obligations pursuant to the Agreement, and it provides a home birth pack in respect of each home birth. The HSE also provides clinical indemnity cover through the Clinical Indemnity Scheme, subject to conditions that the SECM must work within the pathways of care in the MoU and Agreement. The Agreement requires the SECM to indemnify the HSE from and against all proceedings, actions, costs (including legal costs), charges, claims, expenses, damages, liabilities, losses and demands ("liabilities") and to maintain in favour of the HSE policies of professional liability and employer liability.

The woman wishing to avail of the home birth service provided by the SECM is required to complete the form in Schedule 1, "Application/Consent for Home Birth". In the Application form, the woman acknowledges that the service provided by the SECM is pursuant to the terms of the HSE's Home Birth Service. It is the responsibility of the SECM to ensure that the woman's consent is informed and Schedule 8, "Consent", provides that:

> *"consent should not be given by the expectant woman or accepted by the self employed community midwife unless the expectant woman has received, read and understands the contents of the following HSE documents"*.

The Schedule lists five documents, including the Application/Consent Forms. The consent form contains a term whereby the woman agrees to have the management of her care transferred to hospital if a complication were to arise during the pregnancy/labour or postnatal period and furthermore agrees to such transfer by ambulance if deemed necessary by the midwife. Once the application and consent forms have been completed, it is the responsibility of the Designated Midwifery Officer to approve her for the home birth service. The overall legal relationship between the HSE, the SECM and the woman is unusual. *Prima facie*, the HSE is providing a service, pursuant to statute, to a woman, via a person described as an independent contractor. In those circumstances, the relationship, not being one of employer and employee between the State and the SECM, would be classed *sui generis* (of its own type). However, there are strong indicia of the relationship between the HSE and the SECM being one of employer and employee.

3.5 The employment relationship

Despite the nomenclature, "self-employed", the legal relationship between the SECM and the HSE, encompasses elements of both "contracts for" and "contracts of service" (the former relating to self-employment and the latter to an employer-employee relationship).
The law applies a "substance over form" approach in determining the true nature of an employment relationship. The following factors are heavily indicative of a contract of service relationship between the HSE and the community midwives who contract with it.

i. The Revenue has declared that for the purpose of tax, USC and PRSI, community midwives who are contracted to the HSE are to be treated as employees.[40] It is usually the case that a decision by one department or agency of State will be accepted by other departments, once it is established that the correct legal principles have been applied to the facts of the case.

ii. The degree of control and day to day involvement by the HSE in the SECM's practice effectively makes the SECM part of an organisation that delivers the service (as outlined above).

iii. The ability of the SECM to exercise independent judgement in terms of the pathway of care is compromised by his/her agreement to comply with the conditions set out by the HSE in the third schedule of the Agreement that specify conditions and circumstances pertaining to the initial assessment of the woman's availability and intrapartum and postpartum care.

iv. The SECM works subject to the governance arrangements imposed by the HSE.

v. The remuneration of the SECM is entirely determined by the HSE. There is no scope for the SECM to charge additional fees to the woman. This is provided in Schedule 1 (Application/Consent Form).

vi. It is immaterial that a new contract appears to be entered into in respect of the provision of each home-birth service.[41]

vii. The State Claims Agency, through the HSE, provides clinical indemnity cover to the SECM. The provision of clinical indemnity insurance to the SECM is conditional upon the SECM working within the parameters of the HSE's Pathway of Care and the Memorandum of Understanding (MoU) which sets out, *inter alia,* criteria as to the assessment of eligibility and risk management of the pregnancy. If the SECM were to act outside of those parameters the cover could be refused.

viii. The HSE is vicariously liable for the activities/omissions of the SECM (see paragraph 3.6 below).

[40] [05.01.23] Taxation of Community Midwives employed by the Health Service Executive, TaxFind database. Caveat - It is understood that the decision may be subject to further challenge
[41] *Minister for Agriculture and Food v Barry [2009] 1 IR 215.*

It is, however, possible, but in the opinion of the writer unlikely, that a court or tribunal may hold that an individual is engaged under neither a contract for or a contract of services but instead under a contract *sui generis*.[42]

3.6 Vicarious liability

Under the doctrine of vicarious liability, an employer is liable for the acts of its employee if the act has been done in the scope of his/her employment provided that the acts are somehow connected with the acts authorised by the employer. Furthermore, the doctrine of vicarious liability extends outside the relationship of employer and employee once it is established, on a balance of probabilities, that the employer's right of control over the person's work would have been the same irrespective of the nature of the contract of employment and the employer may be found vicariously liable to an injured third party arising out of that person's negligence.[43] With reference to the foregoing discussion, it is likely the case that the HSE would be vicariously liable for the actions of the SECM. It is not a defence for the employer to claim that due to the nature of the work, the degree of skill and exercise of autonomy of the employee, the employer does not exercise control over the employee's activities.

In *Byrne v Ryan*[44] Kelly J found a hospital was vicariously liable for the actions of a consultant surgeon, despite the lack of control which it had over the delivery of his clinical practice. In that case, the Plaintiff argued that the Coombe was vicariously liable for the actions of a surgeon who had been negligent in performing sterilisation surgery. The Coombe denied responsibility arguing that the surgeon was not an employee and that they had no control over his actions. Kelly J cited with approval Denning J in *Cassidy v Ministry for Health*:[45]

> *"who employs the doctor or surgeon – is it the hospital authority? If the patient himself selects and employs a doctor or surgeon … the hospital authorities are of course not liable for his negligence because he is not employed by them but where the doctor or surgeon … is paid, not by the patient but by the hospital authorities, I am of the opinion that the hospital authorities are liable for his negligence in treating the patient ….. the hospital authority accepted the patient for treatment and it was their duty to treat him with reasonable care….. He had no say in their selection at all. If those surgeons and nurses did not treat him with proper care and skill then the hospital authorities must answer for it"*

Kelly J, in finding that the Coombe Hospital was vicariously liable for the surgeon's negligence had regard to the fact that the Plaintiff had not had any say in who would carry out her surgery; she had been referred to the Hospital rather than to a particular surgeon. The surgeon, despite being under a contract for service, was part of an organisation or permanent staff. The performance of the surgery was part of the service provided by the Hospital and the surgeon in question was the person in the hospital's organisation through whom the service had been provided.

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[42] *In the matter of the Social Welfare (Consolidation) Act 2005; Brightwater Selection (Ireland) Ltd v Minister for Social and Family Affairs* [2011] , unreported, High Court, Gilligan J, 27th December, 2011.
[43] *Phelan v Coillte [1999] 2 IR 18; ELR 56*
[44] [2007] IEHC 207; 4 IR 542. Kelly J in determining the issue of vicarious liability noted that the hospital had accepted the Plaintiff as a patient and it was then under a duty to treat the Plaintiff with reasonable care.
[45] (1951) 2 KB 343 Court of Appeal

It is not a defence for the employer to prove that while the impugned activity or failure may have occurred during the course of the employee's duty, the impugned activity or failure was prohibited by the employer.[46] This has implications in situations where liability has arisen from circumstances where the conduct of the SECM is in breach of the terms of his/her agreement with the HSE and the terms of the MoU. The SECM has a duty of care to the HSE, as his/her employer, and also a contractual obligation in respect of the provision of clinical indemnity insurance. The HSE cannot escape its vicarious liability to a third party if injured by the SECM acting in the course of his/her duty. However, it would be open to the HSE to exercise its contractual right of indemnity against the SECM.[47]

Since the European Court of Human Rights judgement in *O'Keeffe v Ireland*[48] it is possible to argue that in certain circumstances the State would be liable for the actions of independent third parties even where the State is remote from the day to day control of the third party. The Supreme Court in *Louise O'Keeffe v Leo Hickey, The Minister for Education and Science, Ireland and the Attorney General*[49] applied the "control test" in in relation to the relationship between the State, the manager and principal of Dunderrow National School. The Plaintiff had been sexually abused by Leo Hickey in the early 1970s. In the High Court she sued the State directly for its negligence in failing to put in place the appropriate measures and procedures to protect and cease the systematic abuse, and in vicarious liability in relation to Leo Hickey and the Manager who had not taken any action following the report of an earlier incident. Prior to that, at least one other complaint against Leo Hickey had been made to the manager.

Only the issue of vicarious liability had been appealed to the Supreme Court. Hardiman J described the relationship of Leo Hickey (a lay teacher at the school), the Church and the State as a triangular one which was "*entirely sui generis".* The manager was the person charged with the governance of the school and the appointment of its teachers including Leo Hickey; the manager was not an agent of the Minister but of the Catholic Church. The manager was responsible for the day to day running of the school. Leo Hickey was not employed by the State but by the manager. While Leo Hickey had to have the requisite qualifications laid down by the Minister and adhere to the 1965 Rules and while the State discharged its role in that respect, he was not engaged by the State and the State could not dismiss him. The Minister laid down the academic syllabus and funded the school in accordance with its Article 42.2 obligation and accordingly paid Leo Hickey's salary. The Minister also had a role in oversight of the system but only from the point of view of appointing inspectors to assess the quality of schools' performances; crucially, the inspectors could not direct teachers in carrying out their day to day functions. The Court dismissed the appeal and held that the State was not vicariously liable in respect of the torts committed by Leo Hickey and the Manager as, on application of the control test, the Minister was removed from the day to day running of the school and furthermore had not been informed by the manager of the incidents of reported abuse.

Ms. O'Keeffe bought a case to the European Court of Human Rights on the basis that there had been a breach of several Convention rights, including Article 3 which provides that no

[46] *Century Insurance Company Ltd v NI Road Transport* [1942] AC 507

[47] A term of the Agreement between the HSE and the SECM provides that the SECM indemnify the HSE for loss sustained as a result of the SECM's actions/failure to act.

[48] 2014 EHRR 15

one shall be subject to torture or to inhuman or degrading treatment or punishment[50]. In a majority judgement, the EHCR acknowledged the *sui generis* nature of the relationship and found that parallel to that the State was aware of the level of sexual abuse against minors through the enforcement of criminal law on the subject. It held that when the State relinquished control at the start of the nineteenth century of education of a vast majority of children to non state actors, the State should have been aware, given its inherent obligation to protect children in this context, of the potential risk to their safety if no appropriate framework of protection were put in place. The risk should have been assessed through the adoption of commensurate measures and safeguards. In the 1970's there was an inherent positive obligation on the government to protect children from ill treatment. That obligation had not been fulfilled when the State, which must be considered to have known of the abuse, nevertheless continued to entrust the management of the primary education of children to non State actors without putting in place any mechanism of effective State control against the risks of such abuse occurring.

Given the somewhat *sui generis* nature of the relationship between the HSE and the SECM and given that the positive obligation[51] of the HSE to provide a maternity service to women is founded in statute, namely the Health Act 1970, and given that the risks inherent in child birth are well documented, it is possible – on application of the ECHR's judgement in O'Keeffe - that even without having to prove the control test the State could be held vicariously liable for the actions of the SECM.

Section 57(1) of the Nurses Act 1985 potentially exposes the HSE to liability under the doctrine of vicarious liability for the actions of independent midwives who are not contracted to it. The section places an obligation on midwives to inform the health board (now HSE) in whose functional area he is or intends to practice of the fact of practising or his intention to practice. Section 57(2) places an obligation on the HSE to exercise general supervision and control over the midwife in accordance with ministerial regulations. These ministerial regulations have not been brought into force.[52] The specific reference to "general control" as opposed to "control" simpliciter, when taken into account with other factors such as the direct private contractual relationship between woman and the midwife, would be a persuasive argument against the imposition of vicarious liability in those circumstances.

3.7 Safety, health and welfare at work

Civil Liability

At common law, there is a duty on employers, employees and the self-employed to take reasonable care not to cause personal injury to another. Civil actions arise in the tort of negligence. In certain cases, actions may arise in civil cases for breach of statutory duty and may also arise pursuant to breach of the contract of employment. Under the contract of employment, the employee must obey the reasonable instructions of the employer; must act with all reasonable care and skill in the performance of his/her duties and must respect

[50] O'Keeffe v Ireland [2014] EHRR 15. Ireland challenged the jurisdiction of the ECHR on the basis that Ms O'Keeffe had not exhausted her domestic remedies as she had not appealed to the Supreme Court the issue of the State's direct liability in negligence. However, the ECHR accepted jurisdiction as it deemed the core grievance of neglect by the State was the same in direct and vicarious liability. This was criticised by Charleton J in his dissenting judgement.

[51] Health Act 1970

[52] For the most part, the Nurses Act 1985 has been repealed and it is possible that upon further commencement of the Nurses and Midwives Act 2011, section 57 may also be repealed.

confidential information obtained during the course of his/her employment. The employer must take all reasonable care for the employee's safety and, in that regard, must employ competent staff; ensure a safe system of work and provide safe plant and equipment.

Criminal Liability

Criminal liability may also arise in the area of safety, health and welfare. In the event of a death that has resulted from unnatural causes, the jurisdiction of the Coroner is invoked.[53] The Coroner has responsibility for deciding whether there should be a post-mortem and/or an inquest and whether such inquest should be before a jury. Under the Coroner's Rules of Practice, certain still births must be reported to the Coroner's office as must deaths which are directly or indirectly attributable to a medical treatment or procedures and where there are allegations against a medical practitioner of negligence or misconduct. Maternal deaths and sudden infant deaths must also be reported. The Coroner may look into the circumstances surrounding the death. Inquests may be adjourned to enable the Director of Public Prosecutions (the DPP) to take criminal proceedings. The Coroner's jurisdiction is limited to making findings of fact. The Coroner may make recommendations for safer work practices or systems of work and has done so in respect of home births. These recommendations have included that midwives are given assistance at home births by at least one other person, that the ambulance service be notified of all planned home births and that the distance from the hospital shall also be considered as a factor in deciding who is approved for a home birth.[54]

There is no crime of corporate manslaughter in this jurisdiction. However, at common law, the crime of gross negligence manslaughter arises where death occurs from a negligent act or omission by the accused in circumstances where there is a very strong risk of death or personal injury to another[55]. The degree of negligence has to be very high. A prosecution could be brought against an SECM or another individual involved in the deceased's care if he/she were accused of being culpable of gross negligence leading to death.

Statutory liability in the area of safety, health and welfare at work is mainly found in:

- The Safety, Health and Welfare at Work Acts 2005 - 2010 (hereinafter referred to as the "2005 Act");
- Regulations made thereunder as well as the related Codes of Practice of the Health and Safety Authority (hereinafter referred to as the "HSA); and
- EU regulations and directives.

The 2005 Act and the Regulations made under it impose duties on employers, employees and the self-employed.[56] The Act places the same obligations in respect of compliance with its provisions and those of the Regulations made thereunder upon self-employed persons, as if they were employers. The Act is penal in nature and, therefore, has to be interpreted strictly. Failure to comply with the provisions of the Act or the Regulations made thereunder may

[53] Coroners Acts 1962 and

[54] Coroner, John O'Dwyer, at the inquest into the death of baby Kai whose mother had elected for a home birth, "Let him go, take me with him", Mayo News, 10th September 2013.

[55] *People (AG) v Dunleavy [1948] IR 95,* Court of Criminal Appeal. In *Joel v DPP and others [2012] IEHC,* Charlton J rejected the claim that gross negligence manslaughter is an unconstitutionally vague offence.

[56] The provisions of the Act and any Regulations made under it apply equally, where appropriate, to self-employed persons, including sole traders, as they do to employers. A self-employed person is defined in section 2(1) as, *"a person who works for profit or gain otherwise than under a contract of employment, whether or not the person employs other persons"*

result in criminal prosecution carrying fines and potential imprisonment on conviction.[57] The provisions may also be relied upon in civil proceedings.

Relevance of the Employment Relationship between the HSE and SECM's to the Act and Regulations

The status of the employment relationship between the HSE and the SECMs is relevant in determining where certain responsibilities lie under the Act and the Regulations. As the Act adopts a "substance over form" approach in defining an employee, it is likely that for the purpose of this legislation, the SECM would be classed as an employee. Relevant to this is the fact that it is the HSE that governs the service and plans and organises the system of work. Under section 8(2)(e), it is the employer's duty to provide a safe system of work. This is an overarching duty that applies from the advance planning of every aspect of the service from contracting the SECM, through to the end of the provision of the homebirth service.

While the Act defines an "employee" as a person acting under a contract of service, the Act makes use of the control test and states that an employer, in relation to an employee, includes a person (other than an employee of that person) under whose control and direction the employee works[58].

Section 2(3)(b) of the Act also extends the definition of employee, for the purposes of the Act to:

> *"an officer or servant of the Harbour Authority, the Health Service Executive or a vocational educational committee is deemed to be an employee employed by the Harbour Authority, the Health Service Executive or vocational education committee, as the case may be".*[59]

This provision is intended to apply to board members and civil servants.[60] Section 84(1) provides that a person is deemed to be an employee until the contrary is shown where that person is found at a place of work where work is going on. In the text that follows, the employment relationship, for the purpose of the Act, is taken to be one of employer and employee. However, as stated above, the duties of an employer apply equally to the self-employed.

Place of Work

The provisions of the Act apply at a person's place of work. "Place of work" is defined to include, *"any place ……. at, in, upon or near which work is carried on …"*[61] and, therefore, includes any place where the SECM provides his/her service, including premises used for antenatal classes, whether that be the SECM's own property or a public place, and the expectant mother's home. Place of work may also include the SECM's car if it is being used in emergency situations to convey an expectant mother to hospital.

At Work

[57] SS 77- 78
[58] Section 2(1)

[60] Annotated statute contained in Irish Current Law 2005, Roundhall
[61] Section 2(1)

"At work" is not defined in the Act. However, in the British Health and Safety at Work Act 1974, the definition is taken to be the time when an employee is "*in the course of his employment".*

Mutual Duty of Employer and Employee towards each other and towards other persons present at the place of work

Employers have a statutory duty not only to their employees but also to any other person present at "a place of work", so defined by the Act, to manage and conduct its undertaking in such a way as to ensure, so far as is reasonably practicable, that in the course of the work being carried on, that neither are exposed to risks to their safety, health and welfare.[62] There is a corresponding duty on employees to take reasonable care to protect their own safety, health and welfare and that of any other person who may be affected by their actions or omissions while at work.[63] Therefore, the HSE and SECM not only have duties towards each other, pursuant to the Act and Regulations, but also toward other persons located on the SECM's place of work, including the expectant mother, birth partner(s) and other persons present.

The Statutory Standard: "reasonably practicable"

In order to comply with its duties under the 2005 Act, the HSE, as an employer, must do what is "reasonably practicable"[64] in exercising all due care; in identifying the hazards and assessing the risks to safety and health likely to result in accidents or injury at the place of work concerned and to take appropriate preventive measures. In this regard, the standard is not an absolute one and does not impose the taking of further preventive measures where these would be grossly disproportionate having regard to the unusual, unforeseeable and exceptional circumstances.[65]

The general duties of both the employer and employee are set out in the Act in sections 8 to 13. More specific and detailed duties are set out in various regulations made under the Act, in EU directives and in Codes of Practice issued by the Health and Safety Authority. The standard of care varies from what is reasonably practicable to an absolute standard in respect of safety.

The General Duties of the Employer (HSE) towards Employees (SECMs) and Other Persons Present at the Place of Work

These general duties of the employer are contained in section 8. Section 8(2)(a) imposes an obligation on an employer to manage and conduct its work activities in such a way as to ensure, so far as is reasonably practicable, their safety, health and welfare.[66] A safety statement[67] must be compiled based on the identification of hazards and a risk assessment.[68] This should specify, *inter alia*, the protective and preventive measures taken and the resources provided for protecting safety, health and welfare at the place of work and also the duties of employees as regards their own duties in this regard.

As an employer, the HSE must compile the safety statement and bring it to the attention of the SECMs at least annually or when amended or when others at the place of work are

[62] Section 12 places a general duty on employers to persons other than their employees
[63] Section 13(1)(a)
[64] The standard of "reasonably practicable" is defined in section 2(1)
[65] Under some of the Regulations and EU Directives the standard of care is an absolute one
[66] Section 8(2)(a)
[67] Section 20
[68] The identification of hazards and assessment of risk carried out under section 19

exposed to a specific risk. Risks specific to the SECM's employment have to be specifically brought to his/her attention together with the protective and preventive measures taken in accordance with the relevant statutory provisions in relation to the risk.[69]

Part 4 of the Act requires the HSE, as an employer, to, *inter alia,* make and maintain arrangements that enable co-operation, consultation and participation of SECMs in the promotion and development of safety, health and welfare. It is obliged to consult regarding any measures likely to affect them, including hazard identification, risk assessment and the preparation of a safety statement; planning and organisation of training and the implications for safety, health and welfare choices available in terms of equipment, working conditions and working environment. The HSE is obliged to consider any representations made and, so far as is practicable, take the appropriate actions.

Section 8 does not prioritise any one of its particular duties. However, particularly noteworthy is the duty in section 8(2)(e), referred to above, which contains a duty to provide safe systems of work that are planned, organised, performed, maintained and revised as appropriate, so far as is reasonably practicable, so as to be safe and without risk to health of the employee or other person on the workplace, which in this case includes the expectant mother, the unborn child and other persons present.

The duty to provide a safe system of work is an overarching duty that applies from the advance planning of every aspect of the system, from the recruitment of the SECM to the conclusion of the home birth service. In this regard, considering the risks inherent in child birth generally and the scope for personal injury to the mother and/or child[70], particular attention should be given to identification of the hazards and the risk assessment of the system of work in place for home-births. In addition to statutory liability, actions also lie in negligence for injuries caused by inherent defects in systems of work. In the context of the HSE's Section 8(2)(e) duty to provide a safe system of work, this would include:

- a safe system for contracting competent SECMs that:
    - are registered as midwives with the Nursing and Midwifery Board of Ireland;
    - are familiar with and compliant with the Codes of Practice and Scope of Practice documents produced by the Nursing and Midwifery Board of Ireland;
    - have relevant experience in home births;
    - have the requisite training and up-to-date knowledge in all relevant aspects of clinical care;
    - have received the requisite training and/or are knowledgeable in any complementary therapies that they intend to use;
    - have the requisite knowledge of their statutory duties in respect of safety, health and welfare at work; in respect of children and vulnerable persons contained in the Children's First Act 2015; the Children's First Guidelines issued by the Department of Health and the Criminal Justice (Withholding of Information on Offences Against Children and Vulnerable Adults) Act 2012
    - have been police vetted and cleared.

[69] SS 20 (3) and (4)

- a safe system for the recruitment of the Designated Midwifery Officer to ensure that they are capable and competent in fulfilling their functions, as outlined in the Memorandum of Understanding and the Agreement.

- a safe system for training of SECMs that,
    - enables them to conduct their own risk assessment at the woman's home and other places of work and put in place preventive or risk reduction measures to protect themselves and other persons present;
    - familiarises them with relevant services within the HSE for the provision of clinical support and advice and equipment (if relevant) and the lone worker policy.

- a safe system in respect of protection of the SECM as a lone worker[71] (see below);

- a safe system in respect of the protection of the SECM from biological hazards, including risks from sharps, and physical protection from risks associated with manual handling[72] (see below);

- a safe system for disposal of biological waste, the use and disposal of sharps and any other biohazards.

- a safe system in respect of the SECM's equipment for the home birth, that
    - either provides equipment to the SECM or ensures that the SECM has the minimum equipment necessary for a safe home birth including emergency equipment; drugs; gases and sharps as well as personal protective equipment[73];
    - ensures that the SECM is competent in using the equipment and, if necessary, has been trained in its use;
    - ensures that the SECM, if personally sourcing equipment, is sourcing it from a reputable supplier[74];
    - ensures that the equipment is checked, that it is working properly, maintained (if relevant) and cleaned (if relevant);
    - a safe system for disposal of equipment[75];
    - there is a system in place identifying who is responsible for monitoring the systems pertaining to the SECM's equipment.

Section 8 (c) places duties on the HSE, as the employer, as regards "the place of work" which, in these circumstances, includes the expectant mother's home and other places where

[71] Regulation 2(3) Safety, Health and Welfare (General Application) Regulations 2007-2016
[72] Part 2, Chapter 4, Manual Handling of Loads Regulations, Safety, Health and Welfare at Work (General Application) Regulations 2007 - 2016
[73] Part 2, Chapter 2, The Use of Work Equipment Regulations, Safety, Health and Welfare (General Application) Regulations) 2007 - 2016
[7474] Section 8(2)(iii) of the Safety, Health and Welfare at Work Act 2005 imposes a duty to ensure, so far as is reasonably practicable, that the design, provision and maintenance of articles are safe and without risk to health. It would be a defence to a claim for personal injury caused by equipment that the equipment had been purchased the equipment from a reputable source.
[75] See below EU (Prevention of Sharps Injuries in the Health Sector) Regulations 2014; the Safety, Health and Welfare at Work (Biological Agents) Regulations (2013) and Safety, Health and Welfare at Work (Chemical Agents) Regulations (2001)

the SECM may provide services, such as antenatal classes. In fulfilling its duty, the HSE must do what is reasonably practicable to ensure that the place of work is of such a condition that is safe and without risk to health and that the design, provision and maintenance of the means of access and egress from it are safe and without risk to health[76]. It should take into account, in preparing the safety statement foreseeable and usual risks that occur and introduce controls to reduce or minimise the problem.

In situations where an employee is working on a third party's premises, the duty of the employer does not diminish, but what might be reasonably practicable for it to do for the protection of the safety, health and welfare of its employee may not be the same as what it would do were the employee working on its premises.[77] If the employer is aware of the risk and has taken reasonable care in minimising the risk of injury that may be sufficient to exonerate the employer from any liability. In *Ian Barclay v An Post and Martin Murray*[78] McGuinness J in the High Court held that An Post had taken reasonable care to deal with the hazard of low letter boxes in so far as it lay within its power. It had accepted that low letter boxes posed a danger to the health of postmen. It had provided manual handling training which warned of the hazards of bending and twisting, it had subsequently succeeded in having height and other specifications for letter boxes included in the Irish standard.

Training Designated Midwifery Officers and/or SECMs as persons competent to identify hazards and carry out a risk assessment should be feasible depending on the circumstances. Furthermore, as an employee, the SECM is under a duty to report to the HSE as soon as practicable, any work being or likely to be, carried on that could endanger his/her safety, health and welfare or that of another person; any defect in place or system of work or in any article or substance likely to endanger him or another person and any breach in statutory provision likely to endanger him/her/another which comes to his/her attention.[79] This ties into the employer's duty at section 8(c). If the SECM were to fail to bring such matter to the HSE's attention and were to suffer injury as result of the matter the HSE could rely on the said failure in an attempt to exonerate itself.

The HSE is obliged to consider the SECM's representations[80] in regard to any hazards or risks brought to its attention.

As regards work equipment, the HSE, pursuant to section 8 (2)(c) (iii) has a duty to ensure, so far as is reasonably practicable, that the design, provision and maintenance of articles[81] are safe and without risk to health. In situations where the HSE provides equipment to the SECM, there is a duty on the HSE make sure the equipment is suitable for its purpose and for use by a particular employee, is safe and is regularly checked for defects[82].
Section 8 also contains duties on the HSE to provide safe systems of work in respect of the prevention of risk to employees' health from the use of any article, substance or other

[76] Section 8(2)(c) (i) and (ii)
[77] *Dunne v Honeywell Control Systems [1991] ILRM 595, page 600.*
[78] [1998] 2 ILRM 385
[79] Section 13(1)(h)
[80] Section 26(4)
[81] "Article" is defined in section 2(1) as meaning *"(a) any plant, machine, appliance, apparatus, tool or any other work equipment for use or operation (whether exclusively or not) by the persons at work,* and *(c) any produce used by persons at work"*
[82] 28 (c) Safety, Health and Welfare at Work (General Applications) 2007, as amended

physical agent.[83] This would require knowledge of the product, its acquisition from a suitable supplier and having in place a safe system for maintenance and reporting of defects.
The section 8 duties require HSE to provide the SECMs with information, instruction, training and supervision necessary[84], so far as is reasonably practicable, for the safety, health and welfare of employees. Information must be provided in plain English and must be in the format prescribed in section 9. Instruction, training and supervision must be delivered in compliance with the duties set out in section 10. Instruction, training and supervision in aspects of safety, health and welfare should be provided on recruitment and when new systems of work, new equipment and new technology are introduced.

The SECM should be familiarised with the HSE document, "Be Safe" and other HSE documentation pertaining to the safety, health and welfare of the SECM and other persons present at the work place.

The section 8 duties also provide that the HSE, as the employer, must determine and implement measures for the protection of employees when carrying out risk assessments and in formulating a safety statement and, in doing so, to take into account the general principles of prevention in Schedule 3[85]; provide and maintain such suitable protective clothing and equipment as is necessary to ensure, so far as is reasonably practicable, the safety, health and welfare at work of employees where such risks cannot be eliminated or adequately controlled or in circumstances as prescribed[86]; keep up-to-date safe systems of work regarding emergencies and/or incidents of imminent dangers[87]; where necessary, maintain the services of a competent person for the purpose of ensuring, so far as is reasonably practicable, the safety, health and welfare of SECMs.[88]

The other general duties on the employer require the HSE to, prevent, in so far as it is possible, any improper conduct or behaviour likely to put the safety, health or welfare at work of its employees at risk[89] specifying the manner in which the safety, health and welfare at work of its employees shall be secured and managed. This places a requirement on the HSE to manage interpersonal behaviour of employees so as to prevent the adverse effects of bullying, harassment and stressful situations caused by conduct and behaviour;

The general duties of the employee are set out in Section 13. Many of these relate to those of the employer. Section 13(1)(e) imposes a duty on the SECM to not engage in any improper conduct or other behaviour which could endanger his/her own safety, health and welfare or that of another person. This encompasses bullying, harassment and horseplay. Pursuant to Section 13, the SECM is obliged to engage in health and safety training, if required[90] and to use personal protective equipment and other devices provided.[91] Section 13(1)(h), referred to above, relates to the SECM's duty to report to the HSE issues of safety, health and welfare arising at work.

[83] Section 8(2)(d)
[84] Section 8(2)(g)
[85] Section 8(2)(f)
[86] Section 8(2)(i)
[87] Section 8(2)(j)
[88] Section 8(2)(l)
[89] Section 8(2)(b)
[90] Section 13(1)(f)
[91] Section 13(1)(g)

Pursuant to section 13(1)(a) the SECM must comply with relevant statutory provisions, as appropriate, and take reasonable care to protect his/her own safety[92] and that of any other person who may be affected by their actions/omissions at work. The sub-section maintains the responsibility at common law of an employee to take reasonable care. In *HSA v John O'Donovan*[93], John O'Donovan was fined a total of €2,000 in Cork District Court on 25th September, 2008, having been found guilty of a charge pursuant to Section 13(1)(a) contrary to Section 77(2)(a) of the 2005 Act. This case arose as a result of serious injuries being sustained by an employee at Cork Airport on 11th August, 2006, when he fell from the top of motorised passenger steps at the door of an aircraft owing to the steps.

The SECM is not required or entitled to completely surrender control over his/her welfare while at work to the HSE. In situations where an employee had discretion as to how to proceed, contributory negligence may be found if the employee fails to exercise an option that would have been safer. This was the case in *Robert Quinn v Jane Bradbury and James Bradbury*[94] where the Defendants, the employers of a professional horseman, the Plaintiff, were held responsible for the accident involving the Plaintiff being thrown from a horse that had become out of control in circumstances where the accident was foreseeable. The employers had directed him to ride the horse past an obstacle that had previously caused the horse to spook. The duty of care owed to the Plaintiff would have entailed directing him to dismount from the horse or be accompanied by another strong rider. However, the Plaintiff retained discretion as to how to proceed. When difficulty began, the option of dismounting the horse had presented itself. This option arose as an emergency measure when the horse had slightly slowed. The Plaintiff would have run the risk of some injury had he taken that measure. The court found contributory negligence on the part of the Plaintiff and reduced damages by 30 per cent.

Sections 13(1)(b) and (c) require that the SECM is not under the influence of an intoxicant to such an extent that he/she risks endangering his/her own safety or that of another person and requires him/her to undergo any reasonable tests for intoxicants. Intoxicant is defined as, alcohol and drugs and any combination of drugs or drugs and alcohol and, as such, includes prescribed medications.

Pursuant to Section 13(1)(c), the HSE, as employer may reasonably request that the SECM be tested for being under the influence of an intoxicant; such testing to be carried out by, or under the supervision of, a registered medical practitioner. However, under the Act, prior to subjecting the employee to testing, it must be shown that the testing is appropriate, reasonable and proportionate. It is likely that any mandatory obligation upon an employee to comply with testing would be held to violate his/her Constitutional right to liberty under Article 40.1.4. Therefore, such testing would probably only be possible with the consent of the employee.

Liability of the Employer's Managers and Directors under the 2005 Act

[92] *Stachowski v Diamond Bar* [2012] IEHC 301 – held by Peart J that an employee must be expected to use his own common sense in any situation which presents itself during the course of a day's work. He must take reasonable care for his own safety and not take unnecessary risks. If presented with a situation he considers to be risky with the potential for personal injury to himself, he needs to explore a safer way of doing the task and if necessary consult with his employer for suggestions or advice.

[93] www.hsa.ie under the heading "Prosecutions 2008"

[94] [2012] IEHC 106, High Court, unreported, Mr Justice Charleton, 18th April, 2012.

Section 80 of the Act provides for personal liability of the employer's managers and directors. Under Section 80, where an offence under the Act has been committed and the act constituting the offence was authorised, or consented to, or was attributable to connivance or neglect of a person, being a director, manager or similar officer of an undertaking or a person who purports to act in any such capacity, that person, as well as the undertaking, would be guilty of an offence and liable to prosecution.

Section 81 reverses the burden of proof, so that there is an obligation on the person charged under Section 80 to prove their innocence.

A successful prosecution could lead to a fine in the sum of €5,000 per charge and/or a custodial sentence of up to six months (on summary prosecution) and a fine of up to €3,000,000 per charge and/or prison for up to two years (on indictment).

The case of *HSA v Clare County Council and Michael Scully (17th February, 2010)* involved a fatal injury to a dump truck driver while tipping materials over an embankment and the dump truck overturned. The risk involved was regarded as one that was foreseeable. The driver was not wearing a safety belt and there were no protective measures in place to prevent overturning. The senior executive engineer of Clare County Council, who pleaded guilty to failing to identify work place hazards and assess risks, was given a 12-month jail sentence on each of the two charges, which was suspended for two years. Clare County Council was fined €50,000 for failing to manage work activities so as to ensure the safety of employees. Griffin J held the Council to be grossly negligent and in dereliction of its duty as regards health and safety issues.

In the case of *HSA v Health Service Executive*[95], the HSE pleaded guilty to two charges – failing to have a written risk assessment and failing to provide information, instruction and training to their employees in relation to the use by their employees of rear-hinged side doors on ambulances, contrary to Sections 8(2)(g) and 19(1) and 77(2)(a), and were fined €350,000 and €150,000.

Codes of Practice, Regulations and EU Regulations and Directives

Codes of practice published by the Health and Safety Authority provide practical guidance as regards the requirements or prohibitions of the relevant statutory provisions including the Regulations made under the Act and EU Regulations and Directives. Under section 61, the codes may be used in criminal proceedings as evidence of failure to comply with statutory obligations. The codes are also relied upon in civil proceedings.

The Health and Safety Authority's website, at http://www.hsa.ie/eng/, maintains a list of current legislation and the codes. Of relevance to the area of the HSE's home birth service are the following:

- Code of Practice for Employers and Employees on the Prevention and Resolution of Bullying at Work (2007);

- The Safety, Health and Welfare at Work (Biological Agents) Regulations (2013) (SI 572 of 2013) and related Codes of Practice which stipulate the minimum standards required for the protection of workers from health risks associated with biological agents in the work-place that are possibly a source of infection,

[95] www.hsa.ie under the heading "Prosecutions 2013"

including biological waste, laundry and contaminated surfaces. The Regulations must be applied where workers actually or potentially are exposed as a result of their work.

- The Safety, Health and Welfare at Work (Chemical Agents) Regulations (2001) (SI 619/2001) which apply to the use of agents that are hazardous if likely to cause harm and include cleaning agents, disinfectants and sterilizing agents, medical gases and pharmaceutical substances.

- The EU (Prevention of Sharps Injuries in the Health Sector) Regulations 2014 relates to the injuries posed by sharps which are defined as objects or instruments necessary for the exercise of specific healthcare activities, which are able to cut, prick, cause injury or infection. Sharps are considered as work equipment for the purpose of Regulation No.2 of the Safety, Health and Welfare at Work (General Applications) 2007-2012. The Regulations apply equally to work provided in a domiciliary care setting. Under the EU directive if the use of sharps cannot be eliminated, they must incorporate safety-engineered protection mechanisms, referred to as "safer sharps", where available; employees may require training in their use. Prior to introducing the "safer sharp", the employer must evaluate whether it is suitable and whether it creates an increased hazard. The employer must also identify a suitable control for the disposal of sharps, including portable sharps containers if transportation is a feature of the work. Disposable gloves should be available for employees as should vaccinations (and records should be kept of vaccinations). The employer should have in place a policy to review the safety, health and welfare of employees relating to the use of sharps. Information must be provided to employees on, *inter alia*, the steps to be taken in the event of an accident, guidance on existing legislation, information on support programmes and the importance of reporting incidents and accidents. The Regulation prescribes mandatory training of those exposed to risk and training should occur at regular intervals. Employees are under a duty to report an injury to the employer and, in the case of off-site workers, employers are required to have sufficiently robust arrangements to allow the employee to access prophylactic treatment, medical tests and, if required, counselling, in a timely manner.

- The Safety, Health and Welfare at Work (General Application) Regulations 2007 – 2016 contain the following Regulations relevant to the HSE's home-birth service,

    - Regulation 2(3) on Lone Working which requires the employer – when identifying hazards and assessing risks pursuant section 19 - to take account of particular risks, if any, affecting employees working alone at the place of work or working in isolation at remote locations. These risks would include exposure to violent and aggressive behaviour[96]; physical injury from manual handling or other hazards and accident and medical emergency situations. The employer should, so far as is reasonably possible, provide a safe system of work for the lone worker and put in place appropriate protective and preventive control measures. This may involve site visits to assess risk arising from the design or construct of the

[96] See "Violence at Work", Health and Safety Authority (www.hsa.ie)

remote work place. The employee is required to co-operate with the employer, take reasonable care for his/her own safety; attend training; use equipment properly; report concerns regarding health and safety including defects in equipment; refrain from engaging in improper conduct and not be under the influence of an intoxicant.

- Part 2, Chapter 2: The Use of Work Equipment Regulations.

- Part 2, Chapter 3: Personal Protective Equipment Regulations

- Part 2, Chapter 4: Manual Handling of Loads Regulations. The manual handling regulation is relevant not only to manual handling of the woman in labour, but also to assisting in activities such as breast feeding. Generic risks must be assessed as well as those that are task specific. In a community work-place setting, cognizance should be had of the variation in floor surfaces and lighting and a risk assessment exercise conducted on the specific location to inform the employer of the changes that may need to be made[97]. The employer has to take such steps as are reasonably practicable to protect the employee.[98]

- Notification of Accidents and Dangerous Occurrences Regulations 1993 (Part 10 of the General Applications of 1993).

3.8 Protected Disclosures Act 2014

This Act provides protection for whistle-blowers at work. An employer cannot penalise or dismiss an employee for making a relevant disclosure of wrongdoing by another that has come to his attention.

3.9 Protection of Children and Vulnerable Persons

Currently, there is not any legal responsibility on health professionals, be they employees or volunteers, who encounter children to report abuse.[99] However, if abuse is suspected and not reported, resulting in harm that could have been prevented by disclosure, the person may be guilty of serious professional misconduct.

SECMs should be familiar with the "Children First: National Guidance for the Protection and Welfare of Children", produced by the then Department of Health and Children, in 2011. The Guidelines set out the principles that assist professionals and relevant bodies or persons whose work brings them into direct or indirect contact with children in identifying and reporting child abuse. The guidelines clearly define four categories of abuse, namely neglect, emotional abuse, physical abuse and sexual abuse.

The Children First Act 2015, places the Children First Guidelines on a statutory footing.[100] On commencement of section 14, persons mandated under the Act, which includes registered

[97] See Guidelines of the Health and Safety Authority on Manual Handling (www.hsa.ie)

[98] As referred to above, in reference to Section 8(2)(c), and in reference to lone working, depending on resources it may not always be possible to conduct a site inspection at every site, but, in the circumstances, it may be reasonable for the Designated Midwifery Officers to train as persons competent to carry out such an assessment.

[99] Pending full commencement of the Children First Act 2015

[100] Children First: National Guidance for the Protection and Welfare of Children, Department of Health (2011)

midwives[101], have a duty to report to the Child and Family Agency as soon as practicable his/her knowledge, belief or suspicion that a child has been, is being or is at risk of being harmed and also to report any disclosure by a child that he or she has been, is being or is at risk of being harmed. The Act defines in section 2:

- Harm, in relation to a child, as meaning, *"to assault, ill-treat, neglect or sexually abuse the child, whether caused by a single act, omission or circumstance or a series or combination of acts, omissions or circumstances, or otherwise[102]".*

- Ill-treatment, in relation to a child, is defined as meaning, *"to abandon or cruelly treat the child, or to cause or procure or allow the child to be abandoned or cruelly treated".*

- Neglect, in relation to a child, is defined as meaning, *"to deprive the child of adequate food, warmth, clothing, hygiene, supervision, safety or medical care".*

- Sexual abuse, in relation to a child, as meaning, (a) an offence against a child, specified in Schedule 3; (b) wilful exposure of the child to pornography; (c) wilful sexual activity in the presence of the child.

- Welfare, in relation to a child, as meaning, *"the moral, intellectual, physical, emotional and social welfare of the child".*

SECMs should also be familiar with the HSE's internal guidelines relating to child protection and welfare practice.

Pursuant to sections 2 and 3 of the Criminal Justice (Withholding of Information on Offences Against Children and Vulnerable Adults) Act 2012, it is an offence for a person to withhold information from the Garda Siochana on offences specified in Schedule 1 of the Act against children and vulnerable adults. These offences include murder, assault, false imprisonment, rape, sexual assault and incest. An offence is committed when a person who knows or ought to have known that one or more of these offences has been committed by another person against a child or vulnerable adult, and the person has information which they know or believe might be of material assistance in securing apprehension, prosecution or conviction of that other person for that offence, and fails without any reasonable excuse to disclose the information as soon as practicable to do so to a member of the Garda Siochana.

There are defences to the offence in section 4 which concern circumstances where the child or vulnerable adult with the requisite capacity made the person acquiring the information aware of their wish for the Garda Siochana not to be informed or when certain persons or professionals hold the reasonable view that An Garda Siochana should not be informed.

3.10 Road Traffic: Health and Safety Issues

A SECM using his or her own car for work purposes will need to ensure that he/she is the holder of a full driver's licence; the car is in working order and has an NCT certificate, if required; is appropriately insured and should notify his/her insurer in advance of whether he/she will carry patients/clients and the nature of equipment that he/she will be carrying. The Carriage of Dangerous Goods by Road and Transportable Pressure Equipment

[101] Schedule 2
[102] Section 2

Regulations refer only to the carriage in bulk quantities and hence would not apply to the carriage of a cylinder of gas for personal use. However, as the carriage of pressurised gas cylinder carries an additional risk of fire/explosion in the event of a road traffic accident, the common law duty of care may require a sign to be placed on the car notifying third parties of the presence of a gas cylinder on board. The midwife is under the same obligations as other drivers to comply with the provisions of the Road Traffic Acts and will be personally responsible for any breach.

3.11 Clinical Indemnity Cover

Clinical Indemnity Cover, which has been referred to above, is provided from the State's Clinical Indemnity Scheme, via the HSE, to the SECM. The cover is conditional upon the SECM complying with the terms of the MoU and Agreement and adhering to the pathways of care set out therein. The clinical indemnity cover is limited to covering personal injury actions in respect of the provision of professional medical services. It does not provide cover in respect of criminal charges brought by the DPP or representation at disciplinary committees or associated litigation costs.

All policies of insurance include terms and conditions. Generally, the breach of a term will render the policy void or voidable (depending on the seriousness of the breach and its consequences) at the discretion of the insurer. From a legal perspective, the clinical indemnity cover is no different in that regard. Even in circumstances where the breach of the terms of the clinical indemnity policy may not have been wilful on the part of the SECM, the State Claims Agency has the right to annul the policy.

In practice, if deviation from the pathway of care were to occur in an emergency situation where the woman, during the birth, refuses to take the advice of the SECM and transfer her care to a maternity hospital, and the SECM were to continue to provide care to her, this would technically be a breach of the clinical indemnity cover. The SECM is compromised in such situations as to desert the woman would likely be a disciplinary matter under the Code of Professional Conduct and Ethics of the Nursing and Midwifery Board of Ireland and could also constitute negligence towards the woman and the baby.

The SECM may, in an attempt, to protect him or herself against that risk, ask the woman to sign an indemnity undertaking to compensate the SECM for any financial loss encountered by a subsequent claim in personal injury incurred by the woman herself and/or by the baby. It is doubtful, however, whether the woman has the right to accept the risk of personal injury on behalf of the unborn child (given the Constitutional protection afforded to the unborn child).

There is a Constitutional duty on the SECM to vindicate the rights of the unborn child in a situation where the conduct of the mother is putting the life or health of the child at risk.[103] Accordingly, if time were to permit, the SECM would be required to seek legal advice with a view to obtaining injunctive relief from the High Court. In circumstances where time is not available, it is respectfully suggested that the SECM fulfil her duty of care by doing what is reasonably possible for the mother and child, including calling upon advice from a consultant obstetrician, and calling an ambulance and encourage the woman to get into it and transfer to hospital.

[103] See discussion on the rights of the child and parental rights (*in fra).*

3.12 Public Liability

Currently, there is a requirement in the Agreement between the SECM and the HSE that the SECM hold a policy of public liability insurance. The Agreement does not specify what risks are to be covered. Public liability cover protects the SECM in respect of his/her legal liability to members of the public, including the expectant mother, in respect of injury or damage to them or their property caused by their negligence. Generally, liability for accidental personal injury or physical damage to property is covered in a policy. However, other risks may also be included such as nuisance, trespass and defamation.

3.13 Employer Liability

There is also a requirement in the Agreement between the SECM and the HSE that the SECM hold a policy of employer liability.

3.14 Occupiers' Liability

The law relating to occupiers' liability is largely governed by the Occupiers' Liability Act 1995[104]. The occupiers' duties under the statute are limited to the risks associated with the static condition of lands and buildings[105]; harm arising from activity on an occupier's lands is adjudged by the rules of negligence.

An occupier need not be the owner of premises, but must be in actual occupation of the premises and have supervision and control over the premises.[106] Clearly this would apply to the SECM's own home and the home of the woman and any other place that the SECM chooses to provide antenatal classes.

The occupier owes a duty of care to persons that come onto his premises. The duty towards visitors[107], which includes persons invited onto the land whether for work or pleasure purposes, is to take such care as is reasonable in all of the circumstances to ensure that the visitor does not suffer injury or damage by reason of any danger existing on the property[108]. The standard is one of reasonable care, the same that applies to the tort of negligence. The occupier may have regard to the degree of care that the visitor should reasonably be expected to take for his/her own safety and if the visitor is accompanied by another person such as a child, the extent and level of supervision and control of that person which should be exercised by the visitor.

An SECM would be well advised to contact his/her insurer in advance of any intended use of his/her own property for antenatal classes or other uses involving the women coming into his/her own home to ensure that he/she has the appropriate level of cover. Likewise, the SECM should also check with the owner of a property that he/she proposes using for such purposes whether there is need for him/her to obtain separate insurance cover.

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[104] In addition, the Safety, Health and Welfare at Work Act 2005 and the Hotel Proprietors Act 1963 contain duties of an employer and of hotel proprietors respectively to people on their premises

[105] Allen v Trabolgan Centre (INCLUDE CITATION)

[106] Full definition is provided in section 1(1)

[107] (who are defined in section 1(1) as an entrant as of right (such as a member of the Garda Siochana); an entrant, other than a recreational user, who is on the premises by virtue of an express or implied term in a contract and an entrant, other than a recreational user, who is present on the premises at the invitation, or with the permission, of the occupier)

[108] Section 3(2)

4. RECORD KEEPING

4.1 Introduction

Keeping a comprehensive medical record is part of the SECM's duty of care to the woman and baby. The SECM should familiarise himself/herself with and - in so far as they are relevant to the home birth service - adhere to the *HSE's Standards and Recommended Practices for Healthcare Records Management"*[109] which set out the standards and principles of good record keeping.

The primary purpose of the medical record is for the provision of maternity, neo-natal and post-natal health care to the mother and baby. The secondary purpose of the medical record is for use as evidence in the event of a complaint, a Coroner's inquest, a claim in civil law or a criminal prosecution. The records of other professionals involved in the woman or baby's care may also be adduced into evidence; these may include the woman-held record; the record maintained by the maternity hospital and the record of the ambulance personnel, which may include voice recordings of the 999 call.

Only notes made contemporaneously may be used in evidence. Hence, if, for example, the SECM were to note down on a post-it note the contents of a telephone call she received from a woman advising her that she was going into labour or was in established labour, that post-it note, complete with the time of the call and the detail of the discussion should be maintained alongside the medical record. The contents of the note could be transcribed into the medical record but it should be borne in mind that errors may occur in transcription.

If there were a dispute over the facts, a comprehensive medical record may be cogent proof with which to corroborate the oral testimony of the SECM. Civil trials may take years (sometimes in excess of a decade) to come to hearing.

It is well established in law that hospitals and self-employed doctors own the medical records that they create, subject to the patient's right of access to them[110]. An SECM, as an independent contractor, would be the owner of the medical records of the women that he/she is providing a service to. As an employee of the HSE, it would be the latter who owned the medical records.

4.2 Confidentiality, Access to Medical Records and Freedom of Information

The women receiving the service have a right to privacy. This right has its source in,

1. Article 8 of the European Convention on Human Rights and Fundamental Freedoms[111]. Under Article 8 everyone has the right to respect for private and family life, his home and his correspondence. The right is qualified and interference by a public authority is permissible if, *inter alia*, it is in accordance with the law, is necessary in a democratic society, is for the protection of the rights and freedoms of others and is in the interest of health or morals.[112]

[109] QPSD-D-006-3 v 3, HSE, May 2011
[110] Healy, *Medical Malpractice* (Round Hall, 2009) 2-48
[111] European Convention on Human Rights Act 2003, Schedule 1
[112] The right to a private life is also qualified by Article 10 (the right to freedom of expression)

2. The Irish Constitution
   There is an implied right to privacy in Article 40.3.1:

   > The State guarantees in its laws to respect and, so far as practicable, by its laws to defend and vindicate the personal right of citizens.

   The implied right was first recognised in *McGee v Attorney General*[113] which concerned the right to marital privacy. It was further considered in *Kennedy v Ireland*[114] which involved the phone tapping of journalists. In that case, the Supreme Court held that,

   > *"….. the right to privacy is one of the fundamental personal rights of the citizen which flow from the Christian and democratic nature of the State……. The right to privacy is such that it must ensure the dignity and freedom of the individual in a democratic society".*

   The right is, however, qualified, and *Kennedy v Ireland* is good authority that its exercise may be restricted by the Constitutional rights of others, by the requirements of the common good and it is subject to the requirements of public order and morality.

3. The common law
   Many areas of the common law concern the protection of an individual's privacy. These include a duty of trust between the health care professional and the patient and the duty pursuant to the employment contract. Remedies lie in civil law for breach of the duty and commonly involve a claim of negligence in addition to specific claims for breach of trust and breach of contract.

4. Individuals are also accountable to their own professional governing bodies, which in this case is the Nursing and Midwifery Board of Ireland, and in any civil action cognisance will be had to the provisions of the Code of Professional Conduct and Ethics as a benchmark against which to measure whether a midwife has breached her duty of care.[115]

5. In legislation
   The enactment of the Data Protection Act 1988 and the Protection of Data (Amendment) Act 2003 (hereinafter referred to as the Acts) is the most significant statutory intervention of the control of personal information, including medical records. The Acts pertains to information held in electronic and manual form.

   The woman receiving the home birth service would be a data subject for the purposes of the Acts. This is defined in Section 1(1) as meaning, *"an individual who is the subject of personal data."*

   Personal data is defined in Section 1(1) as meaning, *"data relating to a living individual who is or can be identified either from the data or from the data in conjunction with other information that is in, or is likely to come into, the possession*

[113] [1974] IR 284
[114] [1987] IR 587
[115] Irish Nursing and Midwifery Board, December 2014.

of the data controller". In the context of the home birth service, personal data would include the woman's PPS number, her name, address and date of birth.

By their nature, medical records also include "sensitive personal data" which is defined in Section 1(1) as including data relating to a person's physical or mental health; racial origin; religious or other beliefs; sexual life and criminal convictions. Sensitive personal data requires special protection under the Acts.[116]

If medical data is kept in a format where it cannot be identifiable to an individual it ceases to be sensitive personal information and privacy concerns become less significant. However, there mere removal of a patient's name is not sufficient to achieve this. There is not any prohibition on the use of anonymised data or pseudo-anonymised data, under the Acts.[117]

A person or entity that exercises responsibility for and control over the data subject's information is regarded as a data controller for the purpose of the Acts. Section 1(1) defines a data controller as, *"a person who, either alone or with others, controls the contents and use of personal data"*.

A "data processor" is defined in Section 1(1) of the Acts as, *"a person who processes personal data on behalf of a data controller but does not include an employee of a data controller who processes the data in the course of his employment".*

"Processing" is defined in Section 1(1) of the Acts as:
"processing of or in relation to information or data, means performing any operation or set of operations on the information or data, whether or not by automatic means, including:

(a) obtaining, recording or keeping the information or data,
(b) collecting, organising, storing, altering or adapting the information or data,
(c) retrieving, consulting or using the information or data,
(d) disclosing the information or data by transmitting, disseminating or otherwise making it available, or
(e) aligning, combining, blocking, erasing or destroying the information or data"

The status of the SECM, as a data controller or a data processor, is dependent upon the nature of the employment relationship with the HSE. In the Annual Report of the Data Protection Commissioner of 2003, the case study 9/2003 confirmed that health care professionals who work as private, sole practitioners are data controllers. A consultant, treating a patient in his/her private rooms, is a data controller. Doctors and other health care professionals employed by health care providers who process sensitive information as employees, are not regarded as data controllers, but as data processors as they process on behalf of their employer. Consultants, treating patients in a public hospital, do so pursuant to a contract of employment as part of a system for the delivery of health care. In that situation, the hospital is the data controller.

[116] Section 2B(1)(a), (b)
[117] The recipient of the data does not have access to the code used by the data controller or processor to anonymise the data subject

Under the Acts[118], a data controller and sometimes a data processor must register with the Data Protection Commissioner before carrying out any wholly or partly automatic processing operation or set of such operations intended to serve a single purpose or several related purposes. A failure to do so constitutes an offence under Section 19(6) of the Acts. There are exceptions under the Act, contained in Section 16. Of relevance is:

> 16(1) In this section 'person to whom this section applies' means a data controller and a data processor (other than such (if any) categories of data controller and data processor as may be specified in regulations made by the Minister after consultation with the Commissioner) except in so far as -
> (a) they carry out
> (ii) processing of manual data (other than such categories, if any, of such data as may be prescribed),

An SECM, in the role of an independent self-employed contractor, providing a service for the HSE which is only manual data would not be required to register as he/she would come under the above mentioned exception in Section 16 (1)(a)(ii) of the Data Protection Acts.[119] If any part of the data were automated, he/she would be required to register as a data controller.

If the SECM were deemed to be an employee of the HSE, he/she would be deemed a processor and would be covered under the registration of the HSE. In such a circumstance, it would be advisable to have a written contract clause regarding the obligations pursuant to the Acts.

The HSE would also be regarded as a data controller of the SECM-held medical record irrespective of the employment relationship between the HSE and the SECM. The HSE exercises a degree of control over the use of the data and this is specifically referred to in Schedule 1 "Agreement/Consent Forms", in the Agreement[120] between the HSE and the SECM, which states in the consent form to be signed by the woman the following acknowledgements,

> *"That a copy of all records created by the midwife in relation to services provided by him/her will be provided by the midwife to the Health Service Executive. This will include any records created where the provision of the service is over and above that which the HSE considers to be a complete Home Birth Service, where such records are created within the time period specified for the delivery of the Home Birth Service, as stipulated below, and I agree as a condition of my participating in the service, for the provision of such records by my midwife.*
>
> *These records are required by the HSE for the following purposes:*

[118] Section 16
[119] SI 657/2007 refers to a "health professional" in the context of Section 16 of the Data Protection Acts and as such is a person that is not exempt from registration. However, the SI defines a health professional as a registered medical practitioner within the meaning of the Medical Practitioners Act 1978 (ie a doctor) and designated persons under Section 3 of the Health and Social Care Professionals Act 2005. The category of designated persons under the said Act does not include midwives.
[120] HSE, March 2014

- To fulfil its statutory obligations
- For the clinical governance and audit of its Home Birth Service.
- To arrange payment to the midwife for services provided"

Registration is required to be renewed annually and there is a fee attached to registration.

Under the civil law, in addition to liability in tort, a data controller may be liable for breach of statutory duty of care pursuant to Section 7 of the Acts. SECMs, as data controllers or processors, must adhere to the eight Data Protection Rules or Principles in relation to the woman's personal information. The principles state that the data controller must:

1. **obtain and process the information fairly**[121]
A person proposing to process sensitive personal data must meet at least one requirement from each of two lists set out in Sections 2A (processing of personal data) and 2B (processing of sensitive personal data).

The woman's consent to the obtaining of data for the purpose of providing health care services must be obtained to satisfy 2A. Her consent may be implied from her conduct in respect of obvious purposes. Non obvious purposes require express consent, for example, audit purposes (for which express consent is provided in the Schedule 1 Application/Consent form) or teaching purposes. If it were intended to make disclosure to another medical professional, consent may be implied if the woman consents to a referral, otherwise, her consent must be obtained.

The provision of health care services meets one of the requirements under 2B. For the processing of health information, the consent of the data subject must be explicit.

The woman must know the identity of the data controller. This is self evident in respect of the SECM. The woman must also know who else will have access to her data. In the context of the home birth service, the woman provides express consent in Schedule 1 "Application/Consent" in the Agreement[122] between the HSE and the SECM, to the uses set out by the HSE (referred to above).

The woman should be made aware of her personal right of access or right to request access and other third party rights of access.[123]

2. keep it only for one or more specified and lawful purposes
The information is kept by the SECM for the provision of medical care. Any uses unrelated to this would require the express consent of the woman.

3. process it only in ways compatible with the purposes for which it was provided

[121] See Section 2D
[122] HSE, March 2014
[123] *"A Guide for Data Controllers. Data Protection Acts 1988 and 2003",* Office of the Data Protection Commissioner

Any use or disclosure must be compatible with the specific purposes for which the information was collected. Additional disclosure is permissible with the explicit consent of the woman. Under Section 8, an SECM could also disclose information if he/she reasonably believed that the use of disclosure was necessary to lessen or prevent a serious and imminent threat to an individual's life, health or safety, or a serious threat to public health[124] and the disclosure was required by law.[125] The SECM should try to obtain the woman's prior consent.

4. **keep it safe and secure**.
   SECMs need to take reasonable care to protect their medical records from loss, unauthorised access or other interference. Records should be securely locked in a filing cabinet or cupboard when not in use; any information on a computer should not be capable of being viewed by the public; access to the computer system should be password protected; a robust back-up procedure should be in place. Documents sent by email should be encrypted or on a secure electronic pathway; communication by text with the woman should only be done with her prior approval and should be restricted to non-clinical information, such as appointment reminders.

5. **keep it accurate, complete and up-to-date**
   The details on the medical record should be kept up to date and contain relevant information only. An action under Section 7 may lie if the SECM fails to observe the duty of care applying to the handling of personal data which may arise in relation to decisions or actions based on inaccurate data. If the decision or action causes personal injury, further actions may lie in tort.

   The woman has a right of rectification of any inaccurate information and a right to erasure and blocking in relation to their personal information which is not in keeping with the principles of the Act.

   The woman also has a right to object to processing likely to cause damage or distress, but this does not apply in a case where she has previously consented to the processing or if the processing is necessary to protect the vital interests of the data subject.

6. **ensure that it is adequate, relevant and not excessive**
   This is self-evident.

7. **retain it no longer than is necessary for the specified purpose or purposes**
   No specific retention periods are specified in the Act. However, the retention period should be in accordance with the *HSE's Standards and Recommended Practices for Healthcare Records Management"*.[126]

8. **give a copy of his/her personal data to any individual, on request**
   The woman wanting to obtain a copy of her record must submit her request in writing to the data controller. A fee can be charged (not exceeding €6.35) in accordance with the Act and the records must be produced within 40 days. The

[124] Section 8(d)
[125] Section 8(e)
[126] QPSD-D-006-3 v 3, HSE, May 2011

request may be legitimately refused if to produce it would be likely to cause serious harm to the physical or mental health of the woman[127]. A refusal must be accompanied by an explanation of the reason. If appropriate, the part of the medical record which would likely cause harm may be withheld. This would also require an explanation to the woman.

The rights of individuals pursuant to the Act are upheld by the Data Protection Commissioner who has powers of enforcement on data controller and processors. The woman has a right to make a request the Data Protection Commissioner for an assessment as to whether any provision of the Act has been contravened. Compensation may be payable to the woman in respect of such a contravention. Offences created under the Act are:

- failing to register with the Data Protection Commissioner, if required to do so[128];
- failing to comply with an enforcement notice issued by the Data Protection Commissioner[129];
- failing to comply with a prohibition notice[130];
- failure to comply with an information notice[131];
- unauthorised disclosure of personal data[132];
- disclosure of personal data which was obtained without authority[133];
- obstruction of or failure to co-operate with an authorised officer[134]

Section 30 provides for prosecution by the Commissioner of summary offences. Section 31 provides that on summary conviction a person shall be liable to a fine not exceeding €3,000 and on conviction on indictment to a fine not exceeding €100,000. Summary proceedings may also be brought for infringement of a Regulation made under the Act.

4.3 Exceptions to the duty of confidentiality

1. Freedom of Information Act 2014 – the Act impacts on records generated by public bodies, including medical records. It is common in negligence proceedings for applications for disclosure of a copy of the Plaintiff's medical records to be made pursuant to the Freedom of Information Act (or in the case of a request for a mother's records, following child birth, pursuant to Section 4 of the Data Protection Act 1988 as amended by Section 5 of the Data Protection (Amendment) Act 2003). Applications are made to the head of the particular public body, in this case the HSE. Therefore, it is important that the SECM co-operate with the HSE in that regard.

   A person has a right to their own medical record under the Act. However, the access may be denied if its production would risk harm to the individual's physical or mental health.

[127] Data Protection (Access Modifications) (Health) Regulations 1989
[128] Section 19(6)
[129] Section 10(9)
[130] Section 11(15)
[131] Section 12(5)
[132] Section 12(2)
[133] Section 22
[134] Section 24

2. By rule of law – before or during legal proceedings, a Court may order disclosure of a medical record.

3. By consent of the woman

4. By statutory justification:

    a. under the provisions of the Children First Act 1915;
    b. under the Criminal Justice (Withholding Information on Offences Against Children and Vulnerable Adults) Act 2012[135];
    c. under the provisions of the Notification of Births Acts 1907 and 1915[136];
    d. under the provisions of the Civil Registration Act 2004 (Sections 19, 28(4) and 37)[137];
    e. under the provisions of the Infectious Diseases Regulation 1981 pursuant to which a medical practitioner is obliged to notify a medical officer of the health or a health board (HSE) of an incidence of an infectious disease (as prescribed by the Regulation). (It is good practice to inform the patient prior to such notification). The Medical Officer must retain the confidentiality of the patient information and cannot disclose the person's identity without their prior consent. However, the Data Protection Commissioner has held that disclosure by a pharmacist (not being a medical doctor as prescribed by the Regulation) was contrary to the Data Protection Act 1988 even where the pharmacist was required to make such disclosure by the Department of Health and Children.[138]

[135] As discussed under Safety, Health and Welfare.
[136] As discussed under Notification of Births Acts 1907-1915

[137] As discussed under Civil Registration Act 2004
[138] Case study 11/2002, Annual Report of the Data Protection Commissioner 2002, page 37.

5. INFORMED CONSENT

5.1 The Requirement for Informed Consent

The law protects a person's right to bodily integrity. To administer medical treatment to somebody without their prior consent, save in exceptional circumstances, constitutes a violation of their Constitutional and other legal rights actionable through the criminal law[139] (trespass to the person/assault/battery) but more commonly through civil law in the tort of negligence.

Trespass overlaps with criminal liability in assault and battery. Battery has been defined as the intentional unauthorised touching of another person, irrespective of whether injury results and irrespective of the motivation or *bona fides* of the defendant. Accordingly, it is important that consent to treatment is acquired from the mother or parent/guardian of the baby.

5.2 The Law and the Principle of Self-Autonomy in Medical Treatment

- The 1914 decision of Cardozo J in *Schloendorff v Society of New York Hospital*[140] provides a clear illustration of the application of the principle that every adult of sound mind has a right to determine what shall be done with their own body.

- This principle is given statutory expression in Section 4 of the Health Act 1953 that provides that nothing in the Act imposes an obligation on any person to avail himself of any service provided under this Act or to submit himself or any person for whom he is responsible to health examination or treatment.

- Article 40.3.1 of the Constitution of Ireland has been interpreted so as to guarantee a right to bodily integrity[141] and a right to health.[142]

- Bodily integrity is also an aspect of Article 8 (right to a private life) of the European Convention on Human Rights. In *Pretty v the UK*[143] the ECHR held that,

> *"in the sphere of medical treatment, the refusal to accept a particular medical treatment might, inevitably lead to a fatal outcome, yet the imposition of medical treatment, without the consent of a mentally competent adult, would interfere with a person's physical integrity in a manner capable of engaging the rights protected under Article 8.1 of the Convention".*

5.3 Persons who may give consent

All adults and minors over the age of 16 years can give consent for medical, surgical and dental procedures[144] once it is established that they have requisite capacity.
Save with the exception of:

- wards of court;
- persons authorised by law to make decisions, and

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[139][139] Non Fatal Offences Against the Person Act, 1997 (sections 2-4)
[140] (1914) 105 NE 92
[141] Ryan v Attorney General 1965
[142] Heeney v Dublin Corporation 1998
[143] (2002) 66 BMLR 147
[144] Section 23 of the Non Fatal Offences against the Person Act provides that the consent of a minor to medical treatment who has attained age 16 years shall be as effective as it would be if he or she were of full age and it shall not be necessary to obtain any consent for treatment from its parent.

- persons in emergency situations, involving a loss of their capacity to make a decision consent may only be given by the putative recipient of the medical treatment.

There is not any statutory definition of capacity. However, Section 3 of the Assisted Decision-Making (Capacity) Act 2015 defines capacity as the ability to understand the nature and consequences of a decision in the context of available choices at the time the decision is to be made.

There is a common law presumption that a person has the requisite capacity to make a decision. The basic common law test states that the person at the relevant time must understand in broad terms the decision being taken and the likely implications and consequences of their decision. Both the common law and the Section 3 provision regard the test of a person's capacity to be time specific and issue specific rather than a test of their general capacity.

If there were reason to doubt the presumption that a person has capacity, an assessment must be made to determine whether they have the capacity to make a decision in respect of the particular treatment being offered. A three-fold test has emerged in determining whether a person has the requisite capacity to make a particular decision[145]. The criteria to be examined are:

- can the person take in and retain information about the treatment including the consequences of not having it?
- Does the person believe what they are being told?
- Can the person weigh the information, balancing risks and needs?

Simply because a decision appears irrational does not mean that the person is lacking capacity although irrationality in decision-making could be an indicator of a lack of competence. In *Fitzpatrick and Anor v F.K. and Anor*[146], Laffoy J stated that:

> "*in assessing a person's capacity, a distinction has to be made between misunderstanding/misperception of the treatment information by the person on the one hand and a decision made for irrational reasons on the other. Only the former may be evidence of lack of capacity."*

Where a person's capacity in decision making is compromised, for instance by exhaustion, pain, medication side effects, it is accepted that they may be supported in their decision making by the provision of further explanation and additional time. Regard should be had to birth-plans that contain advance-based choices and preferences that have been made in consultation with the midwife or other member of the woman's healthcare team.

Relatives and friends of a person who lacks the requisite capacity may not make decisions for her. In such circumstances, under the common law doctrine of necessity, the treatment provider may administer treatment that is regarded as being in her best interest.[147] There is not any clear statement of the boundaries of the "best interest" test. It includes a balance of the benefits, disadvantages, gains and losses in respect of all medical, emotional and all other welfare issues. In recent years, there has also been a move towards ascertaining the "will and

[145] The Irish courts have followed the English decision in *Re C (refusal of treatment) [1992]*
[146] [2009] 2 IR 7
[147] F v West Berkshire (Re F) [1990] 2 AC 1

preferences" of the patient. The Assisted Decision Making (Capacity) Act 2015, moves away from the 'best interests' principle and moves towards the will and preferences model.
The Medical Council's Guide to Professional Conduct and Ethics for Medical Practitioners provide useful guidance on the care of persons lacking capacity[148],

> *"A person may be regarded as lacking in capacity to consent to a proposed investigation or treatment if they are unable to understand / retain / use or weigh up / the information they have been given to make the relevant decision. Just because they may lack capacity to make a particular decision does not mean to say that they will be unable to make that or other decisions in the future.*
>
> *" If a patient is deemed to lack capacity, reasonable steps should be taken to ascertain whether another person has legal authority to make decisions on that patient's behalf. If no such person exists, you decide on the action to take based on, which treatment option would provide the best clinical benefit for the patient; the patient's past and present wishes if known; whether the patient's capacity is likely to increase; the views of other people close to the patient who may be familiar with her preferences, beliefs and values; and the views of other health professionals involved in the patient's care".*

Validity of Consent
In order for consent to be valid, in addition to the person giving the consent having the requisite capacity:

- it must be given voluntarily. It will be deemed invalid if obtained by misinformation, physical force, coercion or undue influence;
- it must be given after the person has been appropriately informed, clear language that is capable of being understood, of the nature of the procedure and its implications.

Form of consent or refusal
Consent may be given in writing; by word of mouth or it may be inferred from conduct, for instance the holding out of an arm for injections or blood pressure monitoring. Consent cannot be inferred from silence unless it is accompanied by conduct capable of being construed as a clear manifestation of consent.[149]

The withdrawal of consent invalidates the lawfulness of treatment. A person with requisite capacity is entitled to withdraw consent at any time. Similarly, such a person may refuse to accept treatment. However, because of the Constitutional protection of the unborn child, in Article 40.3.3., a pregnant woman's autonomy in deciding to refuse treatment is compromised if the refusal would put the life of the foetus at risk. In the HSE's National Consent Policy, it is advised that legal advice be obtained as to whether an application to the High Court would be necessary.[150]

It is considered good practice to maintain a written record of the consent procedure, including details of the advice, the risks, the warnings and the options given and the choice(s) made. In the event of litigation, which process may not conclude in trial until many years following the

[148][148] 7th edition, 2009, paragraph 34.5
[149] *Schweizer v Central Medical Hospital [1974] 53 DLR 9(3d) 494*
[150] Paragraph 7.1.1., page 41, published in May 2013

allegedly impugned event(s), the defendant may be at a severe disadvantage relying on oral testimony only of his/her recall.[151]

In the event of consent of the woman being withheld, particularly in an emergency situation, the SECM could ask the woman to initial the written record of the consent procedure, as outlined above, and/or have it witnessed by a third party present, including the second SECM present for the birth, as this would be helpful if there were a dispute as to the facts in any proceedings before a Court or the SECM's disciplinary body.

There is no right to demand treatment that has not been advised. In *R (on the application of Burke) v General Medical Council*[152] the House of Lords clarified the nature of a doctor's duty towards treatment of his/her patient. It was clearly stated that:

> *"Autonomy and the right to self-determination do not entitle the patient to insist on receiving a particular medical treatment regardless of the nature of the treatment. In so far as a doctor has a legal obligation to provide treatment this cannot be founded simply upon the fact that the patient demands it.*

The Duty and Content of Disclosure Required for Consent / Refusal to be "Informed"
It is not sufficient to obtain consent in general terms. An action may lie in negligence if a woman alleges that she has not been given the appropriate information relating to the risks inherent in a particular treatment/procedure.

There is a duty to take reasonable care to disclose:

- information on all possible treatments which are clinically indicated[153], and
- any material risk that is known or foreseeable complication of a treatment or procedure properly carried out.

The disclosure of risk includes disclosure of risks of not being treated.[154] Warnings given must be adequate in scope, content and presentation and steps must be taken to ensure that they have been understood.[155]

The test of materiality is whether, in the circumstances of a particular case, a reasonable person in the patient's position, would be likely to attach significance to it. This has come to be known as the "reasonable patient standard" used by the courts to assess the standard of the disclosure.[156] Regard is had to the account the severity of the consequences, the statistical frequency of the risk and the particular circumstances in which the patient presents himself. A known or foreseeable complication refers to a risk that is known or recognised, regardless of how remote. The better known the risk and the higher its incidence, the greater the duty to disclose. Where the contemplated treatment is elective, all known risks must be disclosed regardless of how remote. In *Geoghegan v Harris [2000] 3 IR 536* the Plaintiff suffered injury as a result of dental surgery. The incident of risk was statistically less than 1%. Kearns J held that *current Irish law requires that the patient be informed of any material risk,*

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[151] Medical Malpractice Law, 2009, Thompson Reuters (Professional) Ireland Ltd.
[152] (2005) 3 WLR 1132, CA at 1148
[153] *Birch v University Hospitals NHS Trust [2008] EWHC 2237 (QB)*
[154] *Truman v Thomas [1980] 611 P 2d 902 (US) Court of California*
[155] *Lybert v Warrington Health Authority [1996] 7 Med LR 71*
[156] O'Flaherty J's divergent opinion in *Walsh v Family Planning Services Ltd [1992] 1 IR 496*, applied in *Geoghegan v Harris [2000] 3 IR 536, Fitzpatrick v White [2008] 3 IR 551* and subsequent cases. In England, *Montgomery v Lancashire Health Board [2015] AER (D) 113* endorsement of the reasonable patient test.

whether he inquires or not, regardless of its infrequency. Kearns J, in applying the "reasonable patient test", defined the phrase "*in the patient's position*" as meaning "*the patient's age, pre-existing health, family and financial circumstances, the nature of the surgery – in short, anything that can be objectively assessed, though personal to the patient."*

Arguably, the decision to have a home-birth is an elective decision in so far as it is enables the woman to exercise a choice as to location. The HSE's agreement (in Schedule 1) with the woman draws specific attention to the discussion that should have taken place with the midwife that the midwife has explained to her that in the event of unforeseen complications, the decision to have a homebirth could put the baby and herself at risk. In accordance with *Geoghegan*, the risks associated with home-birth, however remote, should be discussed between the midwife and the woman.

The other test used for assessing the standard of disclosure is "the reasonable doctor or professional standard" test[157], which applies the Dunne principles, i.e. whether the medical profession generally (or a recognised school of opinion within it) would regard a warning as necessary; in the event that a general and approved practice contained inherent defects which should be obvious to any person giving the matter due consideration, then the fact that a medical practitioner followed the general practice would not be sufficient defence. The courts retain flexibility in applying the above-mentioned tests. However, the reasonable patient test has greater prevalence.

Therapeutic Privilege

In the UK, the therapeutic privilege exception to disclosure of risks enables a doctor to withhold information as to a risk where it is reasonably believed that its disclosure would be seriously detrimental to the patient's health.

The privilege is also exercisable in this jurisdiction. Its exercise has to take into account knowledge of the patient and their likely reaction to being told of facts or risks and the impact that would likely have on their decision-making. A potential stumbling block would be the requirement to make a judgement on a person's likely reaction. Accordingly, it may prove very difficult to justify the exercise of this privilege.

Kearns J referred to the privilege in *Geoghegan* when he stated that the absolute requirement to disclose could prove counterproductive if it needlessly deterred a person from undergoing an operation in their best interests.

Timing/Conditions of Taking Consent

Consent should be obtained prior to the administration of treatment at as early a stage as possible particularly in non-emergency situations.

In *Fitzpatrick v White [2008] 3 IR 551* the Plaintiff underwent elective surgery to correct a squint. He suffered a rare complication where the medial rectus muscle slipped behind his left eye leaving him with double vision and headaches. He argued, on appeal to the Supreme Court, that the warning of the risks had been given to him 30 minutes prior to the operation, and did not afford him the chance to make an informed decision. Consent had been obtained prior to the Plaintiff being given his anaesthetic medication. The Supreme Court held that it

[157] *Walsh v Family Planning Services Ltd [1992] 1 IR 496* and followed by the Supreme Court in *Bolton v Blackrock Clinic (23rd January, 1997)*

was not good practice to obtain consent at such a late stage particularly in non-emergency situations. However, when the consent was obtained, the Plaintiff was capable of making a rational decision. Therefore, the Defendant had not breached his duty of care.
During the preparation of the birth-plan, the possible, foreseeable complications should be addressed, such as foetal distress and slow progress, to allow the woman prepare for decisions that need to be taken. Doireann O'Mahony has commented that:

> "*the way to preserve a woman's right to self-determination in such cases is to ensure that she is provided with pertinent information throughout the care pathway from antenatal care through intrapartum care and beyond, so that she is aware of the unfolding events and what potential developments and options are on the horizon. That is to say, consent should be viewed not just as an event (the signing of a form) but as a process."*[158]

In accordance with the terms of the HSE's agreement with the woman for the provision of homebirth, there is a requirement that at the commencement of the process, the woman must sign a consent form, having acknowledged that she has been previously provided with – and understands the contents of - an information pack. The terms also provide that she acknowledges that the midwife has explained to her that in the event of unforeseen complications, the decision to have a homebirth could put the baby and herself at risk. This is good practice in terms of the timing of consent.

The Medical Council's Guide to Professional Conduct and Ethics for Registered Medical Practitioners states: *"it is not recommended to seek consent when a patient may be stressed, sedated or in pain and therefore less likely to make a calm and reasoned decision. Where possible, you should explain the risks well in advance of an intervention"*.[159] Professional guidelines regarding consent are relevant as regard may be had to them to determine what constitutes a reasonable standard of care.

Causation

In order for an action in negligence to succeed the Plaintiff must establish a causal connection between the alleged breach of disclosure and the injury complained of. In the recent case of *Heffernan v Mercy University Hospital Cork Ltd,*[160] the Plaintiff underwent a procedure in 2010 for the repair of a recurrent inguinal hernia. Following surgery, over a year, his left testicle diminished in size to a point where it had no mass. The surgery was not elective. Had it not been carried out, the Plaintiff risked sepsis. The Plaintiff claimed that the surgeon had failed to explain the risks involved in the surgery and that he had signed the consent form en route to theatre. This was denied by the surgeon who stated that his standard and invariable practice was to explain the risks involved to the patient and that he had never asked a patient to sign a consent form in the circumstances described by the Plaintiff. Herbert J found against the Plaintiff. He took into account that the surgery was non-elective and that as the risks of not undergoing it were significant he felt sure that the Plaintiff would have signed the consent form anywhere in the hospital. Therefore, the non-elective nature of the surgery weighed heavily on the court. The Plaintiff did, however, succeed on the manner in which the surgery had been carried out.

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[158] Doireann O'Mahony, Medical Negligence in Childcare, Self-Determination in Childbirth: the Law of Consent, page 64.
[159] 7th edition, 2009, para 37.2
[160] *[2014] IEHC 43 (5 Feb 2014)*

6. NEGLIGENCE

6.1 Negligence in the work setting

Negligence is one of many torts that an SECM may encounter. Others include breach of statutory duty; action for trespass to the person, goods or land and action for nuisance. In order to succeed in an action for negligence, the plaintiff must show that the defendant owed her a duty of care; was in breach of that duty and it was reasonably foreseeable that as a result of the breach harm was caused. In contrast, trespass to the person is actionable *per se*, without any proof of injury or damage.[161] Actions in negligence must be brought within two years from the date of accrual of the action or from the date of knowledge.[162]

A child, once it is born alive, that has suffered personal injury as a result of negligence may take an action in personal injury against those involved in its antenatal care, intrapartum, postpartum and neonatal care[163]. The action is normally taken by its mother on its behalf. Under Section 49 of the Statute of Limitations 1957, as amended, a person suffering from a "relevant disability" (which includes legal minority [being under 18 years of age]) has until two years after the disability ceases (that is until age 20) or she dies to issue proceedings. Therefore, if personal injury occurred to the child as a result of negligence of the SECM, the child has until the eve of its 20th birthday to institute an action.

Actions in negligence also survive on the death of a woman. Part II of the Civil Liability Act 1961[164] preserves a cause of action entitled to be commenced by a dead person for the benefit of the estate. However, it excludes exemplary damages, damages for pain or suffering, personal injury or loss of diminution of expectation of life or happiness. The HSE and SECM have a duty of care towards each other and towards the expectant woman and the baby in the delivery of every aspect of the home birth service.[165]

In this context, the HSE's duty is to put in place a safe system of work that is not inherently defective. Henchy J, in *Roche v Pielow*[166], held that:

> *"the duty imposed by the law rests on the standard to be expected from a reasonably careful member of the profession, and a person cannot be said to be acting reasonably if he automatically and mindlessly follows the practice of others when by taking thought he would have realised that the practice in question was fraught with peril for his client and was readily avoidable or remediable. The professional man is, of course, not to be judged with the benefit of hindsight, but if it can be said that at the time, on giving the matter due consideration, he would have realised that the impugned practice was in the circumstances incompatible with his client's interests, and if an alternative and safe course of conduct was reasonably open to him, he will be held to have been negligent."*

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[161] *Walsh v Family Planning Services Ltd [1992] 1 IR*

[162] Section 3 Statute of Limitations (Amendment) Act 1991, as amended by Section 7 of the Civil Liability and Courts Act 2004.

[163] Section 58 Civil Liability Act 1961

[164] Section 7(1)

[165] A duty of care is also owed to children and vulnerable adults. See Children First Act 2015 and the Criminal Justice (Withholding of Information on Offences Against Children and Vulnerable Adults) Act 2012

[166] *[1985] IR 232, page 197.* See also *Collins v Mid-Western Health Board [2000] IR 154* where the general and approved practice in the Emergency Department's admissions system that allowed a junior doctor to disregard the opinion of an experienced GP was found to be an inherently defective practice.

In considering the obligation to put in place safe systems of work (including those referred to in the discussion of Safety, Health and Welfare at Work), safe systems of work would also include:

- a safe system for training of SECMs that familiarises them with the up-to-date clinical guidelines and policy documents relevant to their role in the provision of the home birth service;

- a safe system of clinical governance that ensures that the policy documents, advice and guidelines regarding antenatal, intrapartum and postnatal care are based on best practice;

  [The SECM, as a health care professional, has a duty to familiarise himself/herself with up-to-date developments in clinical practice. However, given the **possible employer-employee or** *sui generis* nature of the relationship between the HSE, the SECM and the woman, the HSE would be well advised to assist the SECM in keeping his/her knowledge up-to-date in the same way that it would do in respect of midwives in its employment].

- a safe system of clinical support for the SECM, particularly during emergencies, ensuring that he/she has access to advice from a consultant obstetrician as well as fellow midwives;

- a safe system for managing the woman-held, the SECM-held and hospital-held medical records, particularly on the transfer of a woman to a hospital;

- a safe system for supervision and control of the SECM by the Designated Midwifery Officer, including auditing the performance of the SECM;

- a safe system of communication between the SECM, the woman and the Designated Midwifery Officer;

- a safe system of governance that sets out clearly the defined roles and responsibilities of persons involved in the home birth service and particularly those persons providing support to the SECM;

- a safe system for the provision of antenatal care including the HSE being satisfied that the SECM has procured the service of a second midwife to be present at the birth. (If the SECM were to ultimately be deemed an employee, support from the HSE in so procuring the services of a second midwife would be required);

- A safe system of intrapartum care including,
  - the provision of advice and guidelines on the necessity for intrapartum transfer; the necessity for the ambulance service to be on call in the event of a home birth which is particularly important if the home is located in an area remote to a maternity hospital or unit and the necessity for the attendance of a second midwife at the home birth;
  - access to advice from a consultant obstetrician or fellow midwife on management of emergency situations;
  - access to advice (including legal advice) on management of emergency situations where the woman refuses to transfer to a hospital; and

- a safe system of handover of a woman and/or baby transferred to a hospital including safe transfer of information on the charts held by the woman and the midwife.

The duty of care of the SECM, in exercise of his/her own autonomy, applies to the full scope of his/her midwifery practice (which is helpfully identified in Article 42 of EC Directive 2005/36/EC on the Scope of Midwifery Practice, under Education and Training (see "Regulation of Self Employed Community Midwives: Education and Training).

The duty of care of the SECM arises in relation to, *inter alia*:

- keeping up-to-date with changes / developments in clinical practice;
- communication with the woman (including obtaining consent) and with colleagues and other health professionals who are or may become involved in the woman or baby's care;
- keeping satisfactory medical records and ensuring that in the event of the woman's transfer to a maternity hospital, her medical records are presented to the midwife or doctor taking over her care;
- proper management of emergencies;
- proper management of medicines including gases and all other actions necessary to protect the safety of the woman and baby;
- proper management of equipment –ensuring that he/she has the requisite equipment, knows how to use it and that it is in good working order and is hygienically clean;
- properly identifying, assessing and controlling risks from the perspective of his/her duties under the Safety, Health and Welfare at Work Act 2005, the Regulations made thereunder, Codes of Practice and EU Regulations and Directives regarding safety, health and welfare.[167]

The duty of care prevails throughout antenatal, intrapartum, postpartum and neonatal care. Negligence in antenatal care may arise in:

- failing to properly screen the woman's eligibility for home birth in accordance with the HSE's criteria as set down in the Agreement;
- failing to properly conduct the requisite antenatal health checks;
- failing to properly screen and refer the woman for treatment of medical conditions that may have contraindications for her health or the health of the baby;
- failing to properly advise the woman of the need to transfer her care to a maternity hospital;
- failing to properly advise the woman of the implications of her decisions on the baby;
- failing to obtain legal advice on conduct of the woman that could jeopardise the health of the baby[168];
- failing to obtain proper consent.

Negligence in intrapartum care may arise in:

- failing to put on notice of the home birth the maternity hospital with whom the woman has registered;
- failing to have on call the ambulance service in locations remote to a maternity hospital;

[167] See Safety, Health and Welfare at Work section.
[168] See discussion on rights of the child and parental rights *(in fra)*

- failing to properly arrange transport to the place of the home birth to ensure no undue delay;
- failing to procure the presence at the birth a second midwife, also contracted to the HSE's home birth service;
- failing to properly monitor and interpret the foetal heart;
- failing to properly recognise and respond to possible adverse clinical features, for example the presence of meconium; blood stained liquor with or without pain, a high temperature;
- failing to properly react or act on an excessive number of contractions;
- failing to properly react to slow progress in labour including circumstances involving malposition of the baby's head;
- undue delay in seeking medical assistance, in arranging for transfer of the woman's care to a maternity hospital;
- failing to properly handle the transfer of the woman's care.

Negligence may arise in postpartum and neonatal care in:
- failing to properly apply resuscitation techniques;
- failing to properly diagnose and react to clinical indicators of brain or other injury to the baby or other clinical conditions requiring attention;
- undue delay in seeking medical assistance, including the transfer of the woman and/or baby to a maternity hospital.

The legal principles for assessing whether a reasonable standard of care has been delivered in the provision of medical care are summarised by Finlay CJ in *Dunne v National Maternity Hospital and Jackson*,[169] which case involved a plaintiff twin suffering severe hypoxic brain injury at birth and the other twin not surviving. During labour, only one of the babies was monitored and, as was the practice at that time, the heartbeat of the second baby was not auscultated.

The Dunne test, as it has become known, was originally applied to doctors and the standard of care in respect of nurses and midwives was traditionally lower. However, in the recent case of *Kiernan v HSE*,[170] Cross J when determining the liability of a public health nurse stated that:

> "*to apply a different or lesser obligation to a nurse than a doctor is to adopt what, in this day, seems to me to be an outdated view dating from a time when nursing was a vocation rather than a professional qualification, and to revert to an age in which nurse had little, if any, professional autonomy and deferred entirely to the directions of doctors*"

Earlier in 2014, in the case of *Claire Hamilton v HSE*,[171] Ryan J applied the Dunne test to determine the liability of a midwife on the rationale that midwives have autonomy – make diagnoses, exercise clinical judgement and prescribe treatment. In that case, the midwife had carried out an artificial rupture of membrane and the umbilical cord prolapsed so that it was in danger of being restricted or occluded by the baby's head. The procedures that followed led to the woman developing post-traumatic stress disorder. An allegation of negligence was made by the woman against the midwife who had carried out the ARM on the grounds that

[169] [1989] IR 91
[170] [2015] IEHC 141
[171] [2014] IEHC 393

she had not exercised proper clinical judgement regarding the need for the ARM nor the circumstances in which it had been carried out. Ryan J took notice of the RCOG guidelines on the procedure and the relevance of the baby's head position.

The principles have also been applied to hospital management.[172] For instance, in *HM v HSE [2011] IEHC 339* where Charleton J found negligence in the defendant hospital's failure to circulate to medical staff members and junior hospital doctors the latest and novel Royal College guidelines that had been published weeks before the Plaintiff's injury. Charleton J held that the hospital was under a duty to have in place a procedure for the circulation of such guidelines. Accordingly, the negligence was not that of the Defendant doctor but of the hospital's management.

The Dunne principles are as follows:

1. *"The true test for establishing negligence in diagnosis or treatment on the part of a medical practitioner is whether he has been proved to be guilty of such failure as no medical practitioner of equal specialist or general status or skill would be guilty of if acting with ordinary care".*

This sets out the principal standard by which the SECM will be measured; it is two-fold, the standard set by peers in the midwifery profession and the legal standard. Accordingly, the SECM has a duty to keep up-to-date with changing professional practices. In *Eckersley v Binnie*[173], Lord Bingham articulated the standard of care required:

> "*He should not lag behind other ordinary assiduous and intelligent members of his profession in knowledge of new advances, discoveries and developments in his field. He should have such an awareness as an ordinary competent practitioner would have of the deficiencies in his own knowledge and the limitations of his skill. He should be alert to the hazards and risks in any professional task he undertakes to the extent that other ordinary competent members of the profession would be alert. He must bring to any professional task he undertakes no less expertise, skill and care than other ordinary competent members of his profession would bring, and need bring no more. The standard is that of the reasonable average, the law does not require of a professional man that he be a paragon combining the qualities of a polymath and prophet."*

2. *If the allegation of negligence against a medical practitioner is based on proof that he deviated from a general and approved practice, that will not establish negligence unless it is also proved that the course he did take was one which no medical practitioner of like specialisation and skill would have followed had he been taking the ordinary care required form a person of his qualifications.*

3. *If a medical practitioner charged with negligence defends his conduct by establishing that he followed a practice which was general, and which was approved by his colleagues of similar specialisation and skill, he cannot escape liability if in reply the*

[172] For instance, in *HM v HSE [2011] IEHC 339* where Charleton J found negligence in the defendant hospital's failure to circulate to medical staff members and junior hospital doctors the latest and novel Royal College guidelines that had been published weeks before the Plaintiff's injury.
[173] [1988] 18 CON LR 1, page 79

plaintiff establishes that such practice has inherent defects which ought to be obvious to any person giving the matter due consideration.

As referred to above, adherence to a general and approved practice that is inherently defective will not be a defence to negligence if it is shown that a reasonable and prudent practitioner who directed his mind to the matter would have known it was inherently defective. A departure from the general and approved practice requires sound reasoning and the reasoning should be documented carefully.

4. *An honest difference of opinion between doctors as to which is the better of two ways of treating a patient does not provide any grounds for leaving the question to the jury as to whether a person who has followed one course rather than another has been negligent.*

5. *It is not for a jury (or for a judge) to decide which of the two alternative courses of treatment is in their (or his) opinion preferable, but their (or his) function is merely to decide whether the course of the treatment followed, on the evidence, complied with the careful conduct of a medical practitioner of like specialisation and skill to the professed by the defendant.*

If an SECM (or the HSE) were relying on the defence of "general and approved practice", the onus may be on the SECM (or the HSE) to prove the existence of such a practice[174] Finlay, CJ, further stated that the general and approved practice need not be universal but it must be approved and adhered to by a substantial number of reputable practitioners holding the relevant specialist or general qualifications.

In determining whether a midwife has met the required standard of care, cognisance will be taken by the Court of relevant protocols, guidelines and procedures, such as those produced by the RCOG and NICE. The criteria for assessment of eligibility for home birth and transfer of the mother and/or child's care, contained in the Schedule of the Agreement and Memorandum of Understanding between the SECM and the HSE, were discussed in the case of *AJA Teehan v HSE*[175] and O'Malley J observed in her judgement that the guidelines set out in the MoU were the outcome of careful, prolonged process carried out with the participation of all stakeholders and were based on and justified by statistical evidence.

In order to succeed in a claim in negligence, the woman would have to prove that the allegedly impugned act of negligence caused the injury. Frequently, there are disputes as to the facts and, therefore, it is vitally important that the SECM keeps detailed medical records. Causation is frequently a difficult issue to determine. The general "but for" test, whereby the Plaintiff proves that but for the action of the Defendant the injury would not have occurred, is the general test. However, due to the inherent difficulties in the "but for" test where causation is not straight forward, a further test of "material contribution" has evolved.[176] Under the latter test, the Plaintiff must show that the negligent act made a material contribution to his injury. Any contribution which is not *de minimus* qualifies as being a material contribution. An application of this test in medical negligence involving neonatal injury may be seen in *Canning-Kishver v Sandwell and West Birmingham Hospital NHS*

[174] *Kelly v Crowley [1985] IR 212*
[175] [2013] IEHC 383, unreported, 16th August 2013
[176] *Bonnington Castings Ltd v Wardlaw [1956] AC 613*

Trust[177] where the condition deteriorated of a seven day old premature baby in NICU. The baby suffered circulatory and respiratory compromise resulting in severe metabolic acidosis. The nursing staff were held to be negligent for failing to call the paediatrician in sufficient time. The Defendants defended the case by alleging that the delay in resuscitation did not cause the resultant injury but that it was due to the extreme prematurity of the baby. Sir Christopher Holland held that the prematurity of the baby could not be excluded as a causative factor but he was satisfied on hearing expert evidence as to the probable causes that it was the impact of events leading up to and following the collapse that resulted in the atrophy of the cerebellum.

The Court looks at the extent to which the Plaintiff should have taken care of herself and if it finds that she is guilty of contributory negligence the damages awarded to her will be reduced in proportion to her contribution to the injury. Such a situation might arise where a woman refuses to transfer her care to a maternity hospital in an emergency situation.

In principle, under the doctrine of *volenti non fit injuria* (to the willing, there is no wrong) a person may, despite advices and warnings of risk of personal injury, assume the risk. Application of the doctrine would only be an effective defence as against risks that the woman knew of and may not succeed if woman states that she believed that she had no real choice. However, it is extremely doubtful that the woman could bind a child born injured as a result of the negligence of the SECM. Arising from the Constitutional duty to vindicate the rights of the child, the SECM should not be agreeable to the woman assuming any risk that may impact adversely on the health or wellbeing of the baby. Even if such a defence were to succeed in an action in negligence, the SECM may face disciplinary proceedings from the Nursing and Midwifery Board of Ireland. If the actions of the midwife were to deviate from the prescribed pathway of care, as provided in the Memorandum of Understanding and the Agreement, his/her clinical indemnity cover could also be put at risk.

Once the SECM has identified an evolving emergency, irrespective of the woman's instructions to the contrary, he/she should call for an ambulance as there is every possibility that the woman may change her mind and agree to transfer to hospital and time may be of the essence. If the woman were to refuse to get into the ambulance, despite advice to the contrary, it would be difficult for her to succeed in any subsequent action in negligence against the midwife for personal injury that occurred following her refusal.

Recent case law not referred to above

In *Dunne v Coombe Women and Infants University Hospital*,[178] the Plaintiff suffered severe dyskinetic cerebral palsy. The allegation of negligence was that there was a delayed resuscitation which resulted in near total hypoxic ischaemia that caused the severe dyskinetic CP and total dependency. The Plaintiff's initial Apgar score which was five at one minute subsequently declined. It was contended that this was due to the midwife's administration of ineffective bag and mask ventilation and the delay in intubating. It took 17 minutes to establish adequate ventilation and 23 minutes for the heart rate to increase. The Plaintiff's evidence was that the injury occurred at and after birth and that had he been more promptly attended to his outcome would have been better.

[177] [2008] EWHC 2384 QB
[178] [2013] IEHC

Irvine J, held that failure by the midwife to deliver effective ventilation was not evidence of negligence because the process was technically very difficult. She held that a hospital such as the one in which P was born must be in a position to have a senior member of paediatric staff capable of carrying out intubation available within five minutes of birth. She stated that there was a mandatory obligation on the midwife to be in a position to identify an evolving emergency situation and to ensure that the call for assistance was made promptly and through the correct channels so as to ensure the arrival of the correct member of staff within that five minute period. She found that the midwife was negligent in failing, having regard to the Plaintiff's condition at birth and over the first minute of his life, to have a senior member of the paediatric staff present and in attendance by the time the P was five minutes of age and that it was the delay that caused the injuries that afflicted him now.

In *Courtney v Our Lady's Hospital Ltd*[179] a woman witnessed the death of her child and this caused nervous shock. She was awarded €150,000 for nervous shock and €10,500 in respect of legal representation at the child's inquest.

Nervous shock is a recognisable psychiatric illness (such as depression) as opposed to normal emotions (such as grief and sadness) which has been shock induced by a once-off incident caused by the Defendant's negligence caused by reason of sustained or apprehended physical injury to her or another. In *Kelly v Hennessy*[180] Hamilton CJ set out the five principles to be proved before Plaintiff can establish nervous shock.

In *Quinn (a minor) v Mid-Western Health Board and Donal O'Sullivan*,[181] the Plaintiff was born at 39 weeks in Limerick Maternity Hospital with severe brain injury, developed cerebral palsy and was diagnosed with periventricular leukomalacia. The Plaintiff's mother was known to be a diabetic and had had episodes of poor diabetic control during the pregnancy. Despite attending the second named Defendant for her ante natal care and confinement she had never had an ultrasound. She contended that proper obstetric care ought to have achieved delivery not later than 35 weeks. She further contended that ultrasounds and other investigations should have been performed in the antenatal period as this would have led to the detection of problems. The Plaintiff was born with severe intrauterine growth restriction. The Defendants accepted that delivery should have been sooner. However, they claimed, based on an MRI scan, that the brain injury had occurred at around the 28th week and that the outcome would not have been any different had the Plaintiff been delivered earlier. The cause of the insult to the brain was not precisely known. However, it was not related to placental insufficiency.

The mother alleged that commencing in the third trimester, the Plaintiff suffered chronic intrauterine growth restriction as a result of placental insufficiency and by week 35 foetal reserves were exhausted. The progressive placental insufficiency and the intrauterine growth restriction caused damage to the white matter of the brain by chronic hypoxia.

In the High Court, O'Sullivan J could not make up his mind as to causation having heard two hypotheses from the witnesses for the Plaintiff and the Defendants. Accordingly, the Plaintiff failed to discharge the burden of proof on the balance of probabilities. On appeal to the Supreme Court, the Plaintiff's case was dismissed.

[179] [2011] IEHC 226
[180] [1995] 3 IR 253
[181] [2003] 10 JIC 1402, [2005] IESC 19

In *Fitzpatrick v National Maternity Hospital*,[182] the Plaintiff was born full term in poor condition with an Apgar score of 1 at one minute, 4 at five minutes and 4 at 10 minutes. He had a low heart rate and a cord Ph of 6.8. He required resuscitation. He was diagnosed as having severe quadriplegia cerebral palsy caused by acute hypoxia ischaemia.
The Plaintiff claimed that the midwives were negligent in that they had failed to properly monitor the CTG and heed its abnormalities; they had failed to stop the administration of oxcytocin when the CTG abnormalities indicated that they should have done so and had delayed in contacting the on duty registrar. The Plaintiff also contended that there was hyperstimulation of the uterus manifest on the tocograph trace which had not been heeded to properly.

The Defendant contended the Plaintiff's mother had caused some of the delay by initially refusing an episiotomy and forceps delivery on arrival of the registrar. There was a factual dispute as to when the registrar was called; the interpretation of the CTG readings; when full dilation had occurred; what had been said on arrival of the registrar with the mother alleging that she had only been advised that if she did not have an episiotomy she would tear anyway and that the baby was getting tired, and the Defendants alleging that they had told her of the risk to the baby's health if she did not consent to forceps delivery and/or episiotomy and that this explanation had gone on for some time. In evidence, the registrar gave conflicting evidence of his knowledge of the mother's wish not to have a forceps delivery.

In finding the Defendants guilty of negligence, Herbert J held, *inter alia*:

- it should have been obvious that the CTG trace was worsening and indicating that the Plaintiff was being compromised and the registrar should have been called at 06.50 hours; to delay in calling him until 07.30 hours was negligent;
- by 07.11 hours the CTG trace had become grossly pathological and the failure to call the registrar at that time was completely incomprehensible, totally unjustifiable and a decision which no senior midwife acting with reasonable care would have taken;
- there was no medical reason as to why it should have taken any longer than 15 minutes to deliver the plaintiff once the registrar had arrived;
- irreversible brain damage commenced around 07.30 hours and got exponentially worse up until 08.30 hours;
- but for the delay in calling the registrar at 06.50 hours the Plaintiff would have been born around 07.15 hours, uninjured;
- it could not be legitimately claimed that the parents were difficult to deal with. They had not realised that in refusing an episiotomy they were causing any danger to the Plaintiff and had they known they would have immediately consented. The registrar and the sister in charge had used inadequate warnings of the imminent dangers to the Plaintiff and thus were negligent in the warnings they gave.

[182] [2008] IEHC 62

7. THE RIGHTS OF CHILDREN AND PARENTAL RIGHTS

7.1 The unborn child's rights

The Constitution

Article 40.3.3. of the Irish Constitution, following the eight amendment in 1983, expressly recognises that the right to life of the unborn child is equal to that of its mother.

> The State acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right.

The Supreme Court in *Attorney General v X and Others, [1992] 1 IR 1* known as "the X case" considered the Article 40.3.3. rights of the unborn in circumstances where it was argued that the continuation of the pregnancy would lead to the death of the mother by suicide. Finlay CJ set out the test to be applied in such cases,

> *"... If it is established as a matter of probability that there is a real and substantial risk to the life, as opposed to the health of the mother, which can only be avoided by the termination of the pregnancy, such termination is admissible, having regard to the true interpretation of Article 40, s. 3, sub-section 3 of the Constitution.*"[183]

O'Flaherty J stated that the danger to the life of the mother has to represent a substantial risk to her life though this does not necessarily have to be an imminent danger of instant death. The law does not require the doctors to wait until the mother is in peril of immediate death.[184]

Egan J found that the risk must be to her life but it is irrelevant that it should be a risk of self-destruction rather than a risk to life for any other reason.

There were two further amendments to the Constitution in 1992, namely the thirteenth and fourteenth amendments.

The thirteenth amendment removed any impediment that may have existed in Article 40.3.3. to the unborn travelling outside of the jurisdiction where such travel would be in conflict with its constitutional rights:

> This sub-section shall not limit freedom to travel between the State and another State.

The fourteenth amendment further removed any impediment that may have existed in Article 40.3.3 to the provision of information on services for the termination of a pregnancy outside of the State.

> This sub-section shall not limit freedom to obtain or make available, in the State, subject to such conditions as may be laid down by law, information relating to services lawfully available in another state.

[183][183] [1992] 1 IR1, 53

[184] Page 87

The fourteenth amendment was enacted in 1995 in "The Regulation of Information (Services outside of the State for Termination of Pregnancies) Act 1995."

The Protection of Life During Pregnancy Act 2013

This statute enacted the eighth amendment to the Constitution. It provides for the ending of the life of the unborn in circumstances where there is a real and substantial risk to the loss of the mother's life from physical illness (including that caused by an accident) and from suicide, and that that risk may only be averted by carrying out the medical procedure. In assessing the latter criteria, regard must be had to the need to preserve the life of the unborn child as far as practicable.

It sets out the procedures that must be followed where the risk of loss of life is from physical illness (Section 7); physical illness in emergency where there is an immediate risk to the life of the woman (Section 8) and from suicide (Section 9). Under Sections 7 and 9, the procedure must be carried out by an obstetrician at an appropriate institution which is defined in Section 2(1) as (a) an institution that is specified in the Schedule, or (b) an institution that is specified in an order under Section 3. In respect of Section 8 the procedure may be carried out by a medical practitioner. The Act does not include any reference to a gestational time-limit outside of which such procedures may not be carried out.

There is a right under Section 10 of the Act for a woman to review the refusal of a medical practitioner to give an opinion (Section 10 (1) (a), or to review the opinion given whereby it is not such as is required for certification for the procedure under Section 7 or Section 9. In such circumstances the woman must be informed in writing that she may make an application for review of the relevant decision. The woman, or a person acting on her behalf, may make an application to the Health Service Executive for review of the relevant decision. The HSE has an obligation under Section 11 to put in place a review panel from which members of the review committee will be drawn. The pregnant woman or a person acting on her behalf has a right of audience before the review committee (Section 14(1)).

Under Part 3 of the Act:

Section 16:

> Nothing in this Act shall operate to affect any enactment or rule of law relating to consent.

Section 17 (1)

> Subject to sub-sections (2) and (3), nothing in this Act shall be construed as obliging any medical practitioner, nurse or midwife to carry out, or to assist in carrying out, any medical procedure referred to in Section 7(1) or 9(1) to which he or she has a conscientious objection.

Section 17(2)

> Sub-section 1 shall not be construed to affect any duty to participate in any medical procedure referred to in Section 8(1).

Section 18 (1)

> Nothing in this Act shall operate to limit the freedom (a) to travel between the State and another state, or (b) to obtain or make available in the State, in accordance with conditions for the time being laid down by law, information relating to services lawfully available in another state.

Section 18(2)

> Nothing in this Act shall operate to restrict any person from travelling to another state on the ground that his or her intended conduct there, would, if it occurred in the State, constitute an offence under Section 22.

Termination on grounds of a risk to the health and well-being of the mother

In the case of *A, B and C v Ireland*[185], the European Court of Human Rights found that the Article 8 rights of the first two applicants had not been infringed by the prohibition on abortion in Ireland when they had travelled abroad for an abortion for health and well-being reasons having regard to the right to lawfully travel abroad for an abortion with access to appropriate information and medical care in Ireland. The Court took into account the profound moral views of the Irish people as to the nature of life and the consequent protection accorded to the life of the unborn. The Court found that the impugned prohibition on abortion in Ireland struck a fair balance between the right of the first and second applicants to respect their private lives and the rights invoked on behalf of the unborn.

In respect of the third applicant, the Court found that her Article 8 rights had been infringed as she had travelled abroad for an abortion when she mainly feared that the pregnancy constituted a risk to her life. She had unknowingly become pregnant when her cancer was in remission. She underwent a series of tests for cancer that were contraindicated during pregnancy.

Termination on grounds of the health of the unborn

It is unlawful to terminate a pregnancy in this jurisdiction on the grounds of fatal foetal abnormality.

Parental Rights and Medical Treatment of the Baby

None of the Health Care Acts refer specifically to the provision of health care for pre-natal children.

Section 4, Health Act 1953 states that nothing in the Act imposes an obligation on any person to avail himself of any service provided under this Act or to submit himself or any person for whom he is responsible to health examination or treatment.

Section 4 is consistent with Article 41.1 of the Constitution wherein,

> Article 41.1.1 - the State recognises the Family as the natural primary and fundamental unit group of Society, and as a moral institution possessing inalienable and imprescriptible rights antecedent and superior to all positive law.
>
> Article 41.1.2 – the State, therefore, guarantees to protect the Family in its constitution and authority, as the necessary basis of social order and as indispensable to the welfare of the Nation and the State.

Under Section 4 there is a voluntariness to availing of medical treatment for oneself or for a person for whom you are responsible. In *North Western Health Board v HW and CW*,[186]

[185] 16th December, 2010, Judgement (Grand Chamber), 25579/05
[186] [2001] 3 IR 622)

which involved the child's parents refusing to have the PKU test administered to their child, Hardiman J stressed that the principle of voluntarism in respect of medical treatment is plainly established in so far as public medical services are concerned. He referred to exceptions relating to infectious/communicable diseases. It was held that it would be contrary to Section 4 to compel the parents to submit to medical treatment for their child.

In contrast to the decision in *North Western Health Board v HW and CW*[187] there are cases where Court has invoked Article 42.5 of the Constitution where a parent has withheld consent to medical treatment for a child to have a blood transfusion on religious grounds.

Article 42.4 states,

> in exceptional cases, where parents for physical or moral reasons fail in their duty towards their children, the State as guardian of the common good, by appropriate means shall endeavour to supply the place of the parents, but always with due regard for the natural and imprescriptible rights of the child.

Hogan J in *Children's University Hospital Temple Street v CD and EF*[188] stated:

> *"the use of the term "failure" in this context is perhaps a somewhat unhappy one, since there is no doubt but that CD and EF, acting by the lights of their own deeply held religious views, behaved in a conscientious fashion vis-à-vis Baby AB. The test of whether the parents have failed for the purposes of Article 42.5 is, however, an objective one judged by the secular standards of society in general and of the Constitution in particular, irrespective of their own subjective religious views*".

7.2 Court's recognition of the rights of pre-natal children to health care

In *G. v An Bord Uchtala*[189] Walsh J stated,

> "*a child has a right to life itself and the right to be guarded against all threats directed to its existence whether before or after birth*".

In *North Western Health Board v HW and CW* [190] the Supreme Court did not override the parents' wishes that their new-born son avoid the routine heel prick test for a fatal metabolic disorder. The PKU test is minimally invasive, has no side-effects and potentially may be life-saving. This was held to be in the range of decisions that could be made by the State and that if the responsibility for making such a decision transferred from the parents to the State it would herald a new era where there would be considerably more State intervention and decision making for children than has occurred to date. Denham J stated, *obiter dicta*, that, in exceptional cases, for example:

> "*where a child is suffering a terminal illness and the parents decide responsibly that she or he has suffered enough medical intervention and should receive only palliative care, this may be within the range of responsible decision which may be taken by parents".*

[187] [2001] 3 IR 622
[188] [2011] 1 IR 665, [2011] 2 ILRM 262.
[189] [1980] IR 32 , Supreme Court
[190] [2001] 3 IR 622

The cases of *Baby Janice*,[191]*; Baby Janice*,[192] and *Baby B*[193] involved Jehovah's witnesses who were refusing potentially life saving blood transfusions to their children, based on religious reliefs. The High Court demonstrated a willingness to override parental wishes in relation to the health care decision making.

Below are two ex tempore judgements subject of article reported in the Medical Legal Journal of Ireland 2012, 18(2), 76-81, by Fiona Broughton, BCL, PGDipEd, MA, Lecturer in Law, Griffith College, Cork. Both involved emergency applications to the High Court in circumstances where a HIV mother refused treatment to reduce the risk of transmitting HIV to her pre-natal child.

South Western Area Health Board v K and Ano,r[194] Finnegan P, advised the pregnant woman that if she refused to give birth in hospital he would have to make "much more serious orders affecting her bodily integrity." The woman agreed to give birth in hospital. An Order was made in respect of the pre-natal child that she would be made a Ward of Court upon his/her birth to allow for the lawful administration of antiviral drugs without the consent of his/her mother. As the mother agreed to give birth in hospital, the extent to which the Court would have gone to in order to protect the health of the unborn were not articulated.[195] Finnegan P held that the Court will interfere, if necessary, with the right to the mother's bodily integrity to protect the life of a pre-natal child.

In *Health Service Executive v F*[196] F discovered she was HIV positive during the first trimester of pregnancy. She was informed of the risk to the unborn child of infection transmission and of antiretroviral treatment which could reduce the risk of infection from 9% to 0.1 %. She became concerned regarding the potential side effects of the proposed medication. She became greatly concerned about the possible effects on the baby and was not convinced that the serious risks posed by the drugs outweighed the risks posed by mother-to-child transmission. She refused to consent to the administration of antiretroviral drugs to herself or to her child. She agreed to have a caesarean Section birth and not to breast-feed in order to reduce the risk of infection. Her medical team applied to the High Court for an order to be made allowing for the administration of drugs to the child once born. A declaration was sought, "that in the existing circumstances it shall be lawful as being in the best interest of F's unborn child as soon as he or she is delivered to receive such medical treatment as may in his or her treating doctor's opinion be necessary, including by not limited to medical treatments for the purpose of reducing the risk of vertical transmission of human immune-deficiency virus (HIV) from F to her child." Orders were also sought restraining her from breast-feeding for not less than 28 days and an order permitting the HSE from the time of the birth of F's unborn child to care for and maintain the said child in such place or places as the HSE considers to be in the best care, protection and welfare interests for a period of not less than 28 days. The Court noted that F, herself, had undertaken to present herself at

[191] unreported, High Court Finnegan J, March 18, 2004
[192] unreported, High Court, Abbot , August 5, 2005
[193] unreported, High Court, Birmingham J, December 28, 2008 (as reported in Medico Legal Journal of Ireland 2012 18(2) 76-81 Fiona Boughton.
[194] High Court, ex tempore, Finnegan P, July 19th 2001
[195] Information regarding the Order is found at: highcourtsearch.courts.ie/hcslive/order_detail.show?sessionID=1661364449&yearNo=2002&recorder=9993&processType=P
[196] High Court, ex tempore judgement, Birmingham J. November 20th, 2010

hospital for the purposes of a caesarean section and had undertaken not to breast-feed. Birmingham J held that if there was a substantial body of opinion of medical professionals voicing concerns about the drugs, even if it were a minority, he would have to come down in favour of the mother. He spoke of the superior position of the family under the Irish Constitution. However, he believed that the risk of the child not being treated was greater than the risks posed by the drugs and ruled, "the unborn child of F as soon as he/she is delivered shall receive such medical treatment as may his/her treating doctors' opinions be necessary including but not limited to medical treatments for the purpose of reducing the risk of vertical transmission of human immuno-therapy virus (HIV) from F to her child.

P.P. v Health Service Executive, High Court, unreported [2014] IEHC 622 (MLJI 2015 21,(1) 41-42.
PP's daughter, NP, suffered brain stem death when she was approximately 15 weeks pregnant. In order to protect the viability of the unborn foetus, she was given life support by mechanical ventilation; she was fed by a nasogastric tube. She was treated for pneumonia, fungal infections, high blood pressure, fluid build-up and urinary tract problems. She was given a tracheostomy operation two weeks following the diagnosis of brain stem death. The treatment was intended to continue for the duration of the pregnancy. PP applied to the High Court for an order directing that the somatic support be discontinued on the grounds that the measures being taken were unreasonable and experimental in nature, with no proper basis in medical science or ethical principles.

The High Court directed that it would, *inter alia*, hear representations made on behalf of the unborn child and on behalf of its mother, NP. Uncontested medical evidence was that there was not any reasonable prospect that the unborn child could be born alive if the somatic measures were to continue. It also heard evidence that the continuing breakdown of NP's body would lead to an increase in infection that would bring the unborn child's life to an end prior to any opportunity for a viable delivery. It was held, in authorising the withdrawal of ongoing somatic support being provided to NP:

1. The withdrawal of ongoing somatic support was in the best interest of the unborn child;
2. A necessary part of vindicating the unborn child's right to life is to enquire as to the practicality and utility of continuing life support measures;
3. Whether the continuance of somatic support was distressing to the unborn child was an important consideration when assessing what in this case was in the best interest of the unborn child;
4. The phrase, "as far as practicable" should be construed in harmony with Article 40.3.1.
5. The phrase, "as far as practicable" should be interpreted as meaning what is practicable rather than what is possible.
6. Considerations of the dignity of the mother continue to be engaged after she has passed away.
7. When a mother who dies is bearing an unborn child at the time of her death, the rights of that child, who is living, must prevail over the feelings of grief and respect for a mother who is no longer living.

7.3 The Criminal Law

The Protection of Life During Pregnancy Act 2013 makes it an offence to intentionally destruct an unborn child. Section 5 of the Act repealed Sections 58 and 59 of the Offences Against the Person Act 1861, as amended, which laws previously criminalised abortion.

Section 22 of the 2013 Act states:

(1) It shall be an offence to intentionally destroy unborn human life.
(2) A person who is guilty of an offence under this section shall be liable on indictment to a fine or imprisonment for a term not exceeding 14 years, or both.
(3) A prosecution for an offence under this section may be brought only by or with the consent of the Director of Public Prosecutions.

Section 10 of the Health (Family Planning) Act 1979 states:
Nothing in this Act shall be construed as authorising

(a) the procuring of abortion;
(b) the doing of any other thing which is prohibited by Section 58 or 59 of the Offences Against the Person Act 1861 (which sections prohibit the administering of drugs or the use of any instruments to procure an abortion),

7.4 Civil Law

Section 58 of the Civil Liability Act 1961:
For the avoidance of doubt it is hereby declared that the law relating to wrongs shall apply to an unborn child for his protection in like manner as if the child were born, provided the child is subsequently born alive. [Section makes a defendant liable to a child for injury caused to him *en ventre sa mere*].

8. NOTIFICATION OF BIRTHS ACTS 1907–1915

8.1 Provisions of the Acts

Section 1 (1)

> In the case of every child born in an area in which this Act is adopted it shall be the duty of the father of the child, if he is actually residing in the house where the birth takes place at the time of its occurrence, and of any person in attendance upon the mother at the time of, or within six hours after, the birth, to give notice in writing of the birth to the medical officer of health of the district in which the child is born, in manner provided by this section.

Section 1(2)

> Notice under this section shall be given by posting a prepaid letter or postcard addressed to the medical officer of health at his office or residence, giving the necessary information of the birth within thirty-six hours after the birth, or by delivering a written notice of the birth at the office or residence of the medical officer within the same time; and the local authority shall supply without charge addressed and stamped postcards containing the form of notice to any medical practitioner or midwife residing or practising in their area, who applies for the same.

An SECM is a qualified informant for the purpose of the Act.

8.2 Civil Registration Act 2004

A midwife is a "qualified informant" under Section 19(6) as he/she is (c) a person present at the birth. The Act requires a qualified informant to register the child born in the State no later than three months after its birth if the parents or surviving parent has failed to do so or if they see are dead, incapable through ill health of doing so. A qualified informant must do so unless he reasonably believes that another qualified informant (see other categories under Section 19(6), including guardian of the child, any person present in the building used as a dwelling at the time of birth, a person having charge of the child) has done so.

Note the same provision provides in Section 37 for a qualified informant to inform the registrar of a death where there is no relative or civil partner or such person is incapable through ill health. Qualified informant may be called on by the Registrar under Section 37(2).

In respect to the registration of stillbirths, registration under the Act is required within twelve months of the date of the still birth. Under Section 28(4) where the stillbirth has not been registered within the 12 month period and the stillbirth occurred in a place other than a hospital or other institution, and a midwife attended the stillbirth, the Registrar may request the midwife to give particulars, as defined in Part 2 of the First Schedule in the Act, of the still birth.

Section 2(1) states that a stillborn child means a child who, at birth weighs not less than 500 grams or has a gestational age of not less than 24 weeks and shows no sight of life and, "stillbirth" shall be construed accordingly.

Under Section 69(3) a person who gives to a registrar particulars or information which he or she knows to be false or misleading is guilty of an offence; under Section 69(5) a person who is required by this Act to give to a registrar the required particulars relating to a birth, a new born child found abandoned, a stillbirth or a death and who, without reasonable cause, fails or refuses to answer a question put to him or her by a registrar in relation to those particulars is guilty of an offence.

Upon prosecution, pursuant to Section 70(1), for breach of Section 69(3), a person may be fined up to €2000 and/or imprisoned for up to 6 months, on summary conviction, or on indictment, fined up to €10,000 and/or imprisoned for up to 5 years. Upon prosecution, pursuant to Section 70(2), for breach of Section 69(5), a person may be fined up to €2000 and/or up to 6 months imprisonment, on a summary conviction.