



**The Coroners Act 2009**

**IN THE LOCAL COURT OF NEW SOUTH WALES  
CORONIAL JURISDICTION**

**Name of Deceased:**        **Roisin Fraser**

**File Number:**                **0817/2009**

**Hearing Dates:**            **2 – 5 April 2012**

**Location of Inquest:**      **Glebe**

**Date of Finding:**          **28 June 2012**

**Coroner:**                      **Magistrate Scott Mitchell, Deputy State Coroner**

**Appearances:**

- Ms K Rees of Counsel instructed by Ms A McCarthy, Solicitor, of the Crown Solicitor's office, appeared to assist the Coroner
- Mr P Strickland of Senior Counsel, instructed by Mr P O'Brien, Solicitor, appeared for Ms Fraser and Mr Stokes

## INQUEST INTO THE DEATH OF ROISIN FRASER

### FINDINGS

1. This is an inquest into the death of Roisin Fraser who was born and, within minutes, died on 27 March, 2009. Roisin was the daughter of Janet Fraser and Trevor George Stokes. There are two older children of that relationship, still living with their mother. Ms. Fraser is a leading figure in a movement called "*Joyous Birth*" advocating *free birthing* which is a method of home birthing where, except in circumstances of quite dire emergency (and, sometimes, even in those circumstances,) the intervention of medical practitioners, nurses and hospitals and, often, as in Roisin's case, that of midwives is avoided.

### Cause of Death

2. Practicing *free birthing* principles and with the assistance of her partner, Trevor Stokes, and a friend, Marianna Duce, both unqualified in medicine, nursing or midwifery, Janet Fraser was delivered of Roisin at her home at about 1.12am on 27 March, 2009. Roisin was pronounced dead at Royal Prince Alfred Hospital, Camperdown at about 2.27am on the same day. An autopsy was undertaken by Dr. R.J. Van Vuuren, Forensic Pathologist, of the Department of Forensic Medicine at Glebe on 30 March, 2009. Dr. Van Vuuren found that Roisin had died of *undetermined natural causes*. The *Autopsy Report* prepared by Dr. Van Vuuren is part of **EXHIBIT 1** in the proceedings. In the course of her *post mortem* examination, Dr. Van Vuuren observed "*a large amount of subcutaneous haemorrhage on the right of the scalp*" and "*subdural and subarachnoid haemorrhages present on the brain.*" The umbilical cord was described as "*730mm – (normal range between 400 and 700mm) which could lead to foetal entanglement and foetal compromise, especially at delivery*" and it was noted that "*photographs taken during the delivery is [sic] not clear but would suggest that the umbilical cord was around the baby's neck.*" Dr. Van Vuuren also reported that "*the baby appears to have been a stillborn.*"
3. Dr. Andrew Child AM is an expert witness with specialist qualifications in obstetrics and gynaecology who heads the Womens' Health Services, Sydney South West Area Health Service. He read the notes of Royal Prince Alfred Hospital and those of the NSW Ambulance Service together with the witness statements contained in the coronial brief

and the *Autopsy Report* and he saw the photographs taken by Marianna Duce at the time of Roisin's birth which are included in the brief together with the *DVD* depicting the delivery and 33 police photographs. He doubted stillbirth having in mind the evidence about *pulse in the cord* and *pinking*. He thought that the duration of labour, which seems to have commenced on 26 March, was not a contributing factor and that, rather, Roisin's death was caused by an hypoxic episode most probably prompted by cord entanglement which fatally compromised the child. One of Ms. Duce's photographs depicts Roisin just emerging from the waters of the birthing pool with the cord apparently looped around her neck. Professor Dahlen who inspected photographs of Roisin at birth and noted, in particular, the contrast presented by the very pallid complexion of her body and the purple colour of her face and head, took a similar view to Dr. Child.

### **The Inquest**

4. In these proceedings, Ms. K. Rees of Counsel, instructed by Ms. A. McCarthy, solicitor, of the Crown Solicitor's Office appeared to assist the Coroner while Mr. P. Strickland of Senior Counsel, instructed by Mr. P. O'Brien, solicitor, appeared for Ms. Fraser and Mr. Stokes. The Officer in Charge of the Police Investigation is Sgt. Anastatios Georgopoulos. Those appearing at the inquest to give evidence were:-
  - The Officer in Charge;
  - Dr. Rianie Janse Van Vuuren, Forensic Pathologist;
  - Marianna Duce, a friend of the mother who assisted at Roisin's birth;
  - Trevor Stokes, Roisin's father;
  - Janet Fraser, Roisin's mother;
  - Dr. Andrew Child AM, Specialist Obstetrician and Gynaecologist and expert witness called by the Coroner;
  - Andrew Szalkay, Paramedic; and
  - Professor Hannah Dahlen, Midwife and expert witness called by the Coroner.

### **Jurisdiction – the Law**

5. The jurisdiction of the coroner to conduct this inquest, if there be jurisdiction at all, depends on section 21 and on "*the death of a person*" - in this case, Roisin. If, as is now contended by her parents, this may have been a *stillbirth*, then there may have been no

death because Roisin may have had no independent life. This is a concept which, in a different context, was extensively discussed in the Court of Criminal Appeal in **R v King** [2004] 150 A. Crim. R. 409.

6. In New South Wales, the State Coroner and her deputies exercise a subordinate jurisdiction and, as a consequence, the strictures enunciated in the High Court of Australia by Fullagar J. in **R v Blakeley; Ex parte Association of Architects, Engineers, Surveyors & Draftsmen** (1950) 82 CLR 54 apply to coronial proceedings. Where there is any doubt, a coroner *“must, of necessity, begin by considering for (himself) the preliminary question whether (he) possessed the jurisdiction invoked. That question may depend on questions of law or questions of fact or questions of both law and fact. ... But the important point is that the decision or finding with regard to the existence of jurisdiction, whether it be affirmative or negative, stands in a radically different position from a decision or finding given or made within jurisdiction on the merits of the case. The latter is conclusive and binding subject only to any appeal that might be given: if no appeal is given it is absolutely conclusive and binding. The former is not conclusive or binding at all. It is open, if it be affirmative and wrong, to prohibition. It is open, if it be negative and wrong, to mandamus.”*
  
7. In **George v Rockett** (1990)170 CLR 104 the High Court of Australia considered section 679 of the *Criminal Code (Qld)* which provided jurisdiction to a justice to issue a search warrant *“if it appears to a justice, on complaint made on oath, that there are reasonable grounds for suspecting...”* certain facts. The section was held to impose a statutory duty on the justice to *“give real attention to”* and to satisfy himself of those grounds, if necessary by receiving evidence. As the learned authors of **Jervis on Coroners** (5-04) have it, *“if there is any doubt as to whether or not a child achieved an independent existence, independent of the mother, before dying, the Coroner should enquire into the death, treating the question of stillbirth as a preliminary issue...”*
  
8. I should note, too, that, as Mr. Strickland of Senior Counsel reminded me, the *born alive rule* remains good law in New South Wales and was recently considered and applied by the Court of Criminal Appeal in **R v Iby** (2005) NSWCCA 178. There the court held that there is no single test of what constitutes *life* for the purposes of the rule which may be

satisfied “*by any indicia of human life*” including, it seems, evidence of a child having taken a single breath or evidence of a single heartbeat.

### **Jurisdiction – The Facts**

9. In these proceedings, a *preliminary hearing* directed to the question of *jurisdiction* was undertaken on 2, 3 and 4 April, 2012 and evidence in that regard was taken from the *Officer in Charge*, from each of Roisin’s parents, from Marianna Duce, the friend of Ms. Fraser who had travelled down from Brisbane to assist her at the birth, from Dr. Van Vuuren and from Dr. Child. In addition, I read the transcripts of interviews given to Police by Ms. Fraser, Mr. Stokes and Ms. Duce and I saw the *DVD* recording of the birth and read the transcript of the same and heard an *audio* recording of the *000* call made to the NSW Ambulance Service from beside the birthing pool and I read the transcript of that call.
10. Janet Fraser, Roisin's mother, gave evidence at the preliminary hearing. She describes herself as a *child birth educator* and it is clear that she is very widely read and knowledgeable on the topic. She possesses an extensive library on child birth matters and she is a powerful advocate of *free birthing* and the leading light and, I think, founder of the *Joyous Birth* movement.
11. At some late time in the course of her pregnancy leading to the birth of her second child, Ms. Fraser retained the services of a midwife, Elizabeth Vella, but their relationship broke down on what turned out to be the day before labour commenced. Ms. Fraser would blame the midwife for the breakdown of their professional relationship but the evidence placed before me suggests that is an unfair conclusion. At any event, Ms. Fraser gave birth at home and without professional assistance but, shortly afterwards, haemorrhaged and was admitted on an emergency basis to *Canterbury District Hospital*. There she explained her situation to medical and nursing staff by way of a series of statements which she now admits were lies. She told the hospital that she had undergone a very short labour whereas the truth was that labour had been protracted. And she gave hospital authorities to understand that a midwife had arrived too late to attend at the birth which, again, was untrue. According to Ms. Fraser, she told these lies at Canterbury Hospital because she was fearful that, should the truth of the

circumstances in which she had just given birth become known, she *“could have been reported to DOCS, really persecuted and risked trauma occurring for me again in the hospital system.”* In a letter to Ms. Vella, Ms. Fraser explained *“I do not like being forced to lie but if I am choosing between a lie and my child’s safety and my mental health it’s not really a contest.”* It is important to note, though, that at no time has Ms. Fraser suggested that she has lied or would lie under oath.

12. It seems to me that the circumstances I have outlined recommend the approach which I think is generally appropriate, namely to afford statements and comments made at or about the time of Roisin’s birth particular consideration. Such statements, caught in the two recordings, were made before anybody had discovered *an axe to grind*, before police and coronial involvement were in prospect and before anybody had taken legal advice or had time to consider all the implications. I think they were made candidly by persons responding to events as they unfolded.
13. The *DVD* recording illustrates that Roisin was born in a very poor condition and Ms. Duce can be heard to ask *“Is the cord pulsing?”* to which Ms. Fraser replies *“Yes. Yes.”* Ms. Fraser told the inquest that, at the time, she was well aware of the significance of a pulsing cord and that she was aware of the importance of providing Ms. Duce, who, at the time, was speaking by telephone to the *000* operator, with accurate information. Although her solicitor in his letter of 27 March, 2012, told the Crown Solicitor that *“We are instructed that Janet Fraser felt the cord with her thumb and finger...”* Ms. Fraser told the inquest that she cannot recall if she had felt the cord (and, if so, whether with fingers and/or thumb or with the flat of her hand) or, instead, merely inspected it visually or both. This apparent shift in Ms. Fraser’s position is unexplained. But Ms. Fraser is confident, she told the inquest, that she acted responsibly in seeking to provide accurate information for the *000* operator.
14. A very short time later, the *DVD* has Ms. Duce saying *“She’s pinking, she’s pinking”* and, as the child is lifted from the pool to a chair, Ms. Fraser again says *“the cord’s pulsing.”* Once again, Ms. Fraser told the inquest that she had been aware of the need at that time to provide accurate information for the *000* operator.
15. The significance of a pulsing cord in determining life or the absence of life is common ground but perhaps the significance of *pinking* isn’t. According to Dr. Child, with 42

years experience in obstetrics and for over 20 years a member of the *NSW Maternal and Perinatal Committee*, a ministerial committee investigating maternal and perinatal deaths in New South Wales, *“the fact that a baby becomes visibly more pink after birth is a positive sign that the circulation of the baby is providing more oxygen in the blood flow around the body and it is certainly a good sign....”* The significance of the baby *pinking*, according to Dr. Child, is that it is indicative of additional oxygen in the blood flow, most probably caused by taking a breath.

16. Although Dr. Van Vuuren, in her *Autopsy Report*, volunteered that *“the baby appears to have been a stillbirth,”* the basis on which she expressed that view is not clear. Dr. Van Vuuren is not an obstetrician and gynaecologist. She is a forensic pathologist and, at the hearing, she was quick to say that matters to do with birth and stillbirth are outside her area of particular expertise. She did not conduct any tests directed to determining whether Roisin was or was not a stillbirth and it is not clear that any such tests were available at any event. There were no scars, bruises or other marks on the body suggestive of stillbirth and, as best I can make it out, her comments with regard to stillbirth were gratuitous and not intended to be relied upon. Dr. Van Vuuren told the inquest that, when she used the term *“stillborn,”* she referred to death occurring *“at any time during labour, either during the labour or when the baby was born”* and that the term was intended by her to encompass a baby born alive but dying soon afterwards.

17. The *DVD* and the *000* recording depict the period leading to the birth of the child and the attempts to resuscitate her. The mother was in an inflatable pool of water and Mr. Stokes and Ms. Duce were attending her. From a very early stage of delivery, contact was made with the *000* operator because it was obvious to the three adults present that Roisin was in a very poor condition. She wasn't breathing, was still and limp and gave little sign of consciousness.

18. About one minute after the birth, Ms. Fraser can be heard saying *“the cord is pulsing. Yes, yes.”* Her evidence is that she cannot be sure how she knew that and whether she felt the pulse or merely observed it and, if the former, whether she touched the cord with fingers, fingers and thumb or the flat of her hand.

19. Then, about three minutes after the birth, the mother can be heard once again to say "*the cord is pulsing.*" And, again, it is not possible to see from the *DVD* just how the mother detected that pulse, whether by touching or merely by observing the cord. Ms. Fraser says she can't recall. At about this time, according to Ms. Duce, she too felt the cord with her hand, perhaps with finger and thumb, and her recollection, she told the inquest, is that she could feel no pulse. Perhaps there was no pulse to feel but, at the time, Ms. Duce was engaged in transmitting information to the *000* operator and she was aware of the need, she told the inquest, to give the information as accurately as possible. To accept Ms. Duce's evidence in this regard is to find that, for no reason which has been advanced, she failed to tell the operator that, in her judgment, there was no pulse and allowed the operator to proceed on the basis that Ms. Fraser was correct and that there was indeed a pulse.

20. At about the same time, about three minutes after the birth, Ms. Duce can be heard to say "*She's pinking, She's pinking.*" And then, resuscitation by way of *CPR*, more or less as directed by the *000* operator, commenced.

21. At the preliminary hearing directed to the question of jurisdiction, a number of theories were tested to determine whether what was said in and around the birthing pool was accurate. It was suggested that, on the occasions when Ms. Fraser indicated that she had detected a pulse, she had inadvertently made a false reading by holding the cord with her thumb and, mistakenly, detected her own heartbeat. Dr. Child's evidence is that such mistakes can sometimes be made but that, even if Ms. Fraser did use her own thumb to take the reading – something she does not recall doing, it is more likely than not that the pulse she detected was Roisin's. It was suggested that the tension of the moment may have rendered Ms. Fraser incapable of accurately detecting or reading a pulse but the *DVD* shows people, including the mother, dealing with a desperate situation in a quiet, determined and efficient fashion. Evidently, this was not an occasion of panic or loss of composure or control and it seems to me that the remarks of the mother at the time are likely to have been truthful.

22. Certainly, those remarks were made before anybody had time to consider what might be the legal and other implications of their statements or of what had happened to Roisin and whether she had been born alive or stillborn and, also, before memory had an

opportunity to fail. At the hospital, later in the morning, Ms. Fraser confirmed that she had detected a *"faint pulse"* in the cord.

23. Regarding Ms. Duce's statement *"She's pinking. She's pinking,"* it was suggested that perhaps the room in which the birth took place was so dim that Ms. Duce could not have known what she was talking about. But the light quality in the room could be observed by simply watching the *DVD* and I thought it was adequate. At the time she made the statement, Ms. Duce did too. She was making a significant report and transmitting important information to the *000* operator and she told the inquest that she had known how important accuracy was. Yet, in the report which she gave the *000* operator, there was no suggestion of any doubt whether prompted by the light quality in the room or any other factor, and I think that I can rely on her as, no doubt, the *000* operator relied on her, to make an accurate report. I accept that, at the inquest, Ms. Duce was not able to recall exactly what she had seen but it had been enough to make a report to the *000* operator in circumstances where, she knew and understood, accuracy was important.

24. Dr. Child's evidence is that each of a *pulse in the cord* indicating a heart beat and a *pinking* indicating additional oxygen in the blood flow is a *positive* sign of the presence of life. As to the pulse in the cord, he says *"the fact that the pulsations were felt whilst the placenta was still attached to the mother would normally be taken as very definitive evidence that this reflects a heartbeat in the baby and therefore means that the baby by definition is born alive."*

25. Dr. Child told the court that the death of a child by reason of cord entanglement *in utero* is *"not likely"* and that the more likely scenario is that cord entanglement caused the baby to be compromised and that she died shortly after birth.

I have taken into account the rebuttable presumption involved in the *Born Alive* rule.

### **Jurisdiction – The Finding**

26. In my view, this is not a case in which one simply cannot say whether or not Roisin was born alive – where the evidence fails to point one way or the other. Instead, I think it is a case where, for reasons I have described, it is significantly more likely than not that Ms. Fraser did detect Roisin's pulse in the cord and that Ms. Duce did see the child *pinking*

and, accordingly, that Roisin was born alive. At the completion of the preliminary hearing 4 April, 2012, I gave reasons to that effect and took jurisdiction.

### **Ms. Fraser's Previous Experiences and The Decision to Freebirth**

27. Ms. Fraser's decision to *freebirth* Roisin was taken, she told the inquest, principally on the basis on her two previous birthing experiences. The first, in 2003, involved a failed attempt to *homebirth* where labour at home was interrupted by an emergency admission to the *Royal Women's Hospital* in Melbourne. There, an *epidural block* was provided as requested and, later, on her own insistence and contrary to medical advice, a caesarian section was performed leading to the successful delivery of her first child. According to the hospital notes, Ms. Fraser "*was explained about [sic] increased morbidity, the possibility of infection, haemorrhage, risk of repeat section, risk of uterine rupture in next pregnancy, placental previa accreta/percreta in future pregnancies, risk of DVT and pulmonary embolism, remote possibility of hysterectomy, anaesthetic complications and injury to bladder and bowel.*" Nevertheless, she "*was adamant about having a caesarian section (and) not prepared to wait even for next assessment.*"
28. The *Joyous Birth* website contains a number of references to this event. In one piece, entitled "*Put Your Anger Where It Belongs – With Your Surgeon,*" Ms. Fraser, less than fairly in the circumstance of her insistence on a *caesarean* in her own case, writes "*The fact is that surgery is a suboptimal way to be born and that most surgeries are not for evidence based reasons. I know. I've had one for no reason and I read the perinatal data...*"
29. Another piece appearing on the *Joyous Birth* website apparently directed to medical and nursing staff and attributed to Ms. Fraser is entitled "*Birthrape, Birthrape, Birthrape, Birthrape, Birthrape.*" Here medical and nursing staff are warned – one might well say threatened, should they "*shove an arm in a woman who's screaming 'no,' rupture the membranes because you have to tick the box and comply with 'protocol' even when the woman screams 'no,' slash a woman's vagina with scissors and she's screaming 'no.'*" The piece goes on to say that, "*your green gown*" – *Your stupid hospital gowns*" will not protect you" and "*I will charge you.*" Medical and nursing staff are reminded, "*Don't forget it, we are angry and we are powerful. We have survived your raping protocols so we can survive anything. Be afraid and don't underestimate us.*"

30. Surprisingly perhaps, the notes of the Royal Women's Hospital, Melbourne indicate that medical and nursing staff sought to dissuade Ms. Fraser discharging herself from hospital which, in the event, she did contrary to advice.
31. According to Ms. Fraser it was "*rough*" and unduly intrusive treatment by a doctor at the Royal Women's Hospital, Melbourne seeking to rupture the membranes and thereby "*causing laceration and acute pain*" which formed part of the basis her decision to *freebirth* Roisin.
32. Strictly speaking, the birth of Ms. Fraser's second child might not have been a *freebirth* because, a midwife, namely Elizabeth Vella, was engaged until the eve of Ms. Fraser's labour. The two fell out and labour proceeded and indeed the child was born without the further intervention of a midwife let alone any other professionally qualified person. But *post partum*, Ms. Fraser was admitted to *Canterbury Hospital* with a *uterine haemorrhage*.
33. Evidently it was on the bases of those experiences that, sometime in late 2008, Ms. Fraser decided to *freebirth* Roisin. On 19 or 20 March, 2009 when John Elder of *The Age* telephoned her, she gave him to understand that she was already in labour – which it now appears was probably not the case, and that she had not seen a doctor or other health professional since becoming pregnant and had undergone no ultrasound, stethoscopic examination, internal examination or genetic testing. She seemed healthy and confident, telling Mr. Elder that "*hospitals are dangerous*" and that "*nothing bad happens quickly in labour and there will be time to get to hospital if things go wrong.*" As she told Mr. Elder "*When you go on a skiing trip, do you call the hospital to say 'I'm coming down the mountain, can you set aside a spot for me in the emergency room?' I don't think so.*"

### **Special Risk**

34. Looking at the midwife's notes regarding Ms. Fraser's second birth, Dr. Child thought that a family history of *diabetes*, a congenital abnormality in the family and a high blood pressure reading recorded there rendered *homebirth*, to say nothing of *freebirth*, inadvisable in Roisin's case but he was most particularly concerned by Ms. Fraser's

previous *caesarean section* as heightening the risk of *uterine rupture*. Ms. Fraser told the inquest that she, too, had considered this factor which, in the event, she believed was neutralised by her intervening successful vaginal birth but Dr. Child's opinion was that the previous *caesarean section* rendered succeeding *homebirths* inadvisable and that the risk of *uterine rupture* increases with each birth. He added that *post partum haemorrhage* which Ms. Fraser had experienced in connection with her second birth, had increased the risk of another or greater bleed in a subsequent birth.

35. Elizabeth Vella, the very senior and experienced midwife retained by Ms. Fraser during most of the pregnancy leading to her second birth had expressed the view that an earlier *caesarean section* should not necessarily rule out a mother undertaking a subsequent *homebirth* but she thought that such a mother should first have an ultrasound to check for placental accretion, should pay particular attention to matters of diet and exercise during pregnancy so as to minimise pressure on the *uterine scar* and should monitor the baby more frequently than usual. Further, Ms. Vella thought that, in such circumstances, the possibility that a hasty transfer to hospital and a further caesarean might unexpectedly arise could not be ruled out. According to her statement contained in the Coronial Brief, Ms. Vella had expressed those various thoughts to Ms. Fraser - matters which Professor Dahlen told the inquest were "*incredibly important*" but there is no suggestion that, as she approached Roisin's birth, Ms. Fraser took any of what Ms. Vella had told her.

### The Birth

36. Labour with Roisin commenced on or about 26 March, 2009 after what Ms. Fraser described as "*a perfectly normal labour like my others... ..really nothing remarkable or different.*" She had consulted no professional and the only preparations she had made were to install in the very cramped study in her home an inflatable wading pool for use as a birthing pool, to arrange for her friend, Ms. Duce to come down from Brisbane for support and to help with her two children and to place some home made cord ties, a towel and a pair of scissors nearby. Essentially she trusted in the assistance of two unqualified people, her partner and Ms. Duce, in her previous birthing experiences which seem to me to have been less than uncomplicated, in herbal tinctures and *homeopathetics* which she says she had gathered and in her own emotional resilience.

Absent were any fluids, drips, cannulas, emergency drugs to staunch bleeding, oxygen mask for the mother and resuscitation equipment for the baby. Nor was there any equipment which might have allowed the baby's heart rate to be monitored. But, as Professor Dahlen, the expert witness called by the coroner observed, *"I don't see any sense in having the equipment if you don't have the skills to use it."* There was no consultation with, let alone attendance by, any midwife, nurse or medical practitioner and none of those present at the birth had any current qualifications in *CPR* or experience in administering *CPR* to neonates. Ms. Duce told the inquest that, when called upon to attempt *CPR* for Roisin, *"I just felt terror. I didn't recall any first aid training despite having done it. All I felt was just fear. That was it."*

37. Essentially, Ms. Fraser was quite unprepared for what happened. There was not even a hard, flat surface available on which Roisin could be placed for resuscitation so these three amateurs – Ms. Fraser, Mr. Stokes and Ms. Duce, first placed the child on the rim of the inflatable pool and, when that proved unsatisfactory, used a chair. They were unable to abandon the chair and place Roisin on the floor in order effectively to administer *CPR* there because, the placenta not having been delivered, *"that was as far as she would reach."* Evidently, it occurred to nobody present to clamp and cut the cord and, anyway, Ms. Duce told the inquest, she had not been aware of the ready availability of any equipment to enable her to do so. According to Ms. Duce, further difficulties were encountered in administering *CPR* because Roisin was slippery and difficult to hold and, evidently, it did not occur to anybody to wrap her in a towel although there were towels nearby.

### **The Paramedic's view**

38. Andrew Szalkay, the Intensive Care Paramedic who arrived at the home at 1.23am told the inquest that, in his opinion, the *CPR* administered to Roisin was likely to have been ineffective for two principal reasons – firstly because, as the *DVD* suggested, compressions may not have been applied consistently and there may have been some stopping and starting of the process and, secondly, because compressions had been delivered while Roisin was lying on the unsupported surface of the rim of the inflatable pool rather than on a hard surface.

39. Mr. Szalkay said that, had he been present at the birth, he would have clamped and cut the cord, taken the baby from the water, established an airway, warmed and dried her, rubbed her chest rigorously and resuscitated.

#### **A Midwife's view**

40. Professor Dahlen said that she would have rubbed the baby in a towel, put two fingers on her chest and used a stethoscope to feel the heart rate. If the heart was not strong, Professor Dahlen would have given the baby oxygen using a bag and, if no improvement, would have resuscitated. Sadly, at Roisin's birth, there was no suitably qualified and trained person available to know about let alone perform these lifesaving tasks.

41. Professor Dahlen told the inquest that a midwife will routinely listen to the baby's heart beat every fifteen minutes and, once full dilation has been achieved, after every contraction. *"You can tell a lot from listening to the heartbeat"* is what she told the inquest but, here, no steps had been taken to allow any monitoring of the baby's heartbeat and no attempt was made to do so. There is no suggestion that anybody felt to see if the baby was entangled in the cord and, apparently, no attempt to disentangle her manually as Professor Dahlen says is the common practice of qualified birthing professionals. According to Professor Dahlen, a qualified midwife, had one attended the birth, might have been expected to respond to cord entanglement *"in a couple of different ways... ...if the birth was immanent, one of the things we would do is get her out of the pool and do an episiotomy, get the baby out really quickly. If we know the birth isn't so immanent, we would call an ambulance and get her to hospital."*

42. In Professor Dahlen's view, one cannot be certain that Roisin would have survived had her birth been attended by qualified people who knew what they were doing. All one can say, according to Professor Dahlen, is that she might have survived and that she would have had a better chance at life than was actually given her. Dr. Child, too, cannot be certain of a better outcome had a midwife attended the birth but, in his opinion, Roisin's chances would have been much more favourable. His evidence is that a qualified midwife would have known to monitor the baby after each contraction and unusual findings of the foetal heart beat and unusual observations regarding meconium would have prompted a timely hospitalisation. As it was, her mother chose to rely on her

own socio-political views about birthing and Roisin's chance of life was deferred to that decision.

### **The Obstetrician's view**

43. In Dr. Child's view, birthing in a hospital would almost certainly have resulted in a different outcome. He told the inquest that cord entanglement occurs in about 20% of births and there are good ways of detecting and dealing with cord entanglement in a hospital environment where it is "very unusual" for a baby to die as a result of cord entanglement.

44. According to Dr. Child, "...it is the usual practice in a maternity unit for the foetal heartbeat to be recorded regularly during labour and, usually in someone with a previous caesarean section, the advice is that the foetal heart should be recorded continuously during labour by a CTG... ...Had such monitoring been in place in a hospital setting or with the presence of an experienced midwife, I think some changes in the foetal heart would have been detected during the labour and could have (been) acted on in order to deliver the baby in a better condition." Dr. Child thought that cord entanglement was "the only mechanism I can see " which caused Roisin's death and he told the inquest that "it's possible, but not very likely" that the cord entanglement caused death before birth but more likely that "the cord entanglement caused a compromised baby to be born."

### **The Mother's view**

45. Ms. Fraser told the inquest that she accepts Dr. Child's view regarding her birthing of Roisin but she added "there are no risk free options and I chose the option with which I was comfortable." Again, she said "with hindsight I could have made different choices but I felt I had made proper choices for myself and my family." It is difficult to see that Ms. Fraser does, in fact, accept Dr. Child's view and it is hard to know how she could have been comfortable with the choice she made. In the first place, Dr. Child's view represents so radical a departure from the view of which, as the principle of *Joyous Birth*, Ms. Fraser has long been an advocate, one might even say an apostle, that it is unlikely that she has changed her mind. And, in the second place, notwithstanding the obvious dangers and the unhappy outcome, Ms. Fraser felt able to tell the inquest that her decisions regarding Roisin's birthing had appeared proper and "appropriate."

## The Website

46. The *Joyous Birth* website controlled by Ms. Fraser offers advice to expecting or expectant mothers some of which is couched in terms which even Ms. Fraser, its principle author, described as *"intemperate."* Visitors to the site are warned of a *"giant birthing industry"* against which Ms. Fraser has dared to pit *"her arrogant feminine self."* *"Hospitals are dangerous"* and *"Obstetricians,"* she warns *"are surgeons at heart ... ..whose skill set is rarely needed."* Mothers to be are advised that *"size estimates are a crock"* and that *"your pelvis works perfectly."* *"Monitoring"* is described as *"you with a bed strapped to your back, monitors wrapped around your belly, probably a scalp monitor shoved through your vagina and screwed into your baby's head thus preventing you from moving around and actually birthing."* Women are warned that their obstetrician is liable to *"manoeuvre"* them into surgery when they really don't need it – *"there's a basic contradiction in going to a surgeon to avoid surgery, isn't there?"* which, they are reminded, will *"guarantee your uterus has more than a hole, it will have a big slice that someone will put their hands in and rip open."*
47. According to Ms. Fraser as she is reported on the *Joyous Birth* website, *"hospitals (places for sick people) have no business dealing with normal, physiological birth (performed by healthy women) but now that they do, they continue to peddle their own importance and kid us that we need them... ..Surgeons create repeat business for themselves in a way that, if it was another industry, would be seen for what it was – shameless money making... ..So it doesn't matter if she looks for another surgeon or hospital (they're run by surgeons, did you realise that?"*
48. This propaganda served up by *Joyous Birth*, of which the foregoing is only a taste, appears typical of an intention to convert women who visit the site to the view that medical and hospital involvement in their pregnancies and births is undesirable and contrary to their interests as women and mothers and that professional involvement, including the involvement of professional midwives, should be kept to a minimum. The plan for Roisin's birth with which Ms. Fraser felt *"comfortable"* is urged upon the visitor to the website as the ideal and as appropriate to almost all mothers.

49. This is a free country and Ms. Fraser can use the *Joyous Birth* website to proselytise as she sees fit. She told the inquest that she has had it in mind for sometime to “*tone down*” some of the intemperate expressions on the site but that she had thought it “*appropriate*” not to do so until the inquest had been completed and, as a Coroner, I had had the opportunity to express my views. I cannot imagine why she hesitated unless it be that the views expressed on the site continue to represent her own views. Whether they do or not, they are wrong views, extravagantly expressed and quite insensitive to the harm they may do to others, whether inexperienced mothers or children like Roisin whose chance of life was so unnecessarily put at risk. If they seem intellectually valid or politically attractive to Ms. Fraser, she might give thought or more thought to the effect they may well have on children like Roisin.

**Finding:**

**I find that Roisin Fraser, who was born on 27 March, 2009, died moments later at her parents then home at [REDACTED] Croydon Park, NSW of an hypoxic episode probably a direct or indirect consequence of cord entanglement encountered during delivery where, at her mother’s insistence, mother and child were unassisted by any person qualified in the areas of medicine, nursing or midwifery.**

Magistrate Scott Mitchell,  
Deputy State Coroner,  
Glebe.  
28 June, 2012.

[REDACTED]