CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of **NA**
Hearing dates:	27-30 June 2016, 2 September 2016
Date of findings:	14 September 2016
Place of findings:	State Coroners Court, Glebe
Findings of:	**Magistrate Harriet Grahame, Deputy State Coroner**
Catchwords:	CORONIAL LAW – Home birth without medical assistance; manner and cause of death
File number:	2015/60842

Representation:	**Ms Sasha Harding, Senior Sergeant, Coronial Advocate Assisting.** **Ms Anderson of counsel for the family, instructed by the Legal Aid Commission of NSW.** **Mr C McGorey of counsel for the Department of Family and Community Services, instructed by Ms O'Brien of FACS legal.** **Mr P Rooney for the Northern NSW Local Health District and the Sydney Childrens Hospital Network, instructed by Curwoods Lawyers** **Mr G Radburn of counsel and Dr Havryk of MDA National for Dr J McKiernan** **Ms B Hazard sought leave to appear amicus for Human Rights in Childbirth (this application remained undecided as Ms Hazard did not reappear or make submissions)**
Findings:	**Identity of deceased**: The deceased person was NA **Date of death**: NA died on 19 February 2015 **Place of death**: NA died at Royal Brisbane and Women's Hospital, Brisbane, Queensland **Manner of death:** NA died as a result of injuries received during and just after birth. **Cause of death:** The medical cause of NA's death was hypoxic ischaemic encephalopathy (brain damage). NA was born breech and without medical assistance. It took some time for effective resuscitation to occur.

Recommendations:	1. That the Royal Australian College of General Practitioners consider developing policy guidelines to assist and support its members in advising patients in relation to requests for non-hospital births. Consideration could be given to the “National Midwifery Guidelines for Consultation and Referral”. 2. That the Northern NSW Local Health District consider implementing an information outreach program to local general practitioners about the services currently provided by Northern NSW Local Health District in relation to mothers wanting non-hospital births.
Non publication Order	Pursuant to section 74 (1) (b) of the *Coroners Act* 2009 (NSW) I direct that there be no publication of the name, address or image of Baby NA or his parents or sibling. This specifically includes, but is not limited to photographs at Exhibit 1, Tab 7 and 16.

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The Coroners Act 2009 (NSW) *in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings in relation to various aspects of the death.*

These are the findings of an inquest into the death of NA

Introduction

On 17 February 2015 a critically ill baby boy arrived at Royal Brisbane and Women's Hospital Intensive Care Nursery. He was less than 24 hours old. Doctors already knew that he had suffered a severe brain injury at birth and that it was unlikely he could survive. Two days later the baby's endotracheal tube was removed. He made no spontaneous movements or attempts to breathe and was soon pronounced dead. The death of this beautiful and perfectly formed baby boy is a terrible tragedy which has affected his family, the community from which he came and many involved in his care.

After his death, the family named the baby, NA.

The injuries which lead to NA's death occurred during and just after his birth at his parent's home, near Nimbin in Northern NSW. There was no doctor or midwife present. Although NA was rushed to Nimbin Hospital and from there to hospitals in Lismore and Brisbane, he could not be saved. His mother's prenatal care and the circumstances surrounding NA's birth have now been the subject of extensive investigation.

The Role of the Coroner

An inquest is intended to be an independent examination of all the available evidence in relation to the circumstances of a person's death. The Act requires the Coroner to make findings as to the identity of the nominated person and in relation to the date and place of death. The Coroner is also to examine the manner and cause of the person's death.[1]

In this case, there is no issue that the child survived his birth and was legally a person. The identity of the baby and the date and place of death are easily established on the available evidence. The medical experts are able to adequately explain the mechanism or medical cause of death. The real issues for investigation in this matter are found in the circumstances leading up to and surrounding NA's death. My job is to shed light on what actually happened during this period and also to consider making recommendations which could help prevent such an unnecessary death happening should similar circumstances arise in the future.[2]

Many in the small community where NA was born had strong views about his death and the reason for it. My role is not to cast blame or judge an individual's right to seek medical care as they see fit. Equally this is not an inquiry into the merits or otherwise of birthing at home. However, in examining the overall circumstances surrounding NA's death I will need to explore whether the prenatal decisions

[1] Section 81 *Coroners Act* 2009 (NSW)
[2] Section 82 Coroners Act 2009 (NSW)

ultimately made were adequately supported by access to high quality information, expert advice and adequate resources. I will need to consider whether there are lessons that can be learnt from this tragedy.

The scope of the inquest

The inquest ran over four days at Lismore Local Court in June 2016. Oral evidence was taken from NA's parents, friends who had been present at the birth and from a variety of involved professionals. Extensive documentary evidence was also tendered including witness statements, expert reports and medical and government records.

Written submissions were subsequently provided by the parties appearing and the inquest reconvened at Glebe Coroners Court on 2 September 2016 for further oral submissions.

Issues to be investigated

An issues list was circulated prior to the inquest, raising the following questions

1. Did F (NA's mother) and P (NA's father) understand that the baby was lying transverse just prior to the due date?
2. Did F and P understand the increased health risks of the transverse presentation in the context of the pre-existing medical issues identified by the GP regarding F?
3. Did F intend to have a homebirth despite the unborn baby lying transverse?
4. Did Dr McKiernan act appropriately in his care and treatment of F?
5. Once the Department of Family and Community Services received a "Risk of Significant Harm Report" in regards to unborn baby NA, did it act appropriately?
6. Did NSW Department of Health respond appropriately to the notification of the impending birth (where notification was via the Child Wellbeing Unit)?
7. Upon the birth of their baby, did F and P carry out life sustaining CPR adequately?
8. Are expectant mothers provided adequate information regarding the associated risks of a high risk birth when presenting to a medical practitioner?
9. What measures can be put in place to ensure the safety of a baby during the birth process when a mother is adamant to proceed with a high risk homebirth?

It is convenient to structure my findings under those headings.

Did F (NA's mother) and P (NA's father) understand that the baby was lying transverse just prior to the due date?

Early prenatal arrangements

At the time of NA's birth F and P had been in a relationship for around eight years and married for five. F was born in Brazil and is French Portuguese. She speaks English well, but as a second language. P had been in the area for many years. They lived together on a 100 acre property near Nimbin, about 30-40 kilometres from Lismore, NSW. At the time of NA's birth, the couple already had a four year old son, A. A had also been born at his parent's home on the property. He was apparently delivered by his father after a lengthy home birth.

F visited her general practitioner, Dr McKiernan at Nimbin Medical Centre on 9 July 2014. She had only seen him once before, but had been to other doctors in the practice[3]. Dr McKiernan confirmed what F suspected, that she was in the early stages of pregnancy. It appears that her delivery plans were not discussed at this appointment but Dr McKiernan provided her with a referral for a "dating" scan.

On 15 July 2014 an ultrasound was performed at North Coast Radiology in Lismore. It showed that the expected due date was on or around 13 February 2015.

It was Dr McKiernan's evidence that following the scan, three letters were sent to F, [4]advising her to make a further appointment to discuss the results of the scan. He explained that while the result had been normal, it was practice policy to re-engage a patient in these circumstances to establish a pattern of antenatal visits.[5]

The appointment on 13 November 2014

Records indicate that F next attended Dr McKiernan on 13 November 2014. At this consultation F indicated that she intended to have her baby at home, without the assistance of a midwife. She indicated that her husband would deliver the child as he had their first. Dr McKiernan gave evidence that "he firmly advised her against this course".[6] He also remembered advising her to "at least have a check-in to Lismore Base Hospital" so that staff there would be aware of the pregnancy.

Dr McKiernan told the inquest that during the appointment he said "I do not advise a home delivery" or words to that effect. He was "struck a little bit by the nonchalance…I remember the sentence like "oh no P's delivered all the other, all his other children" so you know everything else was fine." [7]Dr McKiernan said he again advised against a home birth, but he would not have "stood on the table and

[3] Statement of Dr McKiernan, Exhibit 1, Tab18.
[4] See records of the Nimbin Medical Centre Exhibit 1, Vol 2, Tab 2
[5] Statement of Dr McKiernan, Exhibit 1, Tab 18
[6] Statement of Dr McKiernan, Exhibit 1, Tab 18
[7] Dr McKiernan, evidence at Inquest 28/6/16, p53 @ line 10

pointed", as he was keen to keep his patient engaged and not scare her off completely. I accept his evidence in this regard.

Dr McKiernan noted that at that time F's obstetric examination was normal. He also requested some blood tests and gave her a further ultrasound referral form. At this stage the pregnancy itself was not known to be especially "high risk", the real thing troubling Dr McKiernan was the plan to birth at home, without even midwife support. Dr McKiernan explained to F that there were risks in being so far from obstetric care, including the baby getting stuck and its oxygen getting cut off or the possibility of dangerous bleeding.[8]

A short time later results were received by Dr McKiernan which indicated that F was Hepatitis C Virus (HCV) positive and also mildly anaemic. As a result, Dr McKiernan organised for the practice nurse to send the usual follow up letter to F, requesting her attendance for another appointment.

It was Dr McKiernan's evidence that he also tried to contact F by telephone as he was particularly concerned to speak with her about the HCV transmission risks posed to her child and the risks posed to her own health if she were to lose a significant amount of blood, given that she was anaemic. After numerous attempts he finally made contact with F on 8 December 2014 and an appointment was set for the following day.

The appointment on 9 December 2014

F and P attended together on 9 December 2014. By this time F was over 30 weeks pregnant. Dr McKiernan gave F a physical examination and confirmed that the pregnancy was still progressing normally. Dr McKiernan states that he advised the couple that the baby was in a transverse position. He told them that at this stage of the pregnancy that was not too unusual and that it could still move into a head down position. However he warned them of the dangers and implications if F were to go into premature labour. I accept he spoke to them about his concerns in a straightforward manner, using terms that were easy to understand. The risk was that the baby could get stuck and the cord "squashed" or compressed. He advised them that this was a serious risk.[9] They were advised to go immediately to Lismore Hospital if F were to go into labour.

There was also discussion about the implications of her blood results. F had iron-deficiency anaemia which could have implications if there was serious bleeding and her HCV status presented a risk of transmission to her unborn child. F appeared unconcerned about the potential problems posed by HCV and told the doctor she was already aware of her status in that regard.

There is no doubt that Dr McKiernan gave F a firm warning that her current birth plans were inappropriate. However he was trying to balance giving this advice against the possibility of permanently alienating his patient and thereby losing any possible influence. It was no doubt a difficult task. Both F and P had firmly held views. P told the inquest that although he and his wife liked Dr McKiernan, the doctor

[8] Dr McKiernan, evidence at Inquest 28/6/16, p53 @ line 30 onwards
[9] Statement of Dr McKiernan, Exhibit 1, Tab18, page 5 and evidence at Inquest 28/6/16

was operating under his "conditioning". P said Dr McKiernan advocated for a hospital birth, but it was his "indoctrination' that lay behind his advice. It was P's view that "anyone who works for a hospital would advocate a hospital birth"[10] P remembered the doctor suggesting that any home birth was risky and he said to Dr McKiernan "well I really appreciate your opinion and thank you very much for that and from the people we know, from our life and experience and the many midwives I've been around, they feel that a hospital birth is just as much threat"[11] P believed that he was choosing the safer option and protecting his unborn child from the fear, dogma and illusion prevalent in the hospital system.[12] F's evidence indicates she was certainly influenced in her decision to have her child at home by the strong views held by her husband. She told the inquest that she trusted her husband and wanted to believe in the beautiful world he wanted to share with her. When asked if she trusted her husband more than Dr McKiernan, she answered "No I'm pregnant at that stage and I don't want to have confrontation between where do I choose to have my baby at that stage"[13] She also told the court she understood that the doctor wanted her to go to hospital, because "the practice ask you to go to hospital". She stressed that it was her second pregnancy. She appeared to base her confidence in part on having successfully delivered her first child at home, without medical support.

Dr McKiernan clearly advised F and P of the general concerns he had about a home birth that was unsupervised and far from hospital care. At that time there was still hope that the position of the foetus could change. Of course even if that happened, the anaemia, HCV, lack of a midwife and distance from care remained significant issues. Nevertheless, F and P remained committed to a home birth. They read Dr McKiernan's advice as indoctrination and paid it little real regard. On the other hand, Dr McKiernan was trying not to frighten them off completely. In effect doctor and patient were operating with completely different world views and meaningful communication about the risks associated with the planned home birth was difficult.

I had the opportunity to observe F and P in court as they gave their evidence. At times both found it difficult to remain focussed on the precise question at hand, both frequently gave answers in a tangential manner. I have some sympathy for the difficulties faced by Dr McKiernan in the consultation room. In my view, the parents' pre-existing views about the hospital system made it hard for them to take seriously the issues Dr McKiernan quite properly raised with them.

Dr McKiernan's arrangements on leaving the Nimbin Medical Centre

On or around 29 January 2015, Dr McKiernan left the Nimbin Medical Centre. Nevertheless, he needed to make arrangements for follow-up in relation to some patients he had seen over his time at the practice and he returned to complete those tasks . On 3 February 2015, after reviewing F's file, he printed a further ultrasound request form and had it sent to F. He spoke to Ms Diane Crosby, the practice manager and advised her of his ongoing concerns regarding F's lack of antenatal care and the impending birth. As a result of this, Ms Cosby made attempts to contact

[10] Evidence at Inquest of P, 30/6/16 Page 43@ line15 onwards
[11] Evidence at Inquest of P, 30/6/16 Page 42@ line 3 onwards
[12] Evidence at Inquest of P, 30/6/16 Page 42@ line 3 onwards
[13] Evidence at Inquest of F, 30/6/16 Page14 @ line 33 onwards

F by telephone on 3 February and 4 February, without success. She called the Lismore Base Antenatal Clinic for advice and was told to contact the Child Wellbeing Unit. This occurred on 3 February 2015.

The scan on 6 February 2015

Unbeknownst to Dr McKiernan, F did attend for a scan on 6 February 2015. The scan was performed by Ross Meyer, who was a sonographer at North Coast Radiology. At this point F was over 38 weeks pregnant. Mr Meyer had limited recollection of the appointment, but told the inquest that looking at the pictures it is clear that the foetus was lying in a transverse position during the appointment and that it appeared otherwise normal. He recorded the words "transverse lie" on his worksheet and sketched the foetal position.[14]

Mr Meyer said that it would have been his practise to have pointed out body parts as he went.[15] He was unable to say exactly what he would have said to them about the position of the baby.[16] However, he was certain that he would not have used the word "transverse".[17] In evidence he seemed to agree that he would have said the baby was "laying sideways".[18] He would not have given medical advice about the implications of this.

The scan appears to have been marked "priority"[19] and was reported on by Dr Cappe. That report was apparently sent to Dr McKiernan at the Nimbin Medical Centre on 6 February 2015.[20]

The Court heard that there was a system in place at the Nimbin Medical Centre where if a doctor was absent for any reason then another doctor would have responsibility to "take over and look through their records and their reports and act on anything that needs to be done"[21] This included looking at the downloaded ultrasound reports that were regularly received. Dr Oxlee said he reviewed the report in relation to F's scan on 11 February 2015 on behalf of Dr McKiernan who had left the practice. It is not at all clear why there was delay in reviewing the result.[22]

Dr Oxlee noted that the ultrasound revealed a transverse lie at a late stage of pregnancy. He said that he would have had access to F's file and was already aware that "multiple efforts had been made to encourage F to return for review and cancel her planned homebirth given that she had a high risk pregnancy." [23] Dr Oxlee said that he was aware that Dr McKiernan had warned against a home birth but that F

[14] Exhibit 6
[15] Evidence of Ross Meyer at Inquest 28/6/16 T page 19 @ line35 onwards
[16] Evidence of Ross Meyer at Inquest 28/6/16 T page 26 @line 35 onwards
[17] Evidence of Ross Meyer at Inquest 28/6/16 T page 40 @ line 40
[18] Statement of Ross Meyer, Exhibit 1, Tab 20 and evidence at Inquest
[19] See Exhibit 8 and evidence of Ross Meyer 28/6/16
[20] See Exhibit 7
[21] Evidence of Dr Oxlee at Inquest 29/6/16 page 41 @line 35 onwards
[22] The scan had been reported by Dr Cappe on 6 February 2015, Exhibit 7
[23] Statement of Dr Oxlee, Exhibit 10, paragraph 4

was adamant to have one. Dr Oxlee was aware that a referral to the Child Wellbeing Unit had been made. He said "this plan of management was not altered by the ultrasound findings and given that the patient and her partner were already aware of the transverse lie and its seriousness, I therefore marked the result as "no action" in our medical records."[24]

Dr Oxlee's approach was flawed in a number of respects. Firstly he should not have assumed that the results of the ultrasound had been explained by the sonographer or the reporting doctor. While most patients could be expected to make a follow-up appointment with their doctor after a scan, if Dr Oxlee had looked at the file he would have seen that this was very unlikely to occur, unless she was telephoned.[25]

While Dr McKiernan had previously informed F and P about the foetal position after a physical examination, this had occurred back on 9 December 2014. The situation was certainly more extreme by 11 February 2015 when Dr Oxlee reviewed the recent result. It was Dr Oxlee's own evidence that there was now the potential for "catastrophic" results.[26] He was the only medical practitioner who had this up-to-date information and a way of contacting F. At the very least he should have asked the practice manager to contact F, or tried himself. He could also have contacted the Child Wellbeing Unit again and they in turn may have re-contacted the Department of Family and Community Services. It was a lost opportunity. Dr Oxlee appears to have believed that nothing he could do would have changed F's mind. While it is certainly possible that F's position was already completely fixed, given what was at stake, it was certainly worth a try.

In my view, whether or not the parents had heard or retained the expression "transverse", when F and her family left North Coast Radiology, they knew the foetus was still lying "sideways" and was not engaged, head down. They had previously been told that this presentation presented significant risks.

Did F and P understand the increased health risks of the transverse presentation in the context of the pre-existing medical issues identified by the GP regarding F?

How dangerous was the impending birth if it occurred at home?

By the time the final scan had been done, there was extensive evidence establishing that the birth, if it occurred at home was extremely high risk. The house was around 30 minutes from Lismore Hospital. It was known that F had HCV and had been diagnosed as anaemic. More worryingly an ultrasound performed had now confirmed a transverse lie presentation at a late stage of pregnancy. The planned birth was not supported by a doctor or midwife. There was no resuscitation equipment on hand. As the due date approached and the transverse lie was confirmed the situation was

[24] Statement of Dr Oxlee, Exhibit 10, paragraph 4
[25] P said that they tried to make an appointment but that the Centre was closed. See his discussion of this, Evidence of P, T 30/6/16 p48. See also the statement of Rachel Wood, Practice Manager, Nimbin Medical Centre, Exhibit 1, Volume 2, and Tab 16.
[26] Evidence of Dr Oxlee, T 29/6/16 p43 @ line 15

significantly more dangerous than when F had last seen Dr McKiernan back in early December when there was still a real chance that the position of the foetus would change.

An independent expert report provided by Dr John Mutton was sought and tendered. It is noteworthy, that there was no challenge to the opinions stated in it and Dr Mutton was not required for cross examination.

Dr Mutton was of the firm view 'that a planned breech birth should never occur at home'. Further it was his opinion that an incomplete breech, such as NA should always be delivered by caesarean. He was of the view that an experienced obstetrician should manage the delivery and that the foetus should be monitored in labour by continuous foetal heart rate monitoring. Neonatal resuscitation facilities and trained staff experienced in neonatal resuscitation should be available. One of the many risks to mother and child he identified was asphyxia during birth.[27]

Dr Mutton was of the view that "it is a pity that there were few opportunities for proper obstetric assessment and management of the pregnancy of F. Had there been, she and her partner could have had appropriate obstetric assessment and counselling, and she may have been able to have a healthy baby by vaginal delivery following external cephalic version and induction of labour, or by caesarean section. There is no reason why baby NA should not have been a healthy baby."[28]

Others who gave evidence agreed with the assessment of the substantial objective risk involved. Dr McKiernan was clearly concerned and advised against the birth plan even before he was aware of the transverse lie existing so late in pregnancy. Equally when Dr Oxley was asked about the likely effects of continuing with a home birth with the transverse lie, he offered that there was a "potential for catastrophic events, as happened."[29]

From an objective standpoint, it is clearly established that it was extremely risky to undertake a home birth in the circumstances as they existed on 16 February 2015, when labour pains commenced.

How did F and P assess the risks involved?

As I have said, there is really no doubt that F and P had been generally advised against a home birth. While they initially denied having been advised of the risks, in their later statements, provided during the inquest[30], they conceded that they had been warned by Dr McKiernan. However, given the other evidence presented at the inquest, it is likely that even then both F and P continued to downplay the extent of the warning they had received and to some degree remained less than completely candid about their knowledge of the pregnancy and their birth plans.

[27] Statement of Dr John Mutton,
[28] Report of Dr John Mutton, Gynaecology and Obstetrics Expert, Exhibit 1, Tab 25
[29] Evidence of Dr Oxlee, T 29/6/16 p43 @ line 15
[30] See statements of F and P (exhibits 14 and 15) in conjunction with earlier records of interview at Exhibit 1, Tabs 12 and 13

After NA's birth and tragic death, both parents were undoubtedly shocked and in considerable grief. They also became concerned that they would be blamed for what had happened. In my view it is clear that both F and P knew they had chosen a path that they had been warned against. After NA's death, the parents became aware that the police were somehow involved and while they may not have understood the coronial process, they felt they were at risk. P stated that he had been told by a friend, whilst still in Brisbane, that there was a "crack-down" on home births and he was advised to say as little as possible. P didn't know exactly what it meant but he sensed they may be in trouble.[31] Later he said they were concerned that the investigation had brought police to the community and that had resulted in someone getting "busted with plants" for which some people blamed them.[32]

For these reasons F and P were not altogether honest when doctors and then police spoke with them. It is now unnecessary to track back through all the slightly different versions they told. In my view both parents knew that they had been warned in general terms against proceeding with a home birth. Their pre-existing views made them wilfully blind to the level of risk involved. In my view it is established that they knew the foetus was lying sideways shortly before the due date. However they did not appear to properly understand or accept that they were heading into a potential catastrophe.

Did F intend to have a homebirth despite the unborn baby lying transverse?

Evidence of friends

A number of F and P's friends gave evidence about their knowledge of the preparations made for NA's birth and their attendance at the house on 16 February 2015. During the course of the inquest it became clear that F and P had not shared any of the information they had been given about the range of possible difficulties arising either from F's HCV status or anaemia or due to the fact the foetus was still lying "sideways". As far as any of those involved knew, (aside perhaps from F's mother who did not give evidence), the family were making joyous preparations for an uncomplicated home birth. Jason Bradfield who had only just arrived on the property was assisting by cleaning and preparing a tepee which was to be used either as a birthing area or a celebratory space. [33] Amanda Bayes, Lyndall Gray and Julieanne Eismann were all to be involved in some aspect of the birthing process or as support for F. Each gave evidence that there was no suggestion that anything other than a homebirth was planned. I accept their evidence. Prior to the birth no contingency plans were mentioned, neither was the fact that the baby did not appear to be engaged head down.

Exactly when a labour commences can be difficult to pinpoint and accounts varied to some degree in relation to this issue. However it is clear that there was movement in that direction from the morning of 16 February 2015. During the morning, F was able

[31] Statement of P, Exhibit 15 paragraph 7
[32] Statement of P, Exhibit 15 paragraph 7
[33] Evidence of Jason Bradfield, T 27/6/16

to go into Nimbin with Julianne Eismann to get some "special drops to help with the labour"[34], while others stepped up preparations at home. Various tasks were undertaken, an airbed inflated, furniture moved and water boiled.

At some point Paul called Lyndall and informed her "grab some clothes it looks like it might be coming"[35]. There were contractions throughout the day, that eased at times to the extent that F could do some craft at a table with A[36]. However, it appears clear that everyone was by then aware that the birth was imminent. There were further contractions in the early afternoon. In my view it is abundantly clear, that had F and P wanted to go to Lismore Hospital, they had the time to do it.

Taking into account the preparations being made, what they told their friends and their lack of action when it was indicated that labour was beginning, there is little doubt that F and P had made a firm decision to continue with their home birth plan.

Once the final stage of labour commenced it is established that F was in significant pain and it was by then too late to go. Julieanne Eismann suggested the waters may have broken about 6pm, but time estimates differed. I accept that the final stage of labour was relatively short and it was almost immediately apparent that there was a problem. Julieanne stated "I instinctively thought that there were complications as no one was saying anything"[37] She described seeing NA's feet first and then later one arm. Paul had his hands inside F trying to help the baby out. She too pulled at F in attempt to free the child, who was apparently stuck. She stated, "at no point during the labour was the ambulance called or going to the hospital wasn't an option as they wanted a homebirth"[38] She stated that F was still in pain and had not given birth to the placenta when P held a mirror to the child's mouth and said "hospital". Tragically it was the first time anyone had mentioned getting medical assistance. The lack of oxygen during and just after birth caused unsurvivable injuries to NA.

Exactly how long NA was stuck is difficult to gauge with accuracy. Various versions have been relayed and I accept that time is difficult to judge at moments of extreme trauma. It appears that P told Dr Ingall at Lismore Hospital that it was around 4-7 minutes. [39] Lyndall Gray estimated it was no more than 5-6 minutes but agreed it was very difficult to be accurate.[40]

Did Dr McKiernan act appropriately in his care and treatment of F ?

Dr McKiernan's personal involvement in F's antenatal care

Dr McKiernan was a relatively new GP when he was called upon to care for F. While he had been a medical practitioner for around seven and a half years, he had only

[34] Statement of Julianne Eismann, Exhibit 1, Tab 8 paragraph 16
[35] Statement of Lyndal Gray, Exhibit 1, Tab 11, paragraph 10.
[36] Evidence of Lyndal Gray, T 27/6/16
[37] Statement of Julianne Eismann, Exhibit 1, Tab 8 paragraph 22
[38] Statement of Julianne Eismann, Exhibit 1, Tab 8 paragraph 23
[39] Statement of Dr Ingall, Exhibit 1, Tab 23, paragraph 1
[40] Evidence of Lyndal Gray, T 27/6/16 page 13 @line 25

been a fully qualified as a GP since July 2014. He gave evidence that at February 2015 he would have consulted with only a "handful" of woman in relation to pregnancy in Nimbin. F was the first who had advised him that she was planning a homebirth without a midwife.[41]

As I have stated, he tried to find a way to warn, without scaring off his reluctant patient. Although they initially denied it, F and P finally conceded that they had indeed been warned against the path they chose. Dr McKiernan acted appropriately in this and in organising follow up by having the practice manager contact the Child Wellbeing Unit. It is unfortunate that it was not possible to build a stronger rapport with F, but I am of the view that Dr McKiernan tried to do this to the best of his ability, taking into account what he called P's "alternative beliefs"[42]. I accept that the task Dr McKiernan faced was not easy.

Dr McKiernan gave evidence that his knowledge of the obstetric services in the local area was limited to "The Base Hospital". [43] This is unfortunate, given that there were home birth options available in the local area. F's later risky presentation means that she would not have been eligible to participate in such a program at the time of NA's birth.[44] However, had she been referred to that service early on in the pregnancy before all the risks became clear, she may have benefitted from contact with knowledgeable midwives and had the chance to have been advised of the risks she faced in the context of a stronger therapeutic relationship. Whether she would have accepted such a referral is unknown. Equally had she accepted the referral to Lismore Base Hospital, staff would also have been able to tell her about the options for non-hospital births in the local area.

Breakdown in the follow up processes adopted by Nimbin Medical Centre

While there is no valid criticism of Dr McKiernan, there are certainly lessons to be learnt by the Nimbin Medical Centre. The Centre did the right thing to contact the CWU, but staff should have continued their involvement once the final scan results came into their possession. Someone needed to make that final attempt at direct contact. Dr Oxlee was by then the only doctor with all the information, he knew the potential risks were catastrophic, a phone call, at the very least, was called for.

Once the Department of Family and Community Services received a "Risk of Significant Harm Report" in regards to unborn baby NA, did they act appropriately?

What was the Department of Family and Community Services (Community Services) involvement?

Community Services only became aware of the concern in relation to F's pregnancy on 3 February 2015 when the Child Protection Helpline received a prenatal report

[41] Evidence of Dr McKiernan, T 28/6/16 p68@ line 28 onwards
[42] Evidence of Dr McKiernan, T 28/6/16 p49@line 40 onwards
[43] Evidence of Dr McKiernan, T 28/6/16 p68@line 15
[44] See Exhibit 3, Statement of Catherine Adams

from the Child Wellbeing Unit, Department of Health. The Helpline operator generated a contact record in relation to the report and screened it as "non-risk of significant harm" or "non-ROSH – further assessment".[45] Community Services accept that the report was wrongly screened at this stage and pursuant to relevant policies, it should have been screened as "ROSH Prenatal with Parental risk factor, Other".[46]

Community Services state that this error did not materially affect the subsequent progress of the report through the system. The report was forwarded to the Lismore Community Services Centre (CSC) for assessment and underwent a triage assessment within 24 hours. This process involved staff at Lismore CSC assessing the report to determine a response, having regard to the relative priority and risk involved in other reports received at that time.[47] The Court was informed that the review undertaken at this stage took into account information from the initial report, information sourced from the KiDS History database and factored in current competing requests for resources, but was not influenced by the initial screening error at the Helpline.

Community Services informed the inquest that the Triage Manager who determined whether the matter would be allocated a caseworker was an experienced staff member who had been with the Department since 1993.[48] He made a recommendation that the matter should be closed "due to competing priorities". Information provided to the inquest stated that around the time of NA's birth the Lismore CSC was coping with a "higher than usual number of removal actions" and was experiencing a high volume of work.

The process of allocating resources is undoubtedly a difficult task involving a careful assessment of the seriousness of all the presenting risks. In reviewing the weekly allocation meeting records from the period just before NA's birth, Ms Priivald, on behalf of Community Services, was of the view that other "unborn reports" being considered by the CSC involved "much more serious risk factors." She gave the example of a mother, being a child in out-of-home-care herself, who was experiencing a range of significant issues such as drug and alcohol problems, domestic violence, mental health issues, financial issues and homelessness".[49] I do not accept that the report in relation to NA, when properly understood, could be considered as much less serious. The risk was that there was a real chance that he would die or be seriously injured. In my view the Triage Manager is placed in an impossible situation when asked to decide between these kinds of very different and competing priorities. While it is important to be aware of hindsight bias, on the face of it, both matters should have been followed up.

In any event, a dual closure process was in place at that time and so the recommendation to close the file needed to go to the Manager of Client Services.

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[45] Statement of Lisa Gava, annexure B Exhibit 1, Tab 17
[46] Letter of Ms Priivald, Exhibit 1, Tab 15 and the "Structured Decision Making System Policy and Procedures Manual" Exhibit 1, Tab 16.
[47] See Ms Priivald's statement and later letter, Exhibit 1, Tabs 17 and 15. See also Ms Gava's statement, Exhibit 1, Tab 17 and evidence given at Inquest 29/6/16
[48] Statement of Ms Gava, Exhibit 1, Tab17
[49] Statement of Ms Priivald, Exhibit 1, Tab 13

Unfortunately, the Manager of Client Service, Lisa Gava did not review the recommendation to close the matter until 13 February 2015, owing to her absence from the Lismore CSC and her work volume during that period.[50] Upon her having the chance to review that recommendation to close, Ms Gava declined and queried whether capacity existed to conduct some follow up. She understood that the report seemed "very high risk".[51] Ms Gava queried whether a "High Risk Birth Alert" (HRBA) had issued. Tragically, by the time these inquiries got back to the Casework Manager, NA had already been born and the damage was done.

Ms Gava gave evidence at the inquest and she impressed as a conscientious and dedicated employee of the Department. She told the court that since NA's death she had implemented changes to improve the efficiency and turn around in the dual closure system that seemed to delay the report about NA through the office. Further a direction has now been issued within Lismore CSC confirming that all prenatal reports which are not allocated during triage are to be referred to the weekly allocation meeting. Lismore CSC staff have also been directed to provide antenatal health agencies with the information known to Community Services upon receipt of a prenatal report, in addition to the creation of a HRBA.[52] It should be noted that a HRBA was not issued, as it should have been in NA's case. However, I accept that it would have had little or no impact on the outcome of this case. The real utility of a HRBA is more likely to be found in cases of suspected abuse or neglect after birth.[53]

Ms Gava also gave evidence that as at 29 June 2016 she had "put out another expression of interest" for a caseworker to work in a specifically quarantined role which would deal with prenatal reports. There was also evidence that Helpline staff would be given further training in correct screening of prenatal reports.

I accept that resourcing of Community Services is a complex issue that could never be fully explored during an inquest dealing with the death of a single child. Nevertheless, the inquest heard that 75% of "Risk of Significant Harm" (ROSH) reports forwarded to the Lismore CSC in February 2015 were not allocated a caseworker response[54]. While some of those matters may have been referred to other agencies or been the subject of other investigations, the figure remains shocking and unacceptable. If there is an identified risk of significant harm, identified by using the Department's own criteria, the file should not be closed without investigation. The bare fact remains that the report in relation to NA was not acted upon in a timely fashion because Community Services did not have adequate resources to assign a caseworker, when they weighed NA's case against others that were judged to be more "high risk".[55]

[50] Statement of Ms Gava, Exhibit 1, Tab 17, paragraph 15.
[51] Statement of Ms Gava Exhibit 1, Tab 17, paragraph 15
[52] Statement of Ms Gava, Exhibit 1, Tab 17
[53] I note another significant change since NA's death has been the legislative change since 6 May 2016 which allows private health professionals to lawfully exchange information under Chapter 16A of the *Children and Young Persons (Care and Protection) Act* 1998. For discussion of this see the statement of Susan Priivald, Exhibit 1, Tab 13 paragraph 45.
[54] Letter of Ms Priivald, Exhibit 1, Tab 15, paragraph 5
[55] See for example the letter of Ms Priivald, paragraph 5

What could the Department of Family and Community Services have done?

All the medical evidence suggests that NA's death was preventable, if he had been birthed in an appropriate hospital setting. Notwithstanding advice, we have seen that his parents had already refused an early referral to Lismore Base Hospital. Given this background, and F's right to choose her own medical and prenatal care, it is important to examine exactly what Community Services could have realistically done, even if a caseworker had been assigned in a timely manner. I accept that it is important to examine this question in the context of the extremely limited time available to coordinate any response and the reluctance Community Service workers may have faced in any contact thay had with F and P.

Community Services did not have magical powers to save the situation, however, it was Ms Gava's evidence that a number of strategies could have been attempted. Although difficult in the available time frame, an interagency case discussion could have been arranged and the family and NSW Health could have been invited to attend. Even if the family chose not to attend, a discussion about how to engage them could still have proceeded.[56] It was Ms Gava's evidence that had resources been available, Community Services could have arranged a home visit and an attempt to personally advise the parents of "the serious concerns held by both FACS and NSW Health and imploring them to consider the medical advice and the risks to both baby and the mother. The question would have been asked whether they had considered the serious consequences given that the baby was in a breech position."[57]. Further Ms Gava suggested that temporary accommodation close to Lismore Base Hospital could have been provided if necessary.

While it is impossible to know for certain, what response a Community Services worker would have received had they had visited F and P's home, prior to NA's birth, it was in my view a strategy well worth trying. It is possible that such a visit could have saved NA's life.

The proper allocation of state-wide resources for the protection of children is a matter for the executive arm of government and clearly raises issues that go well beyond the specific concerns of this inquest. All I can do is state my considered opinion that the lack of resources available to assist the hard working staff already employed at the Lismore CSC meant that this child fell through the cracks and that we as a community failed to do absolutely everything that was possible to prevent his tragic birth injury and subsequent death.

Did the Department of Health respond appropriately to the notification of the impending birth (where notification was via the Child Wellbeing Unit)?

Was procedure followed?

The Child Wellbeing Unit is staffed by child protection professionals who provide telephone advice and support to health workers on any safety, welfare or wellbeing

[56] Ms Gava, Evidence at Inquest 29/6/16, page 67 @ line 40 onwards
[57] Statement of Ms Gava, Exhibit 1, Tab 15, para15

concern. On 3 February 2015 the NSW Health Northern Child Wellbeing Unit was contacted by a staff member from the Nimbin Medical Centre in relation to F's plans to have her child at home, without medical support, even though significant risk factors existed. It was an appropriate referral and was immediately acted upon.

Given that there was no known contact between F and NSW Health in relation to the pregnancy, I accept that it was too late for NSW Health to actively put services into place or attempt to establish a therapeutic relationship. The CBU was aware that a referral to Lismore Hospital had already been refused and very limited antenatal care had taken place. It was appropriate to make a report of a suspected "Risk of Significant Harm" in the hope that Community Services, with its broad statutory powers would be able to intervene in some way. Unfortunately as we have seen it did not. In addition it was documented that the CBU was informed that the staff of the Nimbin Medical Centre would continue their efforts to engage F and provide her with antenatal care. Unfortunately, this did not occur.

I accept that the CWU was following established procedures and protocols in relation to its involvement in this matter.

Upon the birth of their baby, did F and P carry out life sustaining CPR adequately?

What resuscitation attempts were there immediately after birth ?

It was P's evidence that "as soon as NA was out, and I realised there was something very wrong, I did my best to perform Expired Air Resuscitation and also cleared the mouth way. I performed EAR in the car all the way to the hospital and was trying to get our baby boy to breathe"[58]

Julianne Eismann, a friend who had been present at the delivery saw P "pushing the baby's chest and blowing into the baby's mouth"[59] I accept that P tried to resuscitate NA to the best of his ability. I accept that F was in no position to do so. She must have been in very considerable pain and distress during and just after the birth. It appears that she gave birth to the placenta in the back of the car as they made their emergency run to Nimbin Hospital. I am sure that she did all that she was capable of in that moment.

Nurse Petria Maher was the first medically trained person to attend the baby on their arrival at Lismore Hospital. She came out to the car and remembered seeing NA lying on the seat between F and P. She gave evidence that when she arrived nobody was giving the baby resuscitation. The baby was "pale, blue, flaccid, apnoeic (not breathing) and not moving…The baby was not wrapped in anything and was cold to touch"[60]. While I accept her evidence about what she saw, I remain of the view that immediately following the birth, P made attempts to revive his child to the best of his

[58] Statement of P, Exhibit 15 paragraph 32
[59] Statement of Julianne Eismann, Exhibit 1, Tab 8 paragraph 22
[60] Statement of Petria Maher, Exhibit 1, Tab 21, paragraph 8

ability. Of course what was actually needed was the skill and resources available at a hospital.

What caused NA's death?

Once NA arrived at Nimbin Hospital, resuscitation commenced very quickly. There had been no prior warning, so it involved setting up equipment and calling for Dr Oxlee to attend from home. Nurse Petria Maher stated that the child was not moving, was unwrapped and was already cold to touch.[61] The child's heart rate was discernible, but low and the nurse commenced treatment providing cardiac massage and providing warmth. A call was made for expert neonatal assistance (through the service operated by Sydney Childrens Hospital Network) and staff were able to get advice from a paediatric expert via this link[62]. Retrieval was arranged to take NA to Lismore Base Hospital.

At Lismore, NA was seen by Dr Ingall. Dr Ingall was immediately aware that the child had a very poor prognosis. While he tried to communicate this, he said that he was met with "stiff resistance" from P, who appeared to be attempting to "heal" the baby. The parents wanted 72 hours of healing, before the ventilator was removed. For this reason, given the limited resources available at Lismore, NA was transferred to Brisbane.

Dr Cartwright was in charge of NA's care in Brisbane. On arrival at the Royal Brisbane and Women's Hospital NA was receiving assisted ventilation via an endotracheal tube, and made only occasional spontaneous respiratory gasps. He had no response to painful stimuli, no gag reflex and his pupils were fixed and dilated.[63] His medical management and treatment continued and he was monitored by further ultrasound and EEG. His condition did not improve and after further consultation with his parents respiratory support was finally removed on 19 February 2016. NA was pronounced dead soon after.

After his death an autopsy[64] was conducted at the Department of Forensic Medicine at Newcastle, NSW. The cause of death was recorded as hypoxic ischaemic encephalopathy (brain damage). It is possible that that NA's brainstem was also injured by traction at the time of his birth.[65] However this finding was not confirmed at autopsy.

Are expectant mothers provided adequate information regarding the associated risks of a high risk birth when presenting to a medical practitioner?

The vast majority of women in NSW give birth in hospital delivery wards. This would be particularly true for woman identified by their medical practitioners as "high risk" for whatever reason. However, NSW Health also recognises that some woman want

[61] Statement of Petria Maher, Exhibit 1, Tab 21, paragraph 8
[62] See the statement of Nurse Petria Maher, Exhibit 1, Tab 21
[63] Statement of Dr David Cartwright, Exhibit 1, Tab 24
[64] See Paediatric Autopsy Report, Exhibit 1, Tab 4
[65] Statement of Dr Ingall, Exhibit 1, Tab 23, page 3

to birth at home or in birth centres and have recently made further efforts to make that possible for women who present with a low risk pregnancy. In some areas, although still a limited program, it is also possible to have a publicly funded home birth.[66]

In assessing risk, NSW Health endorse the guidelines for maternity care set out in the Australian College of Midwives detailed policy[67]document. It outlines how to identify normal risk pregnancy and how to support midwives make appropriate consultations and referrals to other professionals if risk factors arise. The guidelines also offer guidance for midwives when their advice is not heeded. This document has been endorsed by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, who also have their own policy in relation to home births.[68]

In the case of NA, it appears that no midwife or obstetrician was consulted and the only point of contact with the medical system was with a private GP. The NSW College of General Practitioners was asked if it wanted to be involved in this inquest and what its policies were in relation to home birthing issues. The only response to date has been to confirm that it has no policy in this area. It appears to me that doctors such as Dr McKiernan would be assisted by further support from their peak body in this regard. However the proposed recommendation has been supplied to the College, without response.

What was available in relation to non-hospital births in the Northern NSW Local Health District at the time of NA's death ?

It was acknowledged that the Northern NSW Local Health District has a higher rate of non-hospital births than the average across NSW. In 2014 only 2.7 % of mothers in NSW planned to give birth in a birth centre. 85% of those mothers actually did so. The total number of reported planned home births was fairly stable over the period of 2010-2014 and that number represented a small fraction of overall births. In 2014 the Northern NSW Health District had the highest proportion (percentage wise) of planned home births in NSW and the second highest for planned birth centre births.[69]

The inquest received information about what was available for women wanting a non-hospital birth in the local area at the time of NA's death. Due to a recognition by the Northern NSW Local Health District of the greater attraction for non-hospital births in their area compared to elsewhere in NSW, since 2013 the publically funded homebirth model of care has been operating from the former Mullumbimby and District War Memorial Hospital (now from Byron Central Hospital). The program is guided by the "Australian College of Midwives National Midwifery Guidelines for Consultation and Referral" and works closely with the local higher care facilities at

[66] See statement of Dean Bell, exhibit 1, Tab 11
[67] National Midwifery Guidelines for Consultation and Referral, Exhibit 1, Volume 3
[68] See Exhibit 1, Vol 3, Tab 9.
[69] See NSW Mothers and Babies 2014 NSW Government Health Publication extract, Exhibit 16

Lismore and Tweed Heads. It was operating at the time of NA's birth from the Mullumbimby and District War Memorial Hospital.[70]

For reasons that are not entirely clear, Dr McKiernan did not know about this program. It is difficult to know if this gap in knowledge was widespread or unusual. Whatever the case, I am of the view that it is worth the Local Health District making certain that general practitioners in places such as Nimbin are aware of this service. As has already been stated, F would not have been eligible for this service once her risk factors became clear. However, early in her pregnancy she may have been able to access some sympathetic and high quality advice from a practitioner who she could be assured was not necessarily opposed to home birth in all circumstances.

I have also considered whether the real barrier to engaging a midwife in this case was cost. The inquest was told a private midwife may cost up to $5000 but are sometimes obtained through a barter system.[71] While P said that they did not have the money for a midwife, there was never any real suggestion that this was an important factor in their decision. In any event, a registered midwife is likely to have seen the real nature of the risk involved and following the College guidelines would have advised against a home birth.

What measures can be put in place to ensure the safety of a baby during the birth process when a mother is adamant to proceed with a high risk homebirth?

It is essential to remember that women have a right to decide how they will give birth. At common law all competent adults can consent to and refuse medical treatment, which includes prenatal care. Unless a lack of capacity or some kind of coercion is established, an adult mother has a right to birth at home, even if the prevailing medical advice deems the birth "high risk". Until the foetus becomes a person, the relevant medical care is understood as pertaining to the mother.

All we can hope is that decisions are made with the benefit of high quality information and where necessary expert medical advice. In this case, it appears that F and P were firmly committed to a home birth or what was described by the Ministry of Health as a "freebirth"[72] . While they were informed of the risks, they seemed unable to properly comprehend or take seriously what they had been told. It is extremely unfortunate that once the final scan had been done, they were not warned again in the firmest terms, either by the GP practice they had attended or by a worker from Community Services. It is now impossible to know if F would have changed her mind had that extra warning taken place or if she and her husband would have chosen to proceed with their original plans regardless.

In considering what recommendations can be made, it is clear that there is no easy solution. It is positive that the Local Health District is trying to address the desire for

[70] Statement of Catherine Adams. Exhibit 3
[71] Catherine Adams, Evidence at Inquest 30/6/16 page 67 @ 25 onwards
[72] Statement of Dean Bell, Exhibit 1, Tab 11

non-hospital births in the local area. This program should be supported and resourced. Counsel for the family sought a recommendation that such services be better resourced. In 2015 there was apparently capacity for only 200 women to choose this option.[73] However, in the context of this inquest there was no evidence that the service was currently unable to meet the demonstrated need. It is likely that such a recommendation would go beyond the scope of this inquest.

Findings required by s81 (1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased

The deceased person was NA

Date of death

NA died on 19 February 2015

Place of death

NA died at Royal Brisbane and Women's Hospital, Brisbane Queensland

Manner of death

NA died as a result of injuries received during and just after birth.

Cause of death

The medical cause of NA's death was hypoxic ischaemic encephalopathy (brain damage). NA was born breech and without medical assistance. It took some time for effective resuscitation to occur.

Recommendations

I recommend

3. That the Royal Australian College of General Practitioners consider developing policy guidelines to assist and support its members in advising patients in relation to requests for non-hospital births. Consideration could be given to the "National Midwifery Guidelines for Consultation and Referral".

4. That the Northern NSW Local Health District consider implementing an information outreach program to local general practitioners about the services

[73] Statement of Catherine Adams. Exhibit 3

currently provided by Northern NSW Local Health District in relation to mothers wanting non-hospital births.

Finally as I have stated, the lack of resources available to the Lismore Community Services Centre at the relevant time is of grave concern. I direct that a copy of these findings be sent to the Minister for Family and Community Services, for his urgent consideration.

I offer my sincere and heartfelt condolences to F and P and their families. I recognise their grief at losing a child in such tragic circumstances. I extend my condolences to all those in the local community affected by NA's sad death. I thank the medical staff who tried to save NA.

I close this inquest.

Harriet Grahame
Deputy State Coroner

Date: 14 September 2016