IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 2291

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of:	Martha Alice Fraser
Delivered On:	6 October 2016
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank Melbourne 3006
Hearing Dates:	Mention: 22 September 2015 Directions Hearing: 21 March 2016 Inquest: 1, 2 &3 August 2016
Findings of:	Coroner Caitlin English
Coroner's Assistant:	Leading Senior Constable King Taylor
Representation:	Mr Paul Halley of Counsel for Ms Wood and Mr Fraser Instructed by Adviceline Injury Lawyers Mr Chris Blanden QC for Dr Guy Skinner Instructed by Perry Maddocks Trollope

I, Caitlin English, Coroner, having investigated the death of Martha Alice Fraser

and having held an inquest in relation to her death on 1, 2, & 3 August 2016

at Melbourne

find that the identity of the deceased was Martha Alice Fraser

born on 30 May 2011

and the death occurred on 30 May 2011

at 124A Easey Street Collingwood

from:

1 (a) Intrapartum Hypoxia

1 (b) Breech delivery (head entrapment and associated cord compression)

in the following circumstances:

Introduction

I have had the carriage of this investigation following the retirement of Coroner Spooner in February 2014.

1. On 30 May 2011, Ms Celia Wood and Mr Peter Fraser were expecting the birth of their second child, Martha. Ms Wood's pregnancy was full term and three days passed her due date. She had been seen by her obstetrician, Dr Guy Skinner in his rooms that morning and he noted in the medical record that a scan confirmed the baby was still presenting in a frank breech position. At approximately 9.30pm, Ms Wood started having Braxton Hicks contractions, just as she had been having each evening for the previous two weeks. At 10.40pm she had a 'show'[1] and telephoned her mother who was coming to look after her young son. At 11.00pm Ms Wood's waters broke and the couple timed her contractions which were three minutes apart. At 11.09pm Mr Fraser called the hospital and was told to bring Ms Wood in. At 11.15pm Mr Fraser called the

[1] A show is the plug of mucus in the cervix which comes away and is expelled from the vagina. It can be a sign of labour.

hospital again to say the cord and a foot was visible and the baby was coming. He was told to call an ambulance, which he did. Ambulance officers arrived at 11.30pm and by this stage the baby was partially delivered and appeared floppy. Ambulance officers unsuccessfully attempted to deliver the baby's trapped head. Dr Skinner then arrived at the house and delivered the baby's head. After an unsuccessful attempt to resuscitate, he declared baby Martha deceased.

Reportable Death

2. Dr Skinner signed a death certificate for baby Martha on 30 May 2011.[2]

3. The Registry of Births, Deaths and Marriages referred the certificate to the Coroners Court as the death certificate indicated that the baby's heart had beat for 10 minutes following a breech delivery at home.

4. The death of baby Martha was determined to be a reportable death by the coroner pursuant to section 4(2) of the *Coroners Act* 2008 (Vic) (the Act) as baby Martha's heart beat for a period of 10 minutes after her delivery. Her death constituted the death of a person and was not a still birth for the purposes of the Act. Further, her death was unexpected in that, save for the circumstances of her delivery, she was a healthy, full term baby.

5. As a result of the death not being reported to the coroner immediately following her death, baby Martha's body was not brought to Coronial Admissions and Enquiries, nor was she examined by a forensic pathologist at the Victorian Institute of Forensic Medicine.

6. In his evidence at Inquest, Dr Skinner conceded that he had made an error with respect to his advice to Ms Wood and Mr Fraser on 31 May 2011 that baby Martha was 'still born'. He stated: '*It should have been a neonatal death because there was a heartbeat still present after extraction.*'[3]

7. In evidence there was some discussion between the Coroner's Assistant, Leading Senior Constable King Taylor and Dr Skinner as to whether baby Martha's death was 'unexpected.' Dr Skinner's view was that birth asphyxia was an expected process to

[2] Coronial Brief p 1.
[3] Transcript p 179.

occur because of the entrapped head and on that basis, he did not concede her death was 'unexpected.' [4]

8. Whilst medically that might be correct, the circumstances are also relevant to determining reportability. In this case, baby Martha was a full term healthy baby who was expected to live after birth, if she had been born, as planned, in hospital. Her death was unexpected for the purposes of section 4 of the Coroners Act as she would have survived but for the circumstances of her unplanned and unintended home birth.

Coronial Investigation

9. The coroner commenced an investigation and advised Ms Wood and Mr Fraser accordingly. With the assistance of the Coroners Prevention Unit, a letter was sent to Dr Skinner requesting his records and asking his response to a number of questions. Ms Wood wrote to the Court by letter dated 27 July 2011[5] and raised a number of questions. Following receipt of this and Dr Skinner's response dated 28 June 2011, together with his medical records,[6] the coroner obtained an expert opinion from Dr Bernadette White.

10. Ms Wood and Mr Fraser also obtained expert reports from Dr Robert Lyneham and Dr Lucy Bowyer. Dr White and Dr Skinner also responded in writing to those reports.

Request for Inquest

11. By letter dated 3 March 2015, Adviceline Injury Lawyers, acting on behalf of Ms Wood and Mr Fraser, requested an Inquest be held into the death of baby Martha.

12. Baby Martha's death is a reportable death requiring a mandatory investigation in accordance with the Act but the holding of an Inquest is discretionary.

13. The statements revealed discrepancies on the facts regarding what Ms Wood and Dr Skinner each stated Ms Wood had been told about frank breech presentation, risks and birthing options.

14. The medical reports revealed conflict of opinion between the medical experts as to the adequacy and accuracy of the ultrasound conducted by Dr Skinner on 30 May 2011 and whether baby Martha had been correctly diagnosed as being in a frank breech

[4] Transcript p 180.
[5] Coronial Brief p 2.
[6] Coronial brief pp 24 & 92-93.

presentation. The expert opinions also disagreed as to whether baby Martha could have moved position following the ultrasound on 30 May 2011.

15. A coronial brief was prepared by LSC Taylor containing the record of the coronial investigation.

16. After conducting a mention hearing on 22 September 2015, I heard submissions as to why an Inquest should be held.

17. Ms Clark appeared on behalf of Ms Wood and Mr Fraser at the mention hearing. Part of her submission in support of an Inquest was to ensure that families who have a baby presenting in the breech position are given sufficient advice and managed appropriately in the future, in order to prevent a death, such as baby Martha's, occurring again.

18. Further, she argued that if the advice given by Dr Skinner was found to be inadequate, it would then be open for the court to exercise its broader preventative role with the potential to formulate some recommendations surrounding the risks that should be discussed, and the advice that should be given to parents regarding mode of delivery when their baby is presenting in a breech presentation.

19. The broader purpose of any coronial investigation is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[7]

20. Coroners are empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[8] These are effectively the vehicles by which the coroner's prevention role can be advanced.[9]

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[7] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, cf: the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

[8] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.

[9] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

21. I was satisfied the factual differences and conflicts in the expert opinions justified the use of the court's forensic process and granted the application for Inquest.

Focus of the Inquest

22. The purpose of a coronial investigation is to ascertain if possible, the identity of the deceased, the medical cause of death and the circumstances in which the death occurred, in accordance with section 67 of the Act.

23. An inquest was held into baby Martha's death on 1, 2 & 3 August 2016. Seven witnesses gave evidence and three medical experts gave evidence concurrently.

24. There were three main issues explored at inquest.

25. The first issue pertained to baby Martha's medical cause of death and whether cord prolapse should be included in the cause of death.

26. The second issue concerned a factual dispute focussing on:

- Dr Skinner's medical management of Ms Wood's pregnancy, particularly the advice he provided to Ms Wood about the frank breech presentation, the risks and birthing options and,
- The instructions given to Ms Wood about what to do when labour started.

27. The third issue focussed on:

- The accuracy of the ultrasound conducted by Dr Skinner on Ms Wood in his rooms on 30 May 2011 and,
- The likelihood that the baby moved from a frank breech position to a footling position between that ultrasound and Ms Wood going into labour the same evening.

28. In considering the medical cause of death I heard from Dr Yeliena Baber, forensic pathologist at the Victorian Institute of Forensic Medicine and Dr Skinner.

29. The second issue, the two part factual dispute, was the subject of evidence from Ms Wood, Mr Fraser, Mrs Jasmine Howard, midwife, and Dr Skinner.

30. The Inquest also heard concurrent evidence from experts Dr Bernadette White (called by the Court) and Drs Lyneham and Bowyer (proposed by Ms Wood and Mr Fraser). Whilst not resolving any factual disputes in the evidence, the experts were asked to

comment on what they regarded as the 'best practice' birthing options for Dr Skinner to propose to Ms Wood, and whether a planned vaginal breech birth in Ms Wood's case was reasonable. The experts were also asked what would be the best practice advice for a planned vaginal breech birth, including the risks and hospital attendance.

31. A consideration of the evidence concerning what Ms Wood had been told to do when labour started also included a consideration of what 'labour started' means, with input from the experts.

32. The third issue, which was the subject of expert evidence, examined the adequacy and accuracy of Dr Skinner's ultrasound on 30 May 2011, and whether the baby's position could have moved after the ultrasound.

33. The expert witnesses gave evidence concurrently and answered a set of questions prepared by the Coroner's Assistant. The experts were given a copy of the coronial brief and met prior to court to discuss their responses. Dr White was the designated spokesperson. As the experts had differing fields of expertise, they were asked to contain their evidence to only those matters about which they were qualified to offer an opinion on. They were reminded that they were not required to resolve any factual disputes in the evidence.

34. As a result of the expert witnesses giving concurrent evidence the differences between their opinions narrowed, which will be considered in more detail following.

Evidence

35. I have considered the evidence of the witnesses called at inquest, the tendered exhibits, the contents of the coronial brief and the written submissions received from the parties on 19 August 2016.

36. Coronial findings must be made as to the proof of relevant facts on the balance of probabilities. In determining whether a matter is proven to that standard, I should give effect to the principles in *Briginshaw v Briginshaw* [10] when considering the weight of evidence.

37. Justice Dixon stated:

'*The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding*

[10] (1938) 60 CLR 336

are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters 'reasonable satisfaction' should not be produced by inexact proofs, indirect testimony, or indirect inferences.'

38. There are conflicts in the facts in the evidence between Ms Wood and Dr Skinner. The questions of fact will be determined according to the balance of probabilities, subject to the Briginshaw principles.

Identity

39. The deceased's identity is Martha Alice Fraser.

ISSUE ONE: Cause of Death

40. The cause of death refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

41. In the certificate of death signed by Dr Skinner, he described the cause of death as 1 (a) Asphyxia and 1(b) Breech delivery (head entrapment).

42. In his report,[11] Dr Lyneham stated '*In my opinion the death of baby Martha was a direct consequence of the cord prolapse, and on my analysis of the records it is likely that this was associated with a footling breech presentation.*' Dr Lyneham did not give evidence at the Inquest nor was he cross examined about this opinion regarding the cause of death.

43. Dr Skinner gave written and oral evidence that in his opinion Dr Lyneham was incorrect.[12]

44. At my request, Dr Yeliena Baber, forensic pathologist at the Victorian Institute of Forensic Medicine prepared a report[13] based on her consideration of the coronial brief, and gave evidence at the Inquest. She formulated the cause of death as 1 (a) Intrapartum hypoxia, and 1(b) Unassisted breech delivery complicated by cord prolapse and head entrapment.

45. Dr Baber's evidence was constrained by the fact she did not examine baby Martha's body and relied on the contents of the coronial brief.

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[11] Exhibit 14.
[12] Transcript p 184 and Coronial Brief p 33.
[13] Exhibit 12.

46. When asked to explain the phrase 'complicated by cord prolapse' in her formulation of the cause of death Dr Baber stated: *'...so the fact that it was compressed at the time that Martha was being delivered, it may have contributed to the whole hypoxia.'*[14]

47. Dr Baber agreed when asked by Mr Blanden, Counsel for Dr Skinner, that the intrapartem hypoxia could well have been caused by pressure of the baby's head on the mother's pelvis including the cord.

48. When questioned to clarify the role of the cord prolapse in the cause of death, LSC Taylor asked her if it was when the head becomes entrapped and not during the birthing of the body. Dr Baber replied she was not an obstetrician and not able to give an opinion on that but added: *'I don't see how it could be excluded from the cause of death with any certainty.'*[15]

49. In his evidence Dr Skinner agreed with intrapartum hypoxia in Dr Baber's formulation as the cause of death. However, in the context of there being no examination and absent histopathology, he queried Dr Baber's ability to determine the cause of the hypoxia.

50. Dr Skinner's evidence was that the cord prolapse was not related to the cause of death, it was the head entrapment that caused the asphyxia.[16] Dr Skinner described that: *'...during a breech birth the umbilical cord is only about four centimetres distal to the presenting part, being the buttocks. ...So by definition, a cord is prolapsing with every breech birth from a technical level...there is an adjacent cord with the presenting part in every breech birth that occurs...So that cord sits in the pelvis comfortably with the baby's body, with no significant pressure...So by...definition, a relative cord prolapse occurs with every breech birth.'* [17]

51. He went on to state: *'...the concept of a cord being compromised only occurs once the head has engaged the mother's pelvis and the large, rigid structure pushes hard against the cord on the wall of the pelvis and obstructs it.'*[18]

52. In further explanation he stated in a breech birth, *'...the cord enters the pelvis as the body descends as opposed to a head first birth, and the cord isn't compromised by the*

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[14] Transcript p 207.
[15] Transcript p 208.
[16] Transcript p 187.
[17] Transcript p 99.
[18] Transcript p 100.

body of a breech baby. So whether the cord is hanging out or whether it's adjacent to the part, doesn't compromise the baby in the same degree of risk as a head first birth where the large head is actually compressing it from the moment it enters the pelvis. So we don't tend to have the same degree of urgency...So the degree of urgency of potentially hypoxic injury to the baby is much lower in a breech such that we always have the cord in the pelvis during the birth of a breech and that's normal. It doesn't affect the outcome. It's only when the head engages the pelvis does it confer material compression to the cord and compromise the baby.'[19] Dr Skinner agreed that in baby Martha's birth it was the entrapment of the head compressing the cord which caused the hypoxia and/or asphyxiation. '*You just have to lift the head out and the problem is solved in that respect.*'

53. A cord prolapse in a breech birth is not as critical because it does not impact on the oxygenation of the foetus.

54. In his third statement Dr Skinner disagreed with Dr Lyneham's assessment, '*that the baby's poor condition was a direct consequence of cord prolapse and associated hypoxia.*' He stated: '*I maintain the cause of death was head entrapment and associated cord compression leading to hypoxia.*'[20]

55. In view of Dr Skinner's evidence and the constraints of Dr Baber's evidence I am of the view the cause of death is properly formulated without reference to cord prolapse. It is the baby's entrapped head which causes the compression, so the fact the cord is prolapsed is not part of the cause of death. I intend to include 'associated cord compression' to better clarify the role of the cord.

56. I prefer the description Intrapartum Hypoxia as the baby has died from inadequate oxygen supply from the cord during the birth process rather than from asphyxia which implies an inability to breath after birth.

Circumstances of Death

57. For coronial purposes, the circumstances in which the death occurred refers to the context or background and surrounding circumstances, but is confined to those circumstances that are sufficiently proximate and causally relevant to the death, and

[19] Transcript p 182 & 183.
[20] Coronial Brief p 33.

not merely all circumstances which might form part of a narrative culminating in death.

Evidence not in dispute: Time line of events prior to delivery 30 May 2011

58. On the evening of 30 May 2011, Ms Wood agreed that it took her '*a while*,' she estimated about 20 minutes of being 'not sure,' until she realised she was in labour. It is unclear when the 20 minutes of being 'not sure' commenced, however '*...at approximately 10.15-10.30pm I realised I was in the early stages of labour.*'[21]

59. Ms Wood stated '*There was possibly 15 minutes prior to my seeing the show that made me think perhaps things were starting but I wanted a sign to make sure.*'[22]

60. She called her mother at 10.40pm when she had her 'show.' Ms Wood's mother lived 25 minutes away and was coming to look after her young son. Ms Wood thought she was in 'pre-labour' and believed labour started when her waters broke, or she was having regular contractions.

61. When Ms Wood called her mother at 10.40pm, '*I said she needn't worry about rushing just yet.*'[23]

62. Mr Fraser noted in his statement following the 'show' Ms Wood was '*moving freely and showed no signs that she would be giving birth shortly thereafter.*'[24]

63. When Ms Wood's waters broke at about 11pm, she stated: '*I told Pete to call the hospital and I remember saying, '...just wait a minute, I'll time the contractions so that we can give them more information.*''[25]

64. When asked in cross examination, Mr Fraser agreed it was not until Ms Wood's waters broke that he believed that then there was some sense of urgency about the matter. [26]

65. Mr Fraser called the hospital at 11.09pm.

66. Ms Wood agreed Mr Fraser could have called the hospital 20 minutes earlier than he did.

67. Ms Wood also agreed the call to the hospital was made 9 minutes after she knew things had started.[27]

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[21] Coronial brief p 7.
[22] Transcript p 32.
[23] Coronial Brief p 7.
[24] Coronial Brief p 12.
[25] Transcript p 32.
[26] Transcript p 60.

68. Ms Wood agreed that at 11.00pm she knew her position did not allow for any delay in attending hospital.[28] She stated: '*I can't see us getting to hospital with a two year old in 20 minutes.*' She noted that she did not know she had 20 minutes to get to hospital at that point.[29]

69. At 11.21pm Mr Fraser called the hospital to say the cord had prolapsed and a foot had appeared and the baby was being delivered.

70. Mr Fraser stated, '*Within about 10 minutes Martha had been delivered to the point where her head and arm were stuck inside Celia.*'[30]

71. Ms Wood's mother arrived, followed by the ambulance paramedics. The ambulance officers were unable to free baby Martha's trapped head.

72. Dr Skinner[31] arrived at the house and delivered baby Martha's head. He announced it was too late and that baby Martha had died.

73. Mr Fraser confirmed in his evidence the contents of his statement that Dr Skinner did not use adrenalin to attempt to resuscitate baby Martha. Despite the evidence of both ambulance officers and Dr Skinner that adrenaline was administered to baby Martha, Mr Fraser confirmed his belief that adrenaline was not used. [32]

74. Dr Skinner described the length of Ms Wood's labour as a '*smidge under two hours*' and stated, '*Less than two hours is pretty uncommon and would more commonly be associated with a home - an inadvertent home birth....it obviously ramped up quite quickly in the last 40 minutes, from 10.40 through until 11.24 when the baby appears to have delivered. So in the last 44 minutes it went from nothing to everything and that's what caught the circumstances.*'[33]

ISSUE TWO: Dr Skinner's medical management of Ms Wood's second pregnancy

75. As noted above, there is a factual dispute concerning the discussions between Dr Skinner and Ms Wood in the third trimester of her pregnancy, when the baby was noted to be in frank breech position, about risk and birth options. Because of the

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[27] Transcript p 33.
[28] Transcript p 33.
[29] Transcript page 34.
[30] Coronial Brief p 12.
[31] Dr Skinner had coincidentally been at St Vincent's Hospital tending a patient and had been told Ms Wood was labouring at home.
[32] Transcript p 60. Louise Hay, ambulance officer confirmed (at Transcript p 68) she drew up the 500 micrograms of adrenalin and handed it to Dr Skinner who administered it into baby Martha's umbilical cord. Her colleague, Jack Doherty confirmed (at Transcript p 71) he saw Dr Skinner administer the adrenalin to baby Martha.
[33] Transcript p 176.

factual dispute, a close analysis of the written statements and evidence at Inquest is necessary.

76. Dr Skinner was Ms Wood's obstetrician for her first pregnancy with her son, Edward, who was born on 11 February 2009.

77. Ms Wood returned to Dr Skinner for her second pregnancy.

78. During the course of this pregnancy Ms Wood had ultrasounds at EUM Ultrasound (an obstetric ultrasound facility separate from Dr Skinner's rooms) at 12 and 20 weeks which were uneventful.

Advice provided by Dr Skinner about the risk of a frank breech presentation and birth options

- **Statements to the Coroners Court**

79. In a letter to the Coroners Court dated 27 July 2011, Ms Wood stated that at no point did Dr Skinner discuss the option of having a caesarean section[34] with her and that despite asking several times at different appointments what the risks would be, she was not adequately advised of the dangers of a breech birth.[35] The only '*risk explained to us was that the baby's hips might become displaced.*'[36]

80. In her undated second statement Ms Wood stated:

'*Dr Skinner and I never discussed whether I should have a caesarean or whether he should turn the baby.*

During my pregnancy, I never stated that I wanted a natural birth or that I did not want a caesarean. My plan was always to have a healthy baby.

...I asked what the risks were many times as I felt perhaps there could be other risks. It seemed like the baby being in a breech position wasn't an ideal situation because her position was always checked at each appointment. I was told the only risk was displaced hips. That was the only answer I ever got...Although I didn't specifically refer to a caesarean, I did keep asking what the risks were to make sure there were no other risks of which I was not aware.' [37]

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[34] Coronial Brief p 2.
[35] Coronial Brief p 2.
[36] Coronial Brief p 2.
[37] Coronial brief p 5.

81. Further, '*...at 37 weeks...Dr Skinner told me she was in breech and that her bottom was first. I don't recall him ever using the term frank breech but I have since discovered that it is the medical term. I had no understanding that this position was dangerous.*'[38]

82. In contrast, in his statement to the Court dated 28 June 2011, Dr Skinner stated:

'*Celia had a known breech presentation from midway through the third trimester...repeated ultrasound examinations in my rooms had confirmed a frank presentation of the breech baby and assessments of relative risks and benefits in regards to Celia and her baby this time. We had planned for a normal vaginal birth at term.*'

83. Dr Skinner went on to state:

'*I was aware of the breech presentation throughout the course of the third trimester of Celia's pregnancy and we discussed options in relation to the management of the delivery including Caesarean section, vaginal delivery or external cephalic version. Consistently she was happy with proceeding to a vaginal birth if the breech presentation had otherwise favourable risk factors.*'[39]

84. In his statement dated 13 March 2012, Dr Skinner wrote: '*I explained, as I normally do, the main issue of breech birth is the problem of entrapment of the after coming fetal head. I explained, as I normally do, the risk of fetal death is much higher in a woman who has never previously delivered a child vaginally. I explained, as I normally do, that breech birth in a woman who has previously had a normal vaginal birth, has a similar risk to the baby's health as a commonly performed forcep assisted delivery for birth. Ms Wood did not wish for a caesarean section, and appeared happy with continuing with the plan for vaginal birth. At no stage did she refuse vaginal birth or specifically request birth maybe by caesarean section.*' [40]

85. With respect to discussing risks, Dr Skinner stated: '*At the 37 week antenatal visit Ms Wood and I had a discussion about breech birth and the small increased risk it carries in a multigravida woman, as opposed to the significantly increased risk it carries in a first time expectant mother. I would routinely quote a risk of fetal death between 1:300*

[38] Coronial Brief p 4.
[39] Coronial Brief p 25.
[40] Coronial Brief p 27.

– 1:500 for a mulitgravid breech birth and almost all of the risk is due to head entrapment.' [41]

86. In a statement made in March 2013, Ms Wood's partner, Mr Peter Fraser stated he did not attend any third trimester appointments with Ms Wood. When she told him the baby was in a breech position and likely to stay in the breech position he stated:

'...I asked Celia what we should do about Martha, what Dr Skinner had told her, what his recommendations were and whether Celia should have a caesarean. Celia explained that a vaginal breech birth was the birthing option and that the risk to Martha was a displaced hip. Celia told me she had questioned Dr Skinner about what the risks were and was told that displaced hips was the only risk Dr Skinner had mentioned to her. She said that Dr Skinner had not mentioned a caesarean. I immediately questioned the fact that we were not having a caesarean with Celia as I expected a caesarean to be a doctor's advice.' [42]

Evidence at Inquest - Discussion about the risks of a Frank Breech presentation

87. It is not in dispute that at 24 weeks Ms Wood was aware baby Martha was in a breech presentation. During her third trimester, baby Martha's position moved between breech, cephalic and transverse, however by 37 weeks she settled to a breech presentation.

88. At 38 weeks and at 40 weeks 3 days, Dr Skinner conducted scans and baby Martha's position was noted on Ms Wood's 'Maternity Record' as 'Br (Frank)' and also on Dr Skinner's record of Ms Wood's Obstetric Care.[43]

89. Ms Wood's evidence was she did not recall a discussion with Dr Skinner about a *'footling breech presentation'* and she denied Dr Skinner ever discussing with her the *'the problem of entrapment of after coming foetal head.'* When asked whether Dr Skinner talked to her about the baby's head getting stuck as the main problem she stated, *'No...definitely not.'* [44]

90. Ms Wood gave evidence of looking up 'breech' on Wikipedia when she was 38 or 39 weeks and not understanding the different breech positions so, *'I couldn't tell if what I was reading related directly and I read about death and I thought, well that's not*

[41] Coronial brief p 32.
[42] Coronial Brief p 11.
[43] Exhibit 2 and Coronial Brief pp. 10 & 92.
[44] Transcript p 13.

relevant because I haven't been warned about death and ...Pete told me don't read any more...'[45] Ms Wood's evidence was she did not look at any books or have any books at home which may have alerted her to the significance of the breech presentation. [46]

91. Ms Wood's evidence of not knowing the type of breech presentation is at odds with the notes on her medical record which has at two entries, noted at paragraph 88 above. This record was tendered as an exhibit through Ms Wood and she identified it as '*...a card I take in at each appointment and he would fill it in and give it back.*'[47]

92. When asked if she thought of discussing what she had read on Wikipedia with Dr Skinner, her response was that she asked 'what are the risks?' and that the answer she got was '*displaced hips.*'[48]

93. Dr Skinner's hand written medical record has two references to risk, namely: '18/4 Tr – aware risk' and '4/5 Br (scan) discussed risk.'

Evidence at Inquest - Discussion about the methods of delivery – vaginal birth, elective caesarean section and emergency caesarean section

94. It was Ms Wood's evidence that she 'never discussed caesarean' with Dr Skinner.[49] She denied Dr Skinner's statement that they had recurrent discussions on the possibility of her needing a caesarean section for delivery for the last six ante-natal visits at Dr Skinner's rooms.[50]

95. Her evidence was that the only discussion they had about a caesarean section was the possibility of an emergency caesarean section, '*we talked about what would happen on the night and that...I'd have an ultrasound on arriving to hospital, we'd determine the correct position and whether an emergency caesarean would be needed.*'[51] Ms Wood denied any discussion about an elective caesarean.

96. The only other conversation about caesarean section she had was with midwife Ms Jasmine Howard who worked in Dr Skinner's rooms. Ms Howard told her a caesarean section was more risk to her and less risk to the baby and a vaginal birth was more risk to the baby. When LSC Taylor asked if Ms Wood followed this up with Dr Skinner

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[45] Transcript p 37.
[46] Other than a humorous or light hearted book on pregnancy by Kaz Cooke called 'Up the Duff'.
[47] Transcript p 7.
[48] Transcript p 38.
[49] Transcript p 11.
[50] Coronial Brief p 27
[51] Transcript p 12.

she stated she did, however Dr Skinner told her nothing about the risks to the baby of a vaginal birth, such as the possibility of death or head entrapment.

97. LSC Taylor referred Ms Wood to Mr Fraser's statement: '*I asked Celia what we should do about Martha. About what Dr Skinner had told her, what his recommendations were and whether Celia should have a caesarean? Celia explained that a vaginal birth was the birthing option and that the risk to Martha was a displaced hip.*' [52]

98. Ms Wood recalled Mr Fraser saying to her: '*Does this mean Caesar?' to which she replied 'Well Caesar wasn't mentioned. This appears to be - this is the normal way to go.*'[53]

99. LSC Taylor quoted Mr Fraser's statement: '*I immediately questioned the fact that we were not having a caesarean with Celia as I expected a caesarean to be a doctor's advice.*' [54] Ms Wood was asked about her response to Mr Fraser and replied, '*I just said...it wasn't discussed.*' When asked by LSC Taylor if Peter (Mr Fraser) accepted that, she replied '*I guess he did, yes.*'[55]

100. Ms Wood stated she went with what the doctor recommended, she was never asked if she wanted a vaginal birth or a caesarean, and '*I took it to mean, this is the standard practice for a breech baby.*'[56]

101. She stated if she had been advised about the risks associated with a breech delivery, she would have chosen to have a caesarean section.

102. In cross examination Ms Wood denied recalling saying specifically to Dr Skinner she had a preference for a natural birth. She was clear in her evidence that '*the caesarean was never discussed so I don't recall making a preference to a natural birth.*' [57]

103. This is in contrast to Dr Skinner's statement: '*Ms Wood displayed a <u>strong</u> enthusiasm for a normal birth and was inherently keen to avoid significant analgesia for her first*

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[52] Coronial brief p 11.
[53] Transcript p 40.
[54] Coronial brief p 11 and Transcript p 40.
[55] Transcript p 40.
[56] Transcript p 41.
[57] Transcript p 17.

birth. Ms Wood was openly keen to avoid caesarean section unless absolutely necessary.'[58]

104. When asked in evidence about disqualifying factors in deciding whether a woman is suitable for a vaginal breech birth, Dr Skinner's first consideration was: '*you must have a highly cooperative and a[n] enthusiastic mother to take on the conditions of a birth where they're precluded, for example, from an epidural which is very common in modern birthing and she must be cooperative to the point where she really desperately wants to wait for her labour to come and to be enthusiastic about delivering her birth – her baby normally so that's* [the] *number one thing.* '[59]

105. Ms Wood indicated it was only after baby Martha's death she became aware she had been a suitable candidate for a natural birth with a breech presentation because she was tall and slim, had had a relatively quick, vaginal first birth and that baby Martha was an average sized baby.

106. She agreed she was aware that to have a natural birth of a breech presentation it was necessary to be at hospital and have assistance from hospital staff. It is unclear how Ms Wood was aware of this and not aware of the risks of death by head entrapment.

107. Ms Wood's evidence was that she asked Dr Skinner about having an epidural and was told she would not be able to have one. She denied however that Dr Skinner advised her she would give birth in the lithotomy position.[60] This is at odds, however, with Dr Skinner's written record of the same appointment, on 23/5 he has noted 'method of delivery – no epi – lithotomy.'[61]

108. Mr Fraser was unable to explain why he had an expectation a caesarean section would be the mode of delivery for a baby in breech position, however he '*...would have expected at the time that caesar was the advice we should be given.*' [62]

109. Once his expectation (about a caesar) was not met, Mr Fraser was asked if he made any more enquiries '*No, no further than what we'd done that evening. And I don't know why not.*' Mr Fraser confirmed Ms Wood told him she did not discuss having a caesarean with Dr Skinner: '*Well...no, she didn't have – her comments that it was*

[58] Coronial Brief p 31.
[59] Transcript p. 114
[60] Transcript p 24.
[61] Coronial Brief p 92.
[62] Transcript p 56.

never mentioned, other than she'd always asked the risks. What are the risks in doing what we're doing, or what she's doing, the – the course of action she's taking.' [63]

110. Dr Skinner gave evidence that the plan with Ms Wood after her appointment on 30 May 2011 was for a further appointment in a couple of days' time and to be re-assessed. He stated: '*...so they're watched with vigilance and then they have a plan if nothing else occurs...My plan would normally be to do a caesar if they go too far overdue.*'[64] Dr Skinner stated in Ms Wood's case he would only have allowed her to be one week overdue before booking a caesarean section.

Advice provided by Dr Skinner about what to do when labour started

- **Statements to the Coroners court**

111. Ms Wood denied any discussion taking place with Dr Skinner about the need for an early presentation to hospital once labour had started, or the need to avoid delay because of the need to make arrangements regarding care of her toddler, or about the speed at which a second labour occurs.[65]

112. Regarding the birth, Ms Wood stated Dr Skinner told her: '*I should call the hospital once it all started. Dr Skinner did not specify pre labour or labour....I was not told there was urgency.*' [66]

113. In his statement dated 28 June 2011, Dr Skinner stated: '*Celia had extensive counselling from 35 weeks gestation in relation to the importance to attending the hospital given her baby's mal-presentation and the importance of management of the time of birth in a very controlled manner by myself or another senior obstetrician.*'

- **Evidence at Inquest**

114. Ms Wood stated there was only one discussion about labour with Dr Skinner which was to call the hospital '*when things started*' and '*once in hospital he - I would have a proper ultrasound to get a proper idea of her position and that, and that was about it.*'[67]

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[63] Transcript p 62.
[64] Transcript p 172.
[65] Coronial brief p 27.
[66] Coronial Brief p 6.
[67] Transcript p 12.

115. Ms Wood understood that 'when things started' meant when she was in labour, she was to call the hospital. Her understanding of the start of labour was 'waters breaking or regular contractions.'[68]

116. She was asked if she had a 'sense' that once in labour to get to hospital quickly, promptly, or urgently. She replied '*No, not urgently. I knew, I knew I'd be labouring at hospital rather than waiting at home but...there was no sense of urgency.*'[69]

117. Ms Wood's evidence was that Dr Skinner had estimated her labour would be three hours in duration, but she was aware that was a guess.

118. Ms Wood agreed when Mr Fraser called the hospital he was told to '*come in immediately*' and agreed, '*Yes, that was our plan.*'[70]

119. Ms Wood agreed with Mr Blanden that she should have had a sense of urgency to get to the hospital in order to safely deliver baby Martha

120. Ms Wood's plan was: '*Call my mother as soon as I knew things were happening, call the hospital and go to the hospital. I never planned to do any of my pre-labour or labour at home.*'[71] The evidence however suggests that although Ms Wood called her mother at 10.40pm, she told her not to rush, and Mr Fraser did not call the hospital until 11.09 pm. She clearly was in what she believed to be 'pre-labour' at home as she was not sure for 20-30 minutes whether she was in labour.

121. Ms Wood agreed they could have called the hospital 20 minutes earlier than Mr Fraser did.[72]

122. Ms Wood agreed she was aware she may need to have an emergency caesarean section to deliver baby Martha. When asked if, because of the possibility of an emergency caesarean section she was therefore aware of a sense of urgency in getting to hospital, she stated: '*I knew there had to be time to have a scan, yes.*'[73]

123. She agreed she was on notice there was an element of risk involved in the birth.

124. Ms Wood agreed that after her last consultation with Dr Skinner on 30 May 2011 she was aware that Martha was still in a frank breech presentation, she was three days

[68] Transcript p 12.
[69] Transcript p 13.
[70] Transcript p 21.
[71] Transcript p 29.
[72] Transcript p 21.
[73] Transcript p 23.

overdue, that her second labour would be different and likely to be faster than the first, that baby Martha was an average sized baby, that there was a risk she may need a caesarean section and that she was told to call the hospital as 'soon as things started.'[74] Ms Wood, although denying she had a sense of urgency, agreed the combination of those factors put her on notice about the urgency of getting to hospital because she had to be at hospital to have a safe delivery.

125. Mr Fraser stated in evidence the advice Ms Wood gave to him about ringing the hospital was similar to the advice when they had their first child: '*...when labour commences you call the hospital and say 'We're coming in' and that's what I did.*' [75]

126. When asked whether he knew this was different to the birth of their first child, Mr Fraser stated: '*I knew the position was different. The urgency I did not know.*'[76]

127. He knew the second labour would be quicker and that: '*...Celia mentioned that as a guesstimate, she was advised it would be around three hours.*' [77]

128. Mr Fraser was aware that given the presenting position there was a risk that depending how things went that a caesarean delivery may be required.

129. When he asked whether he was aware it was necessary for Ms Wood to be in hospital for the labouring process and to give birth naturally he stated: '*we always intended to be in hospital, yes...I didn't see it as being any more necessary than the first child.*' [78]

130. Unfortunately they did not act as stated in their evidence as when labour commenced, even at the latest point of Ms Wood's waters breaking at 11.00pm, Mr Fraser did not immediately call the hospital.

131. Dr Skinner's mid wife, Jasmine Howard also gave evidence at Inquest. Dr Skinner referred in his first statement to Ms Wood being '*counselled by midwives in my rooms in relation to the importance of attending the hospital.*'[79]

132. Mrs Howard's statement was written in terms of '*what she would usually do*' and it was clear she had no independent recollection, five years on, of her conversations with Ms Wood.

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[74] Transcript pp 27-28.
[75] Transcript p 56.
[76] Transcript p 57.
[77] Transcript p 57.
[78] Transcript p 58.
[79] Coronial brief p 24

133. Her only specific memory of discussions with Ms Wood was about the potential for breech babies to have displaced hips. This confirmed Ms Wood's evidence that this was a risk she discussed with the mid wife.

134. Ms Howard was asked by Mr Blanden to elaborate on the information she would give to women with a breech presentation who was going to give birth naturally as opposed to delivering by way of caesarean section. Ms Howard stated:

'*Women who decide to have a caesarean section, they have a booked caesarean section, so we – talk about having a caesarean section and what's involved with that. Women who have – decided to deliver, we talk about what's involved with that side, and briefly talk about what's involved and what to look out for and when to call us.*' [80]

135. When pressed by Mr Blanden to give more specifics regarding the discussions she has with women who are to deliver by way of natural birth with breech presentations and what was said to these women, Ms Howard replied:

'*More to what to be wary of. When to come in, what – all those sort of factors.*' [81]

136. Mr Blanden persisted: '*What discussion, for example, is there in relation to when to come in?*' to which Ms Howard replied '*As soon as they notice anything different. From what I described in my statement. The set of circumstances.*' [82]

137. Ms Howard was an unhelpful witness. Five years after the events it is not unusual for her not to have a specific recollection of her discussions with Ms Wood. However Ms Howard was either reticent or unable to give any qualitative information in her answers to Mr Blanden's questions about the information she would normally provide to women in Ms Wood's position who are planning a vaginal breech delivery.

- **Evidence about when does labour start?**

138. Ms Wood gave evidence about her understanding of what constitutes labour, as well as Dr Skinner and the experts.

139. Ms Wood's evidence was it took her 20 minutes to half an hour of being 'not sure' to work out she was in labour. [83]

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[80] Transcript p 80.
[81] Transcript p 80.
[82] Transcript p 80.
[83] Transcript p 19.

140. Having decided she was in labour however, she did not ring the hospital. [84]

141. Dr Skinner referred to labour as being a diagnosis made in retrospect,[85] but referred to *'a march of symptoms'* and mentioned a combination of contractions, back pain, pain and nausea. Dr Skinner agreed it would have been difficult for Ms Wood and Mr Fraser to recognise labour prior to *'the point when they started to get the march of symptoms.'* [86]

142. Dr Skinner believed Ms Wood realised she was in labour by 10.40pm when she rang her mum. Although it was put by Mr Halley that Ms Wood believed she was in 'pre-labour' at that point, Dr Skinner indicated, *'You can't really define the pre-labour and labour boundary...It's not clear enough.'* [87]

143. The experts noted it is hard for obstetricians to determine when labour has started, let alone the woman herself. Dr White stated *'It's difficult for professionals to diagnose when labour's started and even harder for our women...the really essential component is regularity of contractions... real labour is getting into a more regular pattern and a sense that things are changing.'*[88]

144. Dr Lyneham noted: *'advice needs to be given about going in when the contractions start, or if the waters break, or a show would be of more significance in this situation (breech) rather than a head-first presentation.'*[89]

145. The experts agreed that regular contractions or waters breaking were an indicator labour had begun, however noted in a breech presentation 'waters breaking for a breech is probably more significant than it is for most women going through labour.'[90]

146. It is not in dispute that Ms Wood was told to call the hospital 'when things get started.'

147. Ms Wood understood that to mean when labour started.

148. Dr White was of the view that the phrase 'when things get started' is probably not specific enough and the woman needs to present relatively early in her labour. [91] She was of the view the woman needed to be able to make a careful assessment of the

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[84] Transcript p 20.
[85] Transcript p 161.
[86] Transcript p 164.
[87] Transcript p 166.
[88] Transcript p 253.
[89] Transcript p 252.
[90] Transcript p 254.
[91] Transcript p 250.

onset of her labour and there is a need to be fairly specific about what they need to have prepared and when you want them to come in. [92]

149. Dr Bowyer was of the view she would impart a sense of urgency about someone having their second child nor 'waiting it out too long' because their first labour was quick. [93]

150. Ms Wood described no other symptoms other than Braxton Hicks contractions commencing at 9.30pm and her 'show' at 10.40pm. Her waters broke at 11.00pm.

151. Whilst she believed 'things had started' she was of the view this was what she termed 'pre-labour' and she wanted the confirmation of 'another sign'. The only further sign was her 'show' at 10.40 pm.

152. Ms Wood explained her understanding of 'labour' was either waters breaking or regular contractions.

153. Ms Wood indicated to LSC Taylor her belief as Dr Skinner had estimated she would have a three hour labour, she had three hours from when her waters broke.

Conclusions from the evidence

Advice from Dr Skinner about the risks of frank breech and birthing options

154. Ms Wood's evidence comprised her two statements, the first of which was made immediately after Martha's death, and her oral evidence at Inquest.

155. Ms Wood was a witness of quiet dignity and composure.

156. Ms Wood stated she never discussed having a caesarean section with Dr Skinner, nor was the option of a cephalic turn discussed. She was not told of any risks of a breech birth except that the baby could have displaced hips.

157. Each time she saw the mid wife at her appointment with Dr Skinner she was asked how she felt about the baby being in breech position.

158. She made no independent inquiries about the significance of having a baby in breech position.

159. She looked up the internet, saw there were different breech positions but stated she did not know which breech position her baby was in.

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[92] Transcript p 251.
[93] Transcript p 252.

160. This seems improbable as her medical card completed for each visit with Dr Skinner tendered has 'Frank' written on it for the 16/5 and 30/5 visits. Further, the only type of breech presentation suitable for a vaginal delivery is a frank breech.

161. When Mr Fraser was told the baby was in breech position he immediately questioned Ms Wood whether she was having a caesar. He has accepted her explanation that she did not discuss it with Dr Skinner.

162. Dr Skinner's three statements and his oral evidence detailed the multiple discussions he stated he had with Ms Wood about the frank breech presentation, the risks for the baby of a vaginal birth and the options for birth such as an elective caesarean. Although his medical record is scant, it documents risks being discussed twice.

163. The evidence of Ms Wood not following up with Dr Skinner when her partner questioned her having a caesar is difficult to understand. As is Mr Fraser's acceptance of her response to his questioning.

164. Ms Wood's evidence was, understandably, less than perfect given the effluxion of time: for example, she could only recall having 2 scans in Dr Skinner's rooms when Dr Skinner's evidence and written record indicate she had 3.

165. She agreed her recollection of events had become 'hazy.'[94]

166. She stated she did not know the 'type' of breech position of baby Martha, despite it being recorded on her visit card [95] noted 'Br (Frank)' on two entries 16/5 and 30/5/ 2011.

167. Cases which require the assessment of one witness's evidence against another are always difficult.

168. Dr Skinner is an obstetrician and his written contemporaneous records support his statements and oral evidence of discussions he had with Ms Wood about risks and birthing options. In Court he was very clear in his explanations of complex medical matters whilst giving his evidence and impressed as an experienced, conscientious and accessible obstetrician.

169. In contrast, some of Ms Wood's evidence seemed inherently unlikely, such as her not being aware of the type of breech presentation and not asking Dr Skinner about an

[94] Transcript p 21.
[95] Exhibit 2

elective caesarean section after direct questions on point from Mr Fraser. There was also inconsistencies in Ms Wood's knowledge, such as being aware of the need for hospital assistance with the birth and the possibility of an emergency caesarean, but not being aware of the main risk to the baby was of head entrapment.

170. Further, I find it difficult to accept the proposition put by Ms Wood that her questions to Dr Skinner about risks of a breech presentation were continually rebuffed with the answer only referring to displaced hips, as if Dr Skinner was refusing to impart information. This does not sit well with his expertise, presentation and evidence at Inquest.

171. Additionally, I accept Dr Skinner's evidence that the most important factor (other than physical factors) in preceding with a vaginal breech birth is that the mother is willing and enthusiastic to labour spontaneously and not have an epidural. Given that, it is difficult for me to be persuaded that Ms Wood was a passive uninformed passenger in this process.

172. I am satisfied the weight of evidence supports the finding that that Dr Skinner did advise Ms Wood about the risks of a frank breech presentation and the birthing options.

173. Dr White gave evidence on behalf of the experts regarding the information about options that would represent reasonable best practice in relation to birthing options so that a woman could give informed consent to the management proposed. I accept that information was provided by Dr Skinner, as contained in the totality of his evidence (both written and oral).

Advice from Dr Skinner about what to do when labour started

174. Ms Wood was told to call the hospital 'when things started.' By 'get started' she thought that meant in labour. By 'labour' she thought this meant her waters breaking or regular contractions. She had contractions from 9.30pm and a 'show' at 10.40pm when she called her mother. Her waters then broke at 11 pm and Mr Fraser called hospital at 11.09pm.

175. It is unclear from Ms Wood and Mr Fraser's evidence why they did not call the hospital when they knew that things had sufficiently started to call Ms Wood's mother at 10.40pm after the 'show'. It is unclear why they did not immediately call the

hospital after Ms Wood's waters broke at 11pm. They were clearly caught unawares by the speed of Ms Wood's labour.

176. Ms Wood and Mr Fraser clearly did not appreciate the importance of getting to hospital quickly. At 10.40pm when Ms Wood called her mother she told her 'no rush' even though she was 25 minutes away. Mr Fraser did not call the hospital immediately after her waters broke as they decided to time the contractions. Ms Wood and Mr Fraser were both aware of the potential need for an emergency caesarean section.

177. Ms Wood agreed that she was aware that for a natural birth of a baby in breech position it was necessary to be at hospital and have the assistance of hospital staff.

178. I am of the view the weight of evidence confirms Ms Wood was aware of the need to get to hospital when labour started. She was aware of the possible need for an emergency caesarean and she agreed with Mr Blanden she should have been 'on notice' about a sense of urgency.

179. I accept Dr White's evidence that the instruction should have been more explicit than 'call the hospital when things get started.'

180. All witnesses expressed surprise at the rapidity of Ms Wood's labour. Dr Skinner had estimated 3 hours but the actual time from the onset of contractions to baby Martha's birth was under two hours.

181. The experts agreed with the difficulty in assessing when labour starts.

182. This appears to have been a tragic misunderstanding by Ms Wood and Mr Fraser, not appreciating the importance or urgency of getting to hospital despite being aware of the need for hospital intervention and the possibility of an emergency caesarean section.

ISSUE THREE

- **The adequacy and accuracy of Dr Skinner's ultrasound on 30 May 2011**

183. In her two pregnancies subsequent to her pregnancy with baby Martha, Ms Wood's evidence was she had formal scans at other services at 34 weeks.

184. Dr Skinner's statement dated 28 June 2011 indicated he performed 4 ultrasounds on Ms Wood in the last five weeks prior to delivery however his oral evidence and his notes confirmed three scans over 5 weeks.

185. Dr Skinner gave evidence of his experience with ultrasound. When he started training in obstetrics and gynaecology at Royal Women's Hospital a standard part of the program was to learn ultrasound. Throughout the first six years of training he had sessions with experts in the ultrasound department, and learnt how to assess the foetal presenting part, where the placenta is placed and to assess the fluid volume. During 1995 -2001 Dr Skinner used ultrasound on a daily basis. Post-graduation, he stated ultrasound is a normal part of his private practice which he performs every day.[96] He described he used ultrasound, '*...not to look for complex things for which I'm not trained in...but I assess on a routine basis the positioning of babies and I give an estimate of size, and that would be a routine thing I still do every day in my rooms now.*' [97] Since being in private practice, Dr Skinner estimated doing between five and fifteen ultrasounds on a daily basis and estimated over his years of specialist practice he had performed tens of thousands of ultrasounds. [98]

186. Dr Skinner agreed with Mr Halley's proposition that where a patient has a breech presentation a formal ultrasound with an expert at 36 weeks would be appropriate in 'certain settings.' [99]

187. It was Dr Skinner's view that the high resolution machine is most useful in 'detecting small abnormalities' but 'doesn't help specifically with respect to the presentation of the baby into the birth canal.'

188. Dr Skinner indicated that 'nowadays' a large proportion of his patients have a formal third trimester ultrasound scan. He described it as 'low yield' with respect to improving outcomes and mentioned a 'cultural change within the industry' and that 'five years prior it would have been extremely rare to have a third trimester scan.' [100]

189. Dr Skinner agreed that Ms Wood was not given an option to have a formal ultrasound at 37 weeks: '*Certainly it wasn't widely practised back in 2011.*' [101]

190. In cross examination Dr Skinner described baby Martha's delivery, based on the reports by Ms Wood and Mr Fraser as '*...one foot came down and one leg stayed in. So it was part frank and part footling.*' He agreed that failing to diagnose a footling

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[96] The Inquest heard Dr Skinner's practice also involved referrals from other doctors of more '*complex medical problems and pregnancy related problems and births.*' Transcript p. 94.
[97] Transcript p 102.
[98] Transcript p 103.
[99] Transcript p 146.
[100] Transcript pp 148-9
[101] Transcript p 161.

breech or a half footling breech or a complete breech would be an '*error*,' although '*error rates are low, in the small percentages.*' [102]

191. Dr Skinner was willing to concede that mistakes can be made with ultrasound, and that continuing education and feedback can about skill levels can potentially help reduce errors. He agreed he had had no continuing education about ultrasound in the ten years prior to performing ultrasounds on Ms Wood. [103]

192. The expert panel was asked to consider whether it was reasonable for Dr Skinner to rely on the ultrasound in his rooms on 30 May 2011 considering his equipment, his experience and his expertise?

193. Dr Bowyer was not of the view that Dr Skinner's equipment was sufficiently reliable to be confident in saying whether the baby was presenting as a frank, complete or footling breech.

194. Dr Lyneham referred to the NSW guideline needing a formal ultrasound and he believed that this is what should have been done.

195. Dr White's initial view was that the equipment was adequate to define the type of breech, but deferred to Dr Bowyer as her not being confident it was sufficient to assess the type of breech.

196. When it came to the type of breech, Dr White was of the view that she could, using bedside ultrasound at the hospital, tell where the baby's legs and feet were. '*I thought perhaps a doctor was able to safely satisfy himself on that basis.*'[104] Dr White deferred to Dr Bowyer's expertise of the actual type of machine being used and how good the image would be and stated '*I'm not sure now that I could comfortably say the doctor could have been confident about the type of breech that the patient had.*'

197. Although this was Dr White's evidence at the conclave, when cross examined by Mr Blanden, Dr White stated that, given there is a clear distinction between a frank breech and a footling breech, if a doctor based on his experience and the type of equipment he has could reasonably be happy he could distinguish one from the other then it was reasonable to consider the option of a vaginal breech birth.

198. The Panel was asked whether Ms Wood should have been referred to a specialist obstetric ultrasound facility on 30 May 2011?

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[102] Transcript pp 141-2
[103] Transcript p 157.
[104] Transcript p 225

199. Dr White indicated that Dr Bowyer and Dr Lynham were clearly of the view that a referral should have been made.

200. Dr White indicated that she was more qualified in her response. In cross examination by Mr Blanden, Dr White agreed she accepted in her original report that Dr Skinner had both the expertise and adequate equipment to allow him to make a distinction of the type of breech and if he could reasonably do that, it was reasonable for him to proceed to diagnose a frank breech presentation at the time of delivery. [105]

201. It was put to Dr White that if Dr Skinner was comfortably satisfied, then based on his experience that was a reasonable way to proceed. Dr White stated that given there is a clear distinction between a frank breech and a footling breech, if a doctor based on his experience and the type of equipment he has could reasonably be happy he could distinguish one from the other then it was reasonable to consider the option of a vaginal breech birth.

202. Dr Bowyer was consistent in her position that a formal ultrasound should have been conducted at 37 weeks. She was of the view there was a significant possibility of diagnosing that the foetus was not in frank breech presentation. [106] She conceded that if a formal ultrasound was done at 37 weeks, it was still possible that the baby could move after that ultrasound and it would not be usual for the formal ultrasound to be repeated. A real time bedside ultrasound would be conducted to determine the presenting position.

203. I am satisfied from the evidence that Dr Skinner had the necessary expertise and experience to enable him to properly diagnose Ms Wood's frank breech presentation at the scan on 30 May 2011 in his rooms. He had conducted three scans of Ms Wood over the previous five weeks, he was familiar with her, having cared for her during this and her previous pregnancy. Further, he had been conducting between five and fifteen scans on a daily basis for many years. I am comfortably satisfied as to his expertise given that high volume daily practice and the specific purposes for which he used the scan, namely to determine the presentation, fluid volume and size. Both Dr Skinner's formal training and his day to day practice are sufficient to give him expertise in this field. I am satisfied for his purposes of ascertaining the presenting position, the ultrasound equipment was adequate and he was appropriately expert in its use.

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[105] Transcript p 233.
[106] Transcript p 244.

- **Whether the baby's position could have moved after the ultrasound.**

204. The expert panel was asked to consider the likelihood that the baby moved after the ultrasound on 30 May 2011.

205. Dr White indicated that they all felt it was a possibility that the baby changed from being a frank breech to a footling breech. The baby had been quite mobile until 36, 37 weeks when it did remain in a breech presentation. But clearly the baby had the capacity to have a little bit of mobility and, *'I think we all felt it is possible...we felt there was a possibility that the type of breech did change between the scan in the morning and the baby's birth later that day.'*[107]

206. Dr White agreed it was possible if the baby's position had changed that it was possible for one leg to pop out during the birthing phase. She stated *'...the baby was quite mobile until quite late in the pregnancy, which does suggest there was a reasonable volume around the baby, a laxity of the uterus and the maternal abdominal wall that are factors that allow a baby to be mobile or not.'* [108]

207. Dr Bowyer stated *'If it had been a mobile foetus as apparently it was, then it's quite possible for the foetus to constantly change position.'* [109]

208. The expert evidence was unanimous that it was possible that baby Martha moved from the frank breech presentation after the ultrasound on the morning of 30 May 2011.

Was a Vaginal breech birth a reasonable option?

209. The expert panel was asked to consider whether a vaginal breech delivery was a reasonable delivery option for Ms Wood.

210. The panel had differences in views as to what the doctor should do to be satisfied as to the size of the baby and the type of the breech presentation.

211. Dr Bowyer was of the view a formal obstetric ultrasound should be performed at 36-37 weeks to determine the actual presentation of the foetus and the estimated foetal weight.

212. By 'formal' ultrasound Dr Bowyer meant a trained sonographer operating ultrasound equipment that gives a lot more depth than Dr Skinner's bedside ultrasound.

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[107] Transcript p 230.
[108] Transcript pp 230-1.
[109] Transcript p 232.

213. Dr Lyneham was of the view, based on the guidelines from the Royal College of Obstetricians and Gynaecologists that a formal ultrasound should be performed before proceeding with a vaginal delivery.

214. Dr White was asked her views about the 'cultural shift' Dr Skinner referred to regarding ultrasounds in the third trimester. Dr White answered this was a huge topic to cover, being the importance of trying to assess foetal weight not just for breech but for all babies. Dr White described a very substantial shift in the last two or three years in trying to accurately predict a baby's weight.

215. Dr White took a slightly different approach to Dr Bowyer and Dr Lyneham regarding assessing a baby's weight and the appropriateness of a vaginal breech birth. It was her view that if you are an experienced clinician and you have looked after a woman in a previous pregnancy, you know how big her last baby was and you have seen her yourself consistently through the current pregnancy you have a sense of how good you are in assessing foetal weight and you have a reasonably slender patient, Dr White was of the view the experienced clinician can be more comfortable in assessing the safe weight range without necessarily having a more formal assessment.[110]

216. The panel was asked what was reasonable best practice obstetric advice to patients at the time (2011) regarding risks and hospital attendance in circumstances of a planned vaginal breech delivery.

217. Dr White responded on behalf of the panel. The women should be advised that most breech babies are born by caesarean section, and also the fact of the doubling of morbidly and mortality for babies in vaginal breech birth compared to a caesarean section. '*We all felt we would want to give the woman a sense of what might go wrong. The two factors of the risk with anything other than a frank breech are firstly, cord prolapse and secondly, the head has to come through in a matter of minutes so delay at that point is clearly a dangerous thing.*'

218. I have reviewed Dr Skinner's evidence and can find no reference to him having advised Ms Wood that most breech babies were born by caesarean section. In evidence he told the Court that for second time mothers '*it's probably in the order of about 60-70% would have a caesarean section,...but the remaining small percentage of breech*

[110] Transcript p 224

presentations will choose to have a vaginal birth will need to be managed very intensively, ...with a lot of information and assessment along the path of the last few weeks of pregnancy.' [111]

Dr Skinner's notes

219. Much of the evidence in Dr Skinner's statements[112] concerning his discussions with Ms Wood regarding birthing options, risk and what to do when labour started, are not noted in his medical records. The records run to a bare two pages,[113] and Ms Wood's maternity record is a single page.

220. However he stated in his evidence that the tragic events of baby Martha's delivery was a rare occurrence: '*We remember them, and you lock in your memory incredibly quickly after a bad event so, you know, for the bad two events I would see a year I remember them distinctly and you lock it in. You know what happens. So you don't lose track of it. I don't have any problem remembering that.*'[114]

221. It was put to Dr Skinner that his notes were 'minimal' and he described them as contemporary for what obstetricians tend to do. He stated that 80% of obstetricians would be computerised and, with the tick a box options, tend to record even less information. [115]

222. The expert panel was asked its opinion of the adequacy of Dr Skinner's records. Dr White's view of Dr Skinner's notes was, in the context of private practice with the advantages of continuity of care (in contrast to the public system), that the notes were a 'perfectly adequate' set of notes for someone managing Ms Wood's pregnancy.

223. Doctors Bowyer and Lyneham agreed, noting there was no column in the records to indicate the engagement of the presenting part.

Conclusions

224. Dr Skinner has conceded he erred in describing baby Martha as a 'still birth' to Ms Wood and Mr Fraser.

225. I find he erred in not reporting her death to the coroner.

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[111] Transcript p. 114
[112] Coronial Brief pp 24-34. Exhibits 8,9 & 10
[113] Coronial Brief pp 92 & 93 and exhibit 2.
[114] Transcript p 182.
[115] Transcript p 181.

226. Baby Martha's death was a tragic event. After considering the evidence I am satisfied as to the advice provided by Dr Skinner to Ms Wood regarding the nature of a frank breech presentation, the risks and the birthing options, as well as what to do when labour started were adequately explained to her.

227. Whilst the expert evidence noted some points of omission and lack of clarity in Dr Skinner's advice, I am not of the view the advice fell short of the standard of what constituted reasonable care.

228. I am satisfied Ms Wood was a suitable candidate for a vaginal breech birth and she was a willing and informed participant in that process.

229. I find the ultrasound conducted by Dr Skinner on 30 May 2011 was adequate given his equipment and expertise to accurately assess the presentation of the baby. Further, the experts agreed it was possible, given her mobility, that baby Martha moved position after that ultrasound.

230. The combination of factors of an unusually speedy labour and baby Martha's rapid delivery conspired against Ms Wood and Mr Fraser from getting to hospital in time.

231. I find baby Martha's death was the result of these unfortunate sequence of events and if she had been in hospital there is little doubt she would have lived.

232. In that context hers was a preventable death, however the speed of her decent during labour could not have been foreshadowed, taking all concerned by surprise.

Pursuant to section 73(1) of the *Coroners Act 2008*, I order that this Finding be published on the internet.

I direct a copy of this finding be distributed to:

Ms Celia Wood and Mr Peter Fraser

Adviceline Injury Lawyers on behalf of the family

Perry Maddocks Trollope for Dr Guy Skinner

Signature:

CAITLIN ENGLISH

CORONER

Date: 6 October 2016