IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 4851

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of: JOSEPH THURGOOD-GATES

Delivered On:	10 May 2013
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne Victoria
Hearing Dates:	2, 6, 7, 8 August 2012 and 15,18,19, 25 and 26 February 2013
Findings of:	CORONER K. M. W. PARKINSON
Representation:	Dr Paul Halley for Southern Health Monash; Ms Katie Styne for Ms Fiona Hallinan; Ms Alexandra Burt for Ms Thurgood and Mr Gates; Mr Simon Martin for Ms Jan Ireland
Police Coronial Support Unit Assisting the Coroner	Leading Senior Constable Tania Cristiano

I, K. M. W. PARKINSON, Coroner having investigated the death of

JOSEPH THURGOOD GATES

AND having held an inquest in relation to this death on 2, 6, 7 and 8 August 2012 and 15, 18, 19, 25 and 26 February 2013

AT MELBOURNE

find that the identity of the deceased was JOSEPH THURGOOD-GATES

born on 16 December 2010

and the death occurred on 21 December 2010

at Monash Medical Centre, 246 Clayton Road, Clayton 3168

from:

1(a) Global cerebral hypoxic injury; and

1(b) Peri partum asphyxia in a setting of uterine rupture.

in the following circumstances:

1. An inquest was held into the death of baby Joseph Thurgood-Gates who died at the Monash Medical Centre ('MMC') on 21 December 2010.

2. The evidence included statements of witnesses who have been called by the Coroner to expand upon their statements and statements from a number of persons who have not been called. The latter include statements of all attending medical clinicians. The brief also includes expert witness statements, a video recording and medical records. A number of documents setting out the concerns of the family and issues which they sought to have addressed in questioning the witnesses were received by the court both prior to and during the course of the inquest.

3. Whilst I do not refer to all of the material or its contents, I have considered all of this material in coming to my finding in this matter.

4. Witnesses who were called to give evidence were: Ms Kate Thurgood-Gates; Midwife Ms Fiona Hallinan and Midwife Ms Jan Ireland; Obstetrics Registrar Dr Kent Kuswanto;

Obstetrician Dr Peter Neal and Director of Monash Newborn at MMC Dr Clive Andrew Ramsden.

5. The following experts also provided reports and gave evidence: Forensic Pathologist, Dr Yeliena Baber; Forensic Neuropathologist, Associate Professor Penny McKelvie; Neonatalogist, Dr Philip Henschke; Consultant Obstetricians, Dr John Campbell and Dr Bernadette White; Professors of Midwifery, Professor Susan McDonald and Professor Maralyn Foureur.

6. The Coroner is required to the extent possible to establish the cause of the death and the circumstances in which it occurred. In this context, factors which may have contributed to the death were examined in the inquest.

7. These included the circumstances of midwife assisted labouring and attempted delivery of the baby at home and the extent to which this caused or contributed to death.

8. Also examined was the management of the emergency delivery at Monash Medical Centre as the family contended that this caused or contributed to baby Joseph's poor outcome. In particular, the family was concerned that the manner of application and use of the ventouse[1] was prolonged and resulted in subgaleal haemorrhage which caused or contributed to the death.

9. Family also contended that failure of resuscitation measures and procedure at the hospital caused or exacerbated the hypoxic injury.

10. The family also contend that there was a failure by the midwife and to some extent the hospital, to advise of the risks of continuing to home birth and vaginal birth after caesarean ('VBAC'), each of which matter they submit caused or contributed to baby Joseph's death.

11. The MMC contends that the hospital delivery room response was reasonable and appropriate in a circumstance where clinicians were faced with an emergency delivery with no capacity to prepare in advance for the possible complications of the particular delivery. They contend that

[1] An instrument involving the application of suction utilised to assist delivery.

it was apparent that the baby was in distress prior to delivery and upon arrival at the hospital and this had occurred during the course of labouring at home.

12. MMC accepted that the resuscitation measures were compromised by failure to revert to manual oxygenation when it appeared that the ventilation was failing. However, contended that this was not causative or contributory to the death, as baby Joseph was born in a condition and with a hypoxic brain injury, which was not recoverable in any meaningful sense.

13. The midwife, Ms Hallinan, concedes that her advice to the family was unclear and that she should have articulated the risks and her views more clearly. She however contends that the mother was intent upon home birth and that there was little she could do to influence that view. It was submitted that her participation in the home birth was not planned, but rather arose out of necessity and her professional duty to support and assist a patient. Counsel for Ms Hallinan conceded in written submissions that there were aspects of her management of the labouring at home which fell short of the standards required.

14. I turn to consider these matters.

BACKGROUND AND CIRCUMSTANCES

15. Ms Thurgood's past history included two caesarean section deliveries. The first in December 2005 and the second of twins born in December 2008 at MMC. During the course of each of these pregnancies she had been diagnosed with gestational diabetes. In March 2010, Ms Thurgood's pregnancy with her fourth child, Joseph was confirmed with a term date of 29 November 2010 and Ms Thurgood made a booking to deliver her child at the MMC birthing unit.

16. On 25 June 2010, Ms Thurgood attended at the MMC clinic for an obstetric consultation. Dr John Campbell, Senior Consultant Obstetrician met with Ms Thurgood and during a consultation of approximately 45 minutes advised that a caesarean delivery would be the safest option for delivery having regard to the previous history and the risks associated with VBAC.

17. The risks which were explained at that consultation were those of uterine rupture resulting in hypoxic injury to the baby, that rupture was unpredictable in timing and extent and that the labour required continuous monitoring by CTG. Other risks associated with the labouring included placental abruption and risk associated with unstable lie.

18. The statistical rate of rupture advised by Dr Campbell was 2% or 1 in 50. His evidence was that the particular circumstances of each patient is relevant to his assessment and advice and that he relies upon 35 years of experience in applying such statistics and making judgements as to risk. Dr Campbell's evidence was:

> "If the rupture occurs it can have disastrous consequences for the baby and the mother and it is only if you're in a hospital and can be in an operating theatre within 15 minutes of detecting the problem that there is a reasonable degree of safety for the baby. Even in hospital we cannot guarantee that a VBAC after caesarean section will be a safe procedure"[2].

19. Dr Campbell observed that in this context, particularly for a woman with a history of two caesarean sections, a home birth attempt was unwise and that nor would he approve a plan which contemplated labouring at home and moving to hospital for delivery and that he advised as such. He documented that he would agree to support VBAC on the basis that this was Ms Thurgood's choice, noted in this way to clarify that he did not advise such course, it was not his recommendation, however he would support her in her choice[3].

20. Ms Thurgood did not agree with Dr Campbell's statistics and contended that the real rate was .07%. Dr Campbell in his evidence stated that the risk increased with the number of pregnancies and prior caesareans.

21. The evidence is that Ms Thurgood did not accept Dr Campbell's advice as to either caesarean or hospital delivery, and did not consider it reliable as she disagreed with his statistical risk assessment.

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[2] Transcript page 708.

[3] Dr Campbell Transcript page 762.18.

22. In August 2010, Ms Thurgood engaged a private midwife, Ms Fiona Hallinan, for the purpose of assisting her to undertake a VBAC at home. Ms Thurgood wished to avoid medical intervention in her pregnancy, labouring and birthing and sought to minimise what she regarded as any unnecessary monitoring during the course of her pregnancy.

23. Their first consultation occurred on 26 August 2010 at 26 weeks gestation. The consultation did not document the matters discussed however I am satisfied that Ms Thurgood expressed a desire to undertake VBAC at home, after two previous caesarean sections. She reported upon the consultation with Dr Campbell and her views about the risk statistics. Ms Hallinan did not at that or in any of her consultations with Ms Thurgood, take issue with Ms Thurgood's analysis of the risks or the correctness of her views as to Dr Campbell's risk analysis.

24. Ms Thurgood stated that the birth plan involved birthing at home, that this was the reason why she approached and engaged Ms Hallinan. She stated that she had difficulty finding a midwife who was prepared to assist her to have a VBAC at home and Ms Hallinan had indicated that she would support her home birth.

25. Scans conducted at 34 weeks confirmed the presentation to be cephalic, not breech. There were no placental abnormalities identified.

26. Ms Thurgood continued to consult with her midwife for ante-natal care and she also attended some appointments for medical review at MMC.

27. On 17 September Ms Thurgood, her partner Mr Gates, Ms Hallinan and Ms Ireland attended at an appointment at MMC with Obstetrician Dr Jude McNaughton to discuss the options which may be available to Ms Thurgood should she decide to have the baby at MMC.

28. There is disagreement between Ms Thurgood and Ms Hallinan, about the purpose and context of the meeting, however the outcome of the meeting was that Ms Thurgood was unhappy that all of her preferences were not able to be accommodated by MMC.

29. Ms Hallinan states that at this point it became clear to her that it was unlikely that Ms Thurgood would be prepared to deliver her baby at hospital and that the baby was likely to be

born at home. Ms Hallinan states that she had reservations about this intention however she did not express those reservations to either Ms Thurgood or Mr Gates.

30. The evidence is that Ms Thurgood advised Dr McNaughton on that occasion, that she wanted it noted that she did not wish to again be advised of the risk of uterine rupture as she considered that the sole purpose of this advice was to 'scare her' into a caesarean and/or hospital delivery. This instruction had also been conveyed to Ms Hallinan. Dr McNaughton reiterated that it was her obligation and that of the other clinicians to advise of the risks.

31. On 9 December 2010, when the pregnancy was 41+ weeks, 10 days past due date, Ms Hallinan recommended that Ms Thurgood attend at MMC for foetal monitoring however Ms Thurgood declined, advising that she would consider doing so at 14 days past her due date.

32. On Monday 13 December at 42 weeks gestation, Ms Thurgood experienced an ante-partum bleed and attended at MMC where she was seen by obstetrics registrar Dr Peter Neil. Ms Hallinan was present at the consultation. Foetal monitoring was normal and ultrasound did not identify any abnormality of the placenta. Dr Neil was unable however to establish the cause of the bleeding.

33. The examination initially identified that the baby was in breach position. Dr Neil recommended hospital admission and a caesarean delivery and again raised the issue of the risks associated with VBAC, in particular uterine rupture and hypoxic injury to the baby.

34. Dr Neil's evidence was that in view of the risks of uterine rupture and other complications with a two week post term delivery in a woman with two previous caesarean deliveries, caesarean delivery was desirable. He stated however that if VBAC was to be attempted, it was necessary for the baby's and the mother's safety for this to occur in the hospital with careful and if necessary continuous monitoring of the baby during the course of the labour and the capacity to intervene quickly if required.

35. Continuous monitoring included the use of CTG which enabled monitoring of foetal heart rate in order to identify early any incidents of foetal bradycardia and ideally this would have been initiated as soon as possible after the labour commenced. I am satisfied that this advice was

provided to Ms Thurgood and that this advice is similar to that provided to Ms Thurgood earlier by Dr Campbell.

36. Ms Thurgood again declined caesarean intervention. The baby resolved to cephalic presentation. After discussion with Ms Hallinan, Ms Thurgood agreed to be admitted to the MMC overnight. She remained in the hospital for two days until the bleeding resolved.

37. Dr Neil continued to advise that a caesarean delivery would be safest option for the baby and for mother and this advice was provided on at least two further occasions, including on a ward round on 15 December 2010. The fact that the baby had resolved to cephalic presentation was not a matter which altered his advice as to the advisability of caesarean section delivery.

38. Ms Hallinan and Ms Thurgood met at the hospital on 14 December 2010 and in their discussions Ms Hallinan states that she encouraged Ms Thurgood to remain in the hospital to deliver the baby. Ms Thurgood does not recall the conversation in these terms. In any event the language which was used was contorted and imprecise. Ms Hallinan stated that she advised Ms Thurgood: *"she should remain in hospital until the baby is born and to remain in hospital until it was deemed that all was safe"*. In response to questions from counsel for the family, Ms Hallinan stated that she talked to Ms Thurgood extensively about staying in another night "*until it was deemed that all was safe"*.

39. I understand Counsel for Ms Hallinan submissions[4] to be that as it was never deemed all was safe, this advice should reasonably be regarded and have been understood by Ms Thurgood as advice that she should stay in hospital for labouring and birth.

40. However I am satisfied that it was never put to Ms Thurgood in those precise terms or with that clarity by Ms Hallinan and it is not surprising that she did not understand that was the advice being given by Ms Hallinan.

41. Ms Thurgood left hospital on the morning of Wednesday 15 December 2010. She was keen to leave the hospital, notwithstanding the advice she had received from Dr Neil. I am satisfied that Dr Neil did not oppose the discharge in the belief that Ms Thurgood had agreed that she would return to the hospital immediately if she identified reduced foetal movement, when

[4] Submissions Ms Stynes - Paragraph 50.

labour commenced or when the membranes ruptured. A further appointment for foetal monitoring was made for Friday 17 December 2010.

42. Dr Neil's evidence was that whilst he would have preferred Ms Thurgood to remain in the hospital, with regular monitoring, he was reassured by her agreement that she would return when labour commenced or in either of the other circumstances. It appears that Ms Hallinan became aware that Ms Thurgood had discharged from hospital on 15 December 2010. Ms Thurgood did not convey this criteria to Ms Hallinan and Ms Hallinan did not make any inquiry as to what had been discussed with the doctors upon discharge.

43. At 4pm on Thursday 16 December 2010, Ms Thurgood telephoned Ms Hallinan to advise that the labour had commenced. She was at home with members of her family. Ms Hallinan did not advise Ms Thurgood to proceed to the hospital. The hospital was not notified the labour had commenced and despite her undertaking to Dr Neil, Ms Thurgood did not go to the hospital.

44. At approximately 6pm, Ms Hallinan arrived at the Thurgood-Gates home and from that time assisted in the labouring and attempts to deliver the baby. Upon arrival, Ms Hallinan did not advise Ms Thurgood that she should attend at the hospital. Her examination at that time described that contractions were mild in nature and that the foetal and maternal observations were within normal range.

45. Labouring continued in a birthing pool provided by Ms Hallinan. At approximately 8.30 pm labour intensified and the head was on view behind membranes. No steps were taken to advise the hospital of the commencement of labour or attempt to arrange for transfer to MMC.

46. Ms Hallinan's evidence was that she formed the view that the birth was imminent and telephoned for the assistance of a second midwife, Ms Jan Ireland. Ms Ireland then attended the home approximately 10 minutes later, arriving at approximately 8.50pm.

47. Present and assisting in the management of the labour by this time were Ms Hallinan, Ms Ireland and Ms Thurgood's sister, Ms Megan Young, who was also a recently registered midwife.

48. The midwifery documentation of the labour is limited and largely retrospective. There was limited intermittent monitoring of the mother and the monitoring of foetal activity was limited to visual, stethoscope and hand held Doppler device as no CTG monitoring was available. There does not appear to be any record of the position of the foetus during the course of the second stage of labour as would be anticipated.

49. A video of the labouring at home provides some assistance in relation to the course of the labour and the timing of events during the labouring at home. The times however are approximate.

50. At approximately 9.00pm the foetal heart rate is identified as dropping to 100bpm, it having earlier been noted as generally at 130 to 140bpm after each pushing urge. This was attributed by Ms Hallinan to an event known as head compression. At about this time there was rupture of the membranes and a bright show. The foetal heart rate after this time never recovers to baseline.

51. At approximately 9.15pm, a further and persisting deceleration in the foetal heart rate was detected. The video (the expert consideration of which I set out in some detail below) identifies that from 9.15pm until 9.35pm, the latter time being the first advice to Ms Thurgood that there was a need to go to hospital, there was a persistent foetal bradycardia, which was attributed by the midwife to 'head compression'[5].

52. It is not possible to ascertain precisely when the foetal bradycardia commenced as there was a 15 minute time lapse between the foetal heart reading at approximately 9.00pm and the next reading at 9.15pm, however by 9.15pm foetal bradycardia was identified by the midwife as persisting. The foetal heart rate was identified as 60, 40, 60bpm at this time.

53. Throughout this period Ms Thurgood was complaining of dizziness. The midwife during this time was having some difficulty locating a foetal heart rate. This difficulty continued. There was no monitoring of maternal blood pressure during this time.

54. At approximately 9.36pm, in the context of persisting foetal bradycardia and failure, despite further attempts, to progress the delivery, Ms Hallinan advised Ms Thurgood that it was

[5] Video recording of labouring at home and midwifery notes.

necessary to transfer to the MMC. Some further time passed before transfer commenced and attempts to deliver the baby continued in this further period.

55. Ms Ireland, telephoned the hospital to notify that Ms Thurgood was on her way. Hospital notes record that this telephone call was received at 9.50 pm.[6] Ms Thurgood was transported from her home to the hospital in Ms Hallinan's private vehicle as it was considered that this would be quicker than by ambulance. Ms Hallinan stated that the drive to the hospital took three minutes.

56. I am satisfied that during the course of the labouring at home and prior to approximately 9.36pm on 16 December 2010 neither Ms Hallinan nor Ms Ireland provided any advice to Ms Thurgood that she should attend at the hospital.

57. Upon arrival at MMC she was transferred immediately to the delivery unit. The time was noted as 9.55pm. The time which had passed since identification by the midwife of persisting foetal bradycardia was now in excess of 40 minutes. The time which had passed since the onset of labour at home was now six hours.

58. Obstetric Registrar Dr Kent Kuswanto attended to the delivery. Owing to the urgency of the presentation he was not able to be fully informed as to the history. A ventouse extraction was required and after two failed attempts, the third attempt after episiotomy was successful.

59. At 10.16pm Joseph was born in a very poor condition. His condition was described by paediatric registrar Dr Raciebe as:

> "Flat at birth, unable to detect HR(heart rate), initial gasp then apnoeic, cords visualised under direct vision, meconium noted in oropharynx, suctioned and intubated 1 -2 minutes, cardiac compressions x 3 cycles, HR >100/min cardiac compressions ceased"[7].

60. As noted resuscitation measures were commenced and Joseph was intubated and successful ventilation achieved at approximately 1-2 minutes after birth. Apgar scores are assigned as 0

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[6] Inquest Brief - Medical records (maternal) page 197.

[7] Inquest Brief – medical notes page 31.

at 1 minute, 3 at 5 minutes, 0 at 10 minutes and 3 at 12 minutes. The umbilical cord lactate is documented as being 13.7mmol/l[8].

61. At approximately 5 minutes after birth, paediatric registrar Dr Padmanabhan became concerned that the endotracheal tube was placed too far into the trachea and repositioned the tube, however it appears that the tube was dislodged from the trachea and therefore mechanical ventilation was no longer effective.

62. As Joseph was by this stage in a resuscitation cot, Dr Padmanabhan initially concluded that the cot was not operating properly, rather than assuming that the intubation had failed. The cot was replaced, however manual alternative oxygen supply was not initiated in accordance with failed intubation or resuscitation protocols. The notes record that breaths and cardiac compressions were continued throughout the period of failed ventilation [9]. At approximately 6- 9 minutes after the repositioning of the endo-tracheal tube, it was established that the tube was placed in the oesophagus and not the trachea. Joseph was re-intubated and full ventilation was restored. Family contend the period of failed ventilation was up to 19 minutes, however I do not accept that this is the case having regard to the medical records and the evidence of Dr Ramsden and Dr Henschke as to their interpretation of the notations and the medical notes[10].

63. Joseph was transferred to the neonatal intensive care unit at 10.40pm.

64. Shortly after Joseph's delivery, Ms Thurgood's condition deteriorated and she experienced a life threatening post partum haemorrhage. She was transferred for emergency surgery which identified uterine rupture. After extensive surgery Ms Thurgood was admitted to the intensive care unit.

65. CT scan and MRI examination revealed that Joseph had sustained severe hypoxic brain injury which was incompatible with meaningful survival. Neonatal paediatrician and Director of

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[8] Inquest Brief – medical notes page 36.

[9] Inquest Brief Medical record Folder 2 page 205 and 206.

[10] Exhibit 17 – Statement Dr Andrew Ramsden at page 2 and Dr Henschke - Transcript 15 February 2013 at page 324 – 326 and 328 and Inquest Brief medical notes at pages 197, 203- 6.

Monash Newborn, Dr Andrew Ramsden reported that clinically, Joseph had evidence of having suffered profound perinatal asphyxia, resulting in multi organ injury. His heart was compromised with evidence of poor contractility on functional echocardiography, hypertension requiring a period of intropic support, elevated triponin, a marker of cardiac ischaemia and his renal function was compromised.

66. Imaging of the brain by cranial ultrasound examination on 17 December 2010 and 20 December 2010 showed evidence of diffuse brain oedema consistent with severe hypoxic ischaemic injury affecting the cerebral cortex, both cerebellar hemispheres and the basal ganglia. There was also transtentorial herniation of the brain. After discussion with family, life support measures were discontinued and Joseph died on 21 December 2010.

67. An autopsy was conducted by Forensic Pathologist Dr Yeliena Baber who stated that the cause of death was 1(a) Global cerebral hypoxic Injury and 1(b) peri partum asphyxia. Dr Baber commented:

> "In my opinion death is directly due to catastrophic global ischaemic brain injury as a result of hypoxic in the peri-partum period. It has not been possible to be specific with regards to the timing of this injury. I agree that it is likely to be due to uterine rupture resulting in a reduced or absent placental blood flow to the baby during labour and delivery, however without the placenta it has not been possible to comment on any hypoxia prior to the delivery. It has not been possible to ascertain time of injury from the examination of the brain".

68. The Forensic Pathologist and the Forensic Neuropathologist commented further upon the nature and cause of the ischaemic brain injury and its relationship to the subgaleal haematoma in their oral evidence. They did not consider that it was contributory to death. This evidence is considered later in this finding.

KNOWN RISKS OF VBAC AND HOMEBIRTH IN THIS PREGNANCY

69. Each of the experts, medical and midwifery agreed that there were significant risks of VBAC in relation to the pregnancy and that contra-indications for homebirth include post term pregnancy of more than 42 completed weeks of pregnancy and previous caesarean delivery.

70. Dr White stated that the factors relevant to this pregnancy were: Previous caesarean birth x 2; Previous post partum haemorrhage; Post term pregnancy of more than 42 weeks completed gestation; Failure of head to engage at full term (in this case unstable lie at greater than 42weeks gestation) and vaginal bleeding at 42 weeks and 2 days gestation.

71. I accept this evidence.

THE VIDEO RECORDING OF THE EVENTS ON 16 DECEMBER 2010 AND MATTERS TO BE CONCLUDED FROM THAT DOCUMENT

72. A video of the labouring at home which became available during the course of the proceedings assisted the court and the expert witnesses in understanding the course of the labour and the timing of events as they unfolded.

73. The expert witnesses were asked to review the video and to provide a report upon their observations as to the progress of the labour. Dr White, Dr Henschke and Dr Campbell provided comprehensive chronology of the events viewed which largely concurred as to the critical events. I accept that evidence as an accurate analysis.

74. The recording is in two parts. As real time is not identified or stamped on any part of the video the analysis is based upon the period of time elapsing during the screening. The commencement times are approximate only. The first part commences at approximately 8.17pm and runs for a period of 50.11 minutes. The second part commences at approximately 9.07pm and runs for a period of 40:05 minutes[11].

75. The first part of the recording identifies a bright show whilst in the birthing pool. It also shows a period of approximately 40 minutes where the foetal heart rate is apparently normal, including up to the period around 8.45pm or 8.55pm. After that time there is greater difficulty in obtaining the foetal heart beat by Doppler.

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11 The actual commencement time is not noted on either of the recordings, however on occasions those present make reference to real time. At 38.33minutes into the first recording the actual time is verbally noted as 'five to nine'. It appears therefore that the first recording had commenced 38 minutes earlier at approximately 8.17pm on 16 December 2010.

76. At about 8.55, Ms Thurgood complains of feeling dizzy and does so on at least one further occasion in the first recording. The first recording ceases at 50.11 minutes. Approximately 3½ minutes passed from the last record of the foetal heart rate at approximately 9pm. It is unclear what period of time passed before the recording resumes, however having regard to the continuity of the activity in the room it does not appear that it was significant.

77. The second recording commences at about 9.07pm and runs for a further 40 minutes and is able to be logged in minutes and seconds as follows:

Time into the recording	Observation
00.20	The foetal heart is checked but is not readily audible.
07.15	Ms Thurgood is assisted out of the pool and is kneeling on the floor.
08.40	The foetal heart is checked but is not audible.
11.06	Vaginal examination is performed and there is a comment "its just there" referring to the baby's head.
12.12	Comment that 'made super progress over 15 minutes, your baby's head is there".
12.57	The FHR is slow. Ms Thurgood continues to push with contractions.
15.13	FHR is slow.
18.30	FHR is slow.
20.00	FHR cannot be heard.
21.30	FHR cannot be heard.
22.42	FHR cannot be heard.
23.38	Comment is made: "Need to get that baby out".
24.16	Foetal heart check – Comment "baby's got a head squeeze".
25.54	Comment "no doubt it's going to come out".
27:45	Appears to be difficulty in hearing FHR.
30.30	Comment " I want to hear this baby, everything's Ok". There appears to be ongoing difficulty in hearing the FHR. Further comment "very common when the head is low."
31.55	Moves to couch and lies on side actively pushing.
33.22	Comment "baby's alive". Further conversation content unclear.
33.48	Comment "Let the labour ward know".
34.36	Heart rate audible but slow. Comment that Ms Thurgood will have a vaginal birth and discussion about cars to transport her to hospital.
37.40 & 38.50	Further attempts to obtain FHR but difficulty hearing the FHR.
40.05	Recording ends.

78. In addition to the noted events there were incidents of blood loss and complaints of maternal dizziness, both in the first and second recording.

79. Dr White observed that about 12 minutes into the second part of the recording, the foetal heart beat sounded slow to the viewer and at times it appeared that there was difficulty in hearing the foetal heart and that it appeared that it was another 20 minutes after that time before plans were made to move Ms Thurgood to MMC.

80. Dr Campbell comments that at about 12.10 minutes into the second part of the recording, the foetal heart was audibly slow and the foetal heart rate was recorded for a short time only. He stated that when a midwife detects a slow foetal heart rate in any labour, it is essential to continue to listen to the heart to determine how long it takes for the heart rate to return to normal. He stated that the appropriate practice in absence of a CTG monitor was to use the Doppler to continue to listen in order to determine the duration of the slow rate. There was no evidence of continuous listening or recording of the duration either on the video or in the notes.

81. Dr Henschke stated whilst Ms Thurgood was in the pool, (in the first part of the recording at approximately 8.47pm) it appeared to him that there was evidence of foetal distress when after spontaneous membrane rupture the midwife attempts to auscultate the foetal heart.

82. Dr Henschke observed that he was unable to hear a foetal heart rate at this time and that a person stated: *"I think we have got head compression"*. He observed that over a time period of 15 minutes from this statement, it appeared that there were a total of 6 attempts to auscultate the foetal heart. He stated that on five occasions he could hear a foetal heart of approximately 100 to 120bpm and on one occasion he states that the recording appears to be consistent with a foetal heart rate of 60 to 80bpm.

83. The key events to be understood from the recording are: Evidence of foetal bradycardia at and prior to about 9pm and of persisting foetal bradycardia from at least 9.15pm; evidence of dizziness in the mother; blood loss on several occasions during the labouring; intermittent, not continuous monitoring of the foetal heart rate and infrequent monitoring of mother's blood pressure or heart rate.

INDICATIONS FOR TRANSFER TO HOSPITAL

84. The expert medical evidence, which I accept, was that that the labour required continuous monitoring by CTG, that labouring should not have continued at home, and that during the course of the labour there were a number of events occurring during the labouring at home which indicated immediate and urgent transfer to the hospital was warranted.

85. Professor Foureur stated that it is not uncommon for uterine rupture to be silent and that obvious indicators may not always be present. Professor Foureur stated that the persisting foetal bradycardia together with a number of other concerning signs including pain in hip and thigh, small gush of blood at onset of second stage and lack of significant progress in the second stage of labour were all signs that transfer to hospital should occur. The foetal bradycardia was a clear indication for a rapid assisted delivery which could only happen in hospital, irrespective of the cause of the bradycardia[12].

86. Dr White stated that whilst other factors led her to conclude that the bleed was not a uterine rupture at that point in time nevertheless:

> "fresh vaginal bleeding is a concerning symptom in a woman labouring who has had a previous caesarean section, as it may be a warning sign of uterine rupture and would warrant careful assessment of maternal and foetal well being".

87. Professor McDonald and Dr Campbell stated that these factors were an indication for immediate transfer to hospital.

88. I am satisfied that there were indications during the course of the labour shown on the recording, that immediate transfer to hospital was necessary. These included the persistent foetal bradycardia, the difficulty in locating the foetal heart beat and inability to continuously monitor in the absence of CTG, the mother's complaint of dizziness and the bright show at 27.40 minutes on the first recording (approximately 8.40pm) which may have been a warning sign of uterine rupture and warranted careful assessment in a hospital setting.

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[12] Exhibit 21 Supplementary report - Professor Maralyn Foureur dated 10 October 2012.

EXPERT OPINIONS AS TO CAUSE OF DEATH

89. The expert medical evidence was that the cause of death was intra partum hypoxia secondary to uterine rupture.

90. In the pathologists report, Dr Baber commented that meconium was identified within alveoli which whilst not overwhelming, the fact that the baby had meconium and squamous cells and lanugo hair deep within the alveoli, indicated that the baby had been distressed and gasping in utero before actually being delivered. Her evidence was that the most likely cause of the catastrophic global anoxia or ischaemia was due to a uterine rupture prior to delivery. Dr Baber's evidence was:

> "Yes I think that there has been some catastrophic event which has caused this baby to become hypoxic and that would be consistent with rupture"[13].

91. Dr Henschke stated:

> " Having regard to the documentation provided by Ms Hallinan and the viewing of the birth video there is clear evidence of a period of foetal bradycardia (80bpm or less) without recovery to baseline for a period of at least 40 minutes. In this clinical setting it is my opinion that this infant sustained a severe and prolonged hypoxic insult during the second stage of labour. The subsequent diagnosis of uterine rupture with broad ligament haematoma in Kate Thurgood makes it highly likely that the uterine rupture was likely to have been a significant contributing factor to the events that resulted in this severe and prolonged hypoxic/ischaemic event"[14]

92. Dr White stated: The post mortem indicated the cause of death to be global cerebral hypoxic injury; peri partum asphyxia. This is most likely to be due to uterine rupture. Post maturity may have been a possible contributing factor. It is possible that undiagnosed gestational diabetes was a factor given that Ms Thurgood's two previous pregnancies were complicated by diabetes and the baby was macrosomic. [15]

93. Dr Campbell stated:

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[13] Transcript 6 August 2012 at page 46.7.

[14] Exhibit 13 – Supplementary report dated 3 September 2012 page 5.

[15] Exhibit 26 – Report Dr Bernadette White dated 15 May 2012 and

"I consider that the cause of death of JTG was intra partum hypoxia secondary to uterine rupture which occurred during labour. It is not possible to definitively state a time of rupture but the development of foetal bradycardia is an important sign of possible uterine rupture and in hospital management, is used as an important indication to proceed rapidly to delivery"[16].

EVIDENCE AS TO ONSET AND TIMING OF THE UTERINE RUPTURE AND CONCLUSION AS TO TIMING

94. Dr Campbell, Dr White and Dr Henschke expressed the opinion that the most likely time for onset of the uterine rupture was during the period of the foetal bradycardia and that the hypoxic injury likely occurred at this time. That is during labour and before delivery.

95. Dr Campbell commented that the persistent foetal bradycardia was an indication that uterine rupture most likely began prior to Ms Thurgood moving to hospital[17].

96. Professor Foureur stated that the foetal bradycardia was a possible indicator of uterine rupture and that in her opinion, whilst she could not be definitive, that it was likely that this was when the rupture occurred. Her view was that it may have also been indicative of placental separation and this also required immediate response. Professor Foureur stated that she would have *"been very suspicious that there was a uterine rupture if I was there with foetal bradycardia"*. She was also of the view that placental separation from the uterine wall may also have been indicated and this would also mean that the baby was not well oxygenated[18].

97. Professor McDonald expressed the opinion that there was a possibility that the uterine rupture may have commenced at home and that precipitated a significant and sustained foetal bradycardia resulting in perinatal asphyxia[19].

98. Dr Kuswanto noted that at hospital Ms Thurgood's recorded heart rate had at times been significantly elevated, in the order of 150 beats per minute. He stated:

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[16] Exhibit 24 – Statement Dr John Campbell dated 5 September 2011.

[17] Exhibit 25 – Statement Dr John Campbell dated 14 December 2012.

[18] Transcript dated 25 February 2013 at pages 614.16 and 615.10.

[19] Exhibit 23 - Statement dated 24 August 2012 at point 2(a).

> "This is a higher level than what I would normally expect to see in response to the pain associated with labour. A possible explanation for the tachycardia is that Kate's uterine rupture had already occurred. The possibility that Kate's uterine rupture had occurred prior to presentation to the hospital would also explain why, notwithstanding Joseph's head was so low, there was difficulty expediting delivery – because Kate's contractions would not be as efficient or as strong as expected had she suffered a uterine rupture."

99. His evidence was that the ineffective contractions, together with the tachycardia was an indication to him that the rupture had already occurred.

100. Dr Kuswanto's evidence and clinical notations[20], which I accept, was that the placenta was located in the vagina and did not require active manipulation to remove post delivery of the baby. This also leads me to conclude therefore that his albeit necessary interventions were not a cause or contributor to the rupture. The pain described by Ms Thurgood at about this time, may have been the complete uterine rupture.

101. I am satisfied that the uterine rupture did not occur as a result of any act or omission on the part of Dr Kuswanto, but rather it was a complication for which Ms Thurgood was known to be at significant risk and that the rupture occurred in this context.

102. Whilst it is not possible to precisely determine the timing of the uterine rupture either full or partial, I am satisfied that the rupture likely occurred during the course of the labouring at home and prior to the delivery at hospital for the following reasons:

- The foetal distress was evident from the foetus becoming bradycardic and bradycardia persisting;
- The labour did not progress, despite advancing to second stage at approximately 8.30pm;
- Mother had been complaining of dizziness throughout the second stage of labouring;

[20] Inquest Brief Medical records Folder 2 at page 210 and Transcript of evidence dated 2 August 2012 at page 20.

- Whilst there was no evidence of palpation of the uterus during the period of labouring at home and upon arrival at MMC the contractions were observed by Dr Kuswanto to be less effective than expected at that stage of labour.

- Ms Thurgood was noted to be tachycardic during the delivery at hospital and it appears from the evidence, that a heart rate of 150bpm at arrival at MMC, initially thought by the delivery room team to be the baby, was in fact maternal heart rate. Dr Kuswanto described this as high even in the context of the stage of labour. Tachycardia may be an indication of a uterine rupture having occurred or in the process of occurring.

- Bleeding was apparent on several occasions, which, whilst not necessarily indicative of rupture in all cases, was concerning in the context of the other indicia. This is notable in the context of Ms Hallinan's statement that she had advised Ms Thurgood that any unexplained bleeding before labour or in labour would need immediate transfer to hospital and that she could not stay home for labour let alone birth if there was blood loss[21].

- The evidence is that it is possible that the position of the baby acted as a tamponade and once the baby was delivered the haemorrhage became apparent[22].

- Each of the expert witnesses have expressed the opinion that uterine rupture was the most likely explanation of the onset of the bradycardia at home.

DELAY IN TRANSFER AS A CONTRIBUTING FACTOR TO DEATH

103. After reviewing the recording Dr Campbell expressed the view that the lack of adequate response to the first detection of a slow foetal heart rate and the continued disregard for the possible significance of persistent or repeated foetal bradycardia was a significant departure from acceptable midwifery practice.

[21] Exhibit 6 - paragraph 42.

[22] Exhibit 23 – Additional Report - Professor Susan McDonald point 2 (b).

104. Dr Campbell commented that the failure to transfer to hospital immediately upon the incident of foetal bradycardia, was poor management in the context of the known risk. He was of the opinion that the delay was a likely contributing factor in the death.

105. Professor McDonald stated:

> "In my opinion the failure to transfer Ms Thurgood to hospital in early labour set in train a sequelae of events, and had the recommended course of admission early in labour been implemented, the outcome would not have been so tragic for the baby or Ms Thurgood and her family".

106. Some issue was taken as to whether foetal bradycardia was definitive in establishing that uterine rupture had occurred. It was conceded by the experts that it not definitive. The evidence is however that it 'may be indicative' as also may be the bleeding during the labour and that the response is required to the possibility of such an event.

107. In her initial evidence, Ms Hallinan stated that the small show during the labouring at home was not regarded by her as significant as it was a common occurrence. Ms Ireland agreed with this evidence. However Ms Hallinan later conceded that it could be indicative of a possible uterine rupture and that this could not be entirely excluded. This evidence is also to be considered in the context of her evidence that she advised Ms Thurgood on 14 December, that any bleeding meant a requirement to go to hospital and that delivery could not occur at home.

108. In the face of the risk profile of this patient, one would have expected that a prudent response would be to assume the worst. If there was any risk that these features were possible indications of uterine rupture, the response should have been immediate transfer to hospital.

109. This is not a case of 'in retrospect' or with 'the benefit of hindsight'. The risks were known in advance to all of the clinicians, including the midwife on her own evidence and were not so small as to have been reasonably disregarded.

BABY'S CONDITION AT BIRTH AND THE SIGNIFICANCE OF THE AGPARS, CORD LACTATE AND THE TIMING OF THE LACTATE.

110. All experts agreed that Joseph was in extremely poor condition at birth with an AGPAR score of 0 at 1 minute, 3 at 5 minutes, 0 at 10 minutes and 3 at 12 minutes. The score of 0 at birth

indicated that immediately after birth Joseph had no detectable heart rate and no other detectable signs of life.

111. Dr Henschke's evidence was that whilst medical intervention and respiratory support may result in an alteration to the baby's colour and heart rate respiratory support, these 'improvements' are not evidence that there has been a recovery or a reversal of the profound hypoxic injury. I accept Dr Henschke's evidence.

112. Cord lactate readings which were untimed were recorded as 13.7 and 13.3 and 27 in documentation transferred to neonatal intensive care unit. Dr Henschke commented upon the significance of the cord lactate in assessing the baby's condition at birth. His evidence was that the cord lactate reading of 13.7 was evidence of profound hypoxic injury prior to birth. He stated:

> ' And in that context, and the ultimate ischaemic or hypoxic injury that was identified, is that consistent with the cord blood gas?---Absolutely. The high blood lactate is generated as the foetus is attempting normal metabolism with insufficient oxygen, a bi-product of that is lactate, and so dramatically elevated lactates in that situation can only represent a prolonged period of inadequate oxygenation at the tissue levels in the foetus. The only other potential cause of that is very rare metabolic abnormalities in the foetus and even in those circumstances, because the placenta is doing such a wonderful job under normal conditions of removing waste products, you don't identify the abnormal findings at the time of delivery. It's only as hours and days pass on that you start to identify that there are significant metabolic abnormalities. So I – in my experience I can't think of another cause for a high blood lactate taken from a cord sample other than prolonged hypoxic ischemic process prior to the birth of the baby'[23].

113. Dr Henschke explained why the time at which the lactate was taken, if it were in issue, was not significant in this case:

> 'If I can just have a brief opportunity to just go over lactate and how it's produced, it may change people's ideas about the significance of a cord snapping. Lactate is produced by tissues in the body when they're metabolising under conditions of low oxygen. It's not produced by exposure to air. So therefore the only way an elevated lactate can be present in a cord sample is that some tissue

[23] Dr Henschke Transcript 15 February 2013 page 272. 12.

has either previously produced that, or the red blood cells remaining in the cord blood that are metabolically active over an extended period of time can contribute a small amount of lactate to that. If I take a sample of blood and open it to the air for an extended period of time, it can't generate lactate. So you could – you couldn't speculate that, say, a cord snapping, exposed to air, could generate a high lactate. The only significance of, as I understand it, the only significance of the timing of cord bloods being taken is if a very prolonged period of time passes between the cord being clamped and the blood sample subsequently being taken, is the red blood cells, which are still metabolically active in the blood, can continue to produce small amounts. It can – can – actually I'd have to rephrase that, I'm not exactly sure whether they could produce lactate, but they can cause alterations in the blood gas by virtue of metabolising. So I would have to say, now given the opportunity to think about this whilst I've been hearing the discussion, the simple answer would be, I can't, with my knowledge of biochemistry and physiology, foresee a scenario how the snapping of the cord could impact on the measurement of the lactate from a cord blood gas.

MS BURT: But if there's blood still moving through the umbilical cord and through the tissues and out of the umbilical cord, then that would be a matter that would affect the lactate, because - - -?---The only way I could see that affecting the lactate would be to artificially lower it rather than increase it[24].

114. I am satisfied that the cord lactate was taken at or shortly after birth and that the readings recorded were reflective of the baby's poor condition at birth arising from an hypoxic insult having occurred during the course of the labour and prior to birth.

RESUSCITATION AND AFFECT OF FAILED INTUBATION

115. The evidence is that there was a failure to initiate appropriate resuscitation protocol when there was indication that ventilation was not occurring adequately. The evidence is that cardiac compression continued in this period as noted in the resuscitation notes[25] and in the retrospective notes produced by Ms Hallinan[26].

116. I am also satisfied that resuscitation continued in the period by CPR and that it cannot be said that there was no oxygenation of the baby in the period until intubation was re-established.

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[24] Dr Henschke - Transcript 15 February 2013 page 294 – 295.

[25] Inquest Brief - Medical Records Folder 2 pages 205 and 206.

[26] Exhibit 7 – Midwifery notes Ms Hallinan page 21.34.

117. Dr Henschke was of the opinion that the time involved in the failed resuscitation was not significant in terms of the outcome for Joseph. He stated that the significant matter was maintenance of cardiac output and thereby circulation. He stated:

> "Now would you agree that that is a significant difference in terms of the amount of time that he was not breathing?---Well I agree that that nine minutes is a significant period of time, but there's a small difference between what was occurring presumably in utero to what was occurring post-delivery, and it's something that people don't fully understand. Oxygen is not that important, heart rate and cardiac output are important. There's lots of very elegant laboratory studies done on poor little animals that basically demonstrate that the – the new born brain in most animal species can actually tolerate low levels of oxygen for quite an extended period of time, but what they don't tolerate is low cardiac output, and that's where it comes back to the importance why obstetricians get uptight about heart rates. Is once a foetal heart rate falls below 100 consistently, the actual cardiac output, the amount of blood being pumped through the circulation, is inadequate to meet the body's needs for oxygen requirement. Now the difference in the resuscitation scenario is that even if we accept that there probably was a brief period where the foetal heart rate had dropped to quite low levels before CPR was introduced, with CPR you still – even though the baby's not doing so well, you are – that's the whole point of CPR, is you're artificially producing cardiac output, so you're actually maintaining the circulation at an acceptable level.
>
> So although you've talked quite rightly about ventilation and oxygen, perhaps a key thing that people need to appreciate in this court, is providing that CPR is being done, is actually the brain is quite resistant for quite an extended period of time, to low oxygen levels and that's why it's been my experience, as I mentioned in my report, that when episodes like this occur in neonatal intensive care where a tube's displaced and there's a delay of several minutes, for example, of getting it back in, is it's my experience that these babies tolerate this remarkably well because nobody's standing there just doing nothing, in fact there is active resuscitation occurring, whose target is to maintain cardiac output[27].
>
> I'll come back to the issue about CPR, but what about for a baby who had suffered some trauma, who had an Apgar at zero, would you expect that a period of nine minutes where it received no oxygen might have contributed to its asphyxia?---I acknowledge in my report that it may have had a small contribution. Is that small contribution that you say it had, greater now you know it was nine minutes rather than several minutes?---I don't think that really is – I don't think that would change things very much. A matter of a minute or two I don't think would have a profound difference. Because the foetal – the foetal – the new born brain actually requires quite a significant period of hypoxia asphyxia, particularly if it's just hypoxia alone".

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[27] Dr Henschke – Transcript 15/02/2013 page 337.9.

118. His evidence was that whilst he acknowledged that a six - nine minute period may have had a small contribution he did not think that it would have changed things very much because the newborn brain requires quite significant period of hypoxia asphyxia, particularly if it is hypoxia alone.

119. Dr Ramsden's evidence in relation to the impact of a six to nine minute period without effective ventilation, where circulation by CPR is maintained, was minimal. He stated that he would not expect serious or catastrophic consequences, in contrast to his concern arising from the baby's status at birth. He stated:

> Just in terms of putting it in context with the circumstances at birth, a baby who is born with an Apgar score of zero, still only has an Apgar score of three at five minutes, has a cord lactate of 13.7, who has a very long period, of sustained foetal bradycardia in whom there's a history of uterine rupture I would be expressing grave concerns to that family. Taking that in isolation, that the risk of death or severe disability would be very high.
>
> MS BURT: You mentioned when you were talking about a baby without the complications that this baby had, you spoke about there being some consequences and not thinking they would be severe, what would the consequences of a normal baby being deprived of oxygen for nine minutes be?
> ---Well, sorry, what I was trying to say is I'd be optimistic in that setting that there may be no consequences from that and I would not be expecting profound consequences of severe brain injury or death arising from that in isolation.
>
> And have you seen cases where a baby has been deprived of oxygen for nine minutes where there have been some consequences for that baby?---I'm not sure how exactly to answer your question because, I mean, one doesn't keep a kind of catalogue of babies that, well, there is this group had circumstances that went on for nine minutes. So I can't in all honesty say to you that, yes, I know Baby A, B and C who each had that level of interruption to ventilation and this was their outcome. What I can do is describe to you my clinical - outcome of my clinical experience, which would be to say in this situation and to summarise that experience that, no, I can't rule out the possibility that there would be some consequence from that. But I would not be expecting grave consequences from that.
>
> I understand what you mean, but when you say that there may be some consequences what types of consequences are they?
> ---Well, in - it is, I have to say, extraordinarily difficult anyway to pinpoint the later consequences of things that happen in the neonatal period. But were one, for example, to be assessing a child who had had a period of interrupted ventilation at a year or two and there was some degree of developmental delay, if I was asked could I be sure that that had not been the result over that period of time I would not be able to say in all honesty I'm absolutely sure of

that. So - - -

So you would be hopeful with a helpful baby that after nine minutes there wouldn't be long term consequences for the baby?---In a setting in which mechanical ventilation - in which cardiac compressions have been maintained, yes.

But there may be some consequences even with a healthy baby of a deprivation of additional oxygen from breathing or ventilation of about nine minutes?---Yes.

Now, with a baby that was not in optimal condition, as this baby was not, do you think the consequence of being deprived of oxygen for nine minutes might be more devastating to a baby that was already compromised?---I don't think that - I don't think that one can know the answer - I don't know the answer to your question. I think it's possible, yes, but even allowing for that I would anticipate that the relative balance of the effects of seven to nine minutes ineffective ventilation compared with what had gone before would be small."[28]

120. The timing of resuscitation events have been examined in some detail in this proceeding. The clinical records vary slightly (as to minutes) as between Dr Raciebe, Dr Padmanabhan and other clinicians, including nursing staff. They are very much approximates not only as to the time at which incidents commenced, the time taken to implement measures but also of the length of time applicable to the measures. It is appropriate to note that the resuscitation was an emergency situation and the times recorded vary as between clinicians depending upon when and by reference to what time the notes were made.

121. It would be unreasonable in the circumstances to attempt to discern which clinician was the most accurate recorder of the time at which the resuscitation events including intubation or re-intubation occurred. The hospital clinicians made best efforts to identify the events from birth and the approximate timing of those events. I am satisfied however that the variation is not significant and does not alter the understanding of the events as recorded.

122. I am not satisfied that that the failure to initiate bag and mask resuscitation resulted in any significant further hypoxic insult, or contributed in any significant manner to the profound hypoxic insult which I am satisfied had already occurred prior to birth and which resulted in Joseph's death.

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[28] Transcript 19 February 2013 at page 515.21

123. I am satisfied that in so far as there was any contribution to the hypoxia by the failed resuscitation its contribution would have been minimal and likely to be measurable in developmental delay rather than as contributing to the death.

THE VENTOUSE EXTRACTION, SUBGALEAL HAEMORRHAGE AND WHETHER THIS CAUSED OR CONTRIBUTED TO THE DEATH

124. The use of the ventouse and the circumstances in which it was applied is to be understood in the context of the emergency situation which presented. Prior to the labour commencing it had been identified that uterine rupture was a possible adverse outcome. By the time Ms Thurgood arrived at the hospital it was too late for a caesarean to be undertaken and immediate emergency measures were required of the obstetric registrar to deliver the baby.

125. That these urgent measures to deliver were taken without the benefit of forward warning and planning, including the possible involvement of a consultant or more senior obstetrician, was due to the absence of any notification to the hospital at the onset of labour.

126. Professor McDonald stated that:

> "arriving at the hospital fully dilated and with the baby's head having been on view for approximately one hour created a situation of great obstetric urgency to complete the birth" and:
>
> "In terms of the assisted delivery the use of a vacuum extraction (ventouse) cup is a safe option when the operator is experienced and an assisted vaginal birth is required. It is also known to be associated with subgaleal haemorrhage. It is difficult to know whether the need for the cup to be reapplied twice was due to the inability to gain a well sealed attachment or was due to the perineal resistance that required an episiotomy to be performed to expedite the birth.
>
> Given the urgency of the situation, the Registrar, Dr Kuswanto had little option than to proceed with the use of the vacuum. The birth was able to be completed quickly once the episiotomy was performed."[29]

[29] Exhibit 22- Statement Professor McDonald dated 10 October 2011at paragraph 19

127. The experts were asked during the course of their evidence to specifically comment upon the family concern that the subgaleal haemorrhage contributed to or caused the brain injury resulting in death.

128. Dr Henschke's evidence was that the subgaleal haemorrhage which resulted from the vacuum extraction was highly unlikely to have resulted in the hypoxic ischaemic injury without some sort of vital sign documentation that the baby was in shock.[30]:

129. Dr Baber's evidence was that the baby was born in a severe state of distress.[31] She stated:

> "This baby was born in a severe state of distress. The Apgars were 0, 3 and 0 and the cord lactate was high which would indicate that a substantial insult had occurred prior to delivery, so the ventouse being placed when the baby was finally delivered and then the haemorrhages occurring after that, it is unlikely that there would have been any effect from these haemorrhages at that point..... So it is my impression that they've had no cause – no affect on the cause of death."

130. Associate Professor McKelvie concurred with the opinion of Dr Baber and her evidence was that the subgaleal haemorrhage was highly unlikely to have contributed to death[32].

131. Dr Campbell, Dr Henschke and Dr Ramsden agreed.

132. I am satisfied that the subgaleal haemorrhage did not cause or contribute to death. It is appropriate to note however that in the circumstances of the delivery it was necessary to deliver the baby urgently and by ventouse. This is one of the consequences which arose from an unplanned emergency delivery and may possibly have been avoided, had medical advice been accepted and careful supervised monitoring of the labour occurred by early admission to the hospital.

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[30] Transcript 15 February 2013 at page 312.1

[31] Dr Baber – Transcript dated 6 August 2012 at page 41.4.

[32] Associate Professor McKelvie Transcript dated 6 August 2012 at page 54. 23.

PLACENTAL ABNORMALITY AND CONTRIBUTION TO DEATH

133. Family has submitted that there may have been reasons other than the uterine rupture for the hypoxia suffered by Joseph. They submitted that placental function or abruption was a possible contributing factor. The evidence is that there was no abnormality of placenta identified at Dr Neil's examination on 13 December. This therefore lessens the possibility that placental abnormality contributed to the hypoxic injury.

134. Whilst placental abruption may result in hypoxic injury to a foetus and may occur in conjunction with uterine rupture, I am not satisfied that it was likely that this was the principal factor in this case. This is because the significant post partum bleed and the necessity for surgical intervention in the circumstance of an identified uterine rupture makes it is more likely that the hypoxia was caused by the rupture and not any placental abnormality.

OTHER POSSIBLE CONTRIBUTING FACTORS

135. Dr Kuswanto perceived, rightly in my view, that his efforts to progress the delivery quickly were being impeded by questioning as to the procedures he needed to urgently undertake including CTG monitoring, which I am satisfied was initially delayed; query of the need for an intravenous drip and initial refusal of episiotomy[33]. He commented that it was difficult to obtain the consent for the episiotomy, but once obtained the delivery was facilitated very quickly. He stated that this was the difference between no delivery and delivery[34].

136. These matters and the requirement upon the doctor to address the concerns as to the need for the interventions, rather than concentrate on the difficult task of delivering the baby, no doubt added to the complexity and degree of difficulty faced by Dr Kuswanto. However they have another significance for this proceeding, as they evidence that neither Ms Thurgood, nor at least one of the midwives had even by this time fully appreciated the nature of the emergency which was unfolding, remaining as they were concerned to minimise medical intervention, even in the emergency circumstance.

137. Dr Kuswanto stated:

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[33] Ms Ireland states "doctor you don't have the patient's consent" and Medical Records pages 197 and 208.

[34] Exhibit 2 - Statement Dr Kuswanto dated 30 July 2012.

> "The baby's vertex was on view, with obvious meconium liquor; it was challenging to assess the clinical situation.... Kate was pushing every one to two minutes with minimal progress. Ventouse delivery of baby with episiotomy was eventually completed at 2216 hours, with maternal consent. The delivery of the baby with Kiwi Cup was unremarkable. The baby was floppy with no signs of life. The baby was handed over to the paediatrician".

138. His evidence was that Ms Thurgood was transferred to surgery as a result of an ongoing post partum haemorrhage. Maternal resuscitation was undertaken in the delivery suite. Examination under anaesthesia revealed uterine rupture, a large right broad ligament haematoma (approximately 1500ml) from a large defect in the right anterior broad uterus[35].

MS THURGOOD'S VIEW AS TO RISK AND THE INFORMATION RELIED UPON IN DECIDING NOT TO RETURN TO HOSPITAL AND TO BIRTH AT HOME

139. Ms Thurgood stated that she was well researched and aware of the risks associated with the option of vaginal birth after caesarean and in her estimation the risks were negligible: Ms Thurgood stated:

> "After having caesarean births with my first child and then with my twins I have done a lot of research into the risks in having a natural birth after caesarean and I understand that the risks are so minimal as to be not something I considered to be a risk".[36]

140. A journal article[37] provided to her by Ms Hallinan, appears to have been another piece of information relied upon by Ms Thurgood as confirming that the risk was minimal. It is however unclear from the document whether the statistical analysis involved attempts at VBAC in home birth situation.

141. Her evidence as also articulated in her statement and in counsel's submissions was that had she known there was a risk to her baby she would not have proceeded with home birth plans and would have remained in hospital to deliver her baby. In retrospect Ms Thurgood stated that she would have had a caesarean section at 40 weeks.

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[35] Exhibit 1 – Statement Dr Kuswanto dated 29 April 2012.

[36] Exhibit 10 - Statement Ms Thurgood dated 11 January 2011.

[37] Exhibit 15 - Systemic review (VBAC).

UNDERTAKING TO RETURN TO HOSPITAL FOR LABOUR AND DELIVERY

142. Ms Thurgood stated that whilst she had given an undertaking to Dr Neal at discharge on 15 December, it was never her intention to return either at commencement of labour or for the delivery. Her evidence is that she, together with the midwife, Ms Hallinan, had intended to mislead the hospital as to this intention and that this was largely to protect Ms Hallinan as a result of the midwives 'guidelines'[38]. The guidelines being referred to were midwifery guidelines adopted by the College of Midwives in 2010. These guidelines set out certain criteria for professional practice in relation to home birth, particularly those identified as being high risk.

143. Ms Thurgood's evidence was that she intended to proceed to labour and give birth at home and that this was well understood by the midwife who supported her in this intention. Her evidence was that the booking with the hospital was maintained as a 'back up' to a home birth, in the event that there was a need to go to hospital[39]. This evidence was given at the resumption of the proceedings in February 2013 and was in direct contradiction of the statements made by Ms Thurgood earlier in the proceedings.

144. Ms Hallinan denies that she had any express or implicit agreement with Ms Thurgood to mislead the hospital. Her evidence is that she did not expect that Ms Thurgood would be discharged from the hospital after her admission for the bleed, that she had intimated her agreement with Dr Neal's advice that she should stay in hospital and that whilst Ms Thurgood may not have seen her agreement being expressed, she had made such an indication. Dr Neal acknowledged that on 13 December 2010, it appeared to him Ms Hallinan was in agreement with his advice to remain in hospital.

145. Ms Thurgood's evidence is at times contradictory and she is frequently unable to recall details of discussions held or information provided to her during the course of her pregnancy. Whilst this is understandable in the context of the tragedy of the events which unfolded, her evidence as to this matter does not withstand scrutiny in so far as it contradicts that of other witnesses.

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[38] Transcript dated 18 February 2013 at pages 446.4 - 446.19.

[39] Transcript dated 18 February 2013 at page 447.18.

146. Whilst it may have been Ms Thurgood's evidence that she engaged in a deliberate deception upon the hospital, I am unable to accept her evidence that there was any express collusion in the deception being perpetrated upon the hospital by either of the midwives.

EVIDENCE OF THE MIDWIFE AS TO HER INTENTIONS AFTER 13 DECEMBER REGARDING HOME BIRTH AND PROPOSITION THAT SHE "HAD NO CHOICE" BUT TO CONTINUE TO ASSIST WHEN THE LABOUR COMMENCED AND PROGRESSED QUICKLY AT HOME

147. Ms Hallinan stated that whilst there had been an intention to labour and to deliver the baby at home, this plan altered, at least in her own mind and intention, after the admission to hospital on 13 December 2010. Ms Hallinan's evidence may be understood to be that whilst the intention was to 'go for VBAC at home' up until 13 December 2010, after that time, the position changed and that it was her expectation that labour and delivery would occur at hospital.

148. Ms Hallinan stated that whilst there may have been a plan or desire to VBAC at home, between 17 September and 13 December, on that latter date it had become apparent to her that this would not be advisable or possible. She accepted that this was not information that she conveyed to Ms Thurgood at any time either on or after 13 December.

149. Ms Thurgood states that even after 13 December, 2010 there had never been any intention on her part, or in her understanding on Ms Hallinan's part, for the delivery to occur at hospital and that it was agreed and intended that the birth would be a VBAC at home assisted by Ms Hallinan.

150. The evidence is that Ms Hallinan expressed her agreement with the advice of Dr Neil on 13 December, however Ms Hallinan concedes that this was likely not to have been seen by Ms Thurgood and was not followed up in discussion with her at a subsequent meeting they had at the hospital on 14 December.

151. Ms Hallinan's evidence was that her views and intention as to the location of the birth varied as the pregnancy progressed. She supported the proposed VBAC, however had reservations in relation to home birth.

152. Her evidence was that she was aware that Ms Thurgood wanted a home birth VBAC from the first consultation, but that she initially attempted to facilitate engagement with MMC with a view to negotiating arrangements for birth which would satisfy Ms Thurgood's requirements.

> "When Kate came to me I was under no illusion that what she wanted was a home birth, but - and she wanted care in her pregnancy, she wasn't wanting to return to the hospital. So there was no - there was never any guarantee or certainty within me about a home birth. We had to go through these processes first.
>
> Well, you were 100 per cent sure that that's what she wanted, you provided her with a fee that - the schedule of fees that said that that's what you were providing. You also had an email from Dr Euan Wallace saying that you were outside the midwifery guidelines and that they wouldn't support a home birth or being a hospital backup in these circumstances. Do you agree with those things? --- Yes".

153. Her evidence was that after the meeting at MMC with obstetrician Dr McNaughton on 17 September 2010, she formed the view that nothing the hospital would be prepared to put in place would satisfy Ms Thurgood. She stated that from that date she knew that they were moving towards a birth at home and that in this context she "didn't do enough to persuade them otherwise"[40].

154. Her evidence was that at 36 weeks she met with Ms Thurgood and her husband and expressed her support for the plan to have the baby at home. She stated:

> You met with Kate and Dwayne at about 36 weeks, is that right? ---Yes, I would have, yes.
>
> And on that occasion did you express to them your support for the plan of having the baby at home? --- Yes, I did.
>
> And you agree that you provided them with a pool, a birthing pool? --- Yes.
>
> And that's on your list of things you provide when you're supporting someone for a home birth on the schedule fee that I provided you with?
>
> ---Yes, or hospital.
>
> Are you saying that you would provide to a mother a birthing pool at her house if you were supporting her going to hospital? --- Yes, because they often use it in labour for pain relief prior to transferring.
>
> Well, I suggest to you that you provided them with a pool for the purpose of having the baby, giving birth to the baby? ---That was a possibility, yes.
>
> It was a possibility unless there was a medical reason to go to the hospital? ---

[40] Transcript 19 February 2013 at page 570.26.

Yes, prior to - in that - prior to 13 December.

Well, we'll come to 13 December. And that you were involved in conversations with them about the fact that if Kate had the baby at home she wished for her twins to be in another room and not present for the birth of the baby? --- I can't recall that specifically but - - -

Well, it's in your notes. Do you want me to take you to your notes? ---It's often a conversation you'd have.

So you can have a look at your notes if you want to or I can read them for you. The note that you've made on 2 November is, "Kate's mum and sister will be there for boys. Kate OK for them to be around during birth. Not wanting the twins to be there for the birth."

So you agree you had a conversation with her about whether the twins would be there for the birth? --- I don't recall it directly but if it's in my notes I must have.

Well, what I suggest to you is that the conversations that you had with them, the fact that you were providing them with a pool which could be used for the birth of the baby, the fact that you were talking to them about what arrangements would be at the birth at home show that during this period you were supporting Kate having a home birth?

---I don't deny that.

So your evidence is that you supported Kate with a home birth between 17 September and 13 December, is that your evidence? ---Yes. [41]

155. The family contend that the objective evidence establishes that Ms Hallinan was always a party to an intended home birth. A document entitled 'Fee Schedule for Home Birth'[42] was provided to Ms Thurgood by Ms Hallinan and sets out the service included in the fees charged.

156. These include attendance at labour and birth by two midwives and the use of birth pool and liner. The birth pool and liner and delivery cot was delivered to the house by Ms Hallinan and was seen on the video recording to have been filled in preparation for use after her arrival at the home on 16 December.

157. The charge which was identified for a home birth was the amount which was paid by Ms Thurgood. Whilst Ms Hallinan's evidence was the charge was the same whether at home or at hospital, the documentation does not refer in any way to 'birth in hospital'.

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[41] Transcript 19 February 2013 at pages 569.1 and 574.

[42] Exhibit 18 – Fee Schedule for Home Birth.

158. The family refer to the fee schedule, to the lack of any documentation that the plan was to birth in hospital and also to a document which was described as a 'Our Birth plan'[43] said to have been discussed with or provided by Ms Thurgood to Ms Hallinan. Each of these documents is relied upon by the family to support their assertion that Ms Hallinan agreed to support a home birth and continued throughout to do so.

159. Ms Hallinan was not able to point to any documentation or notations which identified a change of plan or approach which was in her mind even after 13 December. When asked what agreement or contract she had she said none and that she didn't usually have a written agreement.

160. It is apparent that Ms Ireland was the back up or second midwife referred to in the Fee Schedule for Home Birth document. Her participation in some consultations, including attendance at the MMC on 17 September 2010 with Dr McNaughton and at the home birth attempt on 16 December, indicate that Ms Ireland's involvement was of a professional nature. That there was no agreement directly with her is not surprising having regard to the fee arrangement document, indicating that any fees for the back-up midwife, Ms Ireland, are paid to the primary midwife, Ms Hallinan.

161. Ms Ireland attended at the home on 16 December 2010 and assisted in the attempted delivery. Upon her attendance, Ms Ireland did not advise that a transfer to hospital ought to occur or raise any objection to the continuance of the labouring or the attempt to birth at home.

162. Ms Hallinan conceded that the provision of the birthing pool was in the context of her support for a home birth[44]. In this context she described home birth as a possibility. It is also clear from this evidence that Ms Hallinan supported Ms Thurgood in home birth and did so expressly until 13 December 2010.

163. At no stage did Ms Hallinan provide clear and precise advice that the birth should not occur at home, that birth should occur at hospital or that it would be dangerous in any circumstance in this pregnancy to proceed to attempt to birth at home. Ms Hallinan conceded in her evidence

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[43] Exhibit 28 – Document entitled 'Our Birth Plan'.

[44] Transcript 19 February 2013 at page 570.01.

that until 13 December, it was her intention and that of Ms Thurgood, to home birth unless there was a medical reason to go to hospital[45].

164. Whilst it may be that Ms Hallinan, '*knew in her own mind what her preference was*', it does not follow that this allows the conclusion to be drawn that she was '*not supporting a home birth*'. This is particularly so in the context of the indication she had given to Ms Thurgood and Mr Gates on 2 November 2010 at 36 weeks gestation that she was supporting home birth.

165. Ms Hallinan kept her change of opinion to herself after 13 December, when prior to that date she had expressly supported home birth. It is an exercise in semantics to suggest that this is any way different to 'encouraging a home birth'. Her actions and inaction in fact did exactly that. By her actions and inaction, she gave sustenance to the firmly held views of the mother that it was safe to attempt to undertake a VBAC at home.

166. I am asked to accept that there was never an intention on the part of Ms Hallinan to assist Ms Thurgood to deliver the baby at home. It is submitted that intention to assist to birth at home is not to be imputed to her from the failure to communicate her views on the advisability of hospital delivery to her patient, or the failure to document, nor from the evidence of her actions on the evening.

167. Herein lies the problem with Ms Hallinan's evidence as to her intentions after 13 December 2010:

- None of the documentation which would have been expected to have been completed to indicate any change in plan had been completed by Ms Hallinan;
- If she was intending that the birth occur at hospital and was no longer supporting a home birth, she did not say so when she was contacted by telephone and advised labour had commenced;
- She took no steps to advise Ms Thurgood or Mr Gates that she should immediately go to the hospital; she did not suggest or state that she would meet her there;

[45] Transcript 19 February 2013 at page 569.16.

- She did not reiterate Dr Neal's advice and she did not advise Ms Thurgood or Mr Gates of the risk she would be taking if she laboured at home or attempted to birth at home;

- She called for the assistance of another midwife to attend at the home;

- She participated as a private midwife in the lengthy period of labouring and the attempted birth at home over many hours without objection or issue being raised as to attempting to deliver at home;

168. I am satisfied that Ms Hallinan attended at the home on 16 December 2010, for the purpose of assisting in the labour and in the expectation that there would be an attempt to deliver the baby at home. I do not accept that Ms Hallinan expected that Ms Thurgood would transfer to hospital on that evening or that she was intending to deliver the baby at hospital.

169. In this context, it is to be concluded that after 13 December and up to and including 16 December 2010, Ms Hallinan either supported and continued to support the VBAC at home, or at the very least her conduct gave sustenance to the views of the mother and her belief that what she was doing was reasonable and appropriate.

FAILURE OF MIDWIFE TO ARTICULATE AND PROPERLY INFORM THE PATIENT OF THE RISKS OF VBAC AND HOME BIRTH

170. Ms Hallinan failed to identify and emphasise to the mother the dangers of the course being embarked upon.

171. I do not accept that the nodding of her agreement with the attending doctor, in a circumstance where she concedes that her patient would not have seen her either nodding or indicating her agreement, is in some way evidence of conveying information of a vital nature to the patient for whom she is caring.

172. The midwife was dealing with a patient who has indicated unwillingness to accept the advice of medical clinicians. Her very engagement by Ms Thurgood suggested a level of confidence

in the midwife's views. In such a case it was Ms Hallinan's absolute duty to ensure that her views were clearly and precisely conveyed and documented and this she failed to do.

173. The history of Ms Thurgood in seeking a home birth option and refusing medical intervention was called into support by counsel for Ms Hallinan, as evidence that Ms Thurgood was firmly intent upon pursuit home birth and that she would not be dissuaded from that course, no matter what advice was given her.

174. This may have been significant if advice had been given that it was unwise for the mother to pursue home birth option earlier in the patient-midwife relationship and the appropriate procedural steps taken by the midwife to document the risk and the advice in accordance with the requirements of 'Appendix A' to the Midwifery Guidelines. But it was not.

175. It may also have been significant if advice of this type were given to her by the midwife at any time during the course of providing care to Ms Thurgood. I am satisfied that there was no such express advice given to her by the midwife at any time during the period in which Ms Thurgood was under her care.

176. The midwife did not articulate the risk of uterine rupture as a significant risk. Her evidence was that she did not regard Ms Thurgood as statistically a high risk of uterine rupture in VBAC[46]. The discussions which were apparently held as to risks of VBAC and homebirth, appeared to focus on other issues, such as 'unstable lie', which the obstetric experts state was of much less concern that the uterine rupture risk.

177. There was implicit support for Ms Thurgood's dismissal of obstetric advice, by the midwife's silence as to these matters and her apparent acceptance that Ms Thurgood had sufficient information or knowledge as to the risk of uterine rupture and her compliance with Ms Thurgood's demand that she not be reminded of the risk.

178. The professional obligation is to progress the discussion with the patient and to advise of risk even in circumstances where a patient has indicated they do not wish to hear. The professional obligation is also to consider withdrawing from care in sufficient time to enable the patient to make proper alternative arrangements. In this case as there was an abiding booking for

[46] Transcript 6 August 2012 page 82 – 83.

delivery at the hospital, Ms Hallinan's withdrawal would not have facilitated any serious difficulty for the patient.

THE MIDWIFERY RESPONSE DURING THE COURSE OF THE LABOUR

179. Ms Hallinan's evidence in these proceedings was imprecise. Her evidence as to the course of the labour by reference to the retrospective documentation was inaccurate in a number of crucial respects.

180. Some of these inadequacies may be explained by the traumatic events which ensued however it is concerning that the evidence given by Ms Hallinan prior to the video being produced differs in significant respects from the contents of the video.

181. The recording establishes that during the course of the labour at home there was:

- inadequate monitoring of possible bradycardia and inadequate documentation of same;
- inordinate length of time before responding to foetal bradycardia;
- inadequate documentation of the progression of the labour, including commencement of second stage and examinations undertaken;
- inadequate monitoring of maternal vital signs, in particular blood pressure and inadequate documentation of same;
- inaccurate documentation of the timing of advising the mother that she should go to hospital and inaccurate documentation as to who assisted in the delivery.
- inaccurate evidence as to the course of the labour and in particular the speed at which it progressed.
- A failure to advise the mother in a timely manner of the need to proceed to hospital.

182. The evidence of both Ms Hallinan and Ms Ireland was that second stage ensued quickly and that there was no time to transfer as things progressed too quickly. I do not accept this evidence. The video clearly identifies that there were a number of opportunities to transfer

from the point Ms Hallinan arrived at the home and at any time in the period prior to the bradycardia, a period of at least 3 hours.

183. The midwife's documentation notes that between 20:10 and 20:50 that "wants to stay home" to birth. Although Ms Ireland gave evidence as to this notation as something she may have 'just made up'[47], it appears that this entry was in Ms Hallinan's handwriting, in any event it indicates a clear intention to remain at home to birth.

184. The recording shows that after the first midwife identified incident of bradycardia at approximately 2100 hours attributed to 'head squeeze' and the persisting bradycardia identified at 21.15 hours, the birthing attempt was continued at home, in the birthing pool and out of the water.

185. The midwife is heard to reassure Ms Thurgood that all was ok with the baby on a number of occasions even after the foetal bradycardia was noted and there were difficulties in obtaining a foetal heart rate.

186. Dr Henschke sets out the course apparent on the recording after spontaneous rupture of the membranes when head compression was first noted.

> "At 43 minutes after membrane rupture and 'head compression' was identified by the midwife, there was a further attempt to auscultate the foetal heart rate and a comment made 'you need to get that baby out'."[48]

187. The labouring at home persisted and at 45 minutes after 'head compression' was identified there was a further attempt to auscultate the FHR and Dr Henschke reports that the FHR at this time sounded to be approximately 60bpm.

188. There were options available to the midwife, particularly at the earlier stages of her involvement in care, during the days leading up to the commencement of labour and in particular at the outset of the labouring. This is the view of the expert midwifery witnesses,

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[47] Transcript 7 August 2012 at page 210.19.

[48] Exhibit 13 Statement Dr Henschke page 4 and 5.

Professor McDonald and Professor Foureur. These options included advising the patient that she was not continuing to support a home birth and if necessary withdrawing her services.

189. It is not to the point that on 16 December 2010 she regarded it as too late and that in her view it was her professional obligation to assist in home birth. Labour had only just commenced at 4pm when first contact was made with the midwife by telephone and a second call was made to her at 5pm.

190. One hour later the midwife attended at the home and continued to support the labour for more than three and a half hours before transferring to hospital and then only because it became appreciated that an emergency had arisen relating to the baby. The evidence of the expert midwifery witnesses, Professor McDonald and Professor Foureur[49], was there were a number of times at which transfer to hospital could have occurred during the course of the labour and before the critical events.

191. Ms Hallinan stated in her evidence that she had been advised by Ms Thurgood's sister, Ms Megan Young that Ms Thurgood would have continued to labour at home or 'free birth' in the event that the midwife withdrew her services. This was not a matter which the midwife ever discussed with Ms Thurgood and it is strongly disputed by Ms Thurgood.

192. The evidence does not support a conclusion that Ms Thurgood would have continued to labour at home or "free birth". The evidence is that Ms Thurgood had in fact attended at the hospital for the delivery of the twins, in circumstances where she was unable to continue with an attempt at home birth due to the withdrawal of a midwife. She had also attended at hospital in response to the ante partum bleed on 13 December 2010.

193. I am satisfied that had there been earlier advice to the mother to transfer to hospital that transfer would have been likely to occur. I am satisfied that had there been a withdrawal of service by the midwife, that transfer to hospital would have been likely to occur.

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[49] Exhibit 21 Statement of Professor Foureur dated 10 October 2012 and Exhibit 22 Statement of Professor McDonald dated 10 October 2012.

THE RELIABILITY AND CLARITY OF THE ADVICE OF THE MMC CLINICIANS REGARDING VBAC AND HOME BIRTH RISK AND HOW IT INFORMED THE MOTHER'S RESPONSE

194. It has been submitted by the family that there was a failure of the MMC to properly advise or discuss with Ms Thurgood the risks of VBAC and homebirth, and that this contributed to the decisions she made not to engage further with the hospital, thereby resulting in the death of baby Joseph.

195. Ms Thurgood attended some antenatal clinics at MMC in the pregnancy, however was reluctant to receive or to accept the advice of clinicians in relation to her proposal to undertake VBAC and/or to deliver at home. Her decisions in relation to this matter have been discussed earlier.

196. The evidence is that Ms Thurgood expressly instructed clinicians that she did not wish to hear any further information about the risk of uterine rupture. She considered that they were exaggerating the risk and that they were doing so in order to frighten her with the aim of convincing her to birth in hospital and by caesarean[50]. The hospital notes indicate that the clinicians were aware of her view however Dr McNaughton advised that it was her professional duty to emphasise the risk and as late as 15 December, Dr Neil continued to press his concerns as to risk.

197. The evidence is clear that a number of clinicians, in this pregnancy and in previous pregnancies, in detailed consultations, pressed their concerns and as discussed earlier Ms Thurgood was not accepting of their advice. Ms Thurgood had formed her own opinion of the risk.

198. Counsel for the family has submitted that the advice given by the obstetrician, Dr Campbell, as to the percentage of risk was wrong[51], that as Ms Thurgood knew it to be wrong, she

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[50] Transcript 7 August 2012 at page 240.1

[51] Counsel's written Submission for family paragraphs 43 and 44 dated 26 March 2013 .

therefore had little faith in the clinical expertise of the consultant obstetrician and as a consequence ignored his advice.

199. Whilst I do not accept that the clinician's advice as to statistical risk was wrong, (the other expert witnesses were of a similar opinion to Dr Campbell) debate as to the degree of risk of uterine rupture and the statistics upon which the clinicians based their assessment of that risk is largely beside the point.

200. This is because the specialist obstetric advice is not merely informed by reference to statistics, which may or may not capture the entirety of the risk relating to the individual patient in their care. Dr Campbell's advice was also based upon years of medical experience and his own clinical examination and knowledge of the history and particular risk factors of the patient.

201. To disregard the obstetrician's advice on the basis of a mantra founded in the uncertainty of statistical data obtained from the internet, is a dangerous course to follow. This case is sadly an example of the danger in utilising raw data or statistical information to support a clinical premise as to risk, without knowledge and understanding of the complex myriad of factors relevant to the risk.

202. I am satisfied on the evidence that the risks were clearly articulated to Ms Thurgood by each of the Obstetricians, Dr Campbell, Dr McNaughton and Dr Neil. The evidence is that Ms Thurgood had also been advised of the risks during her previous pregnancy by Associate Professor Euan Wallace. He had written to Ms Hallinan in this pregnancy to express his grave concern, if it were being proposed that a midwife assisted home birth were planned. This advice was conveyed to Ms Thurgood by Ms Hallinan. There was nothing further that the MMC could reasonably have done to either press home the risks or to attempt to facilitate a safe birth at the hospital.

SUBMISSION THAT THE HOSPITAL WAS UNRESPONSIVE OR UNCO-OPERATIVE IN MS THURGOOD'S BIRTHING PLAN AND THEREBY CAUSED THE MOTHER TO OPT INSTEAD FOR HOME BIRTH

203. It was submitted by counsel for the family that the hospital indirectly contributed to the death because they were not minded to accommodate the mother's wishes or to properly communicate with her as to her needs.

204. The evidence does not support a conclusion that the hospital was unresponsive or unhelpful in their approach or their consideration of Ms Thurgood's preferences, such that this might reasonably have deterred her from accepting care in the hospital setting.

205. On the contrary, the hospital clinicians and administration went to great lengths to attempt to engage with Ms Thurgood and her midwife, in an attempt to understand how they (the hospital) may be able to convince her to accept the safest option for delivery of the baby.

206. This is evidenced by the time provided by Dr Campbell to discuss with Ms Thurgood her options and preferences, including the risks and that of Dr Neal in his efforts to reach some accommodation of Ms Thurgood's requirements, even if against his best advice.

207. There is evidence that the nursing and medical clinicians and administrators were prepared to discuss Ms Thurgood's preferred options, they were not however prepared to compromise patient or baby safety by agreement to processes which were not compatible with good clinical care.

'APPENDIX A' - THE FAILURE OF THE MIDWIFE TO FOLLOW THE PROTOCOLS AND GUIDELINES OF THE AUSTRALIAN COLLEGE OF MIDWIVES NATIONAL MIDWIFERY GUIDELINES FOR CONSULTATION AND REFERRAL

208. 'Appendix A' of the Midwifery guidelines provides assistance to midwives in managing complex situations and guidance as to scope and limitations upon practice, the purpose of which is no doubt to prevent the type of tragic outcome which occurred in this case.

209. Ms Hallinan did not follow the protocols in relation to providing private midwife care. In particular she failed to provide a care plan, failed to articulate the agreement between herself as the providing midwife and the patient and failed to act in accordance with the requirements of the guidelines, in particular 'Appendix A'.

210. The guidelines anticipate that there will be a referral of care to a medical practitioner in certain circumstances. They are ambiguous as to whether this then requires withdrawal of the midwife from the status of primary carer, although that would appear to be the practical effect of their application.

211. The guidelines also require that in certain circumstances there be consultation with a medical clinician. The attempt to characterise the meeting with Dr McNaughton on 17 September 2010 or that with Dr Neil on 13 December as a 'consultation' which met the requirement of the guideline to 'consult with a medical or other healthcare provider' is misguided.

212. These consultations occurred in a context relating to the mother's preferred delivery protocols and in the case of Dr Neil, an urgent attendance for the ante-partum bleed. That was the only context in the contemplation of the doctors. They cannot be characterised or brought into aid by the midwife as somehow representing a positive compliance on her part with her professional practice guidelines.

213. There was no 'consultation' between the midwife and the medical practitioner at either of those appointments and there was no frank discussion or disclosure of the midwife's knowledge or understanding of the patient's intention to deliver at home.

214. Nor is the attendance on 13 December 2010, to be properly described as a 'referral' to secondary or tertiary care[52]. It was an attendance by a patient in the context of an antenatal bleed. That was the reason for the attendance and that was the only context in the contemplation of the doctor.

215. The midwife did not discuss any issues of referring the ongoing care with Ms Thurgood or with Dr Neil. She did not document or formalise any referral. What may have been in her mind or intent is not to the point when discussing compliance with the professional practice guidelines. There was no handover of her clinical notes to the hospital or the doctor. There was in fact no note made of the attendance as being in this context.

216. There were a number of aspects of the midwife's interaction with Ms Thurgood which, whilst perhaps designed to create a warm and comfortable relationship between the midwife and the mother, resulted in the removal of the distance required to be maintained to ensure that professional skill and judgement is exercised at all times.

217. Ms Hallinan's evidence was on a number of occasions, both during antenatal consultations and during the course of the labour at home, that she did not advise Ms Thurgood of relevant

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[52] Professor Foureur - Transcript dated 25 February 2013 at page 642.15 to 643.

matters because she didn't want to upset their relationship or she did not want to upset Ms Thurgood[53] during the course of her labouring. As a result of this Ms Thurgood was able to continue to assume the correctness of her decisions and understood the silence as false reassurance.

218. In this context it was concerning that Ms Hallinan's notes indicate that on their first meeting she advised Ms Thurgood that there were "lots of political issues' relating to home birth. This is an example of the type of over familiar conversation which may of itself have led the patient to believe that Ms Hallinan discounted the seriousness or validity of the medical concerns regarding VBAC or home birth and that she was somehow a supporter of the ideas of the mother.

FINDING AS TO CAUSE AND CONTRIBUTION TO DEATH

219. I find that Joseph Thurgood Gates died on 21 December 2010 and that the cause of his death was: 1(a) Global cerebral hypoxic injury and 1(b) Peri partum asphyxia in a setting of uterine rupture.

220. I find that the hypoxic brain injury occurred during the course of the labour and that the hypoxia and asphyxia was due to uterine rupture which occurred during the course of the labour and prior to the birth.

221. I find that the death was preventable had the labour and delivery been undertaken in a controlled hospital setting with appropriate monitoring and medical and midwifery management.

222. I find that the failure to attend at the hospital when contractions commenced resulted in inadequate monitoring of the course of the labour, removed the opportunity to identify any complications arising and prevented early intervention and that this was a contributing factor in the death.

223. I find that the failure to transfer to hospital immediately after foetal bradycardia was identified was a contributing factor in the death.

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[53] Transcript of proceedings 6 August 2012 at pages 96, 98.5, 127 and 136

224. I find that the failure of the midwife to provide clear advice to her patient as to the risks associated with VBAC and home birth, sustained the misguided views of the mother, contributed to her disregarding the advice provided by obstetric medical clinicians and facilitated in her a level of confidence that she may safely proceed to home birth. This conduct indirectly contributed to the death.

225. The evidence does not support a finding that any act or omission of the Monash Medical Centre clinicians caused or contributed to the death.

COMMENTS

Pursuant to section 67(3) of the *Coroners Act* 2008, I make the following comment(s) connected with the death:

226. This inquest was not an inquiry into the appropriateness or otherwise of home birth. The circumstances of this case were such that home birth was never a safe or appropriate option. However, it became apparent during the course of the proceedings that there appears to have been lost to the community an appreciation that childbirth has inherent and unpredictable risk and the debate is currently largely directed towards denial of the risk, particularly in the context of home birth.

227. This risk which was apparent to past generations may have fallen from public consciousness because of increased community confidence gained as a result of the development of obstetric knowledge, monitoring and interventions over the course of the last century and the relative rarity, due to these factors, of neo-natal or maternal death.

228. There also appears to be little current discussion surrounding the proposition that managing that risk or identification of complications may be more difficult where birth occurs at home and absent the technology available in a hospital obstetric unit.

229. Dr Henschke and Dr Ramsden commented on the desirability of clear information being made available to prospective parents relating to birthing issues and on the fact that at the present time such information is not readily discernible from the unrefined data on the internet and other places.

230. The time would appear to be right for a proper and informed public discussion about these issues, not merely focused upon home birth and how it can be facilitated, but also the possible benefits and advantages of hospital birthing in some cases.

231. There appears to be an absence of legislative standards and practical supervision and regulation of private midwifery practice and home birthing in particular. Whilst it might be said that this is also so in relation to medical practitioners, the practice of home birthing is largely undertaken by midwives and it is that practice, rather than the individual profession, which warrants clear standards and supervision. Whether this is appropriately by self regulation and supervision or by legislative regulation is a matter which might usefully be considered by relevant authorities.

232. The midwifery guidelines which have been adopted by the Australian College of Midwifes are unclear and uncertain as to the circumstances in which care should be transferred to a medical clinician and at what point the midwife should withdraw from providing care.

233. Understandably the guidelines provide a great deal of scope for the exercise of professional discretion and are founded upon an expectation that a midwife will exercise appropriate professional judgement. There is however a lack of clarity which allows for debate in critical circumstances about whether the form or intent of the guidelines has been met. This is particularly so in relation to the application of 'Appendix A' of those guidelines.

234. The internet as a source of medical or health information; This case is sadly an example of the danger of untrained users utilising raw data or statistical information to support a premise as to risk, without knowledge and understanding of the complex myriad of factors relevant to the risk. To disregard the obstetrician's advice on the basis of a mantra founded in the uncertainty of statistical data obtained from the internet, is a dangerous course to follow.

235. It became clear in this inquiry that the Forensic Pathologist's examination would have been assisted by the capacity to examine the placenta, which was not available. The pathologist advised that this is a common impediment to the post mortem medical investigation. I would encourage hospitals to adopt a protocol applicable when baby's prospects for survival are not good, that the placenta be retained for examination if required.

RECOMMENDATIONS

Pursuant to section 72(2) of the *Coroners Act* 2008, I make the following recommendation(s) connected with the death:

1. That the Minister for Health give consideration to the appropriateness of regulating the practice of providing home birth services;

2. That the Minister for Health give consideration to developing, in discussion with the respective professional health colleges and other obstetric and midwifery experts, an information resource to enable prospective parents to be fully informed of the issues associated with the various birthing options.

3. That where it is apparent that a baby is born in poor condition and unlikely to survive that hospital maternity units adopt a protocol of retaining the placenta for pathologist examination if required.

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

Ms Thurgood and Mr Gates;
The Interested Parties;
The Minister for Health, the Honourable Mr David Davis MLA;
The Secretary, Department Of Health Victoria;
The Australian College of Midwives;
The Royal Australian and New Zealand College of Obstetricians and Gynaecologists;
The Australian Nursing Federation;
The Australian Health Practitioners Regulatory Authority;
The Expert Witnesses;
The Investigating Member.

Signature:

CORONER K. M. W. PARKINSON
Date: 10 May 2013