Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 35/14

I, Sarah Helen Linton, Coroner, having investigated the death of ***Baby B (name suppressed)*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth****, on* ***30 September – 10 October 2014****, find that the identity of the deceased person was* ***Baby B (name suppressed)*** *and that death occurred on* ***9 May 2010*** *at* ***(address suppressed)*** *as a result of* ***severe hypoxic ischaemic encephalopathy due to apparent perinatal asphyxia*** *in the following circumstances:*

Counsel Appearing:
Ms K Ellson assisting the Coroner.
Mr D Harwood (State Solicitor's Office) appearing on behalf of Metropolitan Health Services.
Ms B Burke (ANF) appearing on behalf of Corrinne Andrew, Susan Cudlipp and Michelle Benn.

SUPPRESSION ORDER

The names of the deceased, the deceased's family and any identifying information are suppressed. The deceased is to be referred to as Baby B.

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INTRODUCTION

1. Baby B was born at home on 30 April 2010 after a short labour. Assisting at the delivery were two midwives. On delivery, Baby B was noted to be floppy and not breathing and the midwives were unable get him to respond.

2. An ambulance was called and Baby B was taken by ambulance to Armadale Kelmscott Memorial Hospital. After various interventions by the doctors, Baby B eventually began breathing on his own. However, 80 minutes had now elapsed from the birth, which was a significant indication of the severity of the neurological insult Baby B had sustained.

3. Later that morning Baby B was transferred to Princess Margaret Hospital for Children (PMH). Over the next few days, testing was performed and on the basis of all of the information obtained the treating neonatal team concluded that Baby B's long term developmental outcome was extremely poor with a very likely severe neurological handicap in the future. As a result of these assessments, Baby B was taken home by his family and he was given palliative care until he died peacefully at home on the morning of 9 May 2010.

4. One of the treating specialists from PMH, Dr Corrado Minutillo, completed a certificate indicating the cause of death was hypoxic ischaemic encephalopathy - severe due to perinatal asphyxia.[1] Given the circumstances of the birth, the death was reported to the Office of the State Coroner and, as part of the investigation, it was decided that it was desirable that an inquest be held into the circumstances surrounding the death of Baby B.

5. I held an inquest into the death of Baby B, as part of a joint inquest into three deaths, at the Perth Coroner's Court from 30 September to 10 October 2014. All three deaths involved babies born at home in circumstances that

[1] Exhibit 3, Tab 1, Medical Certificate of Cause of Stillbirth or Neonatal Death.

were contrary to recognised standards and guidelines for home births in Australia.

6. A primary focus of the inquest into the death of Baby B was to clarify the circumstances in which he came to be born at home with the assistance of two midwives from the Community Midwifery Program (CMP), contrary to the recommendation of an obstetrician from King Edward Memorial Hospital (KEMH). An issue also arose about Baby B's mother's release home from KEMH on the day she went into labour.

7. Oral evidence was heard at the inquest from Baby B's mother and father and the two CMP midwives who attended the birth. Evidence was also given by other midwives and medical practitioners who had involvement with Baby B's mother during the pregnancy, and also by doctors involved in the care of Baby B after his birth.

8. In addition, evidence was given by various experts who had reviewed the matter, including Dr Christopher Griffin, a Consultant Maternal Foetal Medicine Specialist at KEMH and Dr Christine Catling, a qualified midwife and Lecturer in Midwifery at the University of Technology, Sydney, and experts in relation to policies governing home births managed by the CMP.

PAST OBSTETRIC HISTORY OF BABY B'S MOTHER

9. Baby B's mother had previously given birth to a daughter in the Netherlands. There is strong community support for home births in the Netherlands and, although the home birth rate is falling, recent studies suggest about 20% of women in the Netherlands still give birth at home.[2] Therefore, when she became pregnant with her first child, Baby B's mother and her husband discussed their birth choices and chose a home birth with the understanding that it was a normal and mainstream choice in that country.[3]

[2] Exhibit 1, Tab 12.
[3] Exhibit 2, Tab 3 [3].

10. The labour commenced at home, as planned, but Baby B's mother requested to transfer to hospital a few hours into the labour as her dilation was not progressing and she was feeling frustrated. The baby was born shortly after arrival at hospital.[4] Despite being monitored on arrival in hospital, with no signs of foetal distress being detected, the baby was 'flat' on delivery and required emergency resuscitation and some time in intensive care following her birth.[5] Despite testing, including genetic testing, of the child and examination of the placenta, the cause of the asphyxia was unable to be identified and it was simply categorised as "unexpected perinatal asphyxia without apparent cause".[6]

11. Fortunately, despite this unexpectedly bad start, Baby B's parents' first child made an uneventful recovery and has gone on to grow and develop normally.[7]

ACCEPTANCE ON TO THE COMMUNITY MIDWIFERY PROGRAM

12. Baby B's mother discovered she was pregnant with Baby B in 2009, having moved to Perth, Western Australia sometime before.[8]

13. Baby B's mother was still keen to give her baby what she considered to be "the best start, which was a natural birth without drugs or intervention."[9] After speaking to friends and acquaintances, she had not met someone who had experienced such a birth in the hospital system in Perth.[10] She had, however, met numerous women who had given birth with the assistance of the Community Midwifery Program (CMP) and spoke positively of the experience.

[4] T 127; Exhibit 2, Tab 3 [3].
[5] T 128; Exhibit 2, Tab 3 [4].
[6] T 128; Exhibit 2, Tab 3 [6]; Exhibit 3, Tab 3D & 4M.
[7] Exhibit 1, Tab 5, 1.
[8] T 128.
[9] T 128.
[10] T 128.

14. The CMP is managed by the North Metropolitan Health Service (NMHS). It is a midwifery group practice that offers home birthing and domino (in hospital) services to low risk pregnant women.[11] The model aims to ensure clients are offered continuity of care throughout the pregnancy continuum.[12] Each client who is approved a place in the CMP is allocated a primary midwife to care for her in the home and community environment during her pregnancy, throughout labour and delivery and up to four weeks' postpartum. A backup midwife is also allocated to cover absences of the primary midwife and to assist at the delivery.[13]

15. The continuous care model of the CMP was similar to what Baby B's mother had experienced in the Netherlands and is a model that she believed in strongly.[14]

16. Therefore, after attending a CMP information night,[15] Baby B's mother filled in an application form to be accepted into the CMP for the birth of her second child. Baby B's mother was unsure whether she would be accepted on to the program, given her obstetric history, which she outlined briefly in the application.[16]

17. The reason for Baby B's mother's concern is because the CMP inclusion criteria is limited to women deemed to have 'low risk' pregnancies, based on the Australian College of Midwifes' National Midwifery Guidelines for Consultation and Referral (National Midwifery Guidelines).[17] The CMP Midwifery Protocol sets out a number of criteria, any of which, if met, will exclude a pregnant woman from being accepted onto the CMP on the basis of the increased level of risk.[18]

18. At the time the CMP received the application from Baby B's mother on 25 August 2009, the only one of the specified

[11] Exhibit 2, Tab 13, 2 - 3.
[12] Exhibit 2, Tab 13, 3.
[13] Exhibit 2, Tab 13, 3 - 4.
[14] T 128 – 129.
[15] T 128.
[16] Exhibit 3, Tab 4N.
[17] Exhibit 2, Tab 13.1 & 13.2.
[18] Exhibit 2, Tab 13.1 & 13.2.

excluding criteria that may have applied to her was whether she had an "obstetric history which would deem home birth an unsafe option."[19] However, it appears from the examples given that this factor was more focussed at first instance on medical conditions relating to the woman during previous pregnancies and birth, rather than the child that was born.

19. Certainly in the case of Baby B's mother, her obstetric history, which included a significant unexplained neonatal emergency, was not seen as meeting this criterion at the time her application was initially received as she was accepted on to the CMP despite disclosing this history.

20. It was observed during the inquest that following Baby B's death, the inclusion criteria for the CMP was amended specifically to address the circumstances of this case, and an additional exclusion criterion was added for a woman who "has a child with a significant Neonatal history."[20] Therefore, Baby B's mother would have been excluded from the program if the criteria in existence today were applied to her case. But this was not the case in August 2009 and, subject to the opinion of a consultant obstetrician at any stage, she was deemed suitable to join the program.[21]

INITIAL ANTENATAL CARE BY MS BENN

21. After being accepted onto the CMP on the basis of her application information, Baby B's mother was assigned registered midwife Michelle Benn,[22] who worked for the CMP at that time, as her primary midwife. It was then Ms Benn's task to arrange an initial booking with Baby B's mother to complete a full assessment.[23]

[19] Exhibit 2, Tab 13.2, 1.
[20] T 258; Exhibit 2, Tab 13, 2 & 13.1.
[21] T 258 - 259.
[22] Ms Benn was a registered nurse and registered midwife at the time, being registered from 1999 until May 2014. She is not currently registered –T 559; Exhibit 4, Tab 2 [2].
[23] T 262.

22. When accepting a place on the CMP, women agree to certain terms of care. This ensures referral and transfer guidelines are clearly understood to protect the safety of the woman and her baby, should complications occur during the pregnancy or birth.[24] In particular, the terms of care include a declaration confirming that the client agrees to consultation with doctors or medical staff at a nominated hospital and referral to hospital, if the need arises during the pregnancy or birth.[25] Baby B's mother signed her 'Terms of Care' document at the initial booking meeting with Ms Benn on 6 November 2009.[26]

23. During that first meeting, Ms Benn performed various health checks and checked the foetal heart and everything appeared fine. They had a long discussion about the previous birth and Ms Benn recalls that at the time she "thought that everything was okay" but she did suggest that they should arrange an early appointment with whichever hospital Baby B's mother chose as the back-up hospital (as per the standard CMP practice) so that an obstetrician could consider the implications of the previous pregnancy.[27]

24. Following the progress notes written by Ms Benn in Baby B's mother's Pregnancy Health Record (pregnancy record), it seems that Ms Benn did not arrange the appointment immediately, but waited until the second visit on 8 December 2009, after a back-up hospital had been chosen. Ms Benn's note records that Baby B's mother was happy with King Edward Memorial Hospital (KEMH) as the back-up hospital and Ms Benn then wrote a referral.[28]

25. The referral indicates it was faxed to KEMH on 10 December 2009. On the referral, Ms Benn clearly indicated that an earlier appointment was requested for the purpose of an obstetrician reviewing the mother's obstetric history. A brief summary of what occurred at the

[24] Exhibit 2, Tab 13, 3.
[25] Exhibit 3, Tab 4M.
[26] Exhibit 2, Tab 13, 3; Exhibit 3, Tab 4M.
[27] T 562.
[28] Exhibit 3, Tab 4A.

first birth was also provided.[29] Additionally, Ms Benn recalled in evidence making a phone call to KEMH to arrange the appointment.[30]

26. An appointment was scheduled promptly by KEMH after receiving the referral. Baby B's mother was asked to attend on 17 December 2009, when she would be approximately 20 weeks' pregnant.[31]

27. According to Ms Benn, Baby B's mother cancelled that appointment,[32] although Baby B's mother did not seem to recall doing so in her evidence.[33] It is certainly the case that Baby B's mother did not see an obstetrician on 17 December 2009. On 31 December 2009, Ms Benn's note records that Baby B's mother had an appointment with KEMH[34] and on 28 January 2010, Ms Benn made a note that the KEMH appointment was "now 17/2/10".[35]

28. It was on that date in February 2010 that Baby B's mother did finally have her first appointment with a KEMH obstetrician. She was 33 weeks' pregnant by this time. Although Baby B's mother recalls being distressed that the appointment was at such a late stage in the pregnancy,[36] there is no evidence that the delay was the fault of Ms Benn or KEMH.

MEETING WITH DR SAUNDERS

29. It was initially arranged that Ms Benn would attend the meeting with the obstetrician and Baby B's parents at KEMH antenatal clinic. Ms Benn explained that Baby B's mother very much wanted a home birth and she was concerned the obstetrician might not allow it, so Ms Benn agreed to attend the appointment and support her and

[29] Exhibit 3, Tab 4J.
[30] T 562.
[31] Exhibit 3, Tab 4I.
[32] T 562 – 563, 565.
[33] T 132; Exhibit 2, Tab 3 [10] – [11].
[34] Exhibit 3, Tab 4A.
[35] Exhibit 3, Tab 4B.
[36] Exhibit 2, Tab 3 [11].

discuss her options with the obstetrician.[37] In hindsight, if this had occurred as planned then it is likely some of the confusion that followed might have been avoided.

30. However, just prior to Ms Benn leaving to go to the appointment, she received a telephone call from the CMP supervisor, Jennifer White, asking Ms Benn to come and see her.[38] Ms Benn was undergoing a performance management process at that time coordinated by Ms Andrew.[39] Concerns had been raised about an incident on 12 February 2010, unrelated to Baby B's mother, and Ms Benn was required to undergo a substandard performance review due to that incident.[40] Ms Benn told Ms White she was going to a meeting with a client to see the doctor at the back-up hospital and Ms Benn recalls that Ms White said it was more important for Ms Benn to attend the meeting with her to discuss the performance management issue.[41] As a result, Ms Benn telephoned Baby B's mother and gave her an excuse for why she could not attend the obstetrician visit with her, as previously arranged.

31. Jennifer White confirmed in evidence that she called Ms Benn on the morning of 17 February 2010 and asked her to attend a meeting in relation to an incident management form she had received. She understood from Ms Benn that she was on her way to an appointment with a client at KEMH but got the impression it was a standard visit. Ms White's evidence was that if Ms Benn had informed her that there was a potential concern about the client, she would have agreed to Ms Benn attending the KEMH meeting with the client and postponing her own meeting.[42]

32. In the end, Ms Benn went to the meeting with Ms White while Baby B's parents met with the obstetrician. All the parties agreed that, given what occurred later, it would

[37] T 567.
[38] T 566 – 567.
[39] Exhibit 2, Tab 13A, 9.
[40] Exhibit 2, Tab 13A, 9.
[41] T 568; Exhibit 4, Tab 2 [5] – [7].
[42] T 282 - 283.

have been better if Ms Benn had been at the obstetric appointment, as it may have helped to clarify issues. However, at the time the significance of that meeting was not apparent.

33. Baby B's parents saw Dr Clifford Saunders, who at that time was working as a Consultant Obstetrician at KEMH (he is now retired).[43] Part of Dr Saunders' role was to see women who were booked in to the CMP to review them medically and determine whether they were an appropriate candidate for home birth by checking that there were no medical conditions which may increase the risks for the woman or the baby.[44]

34. Dr Saunders had the referral from Ms Benn that specifically requested him to review the obstetric history. Dr Saunders obtained the history of the birth of Baby B's parents' first child from Baby B's mother. He was also given a translated version of the hospital report of the birth from the Netherlands. He understood that the hospital's diagnosis was unexpected perinatal asphyxia without apparent cause. [45]

35. Dr Saunders thought the events were unusual, as there was no problem detected before the birth and yet, after delivery, the baby was clearly very unwell. As the cause was not found, he did not think that a recurrent cause could be ruled out. Accordingly, while he thought it was most likely there would be no problems in this pregnancy, Dr Saunders felt that the pregnancy was a high risk pregnancy because of the obstetric history and it was his view that Baby B's mother should not deliver at home.[46]

36. Dr Saunders explained that his reason for recommending against a home birth was because there is "a huge difference between the level of resuscitation that can be performed at home with a bag and mask and what can be

[43] T 157.
[44] T 157.
[45] Exhibit 2, Tab 6.
[46] Exhibit 2, Tab 6.

achieved in hospital by someone skilled in intubation and neonatal resuscitation."[47]

37. However, as there was no suggestion of a detectable antenatal problem having played a role in the first birth, Dr Saunders considered it was reasonable for Baby B's mother to continue her antenatal care with the CMP midwife.[48]

38. During their meeting, Dr Saunders explained his view to Baby B's mother about her unsuitability for a home birth. He recalled her being very upset but thought that she understood his concerns and recommendation for a hospital birth.[49]

39. Dr Saunders then wrote to Ms Benn. In the letter, he stated that he considered that, given the previous history of foetal hypoxia, while recurrence was unlikely, he thought it was too risky for Baby B's mother to have a home birth. He indicated antenatal care could still be provided by Ms Benn and requested Ms Benn ring him with her plan, by which he meant which hospital Baby B's mother had chosen for the delivery.[50]

40. Consistent with Dr Saunders' explanation of what he meant by plan, Dr Saunders made an entry in the KEMH antenatal record indicating that Baby B's mother would discuss with her husband and decide where to deliver and she could continue to have external care from a midwife but "needs hospital delivery."[51]

41. Dr Saunders also wrote an entry in the hand-held pregnancy record so that if the midwives saw Baby B's mother before the letter to Ms Benn arrived, they would be aware of Dr Saunders' message.[52] In his hand-written note, Dr Saunders wrote:

[47] T 161 – 162; Exhibit 2, Tab 6.
[48] T 163; Exhibit 2, Tab 6.
[49] T 161, 163; Exhibit 2, Tab 6.
[50] T 163, 166; Exhibit 3, Tab 4L.
[51] Exhibit 3, Tab 3G.
[52] T 166 – 168.

> I consider that the previous foetal complications make this too high a risk for a home birth. [Baby B's mother] will discuss with midwife where she wants to deliver. I am happy for her to have midwifery care antenatally and need not return to KMH provided she's not delivering elsewhere [meaning another hospital] until in labour or 41 weeks' gestation. Michelle, will you please ring me and let me know the plans?[53]

42. Dr Saunders did not recall ever receiving a telephone call from Ms Benn in response to his request.[54]

43. Baby B's mother described being shocked and distressed when Dr Saunders told her she should not have a home birth and she could not go to the KEMH Birthing Centre.[55] She was quite far along in her pregnancy at that stage and had been assuming that her plan for a home birth was firm and had been making arrangements with that plan in mind.[56] However, she gave evidence that after seeing Dr Saunders she understood that home birth was not an option, as she had signed the terms of care form with Ms Benn at the first meeting which indicated that the obstetrician had the final say.[57] Therefore, as much as she was distressed by Dr Saunders' decision, she "started to prepare for a hospital birth,"[58] including going on a visit to KEMH to become acquainted with its layout and facilities and packing a hospital bag.[59]

44. Similarly, Baby B's father gave evidence that he attended the meeting with Dr Saunders with his wife and understood that Dr Saunders did not think a home birth was a good idea. Therefore, although his wife was upset, they accepted Dr Saunders' recommendation and left.[60]

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[53] T 167 – 168; Exhibit 3, Tab 4B.
[54] T 167.
[55] T 133.
[56] T 135.
[57] T 133, 134 - 135.
[58] T 133.
[59] Exhibit 2, Tab 3 [16].
[60] T 153.

45. The evidence of all three witnesses who were present at the meeting is therefore consistent that Dr Saunders indicated his view that a home delivery was not a suitable option, given the previous birth history. Baby B's parents, whilst understandably disappointed, accepted that under the CMP terms of care, Dr Saunders' view about the place for delivery was decisive and began to make plans for a hospital delivery at KEMH.

46. One would think that this would have been the end of any plans for a home delivery for Baby B's mother. Regrettably, this proved not to be the case.

DISCUSSION WITH MS BENN

47. After Baby B's mother left the meeting with Dr Saunders, she telephoned Ms Benn. She was very upset and crying. She told Ms Benn that Dr Saunders had told her she really shouldn't have a home birth but she couldn't understand why it wasn't a good idea. Ms Benn suggested she would try to make an early appointment to see Baby B's mother to discuss it.[61]

48. Baby B's mother met with Ms Benn on 26 February 2010, approximately one week after her meeting with Dr Saunders. Ms Benn read Dr Saunders' note in the pregnancy record.[62]

49. Ms Benn's entry in the pregnancy record indicates that they discussed the visit with Dr Saunders and Baby B's mother was now considering a hospital birth and was planning to go on the hospital tour (which it seems she then did). According to Ms Benn, at this stage Baby B's mother had not made a decision to definitely have a hospital birth and she "was still pushing for a home birth."[63] This is contrary to the evidence of Baby B's mother and father.

[61] T 133-134, 568 – 569; Exhibit 4, Tab 2 [10].
[62] Exhibit 4, Tab 2 [8] – [9].
[63] T 570.

50. Although in her statement Ms Benn indicated that it was unclear at this stage whether Dr Saunders' final decision was that the birth must be in hospital,[64] Ms Benn accepted in her oral evidence that her understanding of Dr Saunders' view at that stage, having read his letter and pregnancy record entry, was that he couldn't understand what had happened with the first birth and, although he thought it unlikely to reoccur, she should have a hospital birth.[65]

51. In those circumstances, Ms Benn says she was unsure whether Baby B's mother was still eligible for a home birth on the CMP so she took the matter to her manager, Corinne Andrew.[66]

DISCUSSION BETWEEN MS BENN & MS ANDREW

52. Ms Benn met with her manager, Ms Andrew, sometime after the home visit on 25 February 2010 and before the next home visit on 10 March 2010.[67] Ms Andrew was the acting manager of the CMP at the time.[68] Although it was a pre-arranged performance management meeting, Ms Benn took the opportunity of the meeting to raise her concerns about Baby B's mother with Ms Andrew.[69]

53. Ms Benn had received the letter dated 17 February 2010 from Dr Saunders by this time.[70]

54. Ms Benn recalls that she gave the letter from Dr Saunders to Ms Andrew and explained to Ms Andrew that her client, Baby B's mother, desperately wanted a home birth and was very upset after her visit with Dr Saunders.[71]

[64] Exhibit 4, Tab 2 [13] – [14].
[65] T 570.
[66] T 570.
[67] T 571.
[68] T 298.
[69] T 571 – 572.
[70] T 572.
[71] T 572.

55. According to Ms Benn, Ms Andrew's response was that it was a low risk birth,[72] she had a previous mother who had the same situation and went on to have a home birth without any complications, and on that basis she was happy for Baby B's mother to stay on the program and be supported by CMP to have a home birth.[73] Ms Benn's evidence was that Ms Andrew then said she would contact Dr Saunders by email or telephone and tell him of her decision to support the mother's choice of a home birth.[74]

56. Because she believed Ms Andrew was going to contact Dr Saunders, Ms Benn did not contact Dr Saunders herself.[75] She accepted during the inquest that, in hindsight, it would have been best for her to make contact with Dr Saunders herself, as per his request.[76]

57. Ms Andrew agreed that a meeting took place with Ms Benn about Baby B's mother, during which she was shown a copy of Dr Saunders' letter.[77] Ms Andrew could not recall the date of the meeting but noted that they had the letter from Dr Saunders at the time, which had been received by the CMP on 22 February 2010, so it was after that date.[78]

58. Ms Andrew's account of the meeting with Ms Benn differs significantly from Ms Benn's account.

59. In her statement, Ms Andrew recalled that after reading Dr Saunders' letter she told Ms Benn it appeared Baby B's mother had a choice regarding her care and that she would email Dr Saunders to verify the appropriate care options.[79] Although the reference to "care" in Ms Andrew's statement could be construed widely, Ms Andrew clarified during the inquest that when she referred in her statement to "care" options, she meant the "antenatal care arrangements" only.[80]

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[72] Exhibit 4, Tab 3 [15].
[73] T 572; Exhibit 4, Tab 3 [15].
[74] T 572; Exhibit 4, Tab 2 [15].
[75] T 573.
[76] T 573, 602.
[77] T 301.
[78] Exhibit 4, Tab 3 [8].
[79] Exhibit 4, Tab 3 [12].
[80] T 290.

60. Ms Andrew's evidence at the inquest was that there was no ambiguity in Dr Saunders' letter about the place of birth, as he clearly stated in the letter that he felt it was too high risk for Baby B's mother to continue with the plan of a home birth.[81] At the time of reading the letter, Ms Andrew did not understand Dr Saunders to be leaving open the possibility of a home birth with the CMP.[82] It was only the place of her antenatal care (ie, provided by the CMP or the hospital clinic) that was ambiguous.[83]

61. Ms Andrew indicated that her understanding of CMP policy at the time was that if the obstetrician deemed a home birth unsuitable, the CMP staff could not continue to support a home birth and could only support a hospital birth unless the obstetrician has changed his or her decision.[84]

62. Consistently with her understanding of the policy, Ms Andrew expressly denied that she said to Ms Benn that it was a low risk pregnancy[85] and also denied that she discussed with Ms Benn the possibility that she would email Dr Saunders and indicate to him that she would support a home birth.[86] She stated that she did not have the jurisdiction to make such a decision over that of an obstetrician.[87] Her evidence was that there was never any question in her mind that Baby B's mother would deliver at home.[88]

63. Ms Andrew maintained that what she undertook to do at the conclusion of the meeting was to email Dr Saunders only in relation to Baby B's mother's antenatal care options.[89]

64. Ms Andrew accepted that at the end of the meeting she had taken on the responsibility to contact Dr Saunders,

[81] T 291, 300 - 301.
[82] T 301.
[83] T 290 – 291, 293.
[84] T 294, 296 – 297.
[85] T 302.
[86] T 292, 302.
[87] T 292.
[88] T 293.
[89] T 301 - 302.

but she would have expected to be reminded by Ms Benn or have the matter followed up by Ms Benn to see the outcome of her discussion with Dr Saunders.[90] In any event, the discussion was only to be about antenatal options, not the place of birth.

65. When asked during the inquest if she could explain the difference between her recollection and that of Ms Andrew, Ms Benn could not offer an explanation.[91] Ms Andrew also did not proffer an explanation as to why their accounts might differ so markedly but was adamant the conversation with Ms Benn that Baby B's mother was a low birth risk and she would support her to have a home birth did not occur.[92] In support of her statement, she said it was not her practice to go against obstetrician recommendations.[93]

66. Given the direct conflict in the evidence between Ms Benn and Ms Andrew as to the outcome of this significant meeting, and noting they were both represented by the same counsel, I raised the issue of the conflict with their counsel, Ms Burke. Ms Burke indicated that the conflict had been discussed with both Ms Benn and Ms Andrew and they accepted that they had different recollections. It was left for me to decide how to reconcile the two accounts, which were markedly different on an important point.[94]

67. In order to do that, I need to take into account the later evidence in relation to what conversations took place between Ms Benn and Ms Andrew when Baby B's mother attended the Maternal Fetal Assessment Unit late in the pregnancy. Therefore, I will come back to this issue later in this finding.

[90] T 294.
[91] T 589.
[92] T 295.
[93] T 295.
[94] T 296.

DISCUSSION ABOUT RENEWED POSSIBILITY OF A HOME BIRTH

68. Baby B's mother recalls Ms Benn telephoned her and told her about the renewed possibility she could have a home birth with the CMP.[95] Ms Benn told her that she had discussed the matter with Ms Andrew and that she felt Dr Saunders was "overreacting or being over cautious,"[96] due to his exposure to so many high risk pregnancies at KEMH.[97] Ms Benn then told her that she was happy to support Baby B's mother at home and Ms Andrew had left it in Ms Benn's hands. Ms Benn explained that the CMP criteria involved looking at each pregnancy on its own merits and according to the criteria she still felt that Baby B's mother was eligible for a home birth.[98] Baby B's mother did, however, understand that if she chose to give birth in hospital, Ms Benn would also attend the hospital and support her there.[99]

69. Ms Benn does not mention a telephone call but agreed that at the next meeting with Baby B's mother she told Baby B's mother that her manager was happy to support her if she wanted to have a home birth.[100] She understood that Baby B's mother was still weighing up her choices at that time.[101]

70. Irrespective of how Baby B's mother first became informed of the change, it was agreed by the witnesses that she was told by Ms Benn that, contrary to what she had been told by Dr Saunders, a home birth with the support of the CMP midwives remained an option for her.

71. When Baby B's mother telephoned her husband to tell him of the renewed possibility of a home birth, he was "flabbergasted"[102] as they had resigned themselves to the idea it was going to be a hospital birth. He understood

[95] T 133.
[96] T 133.
[97] T 134.
[98] T 143.
[99] T 142.
[100] T 573.
[101] T 573 - 574.
[102] T 153.

from his wife that the midwives had full confidence that it would be fine and he accepted their opinion and indicated his support for whatever choice Baby B's mother made.[103]

MEETING WITH BACK-UP MIDWIFE

72. In addition to Ms Benn as the primary midwife, the CMP also allocated a back-up midwife to Baby B's mother. The back-up midwife was Susan Cudlipp. Ms Cudlipp is a registered midwife who had been working for the CMP for approximately three years at that time.[104]

73. The normal CMP practice was for the primary midwife to have the ongoing care of the client and conduct the initial visits. The back-up midwife would only meet the client when the pregnancy was approaching the 36 week stage[105] and it was still planned to be a home birth.[106]

74. Ms Cudlipp's first 'back-up' visit with Baby B's mother took place on 19 March 2010 when she was about 36 weeks' gestation.[107] She had not discussed the case with Ms Benn before the visit, so her expectation was that it was a routine back-up visit for a home birth.[108]

75. When Ms Cudlipp arrived, she was struck immediately by the fact that Baby B's mother was quite distressed and angry. According to Ms Cudlipp, virtually the first thing Baby B's mother said to her was, "Well, I'm not sure if I'm going to be birthing at home or in hospital."[109] Ms Cudlipp had not looked at the pregnancy record at this stage so she asked her why that was the case. Baby B's mother told Ms Cudlipp she had had an appointment with Dr Saunders and he had told her "he didn't feel she should birth at home, and she didn't quite know what she was going to do at that stage."[110] Baby B's mother also

[103] T 153.
[104] T 309.
[105] T 317.
[106] T 319.
[107] Exhibit 4, Tab 1 [13].
[108] T 317.
[109] T 317.
[110] T 317.

explained that Dr Saunders' view was based on the unexpected need for resuscitation of her first baby.[111]

76. Baby B's mother provided Ms Cudlipp with the translated copy of the birth record of her first child and she read it and then discussed its contents with Baby B's mother.[112] Ms Cudlipp asked Baby B's mother what Dr Saunders had said about the previous birth record and she was told that Dr Saunders had admitted that the situation was unlikely to happen again, but he felt that it would be safer to be in hospital.[113]

77. Ms Cudlipp asked Baby B's mother if she had discussed this matter with Ms Benn and was told that she had, and that Ms Benn had discussed it with her manager. They had said it was up to Baby B's mother whether or not she would have a hospital or home birth.[114]

78. After they had talked for a while, Ms Cudlipp read through the notes in the pregnancy record.[115] These notes included Dr Saunders' note in the progress notes but Dr Saunders' letter was not included with the pregnancy record. Ms Cudlipp did not see the letter from Dr Saunders until after the birth.[116] Ms Cudlipp accepted that the letter is clearer as to Dr Saunders' intention and her evidence was that if she had seen the letter it would have prompted her to question the birth plan for Baby B's mother and make more enquiry.[117]

79. As it was, Ms Cudlipp read the pregnancy record notes only. In the context of what she had been told by Baby B's mother, she considered Dr Saunders' note to be ambiguous because he had written to let him know the mother's plans as to where she wanted to deliver.[118] Therefore, she believed the place of birth (ie, whether in hospital or at home) was still to be decided by the mother,

[111] T 317 – 318.
[112] T 318.
[113] T 318.
[114] T 318 – 319; Exhibit 4, Tab 1 [18].
[115] T 319.
[116] T 309.
[117] T 310, 339 - 340.
[118] T 320 - 321; Exhibit 4, Tab 1 [20].

in negotiation with Dr Saunders.[119] Her understanding that home birth was still an option was reinforced by the note made by Ms Benn subsequent to Dr Saunders' note, indicating that Baby B's mother was "considering" hospital birth rather than definitely having a hospital birth.[120]

80. Ms Cudlipp documented her meeting with Baby B's mother in the pregnancy record. She noted they had a long discussion about the first birth and Baby B's mother's fears following the 'advice' from Dr Saunders. Ms Cudlipp also wrote that she had reassured Baby B's mother that she would support her to birth at home and would attend earlier than usual at her request to ensure that two midwives were definitely present at the birth.[121]

81. Ms Cudlipp acknowledged during the inquest that the record she made of the meeting was inadequate and that her choice of words was less than ideal.[122] In particular, in reference to the sentence that she had reassured Baby B's mother that she would support a home birth, Ms Cudlipp said, "Those nine words have haunted me ever since I wrote them…because it was an unwise choice of words."[123] Ms Cudlipp accepted that, if you read them as they were written, the words conveyed the impression that she had strongly supported a home birth, without mention of a hospital birth.[124]

82. However, Ms Cudlipp's evidence was that she actually told Baby B's mother that she needed to decide where she felt was the best place for her to birth, and they would support her whether it was in hospital or in the home, under the belief that she had that choice.[125] They discussed Ms Cudlipp attending at an early stage, if she chose a home birth, but they also discussed domino birth and hospital birth generally.[126] Ms Cudlipp said that she did not intentionally sway Baby B's mother as to which place

[119] T 320, 323.
[120] T 323, 339; Exhibit 3, Tab 4B.
[121] T 325; Exhibit 3, Tab 4C.
[122] T 325 – 326.
[123] T 326.
[124] T 326.
[125] T 325.
[126] T 326 – 327, 330.

of birth to choose, but she did want Baby B's mother to feel confident in the midwives and address her fears.[127] Ms Cudlipp accepted that the outcome of that may have been that Baby B's mother felt reassured to make a decision to have a home birth after speaking with Ms Cudlipp.[128]

83. A few days after her meeting with Baby B's mother, Ms Cudlipp telephoned Ms Benn to try to clarify the plan for the birth. Ms Benn told her that she had discussed it with Ms Andrew and that Ms Andrew was going to discuss it with Dr Saunders and they were to continue to provide care as per normal in the meantime.[129] Ms Cudlipp also recalled another brief conversation with Ms Benn sometime later, when she asked whether Baby B's mother had decided and Ms Benn told her that Baby B's mother kept changing her mind.[130] She was never told the outcome of any discussion between Ms Andrew and Dr Saunders and didn't think to speak to Ms Andrew about the matter herself at any time.[131]

HOME VISIT 24 MARCH 2010

84. The next home visit took place on 24 March 2010. Ms Benn's note indicates that Baby B's mother reported feeling much better about the birth after meeting Ms Cudlipp.[132] Ms Benn recalls that Baby B's mother indicated that now that she had Ms Cudlipp and there was a plan to have two midwives attend early, "she felt happier to go the home birth route."[133] This statement indicates Baby B's mother was still seeking reassurance about the choice to have a home birth and Ms Benn believed she hadn't made a firm decision.[134] However, they did discuss what supplies would need to be purchased in advance of a home birth.[135]

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[127] T 327, 330 - 331.
[128] T 327
[129] T 324.
[130] T 328.
[131] T 328 - 329.
[132] Exhibit 3, Tab 4C.
[133] T 575.
[134] T 575.
[135] T 575.

85. Ms Benn had not, at this stage, discussed with Ms Andrew the outcome of her anticipated conversation with Dr Saunders. At the inquest, Ms Benn attributed her failure to follow up this important issue to the fact that she was undertaking the performance management, which she described as extremely stressful and had caused her to take stress leave, as well as being inundated with work. These factors caused her to forget to ask Ms Andrew about her conversation with Dr Saunders.[136]

HOME VISITS 31 MARCH 2010 TO 27 APRIL 2010

86. By the time of the next home visit on 31 March 2010, Baby B's mother had purchased most of the equipment needed for a home birth.[137] This is suggestive of a decision having been made. There is a notation about Baby B's mother having written a birth plan at that stage.[138] Baby B's mother described the birth plan and confirmed it was written on the assumption it would be a home birth.[139]

87. Ms Benn could not recall any details of the birth plan and discussion of a birth plan did not prompt her to follow up with Dr Saunders.[140]

88. The following visit was conducted by Ms Cudlipp, as Ms Benn was unwell. This visit occurred on 7 April 2010. Ms Cudlipp's note of the visit simply records some observations about the health of the baby and the mother.[141] Although it is not noted down, Ms Cudlipp recalls that she asked Baby B's mother whether she had made a decision and Baby B's mother told her she was having a home birth, although she was still a little unsure and had a few doubts.[142] They did not discuss the matter further.

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[136] T 576.
[137] T 576; Exhibit 3, Tab 4D.
[138] Exhibit 3, Tab 4D.
[139] T 136.
[140] T 577.
[141] Exhibit 3, Tab 4D.
[142] T 329.

89. Ms Benn recalled receiving a telephone call from Ms Cudlipp after this visit and Ms Cudlipp indicated that Baby B's mother was still thinking about her plan but might be going to choose a home birth.[143]

90. The next visit by Ms Benn occurred on 14 April 2010. At that stage, Baby B's mother was apparently still considering whether she would have a water birth.[144] Ms Benn accepted that this pointed towards a firm decision having been made by Baby B's mother for a home birth by that stage.[145]

91. The final antenatal home visit was by Ms Benn on 27 April 2010. No discussion about the place or manner of birth appears to have occurred on this occasion, suggesting the birth plan was now settled.

92. Baby B's mother's evidence was that she was reassured by Ms Benn's confidence that she could give birth safely at home and trusted her opinion, and the opinion of the other CMP midwives, over Dr Saunders as she "felt that they were more the experts on natural birth."[146] On that basis, she ultimately decided to try to give birth to Baby B at home rather than in hospital.

ATTENDANCE AT MFAU

93. A few days later, on 29 April 2010, Baby B's mother rang Ms Benn and told her that she had a headache, was experiencing ringing in her ears and wasn't feeling well. Ms Benn was in a meeting with Ms Andrew when she received the call so Ms Benn asked Ms Andrew for advice.[147]

94. Ms Benn's recollection is that Ms Andrew told Ms Benn to call Dr Saunders and tell him about the reported symptoms. Ms Benn says she then called Dr Saunders

[143] T 579.
[144] T 578; Exhibit 3, Tab 4D.
[145] T 578.
[146] T 134, 143.
[147] T 580.

who told her to send Baby B's mother in to see the Maternal Fetal Assessment Unit at KEMH (MFAU). This unit assesses pregnant women over 20 weeks' gestation who present with maternal or foetal complaints or concerns at KEMH.[148] Based on their assessment, the patient is either discharged or admitted to hospital.[149]

95. Ms Benn did not take the opportunity during her telephone call to Dr Saunders to discuss his previous dealings with Baby B's mother. According to Ms Benn, this also did not prompt a conversation between Ms Benn and Ms Andrew about the issue of Dr Saunders' view about whether a CMP-assisted home birth was allowed.[150] Ms Benn said it didn't occur to her at the time.[151] In her statement, she stated that she was not aware at that time that Ms Andrew had not spoken to Dr Saunders regarding the mother's place of birth.[152]

96. Ms Andrew, on the other hand, agrees that they discussed the client's ringing in the ears and Ms Andrew suggested Ms Benn tell her to go to MFAU. Ms Andrew does agree that she told Ms Benn to call Dr Saunders as well, but her evidence was that this was in the context of having been reminded by the call that she had never emailed Dr Saunders. At that time, Ms Andrew says she asked Ms Benn if Ms Benn had discussed the case with Dr Saunders, as Ms Andrew had not emailed him. Ms Benn told her she had not spoken to Dr Saunders, so Ms Andrew recalled asking her to do so.[153] Interestingly, Ms Andrew agreed in questioning that the purpose of asking Ms Benn to have a discussion with Dr Saunders at that time was "[t]o confirm the birth plan. Yes."[154] That is inconsistent with Ms Andrew's earlier evidence that the only area of doubt was in relation to the antenatal care and not the place of birth.

[148] Exhibit 2, Tab 21 [8].
[149] Exhibit 2, Tab 21 [9].
[150] T 580.
[151] T 581.
[152] Exhibit 4, Tab 2 [25].
[153] Exhibit 4, Tab 3 [14]; 301.
[154] T 301.

97. When I then followed this line of questioning by asking Ms Andrew what she was expecting Ms Benn to discuss with Dr Saunders at that late stage, her answer was, "I – to be honest, I'm not sure."[155] Ms Andrew accepted that it couldn't have been in relation to who was to provide the antenatal care, given the stage in the pregnancy.[156]

98. When I put to Ms Andrew that Ms Benn's version of events, namely that the reason Ms Andrew was originally going to contact Dr Saunders was to discuss the place of birth, was more consistent with a need to contact Dr Saunders when the mother was post-term, the most that Ms Andrew could come up with was that since Dr Saunders had asked to be contacted, she thought Ms Benn should contact him, even at that late stage.[157]

99. It was never put to Dr Saunders by counsel for Ms Benn and Ms Andrew that he was telephoned by Ms Benn the night of 29 April 2010. However, given Ms Benn's evidence was that she did not try to prompt Dr Saunders' memory of meeting Baby B's mother during the call, there is no reason that he would be likely to have remembered the call if he had been asked. As a consultant obstetrician at KEMH he would have received many such calls daily, and there is no reason that this one would have stood out for him.

100. After speaking to Dr Saunders, Ms Benn telephoned Baby B's mother and told her to go to the MFAU. Ms Benn also telephoned the MFAU to tell them that Baby B's mother was on her way in for assessment.[158] Ms Benn then met Baby B's mother at the MFAU after her meeting with Ms Andrew had finished.[159]

101. The MFAU Admission form shows that Baby B's mother was assessed at 5.00 pm on 29 April 2010 by a registered midwife, Emma Gates. Her gestation was 40 weeks and 9

[155] T 304.
[156] T 304.
[157] T 304 - 305.
[158] T 789.
[159] T 581.

days on that day.[160] Baby B's mother's complaints of ringing in the ears and other symptoms over the last few days were noted and she reported a headache at that time.[161]

102. Ms Benn says she may have done a handover to MFAU staff but she did not discuss with them that Baby B's mother was planning a home birth, and certainly did not raise the fact that it was against obstetric advice. Ms Benn pointed out that Baby B's records were, however, available for MFAU staff to read.[162]

103. Baby B's mother recalls being asked by staff at the MFAU what her birth plan was and she understood that they knew her plan was to birth at home.[163] She did not have a discussion with any MFAU staff about Dr Saunders' view that she was too high risk to be suitable for a home birth.[164] Baby B's mother had, however, understood from the CMP midwives that Dr Saunders had been contacted and was aware of the change in birth plan and accepted it,[165] so there is no reason why she would have been expected to mention their original meeting.

104. While at the MFAU, a cardiotocograph (CTG) was done to check the foetal wellbeing at 5.17 pm.[166] While they were performing this first CTG, Ms Benn could see that Baby B's mother was experiencing uterine activity, which she had a suspicion were contractions (although uterine activity can also apparently often be seen on a CTG when a woman is not in labour).[167] Ms Benn decided to go home in case Baby B's mother went into labour, so that she wouldn't go over her allowed working hours and would be rested and ready to support her.[168] As will be seen later on, Ms Benn's instincts proved correct.

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[160] Exhibit 2, Tab 21.1.
[161] Exhibit 2, Tab 21.1.
[162] T 594 – 595.
[163] T 139 – 140, 150.
[164] T 140.
[165] T 134, 142, 149 - 150.
[166] Exhibit 2, Tab 21 [25].
[167] Exhibit 2, Tab 23, 9.
[168] T 582 - 584.

105. Baby B's mother was seen at some stage by a KEMH Registrar, Dr Maaike Moller, who ordered certain testing to be completed, with the plan to call Baby B's mother with the results, on the basis her clinical assessment was reassuring.[169] Baby B's mother was released from the MFAU sometime after the first CTG was finished.

106. Dr Jonathon Yao was working as a Registrar in Obstetrics and Gynaecology at KEMH in 2010 and was working on the evening of 29 April 2010 in the Labour Ward and also providing cover to the MFAU. Dr Yao has no independent recollection of seeing Baby B's mother that evening and he believes after looking at the notes that it is likely he only reviewed Baby B's mother's CTG traces and did not review her personally.[170]

107. After Baby B's mother was sent home from the MFAU, the first CTG trace was shown to Dr Yao. The trace showed a drop in the foetal heart rate at the point when the CTG was discontinued, so there was no return of the foetal heart rate to baseline before the CTG ended. Without a return to the baseline, Dr Yao could not be reassured of the foetal wellbeing. Accordingly, Dr Yao asked for Baby B's mother to be recalled and a second CTG done to reassure himself of the foetal wellbeing.[171]

108. As a result of Dr Yao's request, shortly after leaving the MFAU Baby B's mother received a telephone call asking her to come back for another CTG. The person calling reassured her that there was nothing wrong but asked her to come back for further testing.[172]

109. Baby B's mother telephoned Ms Benn to say that she had left the MFAU but had then been recalled for another CTG.[173] During that call, Baby B's mother indicated that she thought she was experiencing contractions.[174] Baby B's mother described having felt light tightenings

[169] Exhibit 2, Tab 21 [45], Tab 22 and Tab 23, 9; Exhibit 3, Tab 4, Progress Notes 29.4.2010, MFAU.
[170] T 237, 247; Exhibit 2, Tab 21 [43] – [44].
[171] T 239 – 240.
[172] T 138.
[173] T 583 - 584.
[174] T 583 – 584.

throughout that day at quite an even pace. They weren't uncomfortable. She had apparently mentioned them to a midwife at MFAU and asked if they could be a sign of early labour, but the midwife didn't think it was.[175]

110. Baby B's mother returned to the MFAU and another CTG was performed at 7.23 pm.[176] This time, Dr Yao was happy with the trace, which was reactive with no decelerations noted.[177] He felt the CTGs confirmed the foetal well-being.[178] Dr Yao made a follow up plan for Baby B's mother to reattend for another CTG on 1 May 2010 and a biophysical profile on 3 May 2010. He then discharged her at 8.00 pm.[179]

111. Dr Yao gave evidence that he had not seen the note made by Dr Saunders in Baby B's mother's pregnancy record until a week before the inquest,[180] and the first time he saw the KEMH note in the antenatal record was at the inquest.[181] If he had been aware at the time he saw Baby B's mother that she was planning a homebirth when an obstetrician considered her too high risk for a homebirth, he would have called the on-call obstetrician as she was going against recommendation.[182]

112. Ms Andrew said in her statement that while Ms Benn was at the MFAU she sent her a text asking Ms Benn to "confirm care arrangements with KEMH and Dr Saunders" (I note she didn't specify what *care* she was referring to in the statement).[183] Ms Benn did recall receiving a text from Ms Andrew while she was at the MFAU but her evidence was that the text did not mention anything about contacting Dr Saunders, but simply asked after the wellbeing of Baby B's mother.[184] Ms Benn did not mention whether she replied to this text.

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[175] T 139.
[176] Exhibit 2, Tab 21 [27].
[177] T 240; Exhibit 2, Tab 21 [21].
[178] Exhibit 2, Tab 21 [23].
[179] Exhibit 2, Tab 21 [22] – [24].
[180] T 241.
[181] T 243.
[182] T 243; Exhibit 2, Tab 21 [57].
[183] Exhibit 4, Tab 3 [15].
[184] T 585.

113. Ms Andrew's evidence was that she received a reply from Ms Benn at some stage informing her that Baby B's mother had been sent home to have her baby.[185] This, at least, seems to be consistent with events. Ms Andrew said that she made an assumption from this information that, for reasons unknown, Dr Saunders or other obstetric staff at KEMH were now happy for the birth to take place at home.[186] Ms Andrew did not try to contact Ms Benn or Dr Saunders to find out why this change had occurred.[187] Even on her version of events, Ms Andrew accepted that, in hindsight, she should have made inquiry with Ms Benn as to why Baby B's mother was suddenly being allowed to have a home birth, contrary to Dr Saunders' original recommendation.[188]

114. Ms Benn and Ms Cudlipp also indicated during the inquest that they took some reassurance from the fact that, having been seen at the MFAU, the doctors there were willing to release Baby B's mother to have her baby at home.[189] As is now clear, their belief that Baby B's mother's discharge home was a sign that KEMH medical staff were happy for Baby B's mother to deliver at home was erroneous. Evidence was heard at the inquest from the current Head of Obstetrics at KEMH, Dr Janet Hornbuckle, who explained that the birth plan was not the focus of the MFAU assessment process, which was to confirm maternal and foetal wellbeing.[190]

115. Dr Hornbuckle told the court that following Baby B's death recommendations were made and implemented in relation to improvements to communication and clinical handover surrounding transfers back to the CMP from KEMH, including the MFAU.[191] It is to be hoped that these changes will reduce the chance of a similar misunderstanding between CMP midwives and KEMH hospital staff in the future.

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[185] T 305.
[186] T 301, 305.
[187] T 305.
[188] T 306.
[189] T 331, 333 – 334, 597.
[190] Exhibit 2, Tab 23, 10 – 11.
[191] T 792; Exhibit 2, Tab 23, 11 - 13.

THE LABOUR AND DELIVERY

116. Baby B's parents arrived home from the MFAU at about 9.30 pm. Baby B's mother could still feel the regular tightenings but wasn't certain she was in labour. She spent the next couple of hours walking around until she was convinced she was in labour.[192] She then woke her husband and he got the birthing pool ready while she called Ms Benn.

117. It was approximately midnight when Baby B's mother spoke to Ms Benn. Ms Benn asked her to call again when the contractions felt stronger. Baby B's mother felt they were getting strong quite quickly so she called Ms Benn back not long after.[193] Ms Benn and Ms Cudlipp both arrived at the home at about 1.00 am.[194] At that time Baby B's mother already had a strong urge to push and the labour progressed relatively rapidly thereafter.

118. Baby B's mother had planned in her mind that if the labour went past six hours she would ask to transfer to hospital as that was about the time her daughter had been born.[195] In addition, if it had seemed like anything was going wrong or anyone appeared stressed she would have transferred to hospital.[196]

119. In the end, the labour was short and of less than six hours' duration. Ms Benn and Ms Cudlipp monitored the foetal heart rate intermittently throughout by auscultation and it was normal and reassuring. At 3.15 am, an artificial rupture of membranes was performed and the liquor was clear, with no signs of meconium. The midwives saw no signs during the labour that there was anything wrong with the baby, so the need to transfer to hospital did not appear to arise.[197]

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[192] T 141.
[193] T 141.
[194] T 141; Exhibit 3, Tab 4E, Birth record.
[195] T 142.
[196] T 142.
[197] T 340; Exhibit 2, Tab 5; Exhibit 3, Tab 4E – 4F.

120. Baby B was born at home at 4.05 am on 30 April 2010. Ms Benn and Ms Cudlipp were both still in attendance. His colour appeared good as he was being born,[198] but on delivery Baby B was noted to be floppy and not breathing. He initially also had no heartbeat, but his heart eventually started beating after external cardiac massage and ventilation provided by the midwives. At that point, Baby B was noted to be fully pink but he still did not respond to stimulation and was not breathing on his own. He had an Apgar of 4 at 1 minute and 4 at 5 minutes.[199]

121. An ambulance was called as a Priority One a few minutes after the birth. The ambulance crew arrived at 4.19 am and took over resuscitation from the midwives. They transported Baby B to Armadale Kelmscott Memorial Hospital, arriving at 4.47 am.[200] After various interventions by the doctors, Baby B was breathing spontaneously, with a good respiratory effort, by 5.25 am. However, 80 minutes had now elapsed from the birth, which was a significant indication of the severity of the neurological insult Baby B had sustained.[201]

122. Later that morning, Baby B was transferred by the Newborn Emergency Transport Service of WA (NETS) to Princess Margaret Hospital for Children (PMH).[202] At PMH, Baby B was given general supportive management. He was extubated the following day and was initially stable.[203]

123. However, on 3 May 2010, he experienced a seizure, and seizures thereafter remained difficult to control during his stay at PMH. An EEG that had been performed during the first 24 hours of his life was reported as being severely abnormal showing electro-cerebral inactivity. An MRI scan performed on 4 May 2010 also showed evidence of severe hypoxic ischaemic injury. On the basis of the history, the refractory seizures and the very abnormal results of the EEG and MRI, the treating neonatal team concluded that

[198] T 340; Exhibit 3, Tab 4G.
[199] Exhibit 2, Tab 5; Exhibit 3, Tab 4F.
[200] Exhibit 2, Tab 11.
[201] Exhibit 2, Tab 5.
[202] Exhibit 2, Tab 5 and Tab 11.
[203] Exhibit 2, Tab 5.

Baby B's long term developmental outcome was extremely poor with a likely very severe neurological handicap in the future. As a result of these assessments, palliative care was offered to Baby B's parents as a management option.[204]

124. After careful consideration, Baby B's parents decided palliative care was the best option for their son and he was discharged home on 6 May 2010 with follow up care at home from the PMH palliative care service and Silver Chain. They spent time together as a family until Baby B died peacefully at home on the morning of 9 May 2010.[205]

125. One of the treating specialists from PMH, Dr Corrado Minutillo, completed the death certificate. He identified the cause of death as hypoxic ischaemic encephalopathy - severe due to perinatal asphyxia.[206] Given the circumstances of the birth, the death was reported to the Office of the State Coroner pursuant to s 17(3) of the *Coroner's Act*.

CAUSE AND MANNER OF DEATH

126. With the consent of Baby B's parents, Dr Nicholas Smith, a Consultant Perinatal/Paediatric Pathologist, conducted an external and internal post mortem examination of Baby B on 12 May 2010.[207]

127. Dr Smith observed that Baby B appeared to be well-grown and normally developed.[208]

128. Dr Smith's colleagues examined the umbilical cord in a separate examination. There were no signs of infection or inflammation but the umbilical cord was noted to be excessively long. Dr Smith surmised that the unusual length of the umbilical cord meant it was possible for the

[204] Exhibit 2, Tab 5.
[205] Exhibit 2, Tab 5.
[206] Exhibit 3, Tab 1, Medical Certificate of Cause of Stillbirth or Neonatal Death.
[207] Exhibit 2, Tab 4.
[208] T 188.

cord to fall down the birth canal during the process of delivery (known as a cord prolapse). If this occurred, then during contractions the force of the contraction would compress the umbilical cord to the point where the blood supply to the baby would be compromised. Dr Smith could not prove this occurred in the case of Baby B, but thought it a likely possibility.[209]

129. The placenta was also examined and found to be slightly underweight, weighing 373 grams when the normal average weight for this gestation is 537 grams. The placenta otherwise appeared healthy, and no abnormality was noted.[210] It was put to Dr Smith that the small size of the placenta might have played a role in the hypoxic event, as was surmised by another expert. Dr Smith's response was that he would have expected in the case of utero-placental insufficiency to find intrauterine growth restriction (the baby poorly grown), which was not the case with Baby B.[211]

130. Neuropathological examination of Baby B's brain was also undertaken. There were limitations on the examination as the brain was examined in an unfixed state. However, within the context of those limitations, it was found that the brain had become very soft and overloaded with fluid, with a loss of demarcation between grey and white matter. This was a sign of severe diffuse global injury to the brain.

131. In terms of timing of the insult which caused the brain injury, Dr Smith indicated that if it had occurred more than 7 to 10 days before death he would have expected to see small cystic areas in the brain, which he did not find.[212] The microscopic observations suggested to Dr Smith that the insult to the brain occurred around 5 to 6 days before death.[213] Histology of the brain identified ischaemic lesions (due to a poor blood supply or lack of oxygen) occurring at or around the time of birth, with no

[209] T 188 – 189, 197.
[210] T 189.
[211] T 190, 196; Exhibit 2, Tab 4.
[212] T 192.
[213] T 193.

pre-existing lesions.[214] There was also no evidence of any abnormality of development, which would be expected if there had been a pre-existing insult.[215]

132. An area of fresh haemorrhage was also located in the brain, which was described by Dr Smith as a pre-terminal event, occurring as part of the process of dying.[216]

133. Putting all of the findings in context, Dr Smith's firm opinion was that the hypoxic event occurred at or around the time of Baby B's delivery.[217]

134. None of the post mortem examination findings contradicted the cause of death entered by Dr Minutillo on the death certificate.[218]

135. I accept and adopt the conclusion of Dr Minutillo, with whom Dr Smith agreed, and find that the cause of death was severe hypoxic ischaemic encephalopathy due to apparent perinatal asphyxia.[219]

136. Although the actual cause of the asphyxia cannot be conclusively determined, there is no suggestion it occurred other than as part of the natural birth process. Accordingly, I find that the death occurred by way of natural causes.

WOULD A HOSPITAL BIRTH HAVE RESULTED IN A DIFFERENT OUTCOME?

137. It cannot be said with absolute certainty that Baby B would have lived if he had been born in hospital that morning. The answer depends, to a certain extent, on when the hypoxic event occurred. If the main insult occurred sometime well before the birth, then Dr Minutillo suggested that the place of birth would have made little

[214] T 194; Exhibit 2, Tab 4.
[215] T 195.
[216] T 192 - 193.
[217] T 194 – 195, 196; Exhibit 2, Tab 4.
[218] T 195 – 196.
[219] T 202.

difference.[220] However, Dr Minutillo was prepared to defer to the opinion of the pathologist, Dr Smith, in that regard[221] and Dr Smith expressed the very firm opinion that the main hypoxic event occurred at or about the time of delivery.[222]

138. Even proceeding on the basis that the hypoxic event did occur at the time of delivery (due to umbilical cord prolapse as postulated by Dr Smith or some other unknown cause) opinions on whether the outcome might have been different are, to some extent, divided.

139. The neonatologist, Dr Minutillo, agreed with the proposition that resuscitation efforts would have been optimal in a hospital environment.[223] However, in Dr Minutillo's opinion, Baby B still received a reasonable standard of resuscitation and care from the midwives, as demonstrated by Baby B's quick response to simple positive pressure ventilation.[224] Accordingly, Dr Minutillo could not say with any certainty that being resuscitated in a hospital environment rather than at home might have improved Baby B's chances of a different outcome.[225]

140. On the other hand, Dr Christopher Griffin, a Consultant Obstetrician at KEMH, expressed the opinion that Baby B's death could have been prevented if the birth had taken place in hospital, through a combination of close monitoring of the foetus during labour, as well as the presence of a neonatologist for rapid resuscitation. In support of his opinion, Dr Griffin pointed to the different outcome in the case of Baby B's parent's first child, where immediate resuscitation was provided in a hospital environment after a similarly unexplained hypoxic event. As Dr Griffin noted, if one were to assume that the two hypoxic events were the same, the difference in the outcome could be attributed to the availability of

[220] Exhibit 2, Tab 5.
[221] T 210.
[222] T 196.
[223] T 209.
[224] T 209.
[225] T 209.

immediate resuscitation by skilled personnel in the Netherlands.[226]

141. In the end, given the conflict in the expert's opinions and the unknown cause of the hypoxia, I am unable to make a finding that Baby B's death could definitely have been prevented if Dr Saunders' advice had been followed, although I do find Dr Griffin's reasoning persuasive.

142. What I do find is that the safest environment for the delivery of Baby B was in a hospital, where the availability of equipment and specialists was optimal. All of the experts who gave evidence at the inquest agreed strongly that Dr Saunders was right to conclude that, based on the obstetric history, the birth was too high risk to be managed by the CMP midwives at home.[227]

WHY WAS DR SAUNDERS' RECOMMENDATION NOT FOLLOWED?

143. In the end, it always remains the mother's choice as to where she gives birth to her child, barring nature taking matters into its own hands. However, this was not a case where the mother of Baby B was determined to have a home birth, regardless of medical advice. A home birth was her preference, but from the outset Baby B's mother understood that the events surrounding the birth of her first child might preclude that option. She clearly indicated this understanding when she first lodged her application with the CMP.[228]

144. Baby B's mother's conduct throughout her pregnancy demonstrated a willingness to be guided by qualified health professionals as to whether her wish for a home birth could be achieved. In particular, I accept the evidence of Baby B's parents that, while understandably disappointed, they were prepared to follow Dr Saunders'

[226] Exhibit 2, Tab 9 [7].
[227] T 185 (Dr Saunders), 208 (Dr Minutillo), 688 (Dr Griffin); Exhibit 2, Tab 10, 11 (Dr Catling & Dr Homer).
[228] Exhibit 3, Tab 4N.

recommendation to have a hospital birth after their meeting in February 2010.

145. It was only the suggestion and support of the CMP midwives, whose opinions she trusted, that emboldened Baby B's mother, with her husband's support, to go against the recommendation of Dr Saunders and attempt a home birth. But for their intervention, I accept she would have had a hospital birth.[229] This is consistent with her decision to give birth to her third child by elective caesarean at KEMH, as she did not want to take the risk something else might go wrong.[230]

146. The midwives involved agreed that, in hindsight, they should have discussed the matter personally with Dr Saunders and confirmed his recommendation.[231] If he maintained his opinion that only a hospital birth was appropriate, they should have told Baby B's mother that they could only support her in a hospital birth.[232] The question arises, 'why they didn't do so at the time?'

147. Dr Griffin was concerned that the midwives' conduct in supporting a home birth contrary to Dr Saunders' advice was deliberate and was prompted by their intention to show the medical establishment was wrong in assigning this case a high risk status and that, "indeed the midwife knows better."[233] This was in the context of Dr Griffin being a strong supporter for the CMP generally, describing the current program as "superb."[234]

148. Ms Cudlipp, Ms Benn and Ms Andrew denied that they deliberately disregarded Dr Saunders' recommendation.[235] Collectively, the midwives' evidence was that there was a lack of communication between the CMP midwives themselves, as well as between the midwives and the medical staff at KEMH, that resulted in a misunderstanding by the three midwives that Baby B's

[229] T 151.
[230] T 151.
[231] T 298, 602.
[232] T 340 – 341.
[233] Exhibit 2, Tab 9 [8].
[234] T 681 – 682.
[235] T 297, 301, 576; Exhibit 4, Tab 3 [11].

mother was permitted to have a home birth on the CMP program, with the approval of KEMH obstetric staff.

149. It was certainly emphasised by Dr Griffin that "the crux of things is…communication"[236] between health professionals when managing births in the community, and there were clear communication failures in this case.[237]

150. Dr Griffin's noted that the midwives did not respond in a timely fashion to defined communication strategies, in particular to Dr Saunders' written request in the pregnancy record, and by letter, to be contacted.[238] They also did not respond to safety timelines for determining the place of birth. I agree with Dr Griffin's conclusion that these omissions and delays in communication resulted in Baby B's mother being under the misguided belief that a home birth was permitted and, indeed, safe.[239]

151. It is reassuring that Dr Griffin has experienced no such communication difficulties with the CMP midwives himself, with whom he presently has regular contact.[240] Dr Saunders' evidence was that this event was the only time in his long obstetric career that he could recall a midwife failing to follow his advice and request to contact him.[241] This evidence supports the view that the problem was isolated to this case, and not endemic. Why, then, did it occur in this case?

Conflict between the accounts of Ms Benn & Ms Andrew

152. It is apparently not uncommon for CMP midwives to disagree with the advice of an obstetrician, and in those cases they usually raise the matter with the obstetrician directly. This sometimes leads to the obstetrician's decision changing and a home birth being allowed.[242]

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[236] T 681.
[237] T 700 – 701, 704.
[238] T 699 – 701; Exhibit 2, Tab 9 [8].
[239] Exhibit 2, Tab 9 [8].
[240] T 702.
[241] T 180.
[242] T 179, 293, 300, 303 - 306; Exhibit 4, Tab 1 [22].

153. All of the witnesses agreed that Baby B's mother was very upset after she was told by Dr Saunders that he considered her circumstances required a hospital birth. Faced with Baby B's mother obvious distress and the unusual nature of the particular case, Ms Benn raised the matter with her manager, Ms Andrew, who was performance managing her at the time. Ms Benn's evidence was that Ms Andrew expressed the view that it was a low risk birth and indicated she would contact Dr Saunders and tell him that she would support Baby B's mother to have a home birth on the CMP.[243] As noted above, Ms Andrew disagreed with Ms Benn's account, and maintained she understood that it could not be a home birth, but volunteered to contact Dr Saunders about the question of the antenatal care.[244]

154. In my view, the differences in the accounts of Ms Benn and Ms Andrew cannot be attributed simply to a misunderstanding. I cannot reconcile how a conversation about the provision of antenatal care, and an undertaking to clarify who would provide it with Dr Saunders, could be mistakenly interpreted by Ms Benn to be an explicit comment that Ms Andrew would support Baby B's mother having a home birth with the CMP[245] and that is what she would communicate to Dr Saunders.

155. In considering whose account is more credible and reliable, I take the following factors into account:

a) Baby B's mother's distress was due to the refusal of Dr Saunders to permit a CMP-supported home birth, not about who would provide antenatal care. In those circumstances, it is much more likely that Ms Benn would raise the case with Ms Andrew to discuss Baby B's mother's concern about the fact she could not have a home birth, rather than the uncontroversial question of whom was to provide antenatal care;

[243] T 572; Exhibit 4, Tab 2 [15].
[244] T 290, 292 - 293Exhibit 4, Tab 3 [12].
[245] T 572.

b) According to Ms Andrew, when Dr Saunders requested in his letter to advise him of Baby B's mother's 'plan', she believed he was referring to whether Baby B's mother would receive CMP antenatal care or at KEMH. She said she would have expected Ms Benn to have a discussion with Baby B's mother to ascertain where she wanted to have her antenatal care and then call (or ask Ms Andrew or Ms Hudd to call) Dr Saunders to tell him of that antenatal 'plan'.[246] Following that line of thought, it would suggest that Baby B's mother should have been spoken to about her preference for antenatal care first and does not support Ms Andrew volunteering to email Dr Saunders immediately. Ms Andrew explained this on the basis that there was some confusion as to which path for antenatal care Dr Saunders would have preferred. On its face the statement, "I think antenatal care may be by yourself or a midwifery clinic," does not suggest any confusion would arise;

c) In comparison, Dr Saunders' note in the pregnancy record does perhaps have some ambiguity about whether a home birth remained a possibility, given Dr Saunders' reference to Baby B's mother discussing "where she wants to deliver."[247] Read together with Dr Saunders' letter, I think it is clear that he was referring to which hospital, but at the time Ms Benn raised the matter with Ms Andrew there was at least a possibility of some confusion about the place of birth, which would support Ms Benn's version of events;

d) Ms Benn was undergoing substandard performance management at the time, coordinated and managed by Ms Andrew.[248] It is extremely unlikely in those circumstances that Ms Benn would, of her own accord, decide to tell Baby B's mother that the CMP would support a home birth, contrary to Dr Saunders' recommendation. It is far more likely that she would

[246] T 293, 302 - 303.
[247] Exhibit 3, 4B.
[248] Exhibit 2, Tab 13A, 9.

discuss the issue with her manager and follow her manager's advice, which is what she said she did;

e) If, as Ms Andrew claims, her purpose in offering to contact Dr Saunders was solely to discuss his preference for the provision of antenatal care, it is difficult to understand what purpose there could have been in asking Ms Benn to call Dr Saunders on the night Baby B's mother went to the MFAU at well over 40 weeks' gestation. Ms Andrew said in her statement she texted Ms Benn to ask her to confirm 'care arrangements' with KEMH and Dr Saunders,[249] which could be interpreted as antenatal care or possibly care during delivery. Ms Andrew did later agree, when it was put to her by counsel, that she in fact instructed Ms Benn to call Dr Saunders to confirm the birth plan. However, this is at odds with her initial evidence about why she intended to contact Dr Saunders and also with her later evidence when questioned by me.[250] When I questioned her at the conclusion of her evidence, Ms Andrew accepted that at this late stage in the pregnancy, the question of who would provide antenatal care was moot.[251] Ms Andrew was unable to provide any explanation as to what she wanted Ms Benn to discuss with Dr Saunders at that stage, other than that there was a need to call him because no one had contacted him in response to his request.[252] She did not say it was to confirm the birth plan, which is unsurprising as she maintains she always thought it was to be a hospital birth until she was told otherwise in a text from Ms Benn; and

f) Despite accepting that Dr Saunders was clear about the need for a hospital birth in his letter,[253] and knowing that Ms Benn had not contacted Dr Saunders before 29 April 2010,[254] Ms Andrew says that when she received a message from Ms Benn that Baby B's

[249] Exhibit 4, Tab 3 [15].
[250] T 301.
[251] T 304.
[252] T 304 - 305.
[253] T 293, 301.
[254] T 301, 304.

mother had been sent home from the MFAU to have her baby, she made the assumption that the birth plan had now changed and she was suddenly permitted to have a home birth with CMP midwife support.[255] Despite being Ms Benn's manager, and performance managing her at the time, Ms Andrew did not consider it necessary to speak to Ms Benn or Dr Saunders to clarify how this change had occurred and who had authorised it.[256] Ms Andrew accepted in hindsight she absolutely ought to have made enquiry with Ms Benn at the time she found out Baby B's mother was going to deliver at home.[257]

156. Weighing up those various factors, I find that Ms Benn's recollection of events is more consistent with the objective facts and I accept her account of what occurred in that first meeting with Ms Andrew about Baby B's mother as the more reliable and credible version of events.

157. Accepting that Ms Benn honestly believed that Ms Andrew was going to contact Dr Saunders and put forward her support for Baby B's mother being permitted to have a home birth, it is inexplicable that Ms Benn would not follow that issue up with Ms Andrew at a later stage. Ms Benn was aware that Baby B's mother was considering her options in the weeks after seeing Dr Saunders and being told by Ms Benn there was still the possibility of a CMP-supported home birth, but she had not made a final decision until close to the time of birth. Her failure to make enquiry of Ms Andrew was attributed by Ms Benn to work pressure and her troubled state of mind while undergoing performance management.[258]

158. If Ms Benn's failure to follow up with Ms Andrew was simply because she forgot, as she said in her evidence,[259] it does not explain why Ms Benn was not prompted to ask Ms Andrew about the result of her discussion with Dr Saunders when she says Ms Andrew asked her to call

[255] T 301.
[256] T 305, 306.
[257] T 306.
[258] T 576.
[259] T 576.

Dr Saunders on 29 April 2010. Ms Benn says Ms Andrew asked her to call Dr Saunders to tell him about Baby B's mother's symptoms.[260] Even so, one would expect that this conversation would prompt her to ask something about what had been discussed.

159. It is also possible that Ms Benn was told by Ms Andrew at this time that Ms Andrew had not spoken with Dr Saunders earlier, although Ms Benn is not entirely certain.[261] Ms Andrew says she did tell Ms Benn and asked Ms Benn to call Dr Saunders. Ms Andrew also said that she later followed this up with a text to Ms Benn asking her to "'confirm care arrangements with KEMH and Dr Saunders."[262] Ms Benn recalled receiving a text, but only to enquire about Baby B's mother's health.[263]

160. Ms Benn's evidence was that when she called Dr Saunders, she did not take the opportunity to discuss the letter with Dr Saunders at that time, because "[i]t was already full term and we were going the home birth."[264] Certainly, it would have been very late in her pregnancy to have to suddenly tell Baby B's mother that, contrary to what she had been told previously, no one had ever contacted Dr Saunders about approving a home birth, his initial recommendation remained and she was not permitted to have a CMP-supported home birth.

161. Ms Benn's retrospective note, written at 5.50 am on 30 April 2010 after Baby B had been admitted to hospital, shows Ms Benn was well aware that they had gone against the obstetrician's recommendation at that time, which she accepted.[265]

162. I note that once again, in relation to the events on 29 April 2010, there is a conflict between Ms Andrew's and Ms Benn's accounts of what occurred. They both agree Ms Benn was told to call Dr Saunders by Ms Andrew, and

[260] T 580 - 581.
[261] T 581; Exhibit 4, Tab 2 [25].
[262] Exhibit 4, Tab 3 [14] – [15].
[263] T 585.
[264] T 580.
[265] T 588; Exhibit 3, Tab E.

Ms Benn did make the call. Their accounts as to why she was told to call differ. There is potential for misunderstanding in that discussion, although it is concerning if that was the case, given the importance of the discussion.

163. As noted above, Ms Andrew and Ms Benn attributed the failure to follow Dr Saunders' recommendation down to miscommunication, combined with workload pressures. Another possibility is that Ms Andrew and Ms Benn realised during their discussion on 29 April 2010 that Ms Andrew had not contacted Dr Saunders as promised, Ms Benn had failed to follow up and remind her, and now, as the mother was due to go into labour at any moment, they were going to have to tell her that she could not have a CMP-supported home birth. However, this possibility was not put to Ms Andrew or Ms Benn during the inquest and so I give them the benefit of the doubt in that regard.

164. However, even on their own accounts, their failure to communicate with each other, and with Dr Saunders and MFAU staff, resulted in Baby B's mother being permitted to believe it was safe to have a home birth with the CMP, contrary to the obstetrician's advice. Their conduct in that regard was well below the standard one would expect of registered midwives and, in particular, midwives working for the CMP. I make this comment even while acknowledging that their behaviour appears to have been out of character, and there were some systemic issues such a workload pressures that contributed to the situation.

Ms Cudlipp's Role

165. Ms Cudlipp also played a role in Baby B's mother's decision to have a home birth. After hearing both Baby B's mother's evidence and the evidence of Ms Cudlipp, I have no doubt that Baby B's mother responded positively to Ms Cudlipp and found the information she provided, and her expressed willingness to be involved in the birth from an early stage, reassuring. At first glance, Ms Cudlipp's progress note in the pregnancy record gives the impression

that Ms Cudlipp provided this reassurance with the knowledge that a home birth was contrary to the advice of Dr Saunders.

166. However, I accept Ms Cudlipp's evidence that she did not provide that reassurance to Baby B's mother with the knowledge that a home birth was against the obstetrician's recommendation. Ms Cudlipp's uncontradicted evidence was that she did not see Dr Saunders' letter until after the birth,[266] so she was working solely from Dr Saunders' entry in the pregnancy record. I accept that this entry was less clear than the letter, as to the birth plan. When Ms Cudlipp read that entry in the context of being told by Baby B's mother, and later by Ms Benn, that a home birth with the CMP was still being considered, it was not unreasonable of Ms Cudlipp to have understood that Ms Benn and Ms Andrew were negotiating a home birth with Dr Saunders' approval.

167. As the back-up midwife, Ms Cudlipp was entitled to rely upon what she was told by Ms Benn, the primary midwife, unless it was inherently unreasonable or clearly wrong. Given the CMP policy was clear that a home birth could not be supported by the CMP in direct contravention of an obstetrician's advice that a hospital birth was required,[267] it was not surprising that it did not occur to Ms Cudlipp that this was, in fact, what was being facilitated.

168. Ms Cudlipp referred to a series of miscommunications rather than a deliberate intention to flaunt advice.[268] I accept that this was indeed the case in terms of her involvement in this matter.

Outcome

169. The end result was that Baby B's mother was convinced that it was safe to have a home birth in contradiction of expert medical advice that the risk was too high. Sadly, that expert medical advice ultimately was proven to be

[266] T 309.
[267] Exhibit 2, Tab 13, 5.
[268] T 341.

correct and Baby B died. As noted above, he may also have died if born in a hospital. However, his chances of survival could only have been improved if the labour had been monitored, and he had been born in a hospital environment.

EVENTS FOLLOWING THE DEATH OF BABY B

Changes to CMP & MFAU procedures

170. Following the death of Baby B, the Department of Health proposed a number of changes to the CMP, most of which have been completed while some are ongoing.[269] The changes are constructive and predominantly aimed at formalising processes for documenting and communicating information. They are positive changes and are to be commended.

171. Two areas of change are of particular note. The first is the updating of the CMP inclusion criteria to include a significant neonatal history in the exclusion criteria, for the sake of clarifying cases such as that of Baby B's mother.[270]

172. The second is the proposal to establish a formal process of handover between KEMH and the CMP for when a client is discharged from the MFAU, and a form has been created for that purpose.[271] This is an important change as, although the evidence was to the effect that the MFAU staff were not in a practical position to review the birth plan of Baby B's mother and their task was to focus upon the wellbeing of the mother and foetus at that moment in time, the discharge of Baby B's mother back to the CMP seems to have led to some confusion on the part of the CMP midwives as to whether a home birth was condoned by MFAU doctors. Therefore, a formal discharge is an important step in improving communication between the health professionals.

[269] Exhibit 9, Attachment A.
[270] Exhibit 9, Attachment A, Recommendation 4.
[271] Exhibit 9, Attachment A, Recommendation 3.

173. However, one area that does not appear to be covered in the discharge form and the related clinical guideline[272] is any confirmation of the birth plan (separate to the management plan on discharge) and its compliance with CMP protocols. Given what occurred in this case, it would seem to me to be prudent to include on the form some acknowledgement in the initial admission information of the birth plan (as at the time of admission to MFAU) and the name of the obstetrician who has approved the birth plan. Next to that could also be a section confirming that upon discharge, no change to the birth plan is thought necessary at that time. This would avoid any possibility of miscommunication between CMP and MFAU staff as to whether any change to the birth plan is required.

174. Linked in with that concept is the submission of Ms Burke[273] that having the obstetrician who conducts the mandatory CMP client obstetric visit complete a 'tick-a-box' form indicating whether a home birth is approved might be a helpful improvement.[274] I am not attracted to the idea of a form simply requiring an obstetrician to tick a box as to whether they will approve a home birth, as in my view that is actually a less effective form of communication, given it omits the explanation for the opinion. Without the explanation, the mother is less likely to understand the reasoning behind the opinion, and so less likely to be persuaded by it.

175. However, I do accept that it would be helpful if somewhere in the pregnancy record held by a CMP client the obstetrician's approval or refusal of a home birth could be isolated out, with room to also record if that decision is reversed, depending upon changing circumstances during the pregnancy. Merely having the entry somewhere in the progress notes of the pregnancy record makes it difficult to locate quickly for people such as the MFAU staff. I note that Dr Saunders wrote a letter, which was different in terms from the progress note entry, and was arguably clearer as to his intent. Baby B's mother and Ms Cudlipp

[272] Exhibit 9, Tabs 5 and 6.
[273] Counsel appearing on behalf of Ms Benn, Ms Andrew and Ms Cudlipp.
[274] T 599, 708.

did not see that letter, as it was not part of the mother's pregnancy record. If a copy of such a letter was provided to the client, either by the obstetrician (as Dr Griffin indicated was his practice)[275] or the CMP midwife who received it, that letter could be included in the record and would be an easy reference point for any other health practitioners who wanted to quickly identify the obstetrician's view.

176. In making that observation, I am assuming that the obstetrician invariably sends a letter in addition to making an entry in the progress notes. That may not be the case. If it is not, then some other form of a similar nature could be used instead.

RECOMMENDATION

I recommend that the North Metropolitan Health Service give consideration to improving the method of recording the result of the mandatory obstetric review required by Community Midwifery Program policy, so that it is easily accessible for all health professionals in the pregnancy record. I also recommend that the Community Midwifery Program Discharge Form be amended to include a section confirming the birth plan and the obstetrician who has approved it, as well as a section indicating whether the birth plan should be reconsidered due to any issues identified during the Maternal Fetal Assessment Unit admission.

Industrial Relations Commission Proceedings

177. The death of Baby B led to an investigation by NMHS under its Misconduct and Discipline Policy. At the conclusion of the investigation Ms Benn, Ms Andrew and Ms Cudlipp were all terminated without notice. They each subsequently appealed that decision.[276]

[275] T 708.
[276] 2012 WAIRC 01062.

178. Commissioner Harrison found that all three midwives were unfairly terminated as there were a number of failings in the disciplinary process.[277] Orders were made for the reinstatement of Ms Andrew and Ms Cudlipp and compensation.[278] However, in relation to Ms Benn, Commissioner Harrison concluded that reinstatement was inappropriate and only compensation was to be granted.[279]

179. Commissioner Harrison also observed that the results of the review of the CMP triggered by the death of Baby B indicated that at the time of the incident, a number of CMP policies were deficient and may have contributed to Baby B's mother having a home birth contrary to Dr Saunders' investigation.[280]

180. Whilst I take note of the outcome of the Industrial Commission proceedings, I am not bound by the findings of fact made by Commissioner Harrison, given the very different nature and focus of those proceedings and the fact that new evidence was received in these proceedings.

AHPRA Investigation

181. Separate to the coronial investigation, the conduct of Ms Andrew, Ms Benn and Ms Cudlipp was referred to the Australian Health Practitioner Regulation Agency (AHPRA), in association with the Nursing and Midwifery Board of Australia (NMBA). Following investigation by those agencies, various penalties were imposed. Information as to the outcomes was provided to the Court by AHPRA in compliance with s 33(3) (c) of the *Coroners Act*.

182. On 11 March 2014, the Performance and Professional Standards Panel decided that aspects of Ms Benn's conduct in relation to the birth of Baby B constituted unsatisfactory professional performance pursuant to the National Law. Ms Benn was reprimanded and conditions were imposed on her registration pursuant to an

[277] 2012 WAIRC 01062 [422].
[278] 2012 WAIRC 01062.
[279] 2012 WAIRC 01062 [432] – [433].
[280] 2012 WAIRC 01062 [422].

undertaking she signed on 24 December 2010. Ms Benn later chose not to renew her registration as a nurse or midwife and her registration ceased on 31 May 2014.[281] Ms Benn indicated she does not intend to practise nursing or midwifery in the future.[282]

183. In relation to Ms Cudlipp, on 14 December 2012, the NMBA took action under the National Law and cautioned Ms Cudlipp. It also appears that Ms Cudlipp was subject to some temporary conditions on her registration.[283] I acknowledge that Ms Cudlipp expressed her regret about the events that led to Baby B's mother birthing at home[284] and gave evidence that since the events surrounding the birth and death of Baby B her "practice has changed enormously."[285]

184. On 10 May 2013, the Board decided under the National Law to caution Ms Andrew for failing to follow up on Baby B's mother's care and ensure that she did not birth at home, as per Dr Saunders' letter.[286] No penalty was imposed and no restrictions were placed upon her practice by AHPRA.[287]

185. Despite those proceedings having been concluded, s 50 of the *Coroner's Act* still permits me to refer a matter to AHPRA if, in my opinion, it might lead them to inquire into or take any other step in respect of the conduct of a health professional apparently disclosed by evidence or information received during the inquest. In the circumstances, it does not appear to me to be likely that further action will be taken by AHPRA or the NMBA. However, for the sake of completeness and to confirm that no new information has arisen during the inquest that was not available to the Board when considering the matter, it is appropriate that a copy of this inquest finding is provided to AHPRA for its consideration.

[281] Exhibit 8, Tab 1A.
[282] Exhibit 4, Tab 2 [53].
[283] Exhibit 8, Tab 1A.
[284] T 341.
[285] T 340.
[286] Exhibit 8, Tab 1A.
[287] T 307.

COMMENTS ON PUBLIC HEALTH

186. The evidence heard in this inquest, and the other two inquests heard at the same time, highlighted the complex issues surrounding home births in Australia.

187. However, unlike the other two inquests, this was not a case where the mother's and midwives' belief in the importance of a home birth outweighed other considerations. Baby B's mother had already experienced the birth of a child who required emergency care at birth, so her desire for a home birth was tempered by the understanding that safety concerns might make that impossible in her case.

188. An evidence-based review conducted in Western Australia in 2011 found that women who fall into the category of low obstetric risk have comparable neonatal outcomes to women who have a planned hospital birth.[288] However, for women who are not defined as at low risk, the risk of an adverse neonatal outcome during home birth appears to be higher.[289] Therefore, the success of the CMP is based upon properly screening cases to ensure that only women at low risk of adverse pregnancy outcomes are included on the program.

189. With the best of intentions, the CMP midwives attempted to facilitate the mother's wish for a home birth, and their confidence in their ability to perform basic resuscitation perhaps reinforced their belief that it would be safe. However, they did not have the level of medical knowledge and experience of a Consultant Obstetrician, such as Dr Saunders, to properly assess obstetric risk.

190. If one or another of the midwives had taken the opportunity to speak to Dr Saunders, as they knew they could do, they would hopefully have realised their mistake but in any event, I would expect that they would have followed his advice. Sadly, the many opportunities to do

[288] Exhibit 8, Tab 24, *Models of Maternity Care: Updated Evidence on Outcomes and Safety of Planned Home Birth, February* 2011, 16.
[289] Exhibit 8, Tab 24, 17.

so were missed and by the time it became apparent that Dr Saunders' concerns were well-founded, it was too late to save Baby B.

191. As Dr Griffin observed, in order for a program such as the CMP that facilitates home births of low risk women to work well, "it requires seamless and perfect communication at all levels between professionals"[290] involved with the client. Dr Griffin is confident that that level of communication now exists between himself and the CMP. That is a positive sign that the miscommunication that arose in this case is unlikely to happen again.

CONCLUSION

192. Baby B was born on 30 April 2010. Prior to his birth, he suffered an unexplained hypoxic event, which caused such severe damage to his brain that he could not be saved. He died 10 days later on 9 May 2010.

193. The focus of this inquest has been upon the reasons why his parents were encouraged by government-employed health professionals to believe that it was safe to plan his birth at home, when medical advice said it was not. The evidence at the inquest supports the finding that the problems arose largely due to the behaviour of individuals, compounded by problems with communication amongst the health professionals involved.

194. It is hopefully a small comfort to the parents of Baby B that lessons have been learnt from his death and everyone involved, as well as many other doctors and health professionals who were not, now understand a little better the importance of communication.

S H Linton
Coroner
8 June 2015

[290] T 669.