IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 000345

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Judge John Cain, State Coroner
Deceased:	Baby A
Date of birth:	29 December 2021
Date of death:	17 January 2022
Cause of death:	1(a) Pneumonia in the setting of malnutrition
Place of death:	[redacted],
Keywords:	Home birth; unassisted birth; malnutrition

INTRODUCTION

1. On 17 January 2022, Baby A was two and a half weeks old when he passed away at his home. Baby A was the first child born to his Mother, who was 24 years old, and his Father, who was 26 years old at the time of his birth. Baby A's parents met in September 2020 and commenced a relationship about five weeks after meeting. His parents shared strong religious beliefs and were married in January 2021. The Mother fell pregnant with Baby A in March 2021.

2. In May 2021, the Mother and Father moved to Geelong and commenced living with the Father's mother (**the Paternal Grandmother**). The Mother and Father lived upstairs at the property, whilst the Paternal Grandmother lived downstairs. The Mother and Father did not seek any medical care throughout the pregnancy, and explained that they did research online, in books and listened to testimonies. They decided that they "*wanted to live by faith in [their] pregnancy*" and therefore wanted to have a birth that was as natural as possible with no invasive procedures.

3. The Mother and Father agreed to have a homebirth, and researched homebirths in their local area. They located a maternal health provider nearby and discussed the possibility of having a midwife present at the birth. The Mother and Father consulted with a potential midwife via FaceTime in June 2021, however ultimately decided they "*wanted to be lead (sic) completely by faith*" and decided against having a midwife present. The Mother and Father discussed the possibility of having a doula present and met with a doula, Hannah Goding, in November 2021. The parents also decided not to have a doula present at the time of the birth, however the doula provided some "*valuable information and [they] really loved her perspective regarding home birth*".

THE CORONIAL INVESTIGATION

4. Baby A's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

5. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

6. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

7. Victoria Police assigned Detective Senior Constable Damian McKeegan to be the Coroner's Investigator for the investigation of Baby A's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, and investigating officers – and submitted a coronial brief of evidence.

8. This finding draws on the totality of the coronial investigation into the death of Baby A including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the deceased

9. On 17 January 2022, Baby A, born 29 December 2021, was visually identified by his Father.

10. Identity is not in dispute and requires no further investigation.

Medical cause of death

11. On 19 January 2022, Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy and provided a written report of his findings dated 30 August 2022.

12. The post-mortem examination revealed a male infant with signs of malnutrition. His body weight was 2.87kg, which was less than the 5th percentile for his age, and much less than his reported 4kg birth weight. The thymus showed involution and atrophy, the liver showed steatosis, there was gelatinous transformation of bone marrow, and the brain showed widespread Alzheimer type II astrocytosis, all being consistent with metabolic injury from malnutrition.

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

13. Dr Young noted dry wrinkled skin, sunken fontanelles, congestive vascular changes in the brain, and elevated sodium, chloride and creatinine in vitreous humour were all consistent with dehydration.

14. Pneumonia was seen throughout both lungs. *Escherichia coli* was cultured from multiple sites throughout the body. Given the presence of early onset decomposition, this may have been due to disseminated infection (sepsis) or post-mortem bacterial overgrowth. Malnutrition is associated with immunosuppression, increasing the risk of developing infections such as pneumonia.

15. The baby was reported to have had difficulty latching with breast feeding. There was no evidence of any anatomical abnormality to account for this, and in particular, no evidence of trachea-oesophageal fistula. Milk products were not identified in the stomach.

16. Toxicological analysis of blood showed the presence of a low level of ethanol (alcohol) at 0.02 g/100mL. Given the degree of decomposition, the presence of ethanol in this case was likely due to bacterial fermentation in the setting of decomposition.

17. Metabolic testing did not reveal a cause for the deceased's malnutrition. The radiographic skeletal survey showed no evidence of unexpected skeletal trauma.

18. Dr Young explained that malnutrition results from a lack of nutrients due to reduced intake (from diet or vomiting), lack of absorption (from malabsorption or infection) or increased loss (from diarrhoea). In this case, the cause of the child's malnutrition was likely due to reduced intake, from an inability to adequately breastfeed. The pneumonia may have been due to aspiration, and would have contributed further toward feeding difficulties, decline, and eventual respiratory arrest.

19. Dr Young also noted that the baby was reportedly co-sleeping with his parents, which is considered an unsafe sleeping environment.

20. Dr Young provided an opinion that the medical cause of death was *pneumonia in the setting of malnutrition.*

21. I accept Dr Young's opinion as to the cause of death.

Circumstances in which the death occurred

22. Baby A's due date was 27 December 2021. He was born at home at 4.03pm on 29 December 2021, in the presence of his Mother and Father. The Mother recalled Baby A was able to breathe immediately and there were no complications from the birth. Baby A was "*born a healthy plump baby boy*" and weighed about 4kg. The parents left his umbilical cord attached for a few hours, as they had researched it was best to leave the umbilical cord attached until it was thin and white. Baby A did not breastfeed immediately, however his Mother recalled breastfeeding him the morning after his birth (30 December 2021). Baby A's parents did not register his birth with Births, Deaths and Marriages and he did not have a birth certificate.

23. Baby A slept on the same bed as his parents and cried when his parents attempted to have him sleep in his own bassinette. His Mother observed that Baby A "*always want[ed] to be on [her] breast*" and was unsure whether this was normal, so she contacted Ms Goding. Ms Goding reportedly advised the Mother that this was normal and that Baby A may have been cluster feeding. On about Baby A's fifth day of life, his parents introduced a structured feeding and sleep schedule for him, feeding him every three hours.

24. On or about 11 January 2022, the Mother advised the Father that Baby A appeared to be looking skinnier than they had hoped for, and he "*appeared blue in colour*". They both thought that Baby A was not getting enough breastmilk. According to the Father, they continued breastfeeding Baby A until 13 January 2022, after which time they switched to formula. The Mother reported this switch occurred on or about 15 January 2022.

25. On or about 15 January 2022, the Mother observed that Baby A "*appeared to be weak*" whilst she was feeding him. She noted that "*he was not moving his arms around as much as he previously had and he appeared to have lost a bit of weight from all over his body*". The Mother explained that she had learnt that it was normal for babies to lose a bit of weight after birth, however she was nevertheless concerned because of Baby A's weight and colouring.

26. The Mother and Father spoke about the issue and thought that Baby A was not getting enough nutrition from breastfeeding, and they decided to introduce Baby A to formula milk. The Mother observed that Baby A's nappies were both wet and dirty from his feeds, however his stool was not as yellow as it should have been and was of a "*clay texture*".

27. The Mother spoke to the Paternal Grandmother on the evening of 15 January 2022 about Baby A's condition. The Paternal Grandmother had Baby A grab her finger and observed that he

was not gripping it tightly enough and she noted that Baby A appeared weak. The Mother purchased baby formula that night and immediately commenced feeding formula. The Mother observed that Baby A could not latch onto the teat of the bottle properly, so she squeezed the formula slowly out into his mouth until the bottle was emptied. She also noted that Baby A's feeding schedule became irregular again after switching to formula, as the feeding took much longer when squeezing it into his mouth.

28. On the evening of 15 January and into 16 January 2022, the Mother and Father continued feeding Baby A with formula. This was a very slow process and after most of the feedings, Baby A vomited some of the formula. Around this time, the Maternal Grandmother suggested to the Mother that she could take Baby A to a nurse from the nearby hospital for free, however the Mother declined and wanted to focus on improving Baby A's nutrition first.

29. At about midnight on 17 January 2022, the Mother awoke in bed with the Father placing Baby A down beside her. Baby A appeared to be sleeping however the Father indicated his concerned to the Mother regarding Baby A's breathing. They both thought that Baby A would recover and together they lay down on the bed and prayed over Baby A.

30. The Father awoke at 3.00am for Baby A's scheduled feed and observed that Baby A "*appeared to be 'fading' and he was turning purple*". The Father carried Baby A into the bathroom where he commenced cardiopulmonary resuscitation (**CPR**), however stopped when he realised that Baby A had passed away. At that point, he woke up the Mother and informed her of Baby A's passing, at which point the Mother attempted CPR on Baby A.

31. When CPR was performed the second time by the Mother, the parents discussed whether or not they should call an ambulance. They decided that they had faith that Baby A would not die and therefore did not call for an ambulance. The parents also explained that they did not think about notifying the Paternal Grandmother, who lived downstairs.

32. Initially, the Mother and Father mourned Baby A's loss in private. They changed his nappy and put him in new clothes and wrapped him up. Later that morning, the Mother and Father spoke to the Paternal Grandmother and advised her of Baby A's passing. The Paternal Grandmother attended her sister's home (**the Paternal Great-Aunt**) and informed her of Baby A's passing. She explained that the Mother and the Father wanted to bury Baby A, however the Paternal Great-Aunt urged her to contact the police. The Paternal Great-Aunt and Grandmother returned to the Paternal Grandmother's house where they explained to the Mother and the Father that they needed to call police.

33. Paramedics attended the scene at 3.50pm, shortly followed by police at 4.02pm. Paramedics examined Baby A and confirmed that he was deceased. Resuscitation was not attempted as it was clear he had died some time ago.

FURTHER INVESTIGATIONS

Subsequent police investigation

34. Police investigated Baby A's passing and sought advice from the Office of Public Prosecutions (**OPP**). The OPP sought a further report from Dr Young, with the following queries:

    a) Whether Dr Young expected to see milk products in the stomach or bowel?

    b) Whether Baby A would have survived if medical treatment was sought at 3.00am on 17 January 2022 or shortly thereafter?

    c) Whether Baby A would have survived if medical attention was sought on the evening of 15 January or on 16 January 2022?

35. Dr Young explained that he may not expect to see milk products within the stomach or bowel due to multiple variables. He noted that the consumption of milk products may have been influenced by vomiting, aspiration into the lungs, lack of swallowing the actual products, which were all possibilities in this case. He also noted that the rate of gastric emptying and transit time through the bowel varies from person to person and cannot be measured post-mortem. Finally, he explained that the appearance of milk products may be altered by the digestion process, thus whilst the contents did not have an overall appearance of milk products, the presence of a small proportion of milk products could not be excluded.

36. Regarding the preventability of Baby A's death, Dr Young explained that based on a review of the circumstances and his post-mortem examination, he could not say if Baby A would have survived if medical attention had been sought at any time prior to the death. However, in the presence of any medical intervention (as opposed to no medical intervention), there is always the possibility that any patient could survive in the given circumstances. Dr Young noted that the question of survivability would be best addressed by a specialist neonatologist or paediatrician.

37. Victoria Police ultimately determined not to issue criminal charges against the Mother and Father of Baby A.

FINDINGS AND CONCLUSION

38. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Baby A born 29 December 2021;

    b) the death occurred on 17 January 2022 at [redacted], from *pneumonia in the setting of malnutrition;* and

    c) the death occurred in the circumstances described above.

39. Having considered all of the circumstances, I am satisfied that whilst I cannot determine that Baby A's death was preventable, there may have been some benefit from specialist maternity or medical support. It appears likely that the earlier the medical attention was sought, the higher the likelihood that Baby A would have recovered and survived. I cannot determine at which point in time the medical attention was required to prevent his death, however, note that any medical intervention would likely have been beneficial.

40. This case is a timely reminder for parents who choose to embark on a 'free birth' or home birth without medical assistance or intervention. There are other coronial investigations into the deaths of newborns during or immediately after an unassisted home birth, where medical intervention may have prevented the infants' deaths. Whilst the decision about where and how a woman chooses to labour is a deeply personal issue for the parents-to-be, this case and other cases highlight the importance of appropriately consulting with medical professionals to ensure the birth and development of the child is safe and healthy.

I convey my sincere condolences to Baby A's family for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

The Mother & Father, Senior Next of Kin

Detective Senior Constable Damian McKeegan, Coroner's Investigator

Signature:

Judge John Cain
State Coroner
Date: 28 August 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.