IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2012 0463

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
*Section 67 of the **Coroners Act 2008***

I, PHILLIP BYRNE, Coroner, having investigated the death of CHLOE KATHLEEN GENT without holding an inquest:
find that the identity of the deceased was CHLOE KATHLEEN GENT
born on 26 January 2012
and that the death occurred on 5 February 2012
at Royal Women's Hospital, Flemington Road, Melbourne

from:

I (a) PERINATAL ASPHYXIA

Pursuant to section 67(2) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

BROAD CIRCUMSTANCES

1. Baby Chloe Gent was born on 26 January 2012 at 12.47 am to her parents, Emma Kilby and Paul Gent. She was born at her parent's home at 8 Taunton Street, Sunshine.
2. Chloe was Ms Kilby's second child. Ms Kilby's first child, Rubi, had been born in an ambulance on the way to hospital due to a spontaneous precipitous labour.
3. Ms Kilby was referred by her General Practitioner Dr Phan to the Birthing Centre at Sunshine Hospital. Her expected due date was 26 January 2012.
4. In November 2011, at around 20 weeks gestation, Ms Kilby was seen by a consultant obstetrician, Dr Thao Le, who assessed her as a low risk pregnancy and therefore suitable for the home birthing program and also for a water birth. Midwife Sally Phillips was assigned to Ms Kilby as the 'known' midwife.

5. Ms Kilby, in her statement to the court, says that the issues she experienced with the birth of Rubi were raised on a number of occasions with medical staff at Sunshine Hospital. She was told that they were not considered to be risk factors in having a home birth in relation to the birth of her second child.

6. At a group meeting with midwives at the hospital at 36 weeks gestation, Ms Kilby was asked whether she was planning on having a water birth. Ms Kilby indicated that she would like to use a pool. After that meeting Ms Kilby and Mr Gent were given an inflatable pool, liners and a pump to take home.

7. In the week prior to 25 January 2012, Ms Kilby experienced labour-like pain and what were described as irregular strong contractions over a period of several hours before fading out again. She was advised to call the hospital if she experienced contractions five minutely, consistently, for an hour.

8. On 25 January 2012, Ms Kilby attended Sunshine Hospital for her 39 week antenatal appointment. Ms Kilby's blood pressure was elevated but not to a level where hospital policy required a referral to be made.

9. That evening, at approximately 10.50pm, Ms Kilby began experiencing irregular contractions.

10. On 26 January 2012, at around 12.15am, Ms Kilby's waters ruptured spontaneously. In their statement to the court, Ms Kilby and Mr Gent say it was at this point they realised Ms Kilby was in labour.

11. At approximately 12.30am, Mr Gent rang the Midwife Service at Western Health to inform the midwife that Ms Kilby's waters had broken. Mr Gent spoke to Midwife Alyssa Nguyen. Midwife Nguyen asked Mr Gent what colour the liquor (her waters) was. He advised her that it was clear. Midwife Nguyen informed Mr Gent that Midwife Sally Phillips was unavailable as she had worked a double shift.

12. At around 12.38am, Midwife Nguyen rang Mr Gent to advise him that midwife Karina Ireland was to attend in the place of Midwife Phillips.

13. At 12.50am, Mr Gent rang Midwife Nguyen with the news that Baby Chloe had been born a few minutes ago in the birthing pool. When Midwife Nguyen asked about the baby, she was told that the baby was crying and "pinking up". During the call, Midwife Nguyen stated she was able to hear Baby Chloe crying in the background.

14. At approximately 12.55am, Mr Gent received a text message from Midwife Nguyen with the contact number of Midwife Ireland. However, the number sent was incorrect and was actually Mr Gent's number.

15. At approximately 1.25am, Midwife Ireland arrived at the family home. She found Ms Kilby, still in the birthing pool, with Baby Chloe in her arms. Midwife Ireland was immediately concerned about Chloe's colour and 'lack of tone'. She immediately took Chloe out of the birthing pool and commenced neonatal resuscitation. She was assisted by Mr Gent and then by Midwife Veronica Zeinstra, once she arrived.

16. A call for assistance to 000 was made at 1.34am. Ambulance paramedics and MICA (Mobile Intensive Care Ambulance) personnel arrived shortly thereafter at 1.40am. Chloe was intubated by paramedics and resuscitated.

17. Baby Chloe was conveyed by ambulance to the Royal Women's Hospital, where she was admitted to the Neonatal Intensive Care Unit (NICU). MRI scans revealed that Baby Chloe had suffered extensive hypoxic injury to the brain.

18. After a period of intensive treatment, it became clear Baby Chloe's condition was irretrievable and after consultation between the family and medical staff, the decision was taken to withdraw life support on 3 February 2012. Comfort measures were provided.

19. On 5 February 2012, Chloe Gent passed away.

20. At Autopsy, Dr Sarah Parsons of the Victorian Institute of Forensic Medicine (VIFM) found evidence of meconium exposure in the form of meconium staining of the membranes and meconium aspiration in the lungs. Dr Parsons considered this was evidence of intrauterine distress.

21. As part of the autopsy, a separate Neuropathological report was sought from Forensic Pathologist Dr Linda Illes. That report confirmed a profound anoxic/ischaemic insult occurring in the perinatal period.

22. Dr Parsons advised death was:

> *"consistent with a hypoxic ischaemic episode in the perinatal period (at or around the time of birth). No definite placental parenchymal changes were identified that could account for this ischaemia. The perinatal aspiration of meconium and the meconium staining of the membranes make it apparent that this has occurred in utero."*

23. Dr Parsons formulated the cause of death as perinatal asphyxia. I will refer to this issue later in the finding.

24. At the outset, I wish to make it abundantly clear that I do not want to seem as advocating, nor denouncing, home birthing per se. I also made that point at the Mention/ Directions Hearing on 27 August 2015. My primary focus has been to investigate the circumstances of this case and also examine whether appropriate practices, procedures and protocols are in place at Sunshine Hospital to ensure, as best as one can, health and safety of mother and child; this latter issue should be seen as part of the public health and safety perspective of the role of a coroner.

COURSE OF CORONIAL INVESTIGATION

25. I took over carriage of this matter in June 2013. It was clear to me from the outset, particularly as Ms Kilby was involved in the Sunshine Hospital home birthing pilot program, that significant further investigation was warranted. I sought and received in early November 2013 a comprehensive statement (with an attachment) from Associate Professor Glyn Teale, Clinical Services Director, Women's and Children's Services, Western Health. In his statement, Associate Professor Teale addressed a number of specific issues I had invited him to address.

26. The material received from Associate Professor Teale was provided to Maurice Blackburn, solicitors to Ms Kilby and Mr Gent, with an invitation to respond.

27. In late January 2014, I received from Ms Emily Hart of Maurice Blackburn, a six page response providing a number of "comments" in relation to Associate Professor Teale's statement. In broad terms, on behalf of her clients, Ms Hart took issue with a number of Associate Professor Teale's contentions.

28. Subsequently, in mid April 2014, matters raised by Ms Hart were formulised in a five page statement made by Ms Kilby and provided to the Court. Interestingly, Ms Kirby made the following pertinent comment in the penultimate paragraph of her statement:

> *"We feel that this Coronial Inquiry gives Western Health an opportunity to make some significant and important changes to the home birth program that would improve the health and safety of other families taking part in the program."*

My coroner's solicitor, Mr Marc Fisken, made a copy of Ms Kilby's statement to Mr Jayz, Legal Counsel, Western Health, requesting Associate Professor Teale to provide a supplementary statement addressing the eleven (11) points raised by Ms Kilby. I also invited Western Health to provide a copy of the Adverse Outcomes Committee Report (AOC) into the

death of Baby Chloe. Associate Professor Teale had already included the AOC recommendation in his statement of 1 November 2013. I wasn't sure whether a public interest immunity claim would be made.

29. Mr Teng advised that Ms Lisa Ridd of Minter Ellison solicitors, Western Health's insurer now acted on behalf of Western Health. In the event, on behalf of their client, Minter Elison did claim public interest immunity over the report, which as they claimed was in effect a formal root cause analysis; I accepted that claim.

30. Subsequently, I received a supplementary statement from Associate Professor Teale dated 5 June 2014 which, on 19 June 2014, under the hand of Mr Fisken, I made available to Maurice Blackburn.

31. In an endeavour to progress the matter, I listed a Mention/Directions hearing for 26 February 2015. By this time, I formed the view that I would seek an independent expert opinion to assist in the resolution of the contentious issues.

32. I referred the matter to the Coroners Prevention Unit for assistance in considering what issues I wanted the expert to address.

33. Following our protocol, I made a request of the State Coroner to obtain an expert opinion. My request was granted on 4 February 2015 and Dr Bernadette White, Consultant Obstetrician, was engaged to provide an independent report.

34. In a most timely manner, on 17 February 2015, Dr Bernadette White provided an expert report in which she provided specific advice on the issues I wanted addressed. I am grateful to Dr White as it meant the hearing listed for 26 February did not have to be re-scheduled.

35. Presumably in readiness for the Mention/Directions Hearing, Ms Kilby and Mr Gent provided, in collaboration, a further statement canvassing: (inter alia)

    - Antenatal care
    - Education in relation to home birth/ birthing pool
    - Advice as to when to summon the home birthing midwife
    - Sequence of events after spontaneous rupture
    - Summary of concerns.

36. At the Mention/Directions hearing, there was a discussion about Forensic Pathologist Dr Sarah Parson's finding at autopsy of meconium staining. Whilst the detail of Dr Parson's findings on

this issue is very technical and complex, the broad thrust of her position is that Baby Chloe was in distress in utero, probably some hours prior to delivery. On one view, this could be seen as a threshold issue. However, I have been unable to definitely determine what, if that was the case, precipitated that situation; nor have I been able to say, with any degree of comfort, whether the outcome may have been difficult if Baby Chloe had been delivered at home in the presence of a midwife, in or out, of the birthing pool, or indeed in hospital if Ms Kilby had decided to go to hospital. Dr Parsons commented:

> *"The neuropathological findings are suggestive of a profound anoxic/ischaemic insult occurring in the perinatal period."*

The cause of death was clear, however the aetiology of the insult is not; it remains undetermined. That may be a matter for determination in another place at another time.

37. At this first Mention/Directions Hearing, the issue of the appropriateness of Ms Kilby as a candidate for the home birthing program was also raised. Dr White opined that Ms Kilby was assessed as suitable but in light of Ms Kilby's previous precipitous labour, perhaps home birthing was NOT the optimal choice. Ms Hart conceded that although Ms Kilby accepted the suggestion to be involved in the home birthing pilot, whether Ms Kilby was given sufficient information to make an informed choice is debatable. I do not propose to pursue this issue; the fact is Ms Kilby freely accepted entry into the program.

38. Although some progress was made at this first Mention/ Directions hearing other matters were not resolved. However, some issues of contention were isolated and better identified with further investigations to be undertaken.

39. Following the first Mention/Directions hearing, important additional material was provided to the court in the form of statements from Midwife Sally-Anne Phillips, Midwife Bao (Alyssa) Nguyen, Midwife Rebecca McGinty (formerly Vincent) and Midwife Karina Ireland, together with retrospective progress notes by Ms Nguyen and Ms Ireland. Through Ms Hibbins, assisting, Ms Hart provided copies of the birthing plan and other documentation provided by the hospital to Ms Kilby and Mr Gent. Once again, although not resolving various issues of contention, at the second Mention/Directions hearing, important material was available, some of which was critical to the major concerns previously raised by Ms Kilby and Mr Gent.

40. Following the 21 May 2015 Mention/Directions Hearing , becoming aware of matters raised in the additional statements, Associate Professor Glyn Teale made a "further supplementary statement", dated 3 June 2015, in which he addressed the protocols for home birth in place as of

January 2012 and the current protocols at 3 June 2015; they were annexed to his statement as Annexures A and B. Importantly, Associate Professor Teale also advised that the current homebirth information pack provided to clients is "currently under major review of context".

41. In his further supplementary statement, an important concession was made by Associate Professor Teale; he wrote at paragraph 4 of the "further supplementary statement":

> 4. *Instructions not to enter the birth pool in the absence of a midwife.*
>
> *I confirm that Ms Kilby was not advised in writing that she should not enter the birth pool in the absence of a midwife.*
>
> *It had been my understanding that Ms Kilby was verbally advised by the midwife on 10 January 2012 that she should not enter the birth pool in the absence of a midwife. However, I note that RM Phillips (who consulted with Ms Kilby on 10 January 2012) has provided a statement to the Coroner specifically noting that she did not verbally advise Ms Kilby not to use the birth pool in the absence of a midwife.*
>
> *My initial understanding has proven to be incorrect and Western Health accepts that Ms Kilby was not advised (either in writing or verbally) that she was not to use the birth pool in the absence of a midwife.*

42. I finally felt real progress was being achieved and having indicated tentatively, the matter probably did not need to proceed to formal inquest, I listed the matter for a third Mention/Directions hearing, primarily to give that indication and provide the parties with opportunity to dissuade me from that view and to enable them to address any other issue they considered unresolved. The hearing was listed for 27 August 2015.

43. At the third hearing, virtually all contentious issues were resolved, save that Ms Birrell of Minter Ellison for Western Health undertook to take instruction in relation to an apparent inconsistency in the protocols in relation to what should occur if birthing is occurring prior to the arrival of the midwife, particularly who should call an ambulance in those circumstances. The two relevant paragraphs in Western Health's Access and Management for the Homebirth Policy of May 2013 were paragraph 7.2.4 where it was suggested the <u>midwife</u> would call the ambulance whereas paragraph 7.3.2 provides the <u>woman</u> is to call an ambulance if birthing prior to the arrival of the midwife. By way of letter dated 17 November 2015, under the hand of Ms Ridd, Minter Ellison advised that Western Health recognised the inconsistency and proposed to amend their policy. For completeness, I include a short excerpt from Ms Ridd's letter which includes the rationale behind the refined/revised policy:

Western Health intents to amend paragraph 7.2.4 to clearly state that the woman (or member of her family), rather than the midwife, telephone Ambulance Victoria in circumstances where the woman is birthing prior to the arrival of the midwife. This will ensure that the woman or member of her family are able to speak to an ambulance officer during the birth and then an ambulance officer can provide assistance in terms of talking the woman through the birthing process.

Ms Ridd added:

Upon receipt of the Coroner's Determination, Western Health will undertake a final review of the Policy to ensure all of the Coroner's recommendations have been taken into consideration and actioned.

I certainly support that proposal, although I am confident Western Health would address deficiencies in their policies and procedures to ensure the efficacy of its home birthing program.

44. The other outstanding matter from the final Mention/Directions hearing was a concern raised on behalf of Ms Kilby and Mr Gent that Western Health's home birth website, at that time, made no reference to a neonatal death under the home birthing program. In a letter dated 13 October 2015 under than hand of Ms Ridd, Minter Ellison advised that various websites, powerpoint presentations and other materials have been amended now making specific reference to the circumstances of Baby Chloe's death. I am further advised that after liaising with Maurice Blackburn, Ms Kilby and Mr Gent are satisfied that their concerns in relation to these additional matters have been allayed.

45. It seems to me that perhaps the most important issue in relation to the efficacy and success of the home birthing program is COMMUNICATION. At each step of the process appropriate communication is vital. I have wondered in this case what may have occurred if Ms Kilby had been aware that Ms Ireland, the midwife rostered on to assist in the birth, would take in the order of one hour to travel to attend the address. I have wondered what may have occurred if Ms Kilby was aware that she should call an ambulance if birth was imminent and the midwife was not in attendance. I have wondered what may have occurred if Ms Kilby was aware she should not give birth in the water bath in the absence of the midwife. I have wondered whether if Ms Nguyen had been hospital trained in, and aware of, the protocols for home birthing in birthing pools, she would have instructed Ms Kilby not to enter the birthing pool in the absence of the midwife. I have wondered if Ms Kilby had been provided with the correct phone number of the midwife in transit so that she would telephoned have Ms Ireland seeking advice.

46. In some respects it would appear "Murphys Law" prevailed so that in combination, all these issues may have been contributed to the tragic adverse outcome. Although I have at length pondered these and other issues, I am not entitled, nor do I propose, to speculate.

47. I am satisfied the coronial investigation, although somewhat protracted for a number of reasons, has been sufficient to satisfy community expectation. In the final analysis, neither party has urged that I proceed to formal inquest. There is a broad acceptance that I have sufficient evidence to finalise the matter "on the papers" by way of Finding without Inquest. The family's concerns/ questions have been addressed and refinements to practices, procedures and protocols have been undertaken to improve and provide additional safeguards to those participating in the program.

48. I formally find that Baby Chloe Gent, 10 days old, died due to:

I (a) PERINATAL ASPHYXIA

At the Royal Melbourne Hospital on 5 February 2012.

COMMENT

49. The autopsy performed at VIFM by Forensic Pathologist Dr Sarah Parsons was exhaustive, including histology, toxicology, radiology, microbiology and metabolic studies. The placenta was also examined by Dr Virginia Billson at the Royal Women's Hospital. Furthermore, x-rays and CT scans were reviewed at the Royal Children's Hospital by Paediatric Radiologist Dr Timothy Cain. In her autopsy report, Dr Parsons included a number of pertinent comments. While stressing that I take no position in relating to home birthing in water, Dr Parson's made a comment that, after some vacillation, I include in this finding as it may relate to issues of public health and safety; she wrote:

> *"The deceased was born into water. Studies have shown that potential adverse risks of water birth to the infant include potential risk of aspiration and hypoxia increased infection and delay in intervention in the setting of foetal distress.*[1] *Studies from New Zealand have shown that warer birth is associated with a greater level of respiratory morbidity than air birth in low risk babies with respiratory distress."*

[1] Sarah Nguyen. Karl Kuschel, Reteteele. Water birth – a near drowning experience. Paediatrics 2002; 110;411-413.

I direct that a copy of this finding be provided to the following:

Ms Emma Kilby and Mr Paul Gent

Senior Constable Andrea Hibbins

Ms Lisa Ridd

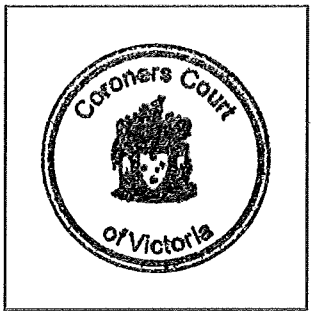
Ms Emily Hart

Dr Louise Owen

Dr Bernadette White

Ms Kathryn Johnson

Signature:



PHILLIP BYRNE
CORONER
Date: 29 February 2016