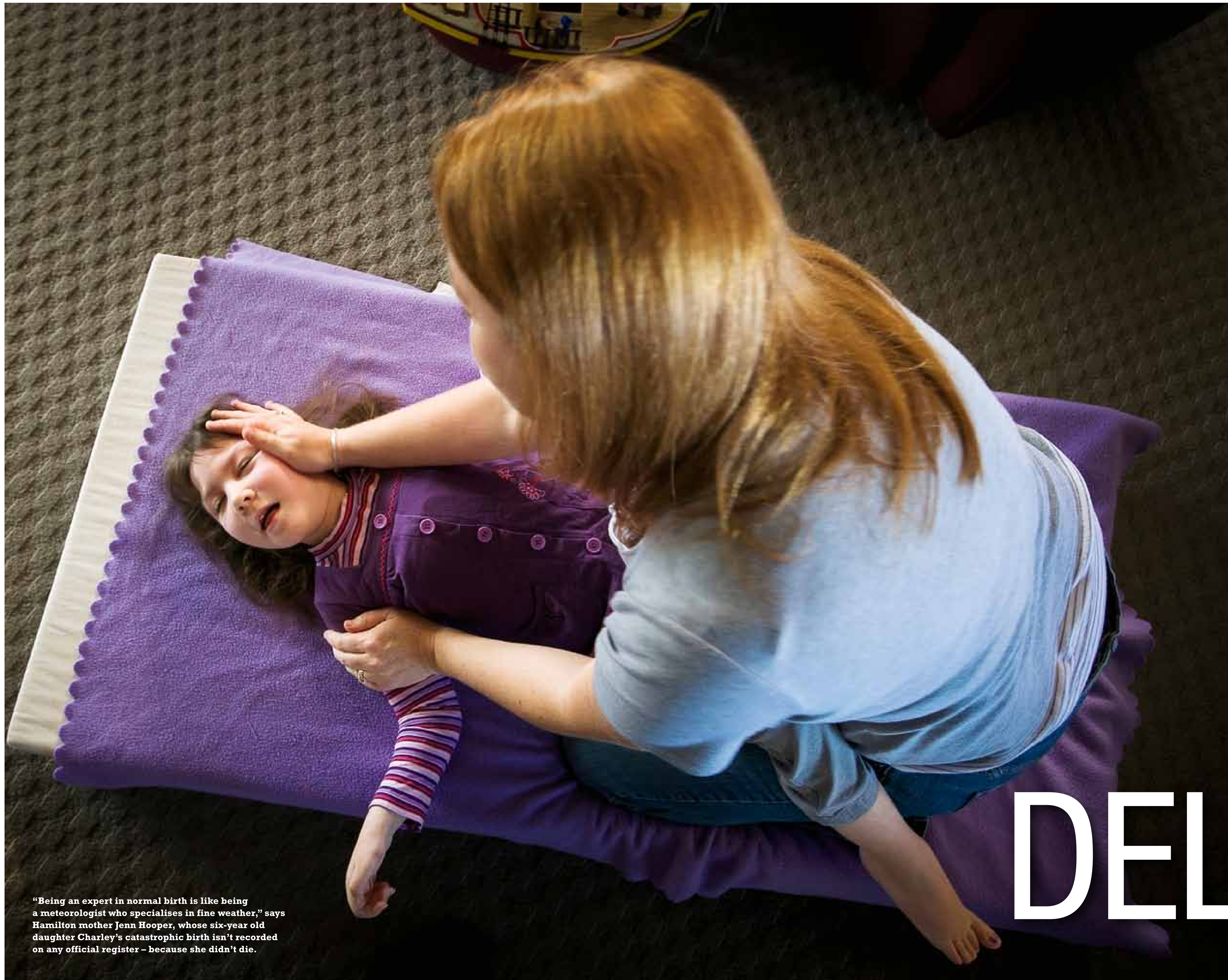

“Being an expert in normal birth is like being a meteorologist who specialises in fine weather,” says Hamilton mother Jenn Hooper, whose six-year old daughter Charley’s catastrophic birth isn’t recorded on any official register – because she didn’t die.

Maternity care in the 1990s changed dramatically, giving midwives autonomy. But with a scandalous lack of information about the impact of those changes, the blame game is still being played about who’s at fault when births go bad. Donna Chisholm investigates.

A FAILURE TO DELIVER

DONNA CHISHOLM IS *NORTH & SOUTH*'S EDITOR-AT-LARGE. PHOTOGRAPHY BY NICOLA EDMONDS, ADRIAN MALLOCH, GUY FREDERICK AND CORBIS.

Above: Jenny Avery's midwife performs a final check on her last visit before a planned homebirth.

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Above: Humans, unlike any other species, need help to give birth. Supported by her husband, midwife and two friends, Avery pushes baby Finn into the world.

If only we could give birth like the monkey mum. She squats on her hind legs, and as her baby is born, his head facing hers, she reaches down to guide him into the world. Once her infant's arms are free, he is strong enough to grab her body and pull himself out.

Despite his head being almost the same size as the diameter of his mother's birth canal, that canal is the same oval shape from entrance to exit, giving the baby monkey a smooth and unobstructed path to life.

Consider, though, the task facing the human baby, who must twist and turn like an Olympic bobsledder down a birth canal whose dimensions change from top to bottom and side to side. He must then emerge facing the opposite direction to his mother, making it almost impossible for her to assist his birth.

Blame evolution. This is, says American anthropologist Wenda Trevathan, the price we pay for modifications to the pelvis which allow us to walk upright – and for our large brains (the cause of our exceptionally big heads in proportion to the size of our bodies) and intelligence.

The baby's journey, she says, through a passageway of changing cross-sectional shapes, makes birth difficult and risky for the vast majority of mothers and infants. It is why humans, unlike any other species, need help to give birth.

In New Zealand in the past 21 years, the baton of responsibility for providing that help has passed from doctors to midwives, the self-described specialists in normal birth.

But do we expect normality too often? And when things do go wrong, are those expectations putting the lives of mothers and babies at risk?

Suze Malcolm has only patchy memories of the day her son Eddie, her second child, was born at Wellington Women's Hospital in August 2009.

One of them is of being wheeled to theatre with a ruptured uterus, after Eddie's birth went almost fatally wrong.

"Can you please save my uterus?" she asked the consultant as she signed the consent form for a possible hysterectomy. He replied, "Well Suze, I'm going to save your life."

For Malcolm, a clinical psychologist, and her husband Richard Tait, a management consultant, the shocking outcome was caused by a system that let them down, as neither their midwives nor the hospital's obstetric registrar took responsibility for the shortcomings in her care which saw her come perilously close to death.

After having had daughter Sylvie 15 months earlier by emergency caesarean when her labour failed to progress, Malcolm and Tait were keen to try for a natural delivery in hospital, with a midwife in attendance but specialist obstetric help on hand should anything go wrong.

Because Sylvie was an IVF baby, they'd been super-cautious during the pregnancy, and booked an obstetrician for the birth. When Sylvie's heart rate dipped during a drawn-out labour, Malcolm was whisked to theatre "within seconds".

Despite the caesarean, Malcolm later felt she'd been over-anxious. "It's this whole thing of having this belief, this cultural thing, that birth is a normal and natural practice. All the information I'd always been told was that giving birth naturally is best for you and best for your baby."

Malcolm's labour with Eddie progressed relatively uneventfully until she was ready to push, although the hospital later admitted its overseas-trained registrar prescribed a drug to hasten labour outside the guidelines which should have been used for a woman with a prior caesarean.

The registrar, in consultation with an obstetrician, told Malcolm's midwives that she should push for no longer than 30 minutes before a second caesarean would be indicated to avoid the risk of uterine rupture. (Both a hospital midwife and Malcolm's independent midwife, accompanied by one of her colleagues and a student, attended the birth.)

As the medical time limit ticked by, the registrar was absent – she had been called

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As this picture was taken, just after the birth of her son in hospital, Suze Malcolm's blood pressure was plummeting. Her midwives continued to massage her rapidly swelling stomach to expel the "clots" they believed were causing her pain. It was two hours before the consultant obstetrician was called. By the time Malcolm was raced to theatre for emergency surgery, she was 30 minutes from death.

to another caesarean. The midwives encouraged Malcolm to keep pushing. By the time Eddie was delivered by the registrar, with a suction device, she had been pushing as hard as she could for 90 minutes – 60 minutes past the medical deadline.

No one is sure exactly what time the base of her uterus split and two to three litres of blood poured into her abdomen. The unfolding catastrophe went undiagnosed by the registrar or the midwives, despite Malcolm's plummeting blood pressure. The midwives continued to massage Malcolm's rapidly swelling stomach to expel the "clots" they believed were causing her pain and weakness.

It was two hours before the consultant obstetrician was called. He told her later that by the time she got to theatre, she was 30 minutes from death. She almost paid for her natural birth, her "womanly badge of honour", with her life.

The district health board later apologised for her "awful" experience; Malcolm is yet to decide if she will complain to the health commissioner.

What went wrong in Suze Malcolm's case says much about what can potentially go wrong at any delivery.

Our investigation encountered recurring themes in problem births:

- Dangerous delays in diagnosis and action when pregnancy or labour departs from the normal.
- Confusion between midwives and doctors over who is in charge when responsibility for care is transferred.
- Unexpected complications occurring at home or in primary birthing units many kilometres from high-tech assistance.
- The unrealistic expectation that because a woman is young and healthy, she will therefore have an uneventful delivery.

What astonished us was how many people we spoke to had personal stories of near disasters involving midwives, or of unexpected complications.

One woman told us that despite repeated calls, her midwife never turned up for the birth – she and her husband ended up alone in a birthing room at Auckland City Hospital and had to press the emergency buzzer to summon help when the baby was coming. Another said her midwife left her lying alone on soiled and bloodied bed linen after her birth in Waihi because she wanted to nip out to The Warehouse.

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"For the past 20 years, the NZ maternity system has been so overwhelmed by the 'birth is a normal life event' philosophy (as opposed to the 'let's have a living, healthy mother and baby at the end of it all' philosophy)..."

Christchurch doctor Lynda Exton, a former GP obstetrician (above).

Then, of course, there are the headline-making inquests into baby deaths, the latest that of Adam Barlow in Waikato, after a mishandled delivery involving a junior midwife, at which calls have again been made for changes to midwifery training.

Who, if anyone, is at fault when births do go wrong and mothers and babies are harmed or die has been the subject of 20 years of bitter debate and finger pointing between doctors and midwives, since midwives regained autonomy in 1990 and were permitted to deliver babies without a doctor being present.

The acrimony deepened later in the 1990s when the government's funding changes resulted in a woman having to choose either a doctor or midwife as her lead maternity carer. Pay rates were such that GPs in their hundreds abandoned obstetrics, leaving many women who might have preferred a doctor to deliver them with no choice but to have a midwife.

College of Midwives chief executive Karen Guilliland says that's not something midwives have any control over – and she contends GPs were deserting obstetrics anyway because of the 24/7 nature of the work. "It's the white middle-class women who think it's a disaster because they can't get their doctor – well, take it up with medicine."

Despite this most profound change in the make up of our maternity workforce, no one can say for sure what the impact has been on the health of our mothers and babies. We don't know because, apart from information kept when mothers or babies die, there is still – despite decades of urging and official recommendations – no perinatal data base to record how many are harmed.

One of the most trenchant critics of the 1990s policy changes is Christchurch GP Lynda Exton, whose 2008 book *The Baby Business* linked the reforms with a raft of worrying trends, and the slowing of the decline in perinatal deaths. About 600 babies die each year after 20 weeks' gestation, a rate of 10 per 1000 births. On OECD figures, we rank well behind Australia but ahead of the United States and United Kingdom.

"It seems to me," Exton told *North & South*, "that for the past 20 years the NZ maternity system has been so completely and comprehensively overwhelmed by the 'birth is a normal life event' philosophy (as opposed to the 'let's have a living, healthy mother and baby at the end of it all' philosophy) that the possibility of human error in outcomes has been systematically ignored and deliberately overlooked."

She says New Zealand research indicates half of all pregnancies and deliveries require some medical assistance. More than a third of all deliveries require intervention.

Exton, a former GP obstetrician, is the co-founder of a maternity care lobby group, Aim (Action to Improve Maternity), along with Hamilton mother Jenn Hooper, whose six-year-old daughter Charley was born severely brain damaged in a birth at which two midwives were found to have been at fault. Aim has a data base of about 500 families whose children have died or been damaged at birth. Says Hooper of midwives: "Being an expert in normal birth is like being a meteorologist who specialises in fine weather."

ADRIAN MALLOCH

Jenn Hooper and her husband Mark, whose six-year-old daughter Charley was born severely brain damaged in a birth at which two midwives were found to have been at fault.

A fit, 60kg 31-year-old when she became pregnant, Amanda Elliot says she'd hoped for a drug-free, "natural" delivery. "I was naive enough to think things didn't go wrong in this day and age."

The Duty of Care

1990: Midwives granted autonomy and allowed to deliver babies independently of doctors. Able to claim from same maternity benefits schedule as doctors, meaning women can have both a midwife and doctor involved in their care.

1992: First intake of direct entry (non nursing-trained) midwives.

1989-1994: Maternity spending blows out from $38 million a year to $89 million.

July 1996: System of lead maternity carers (LMC) introduced in which women have to choose either a doctor or a midwife: the so-called Section 51 scheme. Key features include a $950 fee paid to the LMC for a labour and birth. Doctors paid the same amount if they handled all the labour and birth, but had to pay the midwife $500 if they involved her in the care. Bonuses paid to the midwife for births in low-tech birthing units or at home.

1996-2002: Hundreds of GPs abandon obstetrics. Others remained, developing co-operating groups of midwives and doctors funded by special arrangements with local health authorities and bypassing Section 51.

July 2002: The government terminates all non-standard contracts and makes all maternity providers comply with the former Section 51, now Section 88, maternity notice. Only about 30 GPs nationally continue to deliver babies.

She says Charley's catastrophic birth isn't recorded on any official register – because she didn't die. "My kid doesn't even count. She literally doesn't even count. This whole thing about feeling like a statistic – we don't even get to be that."

Hooper petitioned Parliament in 2009 for, among other things, a review of our maternity system and midwifery training and the establishment of a comprehensive perinatal database. Despite the Health Select Committee recommending the database be introduced and significant changes made to midwifery education and post-graduate supervision, little has changed yet.

We still don't have a comprehensive data base, although outcomes like Charley's, caused by oxygen deprivation at birth, will be included from next year in the Perinatal and Maternal Mortality Committee's annual report.

Committee chair Professor Cindy Farquhar says the rate at which New Zealand babies die around the time of delivery (0.49 per 1000), continues to cause concern. "The majority of these babies are term and not small for gestational age and therefore may have been preventable deaths."

The dearth of nationwide information means debate about the impact of our maternity reforms in the 1990s remains mired in accusation and innuendo.

Sir Peter Gluckman, a former perinatal physiologist and now the Prime Minister's chief scientific adviser, says New Zealand's maternity system has evolved from antagonism rather than collaboration between doctors and midwives. "We've gone into this period of turf war and continued sniping from different sides." He criticises the lack of monitoring set up to gauge the effect of the reforms. "This is the kind of switch that should never happen in the future without it being monitored. This was a large shift – it should have been piloted."

While by definition birth is "natural", he says, "I think for lots of reasons, the public has come to think that birth is always going to be safe. Sadly that's not the case – it will always have a risk. It's a matter of what level of risk can be avoided and what values people place on minimising that risk. The problem with maternity is that things can go wrong and they go wrong really fast."

Unsurprisingly, he says if his daughter were having a baby, he'd recommend she have an obstetrician. "The risk that really matters is the risk of complications which have long-term effects for either the mother or the child. I rate those risks higher, for my family, over the values related to particular ambiences of delivery."

Farquhar says data from Auckland's National Women's Hospital, collected comprehensively since 1947, don't suggest the reforms have caused a major problem and she doesn't have concerns with the way midwives are conducting births. "Most of the time, the system is working."

And yet Farquhar strongly believes graduate midwives should spend their first year working supervised in hospitals to get more exposure to some of the complications of pregnancy and birth that they may not see during their three-year training course.

The same call has been made often since it was first raised by Wellington coroner Garry Evans in 2005, yet nothing has happened.

Evans, when investigating the deaths of two babies in midwife care, said midwives were increasingly becoming sole providers and looking after more high-risk patients subject to emergencies they may not be prepared for.

One of those babies was Cameron Elliot who died at home on the Kapiti Coast, in April 2003, after suffering spinal damage and asphyxia caused by his head taking 11 minutes to deliver. His mother, Amanda Elliot, told *North & South* of her frustration that eight years on, "nothing's happened".

Elliot, who's since had three healthy sons, says her midwife, who was very experienced, encouraged her to stay at home until she was well into the labour. Although the delivery was meant to be in a birthing unit, labour was so advanced by the time the midwife arrived at midnight, she encouraged Elliot to have the baby at home. She failed to do an internal examination, which would have discovered the breech position, until 5am

Amanda Elliot says her midwife never apologised. "She said nothing could have been done differently. It was one of those things."

– 20 minutes before Cameron was finally born. "She only figured it out when she could see a bottom coming and not a head."

Cameron was born with a beating heart but never took a breath. "I was screaming, crying. Just saying, 'Breathe! Breathe!'"

Ninety minutes later, Elliot held her dead baby in her arms in the back of the ambulance heading through early-morning traffic to Wellington Hospital. "I remember being frustrated the ambulance driver wasn't putting his siren on. I was thinking, 'Come on, we've got to get to the hospital, we've got to get to the hospital, someone has to fix this.' He was dead but I was in complete disbelief."

A fit, 60kg 31-year-old when she became pregnant, Elliot says she'd hoped for a drug-free, "natural" delivery. "I was naive enough to think things didn't go wrong in this day and age."

She says her midwife never apologised. "She said nothing could have been done differently. It was one of those things."

Until we do have a comprehensive data base, other measures must be used to try to determine how successfully the system of maternity care is working. One of these is the tenor of complaints to the health and disability commissioner.

Commissioner Anthony Hill says recurring themes around the 60 complaints received against midwives in the past year have included delayed recognition of risk and subsequent call for help, and a lack of communication and integration when a multidisciplinary team is involved in the birth.

Few complaints end up in findings that the midwife has breached the patients' code of rights. Of 97 complaints received in the two years to June 2010, 21 went to formal investigation and five midwives were found in breach.

It's too soon to know the outcome of the latest 60 complaints. In the same period, 44 complaints were laid about obstetricians, resulting in just one breach of the code.

With nearly 3000 practising midwives and just 225 obstetricians, that represents a significantly higher rate of complaint against the medical specialists, but Hill says themes rather than numbers are important.

The history of midwifery in New Zealand shows there are passionate views on each side, he says, "and it's really important that doesn't get in the way".

"I haven't seen somebody not picking up the phone because they didn't want to involve the medical fraternity. What I have seen are failures to see a problem in time and failures to reach for help in time."

He says while he hasn't gone as far as recommending a hospital-based postgraduate year for midwives, "I do think postgraduate mentoring training needs to be strengthened. We need to enable a culture that encourages a conservative approach in assessing risk and getting help. I'm interested in the culture around communication – and the things that might chill that communication."

Exton and Hooper point to other indications all is not well in our maternity system:

• The Health Select Committee, in response to Hooper's petition, acknowledged a "relative slowing of the decrease in perinatal mortality over the most recent decades".

• A 2008 report by Canterbury University economics lecturer Dr Andrea Kutinova concluded that having a GP instead of a midwife reduced the neonatal mortality rate by 10 per cent.

• Of 30,000 ACC medical misadventure claims from 1992 to June 2005, five per cent were for maternal-related events. Of 23,000 treatment injury claims from 2005 to 2009, six per cent were for maternity events. Says Exton: Given the small number of births compared to all health treatments, this number seems vastly out of proportion.

• An increase in hospital admissions for

GUY FREDERICK

pregnancy complications, from 12.9 per cent of live births in 1999 to 28.3 per cent in 2007.

For College of Midwives' Guilliland, the debate over the quality of midwives is frustratingly, tediously circular and anti-feminist. To call Guilliland defensive is to understate the sense of pent-up fury which colours her responses to the "same old" questions about training and competence.

Of the repeated calls for a supervised, in-hospital post-graduate year for midwives, Guilliland implies the only people suggesting it are doctors and lawyers.

"They're all out of the same establishment system – I do think it's gender... I don't know how we move on because I'm just about sick of it to be honest."

She also reacts with despair to questions about the possible negative impact of the move to direct-entry midwifery rather than the mandatory post-nursing training up to the early 1990s. "The fact you sit there and ask those questions means we've gone backwards because 10 years ago you would not have asked me those questions.

"The problem with those views is the lack of understanding about what midwives go through to be a midwife and also the lack of acceptance that a woman's profession may be highly competent. That it's not medicine and it's not nursing but it is something else and it has a very strong and robust education and monitoring system around it.

"In my view it will never be [seen as] strong enough; no matter what we do those questions will remain. And they remain because the establishment of law, medicine and politics is deeply entrenched in thinking that a women's profession really needs help and my view is that completely it does not. A few other people need help and it's not us."

It's what she saw of how pregnant women were treated when she worked as a midwife 30 years ago that motivated her to try to change the system. "They were lined up in a ward, lying there with nothing on, waiting for someone to come and do a vaginal examination. The doctors never talked to you, there were just six or seven people at end of the bed, and this was your antenatal clinic.

"There was no reason whatsoever to do a vaginal examination other than to teach the doctors. And I just couldn't believe it and I thought no child of mine is going to be put through this."

She says the debate about whether midwives should have nursing qualifications is "totally irrelevant" when what mattered was the quality of the midwifery course itself.

> **"Society relies on doctors being the experts in abnormal and us being the experts in normal."**
>
> **College of Midwives chief executive Karen Guilliland.**

"Are you competent with the education system you're given and I'd say absolutely categorically and completely today's graduate is 100 per cent more competent than I was when I was trained in the hospital system."

One midwife who has a unique take on the quality of midwifery and medical training is Rachel Cassie of Hamilton. Cassie trained as a doctor in the 1980s and spent 15 years in general practice before giving up her practice in 2000 as she juggled career and school-aged children.

In 2005, she decided to retrain as a midwife, qualifying in 2008. After coming to midwifery with "some of the prejudices that exist in general practice", she agrees with Guilliland that the three-year polytech training course is "more than adequate" for graduates to practise maternity care safely. There was a strong focus on the recognition of abnormal pregnancies and labour, and the training was soundly scientifically based.

"I came into it ready to be quite antagonistic if I felt I was not being trained adequately and I remember within weeks thinking, 'This is fine, there's nothing wrong with this.'"

She believes those who criticise midwifery education and practice don't understand what the training involves. She says while her medical training enabled her to slip seamlessly back into a hospital setting, a partner in her practice – a direct-entry midwife with no prior nursing or medical training – did equally well.

Midwifery is not anti-intervention, she says. "It comes from a place of saying, 'Hang on, let's examine the evidence. Let's not have intervention without good evidence.' Perhaps we also live in a world where there's an expectation that we can always have perfect outcomes."

But some other midwives have questioned whether their training equips them well enough for independent practice, at least in the early months. Jennifer Rowan, the Hamilton midwife in the much-publicised Barlow case – in which baby Adam died and his mother Linda needed emergency surgery after the birth – was just seven months out of her training at the time. She told Adam's inquest her practice had "changed heaps" since his death in 2009 and that she did not believe her training was robust enough.

Guilliland says she wouldn't argue with Rowan "if that's her perception. But she's been under huge pressure to say it wasn't robust enough, hasn't she? Everyone in the world is telling her that her training let her down."

She says only two new graduates have appeared before the Midwifery Council in the past five years.

Guilliland says midwives are far better trained than GPs to recognise when pregnancy and birth is departing from the norm. They had to be involved in the antenatal care, birth and postnatal care of 40 women and babies in their final year of training, and if they did not see enough abnormal births, that deficit had to be remedied.

"We are the specialists in the physiology, the anatomy and the behavioural science of normal pregnancy but when you know normal back to front and inside out it means you know when it's not right. Society relies on doctors being the experts in abnormal and us being the experts in normal. Then there's a grey bit in the middle which requires the doctors not to abnormalise everything and us not to normalise everything and sometimes that's not easy because the evidence around maternity care is actually pretty grey."

She says with 90 per cent of women having their babies in hospitals, midwives didn't need another hospital-based year because they were there already. The idea was not feasible because hospitals would be unable to take 200 new graduates a year anyway.

The College of Midwives points to its own feedback forms – it collects about 2000 a month – and the Health Ministry to satisfaction surveys of mothers as evidence that midwife-led maternity care is successful and popular.

But Exton and Hooper of Aim say that until this year, parents of babies who died weren't included in satisfaction surveys. Others point out it's up to the midwife to alert the new mother to the fact a form even exists. The woman we spoke to whose midwife never appeared for the birth this year says she was not told about the opportunity to give feedback – but will now do so.

Above: Jenny Avery photographed just after the last push that launched a new life.

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In straitened financial times, the $40 million over four years set aside in this year's Budget to boost the quality and safety of maternity care suggests Aim's criticisms have been heard.

Health Minister Tony Ryall told *North & South* the government had focused on "fewer, more achievable" initiatives to allay public anxieties about aspects of maternity care. These included developing and strengthening a so-called maternity "data mart" which will integrate information on maternity outcomes. Exactly what data will be collected is yet to be decided, he says.

Ryall is also discussing with the Midwifery Council the persistent calls for all graduate midwives to spend a supervised first year in hospitals. He says the council had to take credit for creating the current mentoring system but "it's not as intense or the supervision as close as people would want".

He says while he wouldn't rule out a hospital-based year, the financial implications were large and he would prefer to strengthen the current mentoring system and would set money aside for that.

Funds have been allocated to pay for regular meetings between health professionals involved in every birth to find out what can be learned. Referral guidelines setting out when care should be transferred between providers have also been agreed between doctors and midwives and will be introduced in August.

Maternity records able to be electronically shared between GPs, midwives, hospitals and obstetricians will also improve the flow of information and are being piloted in two district health boards.

A pilot scheme to encourage better liaison between doctors and midwives for patients with difficult pregnancies is also running in Christchurch.

Ryall says government moves to try to encourage GPs back into obstetrics haven't been "wildly successful".

How Midwives Are Paid

Midwives earn an average of $60,000 to $80,000 a year (according to Statistics New Zealand, 72 self-employed midwives earn more than $100,000). Their income is not tied to their level of experience, as they receive a set rate per birth (so a veteran of many years is paid the same as a new graduate). A snapshot of some of the fees they can claim includes:

Antenatal care
First and second trimester: $300
Third trimester: $290

Labour and birth
First birth: $1090
Subsequent birth: $855

Postnatal services
With inpatient postnatal care: $480
Without inpatient postnatal care: $540

NICOLA EDMONDS

The district health board later apologised for Suze Malcolm's "awful" experience; Malcolm is yet to decide if she will complain to the health commissioner.

For Suze Malcolm and Richard Tait, the trauma of Eddie's birth is fading but is not forgotten. Tait says if he was advising others in a similar situation, "I'd be very risk averse and suggest they think about getting an obstetrician. I have a distrust now of the ability of two parallel systems to work together well in practice when everything is hitting the fan.

"Let's face it, the majority of situations where birth goes normally it works OK. But for the small number of times where things are going wrong, it creates tensions, it creates noise in the system which hinders good on-the-spot decision-making and communication and that's what's required to get it right in these touch and go situations."

Says Malcolm: "I still carry grief with me and I always will. It's triggered when people around me have beautiful birth experiences. I'm happy for them but sad for us.

"On his birthday I'm filled with joy we have him and really sad that we lost the experience of his arrival. We are so grateful he wasn't harmed when he was at risk of being harmed. He's a strong, resilient, calm wee man and he was like that from the minute he came into the world. Some God was on our side that day." +

LABOURING UNDER AN ILLUSION

Anyone needing to be convinced about how often childbirth can go wrong needs look no further than Warkworth mum Ainsley Cole's weekly coffee group.

Three of the five mothers had uneventful deliveries. Two – including Cole – had emergency caesareans and their babies later died. "I think if we left things completely up to nature, babies and mothers would die all the time," she says.

Cole, then 22, was in labour at the Warkworth Birthing Centre seven years ago when daughter Lexi's breech position was identified and she was rushed to North Shore Hospital for an emergency caesarean. "I had two to three hours when I wanted to push but I wasn't allowed to."

Lexi was subsequently born with dislocated hips.

Congenital abnormalities took her life before the age of three.

When second daughter Lucy was born a year ago in North Shore Hospital, her labour failed to progress. Lucy became distressed in the womb and Cole needed a second emergency caesarean.

She now believes women should be able to opt for a 37-week scan to check whether their babies are in the right position for a normal delivery.

Hayley Griffiths was also 22 and living in West Auckland in 2009 when a growth scan revealed her son Kobie was a big baby – he was 4791g when born. She didn't have her usual midwife when she went into labour 10 days overdue – she was on a study day.

Griffiths recalls being exhorted to push hard after Kobie's head was born, but "once his head came out the urge to push went away. I kept saying, there's nothing there, I can't push."

When the specialist arrived, he had to push Kobie back inside her and rush her to theatre for an emergency caesarean. "He was basically born just about dead. They tried for 40 minutes to resuscitate him."

Despite his head being born, Kobie had been unable to breathe because his chest was constricted in the birth canal. Kobie died two days later.

Griffiths says she should have been more informed of the risks of having such a large baby. "I was relaxed throughout the whole thing because no one in my family had ever had problems with pregnancies or births and I thought I'd be like them."

At a meeting with hospital staff later, she was told the problem of shoulder dystocia that killed Kobie was a freak occurrence, and no one was to blame.

Daughter Cassidy, now a year old, was born by emergency caesarean last year, weighing 4252g, and Griffiths is now pregnant with her third child.

She says all pregnant women should get the option of a free consultation with a specialist obstetrician, and for her third baby, she'll book in for an elective caesarean two weeks before her due date. "I don't want to go through that again."

The other three coffee group mums, Michelle Fry, Amy Griffiths (no relation to Hayley) and Jessica Tovine, had straightforward births and positive stories to tell about their midwives.

Fry's baby Tayla was born at the Warkworth Birthing Centre with the help of an "awesome" midwife and Griffiths says her daughter Josie had a "textbook" birth on her due date.

Tovine's Jasmine arrived safely with the help of an episiotomy after a seven-hour labour and three hours of pushing – longer than recommended even for a first baby.

"I think I'd go to a hospital next time. If I'd been at a hospital I wouldn't have had to go through quite so much as I did." +

ADRIAN MALLOCH

Above: Ainsley Cole with daughter Lucy. Left: Cole with Amy Griffiths (at left) and Hayley Griffiths.