CORONERS ACT, 2003

SOUTH *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide and Port Lincoln in the State of South Australia, on the 2nd, 8th, 9th, 10th, 13th, 14th, 27th, 28th and 30th days of May 2019 and the 4th day of August 2020, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Laura Angela Willmett.

The said Court finds that Laura Angela Willmett aged 2 days, late of 7 Dunne Drive, Sceale Bay, South Australia died at the Flinders Medical Centre, Flinders Drive, Bedford Park, South Australia on the 16th day of August 2016 as a result of hypoxic ischaemic encephalopathy secondary to intrapartum hypoxia. The said Court finds that the circumstances of her death were as follows:

1. Introduction and cause of death

1.1. This is a complex matter involving the death of a newborn who had been delivered in a country hospital. The baby girl was delivered by way of an emergency caesarean section. The birth took place in the early hours of a Sunday morning at the Ceduna Hospital. She died two days later at the Flinders Medical Centre to which she had been transferred. The child's parents, represented at the inquest by Ms O'Connor SC, are highly critical of the manner in which certain facets of the mother's pregnancy and eventual confinement were handled. Strident criticism of those clinicians handling the mother's labour and delivery has also been levelled, and levelled in respect of just about every step in the process. Not only have the competence of these individuals been questioned, serious allegations against their integrity have also been made.

1.2. Laura Angela Willmett died at the Flinders Medical Centre (FMC) on Tuesday 16 August 2016. She had been born by way of emergency caesarean section at 1:10am Sunday 14 August 2016 at the Ceduna Hospital. This had not been the baby's mother's planned mode of delivery. Laura was originally intended to be delivered by way of a natural vaginal birth.

1.3. Prior to her delivery Laura was shown to have been in foetal distress. Following the baby's delivery by caesarean section she was in a poor condition. Resuscitation that was performed along standard lines following her delivery did not result in spontaneous respirations until about 60 minutes after her birth.

1.4. Laura's mother, Mrs Jennifer Willmett, was at term when Laura was born. Her due date was calculated to have been Saturday 13 August 2016 which was the day before she was born.

1.5. Following her delivery, and after a period of treatment at the Ceduna Hospital, Laura was transferred to the FMC, arriving there at about 1:45pm on 14 August. By that time Laura had already begun to experience seizures and her condition was still very poor. MRI brain assessments revealed a profound degree of hypoxic brain damage, damage that had been sustained in utero before birth. Following discussion with Laura's parents, further care was withdrawn with their consent. Laura was about 44 hours of age at the time of her death.

1.6. The emergency caesarean section that was performed in order to facilitate Laura's birth revealed that her mother had experienced a uterine rupture. In a moment I will return to that aspect of the matter, but it is pertinent here to discuss the evidence relating to the anatomical cause of Laura's death.

1.7. A post mortem examination of Laura was not conducted. Instead, a pathology review based upon the clinical circumstances surrounding Laura's birth and her treatment at the Ceduna Hospital and at the FMC was sought from medical experts at Forensic Science South Australia (FSSA). Two pathology review reports were prepared. The first report dated 22 March 2019 was furnished by Dr Iain McIntyre in conjunction with Dr John Gilbert who is a forensic pathologist at FSSA[1]. The cause of death as described within that report is hypoxic ischaemic encephalopathy complicating emergency

[1] Exhibit C1a

caesarean delivery following uterine rupture. Hypoxic ischaemic encephalopathy (HIE) is the pathological manifestation of brain hypoxia and ischaemia (deprivation of oxygen and blood supply to the brain). The report records the circumstances of Laura's birth and her mother's labour prior to it.

1.8. The first FSSA report records that MRI scanning of Laura's brain at the FMC revealed not only changes of HIE but also an area of restricted diffusion in the right occipital lobe consistent with an intra-uterine infarction. A second report compiled by Dr Gilbert dated 29 April 2019 concerned exclusively the role, if any, that the lesion within the right occipital lobe played in Laura's death[2]. Dr Gilbert reports as follows:

> 'The area of the brain affected by the infarct was relatively small. This area of the brain is responsible for visual processing and loss of function in this region would produce loss of vision in the left half of the visual field. I do not believe that this caused the death or contributed in any way to the death.'

Dr Gilbert goes on to express the view that if Laura had survived with this lesion he would have expected her to be inattentive to visual stimuli in her left visual field, but that the lesion would not have adversely affected her otherwise. I should add here that there is no evidence that this lesion was caused by anything that occurred in connection with Laura's birth or her mother's labour. Nor did it give rise to the circumstances that resulted in the foetal distress that was experienced prior to her birth or to the fatal hypoxic brain injury that was sustained. There was evidence to suggest that the infarct may have occurred earlier in time as a result of placental insufficiency. Aside from the lesion there was other evidence to support the suggestion that there had been a period of placental insufficiency between 36 weeks gestation and the 40 weeks gestation stage at which Laura was born. During that period Laura's foetal weight had decreased in utero, a circumstance that is consistent with placental insufficiency. Although the lesion did not have any direct connection with Laura's death, the underlying placental insufficiency that conceivably caused it is relevant insofar as the insufficiency may also have contributed to the foetal stress and hypoxia that was experienced in the period before her emergency caesarean section delivery.

1.9. That Mrs Willmett had sustained a uterine rupture was only positively established during the emergency caesarean section. The rupture had occurred along the uterine scar formed as a result of the incision involved in a previous elective and successful

[2] Exhibit C2

lower uterine segment caesarean section (LUSCS). The rupture involved an approximate 2 centimetre extension from the original line of the opened scar. Both Laura and the attached placenta were still within the uterus despite the rupture. No placental abruption (separation of the placenta from the uterine wall) was detected.

1.10. As indicated, this was not Mrs Willmett's first pregnancy. She and her husband, Mr Rick Willmett, had a son who at the time of Laura's birth was their only child. Mrs Willmett had given birth to the boy by way of an elective caesarean section approximately 18 months earlier. As that earlier caesarean section had been planned, Mrs Willmett did not undergo any period of labour in connection with the birth. Thus, when she came to have Laura she had no personal experience of what labour entailed.

1.11. A uterine rupture is a recognised potential complication of an attempted vaginal birth after a previous caesarean section (VBAC). It had been intended that Laura's delivery would involve an attempted VBAC. Thus, that attempt would carry some risk of uterine rupture. Obstructed labour, while not of itself a consequence of a VBAC, can pose a risk of uterine rupture in the course of a VBAC delivery.[3] Clearly then, obstructed labour is to be avoided in any VBAC.

1.12. The cause of death as expressed in the first FSSA pathology review contains the suggestion that Laura's hypoxic brain damage was a complication of her emergency caesarean section delivery following Laura's mother's uterine rupture. As to the role played by uterine rupture, the evidence did not support the notion that the hypoxic brain damage resulted from, or was contributed to by, the rupture. During the inquest independent expert evidence was given that the fact that both Laura and the placenta were still within the uterus despite the rupture rendered it unlikely that the rupture was the cause of Laura's in utero hypoxia. I have accepted that evidence.

1.13. Accordingly, insofar as the FSSA pathology review suggests that there was a connection between Laura's hypoxic brain damage and the uterine rupture, I do not accept this contention. I will deal with the evidence in some detail during the course of these findings, but in my view it is clear that the hypoxic brain damage was sustained prior to the emergency caesarean section and not as a consequence of it and that it was not caused by the uterine rupture. I so find. Accordingly, these findings are not specifically intended to address the causes of Mrs Willmett's uterine rupture nor of any

[3] Transcript, page 890

long-term consequences of that rupture. However, the uterine rupture is relevant insofar as it is a known risk of a VBAC, a risk that especially in a rural setting dictated careful management of the mother's labour. For obvious reasons, clinicians involved in an attempted VBAC would need to be especially vigilant for signs of uterine rupture and be prepared to take the necessary action if a rupture was established or suspected. In the event, as things were to transpire, the management of Mrs Willmett's labour was far from orthodox for a VBAC. The rupture is also relevant because it ought to have formed part of a differential diagnosis when Mrs Willmett arrived at the Ceduna Hospital by ambulance late in the evening of Saturday 13 August 2016, approximately 1 hour and 48 minutes before Laura was ultimately delivered.

1.14. I have found that the cause of Laura Willmett's death was hypoxic ischaemic encephalopathy secondary to intrapartum hypoxia.

1.15. As is well known a caesarean section involves an incision of the uterus, undertaken to remove the baby from the mother by surgical intervention. The incision when repaired will ultimately form a scar which may be weakened. Indeed, a VBAC is sometimes said to involve a '*trial of scar*' insofar as a period of labour preceding a natural vaginal birth will involve the trial of the mother's ability to maintain uterine integrity. To that end constant monitoring during that labour will be the norm. Prompt surgical intervention by way of a further caesarean section should be available if necessary.

1.16. In this case Mrs Willmett's desire was to give birth to Laura naturally. She elected to attempt a VBAC. Independent expert opinion, as will be seen, suggested that where a VBAC is attempted less than two years after the date of a previous caesarean section the risk of uterine rupture is increased. Other material suggests that a period of 18 months is regarded as adequate. Laura was born almost exactly 18 months after the caesarean section birth of her mother's first child. Due to the possibility of uterine rupture occurring in labour, continuous cardiotocographic (CTG) monitoring in labour is recommended if not considered essential. An abnormal foetal heart rate pattern as can be revealed by the CTG is often the first sign of rupture.

1.17. With these considerations in mind the expert independent opinion was that VBAC attempts should only be made in hospitals that are capable of facilitating adequate assessment of the mother and foetus through the whole of labour, accurate assessment of when adequate progress is not being made and appropriate assessment of when

urgent delivery by repeat caesarean section is advisable in the circumstances that prevail[4]. In this regard it will be observed that Laura's emergency caesarean section delivery occurred in a remote country hospital which no doubt did not have the resources and expertise that a tertiary hospital such as the Women's and Children's Hospital (WCH) in Adelaide has on tap.

1.18. Against that background, and having regard to the many areas of forensic disagreement that were raised in this inquest, it came as no real surprise that during the inquest a dispute arose as to whether Mrs Willmett had received adequate advice as to where she should have Laura if she was keen to give birth to her naturally, whether in Adelaide or at Ceduna. Dr Ochigbo, a local general practitioner obstetrician whom Mrs Willmett consulted during her pregnancy, and who gave evidence in the inquest, maintained that he was unenthusiastic about managing a VBAC and had advised Mrs Willmett to have the baby in Adelaide if VBAC was her choice. Medical records at least support the notion that Dr Ochigbo explained to Mrs Willmett the advantages, disadvantages and risks of VBAC. In her oral testimony before the Court Mrs Willmett acknowledged that she understood that VBAC was not part of the normal policy at Ceduna or of Dr Ochigbo in particular.[5] However, she was interested in VBAC because she thought it would be nice to experience a natural labour. She said she understood the risks with VBAC. Mrs Willmett denied that the suggestion she should have a VBAC at a larger centre in Adelaide was ever put to her.[6] In her evidence Mrs Willmett insisted that she was not wedded to the idea of a VBAC and said that if she was not going to be allowed to have a VBAC at Ceduna she would have had another elective caesarean section in Ceduna. She denied on more than one occasion during her cross-examination in the inquest that Dr Ochigbo had told her that she would need to have a VBAC in Adelaide. In answer to me Mrs Willmett said that at no consultation nor at any other time did Dr Ochigbo tell her that he would not be prepared to manage a VBAC.[7] For Dr Ochigbo's part he said that although he did not at any stage agree to go ahead with a VBAC, he decided to work with Mrs Willmett and to see how things progressed. Whereas he had been able to talk other women out of having a VBAC, Mrs Willmett was different because of her insistence that she wanted a VBAC and at that stage there

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[4] Exhibit C18 - Report of Professor Roger Pepperell, pages 5 and 7
[5] Transcript, page 71
[6] Transcript, page 73
[7] Transcript, page 79

was no medical contraindication for it. When asked in evidence as to why he simply did not say to his patient that he was not going to allow a VBAC, Dr Ochigbo said:

> 'It's best not to tell a patient off. The best thing is to work with them, and respect their opinion.' [8]

I have found this dispute impossible to resolve.

1.19. Due to an unduly complicated and in my view avoidable set of circumstances that came into being prior to Laura's ultimate birth by way of an emergency caesarean section, Laura's mother was not monitored during the greater period of her labour which occurred during 13 August 2016. She and her husband spent the majority of that period at their home in Sceale Bay, between one and a half and two hours by car from the hospital in Ceduna. Prior to the events of 13 August 2016 which was the day before Laura's birth, there is nothing to suggest that Laura was anything other than a viable foetus who could have been born alive and in reasonable health. The hypoxic brain injury that Laura sustained was likely sustained during 13 August 2016 after Mrs Willmett had attended at and been discharged from the Ceduna Hospital in circumstances that will be the subject of further discussion in these findings. The brain injury could have been avoided by a more timely delivery. To my mind the evidence demonstrates that but for the events of 13 August 2016 Laura probably would have survived, and save for the unconnected brain lesion that might have affected her eyesight during life she probably would have been born well.

1.20. This inquest examined the circumstances surrounding Laura's birth, short life and death and how her death may have been prevented. These are the findings of that inquest.

2. A brief overview of the circumstances of Laura's death – the issues

2.1. So that the complex issues in this inquest can be better understood, I set out here a brief framework of the relevant and for the most part uncontested events and circumstances as they pertain to Laura's delivery in the early hours of the morning of Sunday 14 August 2016. I will expand upon those events and circumstances in greater detail later in these findings. As will be seen the detail is far from uncontested.

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[8] Transcript, pages 400-401

2.2. On Friday 12 August 2016 Mrs Willmett's pregnancy was nearly at term. The due date for a natural delivery was the following day.

2.3. At about 4pm on that Friday Mrs Willmett lost her mucus plug. This did not necessarily signify that Laura's birth was immediately imminent. Mrs Willmett's membranes did not rupture.

2.4. At approximately 9:30pm Mrs Willmett telephoned the Ceduna Hospital from her home at Sceale Bay. She reported contractions occurring approximately every eight minutes. She was told by a midwife at the Ceduna Hospital to come to the hospital.

2.5. Mrs Willmett and her husband arrived at the hospital at 11:59pm. A nursing note timed at 12:20am records that Mrs Willmett was experiencing contractions between seven and eight minutes apart and which were strong on palpation.

2.6. Mrs Willmett spent the night at the hospital with her husband. At 6am (now Saturday 13 August) a nursing note records that Mrs Willmett reported that her contractions were now felt to be further apart.

2.7. At 9:15am Mrs Willmett was examined by a midwife, Ms Alison Higgs. For the first time Mrs Willmett was connected to a CTG. This device monitors and records parameters such as the heart rates of the mother and foetus as well as uterine contractions. Independent expert evidence is to the effect that the CTG trace at this time was '*perfectly normal*'.[9]

2.8. At 9:40am Mrs Willmett was examined by a local general practitioner obstetrician, Dr Ochigbo. This examination which included a vaginal examination revealed that Mrs Willmett's cervix had dilated only to one centimetre. The baby's head was at station -3 and Mrs Willmett's membrane was intact. The general practitioner obstetrician recorded that Mrs Willmett was not in established labour, but was more likely to have been experiencing Braxton-Hicks contractions. Mrs Willmett and her husband were advised that Mrs Willmett was not in labour.

2.9. In circumstances that are disputed as between Mr and Mrs Willmett on the one hand, and on the other the midwife and the general practitioner obstetrician, Mr and Mrs Willmett returned to their home in Sceale Bay, some one and a half hours from

[9] Transcript, page 943

Ceduna. At night, however, the drive is said to take longer due to the presence of kangaroos on the road. The journey at night can be said to take two hours for that reason.

2.10. There was no communication between Mr and Mrs Willmett and Ceduna Hospital staff until later that day at just after 5pm. Mr and Mrs Willmett were still at home. Mr Willmett was recorded in a written note made by the midwife, Ms Higgs, as having stated over the phone at 5:16pm that Mrs Willmett was experiencing contractions three minutes apart. There is a dispute as to what was said during this telephone conversation and in particular about whether there was a need for Mr and Mrs Willmett to attend as soon as possible in Ceduna. Mr and Mrs Willmett stayed at home following this conversation.

2.11. It is further recorded that at 7:43pm the midwife Ms Higgs called the Willmett home to enquire where Mr and Mrs Willmett were and what they were doing. Ms Higgs recorded that they had decided to stay at home contrary to her advice as purportedly imparted during the earlier phone conversation at 5:16pm.

2.12. Ultimately Mr and Mrs Willmett left Sceale Bay to drive to Ceduna. In circumstances that will be elaborated upon in these findings, Mr and Mrs Willmett broke that journey at Streaky Bay where there is a hospital. They are recorded as having arrived at the hospital at approximately 9pm. This hospital did not have the capacity to carry out a caesarean section delivery if necessary. Indeed, it offered no birthing procedures except for emergency situations, and even then only by way of a natural vaginal delivery. A local general practitioner, Dr Oswald, who had experience in delivering babies attended at the hospital and examined Mrs Willmett. His vaginal examination of Mrs Willmett revealed that although she was dilated to eight or nine centimetres, was having regular contractions every four or five minutes and was therefore clearly in established labour, she was not immediately due to deliver because of the state of her cervix at that point in time. A decision was made to keep Mrs Willmett at the Streaky Bay Hospital and to wait for approximately thirty minutes after which a further vaginal examination would be conducted. That second examination was conducted and there was very little change from the previous examination.

2.13. A decision was then made to convey Mrs Willmett to the Ceduna Hospital by ambulance. According to South Australian Ambulance Service (SAAS) records, the

ambulance left the Streaky Bay Hospital at 10:22pm. En route Dr Oswald monitored Mrs Willmett and the yet to be born baby with a Doppler. At approximately 20 kilometres out from Ceduna Mrs Willmett experienced an episode that at the time Dr Oswald thought might have involved a uterine rupture. At the same time the foetus experienced an abnormal acceleration in heart rate which was detected by the Doppler.

2.14. The ambulance arrived at the Ceduna Hospital at approximately 11:22pm. The circumstances of what then transpired I will discuss in some detail during the course of these findings. Dr Ochigbo who had been asked to attend at the Ceduna Hospital for the purpose of overseeing Laura's delivery sought advice from the WCH. To begin with it is clear that Mrs Willmett was expected to deliver Laura naturally. However, given that the CTG revealed that Laura was in distress a decision was ultimately made with the concurrence of staff at the WCH who were contacted by phone that an emergency caesarean section should be effected. The caesarean incision was timed at 1:05am on 14 August 2016 with the baby being delivered at 1:10am. Knife to skin for this procedure occurred one hour and forty-three minutes after the arrival of Mrs Willmett by ambulance at the Ceduna Hospital. This delay had occurred notwithstanding the suspicion held, at least by Dr Oswald, that Mrs Willmett had experienced a uterine rupture en route and/or was in an obstructed labour.

2.15. It was clear that Laura was compromised after her delivery. The uterine rupture was surgically revealed during the caesarean section.

2.16. Both Laura and Mrs Willmett were conveyed to the FMC in Adelaide where Laura died on 16 August 2016 from the cause of death that I have already identified.

2.17. Independent expert evidence was given during the inquest that Laura's poor condition at birth was due to in utero hypoxia, possibly related to a poor placental function during labour, that was not evident when the first CTG monitoring was undertaken on the morning of 13 August 2016 but which must have arisen at some stage during that day and which was presumably related to the contractions that Mrs Willmett had been experiencing.[10]

2.18. The evidence reveals that there is a likelihood that if Laura had been delivered by way of caesarean section at earlier points in time she would have survived with little deficit

[10] Transcript, page 940

other than the in utero brain injury that I have already described and which was unrelated to the circumstances of her delivery.

2.19. The complex issues that the Court had to consider include whether:

- When Mrs Willmett first presented at the Ceduna Hospital late in the evening of 12 August 2016, during that night and in the morning was she in labour?
- Should Mrs Willmett have been discharged from the Ceduna Hospital and allowed to return with her husband to Sceale Bay, approximately 1½ hours away from the Ceduna Hospital?
- Were relevant guidelines relating to VBAC followed in Mrs Willmett's case and if not, did this make any difference in terms of the outcome?
- Did the Willmetts receive appropriate advice during the telephone communication between Mr Willmett and Ms Higgs at 5:16pm that day, and as a result of that conversation should the Willmetts have immediately returned to the Ceduna Hospital?
- Was Mrs Willmett kept at the Streaky Bay Hospital for longer than was necessary or appropriate having regard to her condition and the progress of her labour?
- Upon arrival at the Ceduna Hospital not long before midnight on 14 August 2016 should Mrs Willmett have had an immediately arranged caesarean section?
- Was the ultimate emergency caesarean section unduly delayed?
- Could Laura's poor condition at delivery and her death have been prevented?

2.20. The resolution of those questions has by no means been straightforward. Many of them cannot be resolved. This is due to the fact that in large part the evidence of Mr and Mrs Willmett, who were both called to give oral evidence and both of whom had provided witness statements prior to the inquest, was materially different from the statements and evidence given by medical and nursing staff who played various roles in the clinical management of Mrs Willmett and ultimately the delivery of Laura. This of course does not of itself mean that the material issues cannot be resolved. However, in many instances conflicts between the evidence of various witnesses carried the strong implication that that one or other of the witnesses in conflict were deliberately not telling the truth. Simply put, some versions of events were so diametrically opposed that deliberate untruthfulness on the part of one or more individuals was the only

explanation for the divergence. Throughout the course of this inquest, and having regard to the lengthy and at times prolix cross-examination of witnesses, it is fair to say that I detected nothing in the demeanour of any witness to suggest that any individual witness was deliberately misrepresenting the truth. I saw nothing in the demeanour of any witness to suggest that the witness was lying to the Court on a particular issue. That is not to say that some witnesses did not display signs of unreliability. But compounding the difficulty, particularly from the perspective of Mr and Mrs Willmett, is the fact that they are contradicted by a significant body of documentary evidence in the form of medical and clinical records, much of which was made at a time when the maker of the record had no obvious motive to fabricate. For those reasons it has been difficult for the Court to make positive findings of fact on the balance of probabilities in respect of several material issues. For some of the evidence given by Mr and Mrs Willmett to be accepted by the Court, I would have to find that certain documentation created by medical practitioners and nurses was a fabrication deliberately misrepresenting the true facts. Alternatively, in some instances I would have to disbelieve a witness' evidence about the circumstances in which and the time at which certain documentation was created and whether it had been created at a time at which the witness in question did or did not have a motive to fabricate.

2.21. In order to be satisfied that contemporaneously made documentation had been created with a motive to deliberately misrepresent the facts, or had been created at a time other than that deposed to by the creator of the document with that same motive, I would need to be persuaded about such findings to a very high level of satisfaction. I would need to have regard to the serious nature of findings such as those and to their possible consequences and I would need to ensure that such findings were not based on questionable evidence.

3. The South Australian Perinatal Practice Guidelines - birth options after caesarean section

3.1. The version of these guidelines that was in operation at the time with which this inquest was concerned were tendered to the inquest[11].

3.2. The guidelines deal with a number of issues associated with VBAC. The document describes the average success rate when VBAC is attempted as 72%-76%. I take this

[11] Exhibit C12

as meaning that these figures represent the number of deliveries that do not occur by way of a repeat caesarean section. In developed countries the incidence of any type of uterine rupture after a caesarean section is estimated to be 0.5%-1%. I assume these figures are reflective of VBAC after a lower uterine caesarean section as distinct from a classical upper segment procedure. Mrs Willmett's previous caesarean section was a lower uterine procedure.

3.3. The document lists a number of contraindications for VBAC. None of those contraindications applied in this case. I note that the guidelines are silent on the issue of the required or recommended interval for an attempted VBAC since the previous caesarean section.

3.4. The guidelines also list a number of precautions for VBAC. In this section of the document it is said that induction of labour with a cervical balloon catheter is similar to induction of labour with gels but with fewer maternal and neonatal side effects. However, it states that there is too little information from randomised control trials available to make the recommendation that all women requiring induction of labour who have had a previous caesarean section should have a cervical balloon catheter administered to them. In Mrs Willmett's case induction of her labour by this method was considered and discussed on 13 August 2016 but the device was not available at the Ceduna Hospital that day. Mrs Willmett indicated that in any event she was no longer in favour of this measure.

3.5. Intrapartum care is discussed in the guidelines. Set out within this part of the guidelines are a number of required elements. They include continuous midwifery support of the woman in labour. I note that in Mrs Willmett's case this did not occur. It is clear that regardless of the situation on the morning of 13 August 2016 when Mrs Willmett and her husband left the hospital, her labour would become established during the course of that day and evening and in circumstances in which she was at her home in Sceale Bay where the support of a midwife was naturally absent.

3.6. Also under the heading of intrapartum care is a recommendation that continuous electronic foetal monitoring is maintained once a woman is in established labour. The document observes that several VBAC studies have reported that in over 70% of cases of uterine rupture one of the first signs or symptoms presented is prolonged foetal bradycardia (abnormally slow heart rate). The document also suggests that any lack of

progress in the first or second stages of labour must trigger a complete clinical re-assessment by an experienced obstetrician. An experienced consultant obstetrician would not become involved in the matter until Dr Ochigbo, who himself was not a consultant, phoned the WCH prior to the carrying out of the emergency caesarean section.

3.7. Although Mrs Willmett was connected to electronic foetal monitoring on her first presentation to the Ceduna Hospital, CTG monitoring was not in place once she was in established labour. It would not be re-instituted until her second presentation to the Ceduna Hospital. There can be no doubt that she had been in established labour for some hours prior to that.

3.8. It is clear, therefore, that the guidelines were not followed in Mrs Willmett's case. She did not have constant midwifery care. She did not have continuous CTG monitoring during the duration of her established labour. The reasons for those omissions come to be discussed below.

4. General evidence regarding VBAC and labour

4.1. Evidence on these general topics was given by Professor Roger Pepperell who is an independent expert. Professor Pepperell is a retired Professor of Obstetrics and Gynaecology. He graduated with basic medical degrees in 1965. He is a Fellow of various relevant Colleges in obstetrics and gynaecology. Professor Pepperell has given evidence on many occasions in relation to obstetrics. Professor Pepperell has had both a teaching and clinical obstetric practice.

4.2. Professor Pepperell was asked to provide an expert opinion in relation to the events surrounding the birth of Laura and her mother's labour and delivery. I will mention that evidence in some detail later. However, it is as well at this stage to record the evidence that was given by him in general terms concerning VBAC and its consequences and how any risk associated with it is managed. Much of this evidence was uncontroversial.

4.3. Professor Pepperell gave evidence that ideally a period of two years should lapse between a previous caesarean section and an attempted delivery by way of VBAC. The risk of the scar rupturing during a VBAC is greater if the delivery occurs earlier than two years. He acknowledged that a period of 18 months is sometimes said to be a

satisfactory interval. He noted that Laura was conceived 9 months after her mother's first caesarean section, meaning that the VBAC delivery would have taken place only 18 months after that procedure. I note that it was said during the course of the evidence that in South Australia an interval of 18 months is said to be acceptable. In any event, according to Professor Pepperell, the difference between 2 years and 18 months in terms of risk is very slight[12]. Professor Pepperell did say in relation to the interval in Mrs Willmett's case that there are hospitals that, after having explained the potential risks to the mother, would facilitate a VBAC. Professor Pepperell suggested that certain hospitals manage such deliveries '*carefully and closely*'[13].

4.4. I do not believe that the interval between Mrs Willmett's original caesarean section and the attempted VBAC delivery of Laura is of any relevance in this particular case. I do not believe that it can be said Mrs Willmett's ruptured uterus was contributed to by an 18 month interval as opposed to a 2 year interval. I would not be critical of any decision that was made to facilitate a VBAC delivery simply on the basis of the interval since Mrs Willmett's previous caesarean section. Naturally though, the shorter the interval in a particular case the less one would be inclined to allow VBAC and the more careful one would be to ensure that VBAC guidelines were followed if VBAC was nevertheless allowed.

4.5. In Professor Pepperell's written report[14] that was prepared prior to him giving oral evidence, he suggested that VBAC attempts should only made in hospitals that are able to assess adequately the mother and foetus throughout the whole of labour, are able to accurately assess when adequate progress is not being made and to assess when urgent delivery by repeat caesarean section is advisable under the circumstances that prevail. In his oral evidence Professor Pepperell noted that some medical practitioners might be inclined to tell a woman in Mrs Willmett's position and in the circumstances that prevailed at Ceduna that they would not be prepared to manage a VBAC in Ceduna due to its inherent risks and the fact that the personnel necessary to carry out an attempted VBAC would not be available at that location all of the time. At the same time, however, he acknowledged that there were other medical practitioners who would attempt to ensure that the mother had her wishes met. Professor Pepperell suggested that there is no doubt that the question of resources that would be available at Ceduna

[12] Transcript, page 985
[13] Transcript, page 891
[14] Exhibit C18

would be a matter that would need to be discussed with the mother due to local personnel availability issues, especially given that in a tertiary institution would have ready availability of consultant staff, caesarean section theatres and anaesthetists who would be available 24 hours a day for 7 days a week. He suggested that in most parts of Australia the carrying out of VBACs occurs almost exclusively within tertiary hospitals that have those facilities and personnel available[15]. And overlayed on all of this in the case of the Willmett's was the tyranny of distance from their home to those resources.

4.6. In my view the attempted delivery by way of VBAC in Laura's case exemplifies in textbook fashion the difficulties that Professor Pepperell had in mind in terms of logistics and resources as will be seen.

4.7. Professor Pepperell also spoke of the recommendation, if not requirement, of cardiotocograph (CTG) monitoring during a labour involving an attempted VBAC. I have already referred to this insofar as it is dealt with in the South Australian guidelines. Professor Pepperell suggested that mothers need to be monitored with CTG throughout the whole of their labour because the first sign of uterine rupture will often be detected by such monitoring. The need to alter the woman's management is thereby identified[16]. Professor Pepperell suggested that CTG monitoring should commence at the start of labour and ideally be continued right through the whole of labour. He suggested that this is the only method by which one can detect that a problem is occurring. Furthermore, it enables the problem to be identified at the very earliest phase. He spoke in particular about the need to establish beat to beat variability and the extent and duration of any decelerations in the foetal heart rate, both of which can be indications of foetal distress. Professor Pepperell did acknowledge that if a CTG trace is perfectly normal and contractions are infrequent and irregular, one might remove the CTG for a period of time. However, certainly once the mother experiences more established labour one would want the CTG monitoring on continuously[17]. As will be seen in this case, it is obvious that for a significant period of Mrs Willmett's established labour she was not subjected to CTG monitoring. During her labour she was variously at her own

[15] Transcript, page 893
[16] Transcript, pages 887-888
[17] Transcript, page 904

home, en route to the Ceduna Hospital and for a period of time in the Streaky Bay Hospital.

4.8. Whether that lack of CTG monitoring made a difference is a matter of some conjecture as we cannot know what it may have revealed at earlier points in time. However, when the CTG was reconnected to Mrs Willmett a few minutes after her arrival at Ceduna on the night of 13 August worrying abnormalities including decelerations and low beat to beat variability were soon evident. It seems unlikely that these abnormalities just happened to commence for the first time at that stage. It is possible, if not likely, that if CTG monitoring had been in place at earlier times during the day, abnormalities would have been detected at a much earlier point in time and the necessary action taken. But in any event it goes without saying in my view that if midwifery services and continuous foetal monitoring are standard in VBAC, great care would need to be exercised when considering the question as to whether a woman on the very day her baby is due ought to be placed in a situation in which such care might not be available for a significant duration once established labour commences.

4.9. Professor Pepperell gave evidence about the various stages of labour. He told the Court that at the beginning of labour there is often a latent phase that can be variable in length. This phase extends from the time the cervix is closed to the point where it reaches two centimetres or sometimes three centimetres of dilatation. Professor Pepperell asserted that in many people the latent phase can be very slow and quite prolonged, being as long as 24 hours in some instances. However, he did say that although the latent phase could exist for some hours, some patients start contracting right from the start. Professor Pepperell said that following the latent phase one would expect the cervix to dilate at a rate of about one centimetre per hour until nine centimetres of dilatation has been achieved. The final centimetre may often take a further one or two hours. If progress of that nature is not encountered and is much slower than what he described, then one would have to consider whether lack of progress was related to poor uterine contractions or was due to an obstruction. As will be seen, the rate of established labour was a relevant circumstance in Mrs Willmett's case.

4.10. Professor Pepperell also spoke of Braxton Hicks contractions. During the inquest this phenomenon was occasionally referred to as 'practice' contractions. Professor Pepperell suggested that when the latent phase of labour is very slow one may not know

whether the mother is in fact experiencing Braxton Hicks contractions.[18] He suggested that in some circumstances it is not possible to differentiate between Braxton Hicks contractions on the one hand and the early stages of labour on the other, even on a CTG trace.[19] He said '*you can't tell the difference. You'll see those same sort of patterns of uterine contractions in patients antenatally who just come in for an antenatal screening CTG*'.[20] Professor Pepperell did say that although it is hard to tell the difference in some patients, the stronger the contractions are and the more frequent they become, the more likely the mother is in the active phase of labour and will progress quickly.[21] He added that if on the other hand the contractions or other detected uterine activity become further apart and less painful, this would almost certainly be an indicator that Braxton Hicks contractions were at work.[22] Professor Pepperell suggested that one may not be able to exclude early labour and that only the passage of time will define the position.[23] The question of Braxton Hicks contractions versus labour contractions was also a relevant consideration in Mrs Willmett's case.

4.11. Professor Pepperell also gave evidence about obstructed labour. He suggested that in a trial of scar, that is to say attempted VBAC, the risks to the mother included obstructed labour in which case there would be an increased likelihood of the existing uterine scar giving way. The difficulty from the baby's perspective is that in those circumstances there would be a more rapid foetal pulse rate. If there was also a problem with placental function one would have an abnormal heart rate as detected on the CTG. He went on to say that it was not the uterine scar itself that caused the problem in terms of increasing the risk of obstructed labour, but rather the obstructed labour can have consequences in terms of the integrity of the scar. Professor Pepperell gave evidence that if a woman remained at nine centimetres dilatation for say three hours, one would need to consider obstructed labour. He said in respect of Mrs Willmett's circumstances:

> 'Yes certainly. For how long she'd been at that dilatation before the first PV was done and it was found to be 9 cm, it may have been 9 cm for five hours, six hours. No one knows because she wasn't there.' [24] (PV is an abbreviation for a vaginal examination)

[18] Transcript, page 986
[19] Transcript, page 902
[20] Transcript, page 902
[21] Transcript, page 988
[22] Transcript, page 989
[23] Transcript, page 907
[24] Transcript, page 928

Professor Pepperell also suggested that with a cervix dilated to only nine centimetres it would not be appropriate to instruct a woman to push in order to bring about delivery. He suggested that such an instruction would be completely inappropriate, especially if the baby's head was still significantly above the spines. In those circumstances the mother should not be attempting to push the baby out.[25] It is clear that in the case of Mrs Willmett's delivery of Laura, circumstances progressed to a point where, perhaps in panic, she was instructed to push when she was not ready to do so. A significant and prolonged deceleration of Laura's hear beat then ensued.

4.12. Professor Pepperell also gave evidence about induction processes including the use of the balloon catheter and a stretch and sweep. He suggested that the stretch and sweep procedure improves the chances of a woman labouring spontaneously. In some circumstances one would not allow the woman to leave hospital if such a procedure had been carried out.[26] I add here that Mrs Willmett believed that Dr Ochigbo had performed a stretch and sweep procedure during a vaginal examination on the morning of 13 August but I was persuaded that she was mistaken as to this. Dr Ochigbo denied that he performed this procedure during his examination of Mrs Willmett. I regard it highly unlikely that he performed it. I say no more on that issue.

4.13. Professor Pepperell also spoke of the significance of a woman losing a mucus plug. He stated that this event signifies that the cervix has started to open and that labour is likely to occur sometime over the next few days. He suggested that in many instances labour may occur within a day or so of the plug being lost but that in other instances it might be a few days before the woman actually comes into labour. He said most women would labour within a week of the loss of a mucus plug.[27]

4.14. Professor Pepperell gave evidence that a normal foetal heart rate is between 110 and 160 beats per minute.[28]

5. Mrs Willmett's first presentation to the Ceduna Hospital

5.1. This issue is important as Mrs Willmett's ultimate discharge from the Ceduna Hospital dictated much of what transpired later that day. If Mr and Mrs Willmett had stayed at the hospital or had at least stayed in Ceduna instead of going home it is likely that Laura

[25] Transcript, page 934
[26] Transcript, page 953
[27] Transcript, page 899
[28] Transcript, page 921

would have been born in better controlled circumstances and would have survived. It is clear that on any version of events Mrs Willmett should not have gone home.

5.2. As indicated earlier, Mrs Willmett lost her mucus plug during the afternoon of Friday 12 August 2016. As a result of a telephone conversation that Mrs Willmett conducted with Ms Higgs at the Ceduna Hospital that is recorded as having taken place at 9:25pm that evening, Mr and Mrs Willmett travelled to Ceduna Hospital where they arrived at approximately 11:59pm. This was the first of a number of phone conversations that Ms Higgs would conduct with either Mr or Mrs Willmett or as between herself and other Ceduna Hospital staff about Mrs Willmett. Ms Higgs told the Court that she made handwritten notes of these telephone conversations. These notes comprising three A4 sheets were ultimately placed within the Ceduna Hospital medical record for Mrs Willmett and affixed with her hospital patient details sticker[29].

5.3. Ms Higgs gave evidence that she made the notes contemporaneously with the conversations that they record. I have examined the notes. They are apparently genuine.

5.4. In Ms Higgs' first handwritten note[30] relating to the phone call at 9:25pm on the Friday evening the 12 August she recorded among other things that Mrs Willmett was apparently experiencing a contraction every eight minutes and that the contractions were irregular and not painful. It is recorded that Mrs Willmett was due on 13 August 2016. There is a reference to VBAC with a question mark against it. There is also a notation that Mrs Willmett's membranes were still intact and that there was no loss per vaginam. It is recorded that Ms Higgs discussed with Mrs Willmett the need for her to come into the hospital as soon as possible but to drive carefully. The recorded plan was to see what would happen overnight and that it would be '*better to be safe and come in now*'.

5.5. As things transpired Ms Higgs' note of 9:25pm is mirrored by notes made directly onto the progress notes on Mrs Willmett's Ceduna Hospital file by Ms Beverley Drummond who is not a midwife but is a registered nurse who was on duty at the Ceduna Hospital that night[31]. A note made by Ms Drummond timed at 11pm mentions the call at 9:30pm in which it was revealed that Mrs Willmett was experiencing contractions

[29] Exhibit C6, pages 79-81
[30] Exhibit C6, page 79
[31] Exhibit C6, page 57

approximately '*8 minutely*'. There is no reference to pain in this note. There is reference to the midwife, Ms Higgs, telling Mrs Willmett to come to the Ceduna Hospital. This cautious approach on the part of Ms Higgs is to be contrasted with a level of almost clinical recklessness that Mr and Mrs Willmett suggest occurred the next morning when Ms Higgs was allegedly party to their being sent home.

5.6. A note timed at 12:20am and prepared by Ms Drummond after Mr and Mrs Willmett's arrival at the hospital noted that Mrs Willmett's contractions were '*7-8 minutely*' at presentation and that they were strong on palpation.

5.7. A further note compiled by Ms Drummond and timed at 6am records that Mrs Willmett had settled and had tried to get some rest, that she had been up walking in her room and was not anxious. The note records that she was '*calm ++*', the two plus signs signifying a high level of calmness. The note does record that Mrs Willmett had taken only intermittent rest. The note records information that Mrs Willmett's contractions were '*7-8 minutes apart*' and that Mrs Willmett felt that they were further apart at 6am. The note records that there was no further vaginal discharge. Mrs Willmett denies that she had reported to a nurse that the contractions were further apart at 6am[32].

5.8. Ms Drummond's notes are clearly contemporaneous, apparently genuine and made at a time at which she could not have had any motive to fabricate their content.

5.9. Ms Higgs has recorded in her notes[33] that at 5:23am she called the Ceduna Hospital and was told that Mrs Willmett was asleep and that her contractions had not been painful, were irregular and were far apart. Ms Higgs also recorded that at 6:05am she was called by Ms Drummond. She recorded '*Jennifer sleeping*' and that she was relaxed. Ms Higgs recorded, '*clearly not in labour*'.

5.10. Ms Higgs made her way into the Ceduna Hospital where at approximately 9:15am she examined Mrs Willmett and as indicated earlier Mrs Willmett was further examined by the general practitioner obstetrician, Dr Ochigbo, at 9:40am.

5.11. It is necessary here to set out the versions provided by Mr and Mrs Willmett in relation to the events of the morning of 13 August 2016.

[32] Transcript, page 164
[33] Exhibit C6, page 79

5.12. Mrs Jennifer Willmett made two statements both of which were tendered to the inquest[34]. She also gave oral evidence at the inquest. Her statements and her evidence cover a number of issues in connection with her pregnancy, labour and the birth of Laura. Mr Rick Willmett also gave two statements both of which were tendered to the inquest[35]. He also gave oral evidence.

5.13. In her first witness statement taken on 8 August 2017, almost a year after the events in question, Mrs Willmett asserts that it was her desire to try for a VBAC but that she would have been more than happy to have had a caesarean section if there had been any slight problem. She asserts that the general practitioner obstetrician, Dr Ochigbo, had made it clear that he would monitor her very closely throughout her labour and that if there was any sign of danger she would go straight in for a caesarean section. Mrs Willmett acknowledges that her estimated due date was Saturday 13 August 2016. She describes losing her mucus plug at about 4pm the day before. She indicates in the statement that she thought that this was the start of her labour. I observe, however, that if this belief had been formed purely on the basis of the loss of the mucus plug, this would not have been an accurate assumption. Mrs Willmett also had no previous experience of labour. In any event Mrs Willmett and her husband that night proceeded to the Ceduna Hospital, arriving around midnight. The journey took two hours because they had to drive slowly to avoid kangaroos.

5.14. Mrs Willmett stated that at the Ceduna Hospital she and her husband timed what she believed were contractions which were mostly around eight minutes apart. However, the timing of them was quite inconsistent. She said that throughout the night she was pacing up and down the room and using an exercise ball. She said she could not sleep because of the pain.

5.15. Mrs Willmett states that when Ms Higgs arrived at the hospital in the morning Mrs Willmett was connected to a foetal monitor (a CTG) for about twenty minutes. Once she had been monitored she was told by Ms Higgs that she was not in labour. Mrs Willmett asserts that this surprised her because she believed that she had been in labour for about fifteen hours. Ms Higgs told her that what she was experiencing were

[34] Exhibits C13 and C13a
[35] Exhibits C14 and C14a

like '*practice contractions*', but she did not use the term Braxton Hicks contractions. So much is not in dispute as between Mrs Willmett and Ms Higgs.

5.16. What is in dispute is that Ms Higgs suggested to Mr and Mrs Willmett that they go home, although Mrs Willmett acknowledges that Ms Higgs did say that they could stay and treat it like a holiday.

5.17. Mr Willmett's statements assert that he and his wife had watched some television and had timed Mrs Willmett's contractions. Mrs Willmett had also paced the room '*doing her labour plan*'. Mr Willmett describes things as being '*all very mild at that stage*'[36]. It appears that during the course of the night Mr Willmett slept for some time.

5.18. Mr Willmett's first statement, taken on 8 August 2017, indicates that in the morning Ms Higgs had told them that Mrs Willmett was not in labour but they were welcome to stay at the hospital for a few days and that they could treat it like a holiday. In another more detailed statement provided to the Court at the commencement of the inquest, Mr Willmett again indicates that Ms Higgs told them that Mrs Willmett was not in labour. However, he disagrees that his wife had acknowledged that she was not in labour and also disputes that Ms Higgs recommended that they stay in Ceduna. He contends that Ms Higgs has made that assertion up[37]. He said they would have stayed if they had been advised to do so. Mr Willmett also asserts that Mrs Willmett did not say that she wanted to go home to be with their son as in any event Mrs Willmett's parents were looking after him.

5.19. Ms Alison Higgs gave oral evidence at considerable length. Ms Higgs has been a midwife since 1999. She has worked as an independent midwife in New Zealand. She worked in New Zealand within rural and remote districts. She has also been employed as a call midwife in a tertiary hospital. In 2016 she was working in Ceduna as a midwife both within the community and in the Ceduna Hospital. Her duties as a midwife at the Ceduna Hospital included antenatal and intrapartum duties.

5.20. Ms Higgs' response to a notification from the Australian Health Practitioner Regulation Agency (AHPRA) who have been investigating a complaint made in relation to the circumstances surrounding the death of Laura Willmett was tendered to the inquest.

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[36] Exhibit C14, page 2
[37] Exhibit C14a, paragraph 9

AHPRA documentation[38] indicates that AHPRA were investigating an assertion made by Mrs Willmett that Ms Higgs had inappropriately advised her to leave the hospital and to return home some 150 kilometres away when she was in labour and when it was unsafe for her to do so. Both in Ms Higgs' AHPRA response and in her oral evidence before me she denies that allegation. Ms Higgs asserts that Mrs Willmett was clearly not in labour. She asserts that Mrs Willmett reported feeling well and stated that she was not having any contractions or tightenings. She said that she wanted to go home. Ms Higgs asserts that in a discussion with Mrs Willmett and her husband she recommended that they stay in Ceduna because they lived so far away. Despite this, Mrs Willmett and her husband indicated they were very keen to go home as she believed she was not in labour and that there was no point in staying, a response that is seemingly incongruent with Mrs Willmett's belief that she was due to deliver that day. In any event Mrs Willmett agreed to be examined by Dr Ochigbo whose examination I will come to in a moment.

5.21. I pause here in the narrative to observe that apart from her notes of phone conversations, Ms Higgs also compiled two pages of handwritten notes that relate to her examination of Mrs Willmett at 9:15am. As well, they purport to record what transpired during the subsequent examination by Dr Ochigbo. There is a further note timed at 10:35am concerning Mrs Willmett's discharge to her home. These two pages of notes are situated on the two sides of the one proforma progress note sheet. Although Ms Higgs' notes consist of an entirely separate sheet, they are situated within the progress notes section of Mrs Willmett's file[39]. Ideally, progress notes should be compiled sequentially. A note relating to a particular event should normally start immediately at the end of the note relating to the previous event. New pages are usually commenced when the previous page is full. On the other hand, a retrospective note would conceivably commence on a new page. Notwithstanding that Mrs Higgs' notes are purportedly not retrospective, her notes do not continue on from the end of Ms Drummond's handwritten note timed at 6am. What follows on immediately after Ms Drummond's note is Dr Ochigbo's handwritten note of his examination timed at 9:40am. This is so notwithstanding the fact that Ms Higgs' examination of Mrs Willmett occurred in the intervening period between Ms Drummond's 6am examination and Dr Ochigbo's examination. Ms Higgs' explanation for not compiling

[38] Exhibits C22 and C22a
[39] Exhibit C6, pages 55-56

her own notes following on from Ms Drummond's notes was that at the time she made her notes she had already left the Ceduna Hospital file at the nurses station to be picked up by Dr Ochigbo for the purposes of his examination. It is to be acknowledged that Ms Higgs' not commencing her notes at the conclusion of Ms Drummond's notes and her explanation for not doing so attract the suspicion that her notes were made retrospectively and at a time after Laura's birth or even death. Ms Higgs on the other hand swore in her evidence that her notes were made on 13 August at the time of or very shortly after the events that they record[40]. When tested in the course of a vigorous cross-examination by counsel assisting Ms Kereru, she categorically and repeatedly denied the suggestion that the notes were made retrospectively after the events which they record, and she rejected the notion that they were made at a time after Laura's birth and when Laura's poor condition following her birth was known and understood. In essence, Ms Higgs asserts on her oath that her two pages of notes were made at a time when neither she nor anyone else had a motive to fabricate the matters recorded in the notes. I observe that in her final address Ms Kereru did not make any submission to the contrary. Indeed, Ms Kereru, submitted to the Court that Ms Higgs was a credible witness and that it could not be submitted that Ms Higgs was a liar.

5.22. I set out here the salient features of the note that Ms Higgs made in relation to the 9:15am examination of Mrs Willmett. The note begins by recording earlier events relating to the circumstances in which Mrs Willmett came to the hospital and Ms Higgs' understanding of those circumstances. She records that when she called the hospital early in the morning she discussed Mrs Willmett with the nurse (undoubtedly a reference to Ms Drummond) and that the patient was sleeping with few tightenings. Her plan was to come into the hospital when Mrs Willmett was awake and so she arrived at 8:45am. Mrs Willmett was up and awake and in no pain or discomfort. She recorded that Mrs Willmett was experiencing few contractions that were not painful and which were occurring once in ten minutes. They were mild and irregular. She then recorded the following:

> 'D/w re plan. CTG, VE, and perhaps stay for day. D/w at length re staying in Ceduna – as I felt it would be a good idea – not disrupt toddler / they live far away / wait + watch + monitor. But they had never been apart from toddler before so very clearly wanting to go home if not in labour. Agreed to wait + make decision after CTG + VE.' [41]

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[40] Transcript, pages 839-840, 845 and 848

[41] **CTG** is a reference to CTG monitoring; **VE** is the abbreviation for 'vaginal examination'; **D/w** is an abbreviation for 'discussed with'

5.23. There is some common ground as between Mr and Mrs Willmett and Ms Higgs. That common ground is that Ms Higgs examined Mrs Willmett and formed and stated the opinion that Mrs Willmett was not in labour but that what Mrs Willmett was experiencing were practice contractions or Braxton Hicks contractions which amount to the same thing. However, it is fair to say that the passage in Ms Higgs's notes reproduced above sits uncomfortably with the evidence of Mr and Mrs Willmett, particularly in respect of the recorded assertion that they very clearly wanted to go home if Mrs Willmett was not in labour. Ms Higgs made further notes following Dr Ochigbo's examination in which assertions that Mr and Mrs Willmett were keen to go home are again recorded. I will come back to those notes in a moment. It is convenient here to deal with the examination by Dr Ochigbo.

5.24. Dr Damien Ochigbo is a general practitioner obstetrician. Dr Ochigbo was conferred with his basic medical degrees in 1990 in Nigeria. He was engaged in hospital and general practice in Nigeria between 1993 and 2004. He practised as a general practitioner obstetrician in Botswana between 2004 and 2008. Dr Ochigbo obtained his registration with the medical authorities in Australia in 2007. He practised at the Port Hedland Regional Hospital between May 2008 and June 2010. He had an obstetrics placement at the King Edward Memorial Hospital in Perth in 2008 and 2009. He also practised as a general practitioner obstetrician at the Millicent Medical Centre from 2010 to 2014. Dr Ochigbo obtained an Advanced Diploma in Obstetrics and Gynaecology from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) in 2014 having obtained his ordinary diploma in 2011. From July 2014 onwards he has practised as a general practitioner obstetrician at the Ceduna Family Medical Practice and the Ceduna District Health Service (the Ceduna Hospital).

5.25. In his evidence Dr Ochigbo described in approximate terms the number of babies that he has delivered. He also told the Court about the many caesarean sections he has performed including both elective and emergency. Naturally he has also managed vaginal births. Dr Ochigbo asserted that he had managed women who had elected for VBAC which had ultimately involved caesarean sections. In relation to his practice at Ceduna, Dr Ochigbo produced evidence that as at the time of the inquest he had attended approximately 180 births comprising 115 normal vaginal deliveries, 49 lower

segment caesarean section deliveries and 13 ventouse deliveries. One of those caesarean section deliveries was that of Mr and Mrs Willmett's older child.

5.26. It should be understood that Dr Ochigbo is not a specialist consultant obstetrician. He is not a Fellow of RANZCOG with all of the qualifications that a fellowship confers. As a reflection of this, when it became evident to Dr Ochigbo on the night of Laura's birth that she was experiencing foetal distress he chose to seek out specialist advice from the WCH. I make due allowance for the fact that Dr Ochigbo is not a consultant obstetrician. When dealing with the crisis that unfolded at the Ceduna Hospital on the night of Laura's birth Dr Ochigbo should not be held to a standard of skill and expertise that exceeds that expected of a general practitioner practising in a country hospital with lesser obstetric qualifications than those of a consultant.

5.27. At the time with which this inquest is concerned there was only the one general practitioner obstetrician in Ceduna and that was Dr Ochigbo. Dr Ochigbo told the Court that he was on-call every day for obstetric services. Dr Ochigbo explained that although he was proficient at both natural vaginal delivery and caesarean section, he was not enthusiastic about VBAC and that his usual option was to perform an elective caesarean section in such cases. He said that he made it clear to midwives in Ceduna that he was not comfortable performing a VBAC for a number of reasons including the higher risk associated with VBAC, the distance of Ceduna from Adelaide and the fact that he was the only obstetrically qualified medical practitioner in the region.

5.28. Dr Ochigbo also provided a response to AHPRA's investigation[42]. In that response Dr Ochigbo asserts that he determined from his examination that Mrs Willmett was not in labour and that he informed her of this. This opinion was the same as that formed by Ms Higgs. He also asserts in his response that Mrs Willmett was very keen to go home to her one-year-old son and that she did not want induction of labour that day. He asserted in the AHPRA response that Mrs Willmett was advised to stay in the hospital or to remain in town near the hospital but that she wanted to go home. He says '*she was very concerned about her son … whom she said had not spent a night without her before*'. Dr Ochigbo indicates that given that Mrs Willmett did not want any intervention and that her clinical examination and CTG were unremarkable, they allowed her request to go home but indicated that she should return as soon as she

[42] Exhibit C17b

started contracting. Dr Ochigbo gave oral evidence in the inquest to the same effect, including his opinion that Mrs Willmett had not been in labour and that he told Mrs Willmett that. His advice to Mrs Willmett to that effect had been unambiguous.[43]

5.29. Dr Ochigbo's clinical notes are within the Ceduna Hospital progress notes for Mrs Willmett. As indicated earlier they follow on directly below and on the same page as Ms Drummond's note timed at 6am. His notes occupy most of the second half of that page and about two thirds of the reverse side. Immediately following Dr Ochigbo's notes, and commencing on the same page, there is a nursing note timed at 11:10am. Thus, there is little room for any suggestion that Dr Ochigbo's notes were not made contemporaneously with his examination of Mrs Willmett. I find that they were therefore made at a time at which he or no other person had any motive to fabricate the matters recorded within the note. The salient features of Dr Ochigbo's examination as recorded in the note and as testified to by him in his evidence were that Mrs Willmett was experiencing '*Niggling Pain*'. I am not certain whether the word 'niggling' was meant to have been used as a descriptor of her pain by Mrs Willmett herself or whether it is meant to record Dr Ochigbo's interpretation of the way her pain was described to him. However, the description as written by Dr Ochigbo would tend to refute a suggestion that at the time of the examination Mrs Willmett had described, and was experiencing, significant pain or pain at a level that was alarming or intolerable. Dr Ochigbo noted the CTG results as being unremarkable. He also recorded that on examination Mrs Willmett was '*comfortable*'. He specifically noted that on abdominal examination there were no palpable contractions. A vaginal examination revealed that the cervix was dilated to one centimetre and would admit one finger, the station was -3 and that her membranes were intact. All these observations led Dr Ochigbo to the view that Mrs Willmett was not in established labour. Dr Ochigbo in fact recorded this as follows:

> 'Not in established labour
> Likely Braxton Hicks'

I pause to observe here that there is no suggestion that the CTG trace, recorded over approximately twenty minutes, revealed any abnormality.

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[43] Transcript, pages 424-425

5.30. Dr Ochigbo recorded his discussion with Mrs Willmett about the possibility of catheter induction and noted that the necessary equipment had yet to arrive but that in any event Mrs Willmett was no longer keen for that measure as Ceduna Hospital did not appear to have any experience with it. Dr Ochigbo recorded his reassurance to her that he was personally experienced with the use of that equipment.

5.31. Thereafter Dr Ochigbo recorded what he anticipated should happen from that point forward. That was that he discussed with Mr and Mrs Willmett that if she had not delivered by 41 weeks, which would be the case on the following Saturday, then a caesarean section would be performed. To this end he recorded his plan as follows:

> ‘Plan
> i) Come in if establishes otherwise
> ii) To come in Thursday Morning for assessment +/- ARM or CS on Friday.’ [44]

The nub of this plan appears to be that Mrs Willmett’s desire to deliver naturally in an attempted VBAC would continue to be maintained and that she would return to the Ceduna Hospital if her labour establishes. However, the plan contemplated that this situation should only prevail until the following Thursday morning at which time she should come in for an assessment, and that either an artificial rupture of the membranes would occur with a view to attempting a vaginal delivery, or a caesarean section would be performed on the Friday. It will be remembered, however, that Mrs Willmett’s due date for delivery was actually the very day that she was in the Ceduna Hospital, namely Saturday 13 August 2016.

5.32. Dr Ochigbo’s note says nothing about any desire on the part of Mr and Mrs Willmett to return home that day. However, Dr Ochigbo’s plan naturally contemplates that they would return home in anticipation of labour becoming established, in which event they would return to Ceduna, or in anticipation of Mrs Willmett’s return the following Thursday whichever occurred first. Dr Ochigbo’s note also says nothing about whether Mrs Willmett wanted to stay or wanted to leave the hospital or Ceduna that day and says nothing about whether Dr Ochigbo himself thought that she should stay either at the hospital or in Ceduna.

5.33. On the other hand, Ms Higgs’ 10:30am note of Dr Ochigbo’s involvement, a note also incorporated in the single sheet already referred to, indicated that the CTG was

[44] **ARM** is a reference to Artificial Rupture of Membranes, **CS** is a reference to caesarean section

unremarkable but there were some tightenings noted. It records that Mrs Willmett said that these tightenings were not painful at all. As to the vaginal examination performed by Dr Ochigbo, Higgs' note records that Mrs Willmett was one centimetre dilated. She records that the situation was discussed with Mr and Mrs Willmett and that they were '*very keen to go home*'. She records also that there were discussions with Mr and Mrs Willmett about what the signs of labour were which she recorded as being '*regular/painful contractions/increasing in intensity*'. She recorded that they discussed with Mr and Mrs Willmett the need to come back to the hospital as soon as possible if they had any concerns. There was also a record made of the discussion about the use of the balloon catheter and induction and the plan for induction possibly later in the week. Ms Higgs recorded as follows:

> 'Jennifer wanting VBAC, and very excited as feeling she will go into labour before IOL. D/w re need to come back as soon as contractions as far away + worried about kangaroos. Jennifer + Rick just keen to get home. Script from Dr for Panadeine Forte in case painful cont. on way back. – Jennifer + Rick – going home.' [45]

5.34. Mrs Willmett disputes that when she was examined by Dr Ochigbo she was comfortable and not in labour and that there was no palpable contraction. She asserts that she was still experiencing contractions. In her evidence before the Court Mrs Willmett maintained that during her examination with Dr Ochigbo her contractions were obvious[46]. She said that when she was lying on the bed she would stomp her feet when she was having a contraction and that they were very painful contractions[47]. Mrs Willmett said the same thing prevailed during the twenty minutes in which the CTG monitoring was in place. She said that the contractions at that time were very painful and that on a scale of one to ten they were probably seven[48]. In cross-examination by Mr Lindsay SC on behalf of Dr Ochigbo, Mrs Willmett told the Court that when she arrived at the hospital her contractions were very painful and were about eight minutes apart and very regular[49]. At that stage they were possibly level 5 on a scale of one to ten. She rejected the notion that it was possible that she had slept during the course of the night and stated that she had been wide awake the whole time[50]. She denied that she told Ms Higgs that she had no pain or discomfort[51] or that her

[45] **IOL** is a reference to induction of labour
[46] Transcript, page 45
[47] Transcript, page 45
[48] Transcript, page 46
[49] Transcript, pages 96-97
[50] Transcript, page 97
[51] Transcript, page 99

contractions were not painful. She denied that she told Ms Higgs that her contractions at that point were about one in every ten minutes and that they were mild and irregular[52]. In short, she said that she never told Ms Higgs that she was not having any pain. She said '*I was always having pain*'[53] and she said that she told Ms Higgs she was having painful contractions. She said:

> 'I said to her that I don't understand why she's telling me I'm not in labour when I've been having painful contractions all night; I was confused and I didn't understand why I wouldn't be in labour when I was having painful contractions.' [54]

5.35. Mrs Willmett denied that she told Dr Ochigbo that she was experiencing niggling pain[55]. She could not recall Dr Ochigbo telling her that she was not in labour[56]. She conceded that it was possible that he had told her that. As to the question of '*practice contractions*' she said that she could remember having such a conversation with Ms Higgs, but not with Dr Ochigbo[57].

5.36. I note that a description of niggling pain and a pain of the kind claimed by Mrs Willmett during her examination by Dr Ochigbo cannot live together. Dr Ochigbo's description of niggling to my mind is inherently more likely to be accurate. If Mrs Willmett had described her pain to Dr Ochigbo in the same terms in which she described it to this Court, an interpretation that it was niggling would be utterly remarkable. Dr Ochigbo had no demonstrable motive to fabricate his note of *'niggling pain'* at the time he made that note.

5.37. Mrs Willmett strenuously denied in cross-examination that Dr Ochigbo expressed a preference that she stay in hospital saying. '*no, he didn't suggest that at all*'[58].

5.38. One matter that was of some significance in Mrs Willmett's cross-examination by counsel on behalf of Dr Ochigbo was her denial that there was discussion between her and Dr Ochigbo that she should return to the Ceduna Hospital if labour commenced in the sense of having painful contractions that did not go away. To this she said that she was already having painful contractions, but she denied that Dr Ochigbo said that if that did not take place she should return to the Ceduna Hospital on the following Thursday

[52] Transcript, page 99
[53] Transcript, page 99
[54] Transcript, page 100
[55] Transcript, page 101
[56] Transcript, page 103
[57] Transcript, page 103
[58] Transcript, page 104

morning for an assessment about a possible artificial rupture of her membranes or a caesarean section on the Friday. To this Mrs Willmett's answer was unequivocal. She said, '*that discussion didn't happen*'[59]. The implication of her answer is that Dr Ochigbo's note that I have reproduced above[60] does not represent the truth and is a fabrication. Furthermore, the implication is that it is a fabrication made at a time at which Dr Ochigbo could not conceivably have had any reason to fabricate. Those implications contain inherent unlikelihoods.

5.39. Mrs Willmett maintained in her evidence that she was in labour because she had been having extremely painful contractions all night and that she had lost her mucus plug. She said that her labour not progressing was probably a sign of danger that the Ceduna Hospital staff overlooked[61]. She said that at the time she did not accept their advice that she was not in labour and told Ms Higgs that she was confused because she felt like she was in labour due to the painful contractions that had gone on all night. At a later point in her evidence Mrs Willmett asserted that Dr Ochigbo never told her that she was not in labour, but that it was Ms Higgs who told her that[62].

5.40. On behalf of Ms Higgs, Ms Sloan of counsel cross-examined Mrs Willmett. Mrs Willmett told Ms Sloan that she had not felt that her contractions had slowed overnight and that she was sure about that[63]. Mrs Willmett said that she disagreed with the casenote that Ms Higgs had made that Mrs Willmett was not in any pain or discomfort and that she was comfortable and quite talkative[64]. She said that Ms Higgs told her and her husband to go home. She did not agree with the suggestion that Ms Higgs had said that she had wanted her to stay in Ceduna for the day in case she went into labour as she lived a long way away and that she did not want her to travel back to Ceduna in labour and wanted her to be monitored.

5.41. Of interest is the fact that Mrs Willmett agreed with the proposition put to her by Ms Sloan that Ms Higgs, as a sweetener to persuade Mrs Willmett and her husband to

[59] Transcript, page 108
[60] Paragraph 5.31.
[61] Transcript, page 109
[62] Transcript, page 115
[63] Transcript, page 146
[64] Transcript, page 147

stay in Ceduna, had said that they could treat a stay in Ceduna like a babymoon or a honeymoon[65]. Her response to that was:

> 'She said that but I don't think it was to try and convince us, I think it was to tell us that we could have a little holiday away from our son which I didn't think was appropriate.'

That answer does seem to lend some support to the notion that Ms Higgs was unenthusiastic about the Willmett's leaving Ceduna. I will come to deal separately with the advice if any that Mr and Mrs Willmett were given about either leaving or returning to Ceduna.

5.42. There is one further matter relating to Mrs Willmett's asserted level of pain that I should mention. When Mr and Mrs Willmett left the Ceduna Hospital that morning they were provided with a prescription for Panadeine Forte that had been authorised by Dr Ochigbo. Mrs Willmett asserts that this was provided to her in order for her to manage the current level of pain that she says she was in that morning and further asserts that she consumed a tablet or tablets upon filling the prescription in Ceduna. Mrs Willmett's assertion that she was given the prescription to manage her current level of pain is not accepted by Ms Higgs or Dr Ochigbo as they have both maintained that Mrs Willmett was not reporting any pain of significance that morning. As well, Ms Higgs, as seen, made a note to the effect that the Panadeine Forte was prescribed in case Mrs Willmett experienced painful contractions on her return to the Ceduna Hospital. In his evidence, Dr Ochigbo gave the same explanation for the prescription of Panadeine Forte.[66] Thus there are two competing possible explanations for the prescription which are current pain and future pain. There is nothing inherently unlikely about either explanation.

5.43. I now turn to the evidence of Mr Willmett in relation to the events of the Saturday morning.

5.44. Regarding pain Mr Willmett said that during the course of the night at the Ceduna Hospital his wife appeared to be restless but she did not seem to be in pain[67]. What made him think she was restless was the fact that she was pacing around and frequently going to the toilet.

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[65] Transcript, page 150
[66] Transcript, page 428
[67] Transcript, page 173

5.45. He maintained that Dr Ochigbo told them that they should go home. He said nothing about when they should return[68]. Mr Willmett asserted that Dr Ochigbo never said that they should stay in hospital, although Ms Higgs said that they could have stayed in the hospital and have treated it like a holiday. They were never given any information that leaving the hospital was the wrong thing to do medically[69].

5.46. Asked as to why his wife was given a script for Panadeine Forte he said that she was in pain. Although the script was filled at Ceduna he did not see his wife take the tablets[70]. In cross-examination by Mr Lindsay on behalf of Dr Ochigbo he denied that he had said that their preference was to go home[71].

5.47. Mr Willmett agreed that Dr Ochigbo had asked his wife about her pain level. The following passage of evidence occurred during cross-examination by Mr Lindsay SC on behalf of Dr Ochigbo:

> ‘Q. She told him that she’d had niggling pain.
> A. Niggling pain?
> Q. Yes.
> A. I don’t know if that was the term she used but -
> Q. What term do you think she used.
> A. I don’t know what term she used but she would have said pain of some sort.
> Q. But she didn’t describe high levels of pain.
> A. No.
> Q. Because she wasn’t having high levels of pain.
> A. No, that’s right.’ [72]

This evidence does not support that of his wife about the level of pain she was experiencing. It is a significant point of difference. If anything, Mr Willmett’s evidence supports that of Dr Ochigbo.

5.48. Unlike his wife Mr Willmett acknowledges a recollection that they had been told that if the baby had not arrived by a certain date, which he thought was 22 August 2016, they would attempt to induce labour and agreed that another backup plan was that if they could not induce labour there would need to be a caesarean section[73].

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[68] Transcript, page 177
[69] Transcript, page 177
[70] Transcript, page 178
[71] Transcript, page 187
[72] Transcript, page 188
[73] Transcript, page 193

Mr Willmett's recollection of 22 August 2016 being a relevant date would not be correct as that would have been the Monday of the week after next which would be beyond what was contemplated by Dr Ochigbo as per his note. Nevertheless, the thrust of what Mr Willmett acknowledges reflects the essential elements of Dr Ochigbo's plan.

5.49. In cross-examination by Ms Sloan on behalf of Ms Higgs, Mr Willmett denied that Ms Higgs wanted him and his wife to stay in the Ceduna Hospital or within the town of Ceduna that day. He denied an assertion that would be made by Ms Higgs in her evidence that in this context he had said to her that he did not like hospitals and that the best case scenario for the birth was to drive to the hospital at the last minute, have the baby in the carpark and then go home after the birth. He denied that he had said that as a joke[74]. In her evidence Ms Higgs asserted that Mr Willmett did indeed say that he did not like being in hospitals and said that his 'best case scenario' for a birth would be to go home and labour at home and then come into the hospital in heavy labour and have the baby in the carpark and just turn around and go home so that he did not have to spend time in the hospital[75]. This evidence has something of a ring of truth to it. It does not strike me as being the kind of evidence that would be invented in order to garnish a fabricated account. I note Mr Willmett's denials of this conversation, but I also note that in Mrs Willmett's first witness statement she said the following:

> 'I remember discussing with Alison how far we lived and she even had a little joke with Rick when he said that we liked to 'live on the edge' she responded that we may have the baby on the side of the road. Rick didn't really mean this. It was more sarcasm and he was kind of trying to reassure himself.' [76]

To my mind this conversation as described by Mrs Willmett is so similar in theme to that asserted by Ms Higgs, and denied by Mr Willmett, that in my view Ms Higgs and Mrs Willmett are speaking of the same conversation, the underlying topic being Mr Willmett's personal aversion to and desire to avoid hospitals. Indeed, the best case scenario as articulated in Ms Higgs' version of what was said does smack of '*living on the edge*' in the sense that it involves risk. What Mr Willmett said to Ms Higgs could hardly have been taken seriously, but what he said even jokingly is consistent with him expressing and even harbouring a distaste for remaining in hospital any longer than was necessary which in turn would be consistent with a desire, on his part at least, that they

[74] Transcript, page 207
[75] Transcript, page 661
[76] Exhibit C13, page 7

leave the hospital. On the other hand, Ms Higgs' retort, as described by Mrs Willmett, would seem to be the natural response of a midwife keen to avoid a scenario where the baby might indeed be born en route back to the Ceduna Hospital. As well, Mr Willmett having told his own counsel Ms O'Connor SC in his evidence-in-chief that Ms Higgs had said that they could have stayed in hospital and have treated it like a holiday,[77] when cross-examined on the same topic by Ms Sloan of counsel for Ms Higgs, gave the following evidence:

> 'Q. Ms Higgs tried you to persuade you to stay in that birthing room because it was so nice and so large for the day, didn't she, and told you could treat it like a holiday or a babymoon, didn't she.
>
> A. No.
>
> Q. Are you sure about that.
>
> A. Yes.
>
> Q. She was trying to make it a more appealing option, wasn't she.
>
> A. No.' [78]

The inconsistency in respect of an important issue as displayed by Mr Willmett gave me pause in respect of his overall credibility.

6. The advice given to Mr and Mrs Willmett on the Saturday morning

6.1. I do not believe there is any real dispute that having regard to Mrs Willmett's then current condition, even allowing for the notion that what she was experiencing were only Braxton Hicks contractions, her leaving Ceduna to travel back to their home on the due date of her child's birth was ill advised. The issue is at whose instigation they chose to do that.

6.2. The evidence of Professor Pepperell which I accept is that the CTG tracing taken that morning reveals tightenings that could either have been Braxton Hicks contractions or labour contractions and that a distinction between the two could not have been made with reference to the trace alone[79]. I also accept Professor Pepperell's evidence that while Mrs Willmett's vaginal examination did not indicate established labour at that point in time, the latent phase of labour could not have been ruled out and that only time would have determined that issue one way or the other[80]. That said, Professor

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[77] Transcript, page 177
[78] Transcript, page 208
[79] Transcript, page 902
[80] Transcript, page 902

Pepperell conceded that based on the history of the contractions, on the CTG trace and on Dr Ochigbo's pelvic examination, a diagnosis that Mrs Willmett was experiencing Braxton Hicks contractions was reasonable.[81] But the real question in my view was, in all of the circumstances should Mrs Willmett have stayed at Ceduna in any event and regardless of the diagnosis? To my mind the answer to that question is clearly yes.

6.3. Although Dr Ochigbo's evidence differed somewhat from that of Professor Pepperell's in relation to what the CTG trace demonstrated[82], he gave evidence that he spoke to the Willmett's about the risks of them living far away. He said:

> 'Well the decision is - I have talked to them not to go because of the ... risks, and I know they live about 100 km away from Ceduna but insisted on going.' [83]

There is nothing in Dr Ochigbo's contemporaneous note about that. However, in retrospective notes made by him timed at 8:30am on 15 August 2015, the day after Laura's death, he recorded that he had told Mrs Willmett that she was not in labour and that the only option that was open if she had not delivered at the 41 week mark was a caesarean section. Dr Ochigbo recorded as follows:

> 'At that point, Jennifer was very keen to go home to her 1 year old baby whom she said she has never stay (sic) away from over night before. Since she was very keen for natural birth this time and was not in labour, we agreed that she could go home and return to hospital if starts contracting again.

This assertion has to be evaluated against the fact that these notes were prepared in the light of the tragic events that followed Mrs Willmett's discharge from the hospital on the Saturday morning, events which culminated in Laura's death. However, I have not seen it nor heard it suggested to Dr Ochigbo that these notes were a fabrication in the light of those events, but naturally the weight to be accorded to the notes has its limits. That said, if I was invited to find that Mrs Willmett gave Dr Ochigbo no reason to believe that she was very keen to go home to her one-year-old boy and to make that finding on the balance of probabilities, I would also have to find that Dr Ochigbo's note contradicting this scenario was a fabrication. Naturally, I would also have to find that Ms Higgs' notes to similar effect, which she says she made at the Ceduna Hospital on the Saturday morning when there was no motive to fabricate, would also be a fabrication. As seen earlier, counsel assisting, Ms Kereru, urged me to find that

[81] Transcript, pages 993-994
[82] Transcript, pages 424 and 537
[83] Transcript, page 40

Ms Higgs was a credible witness. I have given very careful thought to that submission coming as it does from counsel assisting this Court and from a counsel who so vigorously cross-examined Ms Higgs. Not only is there an issue as to whether Ms Higgs was lying or not, but having regard to the almost identical content of Dr Ochigbo's ex post facto note it would also be necessary for consideration to be given as to whether collusion between them had occurred both in respect of the compilation of their stories and of their notes. No such accusation was levelled against either of them during the course of their respective testimonies.

6.4. So the issue is not so much whether in the light of Mrs Willmett's clinical condition she should have left the Ceduna Hospital and left the Ceduna environs. The fact that she should not have done so in my view is clear. That morning it could not have been confidently thought that even if Mrs Willmett was only experiencing Braxton Hicks contractions, she would not enter into established labour once she arrived back at Sceale Bay, a circumstance that would have necessitated her immediate return to Ceduna on the same day on which she had been sent home. There would seem to be a pointlessness in Mrs Willmett being sent home when the possibility of her entering into established labour that day could not have been clinically discounted. It seems inherently unlikely having regard to their professional competence and experience that both Dr Ochigbo and Ms Higgs would have been prepared to send a person in Mrs Willmett's position home. And it was not as if she was being sent to a destination that was only a matter of minutes away. There were well understood intrinsic difficulties in the journey including its distance and the fact that Mrs Willmett and her husband might have to drive back to Ceduna in the dark when kangaroos would be a problem. As far as Ms Higgs and Dr Ochigbo were concerned, to use a colloquialism there was no skin off their nose if the Willmetts stayed, either at the hospital or in the Ceduna environs. Some might therefore argue that the fact that Mr and Mrs Willmett did return to their home is more consistent with a keen desire on the part of at least one of them to return to that home and less consistent with them being sent home in effect against their wishes and better judgment.

6.5. Ms Higgs gave the following evidence concerning Mrs Willmett:

> 'She was - she was told clearly, very clearly, repeatedly by Dr Ochigbo and myself that it was our best advice that she stayed in the hospital, particularly because she was high-risk because she was a VBAC, because she lived far away. And our assumption was based on the fact of working in this area for many years that when women have a night of Braxton

> Hicks tightenings, whatever, that kind of fizzle out, it is better that they stay in the hospital. So, saying to someone that you're not labour is not the same as saying please go home, and at no point was she encouraged to go home.' [84]

This evidence replicates the approach that Professor Pepperell in his evidence described as being the correct approach to Mrs Willmett's circumstances. Ms Higgs gave that evidence forcefully and convincingly. I found it impossible to conclude that in giving that answer she was being disingenuous in the sobering light of an ex post facto realisation of what she should have said and done at the time.

6.6. Neither Ms Higgs or Dr Ochigbo would contest the notion that it was not appropriate for Mr and Mrs Willmett to return to Sceale Bay. Both witnesses in their oral evidence asserted that before Mr and Mrs Willmett left the hospital they had wanted Mrs Willmett to sign a discharge against medical advice form which is a common method of recording the fact that despite medical advice a patient should remain in hospital. This evidence, given by both witnesses, unsurprisingly raised eyebrows during the course of the inquest. This was so due to the fact that neither person had asserted in their written responses to AHPRA that arranging for Mrs Willmett to sign such a document was ever contemplated. There seems to have been an opportunity for Ms Higgs or Dr Ochigbo to have secured a signature on such a document before Mr and Mrs Willmett left Ceduna. It is also a fact that neither Ms Higgs nor Dr Ochigbo made any record of any desire or attempt to arrange for Mrs Willmett to sign a discharge against medical advice form. Nor in Dr Ochigbo's retrospective note made on 15 August 2016 is there a record of any such desire or attempt.

6.7. I am mindful of the statement of Ms Rebecca Smith who is a nurse at the Streaky Bay Hospital.[85] Ms Smith is a registered nurse and registered midwife who attended at the Streaky Bay Hospital when Mr and Mrs Willmett attended that night. Among other things contained in Ms Smith's statement is an assertion that Mr Willmett told her that when they had been in the Ceduna Hospital the night before, Mrs Willmett had been contracting every 8 minutes which increased to 5 minutely overnight and then had become irregular. Ms Smith also asserts that Mr Willmett told her that he and his wife '*were told to go home and to return to Ceduna Hospital when the contractions were regular and 5 minutes apart*'.[86] While I accept Ms Smith's assertions that Mr Willmett

[84] Transcript, page 762
[85] Exhibit C15
[86] Exhibit C15, paragraph 33

said those things, having regard to the circumstances in which they were said they possess a self-serving element. To my mind this does not advance the matter as to who is telling the truth about the circumstances in which the Willmetts left the Ceduna Hospital.

6.8. I have been unable to determine where the truth lies in respect of the issue concerning at whose instigation on the morning of Saturday 13 August 2016 Mr and Mrs Willmett left the hospital and left Ceduna to return home. Mrs Willmett was a forthright witness who gave every impression that she believed in what she was saying. Her husband less so. But so was Ms Higgs, and her evidence is supported by documentation. But there are elements of the accounts given by Ms Higgs and Dr Ochigbo that strike me as odd. I am troubled by the fact that nothing was said by either of them in any clinical note nor in any account given to AHPRA that they had tried to obtain a signature on a discharge against medical advice form which would have been an obvious thing for at least one of them to have included in any account of these events. One is left with a nagging doubt that this may be a fabricated after-thought. Yet the accounts of Ms Higgs and Dr Ochigbo to the effect that having regard to their professional experience their best advice had been for the Willmett's to stay has a greater inherent likelihood in my view. In the event I am unable to make any finding about the issue as to the circumstances in which Mr and Mrs Willmett chose to go home to Sceale Bay. The evidence is so delicately poised that it is impossible to determine which of the two versions is the more probable, and in particular whether one version can be said to be more probable than not. That said, in my opinion the facts underpinning the serious allegation that Mrs Willmett was inappropriately sent home to Sceale Bay have not been substantiated.

6.9. As to the advice that should have been tendered to Mr and Mrs Willmett, Professor Pepperell told the Court that he would have said to her:

> 'I would have said that look it's really not appropriate that you want to go home because we need to reassess the foetal heartrate constantly for the next three to four hours at least. We need to repeat the pelvic examination in four hours' time to see if there's any progress that's occurring and that you are in established labour. We can't do that if you're not in the hospital and having that assessment done. If you're not prepared to stay and have that done, then we need to get you sign a discharge against medical opinion.' [87]

I accept that evidence.

[87] Transcript, page 911

6.10. It still remains for the Court to consider whether on the understanding that Mr and Mrs Willmett may have left the Ceduna environs contrary to the advice of the midwife and the doctor, they were nevertheless provided with sufficient information and advice to enable them to determine whether it would be necessary for them to return to the Ceduna Hospital and when. There was much evidence given about the sufficiency and accuracy of information imparted to them in particular by Ms Higgs about the signs and symptoms of established labour and what Mrs and Ms Willmett should have been looking for a far as cues for them to return to Ceduna were concerned. Ms Higgs said in evidence that she provided them with a definition of labour as being regular painful contractions increasing in intensity and causing cervical dilatation. When asked as to how often those contractions might be, she had said that they would be about three in ten. She said she would probably have spelt that out to the Willmetts because that is the type of language that she would use to describe labour. Professor Pepperell told the Court as to the manner in which he would describe labour to a pregnant woman. He said that he would describe labour contractions as contractions usually becoming more frequent, down to every four minutes and when fully dilated usually to about every three minutes. However, he said that is not always the way things transpire and that sometimes contractions remain irregular even though normal progress occurs.

6.11. Professor Pepperell was firm in his evidence that having regard to the fact that the Willmetts lived as far away as they did, it was inappropriate for them to have been told that they should not come back until Mrs Willmett was experiencing one contraction every five minutes, or three contractions in every ten minutes.[88] However, when asked by Ms O'Connor SC whether the advice should have been that Mrs Willmett should return to the Ceduna Hospital as soon as she experienced any contractions, Professor Pepperell said:

> 'It's difficult because her contractions have always been irregular, they've always been much slower than one would normally expect. But sometimes under those circumstances, progress can still occur. I think it's difficult to say absolutely certain, under what circumstances she should have come back, except that there should have been a time for review if she was demanding on going home.' [89]

[88] Transcript, page 950
[89] Transcript, page 965

But then he was asked the following question by Ms O'Connor SC and gave the following answer:

> 'Q. I want you to assume something, I want you to assume that you have a patient who's having Braxton Hicks contractions and they've stopped, and you're discharging them on the basis that they can leave the hospital because the Braxton Hicks contractions have stopped, but they're high risk like this patient was. You would tell her, would you not 'any contractions at all, no matter how far apart they are, you need to come back to the hospital'; would you agree with me.
>
> A. Yes, I would accept that. ' [90]

6.12. In the final analysis I am not sure what advice could have been given if Mr and Mrs Willmett's determination to return to their home was fixed and unmovable. In those circumstances there would have been no point in them returning home if they were given advice to come back to Ceduna if in effect nothing in Mrs Willmett's circumstances had changed. What was needed was for Mrs Willmett to have stayed in Ceduna so that she could be re-assessed in three to four hours as has been suggested by Professor Pepperell[91], a suggestion that I accept. Failing Mrs Willmett's agreement to do that, the definitive advice needed to be given to them as to the time and circumstances in which they should return is difficult to identify.

6.13. Professor Pepperell also agreed with Ms O'Connor SC for Mr and Mrs Willmett that the Willmett's should have been advised that it was important for them to return to Ceduna immediately if Mrs Willmett experienced abdominal pain outside of her contractions. I accept that evidence but would observe that if Mrs Willmett had started experiencing regular contractions, the evidence seems clear that she should have returned to Ceduna in any event.

6.14. So there are two ways of looking at the advice that Mrs and Mr Willmett were given. If it was the case that they were determined to return home, the advice that they were given about the signs of labour and when they should return does not appear to be the subject of valid criticism. If on the other hand Mrs and Mr Willmett were amenable to staying in Ceduna, then clearly the only appropriate advice would have been for them to have so stayed and for Mrs Willmett to have been re-assessed later in the day.

[90] Transcript, pages 965-966
[91] Transcript, page 950

6.15. Due to his superior qualifications and experience, I prefer and accept the evidence of Professor Pepperell that the CTG trace taken on the morning of 13 August did not rule out the latent stage of labour. I am troubled that the advice given to Mrs Willmett by both Ms Higgs and Dr Ochigbo that she was not in labour may have been needlessly categorical, particularly having regard to the fact that she was due that very day, that she and her husband had already travelled from their home to the Ceduna Hospital in the belief that Mrs Willmett was in labour and that they lived so far away. Hindsight suggests that if the advice had been, '*you may or may not be in labour*' it is likely that the Willmetts would have at least stayed in Ceduna.

7. <u>The communications between Ms Higgs and Mr Willmett during the late afternoon and evening</u>

7.1. I have already referred to telephone conversations between the Ceduna Hospital midwife Ms Higgs and Mr Willmett that occurred that evening at 5:16pm and at 7:43pm on 13 August 2016 when the Willmetts were still at home in Sceale Bay. Other phone conversations between them occurred at 8:54pm when the Willmetts were at Streaky Bay and at 10:20pm when they were leaving Streaky Bay for the Ceduna Hospital.

7.2. I will deal firstly with the phone conversation between Ms Higgs and Mr Willmett that took place at approximately 5:16pm. Ms Higgs asserts that she contemporaneously recorded in writing that Mr Willmett told her that his wife's contractions were occurring at three minute intervals, meaning that Mrs Willmett was in established labour, and that in light of that revelation she discussed with Mr Willmett the need for him and his wife to return to the Ceduna Hospital as soon as possible. Her note admits of little room for error in interpretation. At the inquest Ms Higgs gave oral evidence to like effect. However, the content of this conversation as described by Mr Willmett is in sharp conflict in that he said that Ms Higgs told him that he and his wife could come back to the hospital more or less at their leisure and not to hurry because nothing had changed from that morning. He also asserted that she had not said that it was important that they travel to the hospital[92]. He denied that he told Ms Higgs that Mrs Willmett's contractions were three minutes apart, adding in his evidence before the Court that they would have left home to drive to the Ceduna Hospital if that contraction frequency had

[92] Transcript, page 179

been the case[93]. Of course this was a material issue because if Mr and Mrs Willmett had immediately travelled to the Ceduna Hospital much of what took place later that evening could have been avoided, including the need to break their journey at Streaky Bay as well as the very late emergency caesarean section in Ceduna just after 1am the following morning. Moreover, whatever the reason was for the Willmetts not returning to Ceduna as soon as possible following that phone conversation, be it confusion, naivety or simply being overwhelmed by the occasion, one could hardly be critical of Ms Higgs if in fact she had tendered the advice encapsulated in her contemporaneous note. In order for Mr Willmett's version of that conversation to be preferred on the balance of probabilities I would need to find to the same level of satisfaction that Ms Higgs had fabricated her note of this telephone conversation and had lied about that in her evidence. In addition, the Court would have to make such findings in the absence of any submission made by counsel, including both counsel for Mr and Mrs Willmett and counsel assisting, that this document had been so fabricated. In the event, however, and for reasons that I will discuss I have preferred the evidence of Ms Higgs regarding this conversation.

7.3. It is firstly necessary to consider the evidence of Mr and Mrs Willmett as to what was taking place during the period leading up to the phone conversation at 5:16pm. In Mrs Willmett's first statement she asserts that when they arrived home from Ceduna that afternoon her contractions were still irregular in that some were as close as four minutes apart and some might have been ten minutes apart. She asserts that she was starting to feel exhausted and emotional and so her husband rang the Ceduna Hospital and spoke to Ms Higgs. Mrs Willmett said in her second statement that throughout her labour her contractions were never at a rate of three in ten minutes which was the rate suggested to her by Ms Higgs on the Saturday morning as being an appropriate rate. She said that because of that advice this was the '*marker*' that she and her husband were being vigilant for. She said that they were monitoring the contractions to see if they became as frequent as three in ten. Mrs Willmett said that her contractions continued to be very inconsistent right up until the birth of Laura and varied from a rate of five to ten minutes apart to over ten minutes apart. She was not party to the telephone conversation her husband conducted with Ms Higgs at 5:16pm.

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[93] Transcript, pages 210-211

7.4. For his part Mr Willmett in his first statement asserts that he rang Ms Higgs and told her how far apart his wife's contractions were. He said that the contractions were not at that time consistent, '*One would be 8 minutes, then 10 then 15, then back to 8*'. In his second statement he asserts that his wife's contractions were not consistent and describes the same rate. His purpose in making the communication with Ms Higgs was to seek advice about what that meant. As indicated above he denies that he told Ms Higgs that his wife was having irregular but painful contractions coming at three minutes apart.

7.5. Of course, as Mrs Willmett was not being monitored at home there is no independent evidence about what the state of her labour was at the time of this telephone communication. There can be no question, however, that if Mr Willmett had told Ms Higgs that his wife was experiencing contractions at a rate of 3 in 10, the only advice that Ms Higgs could have tendered was what she said she tendered, namely for the Willmetts to come in as soon as possible. The question becomes, is there any other evidence of what the state of Mrs Willmett's labour was at 5:16pm?

7.6. The next piece of independent evidence on the state of Mrs Willmett's labour consists of the examination of Mrs Willmett by Dr Oswald at the Streaky Bay Hospital at approximately 9:10pm. I will deal with the events at the Streaky Bay Hospital in more detail later in these findings. For current purposes, however, it is pertinent here to digress to observe that at 9:10pm Dr Oswald performed a vaginal examination of Mrs Willmett and that her cervix at that point was at about eight or nine centimetres in dilatation. At that time clearly Mrs Willmett was in established labour. However, not having reached cervical dilatation of ten centimetres she was not completely dilated to the point where the arrival of the baby was immediately imminent or at a point where she should push. A further vaginal examination performed by Dr Oswald at 9:40pm revealed that she had made no progress since the previous examination. The cervical dilatation was the same. Using Professor Pepperell's evidence that the cervix might dilate one centimetre per hour between 3cm and 9cm of dilatation, Mrs Willmett may have entered established labour sometime in the mid-afternoon of that day. However, I did not understand Professor Pepperell to be saying that this was an invariable rate. Dr Oswald gave evidence on his oath that either Mr or Mrs Willmett informed him that Mrs Willmett had been in labour for '*four to five hours at least*'[94]. When I asked

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[94] Transcript, page 233

Dr Oswald to relate to the Court the precise language that was used by either Mr or Mrs Willmett to describe the duration of labour, Dr Oswald said:

> 'If I remember correctly then they said that they had been - she had been contracting regularly since about five o'clock.' [95]

The time lapse between 5pm and 9:10pm when Dr Oswald performed his first vaginal examination is between four and five hours. When it was put to Dr Oswald in cross-examination by Ms O'Connor SC that Mr and Mrs Willmett had made it clear to him that Mrs Willmett had been having contractions since she had left the Ceduna Hospital earlier that day, Dr Oswald said that he had been unaware of that. When it was pointed out to him that he had not recorded anywhere in any document or note that he believed that Mrs Willmett had only been in labour for about five hours and the reason for that lack of record was because his assertion in that regard was simply not true, Dr Oswald responded by saying '*you're calling me a liar?*'[96]. Indeed, it was suggested that he had made that up. He rejected that suggestion. Dr Oswald added the observation that if Mrs Willmett had been in labour for as much as nine hours or more as suggested, he would have thought that she would have presented to the Streaky Bay Hospital a lot earlier than she did[97].

7.7. The assertion by Dr Oswald that he believed that Mrs Willmett's labour had commenced at about 5pm had not been put to Mr or Mrs Willmett in cross-examination. To my mind what Dr Oswald had been told by the Willmett's about the duration of labour and his belief as to that issue was a material matter for reasons I will explain in a moment. I recalled both Mr and Mrs Willmett to deal with that issue. Mr and Mrs Willmett both made it plain in their resumed evidence that they considered Dr Oswald to be a liar. Mrs Willmett stated that Dr Oswald had completely made it all up[98]. Mr Willmett in his resumed evidence said that Dr Oswald's evidence was a lie[99]. He denied that he had said anything to Dr Oswald at the Streaky Bay Hospital about any circumstance that had existed at 5pm.

7.8. What then is the significance of an issue that would foment such serious controversy as to necessitate Dr Oswald being accused of making up his evidence? It is this.

[95] Transcript, page 276
[96] Transcript, page 272
[97] Transcript, page 273
[98] Transcript, page 363
[99] Transcript, page 371

Dr Oswald's evidence tends to support that of Ms Higgs when Ms Higgs asserts that at 5:16pm Mr Willmett told her in effect that his wife was now in labour.

7.9. The question then becomes, was the time of 5pm of any particular significance to Dr Oswald? The answer is that his impression of the duration of Mrs Willmett's labour dictated his clinical management of her. Dr Oswald told the Court that his belief that labour had commenced at about 5pm was of some significance to him because it meant that Mrs Willmett's period of established labour had occurred more rapidly than usual, that is to say more rapid than the usual one centimetre per hour. This meant to him that the last centimetre or so of dilatation that was required before Mrs Willmett could deliver might occur reasonably soon after his first vaginal examination. This had given rise to a quandary in his mind as to whether Mrs Willmett should stay at the Streaky Bay Hospital and deliver her baby there naturally rather than for her to be moved on to the Ceduna Hospital. Dr Oswald states that he was mindful of the need to avoid the risk that she might deliver in the ambulance if he immediately sent her to Ceduna after the first vaginal examination. In the event he decided to keep Mrs Willmett at Streaky Bay for another thirty minutes to ascertain what progress if any she would make in that time. As nothing had altered after that thirty minutes, arrangements were then made to transport her by ambulance to Ceduna.

7.10. I did not understand that anything in the evidence of Professor Pepperell excluded the possibility that Mrs Willmett's established labour had commenced at around 5pm. Professor Pepperell did say that Mrs Willmett's account that at no time during the course of her labour did she have regular contractions but that they were irregularly spaced throughout the entirety of her labour was an unusual pattern of labour[100]. Nevertheless, cervical dilatation clearly had occurred but exactly when it had occurred and when it had reached eight to nine centimetres could not be known[101]. When asked to consider the appropriateness of Dr Oswald's performing a second examination thirty minutes after the first, Professor Pepperell was not critical of that decision and did not suggest that Dr Oswald's thinking that labour had commenced at 5pm was out of the question[102].

[100] Transcript, page 913
[101] Transcript, page 913
[102] Transcript, pages 916-917

7.11. But as I say, the relevant point to be made from the evidence of Dr Oswald that he was given to understand by Mr or Mrs Willmett that she had been in labour since about 5pm is that this evidence sits well with Mr Willmett allegedly telling Ms Higgs in the 5:16pm phone call that his wife was experiencing contractions at the rate of three minutes apart, meaning that she was now in labour. To this extent save for the possibility of collusion as between Dr Oswald and Ms Higgs which was never put to either witness, and of which there is no evidence, there is a striking correlation between their evidence. The time of approximately 5pm is the time at which Mr Willmett called the Ceduna Hospital to advise in effect, on Ms Higgs' evidence, that his wife was in labour. It is the same time as testified to by Dr Oswald that he is told that Mrs Willmett's labour had commenced. To my mind the juxtaposition of these facts cannot be attributed to pure coincidence. The juxtaposition leads me to think that at 5pm Mr Willmett, in spite of his denials as to what he said to Ms Higgs, was of the belief that his wife had only just commenced labour.

7.12. I am not able to reject the evidence of Dr Oswald despite the vehement denials by Mr and Mrs Willmett that he was told that Mrs Willmett's labour had commenced at about 5pm. I am also not prepared to reject the evidence of Ms Higgs as to the terms of the conversation that Mr Willmett had with her in the 5:16pm phone call. Furthermore, I find it impossible to reject Ms Higgs' assertions that the notes that she made of that conversation accurately reflect what she was told by Mr Willmett, including the assertion that Mrs Willmett's contractions were now three minutes apart. I do not reject her evidence that she told Mr Willmett that they needed to come to the Ceduna Hospital as soon as possible.

7.13. In the event I have preferred the evidence of Ms Higgs, supported as it is by a contemporaneous note that I find was made at a time when she had no reason to fabricate its content. I find that in the phone conversation at 5:16pm she was told that Mrs Willmett was contracting at the rate of every three minutes, that she told Mr Willmett that there was a need for them to come into Ceduna as soon as possible and that she said to him that they needed to be in Ceduna as Mrs Willmett was now in labour.

7.14. I deal with the subsequent phone conversations in later sections.

8. Mr and Mrs Willmett remain at Sceale Bay after the 5:16pm phone conversation

8.1. If in the light of the 5:16pm telephone conversation Mr and Mrs Willmett had immediately or as soon as possible left Sceale Bay, they could have been in Ceduna at a time significantly before the time they ultimately arrived at the Streaky Bay Hospital which was at 9pm and significantly before their ultimate arrival at Ceduna at 11:22pm.

8.2. As to why Mr and Mrs Willmett remained at their home at Sceale Bay and did not in accordance with advice tendered by Ms Higgs travel to Ceduna as soon as possible after the 5:16pm conversation requires some evaluation. In her first statement Mrs Willmett asserts that she was so focussed on trying to achieve three contractions in ten minutes that she could not '*really remember why I didn't think to be concerned about the long drive*'. She says that she did not want to repeat going to the hospital at the wrong time and be sent away again, so they stayed home and monitored the contractions. Of course, accepting Ms Higgs' evidence as to the content of the 5:16pm phone conversation as I do, Mr Willmett had reported to Ms Higgs that his wife was experiencing contractions that were three minutes apart and for that reason she was considered to be in established labour. Mrs Willmett's evidence in effect is that her contractions continued to be inconsistent with no identifiable pattern. In Mr Willmett's first statement he said that Ms Higgs had said in the telephone conversation at 5:16pm that they should not hurry or stress out because nothing had really changed, presumably meaning changed from the morning. He asserts that he thought that he and his wife should start to get ready for the drive but kept thinking of Ms Higgs' definition of labour. His wife's contractions at that stage were not as Ms Higgs had described. They were still quite a distance apart. Again, this account is contradicted by Ms Higgs. On Ms Higgs' version of events there would be absolutely no reason for Mr and Mrs Willmett to have remained in their home because on Ms Higgs' version it was plain that established labour was in existence and that Mr and Mrs Willmett would have had a good appreciation of that fact.

8.3. I do not know why Mr and Mrs Willmett remained at their home in Sceale Bay after the 5:16pm conversation between Ms Higgs and Mr Willmett. The fact that I cannot divine a sensible explanation for the Willmett's remaining at their home does not shake my acceptance of Ms Higgs' evidence that she urged them to come in.

9. The subsequent phone conversations

9.1. There was a further telephone conversation between Ms Higgs and Mr Willmett while Mr and Mrs Willmett were still at home. According to Ms Higgs' notes it occurred at 7:43pm. The original statements of Mr and Mrs Willmett differ somewhat in respect of the circumstances in which this telephone conversation occurred. Mrs Willmett states that Ms Higgs phoned at around 7pm to ask if they were coming in. On the other hand, in Mr Willmett's original statement he states that he rang Ms Higgs to say that they were coming in. His statement asserts:

> 'Jenny was starting to get very uncomfortable with the pain so I made a bed in the car and rang Alison to say we were coming in.'

The purport of that sentence is that he initiated the conversation because of his wife's condition as distinct from an acknowledgement on his part that Ms Higgs had initiated the conversation because she was concerned about Mrs Willmett. In his oral evidence Mr Willmett acknowledged that Ms Higgs did initiate this telephone call. He said that Ms Higgs rang them and spoke to him. Mr Willmett was not cross-examined about why he had said in his original statement that he had telephoned Ms Higgs to say that they were coming in when in fact it is clear that Ms Higgs initiated that phone call. The issue is material in one way in that the reason why Ms Higgs rang was because she wanted to know where the Willmetts were in the light of her earlier advice that they should come in. Ms Higgs made a note of this telephone conversation. She recorded the time as 1943 which is nearly two and a half hours since the previous conversation. Ms Higgs initiating this communication is consistent with concern on her part that her earlier advice had not been heeded or had been misunderstood. It is at least consistent with concern on her part about Mrs Willmett's labour regardless of whose version one accepts of the content of the earlier conversation that she had with Mr Willmett.

9.2. The content of Ms Higgs' note timed at 1943 speaks for itself and is explicable on no basis other than it reflects a significant level of concern on the part of Ms Higgs. I set out the note in full:

> 'Called Rick ? where are they – as been waiting at hospital for them – was worried as in labour? baby? VBAC? Where were they. They have not left home yet – Decided to stay at home??? D/w that they should drive carefully but come asap. Now 2.40 since spoke to them last – and been waiting for them – still not left. Very concerned. Come ASAP –

> Called Damian to let him know ?? why did they not come in??' [103] (ed. Damian is Dr Ochigbo)

Adjacent to that note is an apparent calculation made by Ms Higgs that calculates the time difference between 5:15pm and 7:45pm which are the rounded up times at which the two phone conversations between Mr Willmett and Ms Higgs took place. The calculation has a result which is encircled in biro of '*2.40*'. I note that that is the duration mentioned in the content of the note. In fact the calculation is incorrect insofar as the duration is actually two hours and thirty minutes. It is a small point admittedly, but the error is perhaps more in keeping with the note having been made contemporaneously with the event that it records rather than retrospectively when time was less of the essence. The note has the hallmarks of genuineness.

9.3. This note, the contents of which Ms Higgs confirmed in her oral evidence on oath, is congruent with the nature of the conversation that Ms Higgs said had earlier occurred at 5:16pm when she had identified a need for Mr and Mrs Willmett to come to Ceduna as soon as possible as they needed to be there. The content of the note is consistent with a level of concern on Ms Higgs' part and a level of puzzlement as to why in the light of their earlier telephone conversation they had not arrived in Ceduna.

9.4. In her oral evidence Mrs Willmett agreed with Mr Lindsay SC of counsel for Dr Ochigbo that she had thought about going to hospital after the 5:16pm call but decided not to until her contractions achieved three in ten minutes. She told Mr Lindsay SC that in between the two phone calls she had become really exhausted and had effectively let her husband make the decisions from that point. In her evidence Mrs Willmett also told Ms Sloan of counsel for Ms Higgs that her husband had told her that Ms Higgs had said they could come in if they wanted to but not to rush. She said that she did not hear the contents of the later phone conversation that occurred between her husband and Ms Higgs. Her first statement on the other hand suggests that she had been aware that in the second conversation her husband had told Ms Higgs what had been happening and that she wanted to come in and have a caesarean section to which Ms Higgs had apparently replied '*oh bless*'. He told her that they were coming in now. Mr Willmett said in his evidence that in between the two calls there had not been any change in his wife in terms of the duration of the contractions and how far apart they

[103] Exhibit C6, page 80

were[104], although she was in more pain. By the time of the second call he believed that his wife had been in labour for more than 24 hours[105].

9.5. Mr Willmett also told the Court that in this second phone conversation with Ms Higgs he told her that his wife was '*over it*' and that she just wanted to get the baby out, to which Ms Higgs had said '*oh bless*'[106]. He passed on the information that his wife was now saying she would have a caesarean section because she had been in labour for more than 24 hours and just wanted it over and done with[107].

9.6. When cross-examined by Ms O'Connor SC on the topic of this conversation Ms Higgs did not accept that she had used the expression '*oh bless*' as a response to the suggestion that Mr Willmett had told her that his wife had changed her mind and was now coming in. I also make the observation that if Mr Willmett had said that his wife had decided to undergo a caesarean it is odd that the Ceduna Hospital was not expecting this when the Willmetts ultimately arrived at the Ceduna Hospital by ambulance. As will be seen, on their arrival there appears to have been an ongoing assumption that Ms Willmett was still going to deliver naturally. Even allowing for the somewhat unusual circumstances in which Mrs Willmett arrived by ambulance at Ceduna, and the uncertainty that may have caused, if the Willmetts had decided to have a caesarean they could have voiced this desire on their arrival at Ceduna at about 11:22pm. There is every reason to think that if they had done so they would have been pushing at an open door and that the procedure would have been arranged well before just after 1am the following morning when it ultimately occurred as an emergency procedure.

10. The journey to Streaky Bay – and the other phone conversations

10.1. Following the second phone conversation with Ms Higgs, Mr and Mrs Willmett eventually left Ceduna in their motor vehicle. Between Sceale Bay and Streaky Bay Mrs Willmett was lying in the back of the vehicle. In her statement she described a terrible feeling washing over her. She felt that something was really wrong as a result of which her husband sped up. Not long before they encountered Streaky Bay there was a collision involving a kangaroo. Mrs Willmett believed that the baby was coming and so she and her husband stopped in Streaky Bay and went to the hospital.

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[104] Transcript, page 181
[105] Transcript, page 181
[106] Transcript, page 181
[107] Transcript, page 181

10.2. The registered nurse and registered midwife Ms Smith to whom I earlier referred asserts in her statement, which assertion I accept, that Mrs Willmett was in a lot of pain and appeared to be frightened. Ms Higgs asserts that Mrs Willmett said that her abdomen was painful all over and that she had significant pain even between contractions. Ms Higgs states that one of the reasons Mrs Willmett was ultimately transferred to Ceduna was the pain between contractions and the fact that she had not progressed from Dr Oswald's initial examination. As will be seen, Dr Oswald in the ambulance en route to Ceduna detected pain between contractions. Also as will be seen, this can be a worrying sign.

10.3. It was at the Streaky Bay Hospital as earlier indicated that Dr Oswald first became involved in the matter. I have already recounted what transpired at Streaky Bay Hospital. It appears that Mr and Mrs Willmett arrived there at approximately 9pm. The two vaginal examinations performed by Dr Oswald occurred at 9:10pm and 9:40pm respectively. It was after the second of those vaginal examinations that Dr Oswald decided that Mrs Willmett should be transported to the Ceduna Hospital by ambulance. An ambulance was arranged for that purpose.

10.4. I have already referred to the fact that Professor Pepperell was not critical of Dr Oswald's management at the Streaky Bay Hospital. The following passage of his evidence concerning Dr Oswald's management of the situation is pertinent:

> 'A. Well, he could not have been aware exactly how quickly she'd got to that dilatation and how long she'd been at it, but in someone who's almost 9 cm dilated, certainly in a multigravida woman, who'd had a previous baby vaginally, you'd expect the delivery to occur within half an hour, which would've been before she got to the hospital. If she'd never had a baby before, it was impossible to know exactly when, if she was progressing normally, the baby would be delivered, but it would be likely to be somewhere around an hour, an hour and a half. And I can understand why he made the decision that he did to assess her, to then, knowing that she's 8 to 9 cm dilated, say 'Well, we need to review you in half an hour and then make a decision as to whether you really should be going through to Ceduna'. And I don't think there was a problem with that decision, although the hospital that he was in didn't approve vaginal births, but someone who arrives at that dilatation, you'd have to be certain that they weren't going to be delivering in the ambulance or in a car on the way to the hospital, if you could do so.
>
> Q. So, you are not critical of Dr Oswald's decision to wait a half an hour to undertake a second vaginal examination.
>
> A. No, I'm critical of that at all.

Q. If Dr Oswald had been told that Mrs Willmett had in fact been in labour for longer - say, 12 to 14 hours - would it still have been appropriate for him to wait as he did, that 30 minutes.

A. He still wouldn't know how quickly she'd got to 9 cm and when that had occurred. I think there'd be some people who would've said 'Well, we still need to wait for half an hour, that will clarify the issue'. Others would've said 'Well, gee, it's been going on for so long, the risk is getting greater that in fact there really is a problem, and you should go straight away'. I think people would vary as to what they advise. I don't think the decision that he made was definitely wrong in either instance.' [108]

10.5. I have accepted that analysis of the situation. I have accepted Dr Oswald's explanation for delaying things for thirty minutes pending the outcome of the second vaginal examination. The fact that Mr and Mrs Willmett had arrived at the Streaky Bay Hospital and had sought care was not of Dr Oswald's making. That said, he was clearly under an obligation to provide the necessary care. However, I do not believe that any criticism of Dr Oswald's care at the Streaky Bay Hospital is warranted. I find that his clinical decisions were made reasonably.

10.6. As to the remaining two phone conversations that occurred between Ms Higgs and Mr Willmett, Ms Higgs recorded that Mr Willmett rang her at 8:54pm to advise that they were then at Streaky Bay because Mrs Willmett felt like pushing and wanted to be assessed. She felt that she was about to have the baby. Ms Higgs recorded that she advised that Mrs Willmett should be assessed but that they should not be delayed in Streaky Bay if Mrs Willmett was not in late labour.

10.7. At approximately 10:20pm Ms Higgs called Mr Willmett to find out where they were. She made another note timed at 2220 hours to the effect that they were all waiting at the Ceduna Hospital for Mr and Mrs Willmett. She noted that she was told that Mrs Willmett was at nine centimetres and Ms Higgs made a note with question marks against the issue concerning whether or not Mrs Willmett was to have the baby in Streaky Bay. However, she noted that they were in the driveway and were leaving Streaky Bay at that time. She noted the following:

> 'Very concerned – what was happening for nearly 2 hours. Rick not sure. Drive carefully – see soon -'

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[108] Transcript, pages 917-918

11. The journey from Streaky Bay to Ceduna

11.1. Dr Oswald accompanied Mrs Willmett in the ambulance. Mr Willmett travelled in his own vehicle.

11.2. At the Streaky Bay Hospital a partogram had been started. Dr Oswald took this with him. As well, he had a Doppler machine that could measure the baby's heart rate. During the journey between Streaky Bay and Ceduna, which took an hour according to SAAS records, Mrs Willmett continued to have regular moderate to strong contractions occurring every three to four minutes. However, a vaginal examination undertaken during the journey indicated that the reality was that she had made no further progress. The foetal heart rate as detected by Dr Oswald was ascertained with some difficulty having regard to the circumstances in which he was operating, but he noted the rate to remain steady at around 140 beats per minute which is acceptable.

11.3. However, at a point about 20 kilometres from Ceduna Mrs Willmett complained of a severe abdominal pain with severe tenderness along the lower abdomen. At the same time the foetal heart rate was noted to rise dramatically to between 180 and 190 beats per minute. I have also seen reference to an estimate of 200 beats per minute. The exact figure is not important as an acceleration of a foetal heart rate to 180 beats per minute is a matter of significance and can signify foetal distress. The foetal heart rate then dropped back to around 150 to 160 beats per minute.

11.4. Dr Oswald told the Court that the abdominal pain and the spike in the foetal heart rate caused him to think that Mrs Willmett may have suffered a ruptured uterus at that point. Prior to that incident Mrs Willmett's contractions did not seem to be getting any worse or any stronger, but were fairly steady. When the baby's heart rate went up to about 180 beats per minute, Dr Oswald also thought that that signified that the baby was distressed[109]. The accelerated heart rate lasted for a few minutes before it dropped back to its earlier levels[110]. The journey from that point to Ceduna Hospital took approximately between ten and fifteen minutes.

11.5. Dr Oswald also told the Court that he thought that as well as a ruptured uterus, or in the alternative to that, Mrs Willmett may have been experiencing obstructed labour.

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[109] Transcript, pages 249-250
[110] Transcript, page 251

11.6. The time at which they arrived at the Ceduna Hospital was 11:22pm according to SAAS records. I deal with the events at the Ceduna Hospital culminating in Laura's birth in the next sections.

12. The 'handover' at the Ceduna Hospital

12.1. Dr Oswald told the Court that at the time of their arrival at the Ceduna Hospital at 11:22pm Mrs Willmett was still experiencing and complaining of lower abdominal constant pain. The contractions were still occurring and were moderate. She was removed from the ambulance and taken into the hospital on a barouche. Dr Oswald's recollection was that Dr Ochigbo and a nurse whom he did not know met Dr Oswald and the ambulance officers in the corridor inside the door of the hospital.

12.2. Dr Oswald was on the left side of the barouche as it was brought in. Dr Ochigbo was directly in front of him and at the head of the barouche. At that point Dr Oswald described the circumstances as being '*all very rushed*'.[111]

12.3. Dr Oswald was asked by his counsel, Ms Sloan:

> 'Q. When you saw Dr Ochigbo what did you tell him.
>
> A. This is in the corridor going - after we'd passed through the front doors. I said to - pretty established labour, I think she may be obstructed and I think she may have ruptured her uterus about 20 k's out.' [112]

Dr Oswald said that he had a clear recollection of imparting that information. However, Dr Oswald said that Dr Ochigbo did not respond. He claimed to have a '*clear recollection*' of that circumstance as well. In any event he believed that as Dr Ochigbo was only a metre away from him he must have heard him. I asked Dr Oswald the following questions and he gave the following answers:

> 'Q. When you said those things whom were you addressing.
>
> A. I was addressing him.
>
> Q. Did he respond to that.
>
> A. No. I thought he was just taking it in. ' [113]

Dr Oswald asserted that Dr Ochigbo did not make any eye contact with Dr Oswald as Dr Ochigbo had his back to him. He also may have been talking to Mrs Willmett.

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[111] Transcript, page 253
[112] Transcript, page 253
[113] Transcript, page 253

12.4. In a retrospective note compiled electronically on the Sunday morning at 11:52am, Dr Oswald recorded that when he handed Mrs Willmett over to the admitting doctor, he expressed his concerns about the possibility of uterine rupture. I also note that in Dr Oswald's letter to the AHPRA investigator dated 17 July 2017 he asserts that he informed Dr Ochigbo verbally that Mrs Willmett was in obstructed labour and that she feared she had suffered a ruptured uterus.

12.5. Dr Oswald also said that he believed that the partogram that had been started at the Streaky Bay Hospital and which had continued during the journey to Ceduna was left with the Ceduna Hospital. He believed that he left the document on Mrs Willmett's lap as she was being wheeled in. He could not recall whether he drew it to anyone's attention. On that partogram Dr Oswald had written '*sharp pains left side*'. The position of this entry coincides with the documented acceleration of the foetal heart rate to approximately 180 beats per minute.

12.6. Dr Oswald did not remain at the Ceduna Hospital after Ceduna staff took over Mrs Willmett's care. Dr Oswald's only obvious means of transport back to Streaky Bay was the ambulance which had brought him and Mrs Willmett to Ceduna. He returned to Streaky Bay in the ambulance.

12.7. Ms Higgs told the Court that she was present when Mrs Willmett was removed from the ambulance on a barouche. Her impression was that Mrs Willmett was not well. She appeared to be very pale and clammy. She looked distressed and appeared to be in a significant level of pain.[114] Ms Higgs said that she was writhing and moving on the barouche. She was also crying.[115] Mrs Willmett said to her that she had a very severe pain on her right-hand side that was not going away. Ms Higgs said this:

> 'I was very concerned because I thought - I had recalled that her husband had said that they had had a collision with a kangaroo and so I was obviously very concerned that she had potentially had an abruption or a uterine rupture because just looking at her like that you couldn't tell the difference because you can't tell the difference until you obviously open up the uterus, or open up the abdomen. But I was very concerned knowing that there'd been a collision or a crash with a kangaroo that something bad had happened.' [116]

12.8. Ms Higgs said that she did not speak to Dr Oswald, although she knew he was there when the ambulance arrived. She believed that she had seen Dr Oswald and

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[114] Transcript, page 692
[115] Transcript, page 693
[116] Transcript, page 693

Dr Ochigbo conversing as the barouche was pushed into the Emergency Department.[117] She said that she did not hear any of the conversation between them, but did hear Dr Oswald indicating that he was very keen to get back to Streaky Bay as soon as possible and to go back with the ambulance crew.

12.9. Ms Higgs said that Dr Oswald handed to her the partogram that Dr Oswald had been compiling. She reviewed the partogram. Ms Higgs told the Court that the partogram was concerning, particularly the section that revealed a foetal heart rate of 180 beats per minute which is tachycardic. Ms Higgs said that this could be consistent with dehydration of the mother although as the heart rate had returned to 140 beats per minute it may have been an isolated event. I take it from Ms Higgs' evidence that she did not take too much from the partogram. However, she saw the notation made by Dr Oswald that there was severe pain on the left-hand side, although as alluded to above, Ms Higgs believed that the pain was on the right-hand side. Ms Higgs thought that this may have been the result of a need for Mrs Willmett to be catheterised. Ms Higgs said that she could not recall whether she provided the partogram to Dr Ochigbo or told him what it demonstrated. She said:

> 'I don't recall. We were all talking about so many things and getting ready to do so many things I don't recall that I actually explained the partogram to him.' [118]

Once they reached the birthing room Ms Higgs said she put the partogram on the end of the bed.

12.10. Dr Ochigbo gave evidence about the arrival of the ambulance and what, if anything, was said. He said that he did not have any conversation with Dr Oswald but between the emergency room and the delivery suite he had heard him say that he had thought Mrs Willmett was going to have the baby in Streaky Bay or in the ambulance. Dr Ochigbo told the Court that he did not hear Dr Oswald say anything about the episode of sharp pain about 20 kilometres from Ceduna.[119] Dr Ochigbo also maintained in his evidence that he did not hear Dr Oswald say that he was worried about the possibility of uterine rupture. He did not hear anybody else describe a concern about rupture. Indeed, he said that he heard nobody describe any type of acute episode in the few minutes before Mrs Willmett arrived at Ceduna in the ambulance.[120]

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[117] Transcript, page 693
[118] Transcript, page 697
[119] Transcript, page 437
[120] Transcript, page 437

12.11. As far as a handover was concerned Dr Ochigbo said that he received a handover from the ambulance officers which had more to do with the state of Mrs Willmett's dilatation and the fact that she had been given a morphine injection.

12.12. Dr Ochigbo asserted that he could not clearly say where Dr Oswald was on the way into the corridor of the hospital, but that he had been behind him. Dr Ochigbo was at the head of the barouche. Dr Ochigbo himself was talking to Mrs Willmett at that point. He did not have any conversation with Dr Oswald when he went inside the hospital doors. He did not receive a partogram or see it on Mrs Willmett's lap.

12.13. Dr Ochigbo said that his impression upon Mrs Willmett's arrival was that she could still have a normal vaginal delivery.[121]

12.14. When cross-examined by Ms Sloan on behalf of Dr Oswald, Dr Ochigbo said that as the barouche was being wheeled into the hospital his concentration at that time was on Mrs Willmett and not on Dr Oswald. He disagreed with the suggestion that he had conducted an actual conversation with Dr Oswald; he asserted that Dr Oswald's comment that he thought the baby was going to be delivered in the Streaky Bay Hospital or the ambulance was a general statement not specifically directed at him. Dr Ochigbo disagreed with the suggestion that just inside the hospital doors he had a conversation with Dr Oswald in which Dr Oswald said that Mrs Willmett had possibly experienced a uterine rupture approximately 20 kilometres out of Ceduna.[122] However he acknowledged that it was possible that he had said that but that he did not hear it.[123]

12.15. Asked as to whether he had asked Dr Oswald for a handover of Mrs Willmett, he said he did not. When asked as to why not, he said:

> 'I don't know - perhaps I was angry with him but I wish now I did.' [124]

When asked whether he should have nevertheless asked Dr Oswald for a patient history, Dr Ochigbo acknowledged '*maybe I should have but I didn't*'.[125]

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[121] Transcript, page 438
[122] Transcript, page 458
[123] Transcript, page 458
[124] Transcript, page 458
[125] Transcript, page 459

12.16. When further cross-examined by Ms Sloan about the partogram and whether Dr Ochigbo should have asked for it, he said:

> 'I should but it was Dr Oswald's responsibility to handover the patient that was brought to us, to also give us all the documents but he didn't do that.' [126]

12.17. Dr Ochigbo acknowledged that it would have been a good idea to have asked Dr Oswald about what had been happening in Streaky Bay and en route to Ceduna in the ambulance, but asserted that at the time of Mrs Willmett's arrival his concentration was more on her and not on Dr Oswald.

12.18. Asked by Ms O'Connor SC for Mr and Mrs Willmett how his being '*angry*' could possibly explain the lack of communication between him and Dr Oswald, Dr Ochigbo said:

> 'Streaky Bay Hospital is not set to deliver babies, they don't have the facilities to deliver babies, they don't have a CTG machine, they don't have facilities to do caesarean section and if Dr Oswald wanted to do a vaginal examination to assess Jennifer, the vaginal examination doesn't take more than five or 10 minutes. He would have done that and they send him along immediately and then at least communicate with me.' [127]

Dr Ochigbo also said that one of the reasons he was angry was his belief that Dr Oswald had caused a problem by delaying the transfer of Mrs Willmett to his care.[128] Indeed, Dr Ochigbo suggested that historically the relationship between the Streaky Bay Hospital 'obstetric team' and that of Ceduna Hospital had not been healthy. He said that this was exemplified by another unrelated allegation that Dr Oswald was tardy in sending test results.[129] He suggested that the delay in presenting Mrs Willmett to the Ceduna Hospital was in keeping with that.

12.19. However, Dr Ochigbo ultimately agreed that Dr Oswald's desire that Mrs Willmett give birth in a hospital rather than in an ambulance sounded reasonable.[130] To my mind it was more than reasonable.

12.20. Dr Ochigbo also agreed with Ms O'Connor SC that from a clinical perspective it had been important to find out from Dr Oswald what observations he had made of Mrs Willmett given that she had been in his care for some time; it was important that

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[126] Transcript, page 459
[127] Transcript, pages 461-432
[128] Transcript, page 462
[129] Transcript, page 462
[130] Transcript, page 466

he could know exactly what condition Mrs Willmett was in when she arrived. Dr Ochigbo agreed that in hindsight he should have made such enquiries.[131] He also candidly agreed that it should not have mattered how angry or annoyed he was because the patient was the first priority.[132]

12.21. In cross-examination Dr Ochigbo consistently maintained that he did not see or had not known anything of the partogram but agreed that there are some significant facets displayed by it including the high foetal heart rate (tachycardic) and Dr Oswald's recording of the very sharp pain on the left hand side of Mrs Willmett's abdomen. However, he suggested that if a ruptured uterus was to have been considered on the basis of these findings, bradycardia is more indicative of that than the tachycardia displayed by the partogram.[133] Dr Ochigbo agreed that if Dr Oswald had told him that 20 kilometres out of Ceduna there had been the onset of sharp pain on her left-hand side and that the foetal heart rate had ascended to as much as 190 beats per minute, this would have suggested that the baby was stressed, but that one would also have to take into account the subsequent descent of the heart rate to normal.[134]

12.22. It was universally observed throughout Dr Oswald's time in the witness box that he was a softly spoken individual. I have no doubt that when Dr Oswald arrived at Ceduna he said for the intended hearing of Dr Ochigbo that he thought that Mrs Willmett may have experienced a uterine rupture or was experiencing obstructed labour. However, it appears that Dr Ochigbo was less than receptive to Dr Oswald and whatever Dr Oswald said, save for the remark not directed to him about him thinking that the baby may have been born at the Streaky Bay Hospital or in the ambulance, was not taken on board by Dr Ochigbo. Consequently, Dr Ochigbo was not made aware of Dr Oswald's concerns that Mrs Willmett had experienced a rupture or had obstructed labour.

12.23. The handover between Dr Oswald and Dr Ochigbo, such as it was, was flawed. This failure of communication was regrettable. Clearly, regardless of the circumstances there should have been a verbal handover between Dr Oswald and Dr Ochigbo that dealt with all of the impressions that Dr Oswald had formed to that point in time. It

[131] Transcript, page 469
[132] Transcript, page 469
[133] Transcript, page 475
[134] Transcript, page 477

was not good enough for Dr Ochigbo merely to rely on what, if anything, the ambulance officers may have contributed to the state of knowledge about Mrs Willmett. Dr Oswald was in the best position to have imparted the key information to Dr Ochigbo.

12.24. I now deal with the evidence of Professor Pepperell on the issue of the flawed handover.

12.25. Professor Pepperell was asked to comment on the episode that Dr Oswald described occurring 20 kilometres out from Ceduna. In Dr Oswald's later notes made retrospectively he recorded that the foetal heart rate had increased to between 180 and 200 beats per minute and that there was abdominal pain that persisted even between contractions. Professor Pepperell said that for him the concern at that time would have been that the scar from Mrs Willmett's previous caesarean section may well have ruptured, or at least in part.[135]

12.26. As to the communication breakdown between Dr Oswald and Dr Ochigbo upon the arrival of the ambulance at Ceduna, Professor Pepperell expressed the view that Dr Ochigbo needed to obtain information from Dr Oswald concerning a number of matters. Those matters were:

1) how often Mrs Willmett had been contracting in the time that Dr Oswald had been seeing her, both in the hospital and since;
2) whether the contraction frequency had changed;
3) whether there had there been any pain between contractions at all or whether she had simply experienced pain with the contractions;
4) whether there had been any vaginal bleeding that would suggest that there may have been some scar rupture;
5) whether Dr Oswald had taken the foetal heart rate apart from what had been reported in the partogram, how often this had been undertaken, how long Dr Oswald had listened for, whether he had defined any decelerations or whether it had simply been the case that there had been the one acceleration between 190 to 200 beats per minute.

[135] Transcript, page 924 lines 32-34

Professor Pepperell added:

> 'He needed to ask all of those questions if in fact he was getting full information on what had been happening in the previous hour or two before she reached the hospital in Ceduna.' [136]

12.27. To Dr Ochigbo's suggestion that it had been his expectation that the doctor handing over the patient would conduct a proper handover, Professor Pepperell asserted that if the doctor handing over did not do that then the receiving doctor would need to ask the appropriate questions. In this regard Professor Pepperell observed that the patient herself could not be relied upon to necessarily provide useful information. For example, Mrs Willmett may not have differentiated pain between contractions and pain during contractions. She would not have known for how long the foetal heart rate assessments had been undertaken. Professor Pepperell said in relation to Dr Ochigbo not obtaining that information from Dr Oswald:

> 'Well I'm critical that he didn't apparently realise the need to ask those questions when he wasn't given the answers by the doctor concerned. I think if he had asked those questions and been given that data the subsequent progress may well have been a lot faster than it actually was.' [137]

12.28. In cross-examination by Ms O'Connor SC, Professor Pepperell agreed that the pain experienced by Mrs Willmett in the ambulance before her arrival at the Ceduna Hospital was consistent with at least a partial rupture and for this reason it was important at a handover for that information to be passed on.[138]

12.29. In cross-examination Professor Pepperell agreed with Mr Lindsay SC for Dr Ochigbo that Dr Oswald, who had the relevant information, had a responsibility to pass on that information to the receiving doctor.[139] When it was suggested that Dr Oswald had the primary responsibility to do that, Professor Pepperell suggested that there was also a concomitant responsibility on the receiving doctor, Dr Ochigbo in this case, to ask the necessary questions. He said:

> 'The reason I say it that way is because he can't be certain of the clinical ability of Dr Oswald in assessing someone who's having what is effectively a VBAC. So if Dr Oswald doesn't mention those matters then he has to ask about them.' [140]

[136] Transcript, page 926
[137] Transcript, page 926
[138] Transcript, page 957
[139] Transcript, page 1001
[140] Transcript, page 1001

12.30. In cross-examination by Ms Sloan on behalf of Ms Higgs and Dr Oswald, Professor Pepperell stated that if Dr Ochigbo had not obtained verbal information from Dr Oswald at a handover it would still have been his responsibility to review the partogram.[141]

12.31. I accept all of Professor Pepperell's evidence on the question of the handover. To my mind the handover miscarried. It is pointless to assign blame. Both Dr Oswald and Dr Ochigbo should have ensured that a proper channel of communication about Mrs Willmett was established and that the necessary information about her condition was imparted.

12.32. As to the relevance of the flawed handover, Professor Pepperell stated that in regard to the two previous examinations in Streaky Bay and the fact that there was no further change when Mrs Willmett came to be examined after her arrival in Ceduna, it meant that there had been a period of about three hours with no change. In addition, there was the potential that this level of dilatation had existed for a period of time prior to the first vaginal examination at Streaky Bay. Under those circumstances one would be thinking it obvious that there was at least obstructed labour and that there may well also have been a problem with the scar in which case the only safe way of managing the patient was to take her to theatre and perform a caesarean section.[142]

12.33. In his evidence Professor Pepperell said that it was difficult to determine exactly when the uterine rupture had occurred. However, he added that when the pain experienced by Mrs Willmett in the ambulance occurred separate from a contraction this was likely to have been the time when the rupture started. When it had become as serious as it was at the time of the caesarean section was impossible to define.[143]

12.34. Professor Pepperell was asked about the significance of the lack of communication between the two doctors and its impact in terms of Mrs Willmett's labour and prospective delivery. Professor Pepperell said that if it had been established as between Dr Oswald and Dr Ochigbo that Dr Oswald thought that Mrs Willmett was in obstructed labour, had described the sharp pain between contractions and that the foetal heart rate had accelerated at a time of significance, Dr Ochigbo would have needed to examine Mrs Willmett himself. If there had been no change they would have needed

[141] Transcript, page 1015
[142] Transcript, page 927 lines 6-15
[143] Transcript, page 1003

to take her to theatre for an immediate caesarean section because it was likely that the scar was becoming worse. He said:

> 'I think he should have then said 'Well I'm going to need to examine her myself now, and if there's been no change we need to take her to theatre for a caesarean section' because it's likely that the scar is getting worse.' [144]

12.35. On the other hand, Professor Pepperell was asked by me as follows and gave the following answer:

> 'Q. Just one further thing about the CTG trace. Again, putting yourself in Dr Ochigbo's position. If we look at p.1 again, if when examining the CTG trace from its outset, he also understood say from information from Dr Oswald, that there had been that event in the ambulance where Mrs Willmett had experienced pain as described on the partogram and had arrived in a very distressed state. Would the CTG from the outset take on a different connotation.
>
> A. No, I don't think so. It's not so severe you would say, heck those findings are consistent and almost certainly proves she's ruptured her uterus. We need to do the caesar straight away. I believe the decision that he made to ask for advice after those first two, if that was when he asked for it, would have been most appropriate.' [145]

I had difficulty reconciling that answer with his previous observation as reproduced in the preceding paragraph. In my view Professor Pepperell's answer as reproduced in the preceding paragraph more accurately describes what needed to occur. To my mind if either of uterine rupture or obstructed labour or both had been properly regarded as legitimate differential diagnoses as they undoubtedly should have been, a caesarean section should have been immediately arranged following Dr Ochigbo's examination.

13. <u>The events leading to Laura's delivery</u>

13.1. Before analysing this subject it is appropriate to set out a timeline of relevant events.

13.2. Those events are as follows:

- At 11:22pm Mrs Willmett arrived by ambulance at the Ceduna Hospital.
- At about 11:30pm Dr Ochigbo examined Mrs Willmett which included a vaginal examination. Mrs Willmett was at 9 centimetres dilatation with the anterior lip of the cervix still evident. The head was at station -3. This meant that Mrs Willmett

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[144] Transcript, page 927 lines 1-3
[145] Transcript, page 1012

had only progressed marginally, if at all, since her last examination by Dr Oswald at Streaky Bay Hospital at approximately 9:40pm. Dr Ochigbo noted that Mrs Willmett was contracting.

- At 11:31pm Mrs Willmett was connected to the CTG machine which measured her heart rate, the foetal heart rate and contractions. At about this time Mrs Willmett was catheterised and approximately 600ml of urine was evacuated.
- Dr Ochigbo documented his plan that included the continuous CTG.
- It is apparent that at 11:30pm there was still an expectation that Mrs Willmett would deliver naturally.
- The CTG soon demonstrated matters of concern in relation to the foetus.
- At around 11:36pm or 11:37pm there was a deceleration in the foetal heart beat to approximately 110 beats per minute[146]. However, it returned to its baseline level within approximately one minute.
- Between 11:38pm and 11:44pm there was abnormally low beat to beat variability below the level of 5[147]. Low beat to beat variability is a sign of foetal distress.
- At 11:45pm there was a further deceleration that Professor Pepperell described as an odd deceleration in that there were no clear contractions being recorded[148]. He opined that normally under those circumstances the mother would be reviewed and clinicians would wait and see what would then happen.
- Between 11:52pm and 11:54pm there was a deeper deceleration to about 115 beats per minute. It was a longer deceleration in duration and lasted for approximately two minutes, which was longer than the previous deceleration described[149]. The trace returned to a baseline of 170 beats per minute which is slightly in excess of normal, suggesting in Professor Pepperell's opinion that there could be obstructed labour.
- Between 11:54pm and 12am there was beat to beat variability at only two beats per minute which is less than the norm[150]. Professor Pepperell opined that the duration of the previous deceleration and lack of variability following that deceleration is a

[146] Event 1 as illustrated and described by Professor Pepperell on the CTG trace, Exhibit C11e
[147] Event 2 illustrated and described on Exhibit C11e
[148] Event 3 illustrated and described on Exhibit C11e
[149] Event 4 illustrated and described on Exhibit C11e
[150] Event 6 illustrated and described on Exhibit c11e – note that Events 5 and 6 as illustrated and described on Exhibit C11e are incorrectly illustrated and described in reverse order

matter that would excite particular concern and would prompt a decision that the mother be taken to theatre and a caesarean section performed.

- At approximately 12am Dr Ochigbo telephoned the WCH for advice. At that time consultant obstetrician Dr Vatani[151] was at the WCH in theatre assisting a registrar, believed to be Dr Masters, in an emergency procedure. The time of this call is taken from Dr Ochigbo's handwritten note in the progress notes[152] where he recorded that he rang and attempted to discuss the CTG with the registrar, Dr Masters, but who was said to be scrubbed and in theatre. Instead, he spoke with a registered midwife. He noted that the CTG trace was faxed to the WCH for the purpose of discussing Mrs Willmett with the consultant. Dr Ochigbo recorded that ultimately he spoke with Dr Vatani. Dr Vatani's statement confirms that shortly after midnight her registrar was paged through the hospital switchboard by a general practitioner who no doubt was Dr Ochigbo. The midwife in theatre took the call because Dr Vatani and the registrar could not take it as they were performing the emergency procedure. Ultimately Dr Ochigbo and Dr Vatani would converse at about 12:30am.

- Beginning at approximately 12:02am a further deceleration to 120 beats per minute, lasting about a minute and a half, then occurred[153].

- In a note timed at 12:05am Dr Ochigbo recorded that a theatre team was called in for the purposes of performing a caesarean section in respect of Mrs Willmett. The same note also records that he spoke to the obstetrician, Dr Vatani, whom he recorded as being '*happy with decision to proceed with EMCS*'[154]. Dr Vatani's statement[155] and own handwritten note records that she called Dr Ochigbo back at 12:30am. Dr Vatani's states that she made her handwritten notes at 12:40am immediately after her telephone call with Dr Ochigbo. Dr Ochigbo's notes do not specifically record the time of his phone conversation with Dr Vatani. I do not believe that Dr Ochigbo and Dr Vatani conversed as early as 12:05am.

- Meanwhile between 12:15am and 12:17am a deeper deceleration down to approximately 80 beats per minute took place[156]. At the conclusion of that

[151] Statement at Exhibit C23
[152] Exhibit C6, page 59
[153] Event 5 illustrated and described on Exhibit C11e
[154] EMCS is the medical abbreviation for emergency caesarean section
[155] Exhibit C23
[156] Event 7 illustrated and described on Exhibit C11e

deceleration the foetal heart rate increased but to a different pattern from previous decelerations in that it did not return to a baseline level.

- At about 12:18am it is recorded on the CTG trace that Mrs Willmett pushed, unsuccessfully so in that it did not result in the delivery of the baby. The circumstances in which and at whose instigation this occurred are not entirely clear. The inappropriateness of this push occurring, given that Mrs Willmett was not believed to have been fully dilated at this point, was also the subject of adverse comment by Professor Pepperell.
- Between 12:18am and 12:25am there was then a very deep, prolonged deceleration down to an alarming 50 beats per minute[157] which did not return to previous baseline level until 12:25am[158]. Professor Pepperell opined that this very long deceleration indicated evidence of likely very severe problems of hypoxia in the baby.
- The CTG trace concludes at approximately 12:30am when the belts were removed.
- Mrs Willmett is taken to theatre.
- As indicated earlier, knife to skin for the purposes of the emergency caesarean section occurred at 1:05am and Laura was delivered at 1:10am.

13.3. It is against that background that the circumstances of Laura's delivery come to be evaluated.

13.4. Ms Higgs told the Court that when the CTG belts were placed on Mrs Willmett's abdomen she said that it was uncomfortable and painful.[159] She said that Mrs Willmett was experiencing a lot of pain but was not having many contractions.[160] Ms Higgs understood that Dr Ochigbo's examination revealed that Mrs Willmett was at nine centimetres with the anterior lip still evident. Ms Higgs was aware that the anterior lip needed to be completely absent before the cervix was to be regarded as fully dilated. Ms Higgs did not accept the notion as suggested to her by Ms O'Connor SC in cross-examination that before the ambulance had arrived at the Ceduna Hospital she must have realised that it was '*on the cards*' that there would need to be a caesarean section

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[157] It is said elsewhere that the deceleration was to 60 bpm – the trace does appear to demonstrate 50 bpm - in any event the discrepancy is immaterial
[158] Event 8 as illustrated and described on Exhibit C11e
[159] Transcript, page 698
[160] Transcript, page 700

for Mrs Willmett.[161] She said that the only information that they had been given was that Mrs Willmett was at nine centimetres dilated and had been given some morphine.

13.5. Ms Higgs also disagreed with the suggestion that a caesarean section could have been arranged to occur within 30 minutes of her arrival. I was not convinced that such a time estimate is realistic in a country hospital. It would have been realistic if those at the Ceduna Hospital were expecting to perform a caesarean section immediately upon Mrs Willmett's arrival and all of the necessary staff had been on hand in that expectation. They were not. As indicated earlier, the expectation was that Mrs Willmett would deliver naturally.

13.6. For Dr Ochigbo's part he told the Court that when Mrs Willmett arrived his impression at that point was that she could still have a normal vaginal delivery.[162] Mrs Willmett did not complain of pain, but complained of pressure in the vicinity of her lower abdomen which he attributed to urinary retention and which he said was relieved by catheterisation.[163] He said that she was very comfortable following this. He said that she did not complain of abdominal pain during contractions or of abdominal pain between contractions. He said that her abdomen gave no hint of uterine rupture and that she was contracting mildly.[164] His vaginal examination revealed dilatation of nine centimetres with the anterior lip of the cervix still in evidence, meaning that the ten centimetres required for the baby to pass through the cervix had not been achieved. The head was also '*a little bit high*'.[165] In Dr Ochigbo's opinion the results of his examination were such that they were inconsistent with uterine rupture.[166] To my mind, the results of his examination did not rule out uterine rupture. As Professor Pepperell said in evidence, which I accept, vaginal bleeding will not necessarily be seen if bleeding caused by the rupture is entering the abdominal cavity, whereas pain between contractions, as had been detected by Dr Oswald, can be a sign of rupture.[167] But of course, Dr Ochigbo was not privy to what Dr Oswald had detected and had thought. And I accept Professor Pepperell's evidence that the pain experienced in the ambulance was probably the beginning of the rupture. I have given careful thought to the question of Mrs Willmett's presentation at Ceduna. Ms Higgs said that Mrs Willmett on arrival

[161] Transcript, page 790
[162] Transcript, page 438
[163] Transcript, page 439
[164] Transcript, page 439
[165] Transcript, page 440
[166] Transcript, page 440
[167] Transcript, page 928

was in a significant level of pain and looked unwell. This impression was in keeping with the observations of her that had been made at Streaky Bay by nursing staff there. I prefer the evidence of Ms Higgs to that of Dr Ochigbo in relation to the question of pain. I do not believe that Mrs Willmett's pain was all attributable to urinary retention.

13.7. Dr Ochigbo maintained that as far as he was concerned at the commencement of the CTG trace things looked normal.[168] Of course all of that evidence, both of Ms Higgs and Dr Ochigbo, and their impressions, were in ignorance of the concern that Dr Oswald said he expressed.

13.8. There appears to have been an assumption by all present at least for the first half hour following Mrs Willmett's arrival at Ceduna, that Mrs Willmett would continue to labour and ultimately deliver naturally.

13.9. The Court examined a number of issues relating to Mrs Willmett's management from the time of her arrival at the Ceduna Hospital to the delivery of Laura. These included the following:

a. Whether Mrs Willmett should have had a caesarean section as soon as possible after her arrival at Ceduna Hospital;

b. Associated with question (a), whether it was reasonable for there to have been an acceptance of the possibility that Mrs Willmett could still deliver vaginally and with no detriment to the baby;

c. Whether the suggestion or instruction to Mrs Willmett to push was appropriate or not?

13.10. Should Mrs Willmett have had a caesarean section as soon as possible after her arrival at Ceduna Hospital?

13.11. I have already commented upon the fact that, in my opinion, and this was supported by the evidence of Professor Pepperell which I accept, the '*handover*' between Dr Oswald and Dr Ochigbo miscarried to the extent that important information in the possession of Dr Oswald was not imparted to Dr Ochigbo. I have already referred to the opinion of Professor Pepperell that if Dr Ochigbo had seen no change in Mrs Willmett after examining her himself, and in fact there was not, a conclusion of obstructed labour

[168] Transcript, page 441

could have been obvious and that there may also well have been a problem with the uterine scar, meaning that the only safe way of managing the patient was to take her to theatre and perform a caesarean section.

13.12. I find that it was appropriate for Dr Ochigbo to have performed his own examination of Mrs Willmett as soon as possible after her arrival. I do not believe that it was unreasonable for Dr Ochigbo to have delayed the decision whether to allow Mrs Willmett to progress naturally or to perform an immediate caesarean section until he had performed that examination. Although Professor Pepperell acknowledged that to begin with there was nothing from either the CTG or from Dr Ochigbo's physical examination that indicated uterine rupture,[169] as indicated above I do not believe that his examination ruled out a uterine rupture. What it did reveal if anything was that the state of Mrs Willmett's cervix had not changed since Dr Oswald's first examination at 9:10pm. It could not be known for how long even before that Mrs Willmett had been at that degree of dilatation. To my mind Professor Pepperell is correct to suggest that the possibility of obstructed labour need to be taken into consideration.

13.13. When proper account is taken of Mrs Willmett's presentation on arrival at Ceduna, the episode in the ambulance that Dr Oswald regarded as evidence of a possible uterine rupture and the possibility of obstructed labour, the conclusion that a decision to perform a caesarean section should have been made immediately after Dr Ochigbo's examination of Mrs Willmett is irresistible.

13.14. <u>Associated with question (a), was it reasonable for there to have been an acceptance of the possibility that Mrs Willmett would still deliver naturally and with no detriment to the baby</u>?

13.15. In the light of the answer to the previous question the answer to this question must be no. The miscarriage of the handover in my view meant that everything from that point forward also miscarried. However, in light of my finding that Dr Ochigbo did not hear Dr Oswald's indication of possible rupture or obstructed labour it is still pertinent to discuss what should then have happened in any event.

13.16. It can be seen from the CTG trace that very soon after it was connected there were indications of foetal distress. At approximately 11:36pm there was the deceleration to

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[169] Transcript, page 1004

110 beats per minute. A minute or so later there began abnormally low beat to beat variability which continued for a number of minutes followed by a further deceleration which Professor Pepperell said would normally prompt a review. There was then a further deceleration between 11:52pm and 11:54pm with the return to a baseline that was slightly in excess of normal and which would suggest there could be obstructed labour. Again, between 11:54pm and 12:00am there was abnormal beat to beat variability. Professor Pepperell opined that these matters would have excited particular concern and have required a prompt decision that the mother be taken to theatre for a caesarean section.

13.17. At this point it is necessary to discuss the evidence of Dr Ochigbo in respect of his management of Mrs Willmett prior to making his phone call to WCH. Dr Ochigbo told the Court that his impression of the CTG trace at its commencement at 11:31pm was that it looked normal. He asserted that the features of the trace that Professor Pepperell regarded as concerning, including abnormally low beat to beat variability between about 11:38pm and 11:44pm, did not demonstrate any stress on the part of the baby. He said there were a few dips but still with good recovery. He also said that when looking at the CTG trace as a whole, it demonstrated '*no sinister features*' until the time that he decided to have '*a quick chat*' with consultants at the WCH to see what they thought.[170] The features that Dr Ochigbo would not regard as 'sinister' would include the abnormally low beat to beat variability that I have already described, the deeper deceleration between 11:52pm and 11:54pm with the return of the trace to a baseline of 170 beats per minute which is slightly in excess of normal (suggesting in Professor Pepperell's opinion there could be obstructed labour) and then further abnormal beat to beat variability between 11:54pm and 12:00am. Professor Pepperell suggested this all should have prompted a decision that the mother be taken to theatre for a caesarean section. I prefer the Professor's evidence to that of Dr Ochigbo given Professor Pepperell's greater expertise.

13.18. In fact, Dr Ochigbo told the Court that when he had his first conversation with the WCH and when he returned to the birthing room he did not consider the baby to be in difficulty. He did not consider the baby to be in difficulty until he saw the very deep deceleration that did not recover quickly, that is the deceleration to 50 or 60 beats per

[170] Transcript, page 442

minute between 12:18am and 12:25am which in Professor Pepperell's opinion indicated evidence of likely very severe problems of hypoxia. Dr Ochigbo said:

> 'A. Yeah so when I go back this time, second time, I saw very deep deceleration that did not recover quickly like the other ones. So I became very concerned at this point.
>
> Q. And what did you think was likely to happen then.
>
> A. At this point the baby is not happy at all. So the baby will need to be delivered quickly. Just then the consultant rang and said this baby is not happy and I need to deliver this baby.'[171]

It was then that Dr Ochigbo called in the theatre team for the purposes of performing a caesarean section. He told Mrs Willmett that the CTG showed that the baby was not happy and he would need to deliver the baby. Asked as to why the theatre team had not been called previously he said:

> 'At that point my thinking was that it was possible Jennifer could deliver this baby vaginally. It was possible. You don't call theatre team and ask to wait, we might need you. There has to be absolute indication that you need them before you ring.'[172]

13.19. Asked in cross-examination as to what he had thought was the possible cause of the significant deceleration Dr Ochigbo said it was possibly a uterine rupture.[173] He also said that rupture was a possibility on his mind even before he rang the WCH for the first time.[174]

13.20. Dr Ochigbo denied the suggestion faintly put to him in cross-examination that he only decided to ring the WCH in the light of the very severe deceleration to approximately 60 beats per minute at approximately 12:18am. He said in effect that if he had witnessed such a deceleration at a time before he rang the WCH, he would not have needed to have telephoned the WCH as he would have known exactly what to do, that is to say to perform a caesarean section.

13.21. I accept Dr Ochigbo's evidence that he telephoned the WCH at about midnight or shortly thereafter in response to the CTG observations that had occurred to that point in time. The timing of Dr Ochigbo's actions is supported by the statement of Dr Vatani of the WCH who asserts that Dr Ochigbo must have rung shortly after midnight when her Registrar was paged via the hospital switchboard.[175] Furthermore, the original

[171] Transcript, page 444
[172] Transcript, page 445-446
[173] Transcript, page 497
[174] Transcript, page 497
[175] Exhibit C23a

concern as noted by Dr Vatani in her notes was expressed to be foetal tachycardia between 160 to 175 beats per minute with reduced variability and deceleration. It was not until later when the CTG trace was faxed from the Ceduna Hospital to the WCH that the prolonged deceleration to 60 beats per minute was revealed to Dr Vatani.

13.22. In cross-examination by Ms O'Connor SC Dr Ochigbo said that until he had seen the reading of 60 beats per minute, which he says he only saw on the CTG trace once he came back into the delivery room after his first phone conversation with WCH, he had assumed that vaginal delivery was still an option for Mrs Willmett. He said:

> 'At that point, yes, there was still a possibility that she could deliver vaginally'.[176]

He said it was the dropping of the baby's heartrate to about 60 beats per minute that constituted the reason why he decided to conduct a caesarean section. I observe that the CTG trace drops to its lowest point of 60 beats per minute or below between 12:19am and 12:20am. If Dr Ochigbo did not decide to perform the caesarean section until or after that time, it might mean that no preparations were made or commenced to affect such a caesarean section until that time.

13.23. Dr Ochigbo's notes[177] suggest that the theatre team was called in at 12:05am. As seen above, Dr Ochigbo told the Court that it was once he had noticed the deep deceleration on the CTG trace, and then heard from the consultant, that he called the theatre team.[178] He told the Court that he had not called the theatre team prior to that as he had been of the belief that it was possible that Mrs Willmett could deliver the baby vaginally. He said there had to be an 'absolute indication' that they were needed before they were called.[179] I observe that if Dr Ochigbo did not call in, or cause to be called in, the theatre team until after both the deep deceleration at 12:18am and his subsequent conversation with Dr Vatani which I find occurred at about 12:30am, the time of 12:05am as recorded on his note stating that he had spoken to Dr Vatani and as a result the team were called in, and that the plan was to prepare for theatre, does not make any sense and must be incorrect. I do not accept that the theatre team were called in as early as 12:05am. To my mind it was later than that, and not before 12:18am when

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[176] Transcript, page 496
[177] Exhibit C6, page 59
[178] Transcript, page 445 line 20
[179] Transcript, page 446 line 3

Mrs Willmett was instructed to push and the resultant severe deceleration to approximately 60 beats per minute.

13.24. The anaesthetist, Dr Senevirathna was called in to the Ceduna Hospital from a nearby location. However, in his evidence he did not provide the Court with a time at which he was called or at which he arrived and there is no note of the same. What he could say was that at the time he arrived he noticed from the CTG trace that the baby had a heartrate of 85 beats per minute. In his evidence he indicated, by reference to the CTG trace, that this occurred at approximately 12:15am or 12:16am. As to his reaction, he said:

> 'I thought it is going to be a serious problem. The baby is in big trouble.'[180]

He then says that he left the delivery room to go to the operating theatre to prepare for a caesarean section. Dr Ochigbo was there. He said that he raised his concern with Dr Ochigbo and told him the heartrate had descended to 85 beats per minute and told the Court that Dr Ochigbo shared the same view as himself. He did not witness the deceleration to a level of 60 beats per minute. The one deceleration that he witnessed, namely to 85 beats per minute, was enough for him to become concerned. In cross-examination by Ms O'Connor SC, Dr Senevirathna denied the suggestion put to him that he had not become very alarmed about the child until he had seen the reading of 60 beats per minute.[181] He also denied that the decision to perform a caesarean section was not made until 12:30am.

13.25. Professor Pepperell suggested that the first evidence of foetal distress on the CTG trace was at point 4 of his identified points on the CTG trace.[182] That event occurred between 11:52pm and 11:54pm during which there was a deep deceleration to about 115 beats per minute. Asked by counsel assisting, Ms Kereru as to whether it was his opinion that a decision should have been made by Dr Ochigbo to undertake a caesarean section, Professor Pepperell said:

> 'If he was used to looking at that sort of thing, yes, otherwise he should have contacted the people in Adelaide, which he did soon after that time'.[183]

[180] Transcript, page 1099
[181] Transcript, page 1099
[182] Exhibit C11e
[183] Transcript, page 934

He also said that the loss of variability as evidenced between 11:54am and 12:00am (at his point 6) would have prompted him to think that it was time that Mrs Willmett was taken to theatre and another caesarean was performed but that is not necessarily to say that a general practitioner obstetrician in Dr Ochigbo's place would have seen things in the same light. However, in relation to the CTG revelations prior to midnight, and whether in the light of that information Mrs Willmett should have been rushed straight away to a surgical environment and caesarean section performed, Professor Pepperell said:

> 'And as I said before when I was giving my evidence before, that that would have applied if I had been looking after her. But if you're dealing with someone who is a GP and who hasn't had the experience that I and most consultants would have had, then it may well be that they waited until around that time to have the phone call on the expectation that that was probably what was going to be advised, but then you'd accept that advice.'[184]

13.26. Of importance, the following questions and answers were given during cross-examination of Professor Pepperell by Ms O'Connor SC:

> 'Q. Would you not agree that with someone who was presenting with the observations that we see here - and I'll ask you to assume a couple of things. One, that she'd been complaining of pain in her abdomen between contractions. Secondly, that she had the event that we can see in the ambulance that caused Dr Oswald to record it. And thirdly, there would be signs of foetal distress that we see from your red markers, one through to five, including six, that at that point there was sufficient information to know that there needed to be a caesarean section, that vaginal birth was now out of the question.
>
> A. Well that's what I said before when I gave my evidence.
>
> Q. But you said about yourself. I'm asking you about whether your view is that a reasonably competent practitioner with the care of this patient, would have also come to the same conclusion.
>
> A. Well if I was dealing with the trainee staff at the Women's Hospital, who have been trained as specialists, they would have certainly requested an opinion from someone like myself, if I was on there in labour ward, when in fact those problems were occurring. No doubt about that. But I don't believe you could make a statement that every GP who is acting as an obstetrician, would have proceeded to a caesarean section until he had advice concerning items 4, 5 and 6.' [185]

The items 4, 5 and 6 are items that occurred just before, and in the case of item 5, just after midnight.

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[184] Transcript, page 973
[185] Transcript, pages 973-974

13.27. All that said, Professor Pepperell stated that he himself would have made the decision in the light of the reduced beat to beat variability just before midnight and he would '*have had the baby out by 15 minutes past midnight*' which is about 55 minutes earlier than Laura was ultimately delivered. Nevertheless, Professor Pepperell was clearly talking about what action would have been required having regard to his own personal expertise, but this would not necessarily have applied to Dr Ochigbo who at around midnight made the decision to seek consultant advice from the WCH. Nevertheless, Professor Pepperell suggested that intervention at about midnight with the baby being delivered shortly thereafter could have affected the overall outcome and he suggested that it was therefore a preventable death.[186]

13.28. As indicated earlier, I have not found it straightforward to reconcile some of the Professor's evidence. Complicating matters is the flawed handover and the fact that Dr Ochigbo did not take on board the information in the possession of Dr Oswald that Mrs Willmett had possibly experienced a uterine rupture and/or obstructed labour. As indicated above, I have also found that Mrs Willmett was in significant pain and discomfort on arrival. While I accept Professor Pepperell's views that due allowances have to be made for Dr Ochigbo's relative lack of expertise when compared to an experiences consultant obstetrician, I do not believe that this excuses any omission that occurred as a result of the flawed handover. Mrs Willmett should have undergone an emergency caesarean section on the basis of her clinical presentation and on the information that should have been imparted to Dr Ochigbo regarding possible uterine rupture or obstructed labour.

13.29. <u>Whether the suggestion or instruction to Mrs Willmett to push was appropriate or not</u>? The evidence of Professor Pepperell is again relevant here. Professor Pepperell said that any instruction to Mrs Willmett to push was

> '.. completely inappropriate in view of the fact she was not full dilated at all and you already had evidence of possible hypoxia with beat to beat variability problems and deceleration.'[187]

13.30. Professor Pepperell went on to say that even if uterine rupture was not suspected or not in existence, he would have still regarded the instruction to push as completely inappropriate. He pointed out that if the baby's head was still significantly above the

[186] Transcript, page 982
[187] Transcript, page 934

spines, Mrs Willmett should certainly not have been attempting to deliver the baby by pushing. Professor Pepperell was asked by counsel assisting Ms Kereru:

> 'Q. Was there ever a case in this clinical setting with the cervical dilatation being what it was, to have asked Mrs Willmett to push at that time.
>
> A. I don't believe so.' [188]

Indeed, Professor Pepperell agreed with Ms O'Connor SC that telling Mrs Willmett to push was a dangerous and wrong thing for her to have been told.[189]

13.31. As to the circumstances in which Mrs Willmett was instructed to push, and what difference it would have made whether adverse or not, the evidence is less than clear. I will deal with both of those issues.

13.32. The notation on the CTG trace as to when Mrs Willmett did push appears at 12:18am. It is signified by the word 'PUSH'. Ms Higgs told the Court that she wrote it, although Dr Ochigbo thinks that he may have written it. Mrs Willmett told the Court that Ms Higgs and Dr Ochigbo were in the delivery room and she recalls Ms Higgs saying words to the effect that the baby was not happy and they needed to get it out. To that end she was told that she needed to push with her next contraction. Mrs Willmett also believed that the anaesthetist to whom I have already referred was also in the room at that point. So naturally was her husband. Mrs Willmett said that Ms Higgs and Dr Ochigbo were on either side of her and each had hold of one of her legs. Mrs Willmett said that she recalled pushing once when Ms Higgs and Dr Ochigbo were in the room. As to the result of that Mrs Willmett said:

> 'I don't really know. I was - it wasn't - I was breathing on gas at the time and I was completely - I don't know. Just in a mess at that time. It felt like sort of felt like I wasn't supposed to be pushing. ' [190]

Mrs Willmett said that after she pushed Ms Higgs and Dr Ochigbo then silently ran out of the room. It will be observed from the CTG trace that immediately following the push the very low deceleration to approximately 50 to 60 beats per minute occurred. On Mrs Willmett's evidence this might explain the reaction of Ms Higgs and Dr Ochigbo with regard to the manner that they left the room. Mrs Willmett said that when they were out of the room the anaesthetist told her to push again. Mrs Willmett

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[188] Transcript, page 934
[189] Transcript, page 976
[190] Transcript, page 55

said that she again pushed, following which the anaesthetist also ran out of the room. This left just Mrs Willmett and her husband in the room. Approximately five minutes later Ms Higgs and Dr Ochigbo returned and announced that they were taking her to theatre. In cross-examination Mrs Willmett denied that Dr Ochigbo had left the room before she pushed and denied that she was mistaken about who had held her legs.[191]

13.33. Mr Willmett in his evidence told the Court that present in the room at the time his wife was encouraged to push by Ms Higgs were a person he described as a '*trainee medical person*', Dr Ochigbo and Ms Higgs. In cross-examination by Mr Lindsay SC on behalf of Dr Ochigbo, Mr Willmett said he was sure that Dr Ochigbo was present. He also said that Dr Ochigbo was holding his wife's leg. He said he was sure about that as well.[192] He said that Ms Higgs was holding the other leg.

13.34. In her evidence-in-chief Ms Higgs was shown the CTG trace and was asked about events between 12:10am and 12:18am which was the time of the push as indicated on the trace. Ms Higgs told the Court that Dr Ochigbo had initially left the room to call the WCH for advice and that he had then returned to the room. When he returned he indicated that he had attempted to speak to a consultant or registrar at the WCH but that one or both of them were involved in theatre. So he had spoken to some other person. It appears that Dr Ochigbo at first did speak to a registered nurse at the WCH. Ms Higgs told the Court that Dr Ochigbo said that the person to whom he had spoken suggested that they try to get the baby out as quickly as possible and to try one push.[193] If Mrs Willmett was almost fully dilated it was thought that this might potentially be the fastest way to deliver the baby but if that did not work they would proceed to caesarean section. Ms Higgs said that Dr Ochigbo then asked Mrs Willmett to push and so she pushed once. When asked to clarify this Ms Higgs said that she did not recall precisely who gave Mrs Willmett the instruction to push, but it was a '*sort of a collective*' effort on the part of everyone in the room to get Mrs Willmett to push. Ms Higgs said that she wrote the word PUSH on the CTG. She confirmed that this event occurred at about 12:18am. Ms Higgs told the Court that the baby's heart rate then experienced a significant deceleration. This prompted Dr Ochigbo to instruct Mrs Willmett not to push again. He then left the room to have a further conversation with the WCH. He also instructed Ms Higgs to fax the CTG trace to that hospital. Ms Higgs left the room

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[191] Transcript, page 134
[192] Transcript, page 199
[193] Transcript, pages 705-706

to do that. In cross-examination Ms Higgs did not agree with the suggestion that Dr Ochigbo was not present when Mrs Willmett was asked to push.[194] She denied that it was her idea that Mrs Willmett push.[195] Furthermore, Ms Higgs denied that it was only when Dr Ochigbo returned to the room that he had seen that there had been a push.[196]

13.35. Ms Higgs told the Court that she believed that at the time at which both she and Dr Ochigbo were out of the delivery room, the anaesthetist remained in it.[197]

13.36. Ms Higgs gave evidence about the appropriateness of the push. At one point in her evidence she seemed to suggest that it was a reasonable thing for Mrs Willmett to have been asked to do.[198] At another point she said that she would not have advised Mrs Willmett to push because she was already concerned about the condition of the baby based on the CTG. This had meant that if the push had been successful there was no-one in the room to help her if the baby was born. Secondly, she believed that at the time there was obviously something wrong on a uterine level from the mother's perspective. She said:

> 'So I wouldn't have been wanting to give direction to a woman in a situation that was potentially life threatening, like I was very concerned.' [199]

13.37. I prefer the evidence of Professor Pepperell that in all of the circumstances instructing Mrs Willmett to push was inappropriate and that the only sensible course at that stage was an emergency caesarean section.

13.38. There was one aspect of Ms Higgs' evidence that in my view clarified an issue and that was that it supported Dr Ochigbo's position that he had telephoned the WCH at a time significantly before the concerning revelations on the CTG between 12:15am and 12:25am.

13.39. Dr Ochigbo's evidence concerning the push was that at the time it occurred he was out of the room making a phone call to the WCH. He returned to the room and noticed the deep deceleration. He asked those present what had taken place and was informed that the deceleration had occurred after a push. He said that Ms Higgs told him that. He

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[194] Transcript, page 725
[195] Transcript, page 726
[196] Transcript, page 726
[197] Transcript, page 795
[198] Transcript, page 729
[199] Transcript, page 797

denied that he had been in the room holding one of Mrs Willmett's legs while she pushed.[200] He said that he would not have suggested that Mrs Willmett push at that point because she was only at 9cm and not fully dilated which meant that the cervical opening was insufficient to allow the baby's head to pass through it. This evidence of course conforms with that of Professor Pepperell. That conformity, however, does not necessarily mean that Dr Ochigbo had no involvement in the push.

13.40. In cross-examination by Ms O'Connor SC on behalf of Mr and Mrs Willmett and Ms Sloan on behalf of Ms Higgs, Dr Ochigbo denied that he had been involved in the instigation of any push.

13.41. Both Mrs and Mr Willmett also said that after Ms Higgs and Dr Ochigbo left the room after the first push, leaving them in the room with the anaesthetist, the anaesthetist instructed Mrs Willmett to push which she did. This led the anaesthetist to run out of the room as well.

13.42. As for Dr Senevirathna, the anaesthetist, he denied that he was present at or involved in any instruction to Mrs Willmett to push. In cross-examination Dr Senevirathna denied that at one point after Dr Ochigbo and Ms Higgs had left the delivery suite, leaving him as the only medical practitioner remaining there, that he then told Mrs Willmett to push.[201] The evidence that Dr Senevirathna gave, if accepted, also tended to refute the suggestion that Dr Ochigbo would have been in the delivery room at the time Mrs Willmett was instructed to push. If anything it supported Dr Ochigbo's account that he had not been present. Dr Senevirathna told the Court that he was present in the room at the time the foetal heart rate descended to about 85 beats per minute at about 12:16am. It will be noted that this event occurred just before the push recorded at 12:18am. Dr Senevirathna said that when this occurred he left the room because at that point he thought the baby was in '*big trouble*'.[202] He then proceeded to the theatre where he found and spoke to Dr Ochigbo. They agreed that the baby required a caesarean section. He told the Court that he did not witness any push or the significant deceleration following it. This evidence does not completely preclude Dr Ochigbo returning to the delivery room just prior to the push. On Dr Ochigbo's own evidence he did return to the room where he says he was told of the push and observed the

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[200] Transcript, page 445
[201] Transcript, page 1130 line 14
[202] Transcript, page 1099

significant deceleration. However, Dr Senevirathna's evidence renders it less likely that Dr Ochigbo was in the room when the push took place.

13.43. It is clear from the statements of Dr Vatani and from her handwritten record that she did not in any way instigate or recommend that Mrs Willmett should push. Her first statement[203] states that based on the information given to her by Dr Ochigbo the patient was not dilated enough for a vaginal birth. She does recall that Dr Ochigbo did ask her in the telephone conversation that occurred at approximately 12:30am whether there could still be a vaginal birth, but she had said no and gave him advice that the patient should have an emergency caesarean section. In Dr Vatani's second statement[204] she asserts that she would not have recommended that Mrs Willmett push because she was not fully dilated and the baby's head was at -3, meaning it was not appropriate for her to push. She states in this statement that she cannot specifically recall if Dr Ochigbo had mentioned to her that he had instructed or that he should instruct the mother to push, but that she would have recorded any such conversation in her notes. It is obvious that she did not record anything of that nature.

13.44. There is no doubt that Mrs Willmett was instructed to push and was instructed to do so in circumstances where it was not appropriate for her to be so instructed. Dr Ochigbo himself accepts that, although he denies any involvement in the push. As with other issues in this inquest it is difficult to determine with precision where the truth lies in relation to the circumstances of the push. One thing is certain and that is that Ms Higgs was party to the instruction to push because she said she was. She said she was involved in this despite asserted misgivings about it. She denies that it was her idea.

13.45. I do not find it necessary to assign responsibility to any individual in respect of the push. What can be said is that the instruction was inappropriate. I accept Professor Pepperell's evidence in this regard. I observe that the push occurred at about 12:18am. The caesarean section procedure would not commence until some 47 minutes later. Although it cannot be known with certainty, the possibility that the instruction to push was born out of the panicked realisation that the capacity to perform an emergency caesarean was not at hand, but was a significant period of time away, has not been eliminated.

[203] Exhibit C23, paragraph 30
[204] Exhibit C23a

13.46. As to the consequence of the push, it is accepted that the first push was the precipitant of the significant deceleration to 50 or 60 beats per minute indicating that the baby was in significant distress and that this was so for an extended period of time.

13.47. As to the contribution that the push may have made in respect of the very adverse outcome, the reader will be reminded that Professor Pepperell, who regarded the deceleration as a very long one over a period of approximately seven minutes, indicated that this was evidence of a very severe problem of hypoxia in the baby.[205] The difficulty in attributing anything exclusively to the push and to the resulting deep and long deceleration is that those events cannot be looked at in isolation. The CTG trace even demonstrated concerning facets of the baby's welfare very soon after it was connected. Moreover, there is nothing that excludes the possibility, if not likelihood, that this baby was suffering from foetal stress at points in time even earlier than when the CTG was connected at 11:31pm. It will be remembered that Professor Pepperell suggested that because of the lack of CTG tracing during the course of the Saturday there was no way of ascertaining what the state of the baby's condition was during that period of time.

13.48. The most that can be said is that the push and the resulting significant deceleration was yet another regrettable circumstance in a list of regrettable circumstances surrounding the birth of this baby.

14. Times at which Laura Willmett's death could have been prevented

14.1. Professor Pepperell dealt with this issue both in his written report and in his oral evidence. In answer to the question, could Laura's death have been prevented, and if so by what means, Professor Pepperell said the following in his report:

> 'YES. If Jennifer had remained in Ceduna Hospital from the time of her admission on 13 August 2016, I believe the abnormal progress would have been defined well before 2100 hours and if the repeat CS had been done then, or even by about 2330 hours, I believe Laura would have been on good condition at birth and survived. I believe it is almost certain that the actual uterine rupture occurred at about 0019 or 0030 hours, but it is impossible to know whether there was clearly any fetal distress evident between 1015 and 2330 hours because of the lack of any prolonged CTG recording during that time period. If a CTG abnormality had been evident during that time period, urgent delivery by emergency Caesarean Section would have needed consideration.' [206]

[205] Transcript, page 932
[206] Exhibit C8, paragraph 3.3, page 7

As has been recorded elsewhere in these findings Professor Pepperell also expressed the opinion that it was likely the uterine rupture commenced at the time Mrs Willmett experienced the sharp pain separate from a contraction when she was in the ambulance on the way to Ceduna.[207] I accept that evidence.

14.2. In his oral evidence Professor Pepperell repeated the observation reproduced above from his report. He added that it was difficult to say exactly at what stage the foetal hypoxia became worse, but that even if Mrs Willmett had been assessed four-hourly, say at 1pm and 5pm on the Saturday, the baby probably would have been delivered at around 5pm, but suggested that this would also be difficult to know because there is no way of determining whether cervical dilatation would have been sufficient at that time. This is due to the fact that Mrs Willmett was not present for such an examination to occur.

14.3. Asked specifically what the situation may have been if Laura had been delivered say between 1pm and 5pm that day, Professor Pepperell said that she almost certainly would have been born alive at that time. He added the rider that there may have been some sign of foetal distress at birth, but it would have been almost certainly nowhere near as severe as it ultimately was and that the baby would have survived without any major deficit, save of course for the unconnected brain lesion that may have left her with a visual difficulty.[208]

14.4. In questioning by me Professor Pepperell agreed with the suggestion that in the period between the two CTG administrations, the first in the morning and the second that night, there was a point between those two times when action could have been taken to have prevented the baby being born in the condition that she ultimately was.[209] Professor Pepperell went on to say that a CTG can demonstrate three significant facets of foetal health, namely beat to beat variability, the presence of decelerations and evidence of possibly obstructed labour with an accelerated heart rate of above 160. The Professor was asked whether during the course of Saturday afternoon those facets had been detected on a CTG and whether in those circumstances Mrs Willmett would have been allowed to continue to labour. He said:

> 'Once you make that decision that there's a problem with the foetal condition and as someone who's had a previous caesar, the recommendation would be we don't know the

[207] See paragraph 12.33 herein
[208] Transcript, pages 941-942
[209] Transcript, page 943

> exact cause, it could be related to a scar giving way as well and the safest method is to deliver you by repeat caesarean section.' [210]

According to Professor Pepperell this of course would be all the more so if the cervix was not dilated to the necessary extent.[211] Of course, it is now known that Mrs Willmett was not dilated to the maximum, even when she arrived at the Ceduna Hospital that night. It seems to me to be an inevitable conclusion, therefore, that if abnormalities had been detected on the CTG during the course of the Saturday afternoon, a caesarean section would have occurred and the child would have been born in a significantly better condition than she was at just after 1am the following morning.

14.5. In cross-examination by Mr Lindsay SC for Dr Ochigbo, Professor Pepperell agreed with the proposition that if Mr and Mrs Willmett had made it back to hospital within an hour and a half of the first set of painful contractions, this would most likely have resulted in the safe delivery of the baby.[212]

14.6. Professor Pepperell was also specifically asked about the preventability of Laura's death if her parents had travelled to Ceduna following the phone call between Mr Willmett and Ms Higgs at 5:16pm. Professor Pepperell was quite clear in his answer to that question. He said that on the assumption that Mr and Mrs Willmett were at the hospital by, say, 6:45pm and it took the same amount of time for Laura to be delivered by caesarean section as it ultimately took, Laura would have been born at about 8:15pm which is about five hours before her eventual delivery at 1:10am. Professor Pepperell said in those circumstances:

> 'Now I don't have any doubt in my mind that if in fact that had happened and she got there that in fact the baby would have been born alive and would have been in reasonable nick.' [213]

14.7. Professor Pepperell told the Court that he would have made the decision to perform a caesarean section at about his point 6 on the CTG. That point as seen earlier represented the six or so minutes of abnormal beat to beat variability that lasted from 11.54pm to 12am. As alluded to earlier, he said *'We would have the baby out by 15 minutes past midnight'*. I took *'we'* to mean that clinicians in an environment that he as a consultant obstetrician would be used to, would have had the baby out by 15 minutes past

[210] Transcript, page 944
[211] Transcript, page 944
[212] Transcript, page 1107
[213] Transcript, page 1019

midnight. He suggested that a delivery at this time could have affected the outcome and to that extent the baby's death was preventable.[214]

14.8. I accept all of Professor Pepperell's evidence in relation to the question of preventability.

15. Conclusions

15.1. Laura Angela Willmett was two days old when she died as a result of hypoxic ischaemic encephalopathy secondary to intrapartum hypoxia. Laura was born in the early hours of the morning of Sunday 14 August 2016 by emergency caesarean section. During this procedure it was discovered that her mother had experienced a uterine rupture. I find that the uterine rupture did not contribute to the intrapartum hypoxia experienced by Laura nor contribute to the cause of her death.

15.2. Mrs Willmett chose to deliver Laura by way of a vaginal birth after a previous caesarean section (VBAC). In the event, a decision was made to allow Mrs Willmett to deliver Laura by way of a VBAC at Ceduna Hospital. I make no finding in relation to the circumstances in which Mrs Willmett came to make her decision in that regard. What can be said, however, is that the pursuit of a VBAC, which ultimately culminated in an emergency caesarean section, was unwise having regard to the resources at the Ceduna Hospital both human and otherwise, and also taking into account the distance that Mrs Willmett resided from Ceduna and the potential complications that this might pose. Regardless of the circumstances in which Mrs Willmett came to a decision to attempt to deliver Laura by way of VBAC, it would have been far better if Dr Ochigbo, in accordance with his usual policy, had refused to participate in a VBAC delivery.

15.3. I find that Mrs Willmett's planned delivery by way of VBAC meant, in accordance with the prevailing guidelines, that her labour should have been the subject of constant CTG monitoring and that she should have been overseen by constant midwifery observation and care. Neither of these two services were in place.

15.4. Mrs Willmett presented to the Ceduna Hospital late in the evening of Friday 12 August 2016 believing she was in labour. She and her husband spent the night at the Ceduna Hospital. I find that when Mrs Willmett was examined the following morning by Ms Higgs, a midwife, and by Dr Ochigbo, a general practitioner obstetrician, both

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[214] Transcript, page 982

clinicians genuinely believed that Mrs Willmett was not in labour and that they advised Mrs Willmett of the same. By the same token, I find that Mrs Willmett and her husband both genuinely believed that in spite of the advice of the clinicians, Mrs Willmett was in labour.

15.5. Based upon the evidence of Professor Pepperell I have found that it is possible that Mrs Willmett was in the latent stages of labour when she was at the Ceduna Hospital on the morning of Saturday 13 August 2016. In any event, given that Mrs Willmett was due that day and given the distance of her home from Ceduna, there is no question but that Mrs Willmett should not have left the Ceduna environs. Mrs Willmett should either have been the subject of constant CTG monitoring or, if she did not remain at the hospital but would remain in Ceduna, periodic examination during the course of that day. I make no finding re at whose instigation Mr and Mrs Willmett left Ceduna to travel to their home at Sceale Bay.

15.6. At 5:16pm on Saturday 13 August 2016 Ms Higgs and Mr Willmett conducted a telephone conversation. I find that Mr Willmett told Ms Higgs that Mrs Willmett was experiencing contractions that were three minutes apart. This signified that Mrs Willmett was in established labour. I also find that Ms Higgs advised Mr Willmett that he and his wife should travel to Ceduna as soon as possible because Mrs Willmett needed to be at the Ceduna Hospital. I make no finding as to why Mr and Mrs Willmett continued to remain at their home at Sceale Bay following this telephone conversation.

15.7. I find that in a further telephone conversation between Mr Willmett and Ms Higgs at 7:43pm Ms Higgs enquired as to where Mr and Mrs Willmett were as she was worried that Mrs Willmett was in labour. I find that she repeated her earlier advice that Mr and Mrs Willmett should come to Ceduna as soon as possible.

15.8. Mr and Mrs Willmett left their home at Sceale Bay intending to travel to the Ceduna Hospital. However, as Mrs Willmett thought during the journey that she might imminently deliver the baby, she and her husband decided to break the journey at the Streaky Bay Hospital. At the Streaky Bay Hospital Mrs Willmett was examined vaginally twice by Dr Oswald, a general practitioner. Mrs Willmett had dilated only to nine centimetres and the station of the baby's head was such that she was not ready to deliver. I find that Dr Oswald's management of Mrs Willmett at the Streaky Bay Hospital, including his decision to delay her departure to the Ceduna Hospital until he

could conduct a second vaginal examination in order to judge the progress of her labour, was reasonable.

15.9. Mrs Willmett was conveyed by ambulance from the Streaky Bay Hospital to the Ceduna Hospital. Dr Oswald accompanied Mrs Willmett. At approximately 20 kilometres from Ceduna Mrs Willmett experienced an unusual level of abdominal pain and that at the same time the foetal heart rate as detected by a Doppler accelerated to approximately 180 or 190 beats per minute which is abnormally high. Mrs Willmett was experiencing pain between contractions. I find that Dr Oswald suspected that Mrs Willmett had experienced a uterine rupture and/or that she was experiencing obstructed labour.

15.10. I find that on the basis of the evidence from Professor Pepperell it is likely that the pain experienced by Mrs Willmett in the ambulance represented the commencement of a uterine rupture. I find that it was also possible that Mrs Willmett was in obstructed labour having regard to her failure to dilate as identified by Dr Oswald at the Streaky Bay Hospital and based upon Mrs Willmett's further examination by Dr Ochigbo at the Ceduna Hospital upon her arrival there.

15.11. I find that Mrs Willmett presented at Ceduna in significant pain and appeared unwell. Her discomfort in my view could not be wholly attributed to urinary retention. I find that both uterine rupture and obstructed labour should have been regarded as differential diagnoses upon Mrs Willmett's arrival at the Ceduna Hospital.

15.12. When Mrs Willmett arrived by ambulance at the Ceduna Hospital, the handover from Dr Oswald to Dr Ochigbo miscarried. Due to a poor level of communication between the two medical practitioners neither Dr Ochigbo nor any of the other clinicians involved in Mrs Willmett's care from that point were made aware of Dr Oswald's opinion that Mrs Willmett may have experienced a uterine rupture and/or that she was in obstructed labour. However, as alluded to above, I have accepted the evidence of Ms Higgs to the effect that Mrs Willmett was experiencing pain and discomfort upon her arrival at the Ceduna Hospital and looked unwell.

15.13. It was reasonable for Dr Ochigbo to perform a vaginal examination of Mrs Willmett upon her arrival at the Ceduna Hospital. It was also appropriate for Mrs Willmett to be connected to a CTG monitor at the earliest opportunity after her arrival. However, I have found that having regard to Dr Oswald's clinical impressions of Mrs Willmett and

the fact that he had considered as differential diagnoses either uterine rupture or obstructed labour or both, a decision to perform a caesarean section should have been made immediately following Dr Ochigbo's vaginal examination. Mrs Willmett should have been subjected to an emergency caesarean section as soon as possible after Dr Ochigbo had completed his examination. In all of the circumstances I have found that Mrs Willmett should not have been regarded as a VBAC candidate following her examination by Dr Ochigbo.

15.14. I find that if there had been a proper handover between Dr Oswald and Dr Ochigbo, and if Dr Ochigbo had the qualifications and experience of a consultant obstetrician, Mrs Willmett would probably have undergone a caesarean section at a time significantly before knife to skin at 1:05am the following morning.

15.15. I find that in any event, regardless of the flawed handover, Mrs Willmett was allowed to labour for too long at the Ceduna Hospital. Soon after her arrival at that hospital, the CTG trace indicated that the unborn baby was experiencing foetal distress. I have taken into account Dr Ochigbo's lesser qualifications than those enjoyed by a consultant obstetrician. I have found that it was therefore appropriate for Dr Ochigbo to have telephoned the Women's and Children's Hospital for advice at about midnight. At approximately 12:18am Mrs Willmett was advised to push. This was an inappropriate instruction having regard to the state of her cervix and the station of the baby's head. Immediately following and as a result of the push the baby's heart rate descended to an alarming 50 or 60 beats per minute which demonstrated severe hypoxia. The circumstances surrounding the push are the subject of dispute and are less than clear, as are the identities of persons present when it occurred. The contribution of the push and the resulting deceleration to Laura's condition when ultimately delivered cannot be determined with precision having regard to the fact that Laura in any event was demonstrably in foetal distress very soon after the connection of the CTG and to the possibility that she was in unmonitored foetal distress earlier in the day.

15.16. I have found that Laura Willmett's death probably would have been prevented:

1. if Mrs Willmett had not travelled back to her home on the morning of Saturday 13 August 2016;

2. if during Saturday 13 August 2016 Mrs Willmett had been the subject of constant or regular CTG monitoring together with the clinical care of a midwife;

3. if Mr and Mrs Willmett had returned to Ceduna as soon as possible following the telephone conversation between Mr Willmett and Ms Higgs at 5:16pm;

4. if a proper and thorough handover had taken place between Dr Oswald and Dr Ochigbo, a handover that included the expression of a differential diagnosis of ruptured uterus and/or obstructed labour;

5. if a caesarean section had been performed immediately or as soon as possible after Dr Ochigbo's examination of Mrs Willmett's upon her arrival at the Ceduna Hospital.

16. Recommendations

16.1. Pursuant to section 25(2) of the Coroner's 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.

16.2. In this matter, a root cause analysis (RCA) was conducted pursuant to section 69 of the Health Care Act 2008. Section 69(4) of the Health Care Act states that the purpose of such an investigation is to identify issues within a system that contributed to or resulted in the occurrence of an adverse incident involving a health services entity and to provide recommendations for measures to prevent a reoccurrence of a similar incident. It will thus be seen that such an investigation has certain parallels with an investigation undertaken in the course of a coronial inquest. The difference, however, is that the investigation pursuant to this Part of the Health Care Act must be conducted in private. Save for an RCA's recommendations, the information provided to and gathered by the investigation and the report of its findings must be kept confidential and may not be adduced in a Court including this Court. Accordingly, this Court was not made privy to any evidence or information that may have been provided to the RCA investigators by any of the clinical participants in this matter. This of course is to be contrasted with the fact that the Court was furnished with certain materials from the AHPRA investigation. There are no means by which this Court can determine whether information given to the RCA investigation by its clinical participants is consistent or inconsistent with what they said in this Court.

16.3. However, in accordance with the provisions of the Health Care Act the Court was provided with the RCA public report of the recommendations that were made following the RCA investigation. The report[215] is exhibited to the affidavit of Mr Andrew Lane[216] who is the Executive Director of Nursing at the Ceduna District Health Service

16.4. Contained within the recommendation report is a description of the event to which the RCA relates. It is as follows:

> 'A labouring woman, with a history of a previous caesarean section, was transferred from a non-birthing health unit to the nearest birthing health unit. Upon arrival, a CTG was performed and noted to be abnormal, leading to a category 1 emergency Caesarean Section.
>
> The baby required resuscitation at birth, including intubation. Both mother and baby were transferred to a metropolitan site and the baby subsequently died.'[217]

The non-birthing health unit referred to in that description is the Streaky Bay Hospital. The nearest birthing health unit referred to is the Ceduna Hospital.

16.5. The public report sets out two recommendations directed to Country Health South Australia Local Health Network (CHSALHN):

'1. Education:
CHSALHN to inform health care providers involved in perinatal care in country SA of the learnings identified, which includes:

a) Increasing awareness of:
   - i. Regional Perinatal Network Committees
   - ii. SA Health Perinatal Practice Guidelines: Vaginal Birth after caesarean section (PDF); and Vaginal birth after caesarean section consumer brochure (PDF)
   - iii. South Australian GO Obstetric Shared Care Protocols
   - iv. Standards for Maternal and Neonatal Services in South Australia
   - v. CHSALHN Emergency Birthing in a Non-Birthing Unit Procedure
   - vi. CHSALHN Inter Hospital Transfer for Obstetric Women in a Non-Birthing Site Procedure
   - vii. SA Perinatal Emergency Education program, Perinatal Advice Line and workforce support including locus services; to assist in supporting clinicians and clarifying their responsibilities when providing perinatal services

b) Provide access to SA Health and CHSALHN practice guidelines and protocols and perinatal support services

[215] Exhibit C20, Annexure AL1
[216] Exhibit C20
[217] Exhibit C20, Annexure AL1

c) Consideration of a ruptured uterus as part of the differential diagnosis when a pregnant woman presents with unexplained and severe abdominal pain, particularly with a history of previous uterine surgery and/or abnormal fetal Doppler / CTG trace

2. Procedure:
CHSALHN Maternity Services Committee to facilitate the review/development of procedures:

a) To guide health practitioners across more than one site, involved in perinatal care to routinely use a collaborative and well documented management plan (in the SA Pregnancy record) that is communicated to maternity service consumers and all clinicians involved.

b) To guide and support health practitioner when labouring woman presents to a non-birthing site.

c) To guide health practitioners from non-birthing and birthing units to communicate before transfer commenced, during transit and upon arrival. This would include comprehensive handover (verbally and in writing) that would help to ensure timely and appropriate ongoing care.'[218]

16.6. It is apparent that Recommendation 1(c) above was based on the RCA investigation of the issue as to whether at the Ceduna Hospital proper clinical consideration had been given to Mrs Willmett's unexplained and severe abdominal pain, her abnormal foetal Doppler and/or CTG trace and her history of previous caesarean section.

16.7. It is also apparent that Recommendation 2(c) above was based on the RCA investigation of the issue as to whether there had been a proper and effective handover between Dr Oswald and Dr Ochigbo at the Ceduna Hospital.

16.8. Apart from annexing the report relating to the RCA recommendations, the affidavit of Mr Andrew Lane describes certain other measures undertaken by Country Health South Australian Local Health Network (CHSALHN) and the Ceduna District Health Services (Ceduna Hospital).

16.9. It is not necessary to describe all of those measures. However, they include:

- Withdrawal of the option of VBAC at the Ceduna Hospital.
- The referral of any woman commencing her antenatal care at the Ceduna Hospital and electing to try for a VBAC to an appropriate general practitioner obstetrician or tertiary centre where the birthing method is permitted.

[218] Exhibit C20, Annexure AL1

- That all women who undertake antenatal care at the Ceduna Hospital and have made a request to try for VBAC must relocate to their chosen VBAC birthing site no later than at 36 weeks gestation. I would imagine that this measure arises out of a consideration of the circumstances that prevailed on 13 August 2016 in respect of Mrs Willmett's labour and the uncertainty and hesitation involved in her leaving the Ceduna environs that morning.
- Since July 2018 all midwives and general practitioner obstetricians who are employed within CHSALHN are required to complete the RANZCOG Foetal Surveillance Education Program (FSEP) which is designed to provide a minimum level of competency and training for all obstetric staff in reading and interpreting a CTG.
- In relation to the transfer of an obstetric woman from a non-birthing facility (such as in this case the Streaky Bay Hospital) to an appropriate birthing facility (in this case the Ceduna Hospital), there must be communication and acceptance of the transfer between the medical officer of the non-birthing facility and the medical officer at the accepting facility. This communication must include a comprehensive handover involving photocopies of all documentation completed at the non-birthing facility accompanying the obstetric woman to the accepting hospital.

This Court endorses all those measures and would suggest that they might equally apply to all country hospitals in South Australia. I would also add that having regard to the inferior level of resources enjoyed at country hospitals, what transpired in the case of Mrs Willmett and Laura demonstrates that it ought to be a rare occurrence for an attempted VBAC delivery to be managed in any country hospital in South Australia. If women are to be allowed to attempt a VBAC in a country hospital, it is imperative that they be full informed of important matters including:

- That the resources in a country hospital are limited compared with those of a metropolitan tertiary hospital.
- That the qualifications of the medical practitioner managing an attempted VBAC in a country hospital may not be as great as those of a consultant obstetrician practising in a metropolitan tertiary hospital.

- That if an emergency caesarean section needs to be performed it may not be performed as expeditiously as it would be in a metropolitan tertiary hospital.
- That the distance from their place of residence to the country hospital may operate as a complicating factor in any attempted VBAC.

I recommend accordingly.

16.10. It will be remembered that on more than one occasion in his evidence Professor Pepperell referred to the skills and qualifications of general practitioner obstetricians and what may have been legitimately expected of them in relation to a complicated and problematic presentation such as Mrs Willmett's. This is reflected by the fact that Dr Ochigbo found it necessary to consult more qualified clinicians at the WCH. All this leads to a conclusion that consideration should be given as to whether a VBAC delivery, whether occurring at a country hospital or at a metropolitan tertiary hospital, should only be managed by a consultant obstetrician. I recommend that such consideration be given. I direct that recommendation to the attention of the Chief Executive of the Department of Health and Wellbeing and to the Chief Executive or equivalent of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

16.11. Counsel Assisting, Ms Kereru, in her final address suggested that the Court should make two particular recommendations. They are as follows:

1. That Country Health South Australia review the VBAC policy for all country hospitals in South Australia to ensure the following:

   that all risks associated with this mode of delivery are considered and in particular having regard to such matters as the resources of the hospital, both human and otherwise, local conditions such as distances from a patient's home and difficulty of travelling to hospital expeditiously.

2. That Country Health South Australia adopts a policy that any woman at 40 weeks of gestation who presents to a country hospital with symptoms that might be labour should be presumed to be in labour unless demonstrated otherwise.

16.12. It appears to me that the first of those recommendation is the subject of a number of the measures that Mr Lane describes in his affidavit and in the accompanying annexures.

16.13. As to the second of Ms Kereru's suggested recommendations, again directed to Country Health South Australia, I am not certain that such a policy would be appropriate. There might be circumstances in which a woman should not be presumed to be in labour. If there is any doubt in the mind of the clinicians caring for a woman in a country hospital, they should seek advice from a more qualified source in the metropolitan area. I recommend accordingly.

Key Words: Infant; Intrapartum Hypoxia; Emergency Caesarean Section; Country Hospital

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 4th day of August, 2020.

Deputy State Coroner

Inquest Number 20/2019 (1567/2016)