CORONERS ACT, 2003

SOUTH  *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign King at Adelaide in the State of South Australia, on the 21st day of December 2022, the 18th day of January, the 17th day of February, the 7th, 8th, 9th 10th, 14th 16th, 17th, 20th and 21st days of March, the 6th day of April, the 8th day of May and the 28th day of July 2023 , by the Coroner's Court of the said State, constituted of Naomi Mary Kereru, Coroner, into the death of Bodhi Leo Searle.

The said Court finds that Bodhi Leo Searle aged 36 hours, late of Moana, South Australia died at the Flinders Medical Centre, South Australia on the 31st day of August 2021 as a result of hypoxic ischaemic encephalopathy due to intrapartum asphyxia. The said Court finds that the circumstances of his death were as follows:

1. Introduction

1.1. Bodhi Leo Searle was the first child of Diana and Jon Searle. Bodhi was born on 30 August 2021. He died the following day, on 31 August 2021.

1.2. In the early stages of her pregnancy, Mrs Searle[1] had been admitted under the Southern Midwifery Group Practice (SMGP) run through the Southern Adelaide Local Health Network (SALHN) at the Flinders Medical Centre (FMC). This was an option available to low-risk pregnancies and involved contact with a particular midwife throughout the antenatal period who would be the primary accoucheur during the delivery.

1.3. Apart from an episode of reduced foetal movements at 38 weeks, Mrs Searle's pregnancy progressed uneventfully.

[1] At the time of Bodhi's birth, Diana Searle was Diana Davidovic. With this acknowledgement, and noting that her name has since changed, I have referred to her as Mrs Searle throughout this Finding.

1.4. On 29 August 2021, Mrs Searle was taken to FMC by her husband after experiencing frequent contractions at home. Once at the FMC, Mrs Searle was confirmed to be in labour and was admitted into a SMGP room on the labour ward.

1.5. Mrs Searle's assigned midwife from SMGP was unwell on that evening, so another SMGP midwife stepped in to support Mrs Searle's labour. That was Ms Stephanie Geyer.

1.6. At approximately 11:36pm Ms Geyer made the decision to move Mrs Searle from the SMGP room to a room in the Birthing and Assessment Suite (BAS). This meant that Mrs Searle would be monitored more closely as her labour was not progressing as it should. Specifically, Mrs Searle was moved so that she could be connected to and monitored by cardiotocography (CTG).

1.7. Once in the BAS, Mrs Searle was connected to a CTG to monitor the foetal heart rate. Curiously the results of the continuous monitoring, for which Mrs Searle was moved, appeared not to have been the primary focus of the midwife caring for Mrs Searle. It has not been disputed at the Inquest that for a period of close to 30 minutes after the CTG was first connected, the CTG was tracing Mrs Searle's heart rate, and not Bodhi's. This was a fundamental and tragic error.

1.8. Dr Elizabeth Lindner, the Obstetric Registrar, who was the most senior obstetrician present in the hospital during Mrs Searle's labour, arrived to assess Mrs Searle in the BAS at approximately 12:25am.[2] A medical review was mandated by the change in the model of care, from SMGP to the BAS. It became apparent around that time that the CTG, which by then had commenced recording the foetal heart rate, revealed severely abnormal decelerations. Dr Lindner formed the view that an urgent forceps delivery was necessary and contacted the on-call consultant who was not onsite, to request her attendance at the hospital. Dr Lindner was a junior registrar in the first year of her obstetrics and gynaecology training, with minimal experience in instrumental deliveries.

1.9. A neonatal nurse practitioner was contacted to attend, as was the policy for an instrumental birth. The room was prepared for a forceps delivery, but upon Dr Lindner

[2] Transcript, page 1137

performing coached pushes with Mrs Searle, and then undertaking an episiotomy, Bodhi was spontaneously born at 12:58am.

1.10. It was immediately evident that Bodhi was in a very poor condition at birth, with APGAR[3] scores of 0 at one minute and 0 at five minutes. The on-call neonatologist was contacted and arrived within 10 minutes. Resuscitation efforts commenced immediately, and Bodhi took his first breath at 20 minutes post-delivery.

1.11. Bodhi was taken to the neonatal intensive care unit where it was established that he had suffered a severe hypoxic brain injury and that his neurological prognosis was extremely poor. A decision was made to palliate Bodhi. Tragically, at one day old, he died on 31 August 2021.

2. Reason for Inquest

2.1. This Inquest focused particularly on the labour of Mrs Searle and whether there were any deficits in the management of the intrapartum stage that may have ultimately contributed to Bodhi's death.

2.2. This Inquest explored the following issues:

2.2.1. The cause of the hypoxic ischaemic encephalopathy which caused Bodhi's death.

2.2.2. Why the maternal/foetal heart rate confusion persisted for close to 30 minutes before it was identified.

2.2.3. The consequences of the maternal/foetal heart rate confusion.

2.2.4. Whether a foetal scalp electrode should have been used at any time to monitor Bodhi's heart rate, and if so, when.

2.2.5. Whether it was appropriate for Dr Lindner, a first-year obstetrics registrar, to be rostered as the most senior obstetrician onsite at the hospital during this shift.

[3] APGAR scores are the clinical indicators of a baby's condition at birth. They include skin colour, pulse, breathing, muscle tone and reflex irritability.

2.2.6. Whether anything could, and in fact should, have been done to effect an earlier delivery time for Bodhi.

2.2.7. If Bodhi had been delivered earlier, whether his death would have been prevented.

2.3. In writing this Finding, I do not purport to summarise all of the evidence tendered or heard at the Inquest, but refer to it only in such detail as appears warranted by its forensic significance. It should not be inferred from the absence of reference to any aspect of the evidence that it has not been considered.

2.4. As will be expanded upon below, there were a number of missed opportunities during the course of Mrs Searle's labour to recognise and adequately respond to the foetal distress that culminated in Bodhi's fatal hypoxic brain injury. For reasons detailed later in this Finding, I have found that Bodhi's death was preventable.

3. Cause of death

3.1. Following Bodhi's death, a post-mortem examination was conducted on 7 September 2021 by Dr Nick Manton, who is a pathologist employed by the Women's and Children's Hospital (WCH) and who performs pathological duties for the State Perinatal Autopsy Service. Dr Manton prepared a Final Autopsy Report on 28 October 2021, which was received into evidence.[4] Dr Manton cited Bodhi's death as '*hypoxic ischaemic encephalopathy*'.

3.2. Hypoxic ischaemic encephalopathy (HIE) simply means a brain injury caused by a lack of oxygen and blood flow to the brain. This was a non-specific finding; however, Dr Manton's report went further to explain that his autopsy finding of HIE was '*consistent with intrapartum asphyxia*'.[5] Dr Manton observed the extensive bilateral haemorrhagic infarction of the adrenals which I understood to be pathological evidence of intrapartum asphyxia.[6] Dr Manton indicated that the cause of the intrapartum asphyxia was not evidenced from the autopsy findings.[7]

3.3. Of particular note in Dr Manton's report was his recommendation that:

> '… given the absence of abnormalities in the baby or the placenta to explain the cause of the intrapartum asphyxia and subsequent outcome, an independent review of the

[4] Exhibit C1a
[5] Exhibit C1a, page 3
[6] Exhibit C1b
[7] Exhibit C1a, page 3

> management in the second stage of labour (particularly the interpretation of the CTG findings) is recommended.' [8]

I understood Dr Manton to mean that his post-mortem examination had not revealed any anatomical or genetic abnormalities that would otherwise explain Bodhi's death. Furthermore, Mrs Searle's antenatal course had been uneventful with usual pregnancy tests and ultrasounds being normal. While the placenta showed acute chorioamnionitis, the inflammation was relatively mild. There was no evidence of a foetal inflammatory response in the placenta.

3.4. In his report, Dr Manton drew the Court's attention to the CTG trace, particularly in relation to Mrs Searle's second stage of labour. It was therefore necessary to examine the clinical circumstances in which Bodhi was born and his condition immediately thereafter.

3.5. Accordingly, the clinical circumstances of Bodhi's birth and death were examined by Associate Professor Stefan Kane. Professor Kane holds a Bachelor of Medicine, a Bachelor of Surgery and a Bachelor of Medical Science which he obtained at the University of Melbourne in 2003. He is a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists. He holds a Subspecialty Certification in Maternal Fetal Medicine (RANZCOG 2018), a Diploma of Diagnostic Ultrasound (O&G) (Australasian Society for Ultrasound in Medicine 2016) and is a Doctor of Philosophy by research (The University of Melbourne 2022).

3.6. Professor Kane has worked as a specialist obstetrician since 2013, and as a subspecialist in maternal foetal medicine since 2018. He provides antenatal, intrapartum and postnatal care to women with predominantly high-risk pregnancies on account of maternal and/or foetal complications, including tertiary-level foetal ultrasound.

3.7. He is currently employed at the Royal Women's Hospital (the Women's) in Melbourne, Victoria, where he serves as the Medical Director of Maternity Services, the Head of the Fetal Medicine Unit, and the Acting Director of the Department of Maternal Fetal Medicine.

3.8. Professor Kane expressed the opinion that, on balance, there was evidence of potential foetal distress as early as approximately 90 minutes before Bodhi was delivered.

[8] Exhibit C1a, page 3

Further, that based on the cord gas results taken after delivery, it was likely cord compression was a contributor to the intrapartum asphyxia but that he could not exclude there being some additional placental concerns.[9] His evidence established that both mechanisms (cord compression and/or placental concerns) would manifest in an abnormal CTG trace, which was evident in Mrs Searle's second stage of labour. This position aligned with evidence obtained by the then unit manager, Dr Sue Kennedy-Andrews from neonatologist Dr Scott Morris who in an email stated:

> 'My assumption is that there was prolonged cord compression in this baby as the aetiology.' [10]

3.9. Leaving aside the mechanism for the intrapartum asphyxia, to which I will return later in this Finding, there was no challenge to Dr Manton's suggested cause of death or any aspect of his Final Autopsy Report. Accordingly, there was no need to call Dr Manton to give oral evidence. I accept the opinions expressed in Dr Manton's report.

3.10. I find Bodhi's cause of death to be *hypoxic ischaemic encephalopathy due to intrapartum asphyxia*.

4. Evidence at Inquest

4.1. The documentary evidence at this Inquest comprised 56 exhibits.

4.2. At Inquest, oral evidence was heard from:

- Thea Koke – Student Midwife
- Stephanie Geyer – Midwife
- Dr Elizabeth Lindner – Registrar
- Dr Kate Gowling – Specialist Obstetrician and Gynaecologist
- Petra Noble – Nurse Practitioner
- Nicole Price – Senior Midwife
- Angela Neary – Clinical Midwife
- Dr Dylan Mordaunt – SALHN Divisional Director
- Associate Professor Stefan Kane – Expert Witness
- Dr David Baldwin – Consultant Neonatologist

[9] Transcript, page 746
[10] Exhibit C7

- Susan Shorrock – Clinical Midwife
- Dr Elizabeth Beare – Head of Unit of Obstetrics and Gynaecology
- Raelene Carroll – Team Leader, Southern Midwifery Group

4.3. Dr Sue Kennedy-Andrews, Head of Unit of Obstetrics and Gynaecology in August 2021, was originally summonsed to give oral evidence but was excused due to illness. In lieu of her oral evidence, Dr Kennedy-Andrews provided an affidavit to address a list of topics.[11]

5. Circumstances leading up to death

5.1. As touched on above, Mrs Searle had planned to give birth to Bodhi through the SMGP, which had organised the management of her antenatal care. The SMGP is a service offered by SALHN for women who have been assessed as low risk for their pregnancy and labour. The SMGP rooms (of which there were three) were located on the labour ward next to the BAS. The SMGP and BAS were co-located to enable a swift transfer between the models of care if it became clinically indicated.

5.2. Mrs Searle provided a statement to the Court. She explained that she had joined the SMGP around the 28-week mark of her pregnancy. She stated her understanding of the service was:

> 'Through this group you don't see an obstetrician if you remain low-risk as they advocate for low intervention as much as possible, so they only take low-risk patients. There is a continuity of care where you are assigned a midwife and she is meant to be with you throughout the birth.' [12]

5.3. Mrs Searle was assigned midwife Joanne Verrall who attended on her at the Searle's home throughout the antenatal period to monitor her pregnancy. A student midwife in her first year of training, Thea Koke, also attended these appointments and developed a rapport with Mrs Searle and her husband. Ms Koke explained in an affidavit provided to the Court that as part of her midwifery training, she was assigned 15 pregnant women to follow.[13] Mrs Searle was the seventh pregnancy she followed.[14] Ms Koke also gave oral evidence at the Inquest. Ms Koke had some understanding of the midwifery role

[11] Exhibit C37
[12] Exhibit C17, paragraph 3
[13] Exhibit C22, paragraph 2
[14] Transcript, page 30

(as a student) but was not present in a clinical capacity, other than to assist the primary accoucheur with basic tasks.

5.4. Mrs Searle started experiencing cramps and contractions on the morning of 29 August 2021 which persisted throughout the day.[15] By late afternoon she was taken to the FMC by her husband. As stated above, Ms Verrall was unwell that evening and unable to attend to manage Mrs Searle's labour. An alternative SMGP midwife, Ms Stephanie Geyer, was contacted to be the primary accoucheur. Ms Geyer had not met Mrs Searle or her husband before this evening and had not been involved in her antenatal care.[16]

5.5. Stephanie Geyer was a SMGP midwife who had obtained her Bachelor of Midwifery in 2013 and worked for five years at the Lyell McEwin Health Service. In 2019, Ms Geyer commenced working for the SMGP at FMC.[17] Ms Geyer deposed to an affidavit dated 20 February 2023 and authored two handwritten ex post facto progress notes dated 30 August and 16 September 2021. These notes were not in the clinical records of Mrs Searle or Bodhi, but were furnished to the Court in the lead-up to the Inquest.[18] Ms Geyer gave evidence over the course of three days. Ms Geyer was extensively questioned about her role in the management of Mrs Searle's labour as the primary accoucheur. As will be dealt with in some detail later in the Finding, I have struggled to accept some aspects of Ms Geyer's evidence.

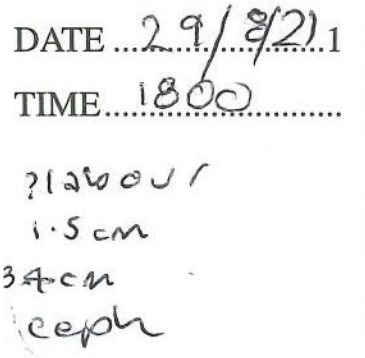
5.6. Returning to the events of the 29 August 2021, the case notes reflected that Mrs Searle arrived at the SMGP room at approximately 5:30pm and was settled into Room 4 by midwife Janine Brown.[19] Ms Geyer took over Mrs Searle's care at approximately 6:45pm.[20] Ms Koke was contacted by Ms Geyer and arrived at 8:39pm. Ms Koke described in her statement entering the group practice room to find Mrs Searle in the shower and experiencing three to four contractions in 10 minutes, with everything appearing to be calm.[21]

5.7. The Court heard that the first vaginal examination was undertaken by midwife Brown, but the results were entered into the clinical record by Ms Geyer who had received a handover from Ms Brown upon her arrival at the hospital. Midwifery clinical practice

[15] Exhibit C17, page 2
[16] Exhibit C23, paragraph 3
[17] Exhibit C23, paragraph 2
[18] Exhibit, C3g
[19] Exhibit C19, page 7
[20] Exhibit C3
[21] Exhibit C22, paragraph 5

requires the cervix to be monitored to assess the dilatation. Once labour has commenced the cervix dilates until it reaches 10cm, which indicates that the labouring woman is in the second stage of labour and can actively push in order to deliver her baby. The Inquest heard from a number of witnesses during the course of the Inquest that it is accepted clinical practice to monitor the cervix of woman who is in the first stage of labour approximately every four hours.[22]

5.8. The entry in the clinical notes by Ms Geyer reflected that at handover she had received information that at 6pm Mrs Searle was '? labour, 1.5cm, 3-4cm, ceph'.[23]


DATE ...29/8/21
TIME....1800.....

?labour
1·5cm
3-4cm
ceph

Ms Brown, who prepared her own retrospective note in the electronic clinical records, noted that the vaginal examination she undertook revealed Mrs Searle was in labour, her cervix was 4cm dilated and soft, 1cm long, 0.5cm thick with a cephalic presentation and above spines.[24] While their accounts of Mrs Searle's progress differed slightly, Ms Geyer explained in her evidence that her record was generally consistent with what Ms Brown had recorded.[25]

5.9. Between 7:30pm and 9:30pm, the Court heard that Ms Geyer undertook two vaginal examinations and recorded them in the clinical notes and the labour partogram document.[26] The results of these examinations revealed that Mrs Searle's cervix was 7cm dilated at 7:35pm and 9cm at 9:30pm. Ms Geyer confirmed these findings in her oral evidence.[27]

5.10. Therefore, between 6pm and 9:30pm, Mrs Searle's cervix dilated approximately 5cm, which was relatively swift for a nulliparous[28] woman. Ms Geyer indicated in her oral

[22] Transcript of numerous witnesses
[23] Exhibit C3, page 60
[24] Exhibit C3b, page 58
[25] Transcript, page 103
[26] A Partogram document is used to record all observations made with the women who is in labour
[27] Transcript, page 105
[28] Nulliparous refers to a female of reproductive age who has never had a live delivery

evidence that it usually takes two hours per centimetre for the cervix to dilate in a woman who is labouring for the first time.[29] While the labouring process is different for every woman, the speed at which Mrs Searle's cervix was dilating was relevant to when full dilatation was achieved (10cm) and the second stage of labour commenced. This was an issue in dispute during the Inquest in the context of how long Mrs Searle had been in the second stage of labour before Bodhi was delivered.

5.11. Both Ms Geyer and Ms Koke gave evidence that just before the third vaginal examination at 9:30pm, Ms Geyer suspected that Bodhi may have been in the right occiput posterior position (ROP). This meant that the baby's head was in the cephalic position (head down in the pelvis), but the face was to the right side. The implication of this position was that it could cause more pain and potentially slow the labour down by preventing complete dilatation of the cervix and cause swelling. It was also around this time that Ms Geyer observed Mrs Searle to be pushing involuntarily.[30]

5.12. Ms Geyer explained to the Court that the involuntary pushing and the possible malposition was the reason for her undertaking the third vaginal examination at 9:30pm. The result of this vaginal examination was recorded in the partogram and was interpreted by Ms Geyer in her statement to mean that there was a small amount of cervix left, there was some swelling (oedema) and Mrs Searle would soon be fully dilated.[31] This meant that three vaginal examinations were undertaken in a four and a half hour period, two of them performed by Ms Geyer. While this equated to more than the recommended one vaginal examination being performed in a four-hour period, I am of the view that it was entirely appropriate to have assessed Mrs Searle's cervix on each occasion due to the rate of dilatation, the observation of involuntary pushing and the possibility of a malpositioned baby.

5.13. At approximately 10pm, Ms Geyer gave evidence that she arranged for Dr Lindner to be contacted to assess Mrs Searle. Ms Geyer explained the reason for this request was:

> 'I had not been entirely confident in my assessment of the foetal position and Diana had been displaying signs of involuntary pushing efforts in the absence of a fully dilated cervix. Malposition may prevent the complete dilatation of the cervix as was noted in this case due to oedema to the cervix.' [32]

[29] Transcript, page 116
[30] Transcript, page 117
[31] Exhibit C23, paragraph 5
[32] Exhibit C23, paragraph 6

5.14. Ms Nicole Price (a senior BAS midwife) who was assigned the role of Team Leader of BAS on that evening shift, gave evidence that Ms Geyer asked her to contact Dr Lindner at around 10pm. Ms Price gave evidence that Ms Geyer approached her at the nurses' station and asked her to contact Dr Lindner to check the position of the baby.[33] On the journey board (the white board in the nurses' station that tracked the progress of patients on the ward)[34] Mrs Seale's cervix was noted to be 7cm dilated. Ms Price told the Court she called Dr Lindner, who was in theatre at the time, and gave her this information.

5.15. Dr Lindner confirmed that the time of the call from Ms Price was 10:15pm and that she arrived at approximately 10:50pm to assess Mrs Searle. I understood that Dr Lindner used her call log on her work phone and the theatre records to determine these times when she was preparing her retrospective note at the conclusion of her shift.[35] Ms Price was clear in her evidence that there was no immediate concern expressed to her by Ms Geyer and so she did not ask Dr Lindner to attend straight away.[36]

5.16. Dr Lindner's evidence was that she had been contacted at about 10:15pm by Ms Price and told that Ms Geyer, the primary accoucheur, had requested a bedside ultrasound because, on vaginal examination, there was uncertainty as to the baby's position.[37] There was a notable consistency between the evidence of Dr Lindner and Ms Price on the topic of the reason for the review of Mrs Searle; namely to check the position of the baby. Both Dr Lindner and Ms Price gave evidence that they were not told of the involuntary pushing by Mrs Searle.

5.17. Upon Dr Lindner's arrival in the labour ward at approximately 10:50pm she assessed the journey board, which she gave evidence reflected Mrs Searle's cervical dilatation to be 7cm. Ms Geyer's evidence was by that time, and as recorded in both the progress notes and the partogram, Mrs Searle was in fact 9cm dilated. A simple explanation for this was that the journey board had not been updated since the 7:35pm vaginal examination. Ms Geyer did not dispute that this was a possibility in her evidence.[38] What Ms Geyer did state was that she gave Dr Lindner a summary of Mrs Searle's progress upon her arrival in the room, which included advising her that the maternal

[33] Transcript, page 542
[34] Exhibit C24, photograph 10
[35] Transcript, page 384
[36] Transcript, page 543
[37] Transcript, page 335
[38] Transcript, page 107

observations and the foetal heart rate were within normal limits and that Mrs Searle was in spontaneous labour following an uncomplicated pregnancy, but was becoming distressed, attempting to resist involuntarily pushing before her cervix was fully dilated.[39]

5.18. In her oral evidence, Ms Geyer insisted that she told Dr Lindner that Mrs Searle had been pushing involuntarily for some time by 10:50pm and that by virtue of requesting a medical review, there was an implied sense of concern for Mrs Searle's labour.[40] In her evidence, Ms Geyer stated her expectation was that Dr Lindner would have attended earlier than she did, due to this implied sense of urgency.[41] Ms Geyer told the Court that she was not told by anyone that Dr Lindner had been held up.[42] This was despite Ms Geyer's entry in the progress notes recording '*BAS TL aware and will notify doctors on return from theatre*'.[43] By virtue of what was written in this note, Ms Geyer was aware that Dr Lindner was not on the labour ward at the time the entry was made.

5.19. Perhaps most importantly, Ms Geyer told the Court that the vaginal examination recorded in the progress notes (but not the partogram), establishing that Mrs Searle was 10cm dilated, was performed by Dr Lindner.[44]

5.20. With the exception of the ultrasound to assess the baby's position, Dr Lindner had a different account of her review of Mrs Searle at 10:50pm. As mentioned above, Dr Lindner made a retrospective note in the clinical records at the conclusion of her shift on 30 August 2021, from her memory[45] which was consistent with her oral evidence. When she entered Mrs Searle's room, she told the Court that she did the following:

> 'So I introduced myself, I stated that my understanding was that I was there to perform an ultrasound to check the position of the baby, midwife Geyer agreed with this. I spoke to Mrs Searle about feeling her abdomen and doing the ultrasound, which she agreed to. I performed an abdominal palpation to feel for the lie of the baby, so tried to determine what side the baby's back is on, and then I performed an ultrasound and looking at the position of the baby in Mrs Searle's pelvis, trying to determine which way the baby was facing, and I could see that the baby was in somewhere between an OP and an OT position, so facing towards her front and towards her side. I communicated this finding to Ms Geyer, which

[39] Exhibit C23, paragraph 6
[40] Transcript, page 138
[41] Transcript, page 138
[42] Transcript, page 109
[43] Exhibit C3, page 57
[44] Transcript, pages 117,137, 138, 139
[45] Transcript, page 334

> she acknowledged, and she indicated to me that she was happy to proceed with managing Mrs Searle's labour and then I left the room.' [46]

5.21. Dr Lindner told the Court that she did not perform a vaginal examination at 10:50pm.[47] Dr Lindner was challenged about this by counsel for Ms Geyer. Dr Lindner stated that there was no possibility that she was mistaken.[48] She explained that based on her understanding of the last vaginal examination (at 7:35pm), Mrs Searle was not due for another vaginal examination as four hours had not yet passed.[49] Her expectation was that the journey board would have been revised and updated, contemporaneously by the primary midwife.[50] Dr Lindner's evidence was that she was unaware of involuntary pushing, but if Ms Geyer had told her about this, Dr Lindner stated the following:

> '… that would've led to a conversation about the most recent examination, which would have led to my understanding that there had been an examination at 2130 and it would have led to a conversation about resisting the urge to involuntarily push.' [51]

Further, Dr Lindner saw her role as undertaking the ultrasound to establish the position of the baby and nothing more. She therefore did not look at the partogram or clinical notes. Dr Lindner told the Court that there was no urgency expressed to her about this review, and she attended as soon as she had finished in theatre.[52]

5.22. While Dr Lindner did not advance this explanation herself, it was clear that Mrs Searle was labouring in a SMGP room where, by virtue of the model of care, medical intervention was kept to a minimum unless clinically indicated. Mrs Searle's primary accoucheur was Ms Geyer, not Dr Lindner. Based on this alone it is certainly arguable that it would have been more appropriate for Ms Geyer to undertake this vaginal examination. Unfortunately, Ms Koke was unable to assist with this topic as she could not remember who undertook the vaginal examination.[53]

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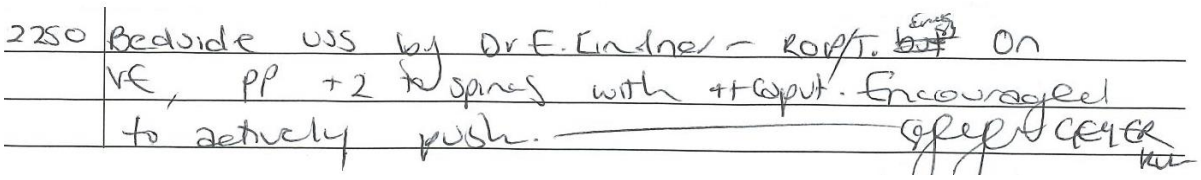
[46] Transcript, page 339
[47] Transcript, page 341
[48] Transcript, page 371
[49] Transcript, pages 341-342
[50] Transcript, page 440
[51] Transcript, page 389
[52] Transcript, page 415
[53] Transcript, page 74

5.23. Curiously, the vaginal examination at 10:50pm was not recorded in the partogram unlike the previous examinations. Ms Geyer explained that she would not document the examination in the partogram if she had not undertaken it herself, but rather would expect Dr Lindner to record her own findings after undertaking the examination.[54] However, there were other clinical observation records missing after 10pm[55] and 10:30pm[56] including maternal pulse and temperature that Ms Geyer agreed she was responsible for recording. Ms Geyer did however make a record of the 10:50pm vaginal examination in the progress notes. This entry was:



5.24. Ms Sally Giles of counsel assisting submitted in her closing address that it could be inferred from the way this entry was written that it was Ms Geyer, and not Dr Lindner who had undertaken the vaginal examination that confirmed full dilatation of the cervix. Ms Giles submitted that the way in which Ms Geyer's note was phrased was suggestive of her doing the vaginal examination as she had written '*bedside USS performed by Dr E Lindner*' but not ultrasound and vaginal examination performed by Dr Lindner. Ms Giles submitted that within that note written by Ms Geyer, there appeared to be a delineation as to who did the ultrasound and who did the vaginal examination. Ms Giles submitted that if Dr Lindner did the vaginal examination, then Ms Geyer would have written that specifically in the note, as she did with the beside ultrasound. There is considerable force in this submission. Coupled with the other evidence, including that from Dr Lindner herself, there were several persuasive reasons why Dr Lindner would not have performed the examination.

5.25. Ultimately, there was no discernible reason as to why Dr Lindner would attempt to distance herself from having performed the vaginal examination. Nothing of significance turned on the results of the examination, regardless of who performed it. Dr Lindner told the Court that if she had performed the examination and discovered that Mrs Searle was 10cm dilated, it was likely, given the malposition, she would have contacted Dr Gowling who was on-call but at home, approximately 25 minutes away. However, she would not have asked Dr Gowling to attend the hospital at that time and

[54] Transcript, pages 105-106
[55] Mrs Searle's pulse was not recorded after 10pm in the partogram - Exhibit C3, page 61
[56] Mrs Searle's temperature was not recorded after 10pm in the partogram - Exhibit C3, page 61

would have encouraged Mrs Searle to continue to labour and actively push in the SMGP room.[57] This is what occurred in any event. Professor Kane opined that Mrs Searle continuing to labour and being encouraged to actively push in the SMGP room, despite the baby in a malposition, was an appropriate clinical path at that time.[58]

5.26. Critical incident meeting

5.27. The Court received into evidence Minutes relating to a meeting that was held on 10 November 2021 at FMC with clinical staff after Bodhi's death.[59] This meeting was chaired by Dr Leen Khoo and Dr Sue Kennedy-Andrews. Dr Lindner gave evidence that she was in attendance in person, as was Ms Geyer who appeared by way of a video link.[60] A number of issues were canvassed relating to the management of Mrs Searle's labour, including the 10:50pm assessment by Dr Lindner. In relation to that assessment, the Minutes recorded the following:

> 'Registrar did not undertake VE at that time as considered there was not a clinical indication as it had been 3hr from last VE. Registrar was not aware patient was involuntary pushing. Subsequent VE by midwife confirmed to be fully [dilated].' [61]

In my view, this was a particularly opportune time for Ms Geyer to have spoken up and challenged Dr Lindner on this topic. There is no evidence that Ms Geyer did so.

5.28. I have found it puzzling as to why Ms Geyer insisted Dr Lindner undertook the vaginal examination at approximately 10:50pm. In her evidence, Ms Geyer left no room for the possibility that she was mistaken about having conducted it.[62] As was submitted by Ms Geyer's counsel, Ms Gavranich, nothing of importance turned on the results of the examination.[63] However, I was asked by Ms Gavranich to find that it was unlikely that Ms Geyer undertook the vaginal examination. In order to make such a finding, it was submitted that I should take into account that Ms Geyer had already conducted a vaginal examination at 9:30pm. Further, the way in which the findings of the vaginal examination were recorded in the clinical notes was strikingly similar to Dr Lindner's entry of a vaginal examination recorded later that evening.

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[57] Transcript, page 396
[58] Transcript, pages 767-770
[59] Exhibit C37, SKA2
[60] Transcript, page 344
[61] Exhibit C6, page 1
[62] Transcript, page 139
[63] Transcript, page 1195

5.29. I am of the view that it was entirely appropriate and clinically indicated for Ms Geyer to have undertaken a further vaginal examination at 10:50pm given the progress of Mrs Searle's labour as I have detailed above. Further, the entry in the notes, while almost identical to the findings of the later vaginal examination of Dr Lindner, was written by Ms Geyer in the progress notes and not referred to by Dr Lindner in her retrospective note written at the end of her shift. While I accept that nothing of substance of itself turned on the findings of this particular vaginal examination in respect of Mrs Searle's labour, the conflict in the evidence required resolution. I considered this necessary as there were several inconsistencies between Ms Geyer's accounts of her shift and those of other staff involved with Mrs Searle's care. I have found a certain unreliability in Ms Geyer's account which permeated her evidence on other topics.

5.30. Based on the evidence as a whole, I find that Ms Geyer did not tell Dr Lindner that Mrs Searle had been involuntarily pushing prior to the 10:50pm assessment. I find that the journey board did not reflect the updated vaginal examination at 9:30pm and that it was Ms Geyer's responsibility to do this, or to ask someone to update it for her. It was not unreasonable for Dr Lindner to have relied on the journey board being up to date. I find that Dr Lindner assessed the position of Mrs Searle's baby on ultrasound when she attended her room at approximately 10:50pm and then left to fulfil other duties. Based on the evidence of Professor Kane, I find that this was not inappropriate. I find that Ms Geyer undertook the vaginal examination. While Mrs Searle may have been fully dilated at an earlier time, and indeed that was most likely the belief of Ms Geyer, I find 10:50pm was when the second stage of labour commenced, based on the evidence of Professor Kane, which I will detail later in the Finding.

5.31. <u>The first decelerations</u>

5.32. After Dr Lindner had left Mrs Searle's room, and the vaginal examination was performed which determined full dilatation, Mrs Searle was encouraged to actively push. Her pushing efforts were noted to be '*not as strong on all fours*', so she was moved to the ensuite bathroom to sit on the toilet. Ms Geyer explained that sitting on the toilet was a good position to allow strong pushes and descent of the foetal head.[64] The Court heard that throughout the period in the SMGP room, the foetal heartbeat had

[64] Transcript, page 118

been measured with regular (15 minute) auscultations[65] using a handheld doppler.[66] This was in accordance with national guidelines for foetal surveillance in low-risk women labouring spontaneously.[67] This continued once Mrs Searle was moved to the bathroom area. Also present in the bathroom was Ms Koke and Mr Searle. The foetal heart rate had been entered into the partogram between 6pm and 11pm.

5.33. At 11:26pm, Ms Geyer made an entry into the clinical records which stated:

> 'Strong pushing efforts…. but no HOV.[68] Fetal heart rate ↓ 100 bpm → returning slowly to 120 bpm between pushes.' [69]

5.34. Ms Geyer gave evidence that while Mrs Searle was sitting on the toilet and she was listening to the baby's heart rate via the doppler, she noticed decelerations in the foetal heart rate. Ms Geyer estimated that she had listened to these decelerations for approximately 10 minutes prior to making the note in the clinical record as set out above.[70] Ms Geyer gave the following evidence:

> 'In the lead up to writing that note there were physiological decelerations with pushes that were returning to base lines[71] spontaneously within an acceptable timeframe and by that point it was getting to a point where they were now taking too long to resolve and I was concerned about them.' [72]

This put the time of the first deceleration that ultimately caused Ms Geyer concern at approximately 11:16pm.

5.35. Ms Koke gave evidence that was consistent with Ms Geyer's account on this topic. The Court heard that while Ms Geyer did not verbally communicate, Ms Koke observed concern on Ms Geyer's face when she was listening to the foetal heart rate while Mrs Searle was on the toilet.[73] Ms Koke formed the impression that Ms Geyer did not highlight her concern at the time to avoid worrying Mr and Mrs Searle. Ms Koke told the Court that after she observed Ms Geyer's concern, Ms Geyer left the bathroom to

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[65] A method of periodic listening to the foetal heartbeat
[66] Handheld ultrasound transducer used to detect the foetal heartbeat
[67] Intrapartum Fetal Surveillance Clinical Guidelines, Fourth Edition 2019, The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Exhibit C34a (Footnote 1)
[68] Head on View
[69] Exhibit C3, page 57
[70] Transcript, page 144
[71] Transcript, page 141
[72] Transcript, page 141
[73] Transcript, pages 42-43

notify a team leader '*straight away*'.[74] Ms Koke remained in the bathroom with Mr and Mrs Searle.

5.36. In her affidavit, Mrs Searle also referred to moving rooms for monitoring. She stated:

> 'I was told that Bodhi's decelerations with my contractions weren't coming up or something along those lines, so they were going to move me for better monitoring essentially, which is when I got moved from the midwifery rooms to the birthing suite.' [75]

5.37. From SMGP room to BAS

5.38. There was no dispute that the purpose of Ms Geyer speaking with the team leader at that time was to move rooms and in doing so increase the level of monitoring of Mrs Searle's labour. There was also a consensus that this was an entirely appropriate decision by Ms Geyer, and I so find. What did arise during the course of the evidence was a dispute as to the basis for the transfer and the level of concern that was conveyed by Ms Geyer to others following the detection of prolonged decelerations.

5.39. Ms Geyer explained that the reason for requesting the move to the BAS was '*because the labour was becoming abnormal or there were symptoms of abnormality in [Mrs Searle's] labour*'.[76] She told the Court that these symptoms included the slow return to baseline for the foetal heart rate and the prolonged pushing in the second stage of labour. Ms Geyer gave evidence that when she requested to move Mrs Searle into the BAS, she told Ms Price that she had heard decelerations that were taking longer to resolve, and that Mrs Searle had been pushing for approximately an hour.[77]

5.40. Ms Geyer was challenged about how long she understood Mrs Searle had been pushing in the second stage. If the move to the BAS had taken place by 11:44pm, as Ms Geyer's note reflected, and Mrs Searle was actively encouraged to push at 10:50pm when noted to be fully dilated, she could not have been pushing for an hour when the request for room transfer was made. There was a level of inconsistency in Ms Geyer's evidence on this topic. In her affidavit, she very precisely stated that Mrs Searle had been pushing for 54 minutes in second stage by 11:44pm.[78] In her oral evidence, when it was

[74] Transcript, page 43
[75] Exhibit C17, paragraph 6
[76] Transcript, page 93
[77] Transcript, page 311
[78] Exhibit C23, paragraph 27

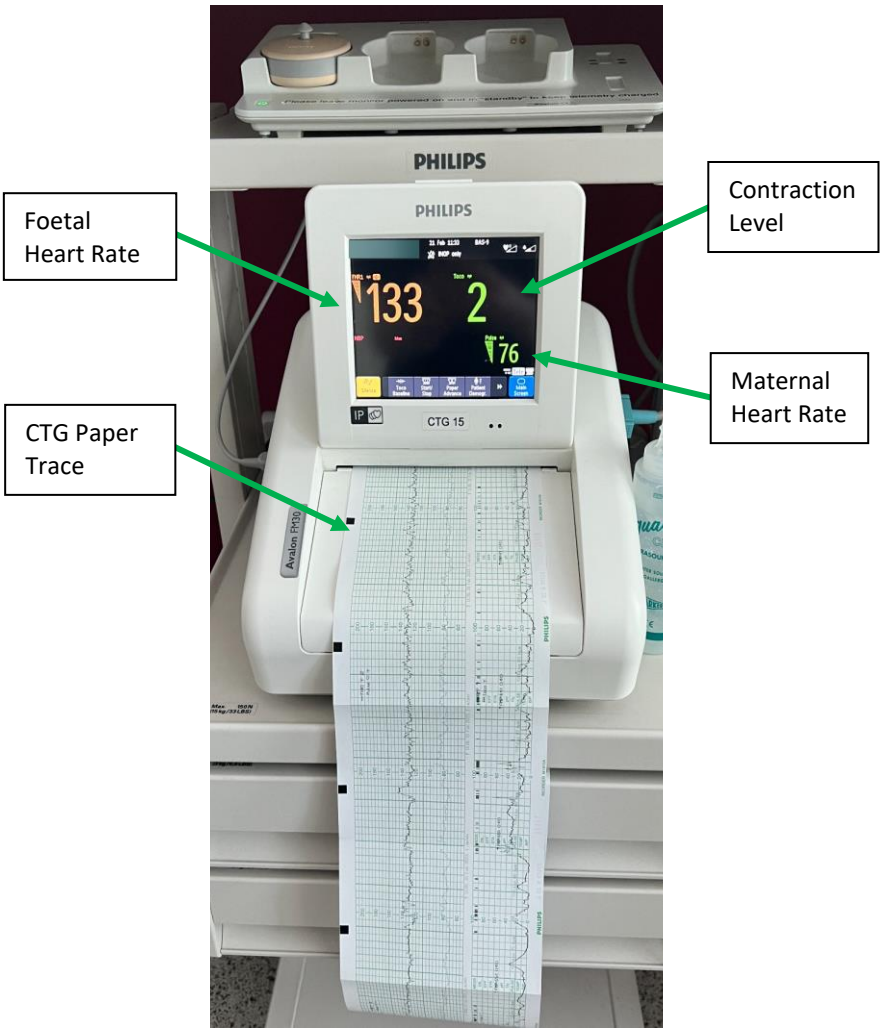
put to her that she told Ms Price the pushing in second stage had been '*over an hour*', Ms Geyer clarified that she considered the duration of the pushing to include Mrs Searle's involuntary efforts before she was fully dilated.[79] While not a crucial point in the overall picture, this evidence went to the length of the second stage as recorded in the Labour and Birth Record which was altered after Bodhi was born. I will address this topic later in the Finding.

5.41. On the topic of moving rooms to monitor the foetal heart rate more closely, Ms Geyer explained that the rooms in the BAS were equipped with CTG monitors which she considered to be necessary at this point. Ms Geyer told the Court that the decelerations she had heard on the doppler were signs of a compromised foetus.[80] Further, that when seeking the room transfer, she conveyed these concerns to Ms Price. In her evidence Ms Geyer left no room for there to have been a miscommunication between her and Ms Price.

5.42. I pause here to explain the relevance of the CTG monitoring in this matter. The Court heard detailed evidence from a number of witnesses about the application of the CTG, particularly when there were concerns for the baby during labour. Photographs were received into evidence depicting the type of CTG machine that was connected to Mrs Searle to monitor her unborn baby.[81] Evidence was heard that once the CTG monitor probes (tocos[82] and transducers[83]) are placed on the labouring woman's abdomen, the monitor records the baby's heart rate, the maternal heart rate and the contractions on an electronic screen. The machine also produces a trace which should show all three readings, depending on the capabilities of the attachments. This trace is printed from the machine as the heart rates are recorded and is physically available to inspect. In the usual course, once the baby is delivered, the trace is placed in the clinical records of the mother. The CTG trace in this matter was of particular importance in the

[79] Transcript, page 148
[80] Transcript, page 150
[81] Exhibit C24
[82] Toco is the term that was used for the tocodynamometer, a pressure-sensitive device called a tocodynamometer is placed on the mother's abdomen over the area of strongest contractions to measure the length, frequency, and strength of uterine contractions.
[83] An ultrasound transducer placed on the labouring woman's abdomen conducts the sounds of the foetal heart to a computer. The rate and pattern of the foetal heart are displayed on the CTG monitor and printed onto paper that comes out from the monitor.

assessment of the circumstances leading to Bodhi's death, as a portion of the physical trace revealed a severely abnormal foetal heart rate.



5.43. Returning to the narrative, Ms Price provided an affidavit to the Court that stated she understood the basis for the request to transfer rooms was a prolonged second stage of labour (over an hour) with no sign of imminent delivery.[84] Ms Price explained that due to the SALHN policy for SMGP patients,[85] if a nulliparous woman had been pushing in the second stage for over an hour, she would be moved to the BAS room for continuous CTG monitoring. Additionally, she would require a review by a doctor. Ms Price stated, '*this is not an unusual situation to occur*'.[86] When Ms Price asked Ms Geyer if there were any other issues, Ms Geyer replied '*no*', she then added that there had been some foetal heart decelerations with maternal pushing. Ms Price explained in her

[84] Exhibit C31, paragraph 5
[85] Exhibit C15, Transfer to Medical Care by Southern Midwifery Group Practice, page 3
[86] Exhibit C31, paragraph 5

affidavit that this is a normal physiological event in second stage. This evidence was clarified with Ms Price stating:

> 'A. … So what Ms Geyer said, I asked her how the labour was going and she said 'Fine, there are normal decelerations with second stage' which is and confirmed with her that the heart rate goes down with the maternal push and the contraction and then returns to baseline. The reason I didn't write 'normal decelerations' in my affidavit that in and of themselves according to the foetal surveillance program is any decelerations is clinically classified as abnormal. But in the context of second stage and a maternal push the decelerations that were evident is within normal physiology of second stage of labour.
>
> Q. So is it your evidence that Ms Geyer told you there had been normal decelerations.
>
> A. Yes.' [87]

5.44. A distinction was drawn during the course of the evidence between decelerations with maternal pushing and prolonged decelerations. In her oral evidence, Ms Price disputed that Ms Geyer had told her about prolonged decelerations during this exchange.[88] Ms Price told the Court that the occurrence of prolonged decelerations was a possible indication of foetal distress, that the baby was becoming more stressed with labour. Had she been told of prolonged decelerations, her reaction would have been different. Ms Price's evidence was this:

> 'Well obviously [prolonged decelerations are] a sign of foetal distress, so my reaction would have been different to what it was. I would have assisted with putting the CTG on and making sure that was on, sort of, ASAP.' [89]

5.45. The evidence was clear that Ms Geyer, with the assistance of Ms Koke, moved Mrs Searle to the BAS, Room 3, after her discussion with Ms Price. Ms Price did not assist with either the move or connecting Mrs Searle to the CTG monitor. Ms Price was insistent that had she been told by Ms Geyer about the prolonged decelerations, she would have been involved in this process in her capacity as both a BAS midwife and the team leader on the night or had another senior midwife assist Ms Geyer. Ms Price would also have requested an urgent review by Dr Lindner.[90] Ms Price told the Court that she did neither of these things, but instead conveyed to Ms Geyer that the phone call to Dr Lindner would be made once the room transfer had been effected.

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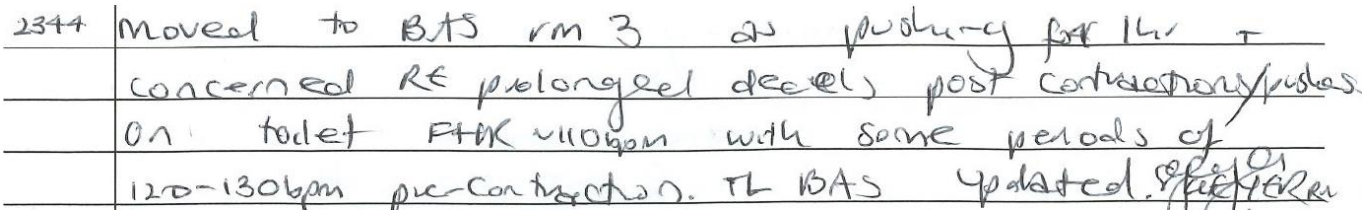
[87] Transcript, page 591
[88] Transcript, pages 551, 591
[89] Transcript, page 591
[90] Transcript, page 640

5.46. While Ms Price had Ms Geyer's contrasting account put to her by counsel assisting,[91] I did not consider her to have been seriously challenged about the conflict in the evidence. On the other hand, Ms Geyer *was* challenged about whether or not she had communicated the prolonged decelerations to Ms Price. It was put to her by Ms Price's counsel, Ms Cliff, that when requesting the transfer of rooms, she did not mention prolonged decelerations at all. Ms Geyer disagreed with this proposition and stated that the prolonged decelerations (and prolonged second stage) were the reasons for the transfer to the BAS, and that she made an entry to that effect in the progress notes.[92] The entry to which Ms Geyer referred was as follows:


2344 Moved to BAS rm 3 as pushing for 1½ hr + concerned RE prolonged decels post contractions/pushes. On toilet FHR 110bpm with some periods of 120-130bpm pre-Contractions. TL BAS updated.

5.47. It is clear that this entry does feature '*prolonged decelerations*'. Whether that was conveyed to Ms Price is another matter. It was submitted to me in closing submissions by counsel for Ms Geyer that it was open to find both witnesses had indicated their general recollection of events and that there had been a miscommunication between Ms Geyer and Ms Price about the information and its significance. Miscommunication in a busy clinical setting is not uncommon. However, the evidence of Ms Geyer, as mentioned above, or her actions (or lack thereof) that followed did not support this contention. That included Ms Geyer's failure to follow up with Ms Price to assist when it became apparent that Ms Price had not arrived in the room as expected. Perhaps more curiously, there was a failure by Ms Geyer to follow up a medical review when Dr Lindner did not attend within 10 minutes, despite the fact Ms Geyer said she felt a medical review was urgent and had expected it to occur within 10 minutes.[93]

5.48. The evidence of Ms Price and Ms Geyer was consistent that when the request for the room change was made, Ms Price verbally conveyed that Dr Lindner was in theatre. Oral evidence heard from Dr Lindner established that she had in fact been in the Emergency Department (ED) and not in theatre, but that was not the understanding of Ms Price at the time and either scenario meant that Dr Lindner was not available

[91] Transcript, page 591
[92] Transcript, 999
[93] Transcript, pages 149-150

immediately. Ms Geyer agreed that she did not ask Ms Price to escalate her request for a medical review to the on-call consultant in light of Dr Lindner potentially being delayed. Ms Geyer was asked about this as follows:

> 'Q. Ms Price told you that Dr Lindner was in theatre, is that correct?
>
> A. Yes.
>
> Q. You must have taken from that that Dr Lindner was not going to come particularly quickly. Is that correct.
>
> A. I can't assume that because I don't know how long she had been there already.' [94]

5.49. I consider Ms Geyer's response to the uncertainty of Dr Linder's availability to be unsatisfactory and inconsistent with the level of concern that she said she held in her evidence. There was also no sense of urgency in either the actions or response of Dr Lindner and Ms Price, which one might have expected had they been made aware of Ms Geyer's level of concern. Dr Lindner gave evidence that had she been told that there were prolonged decelerations, she would have attended urgently and done so within 1 to 2 minutes (jogging from the ED to the BAS) as the matter she was attending to in the ED was not critical.[95]

5.50. The Court heard that shortly after the conversation between Ms Geyer and Ms Price, Ms Price left the labour ward to attend to other duties elsewhere and temporarily handed over the team leader responsibilities to Ms Susan Shorrock, another senior BAS midwife. Ms Shorrock gave evidence that she had received a handover from Ms Price relating to Mrs Searle as follows:

> 'Q. … Did Ms Price tell you why Mrs Searle was being moved to room 3.
>
> A. She told me that she was being moved to room 3 because she'd been pushing for over an hour and that she's - and wasn't progressing. So, when a lady, with her first baby, has been pushing for an hour, the protocol is then that they need medical intervention and we need to put a CTG on. So that was my understanding from Midwife Price, that Mrs Searle had been pushing and there wasn't good progress, and she was moving her into room 3.
>
> Q. You mentioned that they might need medical intervention. Was there any discussion around any sort of medical intervention at that stage during that discussion.
>
> A. No, there wasn't any discussion about any medical intervention, but the doctor would need to be informed at that time. If you've got a primer that's been pushing for an hour and there isn't a lot of progress, then we would inform the medical staff.

[94] Transcript, page 151
[95] Transcript, pages 410-411

Q. And did you have an understanding about whether that had been done or not.

A. No, no.' [96]

5.51. In fact, Ms Shorrock gave evidence that it was *she* who asked Ms Geyer shortly after 12am about whether Dr Lindner had been notified of Mrs Searle's transfer,[97] rather than Ms Geyer following it up due to her concern about the possibility of a compromised foetus.

5.52. Ms Price conceded in her evidence that Ms Geyer was entitled to rely on her calling Dr Lindner to advise of Mrs Searle's room transfer before handing over her Team Leader duties to Ms Shorrock and leaving the labour ward.[98] Ms Shorrock held the same view and went so far as to say that Ms Price should have called Dr Lindner.[99] Had Ms Price done so, it is likely Dr Lindner would have arrived to review Mrs Searle earlier than she did, simply by virtue of being called sooner. It is however difficult to say how much sooner she would have arrived, given the lack of urgency Ms Price attached to the review based on Ms Geyer's communications.

5.53. Counsel for Ms Price submitted that the import of rejecting Ms Price's evidence where it conflicted with Ms Geyer's would be to find that she disregarded concerns raised about a potentially distressed baby, particularly in her capacity as Team Leader. It was further submitted that in order to reject her evidence, I would need to be satisfied that this had been convincingly proven. As touched on above, I hold the view that Ms Price was not seriously challenged in her evidence on this topic. I also formed the view that Ms Price was a credible witness whose oral evidence was consistent throughout her testimony.

5.54. The point in time when Mrs Searle's model of care was changed was perhaps the most significant opportunity to have commenced the close monitoring of the foetal heart rate and to have changed the course of events. After all, that was the very reason for the transfer of rooms. With prolonged decelerations having been heard by Ms Geyer for a period of approximately 10 minutes prior to transfer, it was incumbent on her to effectively communicate her concerns and to persist with them when she did not receive the response she required and expected. I make this comment with particular emphasis

[96] Transcript, pages 895-896
[97] Transcript, page 901
[98] Transcript, page 596
[99] Transcript, page 941

on the widely accepted evidence that once prolonged decelerations were heard, they were unlikely to correct themselves without intervention of some type. Ms Price[100] gave this evidence as well as Professor Kane.[101] Ms Geyer also agreed.[102]

5.55. I am satisfied that Ms Geyer did hear prolonged decelerations when manually auscultating the foetal heart rate in the SMGP ensuite, and so find. I do not however accept that the level of concern Ms Geyer said she held in relation to the decelerations was communicated to Ms Price. I accept that Ms Geyer did convey that she heard decelerations but there was no emphasis on them being prolonged, or any emphasis on a concern for a compromised or distressed baby. Accordingly, it was not unreasonable for Ms Price to have carried on with her own duties without assisting Ms Geyer in Room 3 at that time. I do however find that Ms Price should have contacted Dr Lindner when notified of Mrs Searle's room change and before leaving BAS. I find that Dr Lindner would have attended sooner than approximately 12:22am, had this occurred.

5.56. Connection of CTG

5.57. The period of time between the record of the first concerning set of decelerations being made in the progress notes at 11:24 pm and the CTG being connected in Room 3 of the BAS at 11:40pm was a period of 16 minutes. Ms Geyer explained that Mrs Searle was contracting heavily while attempting to walk between the rooms so it was not a quick process.[103] Ms Geyer told the Court that she recalled listening to the foetal heart rate at this time, but did not record what it was.[104] While 16 minutes is not a lengthy period of time in isolation, if there was concern for a distressed foetus, every minute that passed increased the risk of foetal compromise. However, if Ms Geyer had connected the CTG at 11:40pm and then closely monitored the trace, ensuring it was monitoring the foetal heart rate, for the next 10 to 15 minutes, there is every likelihood that she would have realised that Bodhi was distressed with sufficient time to act. That did not occur.

5.58. The CTG trace was admitted into evidence as an exhibit.[105] The trace reflected that the CTG monitor was connected to Mrs Searle at 11:40:47pm. As was required once a

[100] Transcript, page 552
[101] Transcript, page 835
[102] Transcript, page 249
[103] Transcript, page 1009
[104] Transcript, page 1009
[105] Exhibit C26

patient was connected to a CTG, their details including their name, date of birth and hospital unit record number were entered into the CTG machine. This was referred to in the evidence as 'archiving'. For Mrs Searle, that occurred at 11:44:10pm. The other main step that was required involved networking the trace to the computer to allow it to be displayed on the screen in the BAS and at the nurses' station. At the time of Mrs Searle's admission, a nurse was not allocated the task of monitoring CTGs, rather the team leader would observe (other duties permitting) the trace in the nurses' station for any abnormalities once the trace was '*networked*'. This practice changed after Bodhi's death.

5.59. Ms Geyer repeatedly placed a strong emphasis on the tasks that were required to move Mrs Searle from the SMGP room to BAS throughout her evidence. While the rooms were alongside each other on the ward, Ms Geyer explained that there were a multitude of steps to effect transfer and on this particular night the BAS Room 3 was very poorly stocked and missing vital pieces of equipment required for a safe birth and neonate resuscitation.[106] This required Ms Geyer to leave the BAS for '*brief moments*' between 11:44pm and 12:20am.[107] Ms Koke gave evidence which supported Ms Geyer leaving the room for '*split seconds*' to restock the room.[108] While it was an undesirable state of affairs to have to restock a room for vital supplies while attempting to support a labouring woman, I was left with the impression from Ms Geyer that these additional tasks were such a distraction that they left her with little to no time to effectively monitor the CTG trace which, it was later discovered, was recording a maternal heart rate and not foetal for a period of approximately 26 minutes.

5.60. <u>CTG Trace between 11:44pm and 12:10am (26 minutes)</u>

5.61. It is accepted that a normal healthy foetal heart rate is between 120 to 160 beats per minute. The trace in this timeframe was within that range. However, evidence was heard from a number of witnesses that the CTG trace in this time period had the characteristics of a maternal trace, meaning there were signs to suggest the trace was not recording the foetal heart rate.

5.62. Professor Kane in his expert evidence stated that after allowing a few minutes for the pattern to establish on the trace after connection, there were features from about

[106] Exhibit C23, paragraph 10
[107] Ibid
[108] Transcript, page 56

11:44pm for a period of 10 minutes to have at least raised the question of whether the machine was tracing the maternal heart rate instead of the foetal.[109] He explained:

> '… the primary features here are the presence of accelerations, so a rise in the baseline, or a rise in the foetal heart rate from the baseline for a period of time, and the absence of decelerations, which are common in the active second stage and, I guess, would be in the context of them having been heard on intermittent auscultation previously. So those two things would be the main thing.' [110]

5.63. Ms Price gave evidence that the absence of a second line was indicative that the foetal heart rate was not being recorded, as there should have been two lines – one for maternal and one for foetal heart rate. She also drew the Court's attention to the absence of decelerations which had been heard previously and the presence of accelerations in this portion of the trace, which were not a normal feature of a foetal heart rate in the second stage of labour.[111] Ms Geyer said the presence of only one line did not concern her because she assumed she was using a toco that was not capable of producing two lines,[112] yet this did not accord with Ms Price's evidence that it was very uncommon as at 29 August 2021 to have a toco that was not capable of recording maternal pulse. Ms Price told the Court that if you were not seeing two lines on the trace, you would replace the toco for one with that capability.[113]

5.64. I acknowledge the risk of hindsight bias in the exercise of forensically examining a document such as a trace in order to identify certain trends that were suggestive of the trace being maternal and not foetal. However, the evidence revealed that other than possibly a quick glance, Ms Geyer's focus was not the physical CTG trace. Ms Geyer told the Court that after she connected the CTG machine, she only waited a short time to ensure it was monitoring the foetal heart rate before doing other tasks. Even taking into account the extra duties that Ms Geyer said she undertook, the failure to not examine the physical trace in those 26 minutes is difficult to comprehend, particularly after having heard a concerning pattern of prolonged decelerations earlier. Professor Kane opined:

> 'A key aspect of being able to interpret a CTG is confirming that in fact we are tracing the baby and not the mother, and so in terms of the entire utility of performing this examination, yes, it is concerning that there wasn't a clearly documented distinction

[109] Transcript, page 789
[110] Transcript, page 790
[111] Transcript, page 627
[112] Transcript, page 218
[113] Transcript, page 617

> between the two, and I think that would have been a reasonable expectation in the circumstances.' [114]

5.65. Ms Geyer's explanation was that she was relying on the electronic numbers on the CTG screen and manual palpitation of Mrs Searle's radial pulse which reassured her that the monitor was adequately recording the foetal heart rate. She explained how she did this:

> 'So I am palpating maternal pulse for a minute and I am getting her heart rate, and during that minute I am also looking at the numbers that are on the screen and I'm kind of getting an average of what I've seen on the screen for the last minute and I am comparing her heart rate for the last minute and average of what was on the screen for the last minute.' [115]

5.66. Ms Geyer's evidence, as recorded in her retrospective notes, was that on the occasions she checked maternal pulse manually, it was between 110-120 bpm, and she was reassured the CTG was therefore recording foetal heart rate. Professor Kane's evidence on this topic was that if Ms Geyer had looked at the trace and compared that to the manual checks that she did of the maternal pulse (which she found to be 110 to 120 bpm), she should not have been reassured. That should have in fact raised concerns, or at the very least should have prompted the question that there was not enough evidence to be confident that what was being traced was foetal.[116]

5.67. I found the method that Ms Geyer described of monitoring the foetal heart rate against Mrs Searle's pulse to be unnecessarily complicated and time consuming. Given her complaints of being time poor, the method Ms Geyer depicted seemed particularly labour intensive when there were other much simpler methods available. Ms Price gave evidence that the trace is easier to see on the computer screen, and it would be optimal to put it on the screen in the room.[117] Yet Ms Geyer's evidence was that she did not log on to the computer to view the trace. Ms Geyer said:

> 'I wanted to save time by not logging into the computer and doing all those things.' [118]

5.68. Ms Geyer gave evidence that she did not utilise the computer monitor in the room at all, and instead relied on the CTG paper trace. However, as touched on above, Ms Geyer agreed that she only glanced at the paper trace, and there was no suggestion

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[114] Transcript, page 792
[115] Transcript, page 236
[116] Transcript, page 794
[117] Transcript, page 692
[118] Transcript, page 181

she looked at it in any detail at any time. She seemed to be more focused on just watching the numbers on the screen and listening. Ms Geyer told the Court:

> 'I was listening to the trace and I was looking over at the room at the number on the screen but I didn't have time to stand and look for extended periods at a time to analyse the entire trace because I was doing other things. So I was still listening to the heart rate and I was helping Diana but I couldn't stand and look at the paper to look at it in detail.' [119]

5.69. A contributing factor to the maternal/foetal heart rate confusion persisting unnoticed for as long as it did was that the CTG was not networked such that it was on display in the nurses' station. Had it been, the senior midwives (namely Ms Shorrock) would have been able to see it when they were at the station, even if at that time there was no senior midwife whose job it was exclusively to look at the traces.

5.70. Ms Geyer's oral evidence at one point was that she did ***not*** network the trace. She said she knew it was not networked, meaning that it was not on display in the nurses' station, and that she made a conscious decision not to do so. Her evidence was as follows:

> 'Q. I just want to be clear with your evidence, you're telling me that at the time you connected Mrs Searle's CTG you were aware that it was not being networked.
>
> A. Yeah, I was aware that it was not on the Multiview screen at the nurses' station, yes.
>
> Q. And you also knew that in order to have it networked, you needed to input something into the CTG machine.
>
> A. Someone needed to log into the computer and network it out up to the system so that it could be viewed.
>
> Q. Either you or someone else.
>
> A. Yes.
>
> Q. Did you at any time, prior to Baby Bodhi being born, network that machine.
>
> A. No, it wasn't a priority for me because I needed to primarily try to remedy the situation and make sure I had a foetal heart rate that I could auscultate because there was nobody really at the nurses' station anyway, so it wasn't a huge relevance whether or not the empty nurses' station could see the CTG.
>
> Q. So you knew that there was no-one out watching the screen in the nurses' station.
>
> A. Yes.' [120]

5.71. Ms Geyer gave this evidence despite accepting that the networking process would take only a few seconds.[121] This evidence was difficult to reconcile with the fact that

[119] Transcript, page 176
[120] Transcript, page 175
[121] Transcript, page 176

Ms Geyer told the Court that she had left Room 3 numerous times to collect stock, take calls, and have a break. It was also at odds with the unchallenged evidence of Ms Shorrock that when Ms Geyer approached the nurses' station at approximately 12:05am, Ms Shorrock asked her to network the CTG so she and another midwife could view it. Ms Shorrock told the Court that when she informed Ms Geyer the trace was not networked, Ms Geyer seemed surprised, as if she thought she had networked it and expected it to be available for view in the nurses' station.

5.72. When examined by Ms Shorrock's counsel later in the Inquest, Ms Geyer accepted that she may not have '*done her part*' to network the CTG at the time of her conversation with Ms Shorrock (approximately 12:05am) but did so at a later time.[122] This evidence conflicted with Ms Geyer's retrospective note dated 16 September 2021, which stated '*CTG commenced and networked (able to be viewed from BAS midwives' station by 11.44)*'.[123] Counsel assisting, Ms Giles, suggested to Ms Geyer that this reference in her retrospective note was an attempt on her part to deflect that she had not networked the CTG. Ms Geyer disagreed with this proposition and told the Court that this aspect of her note meant '*the capability was there for someone to be able to view it but it wasn't on display*'. She said what she meant was:

> 'I had done, on my end, what needed to be done, so that if they wanted to put it up onto the central display, they could but I hadn't personally put it up out on the central display because that needs to be done out there.' [124]

Based on Ms Geyer's evidence towards the end of the inquiry, that was not the case until sometime after 12:05am, if in fact she did this at all. Ultimately, someone must have enabled the capability for the CTG trace to be displayed at the nurses' station, as Dr Gowling saw it on a screen upon her arrival in the labour ward at 12:50am.[125] It was not established who this was.

5.73. While an opportunity was lost for Ms Shorrock to have observed that the CTG was tracing only the maternal heart rate when she attempted to view it at the nurses' station at approximately 12:05am, the more glaring issue was Ms Geyer's failure to look at the paper trace in any detail or to log on to the computer and watch it in Room 3, in the way Ms Price described. If she had looked at the trace in any detail, I am satisfied based

[122] Transcript, page 1003
[123] Exhibit C4g, page 3
[124] Transcript, page 188
[125] Transcript, page 485

on the evidence that there were enough atypical features in the trace that should have alerted her to the fact that the CTG was not recording the foetal heart rate.

5.74. A telling aspect of Ms Geyer's evidence was that once Mrs Searle was moved into the BAS, Ms Geyer felt her responsibility for Mrs Searle had diminished. Her evidence was that once the model of care changed, she considered her role in Mrs Searle's labour had become less important, that her responsibilities had decreased, and conversely Dr Lindner's and the BAS midwives' responsibilities had increased at that time.[126] She said that she considered herself, Ms Price and Ms Shorrock had equal responsibility in relation to Mrs Searle once she was moved to BAS, but that she was '*looking to them for extra guidance*'.[127]

5.75. Based on the evidence of Ms Shorrock that Ms Geyer seemed surprised when she was informed that the trace was not networked, there was an inference that until that point Ms Geyer had assumed that a more senior midwife had been monitoring the trace and therefore she did not have to. In my view, there was enough evidence to support the contention that Ms Geyer thought she had networked the CTG trace and had falsely assumed that others were watching it and would alert her if something was wrong.

5.76. I accept the evidence of Ms Shorrock that she asked Ms Geyer to network the CTG around 12:05am after attempting to view it in the nurses' station, and that Ms Geyer expressed a level of surprise that it was not being displayed. I find that in this crucial time period Ms Geyer did not appropriately monitor the foetal heart rate, despite the concerns she had held earlier. Once informed by Ms Shorrock that it was not displayed at approximately 12:05am, she should have taken immediate steps to correct that and to inspect the trace herself.

5.77. The period of approximately 26 minutes where Mrs Searle's heart rate was being recorded instead of Bodhi's was a significant missed opportunity to have recognised that Bodhi was showing signs of distress. According to the evidence of Professor Kane, it was very likely that Bodhi's heart rate would have been showing signs of compromise during this period. His evidence was:

> 'It is likely to have been abnormal, yes. Whether it was abnormal as the trace that ensued from 12:09 onwards is difficult to say, but it is likely that it would've been to some degree abnormal with decelerations. Given that there were decelerations heard prior to the

[126] Transcript, page 154
[127] Transcript, page 154

> application of the CTG and decelerations present on the CTG from 12:09, it is very likely that in the intervening period there would've been decelerations and evidence - some degree of evidence of compromise.' [128]

5.78. Professor Kane expressed his opinion that if the CTG was appropriately connected and monitoring the foetal heart rate from about 11:44pm, it was likely that Bodhi's delivery would have been expedited some time earlier than it was.[129] Based on Professor Kane's expert evidence, in addition to the prolonged decelerations between 11:16pm and 11:26pm, I find that Bodhi's heart rate would have been abnormal in the period between 11:44pm and 12:10am.

5.79. The change in the CTG trace at 12:10am

5.80. At approximately 12:10am there was a dramatic change in the CTG trace. The explanation for the change was that the CTG trace stopped recording the maternal heart rate and commenced recording the foetal heart rate. This change in the trace was described by Professor Kane as a very clear and sudden change which revealed deep decelerations that were very slow to recover. He described this foetal trace as being very, very abnormal.[130]

5.81. A photograph was tendered to the Court with a timestamp of 12:12am[131] which depicted Mrs Searle, who was in the lithotomy position (a supine position where the legs are placed in stirrups) on the bed, with Ms Geyer examining her. Mr Searle was in the background and the foot of the bed was attached at that time. Ms Geyer was asked about this photograph in her evidence and denied repositioning Mrs Searle into the lithotomy position at any time.[132] It is certainly likely that Mrs Searle, moving into the lithotomy position as depicted at 12:12am, and most likely in that position a minute or two before, is what assisted the monitor to commence tracing the foetal heart rate.

5.82. The basis for this contention is that this photograph must have been taken at a time before Ms Geyer had taken her break from Ms Shorrock. I am confident in making that finding as there were events that took place after this time, including the arrival of Dr Lindner at approximately 12:22am and the photograph at 12:24am which depicted Dr Lindner, Mrs Searle and Ms Geyer with an ultrasound machine in the background.[133]

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[128] Transcript, page 835
[129] Transcript, page 835
[130] Transcript, page 804
[131] Exhibit C25, photograph 1
[132] Transcript, page 208
[133] Exhibit C25, photograph 2

In that photograph the foot of the bed was no longer in place. Ms Shorrock's evidence was that she took the foot of the bed off in anticipation of Dr Lindner's arrival while in Room 3, relieving Ms Geyer for her meal break. I will expand upon this evidence below.

5.83. Professor Kane was asked about this topic:

> 'A. … So up until the minute prior to 12:10, if 12:10 is assumed to be that more solid vertical green line that bit of the trace back from that point looks normal and then there's a sudden shift. So one assumes that either the baby moved or something was done at that point. Whether it was maternal position change or the ultrasound transducer rather than the tocodynamometer was adjusted to get a better trace of the foetal heart but something happened at that point and so that's I guess that 12:10 mark. Now the minute preceding it's reasonable to say that a change happened at around 12:10 where we started from that point to get a more accurate of the foetus and preceding that I think it is demonstrated quite clearly there that prior to that there's that very sudden shift from one minute 12:10 to 12:10 and beyond.
>
> Q. So, it appears to you does it something has occurred at around about 12:09 that has resulted in the foetal heart rate then being properly detected. Is that fair to say.
>
> A. Something. Now what that something is as I said it might have been the foetus moving itself. It might have - a range of - or the mother just moving herself. Mrs Searle moving herself. There's a range of things that could have happened that resulted in a change from the monitor identifying what we now believe to be the maternal heart rate to identify the foetus.' [134]

5.84. Based on Professor Kane's evidence, and the evidence of Ms Geyer who described Mrs Searle as preferring to labour on all fours for most of her labour (which can impact reliable foetal heart rate tracing), the photograph at 12:12am of Mrs Searle in the lithotomy position is persuasive evidence for the contention that the change in positions brought about the change in the trace. It is likely that Mrs Searle was moved into this position before Ms Geyer spoke to Ms Shorrock at the nurses' station the first time, just prior to 12:10am. I am however unable to make a positive finding about exactly when Mrs Searle moved into the position depicted in the photograph.

5.85. <u>The short break</u>

5.86. There was no dispute on the evidence that Ms Geyer asked Ms Shorrock for a short break at some point after 12am on 30 August 2021. Ms Geyer had been working for an extended period by this time and was tasked with an additional duty of taking calls

[134] Transcript, page 818

from her SMGP role for patients in this program. This conversation took place at the nurses' station.

5.87. Ms Shorrock gave evidence that she spoke to Ms Geyer at the nurses' station twice sometime after midnight but before 12:20am. The first conversation described above resulted in Dr Lindner being called. Dr Lindner's call records reflected that this phone call was made at 12:10am.[135] On Ms Shorrock's evidence, Ms Geyer then left the nurses' station and returned shortly after to ask for a break. The timing of Ms Geyer's conversations with Ms Shorrock, particularly the first was important. Primarily because at approximate 12:10am there was the dramatic change in the CTG trace as mentioned above. The evidence established that this was when the foetal heart rate was recorded on the trace for the first time. It revealed a picture of a baby in distress with severely abnormal decelerations.

5.88. Ms Shorrock gave detailed evidence about both conversations with Ms Geyer. As touched on above, Ms Shorrock stated that when Ms Geyer approached the nurses' station the first time, she queried Ms Geyer about whether the CTG machine had been connected to Mrs Searle as it was not displayed in the nurses' station. She also asked whether the doctor was aware that Mrs Searle had changed rooms. Ms Geyer told Ms Shorrock that she would network the CTG, and she was not sure if Dr Lindner had been called.[136] This was the reason Ms Shorrock rang Dr Lindner to request the medical review. On Ms Shorrock's evidence, Ms Geyer remained at the nurses' station while Ms Shorrock spoke with Dr Lindner.[137]

5.89. On Ms Shorrock's account, when she conveyed to Dr Lindner that Mrs Searle had been pushing for over an hour, Ms Geyer corrected her and stated that the second stage had started at 9:50pm and not 10:50pm, putting the second stage at over two hours in duration. Ms Shorrock passed this information onto Dr Lindner who queried this timeframe as she had reviewed Mrs Searle at 10:50pm and undertaken an ultrasound, believing her to be 7cm dilated at the time. Ms Geyer then corrected herself and told Ms Shorrock that actually the second stage began at 10:50pm and she had only been pushing for an hour.[138]

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[135] Transcript, page 405
[136] Transcript, page 948
[137] Transcript, pages 924, 927, 946, 948, 954, 955
[138] Transcript, page 901

5.90. Dr Lindner corroborated Ms Shorrock's account of this phone call. Dr Lindner gave the following evidence:

> 'Q. What did Ms Shorrock tell you.
>
> A. She told me that Mrs Searle had been pushing for more than two hours and so needed a medical review which I queried the timing of given that I had seen Mrs Searle at around 10.50 and I hadn't been aware that she was pushing at this point and Ms Shorrock indicated that regardless she had been pushing for too long and needed a medical review and she said that she is being brought out of the birth centre and is being put on the CTG which I interpreted as it was happening currently during the time of the phone call.
>
> Q. Did Ms Shorrock tell you that she had got that information from Ms Geyer.
>
> A. She didn't indicate where she had the information from.
>
> Q. At some point during the conversation did she correct what she told you about Mrs Searle having been pushing for more than two hours.
>
> A. I don't recall her doing that.
>
> Q. What did you understand from this conversation was to be the purpose of you going to see Mrs Searle.
>
> A. Generally if a woman has been pushing for more than one hour and the birth is not imminent it's expected that the doctor will review the woman and so I took from this phone call that she must have been pushing for at least one hour and so I agreed that I would review her.' [139]

5.91. Ms Geyer left the nurses' station and then returned a short time later to request a meal break. Ms Shorrock told the Court that she considered the timing of Ms Geyer's request to be inappropriate. She explained that Mrs Searle was pushing in the second stage of labour and a doctor was on the way for an assessment. She was also busy with her own patient load. Accordingly, Ms Shorrock declined to relieve Ms Geyer at that time. Ms Geyer returned to Room 3 and Ms Shorrock went to check one of her own patients.[140] Ms Shorrock reconsidered Ms Geyer's request, and a short time later, went to Room 3 to relieve her. Ms Geyer was standing in the corridor outside of Room 3 at that time.[141]

5.92. Ms Geyer's evidence was that she approached the nurses' station at about 12:20am to request a break to eat something and to continue re-stocking the room.[142] Ms Geyer did remember Ms Shorrock indicating that she would call Dr Lindner but denied remaining

[139] Transcript, pages 351-352
[140] Transcript, pages 903-904
[141] Transcript, page 971
[142] Transcript, page 1015

in the nurses' station while the telephone call took place.[143] She agreed that the meal break was initially refused by Ms Shorrock but then Ms Shorrock did relieve her a short time later.

5.93. The exchange between Ms Shorrock and Dr Lindner in the presence of Ms Geyer was evidence of a level of confusion in the mind of Ms Geyer as to when the second stage of Mrs Searle's labour began. This was compounded by the entry in the Labour and Birth Summary originally reflecting 9:30pm as the commencement of the second stage, which was then crossed out.[144] I accept that this conversation did take place and that Ms Geyer remained at the nurses' station for at least part of the phone call.

5.94. Another important aspect of the exchange between Ms Shorrock and Ms Geyer was whether or not Ms Geyer had informed her about the prolonged decelerations that she had heard which, in part, precipitated the move to the BAS. The other crucial aspect of the conversation was whether she had followed up on the request for an urgent doctor's review, which by the time Ms Shorrock relieved Ms Geyer for a break, was overdue by approximately 40 minutes. Ms Shorrock was steadfast in her evidence that there was no mention of foetal distress or the expectation of an urgent doctor's review which still had not occurred. Ms Shorrock told the Court:

> '[M]idwife Geyer had never at any point in that night raised any concerns to me about the foetus being compromised at all.'[145]

Ms Shorrock also stated:

> 'Well, Midwife Geyer didn't raise any concerns to me, and I would expect that, if she had concerns, she would have wanted the doctor sooner and would have relayed that to me, but she didn't.'[146]

5.95. Ms Geyer's evidence on the topic of following up a doctor's review and notifying Ms Shorrock of the decelerations changed over the course of the Inquest. She gave evidence early in the Inquest that the delay in the doctor's review was '*most likely discussed*' when she asked Ms Shorrock for a meal break, as she was concerned that the doctor had not arrived after approximately 40 minutes.[147] Ms Geyer also gave evidence that she '*would have notified [Ms Shorrock] of the decelerations*'.[148] In

[143] Exhibit C3, page 56
[144] Exhibit C3, page 56
[145] Transcript, page 957
[146] Transcript, page 964
[147] Transcript, page 259
[148] Transcript, pages 267-268

addition, Ms Geyer told the Court that she was aware of a pattern of decelerations for approximately 10 minutes by the time Ms Shorrock relieved her for her break. She did not consider this to be significant but agreed that she could no longer be reassured by what she was seeing. She gave this evidence:

'Q. So prior to your break at 12.20 had you realised for a period of about 10 minutes that there was an emerging concern with Bodhi's heart rate.

A. I don't recall being acutely concerned because like I said yesterday it's not abnormal for there to be decelerations in the presence of active pushing, because the foetal head had been squished during the contractions, blood supply is being constricted during the contractions. So I was un-acutely concerned at that time because I was seeing decelerations on the CTG and that's relatively normal. I was aware already that we had a history of the prolonging decelerations, that's why I had asked for a review, I knew that there was help coming. But like I said I couldn't see the trace to see any reiterating factors or lack thereof.

Q. You couldn't see the trace.

A. I didn't have time to look at the trace.

Q. But once you saw the numbers on the screen you had time to look at the trace didn't you.

A. I was still preparing for delivery.

Q. But I'm talking at around about 12.20, before you took your break, there had been about 10 minutes where there were concerning signs about Bodhi's heart rate, is that fair to say.

A. Like I said I wasn't acutely concerned because decelerations are not abnormal in that stage. So the fact that his heart rate was dropping was not acutely concerning to me, it was adding to the picture of clinical concern for which I had asked for a medical review.

Q. But did you think that that increased the need for a medical review rather urgently.

A. Yes, like it was the same urgency that I'd wanted anyway.

Q. So you saw on the screen that the trend was changing, is that fair to say.

A. Yes.

Q. The trend was becoming increasingly concerning, is that fair to say.

A. Yes.

Q. You didn't look at the paper trace to see what the trend had been before you left the room to take a break, is that correct.

A. No, correct.

Q. Why didn't you look at the paper trace before you left the room to take your break.

A. Because I just wanted to quickly go on a break and come back. It wouldn't have changed management because the management was to get the doctor into the room. There is nothing that I really could have done differently.

Q. Do you accept now that at the time you've gone on your break there's been a 10-minute period where Bodhi's heart rate has been severely abnormal.

A. I accept that now, yes.

Q. And your evidence is that you recognise that there was an increasing concern with Bodhi's heart rate that that time, is that correct.

A. Yes.

Q. And that the options to try and remedy that situation would have been really to expedite delivery, is that correct.

A. Yes, or change position.

Q. Or change positions. Now, rather than contacting the doctor to expedite delivery or changing positions you went to see Ms Shorrock to take a break, is that correct.

A. Ms Shorrock entered the room at that point to relieve for my break and said that she would probably change position.

Q. Did you tell Ms Shorrock that there had been what you considered to be an emerging concern over the last 10 minutes.

A. I would have notified her about the decelerations, yes.

Q. Did you tell Ms Shorrock that you had been waiting for Dr Lindner for close to an hour by that point after you first heard the prolonged decelerations.

A. Yes, I would have made her aware.' [149]

Ms Geyer clarified this passage of evidence shortly after to state that she ***did*** make Ms Shorrock aware of the decelerations and she ***did*** make Ms Shorrock aware that she was waiting for an urgent doctor's review.[150]

5.96. Astonishingly, towards the end of her evidence Ms Geyer agreed that she had not raised either matter with Ms Shorrock.[151] Ms Geyer's evidence was that she did not raise concerns about the previous decelerations or follow up in relation to the overdue doctor's review with Ms Shorrock, as she assumed the foetal position had changed during Mrs Searle's walk between the rooms and was reassured by her manual readings of Mrs Searle's heart rate which she compared against the heart rate displayed on the CTG monitor.[152] In addition to this concerning change in her evidence, the difficulty that arose with her later evidence was Ms Geyer had formed this view without reference to the very mechanism designed to give this reassurance (the CTG trace). I am of the

[149] Transcript, pages 266-267
[150] Transcript, pages 267-268
[151] Transcript, page 1011-1012, 1019
[152] Transcript, pages 1011-1012, 1015

view that it was not reasonable for Ms Geyer to have made this assessment without having considered the physical CTG trace reading.

5.97. By the time Ms Shorrock entered Room 3 to relieve Ms Geyer, the severely abnormal decelerations had been recorded on the trace for approximately 8 to 10 minutes. Ms Shorrock was of course unaware of this. Ms Shorrock described entering the room and approaching Mrs Searle who was labouring on all fours at the time. She introduced herself and immediately became concerned with the CTG reading. Her evidence was that she was '*not happy with the trace*'[153] and that she felt it was recording a maternal trace.[154] Ms Shorrock told the Court that while she did look at the paper trace, she did not pick it up and look at it in its entirety.[155] It is understandable therefore that she only noticed the part of the trace that had been recording maternal for approximately 26 minutes (11:44pm-12:10am) and did not notice the trace that was closer to the machine, which was the portion of the abnormal trace. As no concern had been raised by Ms Geyer, there was no reason for her to examine the trace more closely.

5.98. To improve the reliability of the trace, Ms Shorrock encouraged Mrs Searle to move into the lithotomy position and removed the foot of the bed. Ms Shorrock explained she did this in anticipation of Dr Lindner's review and to make a full assessment.[156] She also repositioned the toco by angling it in a certain way and viewed the CTG monitor. Ms Shorrock told the Court that the digital orange number in the top left-hand corner of the screen (the foetal heart rate) was displaying a reassuring number of 148.[157] Ms Shorrock's observation of this number was corroborated during the course of her oral evidence with reference to the exhibit of the physical trace. It was noted that at 12:18am and 12:23am Bodhi's heart rate rose to 148 beats per minute.[158] Either of those readings were consistent with the timeframe that Ms Shorrock was in the room before Dr Lindner's arrival, noting a photograph that was taken by Mr Searle, with Dr Lindner in the room at 12:24am.

5.99. It was at this moment, approximately five minutes after Ms Shorrock entered the room, that Ms Geyer returned from her short break. This also coincided with the arrival of Dr Lindner. Ms Shorrock expressed surprise at how little time Ms Geyer had taken and

[153] Transcript, page 933
[154] Transcript, page 934
[155] Transcript, page 974
[156] Transcript, pages 908, 933
[157] Transcript, pages 915, 935
[158] Transcript, page 979

offered to stay with Mrs Searle if she required a longer break. Ms Geyer declined and stated she felt better after eating a banana. Ms Shorrock told the Court that she handed over to both Dr Lindner and Ms Geyer by indicating that she had moved Mrs Searle into the lithotomy position after she had realised that the CTG was picking up the maternal heart rate and there had been loss of contact due to Mrs Searle's previous position.[159] She then left Room 3. Ms Geyer corroborated this account in her evidence.[160]

5.100. I pause here to make an important observation. Ms Shorrock was in Room 3 for only five minutes and in that time had immediate concerns in relation to the CTG trace, realising that the trace was not recording the foetal heart rate. If Ms Shorrock was able to make that assessment within five minutes of being present in the room, it once again raised concern as to how Ms Geyer could have missed the abnormalities in the trace for a period of approximately 26 minutes, and what it was that she was actually doing in that timeframe.

5.101. While Ms Shorrock's involvement with Ms Geyer was relatively limited, she was extensively examined on these interactions. There was a reassuring consistency throughout her evidence. I observed Ms Shorrock's evidence to be delivered in a fair and balanced manner. I found Ms Shorrock to be a credible witness whose evidence I have preferred over that of Ms Geyer's where it conflicted.

5.102. <u>Foetal scalp electrode</u>

5.103. One issue that arose during the course of the Inquest was whether a foetal scalp electrode should have been considered in the BAS by Ms Geyer when there was a difficulty maintaining a foetal heart rate trace. A foetal scalp electrode is a spiral wire that can be placed on the scalp of the baby during labour. This wire connects to a monitor which provides a foetal heart reading. The scalp electrode provides a more accurate reading than a CTG as it is not affected by factors such as maternal movement. It is however a more invasive way of recording foetal heart rate than the CTG and is usually applied when there are difficulties identified with an accurate trace of the foetal heart rate by the CTG.

[159] Transcript, page 937
[160] Transcript, page 1017

5.104. Given what was revealed after Bodhi's delivery, namely that the foetal heart rate was not being monitored for a period of approximately 26 minutes in the BAS, and the evidence of Professor Kane that this was at a time when Bodhi's heart rate was likely to have been abnormal, the foetal scalp electrode would have been of significant benefit had there been awareness of an issue with the trace.

5.105. The difficulty with this in reality was that Ms Geyer had not appreciated that the maternal heart rate was being recorded instead of the foetal heart rate and had not prioritised the monitoring of the CTG, either on the computer in Room 3 or at the nurses' station. For the foetal scalp electrode to have been of any clinical benefit, Ms Geyer would have needed to realise that the CTG was not recording an accurate foetal heart rate and have taken steps to apply the scalp electrode. By the time Ms Shorrock announced that the trace was recording maternal heart rate, Dr Lindner had arrived and taken over the responsibility of care. I consider this to be somewhat of a moot point in the circumstances.

5.106. <u>Dr Lindner's arrival in Room 3</u>

5.107. Dr Lindner gave evidence that she arrived in Room 3 shortly after 12:20am. The timing of her arrival is likely to have been shortly after this, possibly closer to one or two minutes afterwards, based on a photograph taken by Mr Searle which depicted Dr Lindner next to Mrs Searle with an ultrasound machine behind her at 12:24am.[161] Other than Mr and Mrs Searle and Ms Koke, Dr Lindner could not remember who was in the room when she arrived.[162] Ms Geyer must have been nearby at the time of Dr Lindner's arrival as Dr Lindner requested Ms Geyer to retrieve an ultrasound machine,[163] with both the ultrasound machine and Ms Geyer depicted in the same photograph referred to above.

5.108. Dr Lindner described approaching Mrs Searle who was in the lithotomy position. She could see a small amount of the baby's head on view when she was actively pushing. Dr Lindner looked at the physical CTG trace. She said this:

> 'I also looked at the CTG tracing and I could see that prior to my getting there, there had been tracing of what I interpreted to be the maternal heart rate rather than the foetal heart

[161] Exhibit C25, photograph 2
[162] Transcript, page 352
[163] Transcript, page 358

> rate, but for the previous perhaps 10 minutes or so there was tracing of what I interpreted to be a very abnormal foetal heart rate trace which concerned me…' [164]

5.109. Dr Lindner gave evidence that from her initial view of the trace there was a maternal heart rate recorded up to about 12:10am. When asked what it was about the trace that gave her that impression, she stated there were random markings above and below the main trace as though the machine was trying to pick up a second heart rate but not able to. Dr Lindner also gave similar evidence about the characteristics of the maternal trace that Ms Price and Professor Kane had given.[165] In addition, Dr Lindner drew the Court's attention to the sudden change in the character of the heart rate from 12:10am onwards, which was not typical of a maternal heart rate during labour.[166] Dr Lindner described the trace from 12:10am onward as revealing a very abnormal foetal heart rate trace, requiring urgent delivery of the baby.[167] Importantly, Dr Lindner told the Court that both aspects of the trace (before 12:10am and afterwards) were not subtle. She said, '*it becomes obvious quite quickly, by picking up the piece of paper and glancing at it. It doesn't require a great deal of scrutiny*'.[168]

5.110. Upon this realisation, Dr Lindner gave evidence that she sought permission from Mrs Searle to undertake a vaginal examination. She also asked Ms Geyer to fetch the ultrasound machine. Dr Lindner explained her thought process to include the possibility of effecting an urgent delivery with the assistance of an episiotomy. After undertaking the examination, she made the assessment that the presenting part of Bodhi's head was too high in the pelvis for an episiotomy to be either appropriate or helpful (the station of the baby was at + 2)[169] and made the decision that an instrumental delivery was the only way to expedite the birth.[170]

5.111. Dr Lindner told the Court that in order to perform an instrumental delivery safely, she needed to establish the position of Bodhi's head. Dr Lindner explained the reason why this was important in her evidence:

> 'If a baby happened to be facing to the side, in a transverse position, and forceps are used, the forceps are put either side laterally over the head and if the baby was in a transverse position you'd be placing forceps over the baby's face which could cause a lot of trauma to the face and it would - the forceps wouldn't be able to lock into position. And by

[164] Transcript, page 352
[165] Transcript, page 357
[166] Transcript, page 354
[167] Transcript, page 357
[168] Transcript, page 356
[169] Exhibit C3, page 51
[170] Transcript, page 357

> attempting to perform the delivery using the forceps at this point you could cause a lot of trauma to the mother's pelvis as well. And with a ventouse cup, if you can't find the fontanelles then you could risk putting the ventouse cup over the fontanelles which is the soft part of the skull. And given the vacuum that you're creating it could cause bleeding – intracranial bleeding if the ventouse cup was placed over a fontanelle.' [171]

As was submitted by Dr Lindner's counsel, Mr Homburg, in the final address, these risks were not insignificant. Neither the vaginal examination nor the ultrasound assessment assisted Dr Lindner to determine the orientation of Bodhi's head in the pelvis. This was when Dr Lindner formed the opinion that she would require the on-call consultant, Dr Kate Gowling, to attend as she did not feel competent to perform a mid-cavity instrumental delivery with possible rotation.[172]

5.112. It is important at this point to detail the obstetric skill level of Dr Lindner as of 30 August 2021. Dr Lindner was in her first year of Obstetrics and Gynaecology Fellowship training in August 2021. This was following an 18-month Obstetrics and Gynaecology residency at the Northern Adelaide Local Health Network (NALHN). Prior to that Dr Lindner had completed one year as a Service Registrar at the WCH.[173] Dr Lindner was credentialled as a trainee medical officer with a clinical scope of practice defined as providing '*services to SALHN under Consultant supervision and in accordance with the job and person specification/s of the relevant area site in which you are working*'.[174]

5.113. Dr Lindner provided to the Court records extracted from the Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG) which recorded the instrumental births she had performed up to 31 August 2021. Of relevance to the inquiry was Dr Lindner's past experience in performing instrumental deliveries. She had performed three low-cavity[175] vacuum[176] deliveries and nine low-cavity forceps[177] deliveries. However, Dr Lindner had only performed one mid-cavity[178] vacuum delivery and one mid-cavity forceps delivery from the Occipital Transverse (OT) or Occipital Posterior (OP) position. She had not performed any other OP instrumental deliveries.[179]

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[171] Transcript pages 361-362
[172] Transcript, page 425
[173] Transcript, page 322
[174] Exhibit C28c
[175] Leading point of the skull (not caput) is at or below station plus 2 cm and above the pelvic floor
[176] Vacuum extraction, also known as ventouse, is a method to assist delivery of a baby using a vacuum device
[177] Forceps are instruments designed to aid in the delivery of the fetus by applying traction to the foetal head
[178] Foetal head is no more than 1/5th palpable abdominally above the symphysis pubis
[179] Exhibit C28a

5.114. Evidence received during the course of the Inquest revealed that the expectation of the registrar who would undertake night shift obstetric (and gynaecological) duties as the most senior doctor onsite, was that he or she could perform at a minimum a straightforward caesarean section and an instrumental delivery by way of lift out with forceps or ventouse.[180] There was no evidence before the Court that this expectation extended to a mid-cavity instrumental procedure being performed independently. With Bodhi at +2 to spines with the position of the head unknown, this would have been defined as a mid-cavity instrumental delivery.

5.115. Once establishing that Bodhi was too high in the pelvic cavity for an episiotomy and natural delivery, and that she was unable to establish the position of Bodhi's head to ensure a safe instrumental delivery, Dr Lindner was left in the unenviable position of knowing that she needed to urgently deliver Bodhi who was showing signs of severe distress, but not having the requisite level of experience to do so without consultant support.

5.116. Dr Lindner told the Court that after coming to this realisation, she left Room 3 briefly to contact Dr Gowling to inform her that she would be required to attend the hospital urgently to undertake a '*difficult instrumental delivery*'.[181] It was established that this phone call was made at 12:27am on 30 August 2021. While Dr Gowling told the Court that she was left with the impression that Dr Lindner would get started with the delivery herself,[182] Dr Lindner explained to the Court that what she was trying to convey was that she would get the room prepared for Dr Gowling to perform it.[183] Based on the evidence this was clearly a misunderstanding that flowed between Dr Lindner and Dr Gowling, but I am satisfied that it made no material difference to Dr Gowling's swift arrival at the hospital, which was at 12:50am. The real issue was whether Bodhi's delivery could have been effected earlier had Dr Gowling been onsite at the hospital. I will deal with that issue in a separate paragraph.

5.117. In her evidence, Dr Lindner described doing what was necessary to prepare Mrs Searle for an instrumental delivery, including inserting a catheter and applying a pudendal nerve block using local anaesthetic. A neonatal nurse practitioner was contacted to be present as was required for all instrumental deliveries. This was Ms Petra Noble.

[180] Exhibit C37, paragraph 4
[181] Transcript, page 358
[182] Transcript, page 454
[183] Transcript, page 358, page 363, and 369-370

Ms Noble gave evidence that she arrived approximately 10 to 15 minutes prior to delivery.[184] In this period of time Dr Lindner also performed what she described as active coached pushing using the hands-on approach with Mrs Searle in the hope of expediting a natural delivery while awaiting Dr Gowling's arrival.[185] Dr Lindner gave this evidence:

> 'Sometimes a woman might be pushing in the wrong spot, so not making her pushes as effective as possible. So sometimes by placing our fingers just inside the vagina and applying some downward pressure, this indicates to her the correct spot to aim her pushes and it can help with her targeting the right spot so that her pushes are as effective as possible.' [186]

5.118. Dr Lindner gave evidence that these efforts helped to bring about the effective descent of Bodhi's head, such that an episiotomy could be performed. Dr Gowling and Dr Lindner both gave evidence that just before the episiotomy was performed Dr Lindner was notified by Ms Price (who had returned to Room 3) that Dr Gowling was standing just outside the room.[187] Dr Gowling informed Dr Lindner that the baby needed to be born urgently as the foetal heart rate was abnormal.[188] Dr Gowling explained that she had become aware of this from passing the nurses' station and seeing the CTG trace, which was now up on the multi-view screen.[189] Dr Lindner informed Dr Gowling that the foetal head was now at a point where an episiotomy was appropriate (when the foetal head reached the perinium causing stretching) and Dr Gowling told her to proceed but remained outside Room 3. Dr Lindner performed the episiotomy at 12:55am and within the next couple of contractions, Bodhi was born. The time of delivery was 12:58am on 30 August 2021.

5.119. As set out at the beginning of this Finding, it was immediately evident that Bodhi was in a very poor condition at delivery, with APGAR scores of 0 at one minute and 0 at five minutes. Considering the period between Dr Lindner's arrival and Bodhi's delivery was approximately 35 minutes, with Dr Lindner being aware of the severely abnormal foetal trace which commenced at approximately 12:10am, Dr Lindner was asked whether prior to delivery she had expected Bodhi's condition to be so dire. Her evidence was that she had expected Bodhi to be born in what she referred to as a '*flat*

[184] Exhibit C30, paragraph 2
[185] Transcript, page 428
[186] Transcript, page 428
[187] Transcript, page 560
[188] Transcript, page 365
[189] Transcript, page 484

condition' and requiring some resuscitation but did not expect the ultimate outcome.[190] This was notwithstanding Dr Lindner assessing that the foetal heart decelerations had probably been going on for a period prior to 12:10am after viewing the CTG trace. Dr Lindner told the Court that she did not inform Dr Gowling of these severely abnormal decelerations during their telephone call at 12:27am. I asked Dr Lindner why she did not convey this to Dr Gowling. Her evidence was:

> 'I suppose there was a degree of urgency that I was feeling and perhaps wasn't articulating all the information that I should have, given that I was tunnel visioned and focused on getting back into the room to try to continue my assessment and continue my management.' [191]

5.120. As previously touched on, Dr Gowling's arrival was swift. Given her location at the time of the call she could not have conceivably arrived any sooner. While Dr Lindner accepted that she should have conveyed her concerns about foetal heart decelerations to Dr Gowling, her explanation as to why she did not was entirely understandable in the circumstances. In any event, Dr Gowling (who gave evidence after Dr Lindner) told the Court that Dr Lindner did inform her of the decelerations.[192] While Dr Lindner may not have emphasised the severe abnormality in the trace, Dr Gowling had all the information she required to make the decision to attend the hospital urgently, which she did.[193]

5.121. I was impressed with Dr Lindner as a witness. Her evidence of her actions reflected her ability to remain calm and in control of what was no doubt a very tense and stressful situation. This was despite her junior level of training at the time. Both Dr Gowling and Professor Kane expressed the view that it was appropriate for Dr Lindner to wait in circumstances where an instrumental delivery was necessary, but the position of the foetal head could not be determined.[194] In addition, Professor Kane drew the Court's attention to the RANZCOG guidelines which made it very clear that a key prerequisite for an instrumental birth was knowing the exact position of the foetal head for correct placement of the instrument.[195]

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[190] Transcript page 366
[191] Transcript, page 373
[192] Transcript, page 477
[193] Transcript, page 478
[194] Transcript, pages 484 (Dr Gowling) and 827 (Professor Kane)
[195] Transcript, page 828

5.122. I find that Dr Lindner's response to the evolving emergency in Room 3 when she arrived at approximately 12:22am was reasonable and appropriate at every step. That included making the decision not to proceed with the instrumental delivery without Dr Gowling, calling Dr Gowling when she did and assisting Mrs Searle with coached pushes which ultimately saw Bodhi delivered after an episiotomy. I also find that Dr Gowling's response to Dr Lindner's request to attend the hospital was swift and appropriate. The fact that Dr Gowling was not onsite at the hospital as the on-call consultant was an issue that Dr Gowling was not responsible for.

5.123. On-call consultant

5.124. Dr Kate Gowling was the on-call consultant obstetrician at the FMC on 29-30 August 2021. Dr Gowling provided an affidavit to the Court and gave oral evidence. She also made a retrospective entry in Mrs Searle's clinical case notes.[196]

5.125. Dr Gowling told the Court that she remained at her home that evening but was available by phone and would attend if required. This arrangement was endorsed by SALHN. Dr Gowling's home was approximately 25 minutes from the hospital. As already established, Dr Gowling was not critical of Dr Lindner for waiting for her to attend the hospital when Dr Lindner realised that the instrumental delivery would be complicated due to the station of Bodhi and the uncertainty as to the orientation of his head. Dr Gowling gave evidence that she was unaware of Dr Lindner's limited experience in mid-cavity instrumental deliveries in August 2021. She did not know that Dr Lindner had no experience in mid-cavity instrumental deliveries requiring rotation.[197] It is important to clarify that the rostering of registrars (and the understanding as to their level of experience) was not undertaken by Dr Gowling.

5.126. Dr Gowling candidly accepted in her oral evidence that had she been onsite at the hospital in the on-call room, which she estimated was a few minutes away from the labour ward, she could have been in Room 3 very quickly. Upon arrival at the room (after having assessed Mrs Searle herself and determining that it was appropriate to do the delivery in the room as opposed to theatre), Dr Gowling estimated that she could have performed a mid-cavity instrumental delivery within 10 to 15 minutes. This

[196] Transcript, page 455
[197] Transcript, page 461

timeframe accorded with the evidence of Professor Kane, who estimated a 10-minute delivery timeframe for a consultant.[198]

5.127. Two different timeframes were put to Dr Gowling. The first being 12:10am when the CTG trace commenced recording concerning foetal decelerations. Dr Gowling agreed that had she been onsite and aware of the concerning trace, she could have delivered Bodhi at approximately 12:25am. Given that there was no awareness of the abnormal decelerations until around 12:22am, I am of the view that this was an unlikely scenario. However, the second timeframe had more force. Dr Lindner called Dr Gowling to attend the hospital at 12:27am. Had Dr Gowling been onsite at the hospital, and available, she agreed that Bodhi could have been delivered between 12:40am and 12:45am, some 13 to 18 minutes before he was ultimately delivered. Dr Gowling also agreed that this was at a time when Bodhi must have been suffering hypoxia. I am of the view that this second timeframe was another missed opportunity to have delivered Bodhi earlier than he was. That lost opportunity was the failure to recognise or to attach any significance to the fact that Dr Lindner was not sufficiently credentialled to undertake more complicated deliveries without onsite consultant support. It is well-known in obstetrics that a low-risk birth can become high-risk quickly. That is exactly what occurred in this matter.

5.128. As the Obstetric Head of the Unit at the time of Bodhi's death, Dr Sue Kennedy-Andrews was asked to address the issue of how it came to be that Dr Linder was the most senior obstetrician on the ward on the evening of Bodhi's birth, along with a number of other topics in her affidavit. Dr Kennedy-Andrews explained that registrars were assessed and credentialled in terms of their clinical capabilities through discussions with obstetric consultants, including the current supervisor of the registrar. A joint decision was then made by the consultants as to whether a registrar was capable of being rostered on to work weekends and nights.[199]

5.129. Dr Kennedy-Andrews stated that her understanding of Dr Lindner was that prior to August 2021 she had worked on weekends without support and was at least sufficiently skilled to undertake a simple caesarean and lift-out.[200] It was never in dispute that Dr Lindner could undertake such deliveries. The issue that arose with Mrs Searle's

[198] Transcript, page 832
[199] Exhibit C37, paragraph 3
[200] Exhibit C37, paragraph 5

labour was that it started as a low-risk labour and delivery and ultimately became more complicated, which Dr Lindner did not feel appropriately skilled to safely manage independently. It was evident that she simply did not have the experience in mid-cavity instrumental deliveries with the potential for a rotation. Dr Kennedy-Andrews did not address that in her affidavit. She did however state that the COVID-19 pandemic had impacted on the regularity of such discussions due to meetings having to be abandoned due to outbreaks of the virus amongst staff or being close contacts.[201] Implicit within this statement was a concession that discussions were not taking place regularly enough to ensure registrars that were rostered overnight were adequately credentialled for more difficult deliveries. Whatever the reason, it is plain that Dr Lindner did not have the skills required to be the most senior obstetrician onsite on the evening of Bodhi's birth. Concerningly, Dr Lindner gave evidence that after Bodhi's death, she made it clear to her superiors that she did not feel comfortable being rostered as the most senior doctor on duty overnight without an on-call consultant remaining onsite.[202] However, that situation repeated itself on occasions prior to her leaving FMC and taking a residency at an interstate hospital.

5.130. Resuscitation of Bodhi by Ms Noble and Dr Baldwin

5.131. While the instrumental delivery was ultimately not required, the presence of Ms Noble in Room 3 was fortuitous due to Bodhi's poor condition. Ms Noble provided both an affidavit[203] to the Court and gave oral evidence. She also made an entry in the clinical notes after Bodhi's delivery.[204] Ms Noble gave evidence that she was called to attend for an impending instrumental delivery. She was not given any information of foetal heart rate decelerations or any concerns for the wellbeing of the baby.[205] This evidence was not challenged.

5.132. When Ms Noble arrived, she described becoming aware that the other midwives in the room, in particular Ms Price, appeared concerned. Ms Noble told the Court that she was initially confused as to why she had been called as she could not see any

[201] Exhibit C37, paragraph 6
[202] Transcript, page 437
[203] Exhibit C30
[204] Exhibit C2, page 116
[205] Transcript, page 516

instruments being used for the delivery of the baby. However, she remained in the room as there was a level of tension, and she sensed she might be needed. Once Bodhi was delivered Ms Noble described him briefly being placed on Mrs Searle's chest and then moved to the rescusitaire after approximately 45 seconds as he was pale and flat without any tone or respiratory effort. Ms Noble pressed the emergency bell and instructed that Dr Baldwin, the on-call neonatologist, be called immediately to attend. Ms Noble then attempted to intubate Bodhi but was unsuccessful and so commenced ventilation with a laryngeal insertion mask (LMA). Resuscitation efforts continued until 20 minutes post-delivery when Bodhi took his first breath.

5.133. Dr Baldwin arrived at 1:08am and assisted Ms Noble with the resuscitation of Bodhi. That included intubating Bodhi shortly after his arrival following Ms Noble's unsuccessful attempt. Dr Baldwin, who also provided an affidavit and gave oral evidence, was complimentary of the efforts of Ms Noble prior to his arrival. One issue that arose was whether, had Dr Baldwin been present from birth, and an earlier successful intubation effected, the outcome for Bodhi might have been different. Dr Baldwin was of the view that due to Bodhi's severely deranged blood gas analysis at birth (taken from the umbilical cord) there was evidence of a primary apnoea event which meant that he was in a dire clinical situation from the time he was born. Ms Noble's decision not to persist with intubation after one failed attempt but to instead ventilate him with a LMA was entirely appropriate and a decision he would have made himself had he encountered the same difficulty. I asked Dr Baldwin this question:

> 'Q. Ms Noble's decision not to attempt the intubation but to replace it with a laryngeal mask essentially brought about the same effect that intubation would have insofar as it would deliver air into Bodhi's lungs.
>
> A. That's absolutely correct.' [206]

5.134. Tragically, the primary apnoea event, or the intrapartum hypoxia, had already occurred by the time Bodhi was delivered and despite the expert and entirely appropriate actions of both Ms Noble and Dr Baldwin, baby Bodhi died the following day in his parents' arms.

[206] Transcript, page 879

6. Bodhi's chances of survival with an expedited delivery

6.1. The evidence on this topic was given for the most part by Professor Kane who opined that on the balance of probabilities, Bodhi's death was preventable. I have accepted Professor Kane's evidence.

6.2. Professor Kane gave evidence that with the overall clinical picture, the absence of any chromosome karyotype anomalies and the findings of structural normality at autopsy, in addition to the appropriately timed intermittent auscultations showing a healthy foetal heart rate between 6pm and 11:16pm, he was of the view that something changed thereafter in terms of Bodhi's wellbeing.[207] This evidence aligned with the opinion expressed in the post-mortem report of Dr Manton.[208]

6.3. Professor Kane told the Court that at the start of labour it was likely that Bodhi was not hypoxic, was healthy and that a process evolved as labour continued that led to progressive deterioration, being progressive hypoxia to the point that when he was ultimately born, resuscitation was unsuccessful.[209] Professor Kane said this:

> '….if a CTG could be applied immediately [at approximately 11:26pm] and if the foetal heart rate had been able to be traced definitively reliably from that point, it is likely that there would've been sufficient concern there, as I mentioned before, at some point in that ensuing 30, 40 minutes for action to have been taken. And on the balance of probabilities, it is I think more likely that survival would've ensued as a result.' [210]

6.4. If the CTG had been applied at 11:26pm or shortly thereafter, based on Professor Kane's opinion, that would have seen the optimal time of delivery as between 11:56pm and 12:06am, approximately.

6.5. I have found that Ms Geyer did not communicate her concerns about hearing the prolonged decelerations to Ms Price when she notified her of her intention to transfer Mrs Searle to the BAS. Placing her conversation with Ms Price around 11:30pm, shortly after the entry in the clinical notes at 11:26pm, had Ms Geyer raised her concern with Ms Price, there was sufficient time for Ms Price, a very senior midwife, to have involved herself in monitoring the CTG (which would have revealed an abnormal foetal

[207] Transcript, pages 846-847
[208] Exhibit C1a
[209] Transcript, page 847
[210] Transcript, page 848

heart rate) and contacting Dr Lindner urgently. Had this occurred, I am satisfied that Bodhi would have been delivered in the timeframe set out by Professor Kane.

6.6. It will be remembered that the CTG was connected at 11:40pm and archived at 11:44pm. Had Ms Geyer monitored the trace at that time, either by way of watching the physical trace as it was produced by the machine or by displaying it on the computer as Ms Price described, I am satisfied that she would have detected that it was not monitoring the foetal heart rate. There was sufficient time to have corrected it and realised that Bodhi was in distress. Had Ms Geyer taken this course of action, there was an opportunity for the escalation of care to Dr Lindner and Dr Gowling (who was approximately 20 minutes away) for Bodhi to have been delivered in sufficient time to prevent the intrapartum hypoxia from which he died.

6.7. I have found that Ms Geyer thought she had networked the CTG monitor such that it was available for viewing in the nurses' station. When notified by Ms Shorrock at approximately 12:05am that it was not available for viewing in this area, Ms Geyer expressed a look of surprise and indicated that she would do what was necessary to have it displayed. This was another opportunity for a senior midwife (Ms Shorrock) to have independently viewed the CTG trace, which at that time was recording a maternal heart rate. Based on the evidence of Professor Kane, the opportunity to have prevented Bodhi's death post 12:10am was still possible, but less likely as time went on.[211]

7. Altered birth record

7.1. The 'Labour and Birth Summary',[212] primarily completed by Ms Geyer, contained a number of crossed out numbers giving the appearance that this important document had been altered at some time. In particular, these details were the time at which the second stage commenced and the duration of each stage of labour.

7.2. It transpired during the course of the evidence that the alterations had been made by Ms Angela Neary, a BAS midwife. Ms Neary was a midwife who was involved in caring for Mrs Searle the day after Bodhi was born. Although she could not recall the exact circumstances in which she came to amend and complete this document, the evidence was that this was not an uncommon practice for a nurse caring for a patient in the hours or days following their labour.

[211] Transcript, page 851
[212] Exhibit C3, page 56

7.3. Counsel assisting, Ms Giles, submitted that it was inappropriate for anyone to have amended Mrs Searle's Labour and Birth Summary to have recorded 10:50pm as the beginning of the second stage. The basis for her submission was as follows

7.3.1. Information about the commencement of the second stage of labour was critically important in Bodhi's care. As Professor Kane stated, when there have been concerns for foetal wellbeing and the second stage of labour is prolonged, that raises concern.[213] For that reason assumptions should not be made about the commencement of the second stage of labour based on viewing of documentation without input from the primary accoucheur.

7.3.2. It was not appropriate to assume the most favourable version of events; that the second stage of labour commenced at 10:50pm, as even on the face of the document as Ms Geyer left it, there was an inconsistency about when the second stage commenced. The evidence was that Ms Geyer had written 9:30pm and crossed it out. Counsel assisting submitted that making a correction on the Labour and Birth Summary such as it was had the consequence of making the second stage 80 minutes shorter. The evidence reflected that there was confusion, even in the mind of Ms Geyer, about when the second stage commenced. This evidence was:

- Ms Geyer writing 9:30pm and crossing it out;[214]
- Telling Ms Price that Mrs Searle had been '*fully and pushing for over an hour*' at approximately 11:30pm;[215]
- Giving Ms Shorrock different accounts of how long Mrs Searle had been pushing in second stage for, one hour, then two hours and then back to one hour;[216]
- Dr Lindner being told that Mrs Searle had been pushing for two hours and then querying with Ms Shorrock as she had seen Mrs Searle at approximately 10:50pm to undertake an ultrasound, believing at that time she was 7cm dilated.

[213] Transcript, page 841
[214] Transcript, page 293
[215] Transcript, page 547
[216] Transcript, page 901

7.4. Ms Carroll, the BAS Midwifery Manager, gave evidence that alterations and completion of the Labour and Birth Record by someone other than the primary accoucheur was not an uncommon occurrence. Furthermore, Professor Kane expressed the view that the time at which the second stage commenced was reasonably demarcated at 10:50pm by virtue of the vaginal examination at that time, and that the details added to the document by Ms Neary were reasonable in the circumstances.[217]

7.5. I make no criticism of Ms Neary for completing this paperwork. Her evidence was that she was asked to do so, by whom she cannot remember,[218] but she was clearly involved in the post-natal care of Mrs Searle and had a reason to access her clinical notes. I do however make the observation that this document was of vital importance in Bodhi's case and in circumstances where there has been an adverse outcome, it is highly desirable that those in charge of the Department take steps to preserve the paperwork in the state it appears at the time of the adverse event.

8. Stephanie Geyer

8.1. Ultimately, Ms Geyer was responsible for the care of Mrs Searle and during that care there was evidence of significant foetal distress which did not appear to have been appreciated by her at all, or until it was too late.

8.2. Ms Geyer was an experienced midwife who was articulate and well-presented. I did however observe her to be defensive at times and I noted that she struggled to make even the most obvious of concessions. Notwithstanding this, Ms Geyer at one point in her evidene did concede that in hindsight there were many things she would have done differently.[219]

8.3. During her oral evidence, Ms Geyer relied heavily upon two retrospective notes that she had written following Bodhi's birth, dated 30 August and 16 September 2021. These entries had Mrs Searle's identification stickers on them. The first note was written at the hospital at the conclusion of Ms Geyer's shift, in a similar fashion to Dr Lindner, Ms Shorrock, Ms Noble and Dr Gowling. However, rather than include

[217] Transcript, page 755
[218] Transcript, page 668
[219] Transcript, page 257

this note in Mrs Searle's medical file, as was done with Ms Shorrock, Ms Noble and Dr Gowling's notes, Ms Geyer took that note home with her. Her explanation for doing so was:

> 'Because I knew that they were not 100% accurate with times and details because I didn't have access to the CTG and some of the other notes because they were with other people because she was still being cared for. So I didn't have access to of the details and I wanted to be able to have it all together to write it really comprehensively and clearly.' [220]

8.4. The second note was completed by Ms Geyer outside the hospital with a copy of the Mrs Searle's CTG trace to assist her. Both retrospective notes went home with Ms Geyer. She also took Mrs Searle's identification stickers from the hospital and placed them on the retrospective notes.[221]

8.5. The original paper CTG trace had been placed with Mrs Searle's medical records and seized by the Coroners Court. However, a copy was able to be viewed and printed from the computers in the labour ward. Ms Geyer gave evidence that she did not access and print the CTG trace herself, but requested someone to do that for her.[222] She was unable to remember who that person was.[223] Ms Geyer attempted to justify having the stickers and the trace outside the hospital environment through her role as an SMGP midwife, which would involve visiting women at their homes and having personal files in her possession.[224] However, it was common ground that Ms Geyer had not met Mrs Searle before 29 August 2021 and was not involved with her antenatal care. She therefore had no reason to have Mrs Searle's records in her possession. Ms Geyer claimed that she was unaware at the time that taking such documents home with her was inappropriate.[225]

8.6. The practice of a retrospective note being written outside the hospital cannot be seen as inappropriate in and of itself. It depends on the individual circumstances. It is however difficult to justify the practice of taking confidential patient records home without permission to assist with this process. The way in which Ms Geyer went about creating these retrospectives notes raised a number of questions about her motives.

8.7. Ms Carroll gave evidence that she had in fact advised Ms Geyer to prepare a retrospective note so she had '..*something to look back on if she needed to and had a*

[220] Transcript, page 192
[221] Transcript, pages 198-201
[222] Transcript, page 302
[223] Transcript, page 303
[224] Transcript, page 301
[225] Transcript, page 223

clear understanding of what had happened in the events of that day'.[226] Ms Carroll did not provide guidance about how this should be done and did not give her the CTG trace. Ms Geyer produced these notes to Ms Carroll approximately two weeks later, copies of which were provided to Dr Kennedy-Andrews. The Court heard that the original retrospective note dated 16 September 2021 remained in Ms Carroll's filing cabinet by mistake with both notes being produced in the lead-up to the Inquest.

8.8. Ms Carroll made it clear in her evidence that she would not endorse the practice of taking home a CTG trace because '*the CTG would stay with the hospital and it's common knowledge that you would not take that CTG home cos it's part of the patient's record*'.[227] Ms Carroll was unaware that Ms Geyer had taken the CTG trace home with her until just before the Inquest commenced.[228]

8.9. How the CTG trace assisted Ms Geyer in preparing her retrospective notes was unclear. Her evidence on this topic was vague. Ms Geyer was unable to point out specifically what it was on the trace that assisted her in the writing of her retrospective notes. She gave this evidence:

> 'It's difficult for me now to give you specific examples but it's I guess fact checking my retrospective note and the times written on there with the events on the CTG and then piecing in how long it was between events and phone calls, so that I could get a clear timeline I guess.' [229]

8.10. While I accept that Ms Geyer was advised to prepare a retrospective note, and that the late discovery of the note of 16 September 2021 to the Court was an oversight on the part of Ms Carroll, I have difficulty understanding how the CTG trace assisted Ms Geyer in the preparation of her retrospective note, particularly given she had paid such little attention to it during the course of Mrs Searle's labour.

8.11. It was evident during the course of Ms Geyer's testimony that she felt the support she received from the BAS midwives was lacking. This belief appeared to have impacted on her ability to focus on her primary role, the care of Mrs Searle and her labour.

8.12. While an internal review undertaken by SALHN reported on a level of tension that existed between the BAS midwives and the SMGP midwives at the time of Mrs Searle's

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[226] Transcript, page 1059
[227] Transcript, page 1095
[228] Transcript, page 1094
[229] Transcript, page 305

admission, the evidence heard from those involved on the night did not support that any tension existed, such that it may have impacted the care of Mrs Searle. Not even Ms Geyer articulated any real concern other than the BAS room being understocked for an imminent birth and the lack of the physical presence of the other nurses who she acknowledged were very busy that evening. Ms Geyer gave evidence about two interactions with Ms Shorrock and two interactions with Ms Price, most of which were at the nurses' station. It is difficult to reconcile her complaint relating to the lack of support with even her own evidence.

8.13. Given that the real issue at play, at least in the mind Ms Geyer, was the foetal heart rate decelerations, it is a mystery why the stocking of the BAS room was such a distraction and ultimately an impediment to her ability to adequately monitor the CTG trace. As was canvassed during the course of her oral evidence, Ms Geyer had available to her at least two mechanisms by which to alert other staff for assistance, neither of which she utilised. These were a yellow midwife-assist call button or the red emergency call button.[230]

8.14. There was also the issue of Ms Geyer's meal break and the on-call phone that she had in her possession. Based on the times that Ms Geyer recorded on her retrospective note as to when she received these calls, I do not consider them to have seriously impacted on her ability to do her primary role. There were no calls at all between 7:10pm and 12:14am and two brief calls around the time she was on her short break.

8.15. Ms Geyer's request for a meal break came at perhaps the most crucial moment in the CTG trace, at a time where the foetal heart rate was severely abnormal. While it was not unreasonable for Ms Geyer to have needed and requested an opportunity to take a break, the timing of the request was telling. It suggested that Ms Geyer was either not aware of the seriousness of the situation or underestimated it. Given Ms Geyer's knowledge that there had been prolonged decelerations earlier in the labour which, on her evidence, precipitated the move to the BAS, the foetal heart rate should have been her primary focus. The evidence supports the conclusion that the foetal heart rate was not her primary focus, with catastrophic consequences for Bodhi.

8.16. It was submitted to me by counsel assisting, Ms Giles, that an Inquest is a fact-finding exercise rather than a vehicle for the apportionment of blame. Ms Giles clarified this

[230] Transcript, pages 893 and 1004

statement by submitting that this is not to say that individuals or other entities will not be criticised in a coronial Finding. If a departure from an appropriate standard of care has been found to have occurred in connection with a death, the Court will robustly say so. It is often necessary to identify fault in order to devise means by which a dangerous practice generally, or the idiosyncratic behaviour of a specific individual, can be corrected by way of a coronial recommendation.

8.17. Several of the findings that I have made are adverse to Ms Geyer in that they identify faults on her part. In coming to these conclusions I have been mindful of the need to satisfy myself that such findings should only be made based on the relevant evidence presented being reliable and compelling. In doing so I have applied the principles expressed the High Court of Australia in **Briginshaw v Briginshaw**[231] and the recent judgment of the Court of Appeal, **SJ Berry Pty Ltd v McEntee**.[232]

8.18. The position taken by SALHN, which was communicated at the beginning through the delivery of an apology to Mrs and Mr Searle, at the end of the Inquest in counsel for SALHN's closing submissions, and by way of the affidavit and oral evidence of SALHN Clinical Director of the Women's and Children's Division, Dr Dylan Mordaunt,[233] was that system errors were to blame for the failure to appreciate Bodhi's foetal distress and deliver him expeditiously. Dr Mordaunt went so far as to state in his affidavit that:

> '…any failing of Ms Geyer to monitor and assess the trace was due to systems failings which prohibited Ms Geyer from being able to provide the level of clinical care and attention required in this case given she was not provided with an appropriate level of support with respect to her competing duties.'

I have not found any evidentiary support for that position where it related to Ms Geyer.

8.19. With that said, I do agree with the view of Professor Kane who gave this evidence in response to a question about Dr Mordaunt's evidence stated in the above paragraph:

> 'But I think, if I may comment on the intent, I guess, of what I would presume to be the intent of this paragraph, is that acknowledging that there are deficiencies in practice is an important first step. And I think elsewhere from people's own testimonies that has happened. But the critical thing for health services to look at in terms of minimising the chance of this type of thing happening again, is to look at the overall context in which these deficiencies of practice happened, and whether there were systems issues that related

[231] (1938) 66 CLR 336 in particular Dixon J at 361-362
[232] [2022] SASCA 133
[233] Exhibit C32, paragraph 4

> to these deficiencies appearing, and having the consequences they do, given that we acknowledge - in fact it's really important they've acknowledged we all make mistakes - and in healthcare almost more than almost anywhere else, we need to create systems that allow for those mistakes and protect people from their effects. So I'm not suggesting there shouldn't be, of course personal responsibility and accountability, but the way to minimise the chance of these things recurring, because we need to look at A: why that wasn't communicated, what were the reasons why that was the case, is it a policy, is it a training issue, is there some other systems issue that means that someone else in Ms Geyer's position could do exactly the same thing in six or eight months' time and lead to a similar outcome. So really looking at it from the point of view that we need systems that can accommodate people having multiple responsibilities at once and other challenges that we know are part and parcel of healthcare, to minimise the chances of those things happening. So I think, yes, I think there's clear evidence of deficiencies of care here, but the reasons for those, and I guess more importantly what can be done about minimising the chance of them happening in the future requires a human factors approach to incident review, and acknowledging that in fact it is entirely possible that the same outcome could have happened with different people in those roles on a different day, rather than, I guess, personalising the concerns. Now again, if there are performance issues, they should be addressed with additional training and so forth and normally taken into consideration from an overarching period of practice rather than a single incident. But I think, as I said, the key here is to look at it from a systems point of view, because that's the way we'll minimise the chance of it happening in the future again.' [234]

8.20. In line with the above sentiment expressed by Professor Kane, I am of the view that had SALHN had better systems in place for ensuring a CTG was properly displaying foetal heart rate and was on display in the nurses' station, and had there been a senior midwife dedicated to watching that CTG in the nurses' station, it is likely that the impact of Ms Geyer's individual errors in relation to the CTG would have been minimised or even averted. I make this finding acknowledging that Ms Shorrock was at the nurses' station for a period of time, asking to view the CTG.

9. Open disclosure

9.1. On 7 June 2021, section 3(3) of the *Coroners Act 2003* (SA) (the Act) came into operation. This states that:

> 'For the purposes of this Act, a reference to the circumstances of an event may be taken to include matters related to or arising out of the event or its aftermath.'

9.2. It is therefore within the jurisdiction of the Court to examine events arising out of the death of Bodhi. Accordingly, I consider it both important and necessary to make some

[234] Transcript, pages 854-855

brief comments about the open disclosure process between SALHN and Mr and Mrs Searle, and the impact that this had on them.

9.3. Mr and Mrs Searle met with Dr Kennedy-Andrews and others on 21 September and 18 November 2021, to discuss the death of Bodhi. Letters were sent to the Searle's following both meetings. These letters were tendered to the Court.[235] While it was appropriate to have organised a meeting with the family and to have apologised, as was done in the second letter, Mrs Searle in her affidavit indicated that the process was far from open and appeared to her to be an attempt by the hospital to withhold information from her about what went wrong with Bodhi's delivery.

9.4. At the first meeting, prior to the post-mortem report being available, Mrs Searle stated that she and her husband were told that SALHN '*had absolutely no idea what happened, and they didn't mention the stuff up with the CTG at all even though it was in my medical records. Medical records they said they had reviewed prior to the meeting*.'[236] The letter sent after the meeting by the Director of Clinical Governance of SALHN (who was present at both meetings), corroborated Mrs Searle's complaint. At one point in the letter, it stated '*[w]e are at a loss as to why Bodhi was so unresponsive at delivery and ultimately passed away*'.[237]

9.5. It was accepted during the Inquest that by the time the first meeting was held, it was known by at least Dr Kennedy-Andrews that the CTG trace was recording only Mrs Searle's heart rate and not Bodhi's. At the Pit Stop Huddle, conducted on 30 August 2021 at 1:45pm with several labour ward staff, including Dr Kennedy-Andrews, it was discussed that a possible contributing factor to the incident was:

> '[o]n retrospective review of the CTG it has been considered that the period of recording from approximately 23:40pm to 00:10am may have been maternal HR and not fetal.' [238]

9.6. While awaiting the results of the post-mortem it is accepted that there was a level of discernment in not delving into possible theories as to Bodhi's cause of death. However, to positively state that SALHN was at a loss as to why Bodhi was so unresponsive at delivery and ultimately died was simply incorrect and inappropriate to say in the circumstances.

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[235] Exhibits C21a and C21b
[236] Exhibit C17, paragraph 12
[237] Exhibit C21, page 1
[238] Exhibit C8, Pitstop Huddle Review Form, page 3

9.7. Dr Mordaunt was asked to comment on this in his capacity as the Divisional Director of SALHN. He told the Court that if the hospital had known that there had been an error at the time of the meeting with Mr and Mrs Searle, then a letter expressing *'We are at a loss as to why Bodhi was so unresponsive at delivery and ultimately passed away*' was inappropriate.[239] Given the discussions at the Pitstop Huddle, which was led by Dr Kennedy-Andrews, I am of the view that conveying to Mr and Mrs Searle that SALHN were at a loss at to what went wrong with Bodhi's delivery was inappropriate.

10. Conclusions

10.1. The findings I have made are set out in accordance with the issues above. I have come to these conclusions on the basis that I am comfortably satisfied each of them were established on the evidence.

10.2. The Court reached the following conclusions:

1. On 29 August 2021, Mrs Diana Searle commenced spontaneous labour with her first child after an uneventful pregnancy.

2. Mr Jon Searle conveyed his wife to the FMC in the early evening and she was settled into Room 4 of SMGP.

3. Mrs Searle's allocated midwife was unwell on that evening and so another SMGP midwife took her place, Ms Stephanie Geyer.

4. Ms Thea Koke, who had been a part of Mrs Searle's antenatal journey as a Midwifery student, attended the FMC to support Mrs Searle and her husband and to assist Ms Geyer when required.

5. Whilst in the SMGP Room 4, Mrs Searle's labour progressed normally, with reassuring signs.

6. Ms Geyer was unsure of the position of the baby and sought a review from the obstetric registrar, Dr Elizabeth Lindner.

7. This took place at 10:50pm on 29 August 2021 with Dr Lindner confirming the position of the baby at ultrasound to be somewhere between the Right Occiput

[239] Transcript, page 696

Posterior/Right Occiput Transverse position. While considered to be a malposition, Dr Lindner was content for Mrs Searle to continue labouring, believing her to be 7cm dilated at that time. This was an appropriate decision.

8. Ms Geyer undertook a vaginal examination after Dr Lindner's assessment which confirmed she was 10cm dilated at approximately 10:50pm. Mrs Searle was encouraged to actively push.

9. At approximately 11:16pm, while Mrs Searle was labouring in a sitting position, Ms Geyer heard prolonged decelerations at intermittent auscultation. This continued for a period of 10 minutes.

10. At approximately 11:30pm, Ms Geyer spoke with Ms Nicole Price a senior BAS Midwife and the Team Leader on that evening. Ms Geyer requested a BAS room to move Mrs Searle into for continuous foetal monitoring to commence. This was an appropriate and clinically indicated decision on the part of Ms Geyer.

11. Ms Geyer explained to Ms Price that Mrs Searle had been pushing for over an hour and that was the reason for the change in model of care. Ms Geyer did not tell Ms Price that she had heard prolonged decelerations, rather that there were decelerations with maternal pushes. No urgency was conveyed by Ms Geyer to Ms Price about the transfer of rooms.

12. Ms Price told Ms Geyer that she would contact Dr Lindner for a review, as was required when a woman moved from a SMGP room to the BAS. Ms Price did not do this and in fact handed over the Team Leader responsibilities to Ms Sue Shorrock, another senior BAS midwife. Ms Price should have contacted Dr Lindner before she left the ward. I find that this was a missed opportunity for Dr Lindner to have reviewed Mrs Searle earlier than she ultimately did.

13. Ms Price did however handover to Ms Shorrock that Mrs Searle was moving rooms due to a prolonged second stage of labour.

14. The period of time that passed between the request to move rooms (11:30pm) and the first record on the CTG trace (11:40pm) was approximately 10 minutes.

15. The CTG trace was archived at 11:44pm.

16. The BAS Room 3 was not stocked adequately, requiring Ms Geyer to obtain some items. Ms Geyer did not ask Ms Koke to assist her with these tasks. As I have indicated, I have not found that these tasks could have legitimately taken priority over the monitoring of the foetal heart rate.

17. Although Ms Geyer thought she had done so, the CTG trace was not networked by her in order to be displayed at the nurses' station.

18. Until approximately 12:05am, Ms Geyer did not turn her mind to monitoring the CTG trace. This should have been her priority.

19. Just prior to 12:05am, Ms Shorrock and another midwife were in the nurses' station and attempted to view the CTG trace from Room 3. Ms Shorrock was unable to view the CTG and told Ms Geyer at the nurses' station at just prior to 12:10am that she could not view it. Ms Geyer told her that she would do what was necessary in order for Ms Shorrock to view it. Ms Geyer did not do this. I find that this was a missed opportunity for someone to have independently viewed the CTG trace (in this case Ms Shorrock who was at the nurses' station at the time) and detected that it was recording the maternal heart rate and not foetal.

20. During the same conversation, Ms Shorrock asked Ms Geyer if Dr Lindner had been contacted to review Mrs Searle, and Ms Geyer indicated that she did not know. Ms Shorrock then contacted Dr Lindner at 12:10am to ask her to review Mrs Searle who was now in the BAS. Ms Geyer did not tell Ms Shorrock about the decelerations that she had heard between 11:16pm and 11:26pm. Ms Geyer did not tell Ms Shorrock that she was awaiting an urgent medical review which was now approximately 40 minutes overdue. Had she done so, Ms Shorrock would have contacted Dr Lindner and conveyed the urgency to her. This was another missed opportunity for Dr Lindner to have been notified of the urgency of the review.

21. In a second conversation at approximately 12:15am, Ms Geyer asked Ms Shorrock for a short meal break. Ms Shorrock was of the view that this was an inappropriate time to take a break due to Mrs Searle being in the second stage of labour and Dr Lindner's imminent arrival. Ms Shorrock conveyed her thoughts to Ms Geyer and refused to relieve her at that time.

22. Ms Shorrock had a change of heart and went to Room 3 to relieve Ms Geyer for a break. This was approximately 12:18am.

23. Upon Ms Shorrock's arrival in Room 3, she immediately noticed that the physical CTG trace had been recording the maternal trace only and took steps to remedy that. This was the first time someone had recognised that the CTG was not recording the foetal heart rate. Ms Shorrock moved Mrs Searle into the lithotomy position to obtain a better trace and to prepare her for Dr Lindner's review. Ms Shorrock was in Room 3 for approximately five minutes and left at approximately 12:22am when Ms Geyer returned.

24. At approximately 12:22am, Ms Geyer arrived back from her break. At the same time, Dr Lindner arrived in Room 3 and immediately noticed that from 12:10am, the CTG trace was recording a severely abnormal foetal heart rate. This was the first time someone had noticed the severely abnormal foetal heart rate for a period of 13 minutes. Dr Lindner formed the view that an urgent delivery was required.

25. Dr Lindner undertook a vaginal examination and established that the baby was too high in the pelvic cavity to perform an episiotomy. Dr Lindner formed the view that an instrumental delivery was required but could not determine the orientation of the head to safely perform one, taking into account her level of experience and scope of practice.

26. Dr Lindner contacted the on-call consultant, Dr Gowling, at 12:27am who was offsite and asked her to attend the hospital urgently to assist her with a complicated instrumental delivery. Dr Lindner did convey to Dr Gowling that there were decelerations on the CTG. This was an appropriate decision for Dr Lindner to have made. It was inappropriate for Dr Lindner to have been the most senior doctor in the hospital overnight with her level of experience, and without the support of an on-call consultant onsite.

27. Had Dr Gowling been onsite at the hospital, I find that Dr Gowling would have been able to delivery Bodhi by way of a forceps delivery no later than 12:45am, some 13 minutes earlier than he ultimately was delivered. I am not critical of Dr Gowling for remaining offsite whilst on-call. That was a decision that was made by others.

28. While waiting for Dr Gowling, Dr Lindner inserted a catheter and applied a pudendal nerve block with local anaesthetic in preparation for an instrumental delivery. These were appropriate steps undertaken in a timely manner. Dr Lindner then performed coached pushes with Mrs Searle to attempt to bring the baby further down into the pelvis while awaiting Dr Gowling's arrival. This was also appropriate.

29. Ms Petra Noble, neonatal nurse practitioner arrived 10 to 15 minutes prior to delivery.

30. Dr Gowling arrived at the hospital at 12:50am and passed by the nurses' station which now had the CTG displayed on the multi-view screen. It is not known who enabled it to be viewed and at what time. Dr Gowling immediately noticed that there were severely abnormal decelerations and went to the doorway of Room 3.

31. Just after 12:50am, Dr Gowling spoke to Dr Lindner in the doorway. Dr Lindner informed Dr Gowling that her coached pushes had been effective, and an episiotomy was now possible. Dr Gowling indicated that she should continue with that delivery mode but remained outside the room. Dr Lindner cut the episiotomy at 12:55 and Bodhi's head was delivered at 12:56am. Baby Bodhi Leo Searle was delivered at 12:58am.

32. The resuscitation efforts performed by Ms Noble and Dr Baldwin were appropriate and timely, but unfortunately were not enough to reverse the intrapartum damage that had been done.

33. Bodhi died at 1:18pm on 31 August 2021.

34. Between 11:16pm and 11:26pm on 30 August 2021, Ms Geyer heard prolonged decelerations at intermittent auscultations and appropriately recorded them in the notes. She appropriately sought transfer of Mrs Searle to a room with CTG monitoring. Unfortunately, for reasons that are not entirely clear, the level of care Ms Geyer provided to Mrs Searle diminished thereafter.

35. In the period of time between 11:26pm and 12:10am, Bodhi's heart rate was abnormal. Inexplicably, the foetal heart rate abnormality went undetected in this timeframe and no concerns were raised with any other staff. The CTG monitoring

for which Mrs Searle was moved, was not prioritised by Ms Geyer who was the primary accoucheur. Based on the prolonged decelerations she heard between 11:16pm and 11:26pm, this did not meet the expected standard of practice.

36. Had Ms Geyer connected the CTG and reliably monitored the foetal heart rate in the period of time following 11:30pm, I find that there would have been sufficient concerns with the trace to warrant delivery at an earlier time. If that had occurred between 11:56pm and 12:06am or shortly thereafter, I find on the balance of probabilities that Bodhi's death would have been prevented.

37. While I have found that there were other missed opportunities in the management of Mrs Searle's labour from approximately 12:05am onwards, as I have detailed above, they came at time when the preventability of Bodhi's death became less likely. It is difficult to know at what point exactly the hypoxia from which Bodhi succumbed was irreversible. However, it is important to acknowledge that delivering him at any time earlier than he was may have prevented his death. Based on the evidence of Professor Kane, I am unable to place it more highly than this.

11. Recommendations

11.1. It is important to acknowledge that SALHN investigated the death of Bodhi extensively. A number of different investigations were undertaken including, as mentioned earlier, a Pit Stop Huddle, a Clinical Review Meeting,[240] a Clinical Incident Brief,[241] a Root Cause Analysis (privileged),[242] and a Root Cause Analysis (public).[243]

11.2. The Court received evidence about the changes SALHN has made to the labour ward at the FMC in response to these investigations. These are all practical and sensible measures to ensure that there is a safety net for when errors in clinical practice occur. In particular, there is now a check system to ensure the CTG is connected so that it can be displayed at the nurses' station. In addition to this, there is an allocated nurse to monitor the CTGs at all times.

[240] Exhibit C6
[241] Exhibit C5
[242] Protected under Part 8 of the Health Care Act 2008 (SA)
[243] Exhibit C10

11.3. One recommendation arising from these changes related to the introduction of a new credentialling process to avoid situations similar to that which Dr Lindner found herself in on the evening of Bodhi's birth. Dr Elizabeth Beare, the current Obstetric Head of Unit, gave evidence at the Inquest to explain the current process that is in place to ensure that trainees are not rostered on without a more senior person onsite until they are adequately skilled to manage the situations that may arise during the shift. I understood from Dr Beare's evidence that the plan is for a credentialling document for each of the registrars to be made available to the consultants, so the consultants can ascertain for themselves whether they should be on or offsite when rostered on as a consultant with a particular registrar. Examples of that document were tendered into evidence.

11.4. Based on the examples as mentioned above, it is difficult to see how this would be a substantial improvement on the process that was in place at the time of Bodhi's birth. Particularly if a complex emergency arose, as there would be a delay waiting for the offsite consultant to arrive.

11.5. It was established during the course of Dr Beare's evidence that the entire credentialling process, insofar as making the credentialling documents available for consultants to view, was not completed prior to the Inquest concluding. The explanation was that the administrative portion of this process was slow and cumbersome. The Court heard evidence that the current situation places the obligation on the registrar to notify the on-call consultant they will be working with, whether or not they would be more comfortable with the consultant onsite due to their skill level.[244] I consider this to be an unrealistic expectation which places an uncomfortable onus on the registrar. I am reminded of the evidence of Dr Lindner, who expressed that she was concerned when there was not a consultant onsite during her nightshifts, but she did not raise that with anybody, as the culture at FMC was that the expectation was for first year registrars to do nightshifts independently. Dr Lindner's evidence was that this was a common concern shared amongst the registrars.[245]

[244] Transcript, page 1040
[245] Transcript, page 437

11.6. Taking into account the systemic changes and improvements already implemented by SALHN, there is just one matter that requires addressing by way of recommendation.

11.7. I therefore make the following recommendation directed to the Minister for Health and Wellbeing and the Chief Executive Officer of the Southern Adelaide Local Health Network.

11.7.1. That all South Australian maternity hospitals consider the implementation of a policy, to be enforced by the Head of the Department, that ensures the most senior registrar onsite is appropriately credentialled to undertake complex deliveries independently unless there is a consultant onsite and available.

12. Acknowledgements

12.1. I acknowledge the valuable assistance provided to me by special counsel, Ms Sally Giles, in the preparation and hearing of this Inquest.

12.2. I acknowledge the presence of Bodhi's grandmother who attended the Inquest in person on behalf of her daughter and son-in-law.

12.3. I convey my sincere condolences to Mr Jon and Mrs Diana Searle, their family and the loved ones of baby Bodhi Leo Searle.

Key Words: Foetal Monitoring; Hypoxic Ischaemic Encephalopathy; Intrapartum Asphyxia

In witness whereof the said Coroner has hereunto set and subscribed her hand and Seal the 28th day of July, 2023.

Coroner