MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified in relation to the name of the deceased, family, friends, and others by direction of the Coroner pursuant to s57(1)(c) of the *Coroners Act* 1995)

I, Simon Cooper, Coroner, having investigated the death of KN

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is KN;

b) KN died after his birth on 21 October 2019, following a prolonged and difficult extraction in a term breech presentation;

c) The cause of KN's death was global hypoxic ischaemic encephalopathy; and

d) KN died on 3 November 2019 at the Royal Hobart Hospital, Hobart, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into KN's death. The evidence includes:

- Police Report of Death for the Coroner;
- Affidavits establishing identity and life extinct;
- Digital medical records from the Royal Hobart Hospital including *ante mortem* imaging;
- Royal Hobart Hospital Death Report to the Coroner;
- Medical Records – Tasmanian Health Service (including *antenatal* record of Ms DN and *neonatal* records of KN at Launceston General Hospital and Royal Hobart Hospital);
- Précis of Medical Records prepared by Ms L Newman, Clinical Nurse Specialist, Forensic Pathology;
- Digital maternal obstetric records – Launceston General Hospital;
- Report – Dr Yeliena Baber, Forensic Pathologist;
- Report – Forensic Science Service Tasmania; and
- Report – Dr Jonathan Nettle, Specialist in Obstetrics and Gynaecology.

Circumstances of death

Baby KN was just two weeks old when he died at the Royal Hobart Hospital (RHH) on 3 November 2019. He had been born two weeks earlier at the Launceston General Hospital (LGH) via a traumatic labour process which resulted in him suffering a severe hypoxic brain injury.

KN's mother's pregnancy was uneventful. She had received her antenatal care from a team of midwives in the community under the aegis of the LGH. On 21 October 2019, Ms DN presented to the LGH for a planned review at an antenatal clinic. At that review, she was found to be in the early stages of labour - her pregnancy was 39 weeks +3 days on that date. An examination carried out by midwives showed that KN was in a breech position. Ms DN was immediately admitted to the hospital for emergency caesarean section. LGH medical records indicate Ms DN was "keen" for a caesarean section.

The same medical records indicate that in the theatre, immediately after an epidural was administered, Ms DN's membranes ruptured at 3.03 pm and KN's feet and legs were on view. Her amniotic fluid was noted to be meconium stained.

Initial efforts at delivery by the obstetrician present proved unsuccessful and the assistance of another consultant obstetrician was sought at 3.29 pm.

The additional consultant scrubbed at 3.42 pm and assisted with the birth. Various manoeuvres were attempted – each unsuccessful – before a caesarean section was undertaken with a view to freeing up KN's arms and head. That proved successful in the sense that KN was then able to be born – critically unwell – vaginally shortly after.

After approximately 15 minutes of resuscitation, KN was transferred to the LGH neonatal intensive care unit and then flown to the RHH in the early hours of the next morning. At the RHH, KN underwent intensive management. Unfortunately his prognosis was poor due to hypoxic ischaemic injury he had suffered during birth. Ultimately a decision was made to palliate KN and he died on 3 November 2019.

Investigation

The fact of KN's death was reported by the RHH in accordance with the requirements of the *Coroners Act* 1995.

After formal identification, KN's body was transferred to the hospital mortuary. The following day, experienced forensic pathologist Dr Yeliena Baber performed an autopsy. Dr

Baber expressed the opinion that the cause of KN's death was global hypoxic ischaemic encephalopathy. She noted a contributing factor was myotonic dystrophy type I. I accept Dr Baber's opinion. Toxicological analysis of samples taken at autopsy proved unremarkable.

In view of the circumstances of KN's birth and death I asked the Royal Australian and New Zealand College of Obstetricians and Gynaecologists to nominate a suitable specialist to review the circumstances of KN's short life. Dr Jonathan Nettle, a specialist in Obstetrics and Gynaecology and fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists was nominated as a suitable expert to provide a report.

Dr Nettle provided a report. In that report he:

- Set out his qualifications; and
- Outlined the material he relied upon when preparing it.

In his report Dr Nettle made the following points:

- A clear clinical assessment of suitability for attempting vaginally breech birth was not conducted;
- At any time between 3.03 pm when Ms DN's membranes ruptured and 3.29pm on 21 October 2019 it would have been possible to perform a comparatively straightforward caesarean section; and
- KN's birth was a "difficult clinical situation that appears to have been made worse by poor clinical decision-making which did not adhere to standard relevant guidelines… there were multiple opportunities presented to staff present to take an alternative course of action that would have likely avoided the final outcome".

I consider Dr Nettle is well qualified to express the opinion that he did and I accept his views about this unfortunate case.

This finding, in draft, was sent, together with Dr Nettle's report, to the LGH for comment. A prompt reply was received from Dr Amanda Dennis, the Medical Director of Women's and Children's Services. It was accompanied by an email from the Hospital's Executive Director of Medical Services which expressed personal criticism of Dr Nettle's experience. In fairness, unlike Dr Nettle's report, I have to observe that Dr Dennis' report provided no details in relation to her experience nor the material upon which she relied.

Nonetheless, I have had express regard to the contents of her report and given it appropriate weight.

I note that Dr Dennis advises that the LGH is investing in a simple ultrasound unit which midwives and medical staff will be trained to use confirmation of foetal presentation.

Conclusion

Having regard to the evidence as a whole I have reached the conclusion that the birth of KN was mismanaged at the LGH.

In contrast, the care and treatment he received after his birth, both at the LGH and at the RHH was of an appropriate standard. However, by then, the hypoxic brain injury he had suffered during birth meant he had no hope of survival.

Comments and Recommendations

The circumstances of KN's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I convey my sincere condolences to the family and loved ones of KN.

Dated: 8 February 2022 at Hobart in the State of Tasmania.

Simon Cooper
Coroner