



CORONERS COURT OF NEW SOUTH WALES

Inquest: Inquest into the death of Baby MA

Hearing dates: 4 September 2025

Date of findings: 4 September 2025

Place of findings: Coroners Court, Lidcombe

Findings of: Deputy State Coroner, Magistrate Rebecca Hosking

Catchwords: Whether the court has jurisdiction; whether the evidence establishes that the baby was 'born alive,' cause and manner of death.

File number: 2022/50551

Representation: Counsel Assisting the inquest: Rebecca McMahon, instructed by Imogen Pearson, NSW Crown Solicitor's Office

Findings: **Identity of deceased:** Baby MA
Date of death: 19 February 2022
Place of death: Edmondson Park, NSW 2170
Manner of death: Unascertained
Cause of death: Unascertained

Recommendations: To the Commissioner of Police:

That the death of Baby MA be referred to Liverpool Police Area Command for further investigation in the event that any fresh information becomes available.

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Introduction

- 1 Section 81(1) of the *Coroners Act 2009* (NSW) (**the Act**) requires that when an inquest is held, the coroner must record in writing their findings as to whether the person has died and if so, the date and place of the person's death, and the cause and manner of their death.
- 2 In addition, the coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.
- 3 These are the findings of an inquest into the circumstances of the death of the unnamed baby born to MA on 19 February 2022, at Edmondson Park, NSW 2170 (**Baby MA**).

The issues examined at the inquest

- 4 An inquest into the circumstances of Baby MA's death was held in Lidcombe on 4 September 2025.
- 5 The issues identified in the coronial investigation were as follows.
 - (1) Whether this court has jurisdiction to conduct an inquest?
 - (2) If yes, then the findings required pursuant to section 81 of the *Coroners Act*: the identity of the deceased; the time, date and place of death; the cause and manner of death.

The evidence

- 6 Tendered to the court was a 5-volume brief of evidence compiled by the officer in charge of the investigation, Detective Senior Constable Simeun Savic and supplemented by the Assisting Team (**Exhibit 1**).

Findings and recommendations

- 7 I have concluded that Baby MA was born alive and then died on 19 February 2022 at Edmondson Park. Her manner and cause of death are unascertained.
- 8 I have recommended to the Commissioner of the NSW Police that the death of Baby MA be referred to Liverpool City Police Area Command for further investigation in the event that any fresh information becomes available.

Background

- 9 I have drawn from the submissions from the Assisting team in relation to non-contentious issues and I am grateful for their assistance.

MA

- 10 MA, born on 20 November 2002, of Samoan heritage, was a resident of New Zealand before immigrating to Australia in or about 2021. She had one child who was approx. 2 years of age when her second child, Baby MA, was born.
- 11 At the time of Baby MA's death, MA lived at her family residence at Edmondson Park.
- 12 MA's current whereabouts are not known. It is believed that she no longer resides in Australia. Given that, she has not been served with a sufficient interest letter pursuant to s 54(1)(d) of the Act, and she has not been subpoenaed to give evidence.

Events of 19 February 2022

- 13 On 19 February 2022, MA was at the Edmondson Park residence with:

(1) her aunt¹ and uncle

¹ She is MA's biological aunt and also considered her adoptive mother.

- (2) her (approx.) 2 year old daughter
 - (3) her brother
 - (4) four of her cousins including her aunt's daughter (**Cousin**).
- 14 At around 1:00am on 19 February 2022, MA reported awakening with stomach cramps and bleeding. She went into the shower/bathtub and birthed a 'thing' (later described as a placenta, not an infant). MA said she was bleeding heavily and that she blacked out for a while.
- 15 Her aunt participated in an interview with NSW Police during which she stated:
- (1) she was awoken on 19 February 2022 between 1:30am and 1:45am by her daughter telling her to go and 'see what's happened' downstairs
 - (2) when she went downstairs, she observed MA sitting in the bathtub which was filled with a small amount of bath water
 - (3) MA's aunt observed a large amount of blood and a placenta (but no baby)
 - (4) MA's aunt gave MA a robe to cover herself with and took her to sit in the living room and she also instructed her daughter to call an ambulance.
- 16 MA's Cousin was interviewed by NSW Police during which she stated:
- (1) she heard a 'bang' between 1:00am and 2:00am on the morning of 19 February 2022 and went downstairs
 - (2) she observed blood in the hallway leading to the kitchen
 - (3) at MA's aunt's instruction, she retrieved a bowl and latex blue gloves from the kitchen and placed the placenta in the bowl, the cord was still attached to the placenta, although no baby was present

(4) before calling an ambulance, MA's Cousin said she asked MA whether she was pregnant, MA said she was not.

17 At 1:53am, MA's Cousin called Triple Zero and requested an ambulance. She told the operator that MA had:

felt something really heavy...she didn't want to go to the toilet and let it come out...so she went and sat in the bathtub and...the whole thing came out of her...the liquid...the womb and that. It's really big.

18 At 1:57am, NSW Ambulance Intensive Care Paramedics Tim Booth, Aladdin Abu-Sarary and student Shannon Chea responded to a call for a young female who had possibly suffered a miscarriage. They arrived at the Edmondson Park residence at 2:17am.

19 Upon arrival, Abu-Sarary assessed MA and spoke to her about the possibility of being pregnant. MA denied being sexually active. Abu-Sarary observed MA to be bleeding heavily and have low blood pressure. He treated her for blood loss/haemorrhaging and placed her in an ambulance.

20 Booth and Chea were led to the kitchen by MA's aunt who showed them the bowl with the placenta. She is reported to have said:

There is something in there. This is what came out of her.

21 Booth saw a fully formed placenta in the bowl, a large kitchen knife on the ground in the bathroom and large, multiple blood clots on the floor around the knife.

22 Booth went into the living room and asked, 'Where is the baby?' MA, her aunt and Cousin said that there was no baby. They denied that MA had been pregnant.

23 At 2:41am, MA was transported by ambulance to Liverpool Hospital. The ambulance arrived at Liverpool Hospital at 2:56am.

- 24 On arrival at Liverpool Hospital, MA underwent an ultrasound which showed her uterus was tall consistent with her having been carrying a full term baby. MA was assessed to be hypotensive² and tachycardic³. Registered Midwife, Stephanie Fagredine, examined the placenta and confirmed it was consistent with the placenta of a full size baby. Fagredine also spoke with MA, who told her that she 'got her period' the day prior and was having pains and bleeding. MA said that the 'thing in the bowl' (being the placenta) came out of her in the bathtub and that there was 'no baby.'
- 25 At or around 3:49am, a call was made by the Liverpool Hospital Emergency Department NUM⁴ to NSW Police. The NUM disclosed that MA had attended Liverpool Hospital with a placenta although no foetus or newborn was present.
- 26 NSW Police then attended the Edmondson Park residence, arriving at 3:59am. Police saw that much of the home had been cleaned using bleach as there was a strong smell of bleach and minimal blood staining present in the bathroom.
- 27 At or around 4:00am, Police attended Liverpool Hospital and spoke with MA. MA indicated that she felt a stabbing pain, went to the bathtub and birthed a placenta, but no baby.
- 28 At 4:33am, Police found a deceased full-term baby wrapped in a black floral cloth in a black plastic bag behind the downstairs bathroom door. The baby was deceased with no signs of life.
- 29 At 4:38am, Paramedics Joshua Van Magill, Caitlin Burrows and Inspector Braiden Robinson, attended the Edmondson Park residence. The paramedics observed the baby's body in the bathtub. Paramedic Magill conducted a visual assessment and completed the 'verification of death'. He touched the baby's face and neck to check for rigor mortis and lividity, listened with a stethoscope, and conducted an ECG and other checks. The baby was declared deceased.

² Blood pressure reading 85.

³ Heart rate 130bpm.

⁴ Nurse Unit Manager.

30 At or around 5:30am at Liverpool Hospital, Obstetrics and Gynaecology Registrar Dr Melanie Vo Hoang examined MA. According to Dr Vo Hoang's notes, she observed that:

Patient examined by myself – uterus and perineum consistent with immediate postpartum state.

Placenta examined by myself – consistent with normal term placenta.

Full blood count – found to be anaemic with haemoglobin level of 73 g/L. Given blood transfusion and iron infusion over following days.

Perineal repair sutured by another staff member later same day.

Underwent psychiatric assessment a few days later – no apparent psychiatric issue.

Jurisdiction

31 Section 21(1)(a) of the Act provides that a coroner has jurisdiction to hold an inquest into a death or suspected death if it appears that the person's death is (or there is a reasonable cause to suspect that the person's death is) 'a reportable death'.

32 A 'reportable death' is defined in section 6(1)(a) and (b) of the Act and includes, 'a violent or unnatural death' and 'a sudden death where the cause is unknown'. The words 'person' and 'death' are not defined in the Act.

33 In the inquest into the death of unidentified baby, 'Lily Grace',⁵ Deputy State Coroner HCB Dillon was required to consider whether Lily Grace's death fell within the jurisdiction of the Court. In doing so, his Honour stated that:

This court only has jurisdiction to investigate Lily Grace's death if she was alive at birth.

34 Moreover, the *Births, Deaths and Marriages Registration Act* defines death as follows (s 4):

⁵ Inquest into the death of unidentified baby, 'Lily Grace', Glebe Coroner's Court, 10 February 2016.

Death does not include a stillbirth and stillbirth means the birth of a stillborn child.

- 35 In the 'Lily Grace' findings, Deputy State Coroner Dillon cited the definition of 'stillborn baby' in s 4 of the *Births, Deaths and Marriages Registration Act 1995* (NSW):

Stillborn child means a child that exhibits no sign of respiration or heartbeat, or other sign of life, after birth and that—

- (a) is of at least 20 weeks' gestation, or
- (b) if it cannot be reliably established whether the period of gestation is more or less than 20 weeks, has a body mass of at least 400 grams at birth.

- 36 Pursuant to that definition, a stillborn child falls outside the jurisdiction of the NSW Coroner's Court.

- 37 A helpful decision which concerned whether the South Australia Coroner's Court had jurisdiction to hold an inquest into the death of an infant (considering whether the baby was stillborn or not) is *Barrett v Coroner's Court of South Australia*.⁶ Anderson J succinctly described the issues arising for determination as:

1. Whether the Coroner had jurisdiction to inquire into the death of this particular newborn baby.
2. That, in turn, depends on whether the death in this case was a reportable death [as defined in the Act].
3. That, in turn, depends on whether this death was the 'death of a person' within the definition.
4. That question involved an analysis of the decision of the New South Wales Court of Appeal in *R v Iby* (2005) 63 NSWLR 278 and whether the decision should be followed.
5. Assuming *Iby* should be followed then by applying the principles, was there evidence before the coroner capable of showing that the baby was born alive?

⁶ (2010) 108 SASR 568. The baby in that case suffered deprivation of oxygen and appeared to be lifeless at birth.

38 The court in *Barrett*, at [24], set out the born alive rule as described by Spiegelman CJ (with whom Grove and Bell JJ agreed) in *Iby*:

Spigelman CJ described the rule as consisting of two distinct components: first, that the foetus must have completely left its mother's body (although the umbilical cord does not have to be cut); and, secondly, the child must be alive at or after birth, in that sense, has occurred. The 'born alive' rule is satisfied by any indicia of independent life. That is to say, there is no single indicator of life, such as breathing, heartbeat or voluntary movement, which must be present before it can be said that the infant was born alive. On the other hand, evidence that the infant did breathe, have a heartbeat or pulse, move voluntarily, or cry may be sufficient by itself to indicate that the infant was born alive. Further, the 'born alive' rule does not include a requirement of viability in the sense of the physiological ability of a newly born child to survive as a functioning being.

39 The definition of stillborn within the meaning of the *Births, Deaths and Marriages Registration Act* and the common law definition in *Iby* are closely aligned. The requirement relating to 20 weeks gestation in the statutory definition does not arise because Baby MA was found to be full term or close to near full-term.

40 Deputy State Coroner Dillon in the 'Lily Grace' inquest stated that the jurisdictional question is whether 'it is more likely than not that she was alive at birth.' That is, the test is whether, on the balance of probabilities, Baby MA was 'born alive'.

Witness evidence

41 No evidence was adduced that supports a finding that there were any signs of life (for example, crying or breathing). This is likely to be explained by either:

(1) Baby MA was stillborn; or

(2) no one in the home, including Baby MA's mother, saw or heard any signs of life; or

- (3) Baby MA's mother (and possibly others) did see or hear signs of life, but did not report this to medical staff or police.
- 42 The three people who were most likely to have seen or heard any signs of life with respect to Baby MA would have been MA or the two women who attended upon her in the bathroom: her aunt and Cousin.
- (1) MA said that she was not sexually active, she had given birth to a 'thing', and she denied the presence of a baby. She gave no direct evidence regarding any signs of life.
- (2) MA's aunt said she was asleep with her husband when her daughter (Cousin) woke her around 1:30-1:45am on 19 February 2022. She saw MA sitting in the bath, and after seeing the blood became lightheaded and went to sit in the sitting room. She told her daughter to call the ambulance and called MA to come to the couch and wait for the ambulance.
- (3) MA's Cousin stated she was asleep on the evening of 19 February 2022 and was awoken by a loud bang about 1:00-2:00am. She was worried that someone had fallen and hit their head and went downstairs. She stated that she entered the bathroom after MA gave birth to find the bathtub and floor was covered in blood. She collected the placenta from inside the bathtub and placed it in a steel mixing bowl from the kitchen before cleaning the bathroom with bleach. She then contacted 000 to report the matter.
- 43 A Samoan interpreter, Diana Nonutunu-Semanaia, interpreted and transcribed audio recordings captured by CCTV at the Edmonson Park residence on the morning of 19 February 2022 in her statement dated 17 July 2024. The interpreted communications do not shed any light on whether Baby MA was born alive. The only reference to birth is a female voice saying:

'...something probably went wrong...something must have gone wrong with the girl when she gave birth.'

- 44 I accept Counsel's submission that MA's evidence in relation to the circumstances of the birth of Baby MA is unreliable. The medical evidence and the presence of Baby MA's body in the bathroom clearly establishes that MA gave birth on 19 February 2022. MA's denials of being pregnant and stating that there was no baby, cannot be true. I accept that she likely panicked when speaking with police and medical staff. I also accept that she was likely traumatised following the birth. MA must have known she was pregnant. The photographs MA took of herself, visibly pregnant, and her experience of being pregnant with her first child, make it implausible that she was not fully aware that she was pregnant and knew that she had given birth.
- 45 The consequence of her statements to the first responders and medics, that there was no baby and that she was not pregnant, render her evidence unreliable. In the circumstances I place no weight on the absence of any evidence of signs of life of Baby MA in MA's account.

Autopsy and expert assessment

- 46 The following expert reports were tendered in the inquest.
- (1) Post-mortem report of Dr Rebecca Irvine, Forensic Pathologist, following the autopsy performed on Baby MA on 6 April 2023.
 - (2) Placenta Biopsy Report of Associate Professor Nicole Graf, paediatric and perinatal pathologist, dated 28 February 2022.
 - (3) Report of Associate Professor Michael Buckland, neuropathologist, dated 29 June 2022.
 - (4) Report of Associate Professor Sean Seeho, Obstetrician and Gynaecologist, dated 10 March 2025.
 - (5) Joint expert report of Dr Irvine, A/P Graf and A/P Seeho following an expert conclave on 11 August 2025.

47 Dr Irvine found amongst other things that:

- (1) the weight of the baby was 3510g and was assessed as 'slightly within expected weight for 40 +/- 2 weeks gestational age (term)'
- (2) the newborn's growth parameters were within normal range/in keeping with the term of gestation, there were no abnormalities, no gross cause of death, no significant injury, the lungs were without aeration and there was a subcapsular haemorrhage at vertex
- (3) toxicological examination of the baby's post-mortem blood showed no detectable alcohol, common drugs of potential abuse or common therapeutic drugs
- (4) there was no demonstrable cause of death, and thus the cause of death was recorded as 'Unascertained'
- (5) in respect of whether the newborn was a stillbirth or born alive, Dr Irvine opined that the appearance of her lungs was in keeping with a stillbirth. She further opined that:

...it is almost certain that this infant never breathed air, but it is unclear whether this infant meets criteria to be considered stillborn. It cannot be excluded that this infant died prior to birth, although, in the absence of maceration, such a death would have to have occurred about 12 to 24 hours prior to birth.

48 A/P Graf found, amongst other things, that:

- (1) the placenta disc weight was 478g (50th percentile or 37-38 week, but below the 10th percentile for 40 weeks)
- (2) there was a single focus of low grade chronic villitis which was of doubtful clinical significance
- (3) the placenta was otherwise within normal limits for a term/near term gestation.

49 On 29 June 2022, neuropathologist Associate Professor Michael Buckland conducted a neuropathology report, during which he found that there was no significant pathological abnormality.

50 A/P Seeho, stated:

I cannot be certain that Baby [MA], a near-term or term infant weighing 3510 g at autopsy, died within a short period prior to birth, during birth, or shortly following birth.

Ms [MA] is likely to have had a precipitous (<three hour) labour or a labour that did not last much longer than a precipitous labour. That the labour was quick should not be considered unusual or abnormal. Parous women⁷ usually have faster subsequent labour and birth than nulliparous women, particularly during the pushing phase.

Both Dr Irvine and A/Prof Graf have concluded that Baby [MA] appears to have never breathed air. This would not meet the requirements to be classified as a stillbirth in Australia where a baby must show no signs of life after birth. In the case of Baby [MA], it is not known whether there were any signs of life such as cardiac activity or movement following birth.

It is my opinion that it was probable that Baby [MA] was born alive. The reasons for this opinion are:

1. Ms [MA] had a precipitous (or 'near-precipitous) labour, which in a parous woman is common and usually, in and of itself, of no concern.

2. Perinatal outcomes following precipitous labour are generally exceedingly good.

3. Recognising that precipitous labour has been reported to be associated with higher rates of placental abruption in some studies, there is no definitive evidence that placental abruption occurred in this case. I acknowledge the limitations in histological diagnosis of placental abruption. Ms [MA] had a Kleihauer-Betke on admission to Liverpool Hospital, which did not detect any fetal-maternal haemorrhage. I recognise that the Kleihauer-Betke test is not a test for placental abruption (it has a very low sensitivity for abruption), however if detection of fetal cells in maternal blood had occurred in this case, it would indicate some degree of abruption. The testimony provided by Ms [MA] suggests that the baby was born some time before the placenta was expelled from the uterus and that the cord was cut before the placenta was expelled. This would suggest that the placenta and baby were not born in proximity to each other, which sometimes occurs with a large placental abruption where a considerable portion of the placental-uterine interface has already separated.

4. A large amount of blood was detected in the bathroom and bathtub. Due to the unreliability of the history provided by Ms [MA], it remains unknown whether the bleeding occurred before, during, or after birth. It is possible that the bleeding occurred after Baby [MA] was born. Ms [MA] did not have active

⁷ Woman who have previously given birth.

management of the third stage of labour which would have increased the chance of postpartum haemorrhage, especially in the presence of a quick labour. As I have stated in section 4 of this report, the cause of the bleeding and death of Baby [MA] is not consistent with vasa praevia.

- 51 A/P Seeho also outlined in his report additional material which would assist in his assessment. Unfortunately, the material could not be obtained in circumstances where MA is not available and her records from her earlier birth cannot be compelled by the Court as the child was born in New Zealand.

Expert conclave/joint report

- 52 As to the question of whether or not Baby MA had a separate and independent existence from her mother:

- (1) the consensus was that Baby MA died either very soon before or very soon after birth.
- (2) **A/P Seeho** opined that it is most likely that Baby MA was born alive given there were no signs of death having occurred prior to birth.
- (3) **Dr Irvine** described herself as 'sitting on the fence.'
- (4) **A/P Graf** acknowledged that the question was difficult, if not impossible, to answer with certainty. She considered that the baby should have survived and there is no reason to suspect it did not survive the birth absent evidence of placental abruption.
- (5) Further discussions ensued and ultimately **A/P Seeho and A/P Graf** agreed that it is more likely than not that Baby MA was born alive. Dr Irvine remained 'on the fence.'

Findings: Jurisdiction

- 53 I am satisfied on the balance of probabilities based on the evidence adduced from A/P Seeho and A/P Graf that Baby MA was born alive and that she died on 19 February 2022 at the Edmondson Park residence.

54 On the basis of that finding, this court has jurisdiction to conduct an inquest into the death of Baby MA.

Manner of death

55 MA's relatives who were at the Edmondson Park residence were not called to give evidence at the inquest. This was done, amongst other reasons, because I determined it would be inappropriate to do so as a matter of procedural fairness in circumstances where MA could not be notified that the inquest was to take place.

56 Absent further evidence, I have only the initial accounts given to NSW Police by MA, her aunt and Cousin as to the circumstances of Baby MA's death. That evidence was insufficient to allow any findings as to Baby MA's manner of death. As such, Baby MA's manner of death will be recorded as 'unascertained.'

Cause of death

Expert conclave/joint report

57 The experts agreed that potential causes of death, during or post-birth, include placental abruption; cord accident; unknown genetic cause; failure to actively stimulate on birth or asphyxia.

58 No one possibility was favoured by the experts.

59 Based on the evidence before me I cannot make a finding as to cause of death. As such, cause of death will be recorded as 'unascertained.'

Statutory findings required by s 81(1)

60 I make the following findings:

Identity

The person who has died is the unnamed baby of MA, 'Baby MA'.

Place of death

Baby MA died at Edmondson Park NSW 2170.

Date of death

Baby MA died on 19 February 2022.

Cause of death

The cause of Baby MA's death is unascertained.

Manner of death

The manner of Baby MA's death is unascertained.

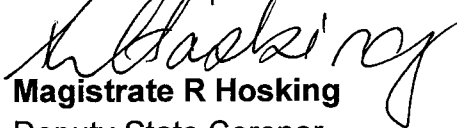
Recommendations

- 61 As outlined above, the evidence adduced at the inquest indicates it is more likely than not that Baby MA was born alive. How and why she died remains unknown. The death of a child is always tragic, no less in the case of Baby MA.
- 62 I recommend to the Commissioner of Police that the death of Baby MA be referred to Liverpool City Police Area Command for further investigation in the event that any fresh information becomes available.

Concluding remarks

- 63 While the manner in which Baby MA died remains unknown, it is apparent that it was a traumatic event for the members of her family present on the day. I extend my condolences to each of them.
- 64 I thank the Assisting Team for their support in the conduct of this inquest. There are no more difficult inquests than those involving the death of a baby.
- 65 I thank Detective Senior Constable Simeun Savic for his work in conducting the investigation and compiling the brief of evidence.

I close this inquest.


Magistrate R Hosking
Deputy State Coroner
Lidcombe
