IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 004768

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Tasman Murray Tribe
Date of birth:	12 August 2022
Date of death:	19 August 2022
Cause of death:	1a: Complications of birth-related traumatic head injury
Place of death:	Mercy Hospital for Women, 163 Studley Road, Heidelberg, Victoria, 3084
Keywords:	Neonate, PPROM, emergency caesarean, impacted foetal head

INTRODUCTION

1. On 19 August 2022, Tasman Murray Tribe was 7 days old when he passed from complications arising during his birth.

2. Tasman's mother, Grace Gaylard, became pregnant in December of 2021 with her partner, Harley Tribe. Grace has a medical history of a Type 1 diabetes mellitus and only one functioning kidney, so the couple stayed in close contact with her GP and endocrinologist during the pregnancy.[1]

3. In the first two trimesters of the pregnancy, Grace maintained a normal lifestyle and the scans showed that baby Tasman was growing well. In the third trimester, at around the 32-week mark, Grace's blood pressure started to rise, but this was satisfactorily managed by medication.[2]

THE CORONIAL INVESTIGATION

4. Tasman'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 an officer to be the Coronial Investigator for the investigation of Tasman's death. The Coronial Investigator conducted inquiries on my behalf, including taking

[1] Statement of Grace Gaylard, Coronial Brief.
[2] Ibid.

statements from witnesses – such as family, the forensic pathologist, treating clinicians 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 Tasman Murray Tribe 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.[3]

9. In considering the issues associated with this finding, I have been mindful of Tasman's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

10. On the evening of 10 August 2022, at 36 weeks and 1 day gestation, Grace experienced some fluid leakage. She reflected on this overnight and reported it to the University Hospital Geelong early the next morning.[4] She was admitted that day and was advised that her waters had broken.[5]

11. By the morning of 12 August 2022, Grace was in early labour, with clear liquor draining. At 3:40 am, Grace was transferred to the birth suite for ongoing care and monitoring, and she progressed normally to full dilation by 9:30 am. She was then allowed an hour of passive descent before she commenced active pushing (second stage of labour) at 10:45 am.[6] Upon review of her progress at 11:45 am, Grace was noted to be 'pushing effectively with good descent'. Grace's primary midwife then discussed with the midwife in charge about

[3] 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.
[4] Statement of Grace Gaylard, Coronial Brief.
[5] Pre-term pre-labour rupture of membranes (PPROM). Statement of Dr David Fuller, Coronial Brief.
[6] Statement of Dr Geraldine Masson, Coronial Brief.

commencing a syntocinon infusion to augment her natural uterine contractions, as Grace had been pushing for an hour and 15 minutes and her contractions had slowed.[7]

12. The Birth Suite Unit (BSU) Medical Registrar is documented as being contacted at 11:46 am, with a request for a review of Grace regarding a prolonged second stage of labour. The BSU Medical Registrar was occupied with another patient and was unable to attend immediately. The SeMi Urgent Gynaecology (SMUG) Registrar was then contacted at around 11:59 am. The advice provided is documented as 'commence syntocinon infusion for next 15-30 minutes'. Syntocinin was commenced at 12:05 pm, and increased at 12:30 pm to 24 ml/hr.[8]

13. At 12:45 pm, Grace was reviewed by the Consultant Obstetrician, Dr Tony Ma. A repeat vaginal examination was performed, and a decision was made to trial an instrumental birth in the operating theatre, with the option of a caesarean section delivery if required. Consent was obtained from Grace and the syntocinon was continued. The procedure was booked as a category 1 procedure[9] at 1:00 pm. Grace was transferred to the operating theatre at 1:10 pm, arriving at 1:25 pm, and then onto the operating table at 1:35 pm.[10] The syntocinon was continued during transit and there were no concerns for the baby's wellbeing on the CTG.[11]

14. At 1:40 pm, a vaginal examination was undertaken in the operating theatre by Dr Ma. Operation notes indicate that the presenting part of the baby was in 'LOT (left occiptotransverse)' position at 'station +1' descent with 'no palpable head above the pelvic brim. Caput' (swelling on baby's head) 'to +2', consistent with deep transverse arrest/prolonged second stage. Dr Ma noted that he was 'unable to manually rotate the presenting part with and without maternal effort'. Syntocinon was increased at 1:45 pm to 36 ml/hr.[12]

15. A Ventouse (vacuum extractor) was applied to the baby's head by Dr Ma at 1:46 pm. There was a single pull of ventouse with no descent of the presenting part and loss of suction. Further attempted vaginal delivery was abandoned. A foetal pillow was applied to stop any further

[7] Statement of Dr David Fuller, Coronial Brief; Expert Report of AProf Ryan Hodges dated 30 June 2024; Barwon Health medical records of Grace Gaylard.
[8] Statement of Dr David Fuller, Coronial Brief; Barwon Health medical records of Grace Gaylard.
[9] Meaning that delivery is intended to take place within 30 minutes.
[10] Expert report of A/Prof Rydan Hodges,
[11] Statement of Dr David Fuller, Coronial Brief; Barwon Health medical records of Grace Gaylard.
[12] Statement of Dr David Fuller, Coronial Brief; Barwon Health medical records of Grace Gaylard.

descent of the head and Grace was returned to supine position for non-elective caesarean section.[13]

16. The BSU Medical Registrar, Dr Mark Farrugia, commenced the caesarean section with skin incision time at 1:56 pm and uterine incision at 2:02 pm. The baby's head was found to be deeply impacted, and Dr Farrugia was unable to easily disimpact it. Dr Ma then took over the primary operator's position. He was also unable to disimpact the baby's head, and requested the anaesthetist to administer sublingual Glyceryl trinatrate to Grace to assist with uterine relaxation. The baby's head remained unable to be disimpacted. Preparation for manual vaginal disimpaction commenced with removal of the foetal pillow and request for attendance of a second Obstetric Consultant. Dr Farrugia provided elevation of the foetal head vaginally by pushing up from below to assist Dr Ma in delivery.[14]

17. Tasman was born at 2:08pm. He was pale, floppy and in poor condition,[15] with Apgar scores of 1 at 1 minute, 0 at 5 minutes and 1 at 10 minutes.[16] His birth weight is documented at 3000g. Tasman is documented to have had an initial gasp at birth but no detectable heart rate. He had no response to initial ventilation via intermittent positive pressure ventilation (IPPV). Cardiopulmonary Resuscitation (CPR) was started and a Neonatal MET call was called, closely followed by a Neonatal Code Blue at approximately 2 minutes of age.[17] IPPV was continued in 100 percent oxygen.[18]

18. Tasman received resuscitation by a paediatric team and return of spontaneous circulation (ROSC) was achieved at 23 minutes of life. Around 26 minutes of life he was transferred to the Special Care Nursery and placed on a ventilator.[19] It was noted that Tasman had an abnormal neurological examination with distal flexuring, and weak suck and gag reflexes.

[13] Statement of Dr David Fuller, Coronial Brief.
[14] Statement of Dr David Fuller, Coronial Brief; Barwon Health medical records of Grace Gaylard.
[15] Cord gases were Arterial pH 7.15 and lactate 4.9 and Venous pH 7.25 and lactate 3.2.
[16] Statement of Dr David Fuller, Coronial Brief; Barwon Health medical records of Grace Gaylard. The APGAR score (referring to Appearance, Pulse, Grimace, Activity and Respiration) standardises the way healthcare professionals evaluate a baby's physical wellbeing at birth and how well each baby makes the physical transition to independent life from their mother. The APGAR score utilises five physical signs and is scored when the baby is 1 minute old and again when they are 5 minutes old. The APGAR score ranges from 0 to 10, with a lower score indicating poorer outcome. However, the maximum score is usually 9, since almost all newborns lose 1 point for blue hands and feet (which is normal after birth).
[17] Statement of Dr Kate McCloskey dated 30 January 2024.
[18] Statement of Dr David Fuller, Coronial Brief.
[19] Statement of Dr David Fuller, Coronial Brief.

Blood tests later confirmed coagulopathy. A cranial ultrasound was ordered which showed presumed subarachnoid haemorrhage and cerebral oedema.[20]

19. Once Tasman had been stabilised, the Paediatric Infant Perinatal Emergency Retrieval (PIPER) team was contacted and activated to retrieve Tasman as he was severely unwell and potentially needing treatments only available in a Neonatal Intensive Care Unit (NICU).[21] PIPER arrived at approximately 5:30 pm and Tasman was transferred to the Mercy Hospital for Women.[22]

20. At the Mercy Hospital, there was an onset of seizures and indications that Tasman was suffering from multiorgan dysfunction and poor cardiac output with need for inotrope support. He was managed with ventilation support and therapeutic hypothermia for 72 hours.

21. An MRI performed on 17 August 2022 showed an extensive brain injury consistent with hypoxic ischemic injury, predominantly in the right cerebral hemisphere.

22. Grace and Harley were counselled about Tasman's condition, and a decision was made to redirect the goals of his care to palliative management. On 19 August 2022, Tasman was extubated and he passed away at 10:10 pm.

Identity of the deceased

23. On 20 August 2022, Tasman Murray Tribe, born 12 August 2022, was visually identified by his father, Harley Tribe. Identity is not in dispute and requires no further investigation.

Medical cause of death

24. Forensic Pathologist Dr Judith Fronczek from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 23 August 2022 and provided a written report of her findings dated 6 January 2023.

25. The post-mortem examination revealed external and internal head injuries and haemorrhages, the latter extending down into the spinal cord. It was not possible to comment on the timing of the various brain injuries due to the prolonged hospital admission.

[20] Barwon Health medical records of Baby of Grace Gaylard.
[21] Statement of Dr David Fuller, Coronial Brief.
[22] Statement of Dr Kate McCloskey dated 30 January 2024.

26. There was a focal acute bronchopneumonia of the right lung, but this is a well-known complication of hospitalisation, especially in patients who were ventilated like Tasman.

27. There was no evidence of natural disease that could account for Tasman's condition at delivery, and there were no congenital abnormalities and no evidence of metabolic disease. Examination of the placenta did not show a reason that could account for his condition at delivery.

28. Toxicological analysis of retained post-mortem samples was not undertaken given that his entire lifespan had been under well documented hospital supervision.

29. Dr Fronczek provided an opinion that the medical cause of death was 1(a) complications of birth-related traumatic head injury, and I accept her opinion.

30. In formulating that opinion, Dr Fronczek had the benefit of a specialist neurological examination conducted by Dr Linda Iles, also of VIFM, on 23 August 2022 and subsequently described in her report dated 28 December 2022. Dr Illes' neuropathological findings were consistent with a head injury and did not reveal any independent cause of death, disease process nor other abnormality.

REVIEW OF CARE

31. Given the medical context of Tasman's death, I directed the independent practitioners in the Health and Medical Investigation Team of the Coroners Prevention Unit (**CPU**)[23] to review the care provided to Grace and Tasman immediately before and after Tasman's birth.

32. The CPU reviewed all available evidence in Tasman's case, including the witness statements, medical statements and deposition, the medical records, the forensic pathologist's report and the balance of the coronial brief.

[23] The CPU is a team made up of health professionals and personnel with experience in a range of areas including medicine, nursing, mental health, public health, family violence and other generalist non-clinical matters. The unit may review the medical care and treatment in cases referred by the coroner, as well as assist with research related to public health and safety.

33. On 12 July 2024, the CPU advised me that, in their opinion, Tasman's death fulfilled the Safer Care Victoria (**SCV**) 'sentinel event'[24] reporting criteria, namely, as a Category 11 (subcategory 1) event: 'all other adverse patient safety events resulting in serious harm or death' involving clinical process and procedure.[25] Though Barwon Health conducted an internal clinical review of Tasman's case, the health service confirmed they did not report his death to the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (**CCOPMM**),[26] nor to SCV as a sentinel event.[27] In these circumstances, I will direct that CCOPMM and SCV be provided a copy of this determination for their consideration.

34. As part of the CPU review, I commissioned an expert report from Associate Professor Ryan Hodges, Obstetrician and Maternal Fetal Medicine Specialist, dated 30 June 2024. Associate Professor Hodges concluded that:

    a) all necessary and suitably experienced medical staff were present at the appropriate times to manage an impacted foetal head in the operating theatre;

    b) appropriate steps were taken to disimpact the foetal head;

    c) the management of the paediatric resuscitation was reasonable; and that

    d) he could not be certain which factors contributed in what proportions to the outcome, such that a contribution of all factors could not be excluded.

35. Associate Professor Hodges also reflected on the findings of Barwon Health's internal review and the recommendations made, namely:

    a) To develop strategies to address the issue of inadequate and incomplete documentation which will lead to improved documentation practice, ensuring comprehensive and accurate medical records.

    b) To ensure current guidelines and documentation templates relating to care in labour are aligned with best practice principles. Identify any gaps or areas for improvement

[24] A 'sentinel event' is defined as 'an unexpected and adverse event that occurs infrequently in a health service entity and results in the death of, or serious physical or psychological injury to, a patient as a result of system and process deficiencies at the health service entity' by regulation 3A of the *Health Services (Quality and Safety) Regulations 2020*.
[25] Safer Care Victoria, *Victorian sentinel event guide* (June 2019): https://www.safercare.vic.gov.au/sites/default/files/2019-06/Victorian%20sentinel%20events%20guide.pdf
[26] Letter from Minter Ellison dated 21 October 2024, Coronial Brief.
[27] Statement of Dr Geraldine Dr Masson dated 2 February 2024.

and implementation of evidence-based guidelines and related documents that align with the best standards of care to improve consistency of documentation when providing care during labour and birth. To this end,

c) To ensure current guidelines include a clear description as to what constitutes a prolonged second stage of labour, the importance of timely recognition and management of a prolonged second stage of labour to reduce the risk of adverse outcomes to the birthing person or neonate.

d) That consideration should be given to incorporating difficult caesarean section scenarios into multi-disciplinary obstetric emergency training for both maternity and theatre teams, including disimpaction of the foetal head at caesarean section.[28]

36. I note that these recommendations had been implemented in whole or in part as at February 2024.[29]

37. Associate Professor Hodges agreed that recommendations (a) to (c) were appropriate, but considered that (d) could be strengthened. Whilst acknowledging that Barwon Health expressed an intention to include difficult caesarean section scenario training within the PROMPT training program[30] when it was next refreshed, he reflected that it is challenging to ensure annual multidisciplinary maternity emergency training (such as PROMPT) for all birth suite maternity staff, as is recommended by Victoria's Managed Insurance Agency (VMIA) Incentivising Better Patient Safety program. He noted that both obstetric medical and midwifery clinicians may be called upon unexpectedly in theatre to perform a vaginal disimpaction, and often this is likely to be a more junior clinician who is not actively scrubbed into the caesarean. He cited a recent survey, where 80% of midwives in the UK reported receiving no training in vaginal disimpaction techniques.[31]

38. Associate Professor Hodges referred to a 2021 report of CCOPMM which responded to a series of serious adverse patient safety events relating to operative vaginal births. In their report, CCOPMM recommended health services design and implement a formal safety time-

[28] Statement of Dr Geraldine Masson dated 2 February 2024.
[29] Statement of Dr Geraldine Masson dated 2 February 2024.
[30] Practical Obstetric Multi-Professional Training. PROMPT provides training for maternity units, including midwives, obstetricians, anaesthetists and other maternity team members.
[31] Cornthwaite, K., Hewitt, P., van der Scheer, J. W., Brown, I. A. F., Burt, J., Dufresne, E., Dixon-Woods, M., Draycott, T., ABC Contributor Group, Thiscovery Authorship Group, & Bahl, R. (2023). Definition, management, and training in impacted fetal head at cesarean birth: a national survey of maternity professionals. Acta obstetricia et gynecologica Scandinavica, 102(9), 1219–1226. https://doi.org/10.1111/aogs.14600

out for instrumental birth and emergency caesarean section.[32] Common themes were poor adherence to guidelines with loss of situational awareness, lack of escalation, inadequate safety systems and inaccurate determination of foetal head position. Associate Professor Hodges opined that a safety checklist gives clear guidance to clinicians in their assessment prior to operative vaginal birth, assembles a multidisciplinary team, supports the obstetrician in the procedure, instructs when to proceed and when to abandon, and ensures timely escalation to additional senior staff. He added that while, in his view, a safety checklist would not have changed the correct decision-making by Dr Ma or the outcome in Tasman's case, health systems should not expect to rely only on expert clinical judgement and the experience of senior clinicians. Rather, they should have safety systems that cater for less experienced obstetric medical staff, especially with after-hours births and in the setting of foetal distress.

39. Associate Professor Hodges therefore recommended that, in addition to being included in multidisciplinary maternity emergency training (e.g. PROMPT), impacted foetal head scenarios should be considered part of the operative vaginal birth and emergency caesarean section 'timeout' (safety checklist) recommended by CCOPMM to provide guidance to clinicians in an emergency setting.[33]

FINDINGS AND CONCLUSION

40. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[34] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

[32] Consultative Council on Obstetric and Paediatric Mortality and Morbidity (2021). Victoria's Mothers, Babies and Children 2019 (May 2021).
[33] Expert report of AProf Ryan Hodges dated 30 June 2024.
[34] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: '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, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

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

    e) the identity of the deceased was Tasman Murray Tribe, born 12 August 2022;

    f) the death occurred on 19 August 2022 at Mercy Hospital for Women, 163 Studley Road, Heidelberg, Victoria, 3084, from 1(a) complications of birth-related traumatic head injury; and

    g) the death occurred in the circumstances described above.

42. Having considered all of the circumstances, I am satisfied that Tasman's death was the unintended consequence of reasonable medical procedures intended to protect both the baby and the mother, executed in a timely fashion by appropriately experienced staff, albeit that in this case those efforts were sadly not successful.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

(A) That Barwon Health review their policies and procedures in relation to the reporting of sentinel events to ensure they are consistent with Safer Care Victoria's Victoria sentinel event guide (Version 2).

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

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

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

Harley Tribe & Grace Gaylard, Senior Next of Kin

Ebony Omond, Slater & Gordon Lawyers

Lorraine Judd, Barwon Health

Barwon Health, C/- MinterEllison

Dr Suhan Baskar, Mercy Health

The Consultative Council on Obstetric and Paediatric Mortality and Morbidity

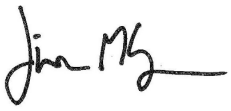
Victorian Managed Insurance Authority

Safer Care Victoria

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Leading Senior Constable Tonino Altimari, Coronial Investigator

Signature:



Coroner Simon McGregor

Date: 18 February 2025

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.