IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

**COR 2023 001846**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

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

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| Findings of: | Coroner Catherine Fitzgerald |
| Deceased: | Baby S[1] |
| Date of birth: | 1 April 2023 |
| Date of death: | 8 April 2023 |
| Cause of death: | 1(a) Hypoxic ischaemic encephalopathy in the setting of a breech delivery |
| Place of death: | Monash Children's Hospital, 246 Clayton Road, Clayton, Victoria, 3168 |
| Keywords: | Breech birth; home birth; free birth |

[1] This Finding has been de-identified by order of Coroner Catherine Fitzgerald which includes an order to replace the name of the deceased, and the names of other persons related to or associated with the deceased, with a pseudonym of a randomly generated letter sequence for the purposes of publication.

## INTRODUCTION

1. On 8 April 2023, Baby S was one week old when he passed away at the Monash Children's Hospital (**MCH**). Baby S had been transferred by ambulance to MCH for urgent medical care following his birth at home, which occurred on 1 April 2023.

## THE CORONIAL INVESTIGATION

2. Baby 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.

3. The role of a Coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and the circumstances in which the death occurred. The 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.

4. 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.

5. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Baby S' death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence.

6. This finding draws on the totality of the coronial investigation into the death of Baby S 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.[2]

[2] 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.

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

### Circumstances in which the death occurred

7. The mother fell pregnant with Baby S in July 2022. The mother was dissatisfied with her experience giving birth to her eldest son in a hospital, so decided that she wanted a home birth for Baby S. She noted that "*a home birth was a safer choice for me and my baby*".

8. The mother reported that she had non-invasive prenatal testing through her regular general practitioner (**GP**), Dr LK, the results of which were normal. When the mother was about three months pregnant, she became unwell with a "*strep infection in late October*" 2022. The mother did not undergo any of the available genetic antenatal blood tests or foetal morphology ultrasound scans early in her pregnancy. Dr LK was informed by the mother that she intended to have her baby at home with a private midwife present.

9. On 27 March 2023, the mother presented to Dr LK in the context of abnormal liver function tests and complaints of itchiness. Dr LK was concerned about a diagnosis of cholestasis of pregnancy and pruritus. Dr LK referred the mother to hospital for further investigations of this condition. She presented to the Angliss Hospital on 28 March 2023, with a referral from Dr LK, which stated that the mother was 38 weeks pregnant, had an estimated due date of 8 April 2023, and was reportedly under the care of a private midwife with a plan for a home birth.

10. The mother attended Angliss Hospital on 28 March 2023, and first spoke with midwife P and explained that she was planning for a homebirth in the presence of a private midwife, however, when queried about the provider's name she stated that she did not want to disclose the name or details of the midwife. She informed midwife P that she was a "*maternity consumer*" and had a good understanding of cholestasis of pregnancy. Midwife P recommended that the mother speak with one of the obstetric staff members, which she agreed to do.

11. Obstetric and Gynaecology Registrar, Dr JK, then consulted with the mother on the same date. He noted a ten-day history of itching, mainly on her palms and the soles of her feet, liver function test derangement and bile acidosis of 66 umol/L (normal <5 umol/L). Dr JK noted that the mother had not had any obstetric growth ultrasound scans during her pregnancy. He noted her intention to birth at home with a private midwife but recommended that she have an induction of labour within the next week, given that she was at term, as per the current guidelines. The mother queried whether this was necessary, given that her bile acidosis was less than 100 umol/L. Dr JK explained the risks associated with an elevated bile acidosis level,

despite not exceeding the 100 umol/L threshold, and recommended close monitoring of her pregnancy, regardless of her decision to have an induction of labour. The mother said she would consider induction if her bile acidosis was above 100 umol/L.

12. Midwife P completed observations and an examination of the mother. She determined that the baby was in breech position and recalled Dr JK who performed an examination, including abdominal palpation and a bedside ultrasound, which demonstrated the baby was in a flex breech position. He explained to the mother that the usual recommended delivery route for a breech birth was via caesarean section, however in appropriately selected cases, a breech vaginal birth could be possible in a well-resourced and supported hospital setting. Dr JK noted that in cases of breech birth, continuous electronic foetal monitoring, use of analgesia, and medical staff attendance at the time of the birth were all necessary. There was also the potential for operative vaginal delivery in some cases. He explained that not all Obstetricians were willing to facilitate a breech vaginal delivery, and that he would need to find an Obstetrician who would be willing to support the mother if she wished to proceed with a breech vaginal delivery.

13. Dr JK explained the risks associated with a breech vaginal delivery, including cord prolapse, head entrapment by the cervix and the need for timely delivery of various parts of the foetus. The mother still confirmed her desire for a home birth, however Dr JK strongly discouraged this and noted that there would likely be a delay in receiving medical intervention if the birth was attempted at home. The mother agreed to Dr JK calling Consultant Obstetrician and Gynaecologist, Dr PL, to ascertain whether he would be willing to facilitate a breech vaginal delivery in hospital. Dr PL agreed to see the mother at his private rooms to discuss her options. The mother declined Dr JK's offers for an induction of labour and caesarean section to be booked at the Angliss Hospital.

14. The mother presented to Dr PL on 29 March 2023. Dr PL checked her blood pressure, which was normal, and confirmed the baby was still in a breech position. Dr PL explained that he had strict criteria before agreeing to support an assisted vaginal breech delivery. This included the type and size (estimated foetal weight) of the baby, which can only be obtained by a detailed obstetric ultrasound. The mother underwent a detailed obstetric ultrasound later that day and made a follow-up appointment, to see Dr PL on 3 April 2023, for Dr PL to review the ultrasound results and discuss options with the mother. At that time, Dr PL had not yet agreed to support a vaginal breech delivery and directed the mother to immediately present to a hospital if her contractions started in the interim.

15. The mother noted that she felt uncomfortable with Dr PL being her obstetrician and that he was not a clinician that she would have chosen herself, however she felt she did not have "*any other options*". She was also uncomfortable with the demeanour of the sonographer who performed the ultrasound she had on 29 March 2023. As the mother took a generally negative view of her experiences with Dr PL and the sonographer, she decided to call her friend.

16. The friend apparently explained to the mother that she was not a doula and did not run a business, however had commenced a 'birth attendant course' in 2022 with a 'birth attendant' named Ms D. According to her website, Ms D claims she has "*trained as a childbirth educator and counsellor*". The friend noted that she attended three births in hospital over 2022 to gain experience, but did not hold any formal qualifications.

17. On the night of 29 March 2023, the friend visited the mother and her husband- Baby S' father, to discuss the birth plans. The mother stated that as she did not have cholestasis, she wanted to have her baby at home. The friend and the father were both supportive of this plan. Once the friend left, the mother says she discussed the plan further with her husband, and changed her mind, deciding to proceed with Dr PL. Whilst she thought about finding another person to assist with the delivery, she was already 38 weeks gestation, and she had a follow-up appointment scheduled with Dr PL on 3 April 2023.

18. On the morning of 1 April 2023, the mother felt "*some tightening*", however did not think this was unusual as she had experienced tightening from about 32 weeks. By about 11.00am that morning, the mother felt the tightening was "*a bit different*" and called her husband to tell him. She him not to come home from work as it was still "*very early days*". She also sent a text message to the friend which read "*somethings (sic) happening, early days*".

19. The mother continued with her day as per usual and observed her contractions were about 30 to 40 minutes apart. At about 2.00pm, the mother called her husband again and asked him to come home. He arrived home at about 2.30pm, and the mother sent him to the shops to get supplies for their eldest son's birthday. When the father returned home, they discussed a plan for the grandmother to pick up their eldest son to care for him. At about 3.30pm, the mother decided to lie down and rest in bed for about 30 minutes.

20. When the mother awoke at about 4.00pm, her husband timed her contractions to be about 10 minutes apart. She decided to have a shower and told the father to call the grandmother to collect their son. The father called the grandmother and informed the friend to come over to

their house. Once in the shower, the mother felt a spontaneous rupture of membranes and called out to her husband that her waters had broken.

21. The mother felt a large contraction that appeared different to the other contractions she had experienced, and "*felt something come out*". She felt a foot had come out, then she "*was no longer having contractions*". She could feel the baby "*moving himself down and [she] could feel him moving his legs*". It seems Baby S' legs first appeared at about 4.14pm.

22. At about 4.41pm, the nape of Baby S' neck was in view. The friend arrived at the home at about the same time and observed the mother in a squatting position, with the baby "*almost born*". The friend could see most of the baby, "*with only his forehead still inside*". The friend asked when the last contraction occurred, however the mother was unable to say when it occurred. The friend was concerned that the umbilical cord was white in colour when it should have been deep blue, and it was decided to call an ambulance.

23. The friend called 000 at 4.52pm. The 000 call-taker provided instructions to the friend, who relayed them to the mother. The call-taker explained that the mother needed to "*push all [her] energy down*". The mother continued pushing until Baby S was born, with the placenta delivered almost immediately after Baby S.

24. When Baby S was born, he was blue in colour and not breathing. This was conveyed to the 000 call-taker who provided instructions. The first paramedics arrived on scene at about 5.12pm, and immediately commenced cardiopulmonary resuscitation (**CPR**). Paramedics on scene contacted the Paediatric Infant Perinatal Emergency Retrieval (**PIPER**) service for additional guidance and support with Baby S' resuscitation.

25. When paramedics first arrived, Baby S did not have a detectable heart rate and required ventilation with a bag valve mask at 100% oxygen. Three attempts at an endotracheal intubation (**ETT**) were required, with a successful ETT placed on the third attempt at 5.22pm. The umbilical cord was cut at 5.30pm and a few minutes later, the ETT required suctioning due to meconium being visible. On PIPER's advice, paramedics transported Baby S to the nearby Angliss Hospital for further treatment. The mother was transported to the Angliss Hospital in a separate ambulance.

26. Paramedics arrived with Baby S at the Angliss Hospital at 5.54pm. Angliss Hospital staff were aware of his impending arrival, and various senior clinicians were assembled in preparation.

Upon his arrival, Baby S' heart rate had risen to 91 bpm, so ventilation continued, and CPR was ceased.

27. Initial testing of Baby S' condition at the Angliss Hospital showed significant metabolic acidosis. Baby S received broad spectrum antibiotics, intramuscular vitamin K and coagulopathy. A plan was formulated to transfer Baby S to the MCH. PIPER collected Baby S from Angliss Hospital at 7.40pm and transferred him to MCH, where he was admitted to the Neonatal Intensive Care Unit (**NICU**).

28. At the MCH NICU, Baby S underwent 72 hours of therapeutic hypothermia and anticonvulsant treatments, however he remained unresponsive with fixed, bilateral dilated pupils. He was ventilator dependent with no spontaneous respiratory effort. An MRI completed on 6 April 2023 demonstrated severe global hypoxic ischaemic encephalopathy (**HIE**). Following consultation with his family, active treatments were ceased, and Baby S passed away at the MCH NICU on 8 April 2023.

**Identity of the deceased**

29. On 8 April 2023, Baby S, born 1 April 2023, was visually identified by his mother.

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

**Medical cause of death**

31. Forensic Pathologist Dr Joanne Ho, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 11 April 2023 and provided a written report of her findings dated 12 July 2023.

32. The post-mortem examination revealed an infant male, consistent with his gestational age. There were bruises to the hands and right knee, and a healing abrasion to the left ankle, which may have been in keeping with medical intervention.

33. Post-mortem radiographic skeletal surgery and a whole-body CT scan (reported by Dr Timothy Cain from the Royal Children's Hospital) showed no evidence of unexpected skeletal trauma.

34. Examination of the placenta showed a singleton placenta, showing eccentric insertion of the cord without compromise. There was widespread acute to subacute meconium exposure

involving free membranes and disc, chorionic villous maturation consistent with late third trimester. No other significant histopathological findings were noted.

35. Dr Ho noted that an autopsy was recommended given the circumstances of a home delivery with only a doula present, and the deceased having possible signs of sepsis. I note that the duty Coroner initially directed that an autopsy be performed, however, there was strong objection from the parents who submitted a reconsideration request pursuant to s 26(2)(a) of the Act. This was granted and no autopsy was performed.

36. Dr Ho explained that a breech delivery is when the baby's feet or bottom is positioned first in the uterus. A vaginal delivery can be complicated and dangerous in those circumstances. Complications can cause injuries and umbilical cord problems, such as flattening or twisting of the cord during delivery, which can cause nerve or brain damage due to the lack of oxygen.

37. Toxicological analysis of ante-mortem samples did not identify the presence of ethanol or any commonly encountered drugs or poisons.

*38.* Dr Ho provided an opinion that the medical cause of death was "*1(a) Hypoxic ischaemic encephalopathy in the setting of a breech delivery.*"

39. I accept Dr Ho's opinion.

**CPU Review**

40. Following receipt of Dr Ho's medical examiner's report and the coronial brief, I directed that the Coroner's Prevention Unit (**CPU**)[3] review this case to determine if the medical care and advice provided to the mother was appropriate, and whether Baby S' death was preventable.

41. The CPU explained that a breech presentation (when compared to a cephalic presentation) increases the risk of harm to the baby due to birth injury or lack of oxygen. A vaginal delivery of a singleton breech at term may still be an option for carefully selected women who plan to birth in a facility where there are appropriately skilled staff and infrastructure (including an operating theatre and neonatal care) to support such a birth. However, not all breech births are suitable for vaginal delivery. I also note that the recommended criteria for vaginal delivery in

[3] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

these circumstances and appropriate management of breech births is outlined in the RANZCOG[4] Clinical Guidance Statement '*Management of breech presentation*', which states that delivery by caesarean section is "*often recommended as a safer method of birth for the breech baby but carries risks for the mother – both immediately and for future pregnancies*".

42. The CPU noted that Dr JK and Dr PL appropriately counselled the mother about the risks of a breech vaginal delivery in comparison to a caesarean section, and strongly advised her not to have a breech vaginal delivery at home. Dr JK invited the mother to return to, or call, the Angliss Hospital birthing suite at any time. Similarly, Dr PL provided appropriate advice to immediately attend hospital if contractions started.

43. The CPU opined that if the mother presented to hospital when her contractions commenced she would have received earlier medical intervention, and this may have led to a different outcome. The CPU noted that in a hospital setting the baby would have been carefully and closely monitored. If there were any complications or issues, experienced medical personnel would have been immediately available to escalate her care as required, including with caesarean section. Delivery via caesarean section most likely would have prevented Baby S' death.

**Conclusions**

44. I am satisfied that the mother's prevailing intention from the outset of her pregnancy was to have a home birth. Even when it was confirmed that Baby S was in a breech position, the mother initially maintained her intention to birth at home and declined a booking for induction of labour and caesarean section at Angliss Hospital. Appropriate information and management were provided about the risk this posed, and there was a referral to a specialist Obstetrician who could review whether it was possible for vaginal delivery to occur. The management was in accordance with the RANZCOG Clinical Guidance Statement.

45. The interaction with Dr PL was also in accordance with the RANZCOG Clinical Guidance Statement. It was necessary for an ultrasound to occur as part of the risk assessment for potential vaginal breech delivery and a follow up appointment was appropriately booked to discuss the results and future management plan. Advice was given by Dr PL to immediately attend hospital if contractions commenced in the interim.

[4] The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (**RANZCOG**). The Clinical Guidance Statement is publicly available and published on the RANZCOG website.

46. Yet, the mother initially decided not to proceed with Dr PL or seek medical assistance with the birth. This is evidenced by the subsequent arrangements made with the friend, when she was told that the intention was still to have a home birth.

47. The mother states she then changed her mind, and a decision was made the night prior to Baby S' birth to attend the appointment with Dr PL. However, when her contractions commenced the next morning at about 11am, the mother did not present to hospital as advised and it was the friend who was notified what was occurring. No medical advice or assistance was requested.

48. From the time the contractions started at about 11.00am, there was sufficient time for an ambulance to be called or for direct presentation to a hospital. There was no call made to 000 until 4.52pm, some 30 minutes after delivery had clearly commenced, and after the friend arrived at the home. By the time 000 was called, Baby S was delivered to the point of his forehead and the umbilical cord had turned white. The timing of the birth suggests his head was trapped for at least 20 minutes, but it may have been longer.

49. The dangerous risks of breech birth are well known and understood. As delivery occurred in a home setting without any medical assistance, it is unsurprising one of the known risks eventuated in this case, namely, brain damage due to lack of oxygen. On the balance of probabilities, I am satisfied that Baby S would have survived if he was delivered in a hospital setting. In those circumstances, I am satisfied that the death was preventable.

50. Whilst the death was preventable, I have not identified any specific prevention opportunities arising from this case. It remains unclear why no medical assistance was sought prior to the friend attending the home prior to 4.52pm. The mother and the father wrote to the Court and indicated that the occurrence of the birth at home was not a deliberate decision, and that having regard to their devastation and distress about the death, they felt unable to provide any further information. They generously acknowledged "*the remarkable diligence and compassion of the emergency services and healthcare workers who cared for* [Baby S]."

51. Although I have not identified any specific prevention opportunities, it may be that knowledge of the circumstances of this case could assist other expectant parents in their decision making regarding the birth of their child, particularly in evaluating the risks of a home birth without medical assistance, and in understanding the general risks of a breech delivery. As such, I have directed that these findings be published with the identities of those involved removed

for privacy reasons, as publication of the identities is not necessary to achieve the purpose I have identified.

**FINDINGS**

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

    a) the identity of the deceased was Baby S, born 1 April 2023;

    b) the death occurred on 8 April 2023 at Monash Children's Hospital, 246 Clayton Road, Clayton, Victoria, 3168, from hypoxic ischaemic encephalopathy in the setting of a breech delivery; and

    c) the death occurred in the circumstances described above.

I acknowledge the ongoing grief and distress of Baby S' parents, and I offer them my sincere condolences.

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 and with all the identities of those involved removed.

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

The father, Senior Next of Kin

The mother, Senior Next of Kin

Eastern Health

Monash Health

Senior Constable Dylan Thomas, Victoria Police, Coroner's Investigator

Dr PL

Dr LK

Signature:


Coroner Catherine Fitzgerald

Date : 21 November 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.