IN THE CORONERS COURT
OF VICTORIA
AT BENDIGO

Court Reference: COR 2010 4201

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: THOMAS FREEMANTLE

Delivered On:	8 April 2014
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	22, 23, 24, 25, and 26 July 2013
Findings of:	JOHN OLLE, CORONER
Representation:	MS J. FREDERICO appeared on behalf of relatives of the Deceased. MR B. LINDNER appeared on behalf of Claire Hall. MS C. CURRIE appeared on behalf of Bendigo Health Care Group. MR C. WINNEKE appeared on behalf of Dr C. Sasse.
Police Coronial Support Unit	Leading Senior Constable T. Cristiano

I, JOHN OLLE, Coroner having investigated the death of THOMAS FREEMANTLE

AND having held an inquest in relation to this death on 22, 23, 24, 25, 26 July 2013
at BENDIGO LAW COURT
find that the identity of the deceased was THOMAS FREEMANTLE
born on 19 October 2010
and the death occurred on 22 October 2010
at Royal Children's Hospital, 50 Flemington Road, Parkville 3052
from:

1 (a) SEVERE HYPOXIC ISCHAEMIC ENCEPHALOPATHY

in the following circumstances:

1. Thomas Freemantle was a term two-day-old baby who died on 21 October 2010 at the Royal Children's Hospital ('RCH') Neonatal Intensive Care Unit.

The Birth

2. Thomas was the third child of Katrina and Garry Freemantle ('the parents'), born at home[1] on 19 October 2010 at approximately 6.56pm.

3. Due to his parlous condition, Ambulance Victoria were called and mobile intensive care ambulance (MICA) promptly dispatched at 7.04pm. Garry performed external cardiac massage and manual ventilations until MICA paramedics arrived at the farm at 7.31pm, after which paramedics estimated a 10-15 minute period elapsed, before cardiac electrical activity was viewed on the cardiac monitor.

4. Dr Wearne, consultant neonatologist assessed Thomas on arrival at Bendigo Hospital, and immediately co-ordinated with the Neonatal Emergency Transport Service (NETS) for retrieval and transport of Thomas to a neonatal intensive care unit.

5. NETS diagnosed severe Hypoxic Ischaemia Encephalopathy (HIE rated as grade 3) and coagulopathy[2] and conveyed Thomas to the Royal Children's Hospital (RCH) Neonatal Intensive Care Unit (NICU). Active treatment continued until it became apparent Thomas' condition was irreversible. He died at 2.30am on 22 October, 2010.

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[1] A family farm approximately 25 kilometres from Bendigo

[2] Coagulopathy (also called clotting disorder and bleeding disorder) is a condition in which the blood's ability to clot is impaired.

Expert Opinions

6. I have been assisted by the expert opinions of Dr Yeliena Baber[3], Dr Bernadette White[4] and midwife Ms Cathy Adams.[5]

Pre existing Obstetric risks in the Setting of a Homebirth

7. Katrina was admitted to hospital at 29 weeks' gestation with her first child, Amy, in relation to threatened premature labour.

8. Second child Cara weighed 4522 grams at birth, and suffered a fractured clavicle during the birthing process. Her shoulders were reportedly stuck for 10 minutes. Following birth Cara recorded APGARS of two at 1 minute; four at 5 minutes and six at 10 minutes. An emergency transfer to Bendigo Hospital was undertaken due to neonatal respiratory distress. In addition, Katrina suffered a post partum haemorrhage.

Overview of identification of risks during Katrina's pregnancy with Thomas

9. During Katrina's pregnancy with Thomas, the risks of Cephalo Pelvic Disproportion (CPD) and the associated adverse impact on mother and baby were identified. Maternity care providers informed the parents of the enhanced degree of risk of CPD, and expressed concern with the proposed home birth.

10. However, in relation to the history of shoulder dystocia, the parents maintained there was 'no conclusive evidence to support identified contributory factors and there has been no investigation of the psychological state of the mother during labour as a cause of shoulder dystocia'.

11. In evidence, the parents agreed that risks of home birth were canvassed, but stated the medical providers were not sufficiently firm in their advice that Thomas should be born at hospital. I return to this aspect shortly.

12. The inquest was conducted over five days in July 2013. My investigation has been assisted by respective members of counsel, and my assistant, Leading Senior Constable Cristiano. My findings are drawn from the inquest brief, evidence and submissions. I thank all members of counsel for their assistance.

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[3] Forensic Pathologist, Victorian Institute of Forensic Medicine

[4] Obstetrian and Gynaecologist

[5] RN;RM;Grad Dip;MaMid

Submissions of Bendigo Health

13. There are several options for pregnancy and maternity care at Bendigo Health, including;

    a) A public antenatal clinic (care provided by Bendigo Health medical and midwifery staff);

    b) Shared care between Bendigo Health and a woman's GP;

    c) The Mamta midwife-led care program; and

    d) Private obstetric care.[6]

The Mamta program

14. Among the models of maternity care available to women seeking to birth at the Bendigo Hospital is the Mamta program, which offers families a model of care in which a small team of midwives care for the participant throughout her pregnancy, birth at the hospital and postnatal period.

15. The Mamta program allows participants to develop an ongoing relationship with one primary midwife assigned to them (backed up by another midwife team member for when they are not available). Participants have continuity of care throughout their pregnancy and birth with their primary midwife, who provides antenatal care and attends at obstetric appointments, the labour and birth (which occurs in the hospital), and then follows through with post natal care.[7]

Mamta Eligibility, Referral and Discharge

16. In respect to Mamta eligibility, referral and discharge Protocol[8], women who are booked in to Bendigo Health for their birth and who are living within a 25km radius of the hospital are eligible to apply, however they will only be offered a place in the program if one is available. The demand for the Mamta program usually exceeds the number of places on offer within the program.

17. The Mamta program is a special midwifery program, not offered in many other hospitals.[9]

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[6] Ex. 25

[7] Transcript pages 310, 328-329

[8] Ex. 24

[9] Submission counsel for Bendigo Health

18. Why the parents chose not to accept the offer of a place in the Mamta program remains a mystery. However, in my view, Bendigo Health went to great lengths to meet the needs of the parents.

19. Garry expressed dissatisfaction with previous attendances at Bendigo Hospital, which regrettably, appear to have significantly influenced his decision making in respect to the impending birth of Thomas[10].

20. In addition, both parents held a general distrust of hospitals.

21. Ms Monique Rosenbauer[11] was an impressive witness. Her contemporaneous notes, of lengthy meeting with the parents on the 7 September 2010 graphically disclosed their mindset:

> "They want to be: 1) informed 2) allowed the opportunity to make their own decisions and 3) left alone to labour. They don't want to be reminded of history they just want 'choice'. Katrina and Garry were offered MAMTA midwifery care service - was explained. Katrina and Garry agreed to think about it and ring MSW in a few days. At this point, they are planning to birth 1) at home with Qld midwife Clare (if available) 2) free birthing at Autumn's home in Bendigo 3) at Bendigo Hospital."[12]

22. The parents initially maintained they did not accept the Mamta offer because they understood Katrina would not be permitted to attend hospital unless an established labour. However, Katrina subsequently withdrew this claim.[13]

Role of Ms Shotton

23. Ms Alison Shotton, Mamta Co-ordinator and Clinical Midwife Specialist, was the head of the Mamta program. She explained the Mamta program is based on a midwifery-led philosophy of care similar to home birth, except that the birth takes place in hospital.[14]

24. On the 15 September 2010, Katrina had a lengthy telephone conversation with Ms Shotton. Katrina described Ms Shotton in glowing terms.

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[10] Bendigo Health were unaware of Garry's perceived dissatisfaction with Bendigo Health.

[11] Maternity Support Worker.

[12] Ms Rosenbauer notes

[13] Transcript page 361

[14] Transcript pages 310-311

25. Katrina told Ms Shotton she remained hopeful a midwife from Queensland would attend. She was adamant, she did not really want a birth in hospital and that she wanted the baby at home.

26. Ms Shotton had a long discussion with Katrina about her birthing options if the Queensland midwife was unable to attend, including:

    a. **Free birthing at home with no midwife in attendance**: Ms Shotton explained and emphasised the high risks attached to that option. She was not an advocate of free birth.[15]

    b. **Birthing at hospital with no monitoring**: Ms Shotton advised that Bendigo Health would not be prepared to 'leave her alone in a room'. Katrina was advised that monitoring and observation would be offered, and that she had the right to decline monitoring but that would be documented.

    c. **Labouring at Autumn's house nearby the hospital**: Ms Shotton cautioned that the problem with shoulder dystocia is that emergency care is needed within 5 minutes if the baby gets stuck because of the risk of hypoxia. Even if Katrina was to labour at Autumn's house, much closer to hospital than the farm, she may still not be close enough to emergency care needed if shoulder dystocia was to occur.[16]

27. In my view, Ms Shotton's evidence was compelling. In evidence, Katrina acknowledged Ms Shotton's provided clear advice that a hospital birth was the safest option.[17]

Bendigo Health Antenatal Clinic Appointments

28. On 22 September 2010, Ms Shotton arranged for Katrina to attend an antenatal clinic appointment at Bendigo hospital with Dr Gajanayaka[18]. This was Katrina's first antenatal appointment[19] at the clinic in relation to her pregnancy with Thomas, there were no records

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[15] Transcript page 291

[16] Submission page 10

[17] Transcript pages 41.18-23

[18] Arranged by Ms Shotton

[19] Cara and Amy having been born at home

available to Dr Gajanayaka to disclose full details of her previous obstetric history.[20] Nonetheless, Dr Gajanayaka was able to take a detailed history from Katrina.[21]

29. Dr Gajanayaka highlighted the high risk of recurrent shoulder dystocia[22]. Further, she advised Katrina the risks included severe hypoxia and death.[2324]

30. I endorse the following submission of Bendigo Health:

> "In evidence, Mrs Freemantle spoke very positively about the contact she had had with Ms Shotton at the time of Amy's birth and what a wonderful job she had done, but then went on to say that in the context of the discussions regarding Thomas' impending birth, Mrs Freemantle was very disappointed with Ms Shotton and felt she had 'shut the door' on her. Ms Shotton was upset by the suggestion that she had 'shut the door' on Mrs Freemantle and denied it. She gave evidence about the lengths to which she had gone in her communications with Mrs Freemantle to try to keep her engaged with Bendigo Health because of her concern that baby Thomas needed to be born in hospital.[25] Ms Shotton agreed that it was possible that Mrs Freemantle's sense of disappointment resulted from the fact that Ms Shotton had been so clear in her views that this birth needed to happen in hospital, which was at odds with Mrs Freemantle's hopes of having a homebirth and her expectation that Ms Shotton would support her home birth.[26]

31. In my view, Bendigo Health sincerely attempted to accommodate the wishes of the parents, having consistently highlighted the serious risks associated with home birth in the context of this pregnancy.

Dr Baber

32. Dr Yeliena Baber, Forensic Pathologist at the Victorian Institute of Forensic Medicine expressed the opinion that the tragic outcome may have been the same had birth been conducted in a hospital with a full medical support. Further Dr Baber considered that on the

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[20] Transcript page 175

[21] Transcript page 175.20

[22] Transcript page 173

[23] Transcript page 174.5

[24] Submission Bendigo Health

[25] Transcript page 325

[26] Transcript page 325

state of the evidence it could not be said that Thomas would have had a better outcome had he been born in hospital[27].

33. I accept the evidence of Dr Baber. Nonetheless, in all the circumstances, in particular the risks posed in consideration of Katrina's obstetric history, home birth was fraught. It follows, the birth of Thomas should have occurred in a setting which offered immediate and comprehensive emergency medical support, namely a hospital.

The role of Claire Hall midwife

34. Ms Hall stated she 'declined to act as Katrina's midwife citing personal commitments, but continued to offer support to discuss her plans and offer friendship via emails to allow Katrina to discuss her concerns. She advised Katrina, if her personal commitments were finished in time and Katrina was unable to find someone else, she may travel to Victoria. Aspects of concern raised by Katrina were discussed, in addition to benefits and risks of birthing at home. In particular, how best to manage labour in circumstances of shoulder dystocia.

35. Ms Hall's decision to attend the birth was made on the morning of 15 October 2010, having learnt that Katrina intended to birth at home, without support. Ms Hall was understandably concerned with Katrina's decision, in particular the distance from hospital, and the previous birthing history.

36. Ms Hall decided to attend as a friend, not a midwife, and to assist in the event of an emergency. She explained to Katrina the limited role she would perform. Katrina agreed not to refer to her as a midwife. According to Ms Hall, Katrina wanted an unhindered labour, and hence 'I carried no equipment other than a neonatal resuscitation device.' Ms Hall charged no professional fees, and with reluctance, accepted payment for travel expenses.

37. During the birthing process, Ms Hall did not keep notes or monitor Katrina's progress. She did however, perform some midwifery tasks, including rupturing the membranes to augment labour, 'felt for a cord around the baby's neck'; and assisted Katrina '... to squat and I tried to feel for the anterior shoulder which I could feel easily but could not move.'

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[27] Following the death of Thomas, Court staff inadvertently incorrectly advised clinicians at the Royal Children's Hospital that the death was not reportable. The advice was subsequently corrected, however the result was that an autopsy was not performed.

Ms Hall gave frank evidence.

38. In hindsight, Ms Hall acknowledged she did not meet the standards expected of a professional midwife. She took no issue with the shortcomings in her conduct, set out in the report of Catherine Adams.

39. I accept her counsel's submissions, namely, that Ms Hall's intentions were honourable and genuine. However they were totally misguided. I accept Ms Hall's explanation that personal circumstances in her life, at that time, adversely affected her judgement.[28]

40. Ms Hall said that in circumstances of high risk of adverse outcome, it was standard for her to bluntly tell the parents that there was a risk of death, and that she believes she had such a conversation with Katrina.[29]

Catherine Adams

41. According to Ms Adams, Ms Hall's conduct did not meet the expected professional standards of a midwife.[30] She noted Ms Hall's intentions appeared genuine and honourable and that she wished to minimize the risk of an adverse outcome.[31] Ms Adams assumed Ms Hall had no knowledge of Katrina's clinical history or previous births.[32] However, Ms Adams was not aware of the extensive discussions between Ms Hall and Katrina over the 4 days before the birth.[33] She was critical of Ms Hall's dual role of friend and 'midwife in an emergency only'. Ms Hall frankly conceded this criticism.[34] Ms Hall further conceded her lack of documentation fell short of the competency standards. While it was appropriate to be present as a friend, Ms Adams concluded that the professional standards for midwifery practice were not met.[35] In particular, she did not take equipment to manage post partum haemorrhage[36] or apinards stethoscope or Doppler to listen to the foetal heartbeat.[37] The

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[28] Transcript page 423

[29] Trascript pages 422, 424-5

[30] P 58

[31] P 58

[32] P 63

[33] Transcript pages 456-7, 396

[34] Transcript page 394

[35] P 62

[36] P 63

[37] P 64

latter is an example of where the roles of friend and midwife blurred as Katrina specifically requested there be no monitoring of the foetal heartbeat by Ms Hall.[38]

42. Ms Hall no longer practices as a midwife or nurse nor holds a new registration in either capacity.[39]

Submissions on behalf of the parents

43. I accept the following submission of counsel for the parents:

> "Mr and Mrs Freemantle believe that the process of birth is of critical importance to the welfare of the child and mother and that a birth with minimal intervention…."

44. Further, I acknowledge the submission that the decision of the original mid-wife:

> "..provide midwifery care to Mrs Freemantle to birth at home in circumstances in which she was aware of Cara's shoulder dystocia[40]" may well have influenced the Freemantle's to believe that is was safe to birth at home.

45. I further acknowledge the previous mid-wife was still planning to support the parents in home birth after it was confirmed that Katrina was not expecting twins. I note this was at 33 weeks.

46. I accept Counsel's submission, that there is no evidence linking the birth at home with the death of Thomas.

47. However, I do not accept the submission there is no evidence as to the appropriateness of home birth in this circumstance. On the contrary, there is a plethora of evidence Thomas should have been born in hospital.

There were clear and serious risks associated with home birth in this circumstance

48. Katrina's pregnancy posed clear and obvious risks. Always, the safety of the child is paramount. The decision to home birth did not meet that objective.

49. My investigation and finding, is not a critique on the merits, or otherwise of home birth. Rather, high risk pregnancies demand birth occur in the safest setting – namely, a hospital which can provide emergency and timely, medical support.

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[38] Transcript page 402

[39] Transcript pages 376-7

[40] Transcript page 227.5-6

50. I previously noted that the efforts of all clinicians dealing with the family were clear and with best interest and endeavoured to highlight the risks associated with home birth.

I do not criticise the parents

51. In circumstances in which a mid-wife who knew the obstetric history, was initially prepared to facilitate a home-birth would potentially mitigate the risks. Following her withdrawal, that another qualified mid-wife, Ms Hall was prepared to assist the home birth process could also lend erroneous comfort to the safe option of home birth, despite clear, unequivocal and repeated highlighting of risks by clinical staff.

52. Dr White deposed:

> "The fact that my midwife is prepared to stay here with me must mean it's okay, because why would she do that if it wasn't all right."[41]

53. Finally, I note the comments of Counsel for the parents for my consideration "in the interest of improving the system". I accept the genuine motivation of the parents to ensure that lessons are learnt which will facilitate children being born in the safest setting. I note a subsequent child of the parents, was safely born in hospital.

54. Although I consider the efforts of clinical staff at Bendigo Health not to alienate the parents, and encourage a hospital birth, were exemplary, I agree with Counsel's submission that the wishes of parents should be considered and where possible, accommodated. However, the safety of the child is paramount and it follows, in cases of identified high risk, the wishes of the parents always secondary to ensuring the safest birthing process.

Communication the key

55. Ms Adams explained her approach to parents expressing a distrust of hospitals:

> ".....outline the absolute – the risk factors, together with the – with tangible data, as in, in this particular case saying that the subsequent baby to Cara has got 10 time greater risk of having shoulder dystocia than Cara because there was a previous one. So, giving very, very hard facts about that. And the mortality and morbidity that is associated with all of those risk factors. I would very, very clearly articulate for each

[41] Transcript page 486.15-17

one of the risk factors what the probable or possible outcomes would be should those events occur, and should those events occur in a home environment."[42]

56. Ms Adams noted that she would clearly articulate those risks and identify the example of the former midwife was not prepared to continue care because she considered home birth too risky.

57. Ms Adams referred to The National Midwifery Guidelines:

> "Formalised plans actually develop in collaboration with medical officers to suggest what has been done, what has been attempted, and that care would continue in collaboration with medical officers, albeit still maybe in the home."[43]

58. Ms Adams acknowledged the frustration expressed by all clinical staff, she remained a strong supporter of home birth:

> "I am a supporter of home birth under safe practices. I have been observing on the periphery some action that's occurring in South Australia at the moment to try and regulate a little bit more, um, robustly, the criteria under which people can practice in the home. I don't know where that's going to go in the end, but I'm feeling a little impassioned about the need for, um, a structure and systems and regulation around homebirth. But having said that I actually acknowledge the Freemantles frustrations with the hospitals and I think sometimes hospital systems, apart from what you've described in the Mamta program, which are fabulous models of care around Australia, similar to that, I think it's important that we get the systems better to appreciate family's wishes and preferences through birth processes so that they can trust and they can feel part of the birth processes and negotiation processes to keep them within the system where possible, particularly where risk is.[44]

Dr Bernadette White

59. Dr White endorsed the Mamta program, which she considered an excellent option for mothers who want natural birth.

60. Dr White highlighted the unpredictability of Thomas' birth, and stressed the importance of clear messages being conveyed from clinical staff to parents. Having reviewed the material,

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[42] Transcript pages 465-466

[43] Transcript pages 466-467

[44] Transcript pages 469-470

she considered the risks were consistently and clearly conveyed to the parents by Bendigo Health clinicians.

61. However, Dr White felt there were limits:

> "I think there's a limit really to how much you can continue to try and engage someone who clearly says "look, what you're offering is not what I want…..", you know, I think there's a level of responsibility on both parties to sort of say, look, we've talked this through, we've done everything we can. We haven't come up with a solution for our problem."[45]

62. Dr White urged the following process

1) Attempt to build a good relationship in the first instance

2) Convey/ensure the parents understand and hear what you are saying and that you are prepared to listen to them. Must have good communication in the first instance.

3) You must acknowledge:

> "look, what is it that you want? What aspect of it is important to you? Why do want to have your baby at home? Look, you had shoulder dystocia, and you need to understand what happened last time. Do you understand what the difficulty was and what had to happen?"[46]

63. Further, clearly explain:

> "You've really just got to go through so that they understand exactly what happened last time, what the risks are, why your concerned about it, what might happen. You know "what were worried about is that your baby's head will come out and we cannot get the shoulders out." From that point the baby's oxygen supply is very limited. We've only got a few minutes or the baby will really be seriously injured. You know, the risk of damage with the pulling and all of that. The risk of maternal injury."[47]

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[45] Transcript page 496

[46] Transcript page 499

[47] Transcript page 500

64. The process is to slowly explain the above and answer all questions posed by the parents and provide the information in 'huge detail, so that in the end you hopefully have conveyed why you are advising what you're advising to that patient'.[48]

65. Having explained the risk of home birth with no assistance and the risk of home birth with a midwife it is not about frightening the couple but fully informing the parents:

> "in the end it comes down to, you know, experienced professional communication about these things, having gone through those things with a lot of other, and appreciating why women are nervous, why they find it hard to accept advice, why they want a certain birth experience. It's quite a complex interaction.....in the very end, and I'm not suggesting that this would ever be at the first consultation, I think it's when you really feel you've run out of all options, I think it kind of does get back to what I was saying, and then you might have to say, "look, I can't go along with what you're wanting because I just don't think that's fair on me as a professional, the colleagues that I'm putting those burdens onto...and that maybe sometimes you just have to say, "look can't do it....."[49]

66. Dr White noted some couples just have an unrealistic understanding of the risks they're taking. They consider it is a natural process what is all the fuss. That the baby will come out fine. In such a case, it is appropriate to convey to the parents "there is a risk your baby will die" or there is a risk your baby will seriously brain damaged because it didn't have enough oxygen.[50]

67. Clear, unambiguous communication is the key. Despite the best efforts of every clinician at Bendigo Health the message did not get through to the parents.

68. I am acutely aware of the devastating loss, suffered by the parents. Further, I acknowledge the pain and anguish suffered by the clinical staff and individuals who sought to assist the birthing process.

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[48] Transcript page 500

[49] Transcript pages 501-502

[50] Transcript page 503

Comment pursuant to S. 67(3) Coroners Act 2008

This case highlights the need for women planning a home birth to undergo a comprehensive risk assessment. The risk assessment could articulate agreed home birth practice during the course of the pregnancy, together with agreed contingency plan in the event of emergency.

I make the above comment for the consideration of:

- The Australian Health Regulation Agency (APHRA);
- The Nursing and Midwifery Board of Australia;
- The Victorian Department of Health

Finding

I find the cause of death of Thomas Freemantle to be severe hypoxic ischaemic encepatholopathy.

I direct that a copy of this finding be provided to the following:
Katrina and Garry Freemantle
IM
Interested parties
The Australian Health Regulation Agency (APHRA)
The Nursing and Midwifery Board of Australia
The Victorian Department of Health

Signature:

JOHN OLLE
CORONER
Date: 8 April 2014