SOUTH *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 1st, 2nd, 3rd and 4th days of June 2010, the 22nd day of July 2010, the 19th day of August 2010, the 26th, 29th, 30th and 31st days of August 2011, the 1st, 2nd, 6th and 30th days of September 2011, the 25th day of October 2011, the 15th, 16th, 17th and 18th days of November 2011, the 23rd day of March 2012, the 3rd day of April 2012 and the 6th day of June 2012, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the deaths of Tate Spencer-Koch, Jahli Jean Hobbs and Tully Oliver Kavanagh.

The said Court finds that Tate Spencer-Koch aged minutes, died at the Women's and Childrens Hospital, 72 King William Road, North Adelaide, South Australia on the 16th day of July 2007 as a result of intrapartum hypoxia.

The said Court finds that Jahli Jean Hobbs aged minutes, died at Hindmarsh Island, South Australia, South Australia on the 26th day of April 2009 as a result of intrapartum hypoxia.

The said Court finds that Tully Oliver Kavanagh aged 2 days, died at Northgate, South Australia on the 9th day of October 2011 as a result of hypoxic ischaemic encephalopathy.

The said Court finds that the circumstances of their deaths were as follows:

1. Introduction

1.1. I wish to acknowledge the excellence of the police investigations in relation to each of these three deaths and the diligence and skill of counsel assisting the Coroner, in the first instance Ms Amy Cacas who assisted the Court during the preliminary inquiry as to jurisdiction, and Ms Naomi Kereru who was counsel assisting the Coroner in the Inquests proper. I thank all other counsel for their assistance. I also thank Ms Tanya

MacPhedran, Personal Assistant to the State Coroner, who assisted in the engrossment of these findings.

1.2. These are the Court's findings in respect of the causes and circumstances of the unrelated deaths of three at term infants who died at the time of or very soon after their births. All three infants died after complications that were experienced in the course of their deliveries. These were complications of a kind that from time to time occur in deliveries of the types involved in these cases, and were therefore not entirely unpredictable. Two of the infants, Tate Spencer-Koch and Jahli Hobbs, were born by way of planned homebirths at the respective homes of their parents. They were both pronounced life extinct within an hour of their births. Both were singleton births. The third infant, Tully Kavanagh, was the second born of twins. The births of the twins also occurred pursuant to a planned homebirth, except that while the first born twin, Ruby, was born safely within her parents' home, the second twin, Tully, was born while her parents were en route from their home address at Northgate to the Women's and Children's Hospital (WCH) at North Adelaide. Tully arrived at the WCH in an unresponsive state. He was ultimately resuscitated. He remained at the WCH for the following two days. When it became clear to WCH clinicians that during the process of childbirth Tully had suffered severe hypoxic brain damage that was incompatible with life, he was discharged into the care of his parents. Tully died expectedly at the home of his parents later that same day.

1.3. Tate Spencer-Koch was born and died on Monday 16 July 2007 at approximately 5:40am. Tate was taken by ambulance from the Largs Bay premises where she was born, to the WCH where she was pronounced life extinct at 6:37am by Dr Chad Anderson.

1.4. Jahli Hobbs was born on Sunday 26 April 2009 at approximately 7:47am. Jahli was pronounced life extinct at 8:38am by Dr Stephen Byrne at the location of her birth on Hindmarsh Island.

1.5. Tully Kavanagh was born on Friday 7 October 2011 at approximately 2:25pm. Following his death at the home of his parents on Sunday 9 October 2011, he was returned to the WCH. This occurred on Monday 10 October 2011. Tully was pronounced life extinct at 3:10pm that day by Dr Amy Keir.

1.6. The Inquests into the causes and circumstances of the deaths of Tate Spencer-Koch and Jahli Hobbs were conducted concurrently. There was no direct connection between these two deaths, except to the extent that the birth of both infants occurred within the respective homes of their parents and that the same midwife had been present at both births. It was therefore felt appropriate that concurrent Inquests be conducted into the cause and circumstances of their deaths. The concurrent Inquests into the deaths of Tate and Jahli concluded with final addresses on Friday 30 September 2011. On that day the Court reserved its findings to a date to be fixed.

1.7. During the course of the Inquests into the deaths of Tate Spencer-Koch and Jahli Hobbs, I received into evidence material that had been gathered in respect of the death of another infant who was the second of twins born during the course of a planned homebirth that had taken place on 3 July 2011 in Western Australia. The midwife who had been involved in the deliveries of Tate Spencer-Koch and Jahli Hobbs was also present at the birth in Western Australia. Although the Court does not have geographical jurisdiction in respect of the Western Australian matter, for reasons that I will identify herein in due course, I regard the evidence concerning that death as relevant and admissible in respect of the cause and circumstances of the deaths of Tate Spencer-Koch, Jahli Hobbs and Tully Kavanagh.

1.8. Following the reservation of the Court's findings in the Inquests of Tate Spencer-Koch and Jahli Hobbs, Tully Kavanagh was born on Friday 7 October 2011 and died on 9 October 2011. As with the previous deaths of Tate Spencer-Koch and Jahli Hobbs, Tully's death was reported to the State Coroner. On 13 October 2011 a post-mortem examination of Tully's remains was conducted. On 25 October 2011 the Court, presided over by myself, commenced an Inquest into the cause and circumstances of Tully Kavanagh's death. That Inquest was adjourned from time to time and concluded with final addresses of counsel on 23 March 2012. Due to certain features of commonality between the deaths of Tate Spencer-Koch, Jahli Hobbs, the infant in Western Australia and Tully Kavanagh, including the fact that they had all arisen in circumstances involving planned homebirths of a kind attended by risk and that the same midwife had been present at all four, I decided that I would hear the Inquest into the cause and circumstances of the death of Tully Kavanagh in conjunction with the Inquests relating to Tate Spencer-Koch and Jahli Hobbs. I would add here that even if I had not regarded the death of the infant in Western

Australia as relevant, I would in any event have conjoined the Inquests of Tate Spencer-Koch, Jahli Hobbs and Tully Kavanagh. I have regarded as cross-admissible the evidence that was taken in respect of the Inquests into the cause and circumstances of the deaths of Tate Spencer-Koch and Jahli Hobbs on the one hand and the evidence taken in the Inquest into the cause and circumstances of the death of Tully Kavanagh on the other. I delayed the delivery of findings in respect of the Inquests concerning Tate Spencer-Koch and Jahli Hobbs until the completion of the Inquest in respect of Tully Kavanagh. These are the findings in relation to the causes and circumstances of the deaths of all three infants.

2. Jurisdiction of the Court

2.1. On 1 June 2010 the Court commenced a discrete inquiry as to whether the Court had jurisdiction to conduct an Inquest into the death of Tate Spencer-Koch. The central issue in that inquiry was whether or not Tate had exhibited a sign of life such that the common law 'born alive' rule was enlivened. That issue was in turn central to the question as to whether or not Tate Spencer-Koch could, in the eyes of the law, have been regarded after her complete delivery as a person and whether therefore the death of a person had occurred so as to confer jurisdiction in this Court pursuant to the Coroners Act 2003. On 4 June 2010 the Court delivered a written judgment in which I ruled that the Court had jurisdiction in respect of the death of Tate Spencer-Koch. On the eve of the commencement of the Inquest proper in August 2010, Ms Lisa Barrett, a registered midwife who had been present at, and involved in the delivery of, Tate Spencer-Koch applied to the Supreme Court of South Australia for a judicial review of this Court's decision as to jurisdiction. That application was unsuccessful. On 9 December 2010 the Full Court of the Supreme Court of South Australia delivered its judgment dismissing the application[1]. On 10 June 2011 an application by Ms Barrett for special leave to appeal to the High Court of Australia was heard and refused[2]. The Inquests into the deaths of Tate Spencer-Koch and Jahli Hobbs were stayed pending the resolution of both appellate processes, thereby delaying those Inquests for nearly a year.

2.2. The evidence taken in this Court during the preliminary inquiry as to jurisdiction in respect of the death of Tate Spencer-Koch is evidence in this inquiry as a whole.

[1] Barrett v Coroner's Court of South Australia (2010) 108 SASR 568
[2] Barrett v Coroners Court of South Australia & Anor [2011] HCAT165

Nothing adduced in the Inquest proper altered my view that the Court had jurisdiction in relation to the death of Tate Spencer-Koch.

2.3. Similar issues regarding the jurisdiction of the Court arose in respect of the death of Jahli Hobbs. During the course of the concurrent Inquests relating to Tate Spencer-Koch and Jahli Hobbs, Ms Lisa Barrett was represented by Mr Mark Twiggs, solicitor. Ms Barrett had also been present at the birth of Jahli Hobbs in her capacity as a midwife. On behalf of Ms Barrett, Mr Twiggs disputed the Court's jurisdiction in relation to the death of Jahli Hobbs, but did not advance any further argument to the Court in this regard. It is nevertheless necessary to deal with the question of jurisdiction regarding the death of Jahli Hobbs as each matter must be considered in the light of its own facts. In the circumstances I did not consider it necessary to conduct a discrete inquiry into jurisdiction.

2.4. Jahli Hobbs was born at approximately 7:47am on the day in question. This occurred at premises on Hindmarsh Island. Following her delivery she was unresponsive and was pale and flaccid with no muscle tone. No heartbeat or respiratory effort on the part of the infant was evident. Nevertheless, resuscitative measures were delivered by Ms Barrett and another midwife who was in attendance at the premises. Shortly after 8:00am the first of two South Australian Ambulance Service (SAAS) crews arrived at the premises. The first crew consisted of two volunteer ambulance officers. In due course a second crew arrived that included a qualified intensive care paramedic by the name of Jenny-Lee Whittenbury. Ms Whittenbury gave evidence during the course of the Inquest. By the time of Ms Whittenbury's arrival Jahli had been removed from the house in which she had been born to an ambulance and was being attended to by the volunteer crew and Dr Stephen Byrne, a local medical practitioner who by then had also arrived. Ms Whittenbury examined the infant whom she described in her evidence before the Court as motionless and very pale[3]. By then a heart monitor had been attached to the infant. Ms Whittenbury told the Court that although the infant was asystolic and that there was no palpable mechanical pulse, during the course of resuscitative procedures the monitor revealed occasional pulseless electrical activity (PEA) rhythm. Ms Whittenbury told the Court that it was important for intensive care paramedics like herself to be able to identify PEA in a patient because detection of the same would serve what she described as '*a grounding board to continue and actually*

get a mechanical response back'[4]. I regarded Ms Whittenbury as an expert in her field and had complete confidence in her ability to accurately identify signs of life in a newly born infant. In Court Ms Whittenbury was asked to examine the documented electrical trace that was obtained over the course of the infant's resuscitation efforts and was able to point out to the Court various instances of where PEA was identified in the infant's heart. I was satisfied that Ms Whittenbury was suitably qualified to be able to furnish the Court with an opinion in respect of what both the trace and the monitoring equipment had identified as PULSELESS ELECTRICAL ACTIVITY, and I was satisfied in the case of Jahli Hobbs that following her complete delivery from her mother she had exhibited PEA.

2.5. Consistent with my ruling in the matter of Tate Spencer-Koch, and of course consistent with the judgment of the Full Court of the Supreme Court of South Australia in that matter, I find that following Jahli Hobbs' complete delivery, she exhibited PEA and that this was a sign of life that satisfied the common law 'born alive' rule. I find that Jahli Hobbs was born alive and that she was a person in the eyes of the law and in particular for the purposes of the Coroners Act 2003. Accordingly, I find that Jahli Hobbs as a person died and that therefore this Court has jurisdiction in respect of her death.

2.6. I should add here that the evidence that was taken during the course of the discrete inquiry into the jurisdiction of the Court regarding the death of Tate Spencer-Koch is to be regarded as evidence in the matter of the death of Jahli Hobbs.

2.7. That the Court has jurisdiction in relation to the death of Tully Kavanagh is beyond dispute. Tully Kavanagh was born alive in the sense that for a time subsequent to his complete delivery he exhibited both a mechanical heartbeat and respirations until the cessation of both bodily functions on Sunday 9 October 2011.

3. Reason for Inquests

3.1. A number of issues arose during these Inquests. It is pertinent firstly to identify what these Inquests were not about. I was not concerned in any of these Inquests, viewed either separately or collectively, with the issue generally as to the desirability or otherwise, or appropriateness or otherwise, of homebirthing in cases involving low

[3] Transcript, page 377

(Please Note – Unless otherwise indicated, transcript references relate to the Tate Spencer-Koch and Jahli Hobbs Inquest)

risk of an adverse outcome occurring in respect of the mother or the infant. The three cases with which these Inquests are concerned, as well as the matter in Western Australia, involved planned homebirths each of which in differing ways are said to have involved an enhanced degree of risk to the unborn infant, being risks that were identified well before the deliveries took place and risks that ought to have been manageable in a more appropriate clinical setting. In other words, it is said that these deaths could and should have been prevented.

3.2. In the case of Tate Spencer-Koch it was established prior to her delivery that she was a macrosomic baby, that is to say a baby that was significantly larger and heavier than the norm. This, it is said, generated an enhanced risk of complications in delivery such as obstructed delivery, in her instance by way of shoulder dystocia. This period of obstructed delivery led to a fatal episode of hypoxia or deprivation of oxygen from vital organs, most importantly the brain.

3.3. Jahli Hobbs was known in advance to be in a breech position. As will be seen, this also carries certain risks in terms of the baby's safe delivery. She too died after an intrapartum hypoxic event being the direct result of a complication arising during delivery.

3.4. Tully Kavanagh was the second born of twins. The fact that Tully's mother was carrying twins was well known in advance of their delivery. It is said that the second born of twins is at an enhanced risk of complication during the course of his or her delivery. Tully died from brain damage sustained during an intrapartum hypoxic event, the product of complications engendered by virtue of the fact that he was the second born of twins. The matter from Western Australia provides another example of the death of the second born twin arising from complications associated with its delivery.

3.5. In addition to the intrinsic and enhanced risk associated with the types of delivery I have just identified, it is said that in the context of homebirthing the management of these risks is unacceptably difficult and in and of itself presents further risk of death or severe disability to the unborn infant such that deliveries of infants in these instances should be managed in settings other than the home. An opposing philosophy involves the notion that although no person wants to see their unborn child

[4] Transcript, page 388

die, the mother has a complete and unfettered choice of venue of birth and may place the at term unborn infant at risk regardless of the type and magnitude of the known risk to the baby, and regardless of the fact that the risk might be ameliorated by the delivery taking place in a hospital. The same philosophy holds that the unborn child at term has no rights in this regard[5]. Underpinning this philosophy is the seemingly unshakeable dogma that an adverse outcome in the homebirth setting would inevitably have occurred in a hospital setting in any event and that the professional services that are available within a hospital would not have altered the outcome.

3.6. As to the contention that was articulated in a number of quarters during these Inquests that an unborn infant at term has no rights in law, this may be accurate in certain contexts, but one does not have to descend into protracted legal or moral debate as to the overall legitimacy of this contention to realise that the thought processes of those who advance it as an argument in support of the existence of an unrestricted right to place an unborn child at risk of harm or death, are fundamentally flawed. One only has to have regard to the fact that in this State it remains an offence to terminate the life of an unborn infant at term except in limited and strictly controlled circumstances relating to the preservation of the life of the mother to appreciate that the notion that an unborn infant at term has no rights in law is simply incorrect[6]. Moreover, the law regards it as a criminal offence to cause the death of an infant who, following birth, dies as the result of the unlawful infliction of injury in utero[7]. It is an undeniable fact that to a significant extent the law protects the right to life of the unborn infant at term.

3.7. In each of the three cases that are the subject of these three Inquests there is no evidence to suggest that, in the period immediately prior to their delivery, the three infants in question were anything other than robust and viable unborn children, all of whom were at or near term and who could in different circumstances have been born in health and without adverse consequences. As will be seen, it has been established in each instance that their deaths arose from complications that were well understood in advance as being risk factors in respect of the types of deliveries that would need to be performed.

[5] Evidence of Ms Lisa Barrett, Transcript, pages 579-580, 650-651 and 991
[6] Sections 81, 82 and 82A of the Criminal Law Consolidation Act 1935
[7] R v Iby (2005) 63 NSWLR 278

3.8. The births of Tate Spencer-Koch, Jahli Hobbs and Tully Kavanagh occurred in the presence of the qualified midwife, Ms Lisa Barrett, to whom I have already referred. The birth of the infant in Western Australia likewise. Ms Barrett obtained her original nursing qualifications in Wales in 1988. In 1989-1990 she undertook an 18 month conversion course to become a midwife. After qualifying as a nurse in the first instance, Ms Barrett practised as such for a period of 9 months before commencing her midwifery training. Ms Barrett worked as a midwife in hospitals in the United Kingdom. She has worked as a midwife in charge of a labour ward and she has also worked within the community aiding homebirths. Ms Barrett and her family migrated to Australia in 2003. At one time Ms Barrett was the midwife in charge of the nightshift at the Ashford Hospital. In 2005 she commenced a homebirthing practice as a privately practising midwife. In early 2011 Ms Barrett relinquished her registration as a midwife and commenced practice as a 'birth advocate' working privately within the homebirth industry. She continued to provide services at homebirths in that stated capacity and charged for her services. In due course I will discuss Ms Barrett's change of occupation description in the context of certain registration and insurance stipulations that now apply to the midwifery profession. Suffice it to say at this point, the change in nomenclature, in my assessment, has not altered the fact that Ms Barrett has continued to perform the clinical tasks and to undertake the clinical responsibilities of a midwife in the context of the intrapartum component of a homebirth. The case in Western Australia and that relating to Tully Kavanagh, both in 2011, are instances in point.

3.9. In these Inquests I examined a number of issues that included whether or not these deaths could have been prevented in the particular setting in which they occurred, namely a homebirth setting, and whether in any event these deaths could have been prevented had their births taken place in a hospital setting. I also examined the issue as to whether, in the individual three cases, the particular risks associated with the complications that these births may have presented had been fully understood and appreciated by the infants' mothers. In examining that issue I examined the related issue as to whether the choices made by the mother in each instance, to undergo the birth of their babies in their homes, was a fully informed one in which they fully understood the risks involved in each case.

4. The cause of death of Tate Spencer-Koch

4.1. In the Court's ruling as to the Court's jurisdiction to conduct an Inquest into the death of Tate Spencer-Koch, I indicated that the evidence pointed to the cause of Tate's death as having been an intrapartum hypoxic event, and for the purposes of that ruling I found that to have been the case. However, I indicated that I would keep an open mind on the subject of the cause of Tate's death because this was a matter that would require a specific finding in the Inquest to be conducted into the cause and circumstances of her death[8].

4.2. Nothing adduced in the Inquest proper in any way altered the tentative view expressed in my preliminary ruling that Tate had experienced an intrapartum hypoxic event. For the purposes of these findings I find that to have been the case. Accordingly, I find that Tate Spencer-Koch's cause of death was intrapartum hypoxia. I now set out the reasons for that finding.

4.3. Tate Spencer-Koch's post-mortem examination was conducted by Dr T Y Khong who is a pathologist employed by the WCH and who performs pathological duties for the State Perinatal Autopsy Service. His role there includes the performance of post-mortem examinations in respect of babies who die around the time of delivery. Dr Khong prepared a post-mortem report in relation to Tate Spencer-Koch[9]. In addition, on 2 May 2008 he was interviewed in respect of his autopsy findings by a police officer attached to the Coronial Investigation Section[10]. Dr Khong also gave sworn evidence during the preliminary hearing into the question of jurisdiction. Dr Khong's post-mortem report does not contain the usual concise recitation of the infant's cause of death. Rather, Dr Khong sets out certain observations in relation to the infant from which a number of conclusions have to be drawn. As will be seen shortly, his evidence in the preliminary inquiry as to jurisdiction clarifies the matter.

4.4. In Dr Khong's report he makes the observation that Tate was macrosomic with shoulder dystocia during delivery, that Tate had experienced peripartum asphyxia as evidenced by petechial haemorrhages on thymus, visceral pleura, pericardium and

---

[8] Paragraph 1.18 of the Ruling dated 4 June 2010
[9] Exhibit C22
(Please Note – Unless otherwise indicated, Exhibit references relate to the Tate Spencer-Koch and Jahli Hobbs Inquest)
[10] Exhibit C22a

epicardium and also cites a finding of occipital osteodiastasis. In his report Dr Khong sets out the following:

> '**CONCLUSION/COMMENT**
> Macrosomic neonates are at risk for shoulder dystocia and birth trauma. The risk is directly related to neonatal birth weight and begins to increase substantially when birth weight exceeds 4500g.'

4.5. In his post-mortem report Dr Khong states that the recorded weight of Tate at birth was 4790g which he characterises as macrosomic. Of this there can be no doubt. Dr Khong asserts in his report the mean weight for a normal female infant of 40 weeks gestation as 3463g ± 414g.

4.6. In his interview of 2 May 2008 Dr Khong opined that the cause of Tate's death was essentially undetermined, but acknowledged that there had been a risk factor associated with her delivery posed by her large size and that the delivery of large babies can be held up and be the subject of morbidity and mortality[11].

4.7. The issue as to Tate's cause of death was explored in greater depth in the course of Dr Khong's oral evidence in the preliminary hearing as to jurisdiction. In his evidence Dr Khong acknowledged that the clinical circumstances associated with the child's birth suggested that the asphyxia that was experienced was peripartum, that is to say in the process of, or before, delivery[12]. For example, when told that the infant had a normal heart rate during the course of the mother's labour, and indeed at a time very close to the point when the baby's head started crowning, Dr Khong asserted that this would suggest that the asphyxial episode occurred intrapartum during the delivery process[13]. Moreover, there was no indication of any abnormality of the placenta or umbilical cord that may have resulted in a deprivation of oxygen during the course of the delivery process[14]. Counsel assisting the Coroner, then Ms Cacas, asked Dr Khong to consider the clinical scenario that had been in existence at the time of the child's labour, including the satisfactory heart rate very close to the crowning of the head and an uneventful and unremarkable antenatal course to which Dr Khong stated:

> 'Okay, in that - what it says to me is that there is nothing wrong with the placenta as such that would have caused the demise of the child. You know, all the abnormalities that are

[11] Exhibit C22a, page 4
[12] Transcript, page 117
[13] Transcript, page 118
[14] Transcript, page 124

> - they are there but they are not, of themselves, sufficient size or significance to cause the child's death.' [15]

Dr Khong agreed that one would then, in establishing a cause for the hypoxia, focus on the delivery process itself[16]. Dr Khong's definitive opinion is encapsulated in the following passage in his evidence:

> 'Well, there is an uneventful pregnancy up to the time of labour, and during labour the head is delivered and then the rest of the body is stuck because of the large-sized baby, and to my mind that would be when the asphyxial event happened. Then the question is, you know, after delivery of the baby I cannot say whether the baby was born alive or not, but certainly this: an acute asphyxial event happened during the delivery of the baby after - well, probably even before the head was delivered or around the time of labour.' [17]

He went on to say that although he had indicated in his police interview that the cause of death was essentially undetermined, he stated that from a clinical and pathological point of view the cause of death was '*asphyxia…….caused by the hold up in the baby's delivery through the birth canal*'[18]. He agreed that a properly stated cause of death was intrapartum hypoxia associated with the prolonged time interval between delivery of the head and delivery of the remainder of the baby[19]. I accept that evidence.

4.8. The circumstances of Tate's birth and death were also examined by Professor Roger Pepperell. Professor Pepperell is a Professor Emeritus at the University of Melbourne. Professor Pepperell was Professor and Chairman of the Department of Obstetrics and Gynaecology at the University of Melbourne (Royal Women's Hospital) from 1978 to 1998. Between 1999 and 2003 he was a Professorial Fellow in the same Department. Following his appointment as Professor Emeritus at the University of Melbourne, from 2004 to 2009 he continued to teach obstetrics, gynaecology and other related medical subjects. Commencing in January 2010, Professor Pepperell undertook a two year appointment as Professor of Obstetrics and Gynaecology at the Penang Medical College in Penang, Malaysia. Although Professor Pepperell is now retired, he continues to undertake clinical work in obstetrics and, in particular, at the Royal Women's Hospital in Melbourne. Professor Pepperell possesses Fellowships of both the British and Australasian Colleges of

[15] Transcript, page 128-129
[16] Transcript, page 130
[17] Transcript, page 135
[18] Transcript, page 139
[19] Transcript, page 140

Obstetrics and Gynaecology. He is also an Honorary Fellow of the American College of Obstetrics and Gynaecology. Professor Pepperell provided written reports[20] and he also gave oral evidence during the Inquests of Tate Spencer-Koch and Jahli Hobbs. I accepted Professor Pepperell as an expert in his field.

4.9. Professor Pepperell expressed the opinion that there would appear to be little doubt that Tate died due to intrapartum hypoxia associated with the prolonged time interval between delivery of the head and delivery of the remainder of the baby. I accept that evidence. Professor Pepperell was also of the view that there was an association between the infant being trapped within the birth canal, in this case due to shoulder dystocia, and the large size of the baby, which he also regarded as macrosomic. I also accept that evidence.

4.10. There was one further feature of Dr Khong's post-mortem examination that is relevant. Upon dissection of the infant's neck muscles he found separation of the base of the skull with the top of the spine. This indicated stretching. He viewed this abnormality as consistent with the affected areas having been stretched when the infant's shoulders were stuck within the birth canal[21]. He suggested that this could have happened during manoeuvres that were made in an attempt to physically extract the baby from the birth canal. In any event, in his view it would have involved something mechanical to have caused such an injury.

4.11. I will come to a more detailed description of the clinical circumstances surrounding Tate's birth and death in due course.

5. <u>The cause of death of Jahli Jean Hobbs</u>

5.1. Jahli Hobbs' post-mortem examination was conducted by Dr Lynette Moore who is a pathologist at SA Pathology. Dr Moore's report[22] expresses a definitive diagnosis as to the cause of death as being intrapartum hypoxia. I find that to have been the cause of Jahli's death. The report does not purport to identify the mechanism by which Jahli Hobbs experienced an intrapartum hypoxic event. Specifically, Dr Moore states that she was not able to comment on the question of placental abruption and suggested that the cause of intrapartum hypoxia was not evidenced from the autopsy findings.

[20] Exhibit C18
[21] Transcript, page 122
[22] Exhibit C25b

5.2. Professor Pepperell provided a report in relation to Jahli Hobbs and also gave evidence in the Inquest. In the course of his evidence he reiterated his reported opinion that it was clear that death was due to intrapartum hypoxia, although he acknowledged that the cause of the hypoxia was not established at autopsy. In his evidence before the Court he suggested that the mechanism for the cause of death was a placental separation at some point during the birthing process[23]. I indicate here that I have accepted that evidence.

5.3. I deal in more detail with the clinical circumstances surrounding the birth and death of Jahli Hobbs in another section.

6. The cause of death of Tully Oliver Kavanagh

6.1. Unlike the cases of Tate Spencer-Koch and Jahli Hobbs, there was a significant period of survival after Tully Kavanagh's birth and a well documented clinical course of approximately two days prior to his death. When Tully was brought into the WCH, having been born en route, he was found by clinicians to be showing no signs of life. However, 13 minutes into the resuscitation process, the infant exhibited signs of an electrical heart rhythm on the cardiac monitor. A minute or so later a pulse was established. Soon after this Tully was stable enough to be transferred to the Neonatal Intensive Care Unit where he was ventilated and supported for the next two days. By Sunday 9 October 2011 it was apparent that Tully had sustained an hypoxic brain injury, no doubt the result of a period of cardiac and respiratory arrest prior to his eventual resuscitation. That afternoon, as already indicated, Tully was placed in the care of his parents and was taken home with the expectation that he would probably die within the next 24 hours. This in fact did take place.

6.2. Following his death Tully was returned to the WCH.

6.3. A post-mortem examination was conducted in respect of Tully by Dr Khong. Dr Khong provided a report[24]. Dr Khong reported the cause of death as hypoxic ischaemic encephalopathy. Dr Khong observed haemorrhagic necrosis of the adrenals consistent with asphyxia. I find that the cause of Tully's death is hypoxic ischaemic encephalopathy.

[23] Transcript, page 873
[24] Exhibit C39 (Tully Kavanagh)

6.4. This begs the question as to what hypoxic or asphyxial event led to his hypoxic brain injury. A consideration of this issue needs to take into account the clinical circumstances in which Tully was born and his condition immediately thereafter. As with the other two infants, Professor Roger Pepperell provided a written report to the Inquest and gave oral evidence as well. I will deal in greater detail later in respect of the circumstances surrounding Tully's birth and death, but suffice it to say at this stage that I accept the opinion of Professor Pepperell[25] that the hypoxia sustained by Tully was almost certainly due to premature separation of the placenta prior to the time of delivery. I add here that this view is also shared by Dr James Harvey who is a consultant obstetrician and Unit Head in Obstetrics at the Adelaide Women's and Children's Hospital. Dr Harvey was called to give oral evidence during the course of Tully Kavanagh's Inquest in relation to another specific matter that I will deal with in due course. However, he was asked for his considered view in relation to the mechanism of, and cause of, Tully Kavanagh's death and he proffered a confident opinion that it was due to a placental abruption[26]. For reasons that will appear in due course, I have accepted the opinions of Professor Pepperell and Dr Harvey. I also add here that the view that a placental abruption had occurred was shared by Tully's mother, Ms Sarah Kerr.

7. Intrinsic risks associated with the births of the three infants

7.1. Tate Spencer-Koch - obstructed labour due to shoulder dystocia

In his report concerning Tate Spencer-Koch, Professor Pepperell makes a number of observations concerning Tate's mother, Jacqueline Spencer, and the circumstances surrounding her previous pregnancy as well as those relating to her pregnancy with Tate, all of which placed Tate's delivery at risk of complication. Professor Pepperell enlarged upon that issue during the course of his oral evidence.

7.2. Ms Spencer's previous pregnancy and labour had culminated in a caesarean section due to foetal distress and slow progress. Ms Spencer had dilated to only 3cm on that occasion. The live baby had weighed 3950g at birth. Professor Pepperell gave evidence that this weight is above the 50th percentile but was not macrosomic, the

[25] Exhibit C9a (Tully Kavanagh, page 4, paragraph 3)
[26] Transcript, pages 236-237 (Tully Kavanagh)
Although the terms 'abruption' and 'separation' can carry different connotations as to the degree of separation from the uterus, for current purposes the terms are used interchangeably

definition of which in his assessment involves a baby heavier than 4200g[27]. Professor Pepperell suggested that a second baby was likely to be larger than the first. This was especially so having regard to the fact that Ms Spencer had a BMI of 37 which is regarded as marked obesity. According to Professor Pepperell, obesity of this nature is associated with:

> '… an increase in virtually every pregnancy complication including a very large baby, increased risk of preeclampsia, problems in labour, obstructed labour, problems at the time of delivery and postpartum haemorrhage.' [28]

7.3. The prospect that Ms Spencer was carrying a macrosomic baby did in fact come to pass. This fact was known in advance of Tate's delivery. Ms Lisa Barrett, who had been providing care to Ms Spencer during the latter stages of the pregnancy, told the Court that some time prior to Tate's labour and delivery she had formed the belief that the baby weighed over 10 pounds[29] (10 pounds is 4536g). Ms Barrett had been able to determine this approximate weight by means of palpation. Such an estimate would imply that the unborn child was likely to be macrosomic. This ultimately proved to be the case. In the event the child weighed 4790g at birth.

7.4. Professor Pepperell was asked to comment upon the implications associated with advance knowledge that an unborn infant was likely to be in excess of 10 pounds. He told the Court that if one knew of the weight of the baby, then certainly one should appreciate that the risks of obstructed labour due to shoulder dystocia are higher than would otherwise be the case[30]. He told the Court that the data clearly indicates that with infants above a weight of 4250g the risks of shoulder dystocia are higher. He suggested that this had been clearly defined by many sources. The other difficulty that he explained was that one could never be absolutely certain how big the baby was, given that clinical examination in the presence of obesity is difficult. Thus he said it is very difficult to make firm and logical decisions concerning care under those circumstances and that one must weigh that as one of the factors involved in making a decision as to care.

7.5. Professor Pepperell suggested that shoulder dystocia was one of the worst obstetric emergencies for a person undergoing natural vaginal delivery as one cannot recognise it in all instances until the delivery process is occurring and the delivery is partially

[27] Transcript, page 822
[28] Exhibit C18, page 2
[29] Transcript, page 513

completed. If the problem is not dealt with within 8 minutes of the delivery of the baby's head, there is a substantial risk of foetal death by way of hypoxia[31]. This is precisely what transpired in Tate's case.

7.6. Professor Pepperell pointed to other circumstances in connection with Tate's delivery that could potentially have been problematic, including the fact that Ms Spencer had previously undergone delivery by way of caesarean section which in turn carries a risk of uterine rupture (involving the rupture of the existing surgical scar) should a natural birth be attempted in the future. I pause here to add that on a statistical basis the risk of rupture in a vaginal birth after caesarean (VBAC) is not high. I deal with the question of VBAC presently. Professor Pepperell also placed emphasis upon the fact that when undergoing labour in respect of her first pregnancy, Ms Spencer's cervix had only dilated to a maximum of 3cm. This could have meant that in relation to the delivery of Tate, she was at increased risk that again she might not dilate to the necessary degree. Furthermore, Ms Spencer had not yet had her vagina dilated by a baby passing through it so that when all things were considered, she might experience all the problems that someone experiences with a first baby[32]. In short, Professor Pepperell suggested that he would have been worried whether the baby was simply too big for the mother's pelvis and would have been concerned about the possibility of obstructed labour in Tate's delivery. His view was that in all of the circumstances the safest course for the delivery of Tate would have been an elective caesarean section. It is difficult to argue with such a conclusion. I here add the observation that, regardless of how unpalatable that course might have been to Tate's parents, there is little doubt that it would have prevented Tate's death. But it would naturally have had to take place in a hospital setting and not at home. Professor Pepperell suggested that in a case such as Ms Spencer's, if she had been intent on having a natural birth notwithstanding the potential difficulties associated with it, then an obstetrician would agree to facilitate that in a hospital. The proper advice given in those circumstances would be that the woman would be watched very closely and that, provided the labour progresses normally in terms of speed of cervical dilatation, there was no foetal distress and she managed to push the baby down and out, then that would be fine but that she would have to accept the risk that the uterine scar might rupture and in those circumstances the baby stood a 50% chance of dying. If the woman was still insistent

[30] Transcript, page 829
[31] Transcript, pages 844-845

on a natural birth, there would be no choice for the clinician but to facilitate that. The woman would need to be managed carefully and closely in a hospital where the woman could be continuously monitored with a cardiotocograph (CTG).

7.7. It is worthwhile observing at this point what Ms Barrett had to say in her evidence about the question of risk presented by a baby that was known in advance to be macrosomic, as she herself knew to be the case with respect to Tate Spencer-Koch. Before dealing with that I should indicate that having regard to her qualifications and experience, I have treated Ms Barrett as an expert in the field of midwifery and have taken her opinions relating to matters within her field of expertise into account. This is not to say, however, that I have preferred her evidence where her opinions differ from that of other experts.

7.8. Firstly, Ms Barrett suggested that in her experience marked obesity in the mother made no difference as far as the prospect of there being a very large baby at the time of delivery was concerned[33]. In any event she suggested that in her opinion a BMI of 37 was not marked obesity. Although discussion of the significance or otherwise of maternal obesity is somewhat academic, in the sense that it was known in advance that Tate was macrosomic regardless of whether there was any connection between that and her mother's then BMI, it serves as one of a number of illustrations of Ms Barrett's tendency to contradict or deny established evidence-based opinion. Secondly, Ms Barrett had this to say in relation to the more pertinent subject of whether there was any increased risk of obstructed labour associated with the delivery of a known very large baby:

> 'If she's giving birth to a very large baby, there's no more increase of obstructed labour, for shoulder dystocia there's not an increased risk because there's the marked and projected risk according to the research and the evidence.' [34]

Specifically, Ms Barrett suggested that she would not be concerned about an increased risk of shoulder dystocia with a baby known to be in excess of 10 pounds[35], but later conceded, based on an American publication, that where a baby was predictably over 5 kilograms, a caesarean section might be considered[36]. However, Ms Barrett's general position as illustrated by the above answer is at odds with the

---

[32] Transcript, pages 830-831
[33] Transcript, pages 544, 958
[34] Transcript, page 545
[35] Transcript, pages 956 and 958
[36] Transcript, page 957

expressed view of Professor Pepperell, at odds with the evidence of the pathologist Dr Khong that the risk of shoulder dystocia and birth trauma begins to increase substantially when birth weight exceeds 4500g, and also at odds with written material that Ms Barrett herself produced in evidence. I unhesitatingly prefer the evidence of the experienced obstetrician Professor Pepperell and that of Dr Khong on this issue and find that foetal macrosomia increases the risk of shoulder dystocia. Further, I find that Tate's likely and expected macrosomia gave rise to such an increased risk.

7.9. On the basis of Ms Barrett's admitted attitude to risk in the context of shoulder dystocia, it could safely be assumed that Ms Barrett would not have regarded her advance knowledge of the likelihood that her client was carrying a macrosomic baby as giving rise to any increased risk of obstructed labour or shoulder dystocia[37], or indeed have shared any such concern with her client, Ms Spencer. Ms Barrett conceded that she did not generally discuss the possibility of shoulder dystocia in these kinds of circumstances with her clients[38]. Indeed, in her evidence before the Court, Ms Barrett openly admitted that she had not specifically spoken to Ms Spencer in advance about the risks associated with having a large baby and specifically of the risk of shoulder dystocia, notwithstanding the fact that she had believed that Ms Spencer's baby was over 10 pounds[39]. Ms Spencer provided two statements to the Inquest and participated in an interview with police[40]. She indicated that she herself had entertained a 'niggling worry' that she would have a bigger baby than her first, but had been told 'many times from many people that size isn't usually a problem and that 10, even 11pd+ baby's (sic) were regularly born naturally both at hospital and home'[41]. In her police interview she asserted that the question of uterine rupture in a VBAC had been discussed with Ms Barrett, but that Ms Barrett had not raised any concerns with her about the size of the baby, that she had not been aware that there may have been complications if she were to have a bigger baby, and that Ms Barrett had never raised the fact that a larger than normal baby may pose a risk to a homebirth[42]. When pressed by counsel as to whether or not Ms Barrett should have raised that with Ms Spencer, to my mind Ms Barrett at first exhibited a distinct

[37] Transcript, page 959
[38] Transcript, page 959
[39] Transcript, pages 955-956
[40] Exhibits C14b, C14c and C14d
[41] Ms Spencer's self-made statement, Exhibit C14d, page 2
[42] Exhibit C14c, pages 14-15

unwillingness to answer the question with a direct answer[43] and then denied that she should have so raised the issue.

7.10. In respect of Professor Pepperell's view that the safest course for the delivery of Tate would have been a caesarean section, Ms Barrett suggested that the American Congress of Obstetricians and Gynaecologists (ACOG) had found that even when a baby is bigger, unless they were over 5000g there would be no benefit in performing a caesarean section because 4000 such babies would have to be sectioned to save one that might have experienced shoulder dystocia[44]. In support of her argument Ms Barrett tendered a Practice Bulletin of ACOG dated November 2002 where one of the stated recommendations is as follows:

> 'Planned caesarean delivery to prevent shoulder dystocia may be considered for suspected fetal macrosomia with estimated fetal weights exceeding 5,000g in women without diabetes and 4,500g in women with diabetes.' [45]

However, the same Bulletin records that foetal macrosomia increases the risk of shoulder dystocia and that a substantial proportion of cases occur among women who do not have diabetes and among infants with birth weights less than 4000g. The thrust of the article it seems was to evaluate the utility of planned caesarean delivery in respect of suspected macrosomic foetuses (> 4000g). The conclusion was that elective induction of labour or elective caesarean delivery for all women suspected of carrying a foetus with macrosomia is not appropriate. That in my view is not the only issue at large in this case. The more important issue is whether or not shoulder dystocia, if experienced in the face of known risk in advance, can be more adequately managed in a hospital setting regardless of the method of delivery.

7.11. I do not in any event see within the article any reference to Ms Barrett's assertion that in respect of babies larger than 5000g, one would require 4000 caesarean sections to save one that had potential shoulder dystocia. What the Bulletin does reveal is that there would be a projected 27% increase in total caesarean section deliveries if one were to be performed for all patients with foetuses that weighed 4000g or more, but that the number of shoulder dystocia cases would be reduced by 'only 42%', which would appear, at least at face value, to be a not insignificant reduction.

[43] Transcript, page 956, Line 17
[44] Transcript, pages 939-940
[45] Exhibit C20g

7.12. Nothing in the ACOG article, nor the evidence of Ms Barrett, undermined the clear evidence of Professor Pepperell that a macrosomic baby, by his definition one greater than 4200g, gave rise to an increased risk of obstructed labour and, in particular, shoulder dystocia. In short I accept that evidence and find that in the case of Tate Spencer-Koch there was a set of circumstances known in advance of the delivery, and which were known to Ms Barrett, that gave rise to and signified an enhanced risk of an obstructed labour and of shoulder dystocia in particular. In this regard it is not being wise after the known event of obstructed labour and shoulder dystocia in Tate's case to suggest that this was an outcome that was not wholly unpredictable.

7.13. In any case Professor Pepperell's opinions are supported in the ACOG Bulletin which sends a very clear message that, while shoulder dystocia is mostly unpredictable and unpreventable, foetal macrosomia does increase the risk of shoulder dystocia and that a substantial proportion of cases occur among women who do not have diabetes and among infants with birth weights less than 4000g. Tate's birth weight was considerably in excess of that and she was unquestionably macrosomic and predictably so in advance.

7.14. In a further report[46] that was sought from Professor Pepperell following Ms Barrett's evidence, and in the light of the ACOG Practice Bulletin that she produced, Professor Pepperell reiterated that there is no doubt that the risk of shoulder dystocia increases as the foetal weight increases over 4250g, particularly over 4500g and more particularly again over 5000g. He did point out that many women with babies at these weights can still deliver vaginally without problems depending upon the size of the maternal pelvis, which in Ms Spencer's case was not known. Professor Pepperell regarded Ms Barrett's comments that in cases were shoulder dystocia is fatal no amount of people to assist actually makes a difference and that this was demonstrated by the fact that fatal shoulder dystocias occur in hospitals with all of its amenities and staff, were out of touch with reality. Professor Pepperell suggested that such a fatal state of affairs is rare in hospitals today.

7.15. The disadvantages to the infant associated with a homebirth where a complication of obstructed labour as a result of shoulder dystocia occurs include the lack of professional assistance required to rectify the obstruction without undue delay and a

[46] Exhibit C18b

lack of immediately available advanced resuscitation resources in the event of the delivery of an infant that requires the same.

7.16. Jahli Hobbs – breech birth with placental separation

In a separate report that Professor Pepperell prepared in relation to the birth of Jahli Hobbs[47], and in his oral evidence, he discusses a number of potential complications that can be associated with vaginal birth in respect of a baby that is in one of a number of possible breech positions, that is to say where the head is not positioned such as to be delivered first. There is no doubt that it was known in advance of Jahli Hobbs' birth that the infant was in a breech position and there was no reason to believe that its position had changed at any time prior to the commencement of labour. As well, Professor Pepperell observed that the mother's (Ms Naomi Hughes') previous successful delivery of a child had taken place by way of caesarean section due to foetal distress and slow progress. This also presented some risk of uterine rupture with a vaginal delivery.

7.17. In his evidence Professor Pepperell explained that in a vaginal delivery of a breech baby the risk of a significant major morbidity or mortality was approximately 5%, whereas if the child is delivered by caesarean section electively, the risk was approximately 1.7%[48]. These statistics were derived from the Hannah Term Breech Trial that I will discuss more fully in a moment. I did not understand Professor Pepperell necessarily to be advocating an elective caesarean section in each and every case of breech presentation, and certainly a caesarean section could not be performed in a homebirth environment. The important aspect of Professor Pepperell's evidence is the fact that, regardless of statistical comparisons, vaginal delivery of breech presenting babies carries its own peculiar risks, particularly in this case because the mother's first child was a large baby being 3960g and that the second baby was probably going to be bigger than that. In the event, this proved in Jahli Hobbs' case not to be the case as her weight at autopsy was 3180g. Although the issue of weight did not give rise to the difficulty that was to be encountered, the child's potential weight was a matter that nevertheless needed to be taken into consideration.

7.18. Professor Pepperell explained that there were four types of breech presentation, all of which involve part of the anatomy of the baby other than the head emerging first.

[47] Exhibit C18a
[48] Transcript, page 858

Where the baby's head emerges first, which by far and away occurs much more frequently, this is referred to as cephalic presentation. Professor Pepperell explained that one of the principal risks associated with breech presentation is the risk of cord prolapse and compression during the course of delivery, coupled with delay in the delivery. Secondly, where there is a delay in delivery in which the uterus alters in size and becomes smaller, this increases the risk of placental separation owing to the fact that there is a smaller area once part of the child is delivered onto which the placenta can remain attached. Professor Pepperell was of the belief that a placental separation occurred in Jahli Hobbs' case as the placenta was delivered at the same time at which the last part of the child was delivered, namely the head. The potential for hypoxia in those circumstances would be very high unless rapid complete delivery of the baby within the uterus was to occur.

7.19. Any such difficulties giving rise as they do to sustained periods of hypoxia are compounded where there is a lack of continuous monitoring that might alert the clinician to a problem with the foetal heart and therefore to hypoxia. According to Professor Pepperell, delays in delivery can be occasioned in cases where there may not be complete dilatation of the cervix such that the legs and lower parts of the child are delivered first through the incompletely dilated cervix and then the head then becomes obstructed.

7.20. Professor Pepperell stated that in a situation where a small presenting part, such as a foot, slips through the cervix before the cervix has reached full dilatation, delivery of the head would be much more difficult and that would increase the likelihood of hypoxia in the baby, or it could result in the baby sustaining neurological brain damage. He suggested this is particularly the case when the time interval between delivery of the foetal abdomen and delivery of the head exceeds 6 to 8 minutes. In essence, Professor Pepperell was of the view that an essential safeguard against an unknown adverse event occurring during the process of a breech delivery was continuous monitoring of the baby's vital signs and taking timely action to expedite the delivery if something adverse was thereby identified.

7.21. As will be seen, various guidelines that are in existence, originating in both the public and private sectors, universally suggest that a known breech presentation and delivery should not be attempted in a homebirth because of the risks presented to the unborn

child. As well, there is widely stated opinion that VBACs should not occur in a homebirth setting. Both elements existed in relation to the delivery of Jahli Hobbs.

7.22. Ms Barrett in her evidence agreed that in a breech delivery there was a risk of cord prolapse, but suggested that there is a high morbidity and mortality with breech birth regardless of the mode of delivery. She also stated that the risk of placental abruption is raised slightly in the case of a breech birth because of the potential for the placenta to separate from the uterine wall as the baby descends through the pelvis and as the uterine wall consequently contracts. This means that when the placenta separates from the wall of the uterus, the baby's oxygen supply is effectively cut off. Ms Barrett agreed that there was a window of only a few minutes following a placental separation before a baby becomes severely compromised[49].

7.23. Much of Ms Barrett's evidence about the desirability or otherwise of a vaginal delivery of a breech birth in the home setting was premised on a number of questionable views that she steadfastly appears to hold. Firstly, she suggests that continuous monitoring is no more effective than intermittent monitoring of the unborn child's heart rate[50]. She maintains that all that continuous CTG[51] monitoring achieves is higher rates of caesarean section. She suggested that the evidence reveals that intermittent listening with a Doppler is as effective a means of monitoring the wellbeing of the baby as continuous CTG monitoring. Secondly, her beliefs are premised on the assumption that with vaginal delivery in respect of breech birth, the outcomes are no different in respect of a child that is born at home as opposed to a hospital. In fact she cites Jahli Hobbs' delivery as an example illustrating her point. I return to that issue in due course[52]. Thirdly, Ms Barrett suggests that the mortality and morbidity is the same for caesarean section as for vaginal breech birth[53]. In dealing with the issue as to whether if Jahli had been born by way of caesarean section she may have survived, Ms Barrett stated that:

> '…..there's just as much risk surrounding an elective caesarean for a breech as there is surrounding a vaginal birth for a breech, so the chances of her dying from a caesarean section are the same of her dying from a normal birth.' [54]

[49] Transcript, pages 618-620
[50] Transcript, page 587
[51] Cardiotocograph
[52] Transcript, page 629
[53] Transcript, page 630
[54] Transcript, page 629

7.24. Ms Barrett purported to advance her arguments by reference to a number of publications that she produced in evidence.

7.25. The debate as to risk involved in a breech birth was largely centred around an argument as to whether an elective caesarean section was the clear and always preferred alternative to a vaginal delivery, regardless of venue. This debate somewhat missed the point insofar as the real issue is whether or not risks associated with vaginal delivery are enhanced in a homebirth setting, or can be managed in such a setting as opposed to a vaginal delivery in a hospital setting. A woman who is minded to undergo a breech delivery in her home is more likely to be persuaded to undergo a vaginal delivery in a hospital than elect for a caesarean section. There was a deal of discussion during the course of the Inquest concerning the well-known Hannah Term Breech Trial[55]. The Hannah Trial in very brief terms had argued that planned vaginal delivery of term breech births is associated with high neonatal risks. As to this Ms Barrett produced a number of publications, two of which were promulgated within the American Journal of Obstetrics and Gynaecology[56]. The conclusion expressed in one of the publications entitled 'Is Planned Vaginal Delivery for Breech Presentation at Term Still an Option? Results of an Observational Prospective Survey in France and Belgium'[57] in 2006, is that in centres where planned vaginal delivery remains a widespread practice, and when complying with rigorous conditions before and during labour, there was not found to be a significant excess risk associated with planned vaginal delivery compared with planned caesarean section for women with a singleton foetus in the breech position at term. The publication suggests that under the conditions discussed in the publication, planned vaginal delivery of singleton foetuses in breech presentation at term remains a safe clinical option that can be offered to women after providing them with clear, objective and complete information. This publication was based on surveys in France and Belgium for the PREMODA Study Group. Neither this article nor any other literature that has been tendered suggests that planned vaginal delivery for a singleton foetus in the breech presentation at term ought appropriately be undertaken in the home. On the contrary, the conclusion reached in the article to which I have referred suggests that in vaginal deliveries, rigorous compliance with conditions before enduring labour is a prerequisite. Professor Pepperell, who examined this material and provided a

[55] Exhibit C20h, Reference 2
[56] Exhibits C20h and C20i

further report to the Court[58], stated that the information contained within these publications is well known to obstetricians. Professor Pepperell states that there is no doubt that the current obstetric opinion is that if attempts at vaginal breech delivery are to be accepted as appropriate, ultrasound examinations should be performed to ensure the breech is of a type associated with less risk than other types of breech presentation, the head is shown not to be extended and that the foetal weight is expected to be less than 4000g. He suggests that such delivery should also be performed in a hospital where progress of labour can be assessed frequently and adequately, where foetal monitoring can be appropriately performed and where appropriate action can be taken urgently where problems are defined. He points out, as I have pointed out, that none of the publications recommend delivery at home as an appropriate option.

7.26. As to the question of continuous monitoring by way of CTG, Ms Barrett produced a review prepared by the Cochrane Collaboration[59] that suggests that with continuous CTG monitoring of foetal heart rate there was no difference in the incidences of cerebral palsy, although other possible long-term effects had not been fully assessed and needed further study, but that continuous monitoring was associated with significant increase in caesarean section and instrumental vaginal births. This was produced to support Ms Barrett's argument that CTG monitoring, which can only appropriately be conducted within a hospital, is no more effective in preventing adverse outcomes than intermittent monitoring, say by way of a Doppler. Professor Pepperell commented upon those assertions and upon the Cochrane Review in particular and pointed out that, regardless of what was said therein, in clinical practice it is clear that CTG monitoring allows recognition of problems which cannot be defined adequately by other monitoring techniques, with this being particularly important in patients having a VBAC attempt, a twin pregnancy, or where the likelihood of placental dysfunction or cord compression, such as with breech presentation, is increased. He suggested it allows the earliest possibility of recognition of signs of foetal distress or uterine rupture and is used routinely in tertiary referral hospitals allowing a VBAC attempt.

---

[57] Exhibit C20h
[58] Exhibit C18b
[59] Exhibit C20e

7.27. As will be seen, if CTG monitoring had been in place in the course of labour relating to Jahli Hobbs, and appropriate action had been taken in the light of what it may have identified, it may have altered the outcome.

7.28. On the morning of Jahli's birth and death Jahli's mother, Ms Naomi Hughes, provided a statement to police[60]. As well, she was later interviewed at greater length by a Detective attached to SAPOL. This occurred on 30 July 2010. As to Jahli Hobbs' mother's appreciation of risk involved in the birth of Jahli, in her interview of July 2010 Ms Hughes told the interviewing Detective that she knew that there had been a small risk involved in Jahli's birth relating to the fact that she was going to undergo a natural birth following the caesarean section that she had experienced in respect of her first born child. She had been made aware by both her general practitioner and by the midwife, Ms Barrett, of quoted percentages of risk of uterine scar rupture, both of which had been stated in terms of less than 1%. She indicated that she had been willing to take that risk. Ms Hughes had also been fully aware that the child was in a breech position at all material times, right to the commencement of labour. She had engaged Ms Barrett in anticipation of a homebirth sometime after her 20 week scan. Ms Hughes knew the child was breech because Ms Barrett had in fact told her this. Ms Hughes asserts that Ms Barrett told her that breech was 'just a variation of normal'[61]. She asserted that Ms Barrett 'doesn't believe that breech is an issue'[62]. As far as an appreciation of risk is concerned, Ms Hughes stated as follows:

> 'Not so much as a risk but I know that the intensity to push isn't as full on you know but, I don't, I don't really, I know we definitely discussed the fact that she was breech and talked about what that meant and talked about the birth of a breech and obviously I had seen live videos of other women birthing breeched babies so there was definitely a discussion about it and just at this moment I don't really what all that was because really obviously, yer because I obviously know that if I was to stay in the hospital system that they would prefer to do a caesarean for a breech and because I didn't want that know we definitely had discussions on it and I know that she would have told me all about it but I never felt as though it was unsafe thing, never.' [63]

As a result of Ms Barrett's assertions that breech was a variation of normal, and because Ms Hughes believed that Ms Barrett was known worldwide for her expertise

[60] Exhibit C39a
[61] Exhibit C39b, page 8
[62] Exhibit C39b, page 9
[63] Exhibit C39b, page 9

and speciality in breech births, Ms Hughes did not feel that there was any danger to her child or to herself[64].

7.29. One thing that at this stage is worthy of mention in respect of the birth of Jahli Hobbs is that in the statement taken by police on the morning of the birth and death of Jahli, Ms Hughes had asserted that when the child's placenta had emerged at the same time that the child was fully born, she had regarded this as something that was not normal. Her partner, Mr Anthony Hobbs, in his police statement taken the same day[65], also had observed that the placenta had been born at the same time as the baby's complete delivery, which he had also thought was not usual. In Ms Hughes' more comprehensive interview in July 2010, she appeared to evince a different belief from what she had first expressed about the simultaneous birthing of the placenta and the baby. She asserted that it was 'usually very normal and not a risk'[66]. As will be seen, the fact that in this case the placenta and the child were born at the same time is some indication that all had not been well during the course of this breech delivery. It signified that there had been a catastrophic placental separation.

7.30. Aside from Ms Barrett being involved in Ms Hughes' care during pregnancy, another midwife by the name of Ms Rosemary Vaher had also been involved. Ms Vaher had in fact examined Ms Hughes at one point and had established for herself that the baby was being carried in the breech position, although she could not establish the exact position. In her evidence before the Court, Ms Vaher suggested that there had been no detailed discussion with Ms Hughes about risks associated with a breech delivery[67], although there had been some discussion in relation to risks associated with vaginal birth after a caesarean section (VBAC). Of course Ms Vaher had not necessarily been present during each and every discussion that Ms Barrett may have conducted with Ms Hughes. For herself, Ms Vaher suggested that she would discuss the risks associated with a breech birth with a pregnant woman. She would discuss with the mother a number of issues, namely whether she wanted to undergo an external cephalic version (ECV), whether she wanted to confirm with ultrasound that the baby actually was in the breech position, the advantages of an ECV and the disadvantages including possible placental separation and the possibility of the baby's

[64] Exhibit C39b, page 9
[65] Exhibit C26a
[66] Exhibit C29b, page 21
[67] Transcript, page 469

cord becoming entangled. She would also advise about possible delay in labour, cord prolapse and cord compression.

7.31. In her evidence Ms Barrett confirmed that she had known that Ms Hughes was carrying a breech baby. Ms Barrett quoted a figure that only 4% of babies will be breech. In her career she had probably assisted the birth of 40 or 50 breech births. Ms Barrett asserted that it is known that morbidity and mortality is high with a breech birth, regardless of the mode of birth and so she and Ms Hughes had talked through the risks of having a vaginal birth, the risks of having a caesarean section birth, what the options were with staying at home or going to the hospital and the option of having an ECV[68]. Ms Barrett has a belief that morbidity and mortality with breech delivery is high regardless of mode of birth and that this had been the subject of discussion with Ms Hughes[69]. Ms Barrett suggested that she had discussed with Ms Hughes the risks of having a vaginal breech birth, but the nature of the advice given to Ms Hughes would have to be examined in the light of the fact that Ms Barrett holds the view that '*there's just as much risk surrounding an elective caesarean for a breech as there is surrounding a vaginal birth for a breech*'.[70]

7.32. In cross-examination by counsel assisting, Ms Kereru, the risk of placental abruption in a breech birth raises slightly, although it is a low risk in every type of birth[71].

7.33. Ms Barrett also admitted that she had not drawn the Australian College of Midwives National Midwifery Guidelines for Consultation and Referral to Ms Hughes' attention. I will mention these guidelines in more detail in a moment, but they recommend in a case such as Ms Hughes', who was experiencing a non-cephalic presentation at full term, that the woman be referred to a medical practitioner. Ms Barrett told the Court that she had refrained from drawing these guidelines to Ms Hughes' attention because Ms Hughes had already made her choice and she already knew the risks involved[72].

7.34. Ms Hughes herself suggests that she was led to believe that breech did not present any danger to her unborn child or to herself and did not believe it was an unsafe thing to

[68] Transcript, page 516
[69] Transcript, page 515
[70] Transcript, page 629
[71] Transcript, page 619
[72] Transcript, page 979

undergo in the home environment. She also appears to have been led to believe that there was a reassuring element of normality about a breech delivery.

7.35. The disadvantage to the infant associated with a homebirth where a complication from a breech delivery occurs include a lack of continuous diagnostic monitoring, a lack of a professional resource that is willing and capable of performing a breech extraction upon the detection of a complication, the inability to perform an emergency caesarean section delivery if indicated and a lack of immediately available advanced resuscitation resources in the event of the delivery of an infant that requires the same.

7.36. Tully Kavanagh - twin birth with placental separation

7.37. Professor Pepperell gave some general evidence about risks associated with the birth of twins. He told the Court that there are increased risks right through the processes of pregnancy and labour and that it was in respect of the difficulties that could arise during labour that most people would exclude them from a homebirth.

7.38. One such difficulty in labour is that once the first twin has been delivered, the risks to the second twin increase the longer the duration between the delivery of the first twin and the delivery of the second. Professor Pepperell gave evidence that if that period exceeded 20 minutes, there is an increased risk of the placenta separating and one is unable to discern whether, if any bleeding is apparent, it is emanating from the placenta of the twin that has just been delivered or the placenta of the twin that is still in-utero. Secondly, there may be a difficulty encountered regarding the presentation of the second twin. If it is in a longitudinal line it might either be head first or bottom first. If the child is not in a longitudinal line it may be transverse or oblique and this would require correction to the longitudinal line because the child cannot be delivered in a transverse or oblique presentation.

7.39. Professor Pepperell suggested that the rule is that one should, where feasible, have the second twin delivered within 20 minutes of the first because the risk of placental separation ever increases, resulting in bleeding and foetal distress if enough of the placenta of the second twin separates. If this is not rectified then the result is that the baby becomes hypoxic. Although placental separation and therefore hypoxia are not necessarily inevitable, the longer one waits the more likely it is to take place[73].

[73] Transcript, page 891

Professor Pepperell suggested that most obstetricians would accept a duration of 20 minutes as being the outside limit between delivery of the two twins.

7.40. In a document attached to his report regarding the death of Tully Kavanagh[74], Professor Pepperell also explained that there is a risk of cord prolapse in respect of the second twin and this becomes more likely after the membranes of the separate sac containing the second twin rupture. This complication becomes more likely if the time interval between the delivery of the twins exceeds 20 minutes.

7.41. Another complication may arise where, following the delivery of the first twin, the cervix reforms from its full dilation such that dilation would have to be re-established for the second twin to be delivered[75].

7.42. Complications and delays with the delivery of the second twin might be compounded by lack of proper and continuous monitoring of the heartbeat of that second twin.

7.43. Dr James Harvey, the obstetrician to whom I have already referred, also told the Court that the second of the twins is exposed to risk. He said that he had attended hundreds of vaginal twin deliveries and that at every one of them had felt anxiety as to what he was next going to be faced with once the first twin had been delivered[76]. Dr Harvey explained that there is a risk of post-partum haemorrhage from the fact that the presence of twins has given rise to an over distended uterus and that with two placental sites there is a greater risk of haemorrhaging[77]. Dr Harvey also explained, as did Professor Pepperell, the risks of placental abruption or separation[78] and stated that complete separation usually involves foetal death[79]. Dr Harvey explained that the larger the abruption the more signs of distress that the baby may exhibit, and one may detect decelerations of the foetal heart rate where it slows down and stays down and is slow to recover, or would detect persistent bradycardia where the pulse rate is low and stays low[80]. Dr Harvey, as with Professor Pepperell, explained that with a second twin there is an increased incidence of hypoxia and foetal death or brain injury if there

[74] Exhibit C9a (Tully Kavanagh)
[75] Transcript, page 895
[76] Transcript, pages 207-208 (Tully Kavanagh)
[77] Transcript, page 216 (Tully Kavanagh)
[78] Transcript, pages 221-222 (Tully Kavanagh)
[79] Transcript, page 222 (Tully Kavanagh)
[80] Transcript, page 223 (Tully Kavanagh)

is a delay in delivery. If the uterus contracts down after the delivery of the first twin, then any shearing or separation of the placenta may occur[81].

7.44. The evidence revealed that there were other risks involved in the birth of twins including shoulder dystocia and the complications that might arise where the babies are in the breech position. However, for the purposes of this Inquest, the relevant element of risk proved to be that of a placental abruption as, in the event, it is clear that this is what took place. As with the delivery of Jahli Hobbs, the delivery of Tully Kavanagh was accompanied by the simultaneous delivery of the placenta.

7.45. I have already alluded to the fact that the matter in Western Australia also involved the death of a second twin. Ms Lisa Barrett had been in attendance at that birth and participated in an interview with Western Australian Police in respect of that matter. It is apparent from what she told police, as recorded in a statement[82], that there had been a placental separation in that case as well and that the placenta had been born at the same time as the unresponsive second twin.

7.46. Although Ms Barrett participated in an interview in respect of the West Australian matter, when questioned in Court about that matter during the Inquest concerning Tate Spencer-Koch and Jahli Hobbs, she refused to answer any questions on the grounds that answers to such questions might tend to incriminate her. I upheld that claim of privilege. When Ms Barrett was later called to give evidence in the Inquest relating to Tully Kavanagh, she again refused to answer questions about that matter on the grounds that answers to such questions concerning Tully Kavanagh would tend to incriminate her. Again I upheld that claim of privilege. In the event there is no evidence from Ms Barrett concerning the question of risk involved in the delivery of twins, either in a homebirth setting or at all.

7.47. Tully Kavanagh's mother, Ms Sarah Kerr, gave evidence in the Inquest into the death of Tully. Ms Kerr had engaged Ms Lisa Barrett to assist at the home delivery of her twins. Ms Kerr had also received advice from a medical practitioner at the WCH while undergoing a period of hospitalisation during the course of, but not directly related to, her pregnancy. In her time in the witness box Ms Kerr exhibited a very detailed knowledge of the risks involved in the birth of twins and demonstrated that she had possessed that knowledge in advance of their delivery. In particular, it is

[81] Transcript, page 226 (Tully Kavanagh)

abundantly evident that she had a clear appreciation of the specific risks attaching to the delivery of the second twin, including the possibility of placental abruption. It is clear that Ms Kerr underwent a homebirth in respect of her twins in the full knowledge of the risks involved. That said, she also asserted a belief that there is no greater risk associated with the homebirth of twins than there is with the birth of twins in a hospital. This might be strictly so purely in terms of the existence of intrinsic risk factors associated with the birth of twins generally, but the evidence demonstrates beyond doubt that once a complication arises, the crisis is far more effectively managed in a hospital.

7.48. The particular risks and difficulties associated with the birth of twins has generally been accepted as giving rise to a need for twin deliveries to take place in a hospital. This was certainly the opinion voiced by Professor Pepperell and also by Dr Harvey. Professor Pepperell suggested in his report regarding Tully Kavanagh[83] that such pregnancies are intrinsically 'high risk' and that they should be handled within a hospital where foetal monitoring (CTG) facilities were available if required, where consultant obstetricians are readily available should a complication occur, where an anaesthetist is readily available should anaesthetic need to be given, and where qualified paediatric staff are readily available should more than the normal resuscitation measures be needed immediately after delivery. He states that it is:

> '… unwise for such patients to be delivered at home, as there is inevitably a time delay in transfer to hospital should this become necessary, with the risk of adverse results for the mother and/or baby being increased.' [84]

In his evidence Professor Pepperell articulated the disadvantages that might be experienced in a homebirthing of twins. There might be a need to stimulate contractions in respect of the yet to be born second twin, which he believed was something that most midwives would not wish to do when the presenting part of the baby is high[85]. In addition, if a syntocinon infusion is required, which also stimulates the expedition of delivery, this is administered intravenously and that it would be unlikely that an intravenous drip would be running in most homebirth situations[86]. Thirdly, there is the difficulty in monitoring, by way of CTG, the wellbeing of the second twin after the delivery of the first. It is Professor Pepperell's view that CTG

---

[82] Exhibit C57c
[83] Exhibit C9a (Tully Kavanagh)
[84] Exhibit C9a, page 5, paragraph 4.1 (Tully Kavanagh)
[85] Transcript, page 893

monitoring is much more effective than intermittent monitoring by way of a Doppler. I prefer and accept the evidence of Professor Pepperell on that issue. Fourthly, a woman may require special forms of pain relief such as an epidural anaesthetic which would not be available in a homebirthing situation. The question of the need for an epidural anaesthetic to be in place during the first stage of labour was a matter for contention during the course of the Inquest. I will return to that issue in due course. Fifthly, Professor Pepperell points out that if transfer to a hospital is required, there is an inevitable delay. Sixthly, in the second stage of labour, assisted vaginal delivery with the use of forceps or vacuum is less able to be administered. Seventhly, if the baby is delivered in poor condition, which it will be in a small percentage of patients who are apparently at low risk, the facilities for resuscitation of the baby are likely to be much less effective than they would be if the birth had taken place in a hospital. Lastly, the management of a post-partum haemorrhage is more difficult within the home and that also carries implications in terms of delay if a transfer to hospital is required. In short, Professor Pepperell was of the view that '*you have got a whole host of potential problems*'[87]. He was of the view that a home delivery for a twin pregnancy was an '*absolute no*'[88].

7.49. Dr Harvey gave similar evidence concerning the disadvantages of a homebirth in respect of twins and cited difficulties such as lack of pain relief, bleeding, persistent foetal bradycardia, encountering difficult lies of the baby, the lack of any means to accurately identify foetal distress by way of continuous monitoring and the difficulty of utilising a Doppler to identify heart rate when there are other tasks that simultaneously need to be performed in a homebirthing situation[89].

7.50. Dr Brian Wheatley, who is the Divisional Medical Director of the women's and children's division of the WCH and who is a specialist obstetrician and gynaecologist, has given a detailed statement to police in respect of the protocols and procedures of the WCH in relation to twin pregnancies[90]. He did not have any direct involvement in the matter of Tully Kavanagh. Dr Wheatley explains that a woman with twin pregnancies requires a greater level of care even prior to the intrapartum stage. In terms of antenatal care there are guidelines about the recommended frequency of

[86] Transcript, page 894
[87] Transcript, page 897
[88] Transcript, page 899
[89] Transcript, page 224 (Tully Kavanagh)
[90] Exhibit C37a (Tully Kavanagh)

monitoring and observation. These guidelines are adhered to by midwives and obstetricians working collaboratively and are dependent on the level of risk or the model of care the individual woman wishes to have. He cites regular observations and ultrasound as examples of the measures that are now standard. These observations may determine whether or not there is a need for earlier than usual delivery, it being generally recommended that the majority of twin pregnancies are delivered between 37-38 weeks. Like others, Dr Wheatley speaks of the increased risk to the second twin, including that occasioned by placental separation.

7.51. Dr Wheatley does not suggest that there is an inflexible rule or practice in hospitals concerning the appropriate time lapse between the delivery of twins. After the first baby is delivered, the position and wellbeing of the second baby is ascertained by monitoring the heartbeat and determining the baby's position by hand or with ultrasound to see if the baby is coming head first. Clinicians would then wait for a period of time, in the absence of bleeding or foetal distress, for the second baby to come down into the birth canal and deliver. Dr Wheatley states that there are wide ranging views about how long one should wait for the second twin to be delivered in these situations. He states that there is no robust evidence that there is a particular timeframe that is categorically associated with risk, assuming there is a normally grown baby, a monitor that is indicating that the baby is well at that time and that there is no concern about the baby's position. He states that if the baby is head first, is being continually monitored and there is no concern about the baby's wellbeing, one would endeavour to wait for the contractions to continue and proceed to another normal birth. However, there is evidence that as time goes on there is an increased risk of the placenta separating and the second baby may become distressed. If this happens a rapid response would be required. Their practice is to artificially rupture the membranes as soon as the second twin's head is at the entrance of the pelvis. A syntocinon infusion may also be administered to stimulate contractions. They endeavour to ensure that the second twin is born generally within about half an hour of the first twin being born. Dr Wheatley states that the evidence suggested that after about a 20 or 30 minute interval there is a sliding scale of increased risk of adverse outcome to the second twin. That said, he suggested there is anecdotal evidence of people waiting some hours without an adverse outcome whatsoever. He suggests that there is no particular point at which there is 100% certainty of an adverse outcome. As far as the risk of separation of the placenta is concerned, in terms of recommended

timeframes relative to expediting the second twin, the action to be taken would depend on whether or not the baby is showing signs of distress at the time. Nevertheless, Dr Wheatley suggests that one would be proactive and preventative, and would consider bleeding to be a sign that things may escalate to a more serious level and that therefore the matter has to be dealt with immediately rather than waiting for it to become a more serious emergency. Once the baby shows signs of distress then a more rapid timeframe is indicated.

7.52. What Dr Wheatley's evidence demonstrates in the opinion of the Court is that natural delivery of twins is not something that is inevitably forbidden or even discouraged in a hospital setting, contrary to what appears to be the conventional wisdom within the homebirthing industry. It is not as if the second twin is immediately and manually delivered regardless of the circumstances. Whether any intervention needs to be conducted depends upon any detected distress in the baby, as evidenced by continual monitoring, and other clinical signs such as bleeding. Dr Wheatley does of course describe situations in which intervention would be required, including in cases of breech presentation where a breech extraction may need to be performed and, naturally, where caesarean section is necessary in other emergencies. He suggests that caesarean section can be achieved within 15 minutes.

7.53. Dr Wheatley was asked to comment upon the circumstances surrounding Tully's birth. He notes of course the blood loss following the birth of the first twin, raising a question as to the possibility of premature separation of the placenta. Like Professor Pepperell, he states that in a case where there are two placentas, one cannot be sure that a blood loss relates to the separation of the already delivered baby's placenta or the second baby's placenta. Dr Wheatley states that the wiser course is to assume that it is from the placenta of the second twin. In those situations it is usual to expedite the delivery of the second twin.

7.54. Ms Judith Coffey, a registered midwife and the Clinical Service Co-ordinator of the Delivery Suite at the WCH, and who was involved in Tully's management at WCH on the afternoon of Friday 7 October 2011, stated in her witness statement[91] that where there are deviations from normal in respect of the delivery of the second twin,

[91] Exhibit C19 (Tully Kavanagh)

there may be a need to intervene quickly and that is one of the benefits of being in a hospital when twins are delivered[92].

7.55. The disadvantages to the infant associated with the homebirth where a complication from the birth of twins occurs include a lack of continuous diagnostic monitoring, the lack of an ability to deliver pain relief to the mother if necessary, a lack of a professional resource that is willing and capable of expediting delivery of the second twin where indicated, the inability to administer a Syntocinon infusion to hasten labour in relation to the second twin if indicated, the inability to perform an emergency caesarean section delivery if indicated and a lack of immediately available advanced resuscitation resources in the event of the delivery of an infant that requires the same.

7.56. Vaginal birth after caeserean (VBAC) – Tate Spencer-Koch and Jahli Hobbs

7.57. The births of both Tate Spencer-Koch and of Jahli Hobbs involved vaginal birth after the caesarean sections that had been experienced by both mothers during previous childbirths. VBAC is considered undesirable in many quarters. A further caesarean section is frequently recommended even in the absence of other risk factors. The risk involved is that of rupture of the surgical scar that is left from the previous caesarean section. Various figures were quoted in the evidence, but the risk is said to be around or below 1%.

7.58. As is by now obvious, the risk posed by VBAC was not the only source of risk in the two cases in which it arose. Its relevance in each case is that it rendered homebirth all the more undesirable and inappropriate. As will be seen in the next section, it too, in and of itself, ought to have triggered certain responses by those responsible for the care of the individuals concerned.

7.59. The Court needs to say no more about VBAC in cases in which it constitutes the only known specific risk factor regardless of venue of birth.

8. The attitudes of various concerned entities to homebirthing

8.1. In this section I shall discuss the evidence concerning the attitude to homebirthing as expressed in documentation promulgated by, and the oral evidence given in the

[92] Exhibit C19, page 22 (Tully Kavanagh)

Inquest on behalf of, certain entities that have a clinical concern in the issue of homebirthing.

8.2. The entities include the South Australian Department of Health and Ageing, the Australian College of Midwives, the Nursing and Midwifery Board of Australia, the Australian Medical Association (South Australian Branch) and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG).

8.3. The South Australian Department of Health and Ageing

Ms Yvonne Fisher is the Network Development Manager of the South Australian Maternal and Neonatal Clinical Network. She is employed in that position by the South Australian Department of Health and Ageing. Ms Fisher has been in that role since 2006. She is responsible for providing strategic leadership advice and support for maternity and neonatal service planning and development in South Australia, including facilitating the development and endorsement of all SA Health state-wide perinatal policies. She has been qualified as a registered nurse and registered midwife since 1979. She has held senior clinical positions in nursing in South Australia.

8.4. Ms Fisher provided two affidavits to the Inquest[93] and she gave oral evidence.

8.5. Ms Fisher told the Court that on 4 July 2007 SA Health promulgated its 'Policy for Planned Birth at Home in South Australia' (the Policy). She explained that the need for such a policy arose out of a degree of uncertainty as to the duties and responsibilities of midwives operating in respect of homebirths within the public health system[94]. Ms Fisher produced the 2007 Policy as well as a revised Policy which is currently in draft form and not yet in operation[95].

8.6. The Policy governs the manner in which homebirth services are delivered within the public health system. The Department provides homebirth services in strictly controlled circumstances in respect of low risk pregnancies and births. Both versions of the Policy state that:

> 'A woman can be supported to give birth at home only if she fits the criteria for a low-risk, singleton pregnancy at term, and the qualified practitioners are confident and competent to assist.'

[93] Exhibits C47 and C48
[94] Transcript, page 783
[95] Exhibit C47, Attachments YLF1 and YLF2 respectively

The low risk that is identified within the document is clearly referring to low risk of perinatal complications. Therefore, the public health system will not support and provide services in relation to homebirths that involve the birth of twins or breech births of any type. In addition, the Policy sets out a number of contraindications that would preclude a woman giving birth at home with the support of the public health system that in the context of these Inquests relevantly include an obstetric history involving previous caesarean section and a body mass index greater than 35, or maternal weight greater than 100kg during the course of the current pregnancy. Ms Fisher explained the reasons underlying such preclusions. They were not inconsistent with the evidence given by other witnesses including Professor Pepperell and Dr Harvey. Within the list of conditions that would operate as contraindications precluding publicly assisted homebirthing, the revised Policy for the first time would include 'current risk factors for shoulder dystocia'[96]. The document does not identify those risk factors, nor did Ms Fisher in her evidence, but it is clear that a foetus estimated to exceed the weights quoted in the evidence adduced in the Inquest would be regarded as a risk factor for shoulder dystocia. In the Court's view, the evidence concerning the birth and death of Tate Spencer-Koch leads to the conclusion that current risk factors for shoulder dystocia are appropriately included within the final revised version of the Policy as a contraindication to homebirthing, but that there is a need for the factors to be identified within the document.

8.7. Ms Fisher told the Court about the existence of publicly funded planned homebirth services offered through the Lyell McEwin Health Service and the WCH and possibly by now the Flinders Medical Centre. Of course the Policy applies in relation to such services, that is to say they are only available in respect of low risk cases.

8.8. It is worthwhile observing that even where low risk cases attract publicly funded homebirthing services, there are strict requisites in terms of the type of assistance that must be engaged and the type of equipment that must be present at the birth. The Policy stipulates that the care of the woman who has planned a birth at home should be managed by two qualified practitioners being a registered midwife and/or a medical practitioner. One of the qualified practitioners must be in attendance at all times from the commencement of active labour and two qualified practitioners must be in attendance at all times from the commencement of the second stage of labour

[96] Exhibit 47, , Attachment YLF2, page 5, Obstetric History - Previous

until the completion of the third stage. Both versions of the Policy stipulate that the qualified practitioners may continue to provide care and the Policy specifically points out that a separate duty of care is owed to the child as well as to the mother. This stipulation appears to apply not only in respect of the intrapartum aspect of the planned homebirth, but also in respect of care provided during the course of pregnancy. There appears, therefore, to be a certain tension between this stipulation on the one hand, and on the other the attitude that pervades the private homebirthing milieu wherein the unborn child is essentially deemed to have no rights.

8.9. Ms Fisher produced in evidence material that has clear significance in terms of risk based upon evidence gained statistically in the last 20 years. Specifically, Ms Fisher produced a research paper dated 18 January 2009, published in the MJA Volume 192, Number 2, concerning the incidence of planned homebirths in South Australia in the period 1991 to 2006[97]. Among other things that the research established, as reported within this document, is that one third of deaths among planned homebirths were due to intrapartum asphyxia compared with a rate of 3.6% among planned hospital births[98]. It reports that both intrapartum deaths and deaths attributed to intrapartum asphyxia were considerably more frequent within the homebirth group than within the hospital birth group. The research also identified that there were a number of perinatal deaths in the 16 year study period in respect of which a reasonable assumption could be made that a different choice of care provided, location of birth, or timing of transfer to hospital might have made a difference to the outcome. Characteristics of those births included twin pregnancy and inadequate foetal surveillance during labour. This accorded with excess perinatal mortality in other planned homebirth studies and the suggestion is made that they may have been avoided if the policy for planned homebirth at home in South Australia had been available in that period and had been followed. The information contained within this research paper has been adopted within the draft revised Policy which states as follows:

> 'Recent South Australian data shows that for homebirth compared with hospital birth there are higher rates of intrapartum asphyxia (insufficient oxygen going to the baby before birth) or death of the baby in labour. This may be partly accounted for by inappropriate assessment / selection of women and/or babies with known risk factors that should preclude homebirth.'

[97] Planned Home and Hospital Births in South Australia, 1991-2006: Differences in Outcomes
[98] Page 78 of the Report

Finally, Ms Fisher made it plain during the course of her evidence that if a woman who initially qualified for a homebirth under the South Australian Homebirth Policy, but at some point during her pregnancy for whatever reason ceased to qualify, for example a high risk factor precluding publicly funded homebirth unexpectedly arose, the system would not abandon that woman. In the first instance counselling would be given to the woman in the hope and expectation that her care might be transferred to a participating hospital. In addition, homebirthing would be strongly discouraged in those circumstances. However, if the woman then chose to labour at home regardless, in the sense that she was flatly refusing to attend at the hospital, Ms Fisher made it plain that the woman would not be left alone by the system. Her care would continue and there would be an effort made to have the two qualified practitioners attend. However, Ms Fisher also made it plain that their experience to date is that if these women receive appropriate counselling, then generally speaking success is achieved in transferring their care into the hospital environment.

8.10. Australian Medical Association (South Australian Branch) Inc

A letter dated 17 August 2010, written by Dr Andrew Lavender, the then President of the Australian Medical Association (South Australian Branch), was received into evidence[99]. Dr Lavender also gave oral evidence in the Inquest. The letter indicates that the AMA(SA) and the medical profession has no general objection to homebirthing, but maintained an objection to homebirthing attended by the well-known risks. The risks that he identifies are those already mentioned. The letter states that where the parents have a strong desire to have a child born at home, the AMA(SA) believes that this must be within the parameters of the lowest potential risk to the baby and mother and must also be within the context of fully informed consent based upon knowledge of the increased risks associated with delivery in a home environment away from acute medical intervention facilities.

8.11. Dr Lavender's letter asserts that the literature for statistics worldwide shows strongly that homebirthing poses increased risks to foetal mortality. Dr Lavender's letter makes the point that within the community there is a small group of people with a very strongly held support for homebirthing 'that sometimes has taken almost religious mantra' despite the well-known risks. The AMA is concerned that misinformation about the risks is sometimes spread and that there is blindness to some

[99] Exhibit C51

of the risks that may occur. In this context, by way of example, I refer to what appears to have been a limited appreciation by Ms Spencer as to the actual risk posed by the macrosomic state of her unborn child and, in the case of Ms Hughes, a limited understanding of risks involved in the delivery of breech positioned infants.

8.12. In his evidence Dr Lavender made a number of additional points. Firstly, he stated that clinicians always advocate for their patients and in the circumstances under discussion, the patients include both the mother and the baby. Secondly, Dr Lavender quoted statistics to the effect that over a certain period, being the calendar year 2009 in South Australia, the perinatal mortality for homebirthing was 32 per 1000 where the equivalent for babies born in hospital was 10 times less than that figure. Thirdly Dr Lavender, both in his letter and in his evidence, referred to certain undesirable community based consequences that might not be foreseen or fully understood by those parents intending to participate in a homebirth. His letter explains that medical practitioners have frequently complained that in many situations where homebirths have occurred and problems have arisen, they become involved at a very late stage in which they feel compromised in their ability to provide treatment in a situation where there has already been an adverse event. There is a reasonable apprehension, or at least concern, that such practitioners might be vicariously included in any malpractice litigation that might arise. To my mind that is not an insignificant concern and one that parents contemplating a high risk homebirth should carefully bear in mind. In a similar context, Dr Lavender suggested that if one was to assert the right to be delivering a baby at home, then there ought to be certain responsibilities about safe practice. Dr Lavender makes the point that there is a joint responsibility placed upon members of the community for the health of other members of the community, and that this would include in the context under discussion, for the health of the unborn child. He also points out that within this wider community responsibility, one is obliged to look after one's own welfare because costs may be incurred and burdens may be placed that will ultimately affect the health care that is available to the community at large[100].

8.13. Dr Lavender also mentioned the need for a minimisation of trauma or emotional upheaval that might be experienced by clinicians in hospitals including doctors, nurses, emergency staff and ambulance officers where, in some cases, there is a need

[100] Transcript, pages 737-738

for counselling and debriefing after adverse events of the kind under discussion have occurred. What Dr Lavender was speaking of was exemplified by the experience of a long serving registered midwife at the WCH who, in her statement to police investigating the death of Tully Kavanagh, states that when Tully was brought into the WCH on the afternoon of Friday 7 October 2011 she had to remove herself from the resuscitation room because she was completely overwhelmed with emotion as she had previously 'dealt with another two home births which had gone pear shaped and I thought, great this is the third one'[101].

8.14. Dr Lavender agreed with the proposition that in certain cases the risks to the baby are not properly taken into account, but rather the focus appears to be on the need to enhance the experience of the mother[102]. He suggests in this context that people can be wilfully dismissive of the risks and adopt an attitude whereby '*it's my body, I'll do what I like*'[103].

8.15. In his evidence Dr Lavender identified that the AMA specifically holds the view that it is in the interests of both the mother and the unborn baby that in breech cases a caesarean section is the appropriate intervention. In respect of cases in which the mother has a BMI greater than 35, it is recognised that there are certain risks involved in the delivery of the child, including the possibility of a very large baby and obstructed labour. As well, he points out that women who have a degree of marked obesity can be the subject of difficult administration of spinal or epidural anaesthetic, and might also be potentially unable to be intubated should a general anaesthetic be required.

8.16. Finally, Dr Lavender stated in respect of women who wish to have a homebirth outside the public health system policy that I have already referred to, that the AMA has strongly argued for many years that there needs to be an increase in resources for alternative birthing centres[104].

8.17. <u>RANZCOG</u>

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists' College Statement of August 2009[105] asserts that homebirth is associated with an

[101] Exhibit C38a, page 5 (Tully Kavanagh)
[102] Transcript, page 740
[103] Transcript, page 741
[104] Transcript, page 741
[105] Exhibit C52

unacceptably high rate of adverse outcomes and should not be offered as a model of care, as there is a reasonable public expectation that any model of care that is offered has a margin of safety that would be acceptable to most women. This is not present in the setting of homebirth. The document suggests that RANZCOG cannot support the practice of homebirth due to its inherent risks and the ready availability of safer birthing practices. However, it recognises that homebirth will remain in demand by a small number of women 'who choose to prioritise this aspect of their birth experience above that of risk minimisation'[106]. In such cases women choosing homebirths should be cared for by both an experienced medical practitioner and a registered midwife, each of whom has agreed to participate. It suggests that health professionals supervising homebirths should have appropriate indemnity insurance. I return to the question of insurance later in these findings. It also speaks of contingency plans in the event of an emergency and to the need for a woman contemplating homebirth to be provided with accurate information about the risks involved.

8.18. In short, RANZCOG does not support homebirths in any circumstances, even low risk births.

8.19. The RANCOG Statement contains some statistical information to the effect that there was a 3-4 fold increase in perinatal mortality during the years 2000 and 2006 where homebirths occurred. It refers to an inquiry into homebirth that was undertaken at the request of the Western Australian government that had revealed apparent inappropriate selection of patients for homebirth and evidence that the perinatal mortality associated with care by an independent midwife can, at least in part, be ascribed to poor screening of women by the independent midwife. In the Western Australian study there was a similar 3-5 fold increase in perinatal mortality amongst women booked under an independent midwife compared to conventional care.

8.20. <u>Australian College of Midwives</u>

Dr Hannah Dahlen is the media spokesperson for the Australian College of Midwives (the ACM). Dr Dahlen is a midwife who received her PhD in nursing and midwifery in 2007. At the time of the Inquest she was the immediate past national President of the ACM. She was the Secretary of the NSW Branch of the College for 12 years, concluding in 2009. Prior to the Inquest Dr Dahlen, who was then President of the College, together with other members of the College's board, prepared an ACM

[106] Exhibit C52, Paragraph 8d

statement on homebirth for the specific purposes of this coronial Inquest. Dr Dahlen also produced what at that time was a general interim position statement on homebirth prepared by the ACM and published on 4 August 2011. There is now a definitive position statement of the College dated 8 November 2011[107].

8.21. Dr Dahlen gave oral evidence at length. The Court was greatly assisted by that evidence. While I repeat that I do not wish to involve the Court in a debate about the desirability or otherwise of homebirth in general, and in particular those homebirths involving low risk, it is pertinent to observe that the evidence of Dr Dahlen is that the College's attitude is that the evidence at large shows that planned homebirth is a safe option for women and their babies when women are at low risk of complications, and when they receive care from suitably qualified attendants with adequate access to support, advice and referral and transfer mechanisms. This attitude is expressed in the ACM interim position statement on homebirth[108]. Neither the interim position statement on homebirth nor the definitive position statement on homebirth, nor the statement prepared for the purpose of the Inquest by the College, in terms identify a defined position in respect of high risk homebirths such as twin births and breech births. The statement prepared for the purpose of the Inquest does acknowledge the debate regarding that issue and acknowledges the reality that some women will make a choice to undergo a homebirth despite the risk associated for them and possibly their baby[109].

8.22. Dr Dahlen, however, acknowledged in her oral evidence the reality that increased perinatal mortality is seen when women with risk factors are part of homebirth programs. She indicated that although in the opinion of the College it is a woman's choice as to whether or not she undergoes a homebirth, the College would not recommend homebirth in situations involving increased risk and in circumstances where one is seeing perinatal mortality and morbidity[110]. She stated that this is seen predominantly amongst twin births and breech births. She said:

> 'I think there is little doubt that twin and breech birth is, has added risk compared to vaginal birth.' [111]

[107] Exhibit C50f
[108] Exhibit C50b
[109] Exhibit C50a, page 2
[110] Transcript, page 660
[111] Transcript, page 660

8.23. In this regard she asserted that there is a higher rate of stillbirth with twins, a higher rate of malpositioned babies by way of breech or shoulder presentation and a higher rate of cord prolapse. In this context Dr Dahlen spoke of experiences of women who, in delivering twins in a hospital, have had their options limited to undergoing an epidural and a cannula and being continuously monitored, thereby having no other option but to actually leave the hospital premises in order to avoid those types of interventions. She suggested that the stillbirth rate amongst breech presentations is also higher and explained why that is so, consistent with other evidence already spoken of in these findings. She stated that she would not attend a breech birth at home and the College would not support that in any event. Dr Dahlen indicated in respect of the Hannah Term Breech Trial[112] that it had demonstrated that a planned caesarean section was safer than a vaginal breech birth[113]. That seems to be at odds with the evidence of Ms Barrett on the same subject. That said, Dr Dahlen indicated that when very strict criteria are utilised around breech births and skilled people are involved, there is no difference in outcome for breech birth in hospital. When asked to explain what those very strict criteria involved, she stated that it was ensuring that it was not a footling breech, making sure that the progress is seamless, and making sure that the baby's heart rate remains good along with having skilled people who are able to perform breech births in a variety of positions[114]. She suggested that hospital is the ideal[115]. Dr Dahlen suggested that although there were some risks associated with births that were higher than those associated with twins, the risks associated with the delivery of twins and breech presentations were a '*commonly reocurring issue*', in fact those being the two prominent ones.[116].

8.24. Dr Dahlen also spoke of the risk of shoulder dystocia which is difficult to predict, even when the baby is large[117]. She did acknowledge, however, that a baby that is very large on palpation is one possible predictor[118]. She also indicated that shoulder dystocia is more likely to be experienced where the baby is over 4kg[119]. At another point in her evidence Dr Dahlen indicated that a baby in excess of 4.5kg is considered to be a large baby for these purposes.

[112] Exhibit C20h, Reference 2
[113] Transcript, page 684
[114] Transcript, page 685
[115] Transcript, page 685
[116] Transcript, page 693
[117] Transcript, page 664
[118] Transcript, page 666
[119] Transcript, page 667

8.25. Dr Dahlen commented upon a number of issues that involve the participation of midwives in homebirthing scenarios. These included the desirability, if not need, for two midwives to assist at a homebirth for a number of different reasons, including the desirability of having 'someone else to bounce ideas off'[120], to provide respite in exhausting and very long labours and, specifically, in an emergency such as shoulder dystocia where a second midwife is necessary to assist with the relieving manoeuvres. When asked as to whether a second midwife is important in such a situation she said '*very much so*'[121]. Dr Dahlen went so far as to say that certain manoeuvres that involve the administration of external suprapubic pressure cannot be administered on one's own. It will be seen that in the case of Tate Spencer-Koch that it was only when a second person became involved in this very difficult obstructed delivery that the problem of shoulder dystocia was ultimately overcome, albeit too late to prevent the child's death.

8.26. Dr Dahlen provided evidence concerning the duty of care in respect of ensuring that private patients make informed choices and she spoke of the need to ensure that the College is aware of instances where midwives are not fulfilling their professional obligations in facilitating informed choice. She gave as an extreme example midwives who might say to a woman that it was far safer to have twin babies at home, although I do not suggest that any such advice was given in the cases at hand. As well, Dr Dahlen was aware of cases where midwives would not present the information in a truly unbiased and informed way[122]. The point can be added to this that fully informed consent and a fully explained and accurate analysis of the magnitude of risk by midwives practising privately in the homebirth environment is clearly of major importance having regard to the fact that, as Dr Dahlen pointed out, privately practising midwives tend to be involved in the cases presenting most risk. This is due to the fact that low risk cases can be managed in South Australia in accordance with the SA Health policy for planned birth at home.

8.27. In her evidence Dr Dahlen referred to a document that is promulgated by the ACM entitled 'National Midwifery Guidelines for Consultation and Referral' (the ACM Guidelines). There have been two editions of this document promulgated so far. The

[120] Transcript, page 690
[121] Transcript, page 691
[122] Transcript, page 697

first edition was promulgated in 2004 and the second in 2008[123]. The first edition was in operation at the time Tate Spencer-Koch's death and the 2008 version was in operation at the time of the Jahli Hobbs and Tully Kavanagh deaths. Neither document is confined in its operation to homebirths. The document in fact applies in relation to the practice of midwifery generally, regardless of whether the midwife might be practising in the public or private sector. The stated aim of both versions of the ACM Guidelines is to provide midwives with an evidence informed national framework for consultation and referral of care between midwives and other healthcare providers in respect of women receiving care. The ACM Guidelines also aim to inform decision making by midwives on the care provided to women during pregnancy and the antenatal period and during labour and birth. As will be seen, the ACM Guidelines are now referred to in national uniform legislation governing the practice of health care professionals, and in particular midwives. The guiding principles as to the utility of the ACM Guidelines include reference to their being for the use of the midwife in making decisions. The later version of the document places emphasis on the midwife providing information to enable the woman to make an informed choice as to her care that includes an explanation of the operation of the ACM Guidelines themselves. The later version of the document also states that where a woman's choice is significantly at variance from professional advice or guidelines, the woman's decision and the information provided by a midwife should be carefully documented. In fact, provision is made within the document for a particular form to be raised whenever that variance takes place[124]. Both versions of the document focus heavily upon the need for consultation in certain scenarios and insist that decisions regarding ongoing clinical roles and responsibilities must involve a 'three-way discussion between the health care provider, the midwife and woman concerned'[125]. Both documents refer to three possible levels of consultation and referral depending upon the nature of certain parameters regarding the woman's pregnancy, previous history and expected or possible complications arising during labour and birth. The various parameters need to be considered at different stages of the pregnancy and delivery. The more serious the potential complication, the greater need for consultation and referral of care. Both documents set out three different levels of care referred to as Levels A, B and C, with Level C contemplating a greater level of care.

[123] Exhibit C50g
[124] Appendix A to the ACM Guidelines
[125] Exhibit C50g, Paragraph 4.2.5

Level A contemplates care being provided by a midwife. Level B contemplates circumstances in which care would be provided by a medical/health care practitioner and/or midwife depending on agreements. Level C involves a situation requiring medical care at a secondary or tertiary level for as long as the particular enlivening situation regarding the woman's pregnancy exists. It contemplates care being provided by a medical practitioner and, where appropriate, the midwife continuing to provide midwifery care. The document as a whole reflects the very clear consensus expressed in the evidence by various concerned entities that there are certain states associated with pregnancy that give rise to a greater risk and therefore a need for a higher level of care. Relevantly for the purposes of these Inquests, where an expectant mother has a maternal weight greater than 100kg or a BMI greater than 35, this would be regarded as giving rise to a need for Level B care. Interestingly, this factor only appears in the ACM Guidelines for the first time in the later edition of the document[126]. Also, interestingly and perhaps incongruently with other guidelines including the SA Health Guidelines, there is no reference to the risk of shoulder dystocia or the expected weight or size of the unborn infant, shoulder dystocia only being regarded as a serious complication as and when it happens. A previous caesarean section is also regarded as requiring a Level B regime of care and consultation. Both versions of the ACM Guidelines quite clearly regard multiple pregnancies and non-cephalic (breech) presentations at full term as requiring a Level C regime of consultation and referral. Therefore the effect of the ACM Guidelines in such cases is to place upon a midwife a responsibility to refer the pregnant woman under her care to secondary or tertiary care. When such primary care is referred from a midwife to a medical practitioner by virtue of that regime, that professional, in consultation with the woman and the midwife, assumes full responsibility for subsequent decision making, although the midwife may continue to provide midwifery care within the scope of her practice in collaboration with the medical practitioner. In the case of a referral in respect of a breech presentation, Dr Dahlen suggested that a medical practitioner would probably perform an ultrasound and discuss with the patient the option of undergoing an external cephalic version (ECV) that might rectify the breech presentation.

8.28. The original version of the document, operating as it did in 2007, had applicability to Ms Spencer insofar as it indicates that because of her BMI and previous caesarean

[126] Exhibit C50c, Paragraph 6.1.11

section, she would have been regarded as borderline Level B/C that would have at least involved a recommendation by her midwife that Ms Spencer consult a medical practitioner, the implication being that one would consult the medical practitioner about the identified parameters that enliven the operation of the ACM Guidelines in her particular case[127]. As I understood the evidence, once Ms Barrett became involved as Ms Spencer's midwife, there was no further consultation with a medical practitioner or recommendation made regarding the same and no further interaction with the WCH after 9 May 2007, at which point she was at 30 weeks, when she told Women's Assessment at that hospital that she intended to have a homebirth.

8.29. The later version of the ACM Guidelines clearly gave rise to a need for Jahli's mother, Ms Hughes, by virtue of her breech presentation, to have been referred to secondary or tertiary care and, in particular, to a medical practitioner who would have assumed full responsibility for subsequent decision making. Likewise Ms Sarah Kerr in respect of her multiple pregnancy. Ms Kerr, of course, did have the benefit of advice from practitioners at the WCH when she was hospitalised there during the course of her pregnancy for an unrelated illness. Nevertheless, the care that was provided to her was exclusively thereafter provided by the midwife, Ms Barrett.

8.30. The revised version of the ACM Guidelines provides for documentation to be completed in circumstances where a woman chooses not to follow the advice or recommendation tendered by the midwife in accordance with the ACM Guidelines. This is provided in Appendix A attached to the later version of the ACM Guidelines. It stipulates that where a situation arises in which a woman chooses care outside the recommendations in the ACM Guidelines, the midwife:

> '… must engage with the woman and her family and with hospital staff through identified channels where applicable, in a thorough discussion of the request, looking for options and resolutions within midwifery professional standards to address the woman's need.'

Where a solution simply cannot be found, and the woman refuses to follow the appropriate advice in accordance with the ACM Guidelines, Appendix A establishes a course of action for a midwife to take. The course of action involves tendering advice to the woman as to the recommended ACM Guideline and specifically its rationale and evidentiary base, consulting with other professionals and documenting the course

[127] Exhibit C50c(a) - See Paragraph 4.2.4

of action taken. If an impasse is still apparent, the midwife must decide either to continue care and respect the woman's choice, while at the same time continuing to make recommendations for a safe course, or discontinue care and clearly communicate that to the woman. Naturally, the Appendix stipulates that in urgent situations or within the course of labour, a midwife may not refuse to attend a woman. When asked as to whether there was any sensible reason why a midwife would not at least advise the mother of the existence of the ACM Guidelines and explain to the woman how she might be treated within those guidelines, Dr Dahlen suggested the main reason was a realisation that if the woman adopted any of the recommended courses, her options would then be taken away from her[128].

8.31. In her evidence Ms Barrett was asked about her attitude towards the ACM Guidelines. Among other things Ms Barrett asserted that the ACM Guidelines could not override a woman's choice[129], that the ACM Guidelines, as originally promulgated, were '*just a set of guidelines*'[130]. She admitted that although Ms Spencer had fallen within Level B or C of the Guidelines due to her previous caesarean section, she did not facilitate any of the actions that the ACM Guidelines contemplated as far as any further professional care was concerned. Ms Barrett told the Court that she would not have followed the ACM Guidelines in 2007 if the woman did not want to adopt the recommended course and saw no reason to do so, or to document something that her client had already said that she did not want to do, as in the case of Ms Spencer. Ms Barrett also admitted that she had never drawn the ACM Guidelines to the attention of any client who might be affected by the ACM Guidelines[131]. This obviously included Ms Spencer, but it also included her client Naomi Hughes, the mother of Jahli Hobbs, by which time the second edition of the ACM Guidelines had been promulgated. Ms Hughes, of course, was at the highest level, namely Level C, having regard to her non-cephalic presentation at term. The ACM Guidelines clearly contemplated in such a case that the midwife would refer the woman to secondary or tertiary care and that the medical practitioner would assume full responsibility for subsequent decision making. Ms Barrett explained that Ms Hughes already knew that her baby was breech and that they had discussed all of the options that included whether or not she wanted

[128] Transcript, page 712
[129] Transcript, page 929
[130] Transcript, page 974
[131] Transcript, page 984

to have an ECV, a hospital birth or a caesarean section, all of which she declined[132]. Ms Barrett did not inform Ms Hughes of the existence of the ACM Guidelines and what they recommended because '*the choices were already made*'[133] and that Ms Hughes had an appreciation of the risks involved. Ms Barrett accordingly did not advise Ms Hughes of the existence of the recommended ACM Guideline as it applied to her, nor the evidence behind the guideline that operated in her particular case.

8.32. Dr Dahlen was asked in evidence as to the possible reasons why a midwife might choose not to follow the ACM Guidelines. In answering that question Dr Dahlen suggested that the ACM Guidelines had been setup in a way that they are not dogmatic and provide flexibility and that an '*out*' could always be considered to be within them[134]. However, she suggested that she did not know why a midwife would not use them. She said that the ACM suggests to midwives that they are obligated to provide care that is based on the Guidelines. She did agree with the suggestion that a midwife might want to refrain from referring a Level C patient to an obstetrician out of fear or an expectation that the obstetrician was likely to dissuade the woman from having a homebirth, or that the obstetrician might persuade the woman to undergo a caesarean section.

8.33. There are two other relevant documents to which the ACM has subscribed. They are the Code of Ethics for Midwives in Australia and the Code of Professional Conduct for Midwives in Australia[135]. It is apparent that the Australian Nursing and Midwifery Council, as well as the Australian Nursing Federation, have also subscribed to these documents. Both documents appear to have been in operation at the times with which these Inquests are concerned. They do not distinguish between practice in the public or private sectors.

8.34. The Code of Ethics purports to 'guide ethical decision making and midwifery practice'[136]. It stipulates that the midwife's primary professional responsibility is towards each woman and her infant(s). It also states that the midwifery profession recognises the universal human rights of people, and in particular of each woman and her infant(s). This is said to include recognising, respecting, actively promoting and

[132] Transcript, page 978
[133] Transcript, page 979
[134] Transcript, page 711
[135] Exhibits C54a and C54b respectively
[136] Exhibit C54a, page 3

safeguarding the right of each woman and her infant(s) to the highest attainable standard of midwifery care as a fundamental human right[137].

8.35. Within the document 'infant(s)' is defined to include the unborn baby[138].

8.36. The Code of Ethics contains a number of 'value statements' all of which apply to the conduct of midwives in respect of their care of women and their infants. Within value statement 1 is a duty upon midwives to 'strive to ensure that the infant's health needs are met, including promoting a safe birth and the establishment of breastfeeding'[139]. Value statement 2 places a duty on midwives to 'promote a healthy experience and prevent or reduce possible harm'. Value statement 5 stipulates that in respect of both a woman and her infant(s), midwives value a woman's legal and moral right to self determination on the basis of 'informed decision making'[140]. Value statement 6, in respect of the woman and her infant(s), stipulates that midwives take action when they identify a woman and her infant(s) are at risk, 'reporting this to relevant authorities'. This latter statement would seem to apply to the need to at least comply with the ACM Guidelines insofar as those Guidelines stipulate a course of action to be taken in cases of risk by way of referral to other medical entities.

8.37. The separate Code of Professional Conduct for Midwives in Australia contains a number of similar sentiments said to amount to 'minimum standards of conduct'[141]. The Code of Professional Conduct statement 2 stipulates that 'Midwives are guided by the profession's guidelines for consultation, referral and transfer – the *National Midwifery Guidelines for Consultation and Referral*'. This would appear to at least negate the suggestion that the ACM Guidelines are 'just a set of guidelines' that can be ignored or otherwise put to one side by a midwife privately practising in the homebirthing industry.

8.38. To counter the suggestion that there were aspects of the Code of Ethics for Midwives in Australia that may have had application to her own activities, Ms Barrett at first suggested that reference to an 'infant' in the Code of Ethics refers to a born baby. Such an interpretation would no doubt be seen by some to sit nicely with other evidence given by Ms Barrett that an unborn baby has no rights. Of course, as seen,

[137] Exhibit C54a, page 3
[138] Exhibit C54a, page 4
[139] Exhibit C54a, page 5
[140] Exhibit C54a, page 9
[141] Exhibit C54b, page 1

the Code of Ethics applies to unborn babies by virtue of the definition of 'infant' contained within the document. When this was pointed out to Ms Barrett, she suggested in her evidence before the Court that although consideration is given to the unborn baby, ultimately the woman has the right to choose and that her role was to be with the woman and to support her in the choices that she makes[142]. Ms Barrett argued that nothing alters the fact that the woman is able to choose where she gives birth, and to choose to give birth at home regardless of the risk to her and her unborn baby[143].

8.39. Finally in relation to the attitude of the ACM in respect of homebirths, Dr Dahlen in her evidence referred to a greater level of supervision of midwives as exists in the United Kingdom that would both support midwives and identify midwives who '*perhaps are not practising as they should*'[144]. Dr Dahlen referred to a position in the United Kingdom known as the Supervisor of Midwives. She also referred to a document promulgated in the United Kingdom entitled Modern Supervision in Action – A Practical Guide for Midwives[145]. Dr Dahlen explained that by virtue of the United Kingdom scheme, a midwife has access to a Supervisor of Midwives who is available if a midwife finds him or herself in a situation where there is risk to a client who should not be abandoned[146]. The Supervisor of Midwives also has a disciplinary function. The document to which I have just referred in fact exemplifies how such a difficulty might be solved and provides, as an example, a case in which a woman had resolved not to undergo CTG monitoring, but where there is a policy in existence stating that admission traces should be carried out on all women, and the woman is told by the midwife that she must undergo CTG monitoring. In such a situation the Supervisor could assist the midwife in a number of ways. Specifically, it is also stated that the Supervisor may assist midwives in homebirths, particularly if risks or problems are identified. Of course, such a regime would only have utility in respect of the activities of midwives who choose to call themselves that and abide by the stipulations contained within the document.

[142] Transcript, page 992
[143] Transcript, page 993
[144] Transcript, page 694
[145] Exhibit C50d
[146] Transcript, page 694

9. The legislative regime concerning the practice of midwifery in the homebirth setting

9.1. The practice of midwifery is now governed within the State of South Australia by uniformly enacted legislation that is in operation in each State. The South Australian governing legislation is entitled the Health Practitioner Regulation National Law (South Australia) Act 2010. This legislation came into operation on 1 July 2010. The Health Practitioner Regulation National Law (the National Law) is contained within Schedule 2 to the Act. The stated objectives and guiding principles of the National Law are the establishment within the entire country of a national registration and accreditation scheme for the regulation of health practitioners, including those practising the health profession of midwifery. The Act establishes the Australian Health Practitioner Regulation Agency (AHPRA). AHPRA in effect is the umbrella organisation for the various individual health professional governing boards in Australia. This includes the Nursing and Midwifery Board of Australia. In fact, under section 31 of the National Law, the Nursing and Midwifery Board of Australia is established.

9.2. Although the National Law provides for the registration of health practitioners, it does not provide any sanction against unregistered persons who practice as a health practitioner, including persons practising midwifery either privately or publicly. Rather, section 113 of the National Law renders it an offence for a person to knowingly or recklessly use the title of ‘midwife’ or ‘midwife practitioner’ in a way that could be reasonably expected to induce a belief in others that the person is registered under the National Law, unless the person is so registered. In addition, section 116 of the National Law renders it an offence for a person who is not a registered health practitioner to knowingly or recklessly claim to be registered under the National Law. Monetary penalties apply in respect of contraventions of either section 113 or 116. Thus it is that a person might perform the clinical duties and undertake the clinical responsibilities of a midwife so long as they do not take or use that title in a way that might engender a belief in others that they are registered as a midwife under the National Law. It is this lacuna that continues to enable privately practising unregistered midwives to practise as such in the homebirthing industry, and as will be seen there are clear disincentives to registration.

9.3. Registration as a midwife and practice as such carries certain implications under the National Law. Firstly, section 39 of the National Law empowers a National Board, in this case the Nursing and Midwifery Board of Australia, to develop and approve codes and guidelines to provide guidance to the midwives it registers. Secondly, an application for renewal of registration as a health practitioner, in this case a midwife, under section 109 of the National Law must include or be accompanied by a statement that includes a declaration by the applicant that the applicant has met 'any recency of practice requirements', that the applicant has completed required continuing professional development during the applicant's preceding period of registration, that the applicant has not practised during the preceding period of registration without appropriate professional indemnity insurance and that if the applicant's registration is renewed, that the applicant will not practice the health profession unless appropriate professional indemnity insurance arrangements are in place.

9.4. Section 129 of the National Law governs professional indemnity insurance arrangements. Section 129(1) mandates that a registered health practitioner must not practice the health profession in which the practitioner is registered unless appropriate professional indemnity insurance arrangements are in force in relation to the practitioner's practice of the profession. Although this provision would render as unlawful the activities of a registered health practitioner practising without insurance arrangements in place, such activity does not constitute an offence but may constitute behaviour for which other action might be taken.

9.5. Section 284 of the National Law for the time being provides an exemption from the requirement relating to professional indemnity insurance arrangements for midwives practising private midwifery. This exemption came into operation on the date that the entire National Law came into operation, namely 1 July 2010. The exemption has a sunset clause insofar as under section 284(3) of the National Law, the exemption will cease on 1 July 2013. Thus the exemption is currently in force. The exemption is couched in terms that a midwife does not contravene the insurance requirements of section 129(1) merely because the midwife practises private midwifery. The exemption only applies, however, if a number of conditions are satisfied. Relevantly for the purposes of the issues under discussion in this Inquest, one of the conditions for exemption is that informed consent has been given by a woman in relation to whom a midwife is practising private midwifery. Another condition is that the

midwife complies with any requirements set out in a code or guideline approved by the National Board, being the Nursing and Midwifery Board of Australia, under section 39 of the National Law about the practice of private midwifery, including any requirement in a code or guideline relating to the safety and quality of the practice of private midwifery.

9.6. The section 284 insurance exemption only applies to the practice of private midwifery which by definition is confined to an attendance at a homebirth. In other words, the exemption only applies to intrapartum care and not to antenatal or postnatal care in respect of which insurance is still required. These arrangements are explained in the statement of Ms Anne Copeland who is the Chair of the Nursing and Midwifery Board of Australia[147]. Ms Copeland explains in her statement that the limited exemption was introduced into the National Law following the identification of the absence of accessible and affordable indemnity insurance for midwives providing intrapartum care in homebirths and their consequent inability to comply with the requirement of the National Law for all health practitioners to meet the requirements of their respective Boards' insurance standard[148].

9.7. The informed consent that is identified in section 284 of the National Law means written consent given by a woman after she has been given a written statement by the midwife that includes a statement that appropriate professional indemnity insurance arrangements will not be in force.

9.8. The Court understands that at the present time there is no insurance entity through which professional indemnity insurance can be obtained by privately practising midwives in respect of intrapartum care in homebirths. It is conceivable that this may remain the case for the foreseeable future. This would mean that unless the operation of section 284 is extended, the insurance exemption would cease on 1 July 2013 and the operation of section 284 as a whole would also cease. On the other hand if insurance in relation to intrapartum care in homebirths was made available at that time, and as a result section 284 is allowed to cease its operation for that reason, it will mean that registered midwives could practice unrestrictedly and no longer be required to comply with the requirements set by the National Board that would otherwise have enlivened the insurance exemption.

[147] Exhibit C54c
[148] Exhibit C54c, Paragraph 28

9.9. It will be seen that a registered private midwife who desires to provide intrapartum care in a homebirth would only be lawfully permitted to do so if either (a) professional indemnity insurance covering intrapartum care is in place, which appears to be unavailable at this point in time, or (b) the conditions for the insurance exemption are satisfied, most relevantly for the purposes of the Inquest into the death of Tully Kavanagh, compliance with the Nursing and Midwifery Board of Australia's codes or guidelines relating to the safety and quality of the practice of intrapartum care in a homebirth is undertaken.

9.10. Following the enactment in mid 2010 of the National Law in the various jurisdictions in Australia, the Nursing and Midwifery Board of Australia promulgated a 'Safety and Quality Framework for Privately Practising Midwives attending homebirths'[149]. This document serves as a code or guideline approved by the National Board under section 39 of the National Law for the purposes of section 284(1)(c)(ii). In other words, in order to qualify for the insurance exemption in relation to the intrapartum aspect of midwifery care in homebirth, the registered midwife must comply with the requirements set out in this document. According to the statement of Ms Copeland, for all midwives including privately practising midwives attending homebirths, the Board has endorsed the Australian College of Midwives National Midwifery Guidelines for Consultation and Referral (2nd edition, September 2008) (the ACM Guidelines) and the Position Statement on Homebirths developed by the Australian College of Midwives[150]. In addition, the Board has endorsed the Code of Ethics for Midwives and the Code of Professional Conduct for Midwives to which I have already referred.

9.11. According to the Safety and Quality Framework promulgated by the Board, privately practising midwives providing intrapartum care in a homebirth are expected to adhere to the recognised Consultation and Referral Guidelines developed by the College (the ACM Guidelines) and to take into account distance and time to travel to an appropriately staffed maternity service and undertake an assessment of risk for this birthing option. I do not need to repeat the requirements of the ACM Guidelines that dictate rigorous consideration in respect of high risk homebirths. In addition, for the purposes of the insurance exemption, the Safety and Quality Framework insists upon a need for midwives to be able to provide evidence in relation to various aspects of his

[149] Exhibit C47a, Attachment YLF15 - Safety and Quality Framework for Privately Practising Midwives attending homebirths

or her practice, including '*Clearly articulated referral pathways for referral and / or consultation in accordance with ACM Consultation and Referral Guidelines*' and a '*Risk profile analysis*' being a '*Documented process for identification of evaluation of clinical risk and evidence of correcting, eliminating or reducing these risks.*'

9.12. It will be seen from the above analysis that all of these rigours and requirements in respect of midwives providing intrapartum care at homebirths, whether for fee or reward or not, can be completely avoided by electing not to be registered under the National Law as a midwife. The insurance requirements and/or exemptions also become a non-issue if registration is eschewed. To this extent the scheme operates as a disincentive against registration in respect of privately practising midwives who provide intrapartum care in homebirths. There is no available sanction against an unregistered midwife providing clinical intrapartum care in a homebirth provided the midwife does not use that term in respect of him or herself in a manner that implies that they are registered. On the other hand, if a registered midwife desires to continue practising privately and to provide intrapartum care in a homebirth, the only way he or she could do so would be to qualify for the insurance exemption. This in turn, however, would require compliance with the Nursing and Midwifery Board of Australia requirements relating to the safety and quality of practice. There is a definite incentive for these requirements to be avoided within the homebirth industry because the requirements, if met in a particular instance, might well deter the client/ mother from proceeding with a homebirth because of the prospect of intervention of other professional medical services apart from the services provided by the midwife.

9.13. By refraining from registering, a privately practising midwife operating in the context of homebirthing can avoid compliance with the following professional obligations:

(i) To recommend that a woman consult a medical practitioner or other health care provider in the case of a woman contemplating a homebirth who has a maternal weight greater than 100kg or with a BMI greater than 35, or who has had a previous caesarean section[151];

[150] Exhibit C54c, Paragraph 36c
[151] As per Level B within the ACM National Midwifery Guidelines for Consultation and Referral

(ii) To refer a woman to secondary or tertiary care, that is to a medical practitioner who would assume full responsibility for subsequent decision making, in cases of multiple pregnancy or non-cephalic presentation (breech)[152];

(iii) To advise a woman who has refused to follow advice that a certain course of action must be followed in order for the midwife to comply with the midwifery standards of practice of the recommended guideline and also to explain the rationale and the evidence behind the guideline[153];

(iv) To use her ethical judgment in deciding whether to continue care in respect of a woman who has refused to follow advice in accordance with the ACM Guidelines, or to discontinue care;

(v) To practice midwifery in accordance with the Code of Ethics for midwives in Australia;

(vi) To practice midwifery in accordance with a professional responsibility to the unborn child as well as the mother, as per the Code of Ethics;

(vii) To practice midwifery recognising the universal human rights of people, including the unborn infant(s) as per the Code of Ethics;

(viii) To comply with the Australian College of Midwives Position Statement on homebirth services;

(ix) To provide to the Board evidence of referral pathways as contemplated by the Safety and Quality Framework for Privately Practising Midwives attending homebirths and the ACM Guidelines; and

(x) To provide to the Board evidence of a documented process for identification, evaluation and elimination of clinical risk as contemplated by the above Framework..

The unregistered midwife would also naturally avoid any scrutiny under and by virtue of any disciplinary or regulatory measures available under part 8 of the National Law.

[152] As per Level C within the ACM National Midwifery Guidelines for Consultation and Referral
[153] Appendix A within the ACM National Midwifery Guidelines for Consultation and Referral

9.14. It will be observed that the National Law and the rigours that it would visit upon a privately practising registered midwife attending homebirths was not in operation at the time of either the birth and death of Tate Spencer-Koch or that of Jahli Hobbs. Ms Barrett was a registered midwife at the time of both events. On the other hand Ms Barrett told the Court that since the beginning of 2011 she was no longer a registered midwife. This de-registration occurred only a matter of months after the National Law came into operation on 1 July 2010. When Ms Barrett gave evidence, she gave her occupation as 'birth advocate'. It will be remembered that Ms Barrett gave her evidence at a time after the Western Australian twin birth incident, but before the Tully Kavanagh incident. In her evidence she acknowledged that she had handed in her registration as a midwife in response to the change in the law. She said '*I didn't want to be a midwife anymore*'[154]. Ms Barrett suggested in her evidence that her becoming a birth advocate was not simply a change in nomenclature. She asserts that in her capacity as a birth advocate she did not and does not perform the clinical duties of a midwife in the context or a homebirth or at all. She said:

> 'No, I don't provide any midwifery care, because I'm not a midwife.' [155]

She explained that the essential difference between a midwife and a birth advocate was that the birth advocate does not have any clinical duties; a birth advocate advocates for women and in that capacity the birth advocate provides women with information, education and help[156]. It will be seen specifically when the circumstances of the Tully Kavanagh incident are discussed below that this was a disingenuous assertion and that in reality Ms Barrett practices as a midwife, notwithstanding the occupation description that she has lately adopted.

9.15. Ms Barrett made another assertion in her evidence that is simply not correct. She suggested that the ACM Guidelines were not a prescriptive document and remained only as guidelines, notwithstanding their having been embraced as part of the Nursing and Midwifery Board of Australia Safety and Quality Framework for Privately Practising Midwives attending homebirths. This assertion is manifestly incorrect insofar as the ACM Guidelines now govern the manner in which registered midwives must provide care in relation to all aspects of a planned homebirth[157].

---

[154] Transcript, pages 563-564
[155] Transcript, page 564
[156] Transcript, page 564
[157] Transcript, page 931

9.16. Ms Barrett denied the suggestion put to her by Ms Kereru, counsel assisting, that the reason she did not continue with her registration as a midwife was because she would not be able to qualify for the insurance exemption as she would need to work within the Safety and Quality Framework for Privately Practising Midwives attending homebirths and that she was not prepared to work within the ACM Guidelines[158]. Rather, she said that the reason she handed in her registration as a midwife was because the new regime prevented women from making choices[159]. She suggested that the regime actually encouraged midwives not to take on women but to leave them by themselves and that is what she found objectionable. Thus she did not want to be a midwife anymore and did not work as such[160]. She also rejected the suggestion that her motivation in not renewing her registration was to avoid closer scrutiny of her practices and to enable her at the same time to continue to do exactly what she had been doing before the new regime commenced its operation. I reject that evidence and find that Ms Barrett handed in her registration as a midwife because she well knew that in order to practise as a registered midwife with the benefit of an insurance exemption in respect of intrapartum care in homebirths, she would have to conduct her practice within the Nursing and Midwifery Board of Australia's Safety and Quality Framework and the ACM Guidelines. I further find that she was not prepared to do this as it would act as a hindrance to her homebirthing practice in respect of high risk homebirths.

9.17. If there was legislative regime in place that prohibited a person from performing the clinical duties and responsibilities of a midwife for fee or reward while not being a registered health practitioner under the National Law, Ms Barrett and other persons practising in the same manner as she would have to comply with the requirements that enliven the insurance exemption for intrapartum care in homebirths and thus practice in accordance with the relevant safety requirements.

10. The circumstances of the births and deaths of the infants

10.1. In this section I deal with the evidence concerning the births and deaths of the three infants with which these Inquests are concerned. I also will deal briefly with the birth and death of the child in Western Australia.

[158] Transcript, page 987
[159] Transcript, page 989
[160] Transcript, page 990

10.2. Among other topics, I will describe the reason in each case why the woman in question elected for a homebirth, the circumstances surrounding the homebirth in each case and whether or not the outcome in each case may have been altered if the births had taken place either in differing circumstances within the home or had occurred within a hospital setting.

10.3. As indicated earlier, I should say at the outset of this section that there is no reason to believe that any of these unborn children were other than healthy and viable in the period immediately preceding their labour and births. As a measure of this, there is no reason to suppose that if they had been delivered by way of elective caesarean section, they would not have been born alive and healthy. However, there is a further question that needs to be considered and that is whether or not in a hospital setting in which a natural birth was opted for in the first instance, measures may have been taken to prevent the death or serious harm in each case.

10.4. <u>The circumstances of the birth and death of Tate Spencer-Koch</u>

Tate's birth took place at the Largs Bay home of her parents, Jacqueline Spencer and Philip Koch.

10.5. Aside from Tate's parents, the persons present at Tate's birth were Ms Barrett and a friend of Ms Spencer's, Ms Gemma Noone. Ms Noone had met Ms Spencer around the beginning of 2007. Ms Spencer was pregnant at that time with Tate. As it so happened, at that time Ms Noone was undertaking a part time midwifery course at the University of South Australia. Ms Noone gave evidence in the Inquest. She had also provided two witness statements[161]. The first of those statements was given on 19 July 2007, three days after the events in question. Ms Noone attended at an antenatal clinic at the Queen Elizabeth Hospital with Ms Spencer on 29 March 2007. She was interested in Ms Spencer's pregnancy given the fact that she was studying midwifery herself and that her course involved a requirement that she follow a woman through the course of her pregnancy. She decided to follow Ms Spencer. However, in due course Ms Noone became aware that Ms Spencer had decided to undergo a homebirth. This would not have fulfilled the course's requirements. This meant that Ms Noone was not able to follow the pregnancy and birth in her capacity as a midwifery student. Notwithstanding this, Ms Noone agreed to be Ms Spencer's support person at the birth. Ms Noone understood from Ms Spencer that because Ms

Spencer had not had a positive experience with the birth of her first child, Ms Spencer had decided to adopt a different course with the second child. In her own statements to police, Ms Spencer indicated that the experience of her first delivery at the WCH that had culminated in what she described as 'an emergency caesarean' had greatly upset her and that she had been significantly shaken by the experience. Ms Barrett had been recommended to Ms Spencer through the 'Midwives Association'. From the 25th week of her pregnancy Ms Barrett had become her primary caregiver and took on all of the antenatal visits at her home. Ms Spencer makes it plain that Ms Noone was not to be regarded as a 'midwife' present at this homebirth, but had been there simply to offer support. Ms Noone, in her evidence, was at pains to point out that she had not contemplated taking part in or providing any midwifery services to Ms Spencer during labour and birth. Indeed, she was not there even in her capacity as a student. I accept Ms Noone's evidence in this regard. In the event, Ms Noone would be tasked to assist in manoeuvres that would be attempted by Ms Barrett to relieve Tate's shoulder dystocia. But Ms Noone told the Court that she had not, in her course, studied that aspect of midwifery. Ms Noone also told the Court that she had no idea that Ms Spencer was predicted to have a large baby,[162] a fact known both to Ms Spencer and Ms Barrett.

10.6. Ms Noone was telephoned by Ms Spencer in the early hours of the morning of Monday 16 July 2007. Ms Spencer explained that she was then having contractions. Ms Noone made her way over to Ms Spencer's premises at Largs Bay. Ms Barrett arrived sometime later. In the meantime Ms Spencer's waters had broken.

10.7. Ms Spencer spent some time in a birthing pool. From time to time Ms Barrett checked the unborn baby's Heartbeat with a Doppler. Ms Noone made notes in respect of what was taking place but to this point played no role in respect of Ms Spencer's care.

10.8. There is no significant dispute as to what took place in respect of Tate's birth in the initial stages. Tate's foetal heart rate was at all material times within the limits of normality. At 5:10am the head of the child crowned and at that point the child's heart rate was 120 beats per minute, which is at the lower end of the scale of normality. Earlier there had been higher foetal heart rates recorded. The heart rate

[161] Exhibit C17 and C17a
[162] Transcript, page 276

of 120 beats per minute at 5:10am was the last measured heart rate prior to the eventual delivery of the child approximately 30 minutes later. The heart rate at 5:10am was regarded as satisfactory.

10.9. At 5:20am the child's head was delivered and at that point she became entrapped within the birth canal due to shoulder dystocia. Although the head of the child was delivered, the child in this position would not be expected to breathe and the compression of its chest would make it very difficult, if not impossible, for the child to do so in any event. Tate at that point continued to rely upon her mother for the delivery of life sustaining oxygen by way of the still attached umbilical cord and the placenta, but the entrapment resulted in Tate sustaining hypoxia. The child remained in this position until her eventual delivery some 20 minutes later. It was during this period, I find, that Tate experienced the hypoxic event that ultimately proved to be the cause of her death.

10.10. Tate was born at approximately 5:40am. The child was born unresponsive without detectable Heartbeat or respirations, although pulseless electrical activity was detected.

10.11. The circumstances surrounding the eventual extraction of the infant following the delivery of the head bear close scrutiny. In her first statement to police made three days after the event, Ms Noone describes what took place following the delivery of Tate's head. Ms Spencer emerged from the birthing pool and Ms Barrett instructed her to place herself on all fours. At that point Ms Noone was instructed to call an ambulance, which she did. In the event the ambulance would be called twice. The WCH was also called in anticipation of the child being born and possibly being in extremis requiring transfer to hospital. Ms Noone says in her statement that, as part of her midwifery syllabus, she had not yet studied difficulties encountered during birth with the result that she was not entirely sure what Ms Barrett then did. Ms Noone does say that she had an appreciation at the time that shoulder dystocia had taken place. She describes certain manoeuvres made by Ms Barrett in an attempt to free the baby from its obstructed position. She indicates in her statement that Ms Barrett tried different things in an attempt to extract the baby but without success. Ultimately Ms Barrett said to Ms Noone 'you have to help me' to which Ms Noone

replied 'I can't, I'm not allowed'[163]. To this Ms Barrett said 'you have to, my hands are seizing up'. Ms Noone was conscious of her University's policy about students not actively being involved in births, but in the circumstances Ms Noone decided that she really did not have any choice but to assist. The assistance that Ms Noone rendered was rendered right at the very end. Ms Noone describes in her statement what she did. She had some knowledge of the mechanism of birth to the extent that she believed that if she was able to extract an arm it would perhaps relieve the situation. That was the only thing that she could think of to do. She managed to extract one of the baby's arms and then the baby immediately came out. Although she could not say what would have happened had she not rendered assistance[164], Ms Noone told the Court that she believes that if she had not rendered the assistance that she described, the baby would possibly have still been stuck at the time of the arrival of the ambulance. She was confident that she had been substantially instrumental in freeing the baby.

10.12. During the manoeuvre that Ms Noone performed herself, she said that she did not believe that Ms Barrett had her hands on Ms Spencer at all.

10.13. Ms Barrett's account of these events is that the baby's head was born at 5:20am. Following this there was another contraction but there was no further movement of the baby. At that point Ms Barrett asked Ms Spencer to stand up in order to change the diameter of the pelvis, but this occurred with no effect. Ms Spencer was then asked to emerge from the pool and Ms Barrett asked for an ambulance to be called. Ms Spencer was asked to get on all fours on the floor to await the next contraction. When the next contraction occurred Ms Barrett attempted to rotate the shoulder of the baby without effect. She told Ms Spencer to lie on her back and Ms Barrett then performed the McRoberts manoeuvre. She also attempted what she described as an external Rubins manoeuvre. She describes other attempts to remove the baby that involved an attempt to hook the baby's armpit, at the same time pushing on the exterior of the abdomen. Ultimately she asked Ms Noone for assistance. Meanwhile the baby's head had turned purple in colour. Ms Barrett states in her statement that the baby was born with the help of Gemma Noone. The baby was unresponsive. In her evidence before the Court, Ms Barrett told me that she had asked Ms Noone for

[163] Exhibit C17
[164] Transcript, page 265

assistance when her hands had become cramped[165]. She acknowledges that Ms Noone expressed some reluctance to help as she believed that she was not allowed to do so, but that when Ms Barrett said that it was an emergency Ms Noone put her hand into grab under the posterior shoulder of the baby and was able to pull the baby out.

10.14. Ms Barrett acknowledged that the baby was stuck in the birth canal from 5:20am to 5:40am, a period of 20 minutes[166].

10.15. Contrary to what Ms Noone had told the Court, Ms Barrett asserted that she was still rendering physical assistance at the time Ms Noone performed her successful manoeuvre[167].

10.16. Ms Barrett asserted that if the baby had experienced this severe shoulder dystocia in a hospital, the baby would have had exactly the same outcome[168]. She asserted that:

> 'With a severe shoulder dystocia like this one, the outcome is the same wherever the venue.' [169]

She stated that regardless of any additional assistance that might have been employed or have been available, the outcome would have been the same whatever the venue of birth[170].

10.17. In another section in her evidence, Ms Barrett asserted that she had done everything that she could and that when shoulder dystocia is catastrophic and the baby is really stuck, nobody can prevent it[171]. All of this seems to beg the question as to how, if the baby was so stuck, it was ultimately relieved by a manoeuvre essentially performed by an untrained individual.

10.18. Ms Barrett also asserted that in a case where a shoulder dystocia is fatal, no amount of people actually make any difference[172].

10.19. Professor Pepperell's report in relation to the death of Tate Spencer-Koch[173] indicates that when a diagnosis of shoulder dystocia is made, a number of techniques are used

[165] Transcript, page 510
[166] Transcript, page 603
[167] Transcript, page 606
[168] Transcript, page 608
[169] Transcript, page 608
[170] Transcript, page 608
[171] Transcript, page 944
[172] Transcript, page 962

in an attempt to deliver the shoulders. If the shoulders are not delivered within 7 to 8 minutes of the baby's head being born, significant hypoxia occurs and the baby is likely to be stillborn. There is no doubt that is what occurred in this particular case. In the event the delay between delivery of the head and ultimate delivery of the child was 20 minutes.

10.20. Professor Pepperell was asked to comment upon the measures that had been undertaken in an attempt to free the baby and expedite the delivery of the shoulders in particular. Professor Pepperell gave evidence that the McRoberts manoeuvre that Ms Barrett said she applied in an attempt to deliver the baby involves a hope and expectation that the angle of entry in the pelvis is altered such that the shoulders will descend into the pelvis. However, he indicated that if this did not work with traction alone, then another person was required to apply external suprapubic pressure. The application of this pressure in the McRoberts manoeuvre, together with traction on the head, results in delivery of 95% of babies who have shoulder dystocia[174]. In respect of the small number of babies in which this manoeuvre was not successful, there may be a need to enter into the vagina to rotate the shoulders. If that does not work then one would have to place one's hand into the uterus. Professor Pepperell suggested that this is a technique that is very difficult and he did not believe that there would be many midwives in the world who would have been able to do that because it is so rarely necessary if other techniques are attempted in the first instance[175]. When examining Ms Barrett's evidence as to the manner in which she performed the various manoeuvres, Professor Pepperell did not believe that initial traction had been applied appropriately and that it did not appear that adequate suprapubic pressure was ever applied. He assumed this because he did not think that this could be done alone having regard to the fact that one needs to have two hands on the head to pull the child downwards and at the same time pressure needs to be applied by some other person to the suprapubic area. It is clear from Ms Barrett's evidence that in conducting the McRoberts manoeuvre she did not have any other person to apply suprapubic pressure while she applied traction. She said that she had applied suprapubic pressure herself, but that Gemma Noone was reluctant to help so '*I did the best that I could at the time*'[176]. When it was pointed out to her that the

[173] Exhibit C13a
[174] Transcript, page 837
[175] Transcript, page 837
[176] Transcript, page 961

evidence of Professor Pepperell was that all of this could not be done by the one person, Ms Barrett said:

> 'Well, I did the best that I could, so.' [177]

10.21. As alluded to earlier, Dr Dahlen said in her evidence that the presence of two midwives at a birth was a fundamental requirement. When asked as to whether the presence of a second midwife to assist with manoeuvres to relieve shoulder dystocia was important, she replied '*very much so*'[178]. The reason why that was so, as explained by Dr Dahlen, is that in conducting a McRoberts manoeuvre the second midwife can apply external suprapubic pressure. When asked as to whether these manoeuvres are difficult to manage on one's own, she suggested simply '*well you can't*'[179]. She explained in this regard that a certain amount of expertise was required in these cases because one needed to understand how to manipulate the shoulder in the correct direction. She suggested that it would be very difficult to ask a woman's partner to do that[180]. Professor Pepperell suggested that the suprapubic pressure in itself will usually require two hands[181] so that one would want at least two people present because the extra person is required to administer the suprapubic pressure.

10.22. Professor Pepperell believed that an adverse outcome from a shoulder dystocia would be much less likely to occur in a hospital because of the presence of other trained people who can assist in the application of significant pressure and generally assist with the delivery if there are difficulties. The corollary of that in his opinion is that the likelihood of an adverse outcome would be higher if a problem occurred at home and the delivery could not be expedited as quickly as it would be within the hospital[182].

10.23. In respect of Tate Spencer-Koch, Professor Pepperell said that he was not surprised that Tate was not able to be delivered by the techniques that were used in the circumstances in which they were used. He suggested that the techniques were not maximised. Ms Barrett was applying some traction but suprapubic pressure was not being applied at the same time[183]. Professor Pepperell could recall only one occasion

---

[177] Transcript, page 961
[178] Transcript, page 691
[179] Transcript, page 691
[180] Transcript, page 691
[181] Transcript, page 850
[182] Transcript, page 848
[183] Transcript, page 849

when he had been unable to rectify a shoulder dystocia. On that occasion it had been established that the baby had been dead in any event for at least 12 hours. On all other occasions he had been able to deliver the baby within an appropriate time limit and in good condition. Furthermore, the advantages of a hospital setting when shoulder dystocia is experienced also included the patient being placed on a couch rather than in a bath such that the problem of shoulder dystocia would be detected earlier because of greater visibility.

10.24. Finally, Professor Pepperell's opinion was that if Tate's delivery had been undertaken in a hospital setting by way of vaginal birth, he believes that the baby would have been much more likely to have survived and probably would have been in good condition at the time of birth. He explained that the delay that occurred in her delivery would probably not have occurred. Expedition of the delivery would have occurred more quickly because of the availability of extra staff to assist in that process. He also suggested that the difficulty of shoulder dystocia probably would have been identified earlier than it had been by Ms Barrett who had waited for the next contraction to occur before she took any particular action.

10.25. Had an elective caesarean section taken place, Professor Pepperell suggested that almost certainly the outcome would have been different. He suggested that in those circumstances the chance of the baby being in good condition and alive and well at birth would have been 99.5% at least.

10.26. <u>The circumstances of the birth and death of Jahli Hobbs</u>

Ms Naomi Hughes, the mother of Jahli, says in her witness statement[184] that her previous pregnancy had culminated in an 'emergency caesarean' at the Flinders Medical Centre because the doctor believed that the baby on that occasion had been 'too big for me to have naturally'[185]. She states that she and her partner decided to have Jahli born at home because she believed that she should not have had a caesarean with her previous delivery and that she did not want to repeat the experience. Indeed, as seen earlier, Ms Hughes' first born child had been a large baby being a boy weighing 3960g. In his report concerning the birth and death of Jahli Hobbs, Professor Pepperell describes his understanding of Ms Hughes' labour

[184] Exhibit C39a
[185] Exhibit C39a, page 2

and delivery in respect of her first baby[186]. He reports that labour did not occur until 41 weeks of gestation. Although ultimately the cervix had reached 9cm dilation, there had apparently been slow progress and foetal distress. He understood that for those reasons the boy had been delivered by emergency lower uterine segment caesarean section. In her later interview with a Detective, Ms Hughes explained that because of her previous caesarean section the hospital at Victor Harbor would not allow her to book in for a natural delivery and that Flinders Medical Centre would only allow her to labour naturally for a maximum of 8 hours before they too would insist on a caesarean section. Thus she had consulted Ms Barrett. Following this she had not discussed the need to see an obstetrician because she was definite in her choice that she did not want to go back into the system and had complete faith in Ms Barrett. It is plain that Ms Barrett did not refer Ms Hughes to the ACM Guidelines. The Appendix A requirements were also thus ignored.

10.27. Ms Hughes explained in her various statements the circumstances in which she came to engage the midwife, Ms Barrett. I have already discussed her interaction with Ms Barrett during her pregnancy in another section of these findings and do not need to repeat it here. In her interview with the Detective[187], Ms Hughes was asked whether she had discussed a plan with Ms Barrett as to what would be done in the event of a complication during labour and whether there was any emergency plan. Ms Hughes said that the plan was that they would get in their car and go to the Victor Harbor Hospital. At that time Ms Hughes and her partner were residing at premises on Hindmarsh Island.

10.28. On the other hand, the midwife Rosemary Vaher and Ms Barrett herself originally had an understanding that Ms Hughes, for the purposes of the labour and birth, would move to premises at Hahndorf in order to be closer to more appropriate hospital facilities in the event of a complication. In the event, this move did not happen and the labour and delivery occurred at the relatively remote premises on Hindmarsh Island. When it transpired that things did go wrong, rather than executing a plan to go to Victor Harbor Hospital, an ambulance was called and in the first instance an ambulance staffed by voluntary ambulance officers attended. I return to the circumstances of that attendance shortly.

[186] Exhibit C18a
[187] Exhibit C39b

10.29. I should explain at the outset that due to a misreading of handwritten notes that had been made by Ms Vaher at the time of Jahli's labour and birth, it was originally believed that there had been some significant delay between the delivery of Jahli's foot and the eventual entire delivery of the child, possibly as much as 34 minutes or longer since the foetal heart rate had last been ascertained by use of a Doppler. Specifically, Professor Pepperell had understood from these somewhat ambiguous notations that there had been a long delay in completing delivery of the baby after the buttocks had been delivered, and during which there had been a cord prolapse. This had led Professor Pepperell to conclude that there had likely been cord compression and that this had been a component in the cause of the hypoxic event that the child undoubtedly experienced. In the event, when the precise nature of the notations that had been made by Ms Vaher were properly understood, the timeline involved in the delivery of Jahli was seen to be somewhat different to what had previously been believed. Professor Pepperell revised his opinion as to what may have given rise to the hypoxic event and concluded that the hypoxic event had more likely been caused by a placental separation that had occurred at some point in time during the delivery process, as evidenced by the fact that the placenta was ultimately delivered at the same time as the baby's head.

10.30. Ms Vaher who was called to give oral evidence at the Inquest deciphered her handwritten notes and it now appears clear that the timeline of events is different from what had originally been understood. Prior to Ms Vaher's arrival at approximately 6:15am on the morning in question, Ms Barrett herself had made her own handwritten notes in respect of Ms Hughes' labour and at various points during the course of the night, she has recorded establishing the baby's foetal heart rate by use of a Doppler. These heart rates are, for the most part, reassuring and there is nothing to suggest that Jahli was in any distress.

10.31. Following Ms Vaher's arrival, Ms Vaher made notes. The last recorded measurement of the child's heart rate was at 7:23am when Ms Vaher noted a heart rate as measured by the Doppler at 120 beats per minute, which is satisfactory. This was in fact the last recorded measurement of the unborn infant's heart rate, a factor that Professor Pepperell regards as questionable and not, as it were, best practice as far as the management of a breech delivery is concerned. It is now known, according to Ms Vaher's now deciphered notes, that at 7:32am one of Jahli's feet was delivered

and that the entire birth occurred at 7:47am. Ms Vaher's notes as originally understood had led those investigating the matter to believe that the entire birth had occurred at 8:06am. Indeed, according to Ms Barrett's statement regarding this matter, she had also understood Ms Vaher's note to indicate 8:06am as the time of birth. This time is not correct. The salient features of the timeline are events at 7:23am (last recorded heart rate of 120bpm), 7:32am (delivery of foot), and 7:47am (entire delivery). The duration from the delivery of the baby's foot to the entire delivery was thus 15 minutes.

10.32. Jahli was born unresponsive and an ambulance was called. In due course an ambulance arrived which was followed by the arrival of another ambulance. A local medical practitioner also attended.

10.33. In his evidence Professor Pepperell expressed the view that the type of breech delivery that had occurred in Jahli's case was known as a 'complete breech'. This involves the legs being flexed. It also involves a diameter of the cervix that is satisfactory providing the gestation has reached beyond 37 weeks. As I understood Professor Pepperell's evidence, out of all types of breech deliveries a complete breech delivery signifies the least risk as it usually involves a diameter of the cervix that is wide enough to accommodate the eventual delivery of the child's head. Professor Pepperell explained that if one had to perform mechanical intervention in a breech delivery of this kind, known as an assisted breech delivery, one is able to pull on the feet. Generally speaking, the strategy to be employed in a breech delivery in Professor Pepperell's view was to do nothing except just watch and make sure progress is occurring and that there is no delay[188]. Provided progress is occurring and there is no delay, one does not need to interfere and there is no need to pull on the child to assist the delivery. If there is a problem with the foetal heart rate as revealed by continuous monitoring during the process, or there is bleeding, then one would expedite delivery by way of a breech extraction.

10.34. Professor Pepperell also commented upon the timeline that had now been clarified by Ms Vaher. He regarded the foetal heart rate that had been determined to be 120 beats per minute at 7:23am as a normal rate, but there was no way of determining at that point whether there were any decelerations occurring or what the beat variability was. However, he asserted that on the basis that the foot was delivered at 7:32am

and that complete delivery occurred at 7:47am, that such a time span was not excessive, was indeed normal and involved no delay[189].

10.35. Ms Barrett's statement to the police which was given on the day of this incident[190], describes a timeline of events that is based on the original erroneous interpretation of Ms Vaher's notes. Ms Barrett describes a phase of the delivery that at one point involved the delivery of a second leg and the child's buttocks at which she could see up to the baby's hips thereby allowing her to sight the umbilical cord and to establish that the baby was a girl. I am not certain how accurate this description of events is having regard to the fact that it appears to have been underpinned by an erroneous interpretation of Ms Vaher's notes. Ms Vaher's notes, as properly read, do not describe the events in these terms. In her oral evidence in the Inquest Ms Barrett gave her account of these events from her memory. Ms Barrett accepted that a more accurate timeline involved the final check of the baby's heart rate of 120 beats per minute occurring at 7:23am, that the right foot of the baby came out at 7:32am and the baby was born entirely at 7:47am. She accepted that on that basis an hypoxic event must have occurred between 7:23am and 7:47am. When asked as to what may have caused this, she suggested that it could have been a placental abruption, it could have been that the cord was trapped or '*it could have been anything*'[191]. Ms Barrett appears to have agreed in her evidence that if during the period between 7:23am and 7:47am a Doppler had been applied in order to detect foetal heart rate, then foetal distress would have been picked up as the baby obviously died at some point during that period[192]. Ms Barrett suggested that the two most obvious causes of intrapartum hypoxia in the circumstances would have been either placental abruption or cord compression. She agreed that in a breech birth, once the body and the head of the baby come into the pelvis, there is a chance that the cord can be occluded against the pelvis. She acknowledged that an abruption is due to the fact that the uterine body is contracting because the majority of the baby is coming down into the pelvis[193]. She agreed that in the particular circumstances of this case where the baby and the

---

[188] Transcript, page 865
[189] Transcript, page 872
[190] Exhibit C20c
[191] Transcript, page 626
[192] Transcript, page 625
[193] Transcript, page 627

placenta were delivered at the same time, it could be an indication that there had in fact been an abruption[194].

10.36. Professor Pepperell is now of the firm view that there had been a placental separation at some point in time[195]. I accept that evidence. He suggested that from Ms Vaher's description of events, that included her observation that there had been a large dark red clot on top of the placenta when it was delivered, it meant that bleeding had occurred at some stage, presumably underneath the placental bed. The colour of the blood also suggested to him that the abruption had not occurred immediately prior to delivery. The fact that the foetal heart rate had been 120 beats per minute at 7:23am meant that if there had been a placental separation prior to then, it had not been sufficient to cause the baby to die. He suggested that there are not necessarily any clinical signs of an abruption during labour[196]. Professor Pepperell suggested that although one could be reasonably certain that placental abruption had been playing a role in the child's deterioration, it could not be determined when it had occurred. However, from the fact that the baby was found to be hypoxic at autopsy, and that the placenta was born with the baby, it meant that there had been a period of virtually no oxygenation for the whole of the time from 7:32am to 7:47am, a period of 15 minutes and possibly longer[197]. He opines that at 7:23am when by means of a Doppler the heart rate was established to be 120 beats per minute, that this was incomplete data. The fact that there had been no continuous CTG monitoring meant that that one only had a single assessment administered externally[198].

10.37. Professor Pepperell stated that there is clear evidence in the world literature that if a placenta separates for more than 15 or 16 minutes, it is almost certain the baby will be born dead or very close to it. He suggested that when placental separation occurs, one would detect a deterioration in the child's wellbeing on CTG monitoring and by use of a Doppler[199]. What would be seen would be evidence of bradycardia, often prolonged and persistent with a slow pulse rate, usually under 100bpm. On the other hand there may be difficulty in distinguishing a slowing pulse rate of the foetus from the pulse rate of the mother which is in any case lower than that of the baby[200].

[194] Transcript, page 628
[195] Transcript, page 873
[196] Transcript, page 874
[197] Transcript, page 879
[198] Transcript, pages 879-80
[199] Transcript, page 875
[200] Transcript, page 875

Therefore, one would need to apply a Doppler immediately after every contraction so that a baseline between contractions can be achieved. Professor Pepperell suggested that the lack of foetal monitoring after 7:23am in this case was an issue of concern[201].

10.38. During the course of Jahli's delivery Ms Barrett and those present were completely oblivious to any deterioration on the part of the unborn baby. The first and only sign of distress occurred upon simultaneous delivery of the entire and unresponsive baby and the placenta. To this Professor Pepperell agreed that where a breech delivery was occurring within a normal timeframe, the only means by which one could identify a need to expedite a breech delivery would be through monitoring the heart rate[202].

10.39. Professor Pepperell suggested that the ideal management of Ms Hughes' labour and delivery ought to have involved the provision of advice that because of her previous caesarean section, the baby needed to be monitored continuously throughout the whole of labour until Jahli was born[203]. His own recommendation would have been not to attempt a vaginal delivery having regard to the potential risks that, according to the Hannah Term Breech Trial, were three times those of a caesarean section. Regardless of the mode of delivery he suggested that he would have advised Ms Hughes that because of potential problems associated with delivery of a baby as a breech, it should occur in a hospital[204]. He suggested that Ms Barrett's opinion to the effect that the risks associated with caesarean section are higher than the risks associated with vaginal breech birth is '*clearly not right*'[205]. He suggested that Ms Barrett's opinion was correct in terms of the risk to the mother, but was not correct in terms of risk to the baby which was much higher with vaginal delivery than caesarean section[206].

10.40. As to the possibility of an alternative outcome for Jahli had things been managed differently or at a different venue, Ms Barrett and Professor Pepperell expressed polarised opinions. Professor Pepperell suggested that if foetal distress had been identified by monitoring beyond the last measurement at 7:23am, a breech extraction ought to have occurred by way of pulling on the legs to ensure that the baby

[201] Transcript, page 876
[202] Transcript, page 878
[203] Transcript, page 882
[204] Transcript, page 882
[205] Transcript, page 883
[206] Transcript, page 883

descended satisfactorily. Professor Pepperell suggested that this could be achieved either in a homebirth setting or in hospital, except that the mother in a hospital would be positioned with stirrups so that the manipulation would be easier to achieve[207]. Professor Pepperell opined that if the events concerning Jahli's birth had been replicated in a hospital environment, where a CTG had picked up an abnormality, a breech extraction would have been performed. If however there was an inability to grasp a leg in order to effect a breech extraction, in those circumstances the mother would be taken to theatre and an emergency caesarean section performed, realising that this could take 10 or 15 minutes to be achieved. Professor Pepperell suggested in this case that if CTG monitoring had picked up a deceleration, then a breech extraction probably would have resulted in the child being born alive.

10.41. As to the question of a breech extraction in the case of Jahli Hobbs, Ms Barrett told the Court that the birth did not need to be expedited. She quoted certain literature that suggested that there was not enough evidence to support the intervention in assisting a breech baby to be born. I do not think that Professor Pepperell disagreed with that proposition except to the extent that where a complication in the unborn infant's wellbeing is identified, one would then proceed to consider a breech extraction. In this regard Ms Barrett suggested that there was no indication that the baby had been in distress and that, even if there had been such an indication, an extraction would not have made the birth occur with any greater rapidity. At one point she could see that once the baby was delivered to the abdomen, she could see the cord and it looked full and pulsing and so there was no indication that there was any need to perform a breech extraction. As well, Ms Barrett suggested a breech extraction could not have made the birth any quicker but could have damaged the baby further and so she suggested that Professor Pepperell's assertions that the baby probably would have been born alive if a breech extraction had been undertaken, was not correct[208]. Clearly, however, there must have been a point in time prior to Jahli's delivery where distress would have been identified by either continuous monitoring or by intermittent use of the Doppler beyond the time of 7:23am.

10.42. Ms Barrett asserted in her evidence that if Ms Hughes had made the same choice to have a vaginal birth at a hospital, the outcome would have been the same. Ms Barrett went so far as to say that it would be impossible to tell whether a planned

[207] Transcript, page 877

caesarean section would have resulted in the child being born alive. She goes so far as to suggest that the risks associated with caesarean section are higher than the risks of vaginal birth and that the risk associated with caesarean section and the morbidity and mortality of breech is the same in vaginal birth and caesarean section, and so it would be impossible to answer the question as to whether hospital birth would have altered the outcome. When asked as to whether there would be any reason to think that if Jahli had been born by way of elective caesarean section the child would not have survived, she said:

> 'Well, yes, because there's just as much risk surrounding an elective caesarean for a breech as there is surrounding a vaginal birth for a breech, so the chances of her dying from a caesarean section are the same as the chances of her dying from a normal birth.' [209]

This opinion is simply manifestly incorrect. It causes me to doubt the genuineness of other assertions made by Ms Barrett in the context of Jahli's birth, especially those concerning the feasibility and effectiveness of a breech extraction in her case. I prefer the evidence of Professor Pepperell that the risks of an adverse outcome in an elective caesarean section are significantly less. I also prefer the evidence of Professor Pepperell that a timely breech extraction, the need for which could and should have been identified by more rigorous monitoring, a measure that undoubtedly would have been available within a hospital, probably would have altered the unfortunate outcome.

10.43. I have already referred to the fact that an ambulance was called to the premises on Hindmarsh Island. In fact two ambulances attended. The first of those was crewed by volunteer staff stationed at Goolwa. The second ambulance included the intensive care paramedic, Ms Whittenbury. The second crew came from the Victor Harbor depot. The first call to the ambulance service was received at 7:49am with the voluntary crew receiving the relevant page at 7:51am. Their arrival at the scene is timed at 8:01am.

10.44. The second ambulance crew arrived at the scene at 8:13am.

10.45. There was a great deal of evidence adduced during the Inquest concerning the ambulance officers' perceptions of the resuscitative measures that were being

---

[208] Transcript, page 950
[209] Transcript, page 629

administered to Jahli Hobbs upon their arrival. In addition, there was considerable discussion about whether the resuscitative efforts should have taken place in the house or at the back of the ambulance in light of the poor lighting conditions and the weather. It has not been necessary to resolve those issues beyond observing that the nature of the response of SAAS was apparently not what those who summoned the ambulance were necessarily expecting. As I have mentioned, the first crew was staffed by two voluntary ambulance officers who were not trained in such measures as intubation which in any advanced resuscitation is fundamental. This is no criticism of those ambulance officers. On the contrary, they did everything they possibly could and it must be said that their response time was surprisingly swift. The situation that confronted them involving an unresponsive baby and an environment no doubt charged with emotion was not of their making and the fact that they were the first ambulance crew to arrive was also a matter over which they had no control. But what this does illustrate is that persons contemplating homebirths, particularly at a relatively remote location, have to bear in mind that summoning an ambulance when a life threatening complication arises is not always going to be the optimal solution and that the resuscitative measures that are immediately available in a hospital when a complication arises will naturally be intrinsically superior.

10.46. <u>The circumstances surrounding the birth and death of Tully Kavanagh</u>

Both of Tully Kavanagh's parents gave oral evidence in this Inquest. Ms Kerr explained her reasons for opting for a homebirth despite the fact that she was expecting twins. Prior to Ruby and Tully, Ms Kerr had four previous singleton pregnancies, all of which had involved the birth of healthy children. These births had taken place on 27 December 2003, 1 October 2005, 30 March 2007 and 18 March 2009 at places in other States. They had all involved natural deliveries. Her first child had been born in a birthing centre. The second child had been born in hospital. The third and fourth children had involved births at home with no professional clinical support or intervention, except that both had been attended by a support person. By the time of the birth of her twins in October 2011, Ms Kerr was no stranger to homebirthing. The birth of her second child in hospital had involved what appears to have been a bimanual compression that is designed to compress the uterus in order to prevent further haemorrhaging. As I understood the evidence about this particular incident, this had involved an invasive measure without pain relief. Ms Kerr told the Court that this had also taken place without her consent.

Both Mr Kavanagh and Ms Kerr told the Court that Ms Kerr had been significantly traumatised by this event and it was essentially this experience that had led them to decide that their third and fourth children, and then the imminent twins, would be born at home. There is no evidence to suggest that the homebirths of the third and fourth children had involved any specific element of risk.

10.47. Mr Kavanagh is a member of the Australian Defence Force and as a result the family has moved from State to State a number of times. The family moved to Adelaide to premises at Northgate in January 2010. In early 2011 Ms Kerr discovered that she was pregnant.

10.48. Ms Kerr consulted a general practitioner, Dr Moira McCaul, on 11 May 2011. Dr McCaul has a practice in the city. By this stage Ms Kerr had engaged the midwife, Ms Barrett, to care for her. Ms Kerr was 18 weeks pregnant and she indicated to Dr McCaul that she had undergone a check-up with her midwife the previous day and that all had been going well. Ms Kerr indicated that she intended to undergo a homebirth. At this stage it was not known that Ms Kerr was going to have twins. Ms Kerr did not want Dr McCaul to examine her in light of the check-up the day before. It was established during this consultation that Ms Kerr had not undergone the usual scans and blood tests which, at that stage of her pregnancy, was unusual. Ms Kerr herself made a specific request for a morphology scan that is undertaken at around 18 weeks gestation. This scan examines the baby in considerable detail, involving a check of the baby's heart function, palate and limbs and it is designed to check thoroughly whether at that stage there are any potential health issues for the baby. The other request that Ms Kerr made was that she wanted a script for Syntometrine which is a drug administered following delivery to contract the uterus with a view to either preventing or stopping bleeding.

10.49. Dr McCaul gave evidence in the course of the Inquest. She indicated to the Court that she was uncomfortable about certain aspects of this consultation including, but not limited to, the fact that Ms Kerr was undertaking a homebirth and had no connection with any hospital care. What had added to her concern was the fact that she had not been asked to prescribe Syntometrine before and was confused as to why she was being asked for it. Dr McCaul had been under the impression that a homebirth midwife would have access to this substance as part of their emergency kit. The impression that the Court has in respect of this unusual request is that even

by this stage Ms Kerr was locked into the idea that she would undergo a homebirth. Of course, this would be totally in keeping with the fact that Ms Kerr's two previous deliveries had occurred at home, but they had been singleton pregnancies and Ms Kerr at this stage knew nothing of twins.

10.50. Dr McCaul told the Court that Ms Kerr told her that she had experienced a post partum haemorrhage in respect of one of her previous deliveries and that she had found the whole hospital experience very traumatising. She did not share the detail. In the event Dr McCaul decided that she would prescribe the Syntometrine for Ms Kerr, although she was not very happy about it. Dr McCaul explained to me that if Ms Kerr was determined not to book in with a hospital, then on a risk analysis she thought it was better that Ms Kerr have the substance available to her if she was going to go ahead with a homebirth.

10.51. Dr McCaul provided Ms Kerr with a prescription for Syntometrine. The prescription was at no time filled by Ms Kerr.

10.52. Ms Kerr consulted Dr McCaul again on 27 July 2011. In the intervening period since the first consultation in May 2011, Ms Kerr had been hospitalised at the WCH and had also been made aware of the twin pregnancy. In the meantime the results of the tests that Dr McCaul had ordered in May were now available and of course they too revealed the twin pregnancy. At the consultation on 27 July 2011 Dr McCaul told Ms Kerr that she did not think it was safe to deliver twins at home, that the risk was too high, that the risk of complications were high involving most pregnancy complications that one can think of and that at the time of delivery there was also high risk. Ms Kerr indicated to Dr McCaul that she knew all of that and had conversed and discussed the risks with staff at the hospital. Notwithstanding all of this, Ms Kerr indicated that she was still planning to go ahead with the delivery at home.

10.53. As it happened, there was an abnormality in the blood test in respect of liver function and there had been a bout of gastrointestinal disturbance that had led to hospitalisation at the WCH. As a result Dr McCaul wrote a letter of referral to an obstetric physician but it appears that no consultation with that practitioner ever took place. Dr McCaul left Ms Kerr with the recommendation that it would be better to

deliver her twins in a hospital, but Dr McCaul felt that this had no influence on Ms Kerr's mindset.

10.54. Dr McCaul told the Court that she did not regard herself as Ms Kerr's general practitioner having responsibility for antenatal care because Ms Kerr had made it plain that the midwife, who she did not identify by name, was providing that care. In any event Dr McCaul told the Court that she would have declined to take on Ms Kerr's care having regard to Ms Kerr's determination not to follow medical advice. Dr McCaul told the Court that if she had had her time over again, she would not have prescribed Syntometrine especially in the knowledge that since she prescribed it, it had been established that Ms Kerr was carrying twins. The same applies if she had been given to understand at that time that the midwife who might be called upon to administer Syntometrine was unregistered[210].

10.55. I add here that Ms Kerr told the Court that she did not contemplate a midwife administering Syntometrine. Rather, it was to be administered by a paramedic if it came to that.

10.56. Dr McCaul had been placed in a very awkward position by Ms Kerr. The impression one is left with is that Ms Kerr simply wanted to establish the viability of the unborn child, it being believed on the earlier occasion that it was only a singleton pregnancy, and to obtain a supply of Syntometrine in respect of a planned homebirth. There does not appear to have been any other reason why Ms Kerr consulted a medical practitioner at all. One thing is certain and that is Ms Kerr did not follow any of the medical advice that was tendered to her by Dr McCaul. To my mind no criticism attaches to Dr McCaul's conduct. Dr McCaul made a judgment based on her appreciation of risk, not knowing at that time that Ms Kerr was expecting twins. She had been told of a prior post partum haemorrhage that Ms Kerr had experienced and Dr McCaul's intention was to mitigate the risk of that again occurring, this time in the context of a homebirth. It was obvious to Dr McCaul even at the first consultation that Ms Kerr was determined to undergo a homebirth and would not be amenable to engaging with any hospital care or specialist medical care and that in the circumstances it was, on a purely risk analysis basis, better to prescribe Syntometrine than not, particularly if it could be administered by a midwife whom she understood would be present at the homebirth. Furthermore, she wrote a letter of referral to a

specialist, and one of her motivating factors behind that was the hope that the specialist would engage Ms Kerr in a dialogue about the undesirability of undergoing a homebirth, especially with twins. It is difficult to see what more that Dr McCaul could have been expected to do. It is difficult to see how anything that Dr McCaul did could be regarded as inappropriate having regard to the position in which she had been placed by Ms Kerr.

10.57. I indicate here that I intend to recommend that healthcare practitioners be mandated to notify a relevant authority if it comes to their attention that a patient intends to undergo a homebirth which is attended by particular intrinsic risks, such as the homebirthing of twins.

10.58. I have already alluded to the fact that Ms Kerr was hospitalised for a time at the WCH. It was during this period that advice was tendered to her about the risks associated with the homebirth of twins. This information was imparted to Ms Kerr by more than one clinician but most significantly by Dr Puvana Raman who at that time was a second year resident in obstetrics at the WCH. Dr Raman had been requested to speak to Ms Kerr by Dr Harvey to whom I have already referred. I do not need to go into the detail of what Dr Raman told Ms Kerr because, as already indicated, it was obvious from Ms Kerr's own evidence that she was fully aware of the risks involved in delivering twins at home and, in particular, the risk to the second twin. Dr Raman was also informed by Ms Kerr about the traumatic experience that Ms Kerr had sustained in respect of the birth of her second born child and inferred that what Ms Kerr had undergone was a bimanual compression. There was also some discussion between them about whether or not there would be a need for Ms Kerr to undergo an epidural if she were to elect to deliver her twins in hospital. Dr Raman maintained in her evidence before the Court that she did not tell Ms Kerr that a hospital would deem an epidural as mandatory if twins were to be delivered naturally in hospital, although she had said that it would be recommended. It is a fact that an epidural is recommended in natural twin deliveries in case complications are encountered, particularly with the delivery of the second twin, so that pain relief is already on board if painful intervention to extract the second twin is required. A general anaesthetic can also be administered for this purpose if need be. It is difficult to know from the evidence of Dr Raman and Ms Kerr, who were the

[210] Transcript, page 408 (Tully Kavanagh)

only people present at this discussion, what impression Ms Kerr was left with about the desirability, or indeed mandatory nature, of an epidural in the course of a hospital natural delivery of twins. I am satisfied, however, that Dr Raman did not say in terms that an epidural was absolutely mandatory. Ms Kerr maintained in her evidence that if anything may have changed her mind about delivering her twins at home, it would have been some reassurance that there would not be any intervention by way of epidural anaesthesia, or that a Jelco for the delivery of other medication fluids would not be administered[211]. This debate was something of a distraction in that my view of Ms Kerr was that she was intent on undergoing a homebirth in any event. When asked in evidence as to whether what Dr Raman had said in fact had any effect on her at all, Ms Kerr said:

> 'Like I said, it's hard in hindsight. It's likely I would have had a home birth, yes.' [212]

She said at another point that she did not trust the hospital system to keep their hands out of her. The other point that needs to be made about the issue of epidural or other intervention is that the evidence would in any event suggest that an epidural would not necessarily be required in a hospital setting in respect of the delivery of twins. After all, if a woman was to refuse to have an epidural then this could not be forced upon her, regardless of the circumstances.

10.59. There was one other issue as between Dr Raman and Ms Kerr that attracted the Court's attention. That issue concerned what Ms Kerr had allegedly expressed to Dr Raman as far as her attitude towards risk was concerned. Dr Raman alleges that when she explained to Ms Kerr that there was a possibility that the twin might die if Ms Kerr did not come into hospital and if she were to face any of the known possible complications, Ms Kerr said that she did understand that there was a possibility that the twin could die but that she was willing to accept that risk[213]. At another point in her evidence Dr Raman said that Ms Kerr had indicated that she was willing to accept the risk of either one of her twins dying '*as much as she didn't want to*', meaning one assumes that Ms Kerr had indicated that it was not an outcome that she desired[214]. Ms Kerr, in her own evidence, said that she did not believe that she had said what Dr Raman had alleged. She did tell the Court that her mindset was that she

[211] Transcript, pages 438-439 (Tully Kavanagh)
[212] Transcript, page 456 (Tully Kavanagh)
[213] Transcript, page 141 (Tully Kavanagh)
[214] Transcript, page 154 (Tully Kavanagh)

would take full responsibility for every choice that she made[215], but she regarded as disgusting the suggestion that she would view the death of a second twin as 'collateral damage'[216]. I am not certain as to what exactly was said during this conversation about Ms Kerr's attitude to risk. I am not wholly convinced that Ms Kerr put it as bluntly as she did. However, it seems to the Court that the reality was that having regard to Ms Kerr's level of knowledge about risk and of the types of complications that would give rise to risk, she must in her own mind have accepted that there was a possibility that any complication that might occur could result in the death of one of the twins. That said, having observed Ms Kerr giving evidence over some period of time, I would be very surprised if she regarded such an outcome as a strong possibility.

10.60. It appears that underlying Ms Kerr's desire to give birth at home were a number of assumptions that included a resignation on her part that she would need to have an epidural, regardless of whether any complication was experienced and that even if she were to have her twins in hospital naturally, that the delivery of the second twin would inevitably be manually managed and that a time limit would be imposed on the delivery of the second twin[217]. She also appears to have subscribed to the homebirth mantras that continuous CTG monitoring was merely conducive to increasing the likelihood of a caesarean section taking place[218] and that having twins at home was no riskier than having them in hospital[219]. The nub of Ms Kerr's objections to a hospital birth of her twins seems to have been the probability in her mind that a manual removal of the second twin in hospital would be virtually inevitable, coupled with a requirement that an epidural in anticipation of that would also be inevitable. If that impression was genuinely held by Ms Kerr, and I am not entirely certain that it was, there is little evidence to suggest that any person, be it a clinician at a hospital or Ms Barrett, dispelled that notion. In some parts of her evidence Ms Kerr appeared to suggest that she had been open to negotiation about the conditions under which she might be prepared to have her twins in hospital, but that her impression from the conversation with Dr Raman was that nothing was negotiable and even if she had been given some assurance that she would be managed naturally in hospital, come the day she could not be certain that promises to

[215] Transcript, page 73 (Tully Kavanagh)
[216] Transcript, page 73 (Tully Kavanagh) – The expression collateral damage was Ms Kerr's
[217] Transcript, page 95 (Tully Kavanagh)
[218] Transcript, page 80 (Tully Kavanagh)

that effect would be kept. Regardless of all of that, it is my firm opinion that Ms Kerr herself was fixed in her ideas about having a homebirth and that in reality as far as she was concerned little was open to negotiation in any event.

10.61. In a document that Mr Kelly, on behalf of Ms Kerr, submitted to the Court on the day of final addresses in the Tully Kavanagh Inquest, a document that purports to be a further statement from Ms Kerr, Ms Kerr speaks at length about her interactions with Dr Raman at the WCH and suggests that if certain things had occurred differently she may have reconsidered her decision to deliver twins at home. She suggests that the information that was imparted by Dr Raman was incomplete and, if anything, dogmatic in its terms, particularly in relation to an alleged assertion by Dr Raman that an epidural for twin delivery was mandatory[220]. She also suggests that if Dr Harvey himself had spoken to her and had referred her to certain guidelines concerning managing women in distress after a traumatic birth experience, then her own frame of mind may have been open to negotiation, at least that is one interpretation of what Ms Kerr is endeavouring to say within this document. The fact of the matter, however, is that any discussion that Ms Kerr had with clinicians at the WCH about her intention to have a homebirth delivery of twins had arisen purely fortuitously because Ms Kerr was within the hospital for reasons unconnected with her pregnancy or her intended homebirth. There is no reason to suppose that if Ms Kerr had not unexpectedly been hospitalised during her pregnancy, that she would have actively sought out any professional advice about the appropriateness or otherwise of homebirthing in respect of twins. It will be remembered that she consulted Dr McCaul, both before and after her period of hospitalisation at the WCH and there was no hint of any vacillation on Ms Kerr's part about her intent to undergo homebirth of twins. On the contrary, she had at one point in time even gone to the unusual extent of requesting Syntometrine in an anticipation of a homebirth. On the second of those occasions there is no evidence that Ms Kerr in any way endeavoured to engage Dr McCaul in any discussion about the pursuit of alternatives to homebirthing twins.

10.62. Ms Kerr engaged Ms Barrett to assist at the homebirth. She too insisted that Ms Barrett was not assisting in her capacity as a midwife. She understood that Ms

---

[219] Transcript, page 93 (Tully Kavanagh)
[220] Exhibit C40, page 22 (Tully Kavanagh)

Barrett was not registered as a midwife. Ms Kerr told the Court that Ms Barrett's fee was $3,000.

10.63. As to the circumstances of Tully's birth, Ms Kerr told me that on 7 October 2011 she went into labour and started having regular strong contractions at about 10:30am. At that time she, her partner and her children were at home. A birthing pool was set up. Ms Barrett was called and attended at the premises. Ms Kerr believed that she attended about 11:30am.

10.64. The first twin, Ruby, was born while Ms Kerr was in the birthing pool. This took place without complication at about 1:15pm. The placenta for this child would not be delivered until later. While Ms Kerr remained in the birthing pool, Ms Barrett indicated that she would like to check the second twin's heart rate. Apparently there was some difficulty with this having regard to Ms Kerr's position in the pool. One thing that Ms Barrett at this point was able to determine, according to Ms Kerr, was that the second baby's presentation was longitudinal. This is an important observation because if the baby was transverse it might require correction to a longitudinal presentation. When Ms Barrett indicated that she wanted to listen to the baby's heart and attempted to apply the Doppler, some blood loss was detected. Ms Kerr told the Court that she placed herself onto her knees and there was another episode of blood loss which prompted a decision that Ms Kerr should emerge from the pool. Ms Kerr told the Court that she then sat on a couch and that once there Ms Barrett used a Doppler and ascertained that the baby's heart rate was 100 beats per minute. Ms Kerr suggested that the act of her getting out of the pool and sitting on the couch occurred about 20 minutes after the birth of the first child. At about 15 minutes after the birth of Ruby, Ms Kerr went into active labour again and she endeavoured to push in order to give birth. Ms Barrett performed another foetal heart rate at a point approximately 20 to 25 minutes since the birth of Ruby, and the second baby's heart rate was now at 80 beats per minute. Not long after that there was a further heart rate established to be 70 beats per minute. These latter two heart rates are not reassuring. Ms Kerr decided to perform a self vaginal examination and when she did this she passed what she described as a 'huge clot'[221]. This occurred at a point in time 25 to 30 minutes since the birth of Ruby. These times accord with a written description of events made in the WCH clinical record by the midwife, Ms

[221] Transcript, page 85 (Tully Kavanagh)

Judith Coffey, who it is acknowledged must have obtained these times from different hearsay sources. However, the clinical note that she made recorded that Ruby was delivered at 1313 hours which is in approximate accordance with Ms Kerr's estimate and that the clot that Ms Kerr described passing had occurred at 1345 hours. This event therefore occurred, as Ms Kerr estimated, approximately 30 minutes following the birth of Ruby. The passing of the clot was also regarded as an adverse sign. This event was accompanied by Ms Barrett saying words to the effect that '*this isn't okay*'[222]. Ms Barrett then performed a vaginal examination and announced that she could not feel the baby's head but that the other membranes were bulging. As it happens this was a twin pregnancy that involved two sacs. At that point Ms Kerr suggests that Ms Barrett announced that they needed to transfer to hospital.

10.65. According to Ms Coffey, Ms Barrett rang her sometime before 2:00pm to advise her that she was accompanying a woman to the WCH. Ms Coffey would note in the record that Ms Barrett told her that at that point the first twin had been born 30 minutes previously but that the mother was now passing clots per vaginam. She noted that once at hospital the woman was seeking a caesarean section as a preferred option. Ms Kerr's own understanding of what was taking place at the time was that she was experiencing a placental abruption[223]. Indeed, that is an accurate assessment of what was taking place.

10.66. I am not certain of the exact time at which Mr Kavanagh, Ms Kerr and Ms Barrett left the premises at Northgate to head to the WCH in the family vehicle, but it must have been sometime around 1:50pm or 1:55pm. At a point en route not far from the WCH, the membranes relating to Tully ruptured. The vehicle was pulled over to the side of the road. I do not need to go into unnecessary detail except to state that Tully was born there at an approximate time of 2:20pm to 2:25pm. We know that this was over an hour since the first twin had been born and over 30 minute since Ms Kerr had experienced the passing of the large blood clot, an event that had been accompanied by the non-reassuring heart rates established by way of Ms Barrett's Doppler.

10.67. The arrival at the WCH occurred within a few minutes of the birth of Tully.

[222] Transcript, page 85 (Tully Kavanagh)
[223] Transcript, page 87 (Tully Kavanagh)

10.68. Tully was already unresponsive as I have already indicated. I do not need to describe the efforts of resuscitation and his clinical course over the next 2 days.

10.69. The placentas in respect of both twins were delivered at the same time as Tully. This provides an indication that there had been, sometime prior to the delivery, a placental separation in respect of Tully.

10.70. At no time between the birth of Ruby and the birth of Tully did Ms Barrett attempt, or suggest to Ms Kerr that she should attempt, an artificial rupturing of the membranes relating to Tully. No other intervention that might have stimulated labour and birth in relation to Tully was offered. Tully's birth and death appears to represent a textbook but poignant example of how risks to the second delivered child can manifest themselves in an unhappy outcome.

10.71. It is worthy of note that Professor Pepperell gave his oral evidence in the Inquests of Tate Spencer-Koch and Jahli Hobbs at a time prior to the birth and death of Tully Kavanagh and that in his oral evidence he dealt generally with the risks associated with twin births and, in particular, risk to the second born twin. He gave that evidence in a context in which the death of the twin in Western Australia had been regarded as relevant in respect of the issues in the Tate Spencer-Koch and Jahli Hobbs Inquest. Professor Pepperell there spoke of the possible effect of delay following the birth of the first twin and explained that in order to manage the risks of placental separation associated with that delay, a syntocinon infusion would be administered to stimulate uterine contractions if after 10 minutes labour was not established. That of course assumes that the deliveries were taking place in a hospital. He also spoke of the presence of an epidural anaesthetic in case one needed to perform internal manipulation. He suggested that, as already indicated, the second twin should ideally be out within 20 minutes of the first. He was asked by counsel assisting what the appropriate course of action would be where, in a homebirth, that period of 20 minutes was exceeded. Professor Pepperell suggested that delivery should be expedited and that would involve rupturing the membranes and stimulating contractions, but that might not be something that midwives would wish to do when the presenting part of the child is high, but is something that has to be done if there is a problem.

10.72. Following Tully's birth and death Professor Pepperell provided a further written report concerning that matter[224]. As I have already indicated, in that report he expressed the view that a placental abruption had occurred prior to delivery. Professor Pepperell appears to have formed an impression that the vaginal bleeding was noted at 2:00pm. On that basis he has suggested that the premature separation of the placenta had occurred prior to or at about 2pm. However, it is more likely that this episode, together with the non-reassuring heart rates, were evidenced at about 1:45pm. I am not certain if the discrepancy particularly matters. What is certain is that there was in fact a placental separation and this appears to be universally accepted. As well, it occurred probably as the result of delay between the delivery of Ruby and the delivery of Tully.

10.73. Professor Pepperell was asked to comment on what the management of Ms Kerr's labour and delivery would have been in a hospital environment and whether that would have made any difference to the outcome regarding Tully. To this Professor Pepperell suggested that one measure would have involved a syntocinon infusion commenced 10 minutes after the first twin was born. However, he recognises that this may not have been acceptable to a person in the position of Ms Kerr, even in hospital. That being the case, when her vaginal bleeding was noted, an artificial rupture of the membranes would then have been performed and delivery expedited. Professor Pepperell offers the opinion that it is likely that this delivery would have been spontaneous and quickly achieved, although forceps delivery may have been necessary. Professor Pepperell goes on to say that if a syntocinon infusion had been administered, it is most unlikely that premature placental separation or abruption would have occurred as delivery would have been completed at an earlier time. He suggested that if an artificial rupture of the membranes had been undertaken, say at 2:00pm, it is highly likely that Tully would have been delivered within the next 5 minutes and that his condition at birth would almost certainly have been better than it was at 2:20pm and he probably would have survived[225].

10.74. As to the question of whether an epidural would have been absolutely necessary in a hospital, Professor Pepperell suggested that delivery in hospital without the use of an epidural was certainly an option, but that the mother would probably need to accept that a vaginal examination would probably be necessary if problems did occur. Ms

[224] Exhibit C9a (Tully Kavanagh)

Kerr told the Court that she had consented to a vaginal examination by Ms Barrett. It was then that Ms Barrett had established that the membranes relating to Tully were bulging at that point in time. In my view if Ms Kerr had been in a hospital environment, and even if she was electing to have no intervention by way of epidural or infusion, it is almost inconceivable that she would not have consented to an examination if it was said to be necessary in order to save the life of her unborn baby.

10.75. The evidence is not clear as to why it was that no attempt was made at the home of Ms Kerr to expedite the delivery of the second baby, Tully. It will be observed that Tully was born more than an hour after the first twin. The spontaneous rupture of the membranes relating to Tully occurred en route from the parents' home to the WCH. According to Ms Kerr this occurred at the top of Melbourne Street at North Adelaide. Ms Kerr stated that the car pulled into a laneway and it was there that her membranes ruptured. This resulted in a cord prolapse which prompted Ms Barrett to suggest that Ms Kerr needed to deliver the baby very quickly. Ms Kerr said that she then started pushing and the baby was then delivered with the placentas. From that description it is plain that the rupture of the membranes was followed by a rapid delivery of the child and the placentas. Ms Kerr gave evidence on two occasions. On the first of those occasions she told the Court that following the birth of the first twin Ms Barrett had established that Tully was in a longitudinal position. A vaginal examination conducted by Ms Barrett had prompted Ms Barrett to indicate that the membranes were bulging. In evidence that she gave on a later occasion, Ms Kerr stated that the placenta had been covering her cervix and, because of this, it would have been inappropriate for the membranes to be ruptured artificially at home. Ms Kerr told the Court that she had spoken to Ms Barrett since these events and Ms Barrett had indicated that it would have been dangerous to have done something like that. Professor Pepperell in his report has suggested that this may have been something that a midwife would not have been keen to do in the home environment. This is not to say, however, that if Ms Kerr had been in a hospital that this could not have been done safely and effectively.

---

[225] Exhibit C9a, paragraph 4.11 (Tully Kavanagh)

10.76. During the course of Tully Kavanagh's Inquest I asked Ms Kerr the following question and she gave the following answer:

> 'Q. In the light of your experience and just going on from what you just said a moment ago, would you say the same thing to other prospective mothers who are contemplating having their twins at home.
>
> A. I would say to them that when you are looking at the risks, one looks like a really small number, but somebody has to be the one and if you are the one, it's really final and you can't do it over, and I was the one.' [226]

10.77. <u>The incident in Western Australia</u>

To my mind this was a relevant matter for the Court to consider. As will be seen, this event occurred in circumstances very similar to those involved in the death of Tully Kavanagh later in 2011. To that extent it is pertinent for the Court to have regard to the fact that Tully Kavanagh's death in South Australia, in respect of which I have conducted an Inquest, is not an isolated event. The Western Australian matter is also relevant in the consideration of any recommendation that the Court might make in order to prevent a death similar to Tully Kavanagh's occurring in the future. It was also relevant to enquire whether Ms Lisa Barrett, following her voluntary deregistration at the beginning of 2011, was in fact continuing to practice as a midwife and whether in the practice of midwifery she was conducting her practice with reference to idiosyncratic views as to risk.

10.78. It is clear that the mother in Western Australia was keen to avoid giving birth to twins in a hospital. According to her statement to the Western Australian police[227], she did not wish to have medical intervention at birth. Her partner indicated in his statement[228] that the relevant hospital in Perth with which they had contact, had indicated that they wanted the mother to have an elective caesarean section. Furthermore, a Community Midwife Program in Western Australia was not prepared to assist in a homebirth as they considered that the delivery of twins in water at home was high risk. That attitude is in keeping with the attitude of relevant authorities in South Australia.

10.79. In the event, the homebirth of twins which took place in Western Australia on 3 July 2011 involved the first twin being born at 2:37am and the second twin being born 38

[226] Transcript, page 444
[227] Exhibit C57a
[228] Exhibit C57b

minutes later at 3:15am. The second twin was born simultaneously with its placenta and was born unresponsive and later died. There is reason to believe that a placental separation had occurred prior to the delivery of the second twin and that this separation had occurred in the period between the two births. This appears to have been an almost identical scenario to the incident involving Tully Kavanagh that would occur later in 2011.

10.80. It is apparent that Ms Barrett had indicated to the Western Australian couple that although she was qualified as a midwife and had been registered as such in the past, she was no longer registered at the time of these events. It is also evident that there was an arrangement in place that she would charge $3,000 for her services plus the airfare from Adelaide to Perth. It is not known to this Court precisely what intrapartum services were provided by Ms Barrett, except that it is clear that she used a Doppler to detect and measure the heartbeats of the two unborn infants and then that of the second infant once the first had been delivered. According to the statement of the father, Ms Barrett and another assistant had identified what had appeared at first to be a clot that was presenting at the same time as the second twin's head, but which turned out to be the placenta and that they tendered advice to the mother to hurriedly push. CPR was also administered by them to the unresponsive baby. Ms Barrett, in her own statement to police[229], stated that she had checked the heartbeat in respect of the second baby. She stated that she had identified this just prior to the second baby being born, that she had seen his placenta and knew that this was not a good sign as the placenta had come away from the womb and as a result the baby was not getting oxygen. She stated that she had administered CPR after the unresponsive second baby was born.

10.81. According to the mother's statement to police, the refusal on the part of the WA Community Midwife Program's to assist her in a homebirth had prompted the mother to attempt to find a private midwife in Western Australia to assist in her homebirth, but that her searches within WA had been unsuccessful. Ultimately, the mother had identified Ms Lisa Barrett via the internet.

[229] Exhibit C57c

11. The nature of Ms Lisa Barrett's practice since early 2011

11.1. As indicated earlier, Ms Barrett relinquished her registration as a midwife at the beginning of 2011. She maintains that since that time she was practising as a birth advocate. She attended the birth in Western Australia in July 2011 and of Tully Kavanagh in October 2011.

11.2. I have indicated in the previous section something of the nature of Ms Barrett's activities in respect of the birth in Western Australia. As far as the birth of Tully Kavanagh is concerned, it will be recalled that on more than one occasion Ms Barrett used a Doppler to check the foetal heart rate and no doubt took into account the significance of those measurements in assessing what needed to transpire in respect to the delivery of the second child. She performed an examination of Ms Kerr following the delivery of the first baby that had led her to the stated conclusion that the second baby was presenting longitudinally. No doubt Ms Barrett appreciated the significance of this, having regard to the fact that a transverse presentation might complicate the delivery of the second twin and therefore require rectification. In addition to that examination, according to Ms Kerr Ms Barrett performed a vaginal examination at least to the extent of establishing that the membranes relating to Tully Kavanagh were bulging and presumably intact. No doubt Ms Barrett had regard to the significance of that. It will also be remembered that when Ms Kerr passed what she described as a huge blood clot, Ms Barrett stated that she regarded that as a non reassuring development, as a result of which she suggested that transfer to the WCH was then indicated. Ms Barrett made the phone call to Ms Coffey at the WCH and engaged in conversation with Ms Coffey that involved informing Ms Coffey of the clinical observations that had been made to that point in time.

11.3. Both the family in Western Australia and Ms Kerr and Mr Kavanagh all had an appreciation of the fact that Ms Barrett was a qualified midwife, but that she was no longer registered. In her evidence before the Court, Ms Barrett denied the suggestion that in reality since the beginning of 2011 she had continued to practice as a midwife. She described her occupation as that of a birthing advocate and as such she had no clinical duties because a birthing advocate is not a clinician[230]. At that time, which was at a time prior to Tully Kavanagh's birth and death, Ms Barrett testified that she

[230] Transcript, page 564

did not normally perform vaginal examinations[231]. According to Ms Kerr, Ms Barrett came to perform a vaginal examination prior to Tully Kavanagh's birth.

11.4. Ms Barrett suggested that as a birth advocate she could do anything that a member of the general public could do and no more[232]. She suggested that anyone can listen to a baby's heartbeat with a Doppler, a device that can be purchased by any member of the public. She did not regard listening to a Doppler in order to establish heartbeat and rate as a clinical skill of a midwife[233]. When asked as to how a lay person could interpret what was being heard using a Doppler, Ms Barrett said:

> 'I have no idea.' [234]

She said that anyone is capable of counting a baby's heartbeat and as long as they can count over 100 they would be fine. She suggested that most people would be '*slightly aware*' of what a normal heartbeat is, and that such information could be obtained via Google.

11.5. In the context of the intrapartum stages of a pregnancy, Ms Barrett said that as a birth advocate she could not manage any of the stages of labour that a midwife could. When asked as to the nature of any action she would take if there was a complication at a homebirth, Ms Barrett suggested that because she was qualified she could do whatever needed to be done in an emergency. For example, in a shoulder dystocia she would do the same as anybody in the Court would try to do and provide emergency assistance to the best of her ability. She suggested that what she would do in that situation would be no different to what anybody else might do. In this context Ms Barrett would not be drawn on whether the emergency assistance she might provide is that within the skill set of a registered midwife. She did say that she would be able to use those skills but only in an emergency, but she then went on to say in the same answer, she would do '*like any general member of the public would do to make the best of what we had to deal with*'[235].

11.6. Ms Barrett specifically denied the suggestion that was put to her that, in reality, she was attending homebirths in her capacity as an unregistered midwife. She rejected that suggestion. She rejected the suggestion that she conducted the intrinsic duties

[231] Transcript, page 564
[232] Transcript, page 565
[233] Transcript, page 565
[234] Transcript, page 565
[235] Transcript, page 570

and responsibilities of a midwife in homebirth situations. Specifically, Ms Barrett rejected the suggestion that her presence at a homebirth, and her preparedness to conduct an emergency measure if need be, was part of the intrinsic duties and responsibilities that a midwife performs[236].

11.7. In her evidence before the Court, Dr Hannah Dahlen spoke of the role of doulas or birth advocates in homebirths. She suggested that doulas have become the new midwife and spoke of unqualified doulas overstepping their roles and providing services that Dr Dahlen would regard as clinical skills. She cited as examples vaginal examinations and the use of Dopplers to listen to a baby's heart rate[237].

11.8. Ms Coffey, the senior midwife at the WCH, in her evidence also spoke of the role of doulas who do not have a clinical role. When asked as to whether a doula would appropriately perform a vaginal examination, Ms Coffey said that she believed that such a measure was within the scope of the practice of a registered midwife[238]. She suggested that unless a doula had some other underlying curriculum or experience, she would not anticipate that a doula would be able to interpret what was felt in a vaginal examination. When asked as to whether a doula would be able to perform a heart rate examination, Ms Coffey said that anyone can auscultate a foetal heart rate, but the point was that one has to consider interpreting how the rate fits with the gestation of the woman, the clinical scenario, what is happening with the woman at the time and how relevant the rate might be against that clinical background. The rate on its own is not clinically significant and anyone who observes a person performing a heart rate could probably replicate it, but they would not have the underlying training to interpret it[239]. She suggested that determining the lie of a second undelivered twin would not be a skill that someone would be able to learn from observation or experience whereas a midwife performs that task routinely throughout the course of labour. She did not understand that this was a process that a doula would normally undertake. Ms Coffey suggested also that a doula would not be able to identify an abruption or some other complication that might compromise the health and wellbeing of an undelivered twin. She suggested that a doula might recognise an unusual amount of bleeding if they had seen this occur at another birth and that this might alert them to some difficulty, but midwives are trained to

[236] Transcript, page 572
[237] Transcript, page 705
[238] Transcript, page 327 (Tully Kavanagh)

recognise what that was. She said a doula could not administer drugs such as syntocinon because it would involve an assessment of the necessity to give it in the first place.

11.9. It is obvious to the Court that in respect of the birth in Western Australia and of Tully Kavanagh, Ms Barrett was performing the clinical duties and responsibilities of a midwife and was not merely present as a birth advocate. Even if she had not been called upon to perform any of the usual tasks that a midwife performs in the intrapartum aspect of a birth, she was certainly there and on hand to deal with any complication or emergency that might have arisen and was prepared to take the necessary action and make the necessary decisions in that regard. Her mere presence with those intentions is clearly part and parcel of the clinical duties and responsibilities of a midwife.

11.10. To my mind, Ms Barrett's evidence that she was a mere birth advocate, not performing the duties and responsibilities of a midwife, has to be rejected.

12. Conclusions - Tate Spencer-Koch

12.1. Tate Spencer-Koch

The cause of death of Tate Spencer-Koch was intrapartum hypoxia.

12.2. The intrapartum hypoxia that was the cause of Tate's death was caused by a prolonged period of obstructed delivery that was the result of shoulder dystocia experienced during her birth.

12.3. In the period immediately before Tate's delivery she was a healthy unborn infant and there is no reason to believe that had a complication with her delivery not occurred, she would not have been born in a healthy state. As it happened, Tate was a macrosomic baby with a birth weight of 4790g. That she was macrosomic was, in advance of her birth, understood to have been the case. The midwife who was present at her birth, Ms Lisa Barrett, believed in advance of her delivery that Tate was in excess of 10 pounds (4536g).

12.4. The fact that Tate was believed to be macrosomic in advance of her delivery gave rise to an enhanced risk that there may be an obstructed delivery by way of shoulder dystocia.

---

[239] Transcript, page 328 (Tully Kavanagh)

12.5. Tate's death may have been prevented if another trained individual had been present at her birth and who could have assisted in the administration of a McRoberts manoeuvre that required the application of suprapubic pressure. I find that the McRoberts manoeuvre was not applied in an optimal manner due to the limitations of the assistance that was present.

12.6. I find that if Tate's labour and delivery had occurred in a hospital, there would have been a greater level of assistance to properly manage the complication of shoulder dystocia and that on a balance of probabilities the delay in Tate's delivery caused by the resulting obstruction would have been minimised. Her death may therefore have been prevented.

12.7. I find that as a matter of certainty that if due to the perceived risk of obstructed delivery Ms Spencer had undergone an elective caesarean section, Tate would have been born in a healthy state.

12.8. Jahli Hobbs

The cause of death of Jahli Hobbs was intrapartum hypoxia.

12.9. The intrapartum hypoxia in Jahli's case was caused by a placental separation that occurred at some point during the labour and delivery process.

12.10. Jahli was immediately prior to her labour and delivery a healthy unborn infant.

12.11. It was known in advance of Jahli's delivery, and in particular by the midwife Ms Lisa Barrett, that Jahli was in a breech position within the uterus.

12.12. Jahli was in fact delivered in the breech position, involving a complete breech presentation.

12.13. During Jahli's labour and delivery there were no clinical signs of distress on the part of Jahli or of any other complication. The last recorded foetal heart rate was 120 beats per minute. This was established some 30 minutes prior to her completed delivery. This recorded heart rate was achieved by way of the administration of a Doppler machine. I find that there was thereafter inadequate monitoring of Jahli's heartbeat.

12.14. Jahli's death may have been prevented if a more rapid identification of foetal distress, such as would have been achievable by way of continuous monitoring by

way of a CTG, had taken place. If foetal distress had been thereby detected, a breech extraction may well have been successfully attempted.

12.15. If Jahli's mother, Ms Naomi Hughes, had undergone a natural childbirth in hospital it is likely that she would have been the subject of continuous monitoring and that foetal distress may well have been detected at an earlier point in time, thereby hastening Jahli's delivery.

12.16. I find as a matter of certainty that if Ms Hughes had undergone a caesarean section, Jahli would have been born in a healthy state.

12.17. Tully Kavanagh

The cause of death of Tully Kavanagh was hypoxic ischaemic encephalopathy.

12.18. The hypoxic ischaemic encephalopathy was the result of an intrapartum hypoxic event that was due to a placental separation during the labour and delivery process.

12.19. Tully was immediately prior to his labour and delivery a healthy unborn infant.

12.20. There are clearly identified risks associated with the delivery of twins, and in particular to the second born of twins.

12.21. Tully was the second born of twins. Tully was born en route to the Women's and Children's Hospital from the home of his parents. The first twin, Ruby, had been born at that home. There was a delay in excess of one hour between the delivery of Ruby and the delivery of Tully. I find that this delay was a substantial contributing factor in Tully's death. During that period, a placental separation occurred, thereby giving rise to the fatal hypoxic event.

12.22. The death of Tully Kavanagh would probably have been prevented if the labour and delivery had occurred in a hospital. Foetal distress was detected by Ms Lisa Barrett by way of the use of a Doppler, and by reason of clinical signs as evidenced by Tully's mother's blood loss. Tully's delivery could have been expedited and accelerated by an artificial rupture of the membranes of the sac containing him, thereby stimulating and hastening his delivery. I am not certain that this could appropriately have been undertaken within Tully's parents' home, but it is likely that it would have successfully been undertaken in a hospital.

12.23. It can be said with certainty that if Tully had been born by way of elective caesarean section, Tully would have survived.

13. Recommendations

13.1. Pursuant to Section 25(2) of the Coroners Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent or reduce the likelihood of a recurrence of an event similar to the event that was the subject of the Inquest.

13.2. As seen from the terms of the Court's power to make recommendations, the emphasis is placed upon prevention of adverse events in the future. A proper interpretation of the power to make recommendations is that it does not need to be demonstrated that the recommended measure would have prevented the death that is the subject of the Inquest. Rather, the Court's recommendation is designed to possibly prevent, or reduce the likelihood of, a recurrence of an event similar to the death that was the subject of the Inquest. In other words, it does not have to be shown that the recommendation would inevitably prevent a recurrence of the exact same set of circumstances that arose and that were the subject of the Inquest. This is due in part to the fact that the circumstances of the particular event that is the subject of a coronial Inquest can never wholly be reproduced in all of its facets.

13.3. I turn firstly to the question of the registration of privately practising midwives, having regard to the introduction of the National Law in 2010 and taking into account Ms Barrett's ceasing to continue her registration as a midwife. The recommendation that I intend to make in relation to this particular subject matter would ensure that midwives who are tasked with the care of a woman who will undergo the delivery of babies that are attended by an enhanced risk are under an obligation to ensure that the requirements outlined in the relevant Guidelines and codes are adhered to. This in turn would hopefully ensure that independent and impartial professional advice is provided to the woman contemplating a homebirth involving enhanced risk.

13.4. In his final submission in the Spencer-Koch/Hobbs Inquests that concluded in September 2011, Mr Riches, counsel for the South Australian Department of Health and Ageing, informed the Court that with the introduction of the national reforms that I have described, SA Health took a leading role in raising the issue of private midwifery regulations to the Nursing and Midwifery Board of Australia in their role

as the peak regulatory body for midwives. Mr Riches referred to the statement of Ms Copeland and the annexures that were provided to the Inquest. He advised that SA Health is now satisfied with the work undertaken over the last 12 months and that it now believes there is a comprehensive and consistent framework for the regulation of private midwives who provided for women having planned homebirths. That is possibly so in relation to registered midwives but the fact remains that as matters currently stand, unregistered practising midwives providing care for women having planned homebirths are essentially beyond the reach of the law. Mr Riches agreed that there was no legislative prohibition or sanction prohibiting an unregistered person from providing midwifery services, provided the person does not assert that they are registered. Mr Riches drew my attention to a new legislative scheme in South Australia that involves amendments to the Health and Community Services Complaints Act 2004 that deal with unregistered health practitioners in general, but which are not specifically related to midwives or the homebirthing industry. As will be seen, this legislation, and the subordinate legislation made under it, still does not prohibit unregistered health practitioners from practising.

13.5. Mr Riches drew the Court's attention to the SA Health and Community Services Complaints Act 2004 (the principal Act). In particular my attention was drawn to certain amendments to that Act that have been enacted by virtue of the Health and Community Services Complaints (Miscellaneous) Amendment Act 2011 (the Amendment Act). The provisions of the Amendment Act and the amendments that it makes to the principal Act have come into effect with the exception of section 10 of the Amendment Act which would insert a new Part 6 Division 5 of the principal Act. The purported effect of Part 6 Division 5 as it would exist when it comes into operation, is to provide a code of conduct in respect of unregistered health practitioners and to proscribe certain measures and action that might be taken in the event of a breach of the code relative to the particular profession, or where there has been a finding of guilt in respect of a prescribed offence against the principal Act.

13.6. As I understand the suggestion, the new Part 6 Division5 of the principal Act is intended to overcome the lacuna that I have already identified within the National Law that sees unregistered privately practising midwives being able to circumvent the intrinsic requirements of the practice of midwifery, including the need for insurance for intrapartum care or in the alternative, compliance with certain requirements in the absence of such insurance. Mr Riches drew my attention to the

second reading in respect of the Amendment Bill in the House of Assembly wherein the Minister for Health stated:

> 'Unregistered health practitioners include a range of complementary/alternative practitioners, such as naturopaths and homeopaths, as well as mainstream health practitioners, such as social workers or speech therapists and any other health practitioner who does not need to be statutorily registered in order to practise their occupation. The vast majority of these practitioners are entirely conscientious in the way they do their jobs.
>
> Some however, and particularly those who came to the attention of the Social Development Committee, have used their positions to exploit people. Some claim to be able to cure cancer while others resort to treatment that is essentially nothing more than sexual voyeurism. Some don't offer receipts and request that all payments be made in cash and others won't give refunds to families when a course of treatment is paid for, but the patient dies part way through the treatment.' [240]

13.7. Although the new Part 6 Division 5 of the principal Act is headed 'Action against unregistered health practitioners', nowhere within the text of the Division is the expression 'unregistered health practitioners' utilised. Rather, the Division speaks in terms of the regulation of health service providers who provide 'health services that fall outside the ambit of operation of a registration authority'[241]. The relevant registration authority, insofar as it applies to midwives, is the National Board pursuant to section 31 of the National Law, namely the Nursing and Midwifery Board of Australia. The difficulty with this provision having operation in relation to unregistered midwives practising midwifery and providing midwifery services is that the health services that they would be providing do not fall outside the ambit of operation of the Nursing and Midwifery Board of Australia. Indeed, the provision of midwifery services, regardless of whether the midwife is registered or not, falls within the ambit of operation of the Nursing and Midwifery Board of Australia to the extent that this entity has responsibility for the registration of suitably qualified persons as registered midwives. I am therefore not certain that the legislation as currently worded would attract unregistered practising midwives to its field of operation. Thus, the new Part 6 Division 5 would not have any effect in relation to the practice of midwifery by unregistered midwives. This would mean that the code of conduct relating to the provision of the health service of midwifery would not be imposable upon unregistered midwives. It seems to the Court that what Part 6

[240] Hansard, House of Assembly, Wednesday 27 October 2010 , page 1786

Division 5 is designed to regulate are the activities of fringe health services that are not regulated by the National Law.

13.8. In any event, regardless of the scope of operation of this new intended legislation, it is the opinion of the Court that the practice of midwifery should be permissible only in the case of midwives registered under the National Law and that it ought to be regarded as an offence, punishable by law, for midwives to practice midwifery without registration with the Nursing and Midwifery Board of Australia pursuant to the National Law.

13.9. I refer to repealed New South Wales legislation in this context, namely the repealed Division 2 of Part 2A of the Public Health Act (NSW) 1991. Division 2 of Part 2A of the NSW Public Health Act 1991, among other things, established a regime of conduct in respect of what was described within the legislation as 'restricted birthing practices'. A restricted birthing practice was defined within the legislation as 'the care of a pregnant woman involving the management of the 3 stages of labour and childbirth'. This definition would clearly have embraced labour and childbirth regardless of venue and would therefore have operated in respect of homebirths. Section 10AG of the NSW Public Health Act 1991 as it then existed, rendered it an offence for a person to engage in a restricted birthing practice unless the person was a registered midwife, a registered medical practitioner or a medical, nursing or midwifery student acting under appropriate supervision. There was an exception to this requirement in cases where the assistance to a woman giving birth to a child was rendered in an emergency. Penalties including fines and/or imprisonment were proscribed in relation to contraventions of this provision. This legislation appears to have been repealed when, after the enactment of the uniform National Law, the NSW Public Health Act 1991 was amended by the insertion of section 10AM that allows for the prescription of codes of conduct in respect of health practitioners who are not required to be registered under the National Law.

13.10. In any event, I intend to recommend that as well as bringing into operation Part 6 Division 5 of the South Australian Health and Community Services Complaints Act, legislation should be enacted to render it an offence for a person who is not a registered midwife or registered medical practitioner to engage in the delivery of midwifery services, regardless of the venue. That would then have the effect of bringing privately practising midwives who deliver intrapartum services at

[241] Section 56A(1)

homebirths within the purview of section 284 of the National Law, thereby securing compliance with the requirements that enliven the exemption to insurance in respect of intrapartum care in homebirths.

13.11. There is also a need in my opinion for the public health authority in South Australia to be made aware in advance of a person's intention to undergo a homebirth that is attended by enhanced risk. There ought to be a duty imposed on midwives in particular to report any such intention to SA Health.

13.12. I am aware of the contention that the strict regulation of privately practising midwives in the homebirth environment might have the effect of driving those women who are intent on undergoing a homebirth underground as it were, thereby leaving them without professional assistance or support. I have given careful consideration to this issue. It is difficult to gauge the legitimacy of such a contention when regard is had to the fact that the contention is mostly supported by evidence that is anecdotal in nature and, secondly, when it is possible that one of the reasons that women are prepared to undergo homebirths that are attended by enhanced risk, such as the homebirth of twins, is the availability of unregistered privately practising midwives who are not regulated by the regime imposed under section 284 of the National Law. The other point that ought to be made is that one suspects that those people who would choose to freebirth in relation to pregnancies associated with risk probably do so without full knowledge and understanding of the potential consequences. In this regard I refer to the commonly held misconception that appears to be promoted by those who advocate homebirthing in risky circumstances, that adverse outcomes that occur in a homebirth would inevitably have occurred in a hospital. There is also the misconception that twin births in hospital will inevitably involve the second twin, to borrow the expression of Dr Hannah Dahlen, being 'whipped out within about 3 minutes'[242]. There are other misconceptions that these Inquests have identified.

13.13. The evidence in this Inquest has demonstrated that there is a need for education of the general public in respect of the risks associated with certain types of childbirth within the home and in order to dispel what appear to be widely held myths concerning the circumstances in which these births are managed in hospital.

[242] Transcript, page 661

13.14. I make the following recommendations:

Directed to the Minister for Health

1) That the Minister bring into operation section 10 of the Health and Community Services Complaints (Miscellaneous) Amendment Act 2011 which would insert within the principal Act a new Part 6 Division 5, and in addition introduce legislation that would render it an offence for a person to engage in the practice of midwifery, including its practice in respect of the management of the three stages of labour, without being a midwife or a medical practitioner registered pursuant to the National Law;

2) That the Minister consider introducing legislation that would impose a duty on any person providing a health service, including midwifery services, to report to the South Australian Department of Health and Ageing the intention of any person under his or her care to undergo a homebirth in respect of deliveries that are attended by an enhanced risk of complication, for example but not limited to, homebirths involving the birth of twins or known breech birth at term;

Directed to the CEO of the South Australian Department of Health and Ageing

3) That upon notification of a person's intention to undergo a homebirth attended by an enhanced risk, that the Chief Executive Officer of the South Australian Department of Health and Ageing cause advice to be tendered to that person from a senior consultant obstetrician as to the desirability or otherwise, in the circumstances of the particular case, for a homebirth to be conducted;

Directed to the Minister for Health and the CEO of the South Australian Department of Health and Ageing

4) That consideration be given to the establishment of a position known as the Supervisor of Midwives based upon the position described as such in the United Kingdom;

5) That consideration be given to the establishment of alternative birthing centres as contemplated by the Australian Medical Association (South Australian Branch). I here refer to the evidence of Dr Lavender at T741-743 in the Inquests re Tate Spencer-Koch and Jahli Hobbs.

Directed to the CEO of the South Australian Department of Health and Ageing

6) That education in the form of written advice distributed generally to the public be provided in respect of the following matters concerning homebirths:

   a) The risks associated with certain types of birth, including but not limited to, twin births and breech births;

   b) How those risks might be affected by a choice to undergo such deliveries within the individual's home;

   c) To dispel the notion that adverse outcomes in homebirthing cases would inevitably have occurred in a hospital setting in any event;

   d) To dispel the notion that the second born of twins would inevitably be the subject of immediate intervention following the delivery of the first twin;

   e) As to the need and desirability of epidural pain relief and whether such is mandatory or not in certain birthing environments within a hospital;

7) That the revised policy for Planned Birth at Home in South Australia be brought into operation, with an addition that current risk factors for shoulder dystocia be specifically identified;

8) That in any case where it comes to the attention of clinicians in a public hospital that a patient intends to undergo a homebirth that is attended by an enhanced risk of complication, that appropriate advice be tendered to that person by a senior consultant obstetrician.

Key Words: Homebirth; Midwife; Birth Accident; Pregnancy & Birthing

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 6th day of June, 2012.

Deputy State Coroner