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 P (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 P (name suppressed)*** *and that death occurred on* ***3 July 2011*** *at* ***Fremantle Hospital*** *as a result of* ***intrapartum hypoxia due to placental abruption*** *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.
Mr M Twiggs (North East Lawyers) appearing on behalf of Lisa Barrett.
Mr M Cuomo (Legal Aid) appearing on behalf of Theresa Clifford.
Ms B Hazard (BW Law) appearing on behalf of the parents of Baby P.

SUPPRESSION ORDER

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

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INTRODUCTION

1. In the early hours of the morning of 3 July 2011, Baby P's mother gave birth at home to twin boys. The first twin was born at 2.37 am. He cried spontaneously and was assessed as healthy at birth.

2. The second twin, Baby P, was born at 3.15 am. He was delivered at the same time as the placenta and showed no signs of life at birth. He was taken by ambulance to Fremantle Hospital and was seen by doctors at 3.50 am. Considerable attempts were made to resuscitate Baby P, lasting more than an hour. Just prior to ceasing resuscitation efforts, a slow, faint heart rate was detected. However, the doctors concluded at that time that his outcome would be very poor, and a decision was made to cease resuscitation, despite the sign of a heart rate.

3. Baby P's death was declared by a doctor at 4.21 am.

4. During initial discussions between hospital staff and the Coroner's delegate, the information provided suggested Baby P fell within the definition of a still-birth, in the sense that he never exhibited a sign of life after being separated from his mother.[1] It is generally accepted that coronial jurisdiction in Western Australia does not extend to still-births, consistent with coronial jurisdictions in other states. The underpinning rationale is that the role of the coroner is to investigate reportable deaths, and there can be no death where there has not been independent life.[2] On the basis of the preliminary discussion, the reporting doctor was advised it was not a reportable death and he proceeded to complete a death certificate.[3]

5. However, after further consultation between doctors and officers of the Coroner's Court, it became apparent that there was some ambiguity around the circumstances in which Baby P was born and whether Baby P was properly

[1] Exhibit 6, Tab 6, Emergency Department Clinical Record 3.7.2011.
[2] See *Jervis on Coroners* (12th Edition) at page 68.
[3] Exhibit 6, Tab 2 [37] – [40].

described as still-born from a coronial perspective.[4] Some evidence suggested the possibility that resuscitation attempts had elicited a sign or signs of life from Baby P before he was declared deceased.[5]

6. The jurisdiction of a coroner is defined in s 19(1) of the *Coroner's Act 1996* (WA) to include investigating a death if it appears to the Coroner that the death is or may be a reportable death (emphasis added). The term "death" is defined in s 3 of the *Coroner's Act* to include a "suspected death."

7. As there was some evidence to suggest Baby P achieved an existence independent of his mother, he was treated *prima facie* as a reportable death and a coronial investigation was commenced to explore the circumstances surrounding Baby P's birth, in order to make a final determination as to whether this matter involved a reportable death.

8. As part of the coronial investigation, I held an inquest into the death of Baby P.

9. The inquest was held, 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 were contrary to recognised standards and guidelines for home births in Australia. It was only in relation to the birth of Baby P that a jurisdictional question arose as to whether he was 'born alive' or was still-born.

10. Evidence was led at the inquest in relation to what, if any, signs of life were observed by the various people who cared for Baby P after his birth. In addition, evidence was led to clarify the circumstances in which he came to be born at home, contrary to medical advice and the understanding of the King Edward Memorial Hospital (KEMH) obstetricians that Baby P's mother intended to have a hospital birth.

[4] Exhibit 5, Tab 18 [46].
[5] Exhibit 5, Tab 21, Letter to Deputy State Coroner dated 7 July 2011 from Dr C.T.Cooke and Dr G.P.Jevon; Exhibit 6, Tab 6, Integrated Progress Notes 3.7.2011.

JURISDICTION OF THE COURT

11. The preliminary question that must be answered in this matter is whether there has been a "reportable death" in this case, thereby enlivening my jurisdiction to make findings and comments pursuant to s 25 of the *Coroner's Act*. It is a matter of law and fact.

12. The relevant law is often referred to as the "born alive" rule. As explained by Spigelman CJ (with whom Grove and Bell JJ agreed) in ***R v Iby***,[6] the rule consists of two distinct components. First, that the foetus must have completely left its mother's body. Second, the child must be alive at or after that separation from the mother has occurred.[7]

13. This statement of the rule was accepted and applied by the South Australian Full Court in ***Barrett v Coroner's Court of Australia***,[8] a case involving a question of coronial jurisdiction similar to the present matter.

14. The rule does not encompass a requirement of viability in the sense that the newly born child must be able to survive as a functioning being.[9] Rather, what constitutes an indicia of independent life has been interpreted broadly, such that any sign or evidence of life after the completed delivery is sufficient.[10]

15. Therefore, it has been said that a very small reading of pulseless electrical activity (PEA) will be sufficient to satisfy the 'born alive rule', as will the smallest amount of breathing or heart-beat "even in circumstances where it is patent that the baby will not be able to survive."[11]

16. The authorities also support the proposition that whether that function has been achieved by medical assistance or stimulus is irrelevant.[12]

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[6] ***R v Iby*** (2005) 63 NSWLR 278; (2005) 45 MVR 1; (2005) 154 A Crim R 55; [2005] NSWCCA 178.
[7] Ibid [27].
[8] ***Barrett v Coroner's Court of South Australia*** [2010] SASCFC 70.
[9] Ibid [54].
[10] Ibid [64]; ***Barrett*** [26] (White J), [93] & [146] (Peek J).
[11] ***Barrett*** [108] (Peek J).
[12] For example, see the cases discussed by Spigelman J in ***R v Iby*** at [46] – [49].

17. In refusing an application for special leave to appeal to the High Court of Australia from the decision of the South Australian Full Court in ***Barrett***, his Honour French CJ observed that the question in such a case as this is "one of characterisation of primary facts relating to the state of health of the child at birth."[13]

18. It is necessary, then, to consider the particular facts in this case in the above legal framework. The central question is whether or not Baby P exhibited a sign or signs of life after his birth. If he did not, he can properly be described as a still-born child and my jurisdiction to inquire further into the events surrounding his birth will cease. If he did, then for the purposes of the *Coroner's Act* it can be said to have been a death, and there appears to be no dispute that if it was a death, it was a reportable death pursuant to s 3 of the *Coroner's Act*. To this question, I apply the civil standard of proof, namely the balance of probabilities.

19. Written submissions on this jurisdictional point were provided to the Court on behalf of the family of Baby P.[14] In summary, they submit that the evidence led at the inquest strongly supports the proposition that Baby P was still-born. They submit that any evidence of PEA or a heartbeat recorded at approximately one hour post-delivery is tenuous and should not be found to be a sign of life for the purposes of grounding coronial jurisdiction. No other submissions were provided on this issue on behalf of any other party.

Evidence in relation to the delivery

20. At the time she went into spontaneous labour, Baby P's mother was aware that she was pregnant with twins. She elected to give birth at home, and both babies were born in the presence of both parents, a registered midwife, Ms Theresa Clifford, a doula, and a woman named Ms Lisa Barrett, who referred to her role as a 'birth advocate'[15] and

[13] ***Barrett v Coroner's Court of South Australia*** [2011] HCA Trans 165 [355] – [360].
[14] Outline of Submissions on behalf of Family P dated 31 October 2014.
[15] T 467 – Note that Ms Barrett gave evidence under compulsion pursuant to s 47 of the *Coroner's Act* (T 466).

who had formerly been a registered midwife. The first twin was delivered at 2.37 am on the morning of 3 July 2011.

21. After the birth of the first twin, Baby P was apparently monitored by Ms Barrett and Ms Clifford by use of a Doppler after every contraction, which was approximately every 5 minutes (noting no records were made of the times and actual rates).[16] Baby P's heartbeat was said to have been checked and heard for the last time approximately 5 minutes before he was delivered.[17] His heartbeat was considered to be within normal limits at all times.[18]

22. Baby P was born approximately 40 minutes after the first twin, the time estimated by the witnesses as 3.15 am. He was delivered at the same time as the placenta, a sign of placental abruption indicating Baby P had been deprived of oxygen during his birth.[19] On delivery, Baby P was said by the witnesses to be very pale, limp, not breathing and with no detectable heartbeat using the equipment available, namely the Doppler.[20] No electrical monitoring equipment was available.[21]

23. Resuscitation was attempted, with Ms Clifford delivering oxygen by way of a self-inflating bag and mask and Ms Barrett performing chest compressions.[22]

Evidence of the ambulance officers

24. Resuscitation was still being performed when an ambulance arrived at 3.33 am, approximately 18 minutes after delivery. A paramedic immediately entered the house and took control of Baby P. He took Baby P to the van and they began to provide him with oxygen via a bag and mask while performing compressions, and paediatric pads were attached to permit electrical monitoring. Resuscitation attempts continued all the way to Fremantle Hospital. During the drive to the hospital, the paramedics checked

[16] T 486.
[17] T 489, 536.
[18] T 488, Exhibit 5, Tab 6 [42].
[19] Exhibit 5, Tab 8 [26] – [27]; Exhibit 6, Tab 5, 2.
[20] Exhibit 5, Tab 6 [43], Tab 7 [67], Tab 8 [27], Tab 9 [37], [41].
[21] T 540.
[22] Exhibit 9 [39] – [40].

Baby P several times for signs of life both physically and on an ECG monitor and, at each time, he was found to have no pulse and was asystolic.[23] Therefore, at least from the time Baby P was in the ambulance and electronic monitoring began, approximately 20 minutes after birth, it is clear that the absence of a heartbeat or pulse was not associated with PEA.[24]

Evidence of observations at Fremantle Hospital

25. Baby P was seen by doctors at Fremantle Hospital at 3.50 am.[25] Dr Sven Todd was part of the medical team in the Emergency Department who took over the care of Baby P. At that time, Baby P was receiving 100% oxygen, appeared blue, had no respiratory rate, his pupils were fixed and dilated, and his heart rate was recorded as less than 60 beats per minute.[26] Dr Todd acknowledged in oral evidence that the notation of a heart rate of less than 60 beats per minute can mean there was no actual heartbeat recorded. Dr Todd's recollection, however, was that there was PEA recorded via ECG monitoring at some stage during the resuscitation attempts.[27] This is consistent with an entry by Nurse Canard in the neurological observation notes of a rhythm check being performed at 4.02 am, during which PEA was noted.[28]

26. Dr Todd recalled that a number of doses of adrenaline were given in an attempt to restart the heart, given the presence of PEA.[29] Dr Todd did not recall any auscultated heart rate being detected, but he accepted that it was possible that another doctor had detected a very faint heartrate on auscultation. He did recall something being detected that prompted the paediatric registrar to telephone a consultant, before all resuscitation efforts were ceased.[30]

[23] T 514 – 515, 518 - 519; Exhibit 5, Tab 11 [11], [19] – [36].
[24] Exhibit 6, Tab 5, 3.
[25] Exhibit 6, Tab 2 [11].
[26] Exhibit 6, Tab 2 [17] – [18].
[27] T 553, 556; Exhibit 6, Tab 2 [29], [32].
[28] Exhibit 6, Tab 6, Neurological Observation Sheet, 2.
[29] T 554.
[30] T 554.

27. Dr Nigel Hendrickson was also part of the initial treating team. He observed that Baby P showed signs of cyanosis and he briefly palpated for a pulse at the umbilicus base and found no palpable pulse.[31] He recorded Baby P's heart rate as less than 60 beats per minute, a significant threshold in the neonatal resuscitation protocol, intending to convey that there was no palpable pulse following a short period of palpation and this indicated that neonatal resuscitation was required.[32]

28. Dr Scarlette Tung was the paediatric registrar on duty at Fremantle Hospital that morning. Dr Tung attended shortly after Baby P had been brought into hospital and had begun to be treated by Dr Todd and others. At that time, Dr Tung noted that there was no spontaneous respiratory effort and no heart rate was detectable on auscultation.[33] After Baby P had been intubated, given multiple adrenaline doses and CPR and bag-tube ventilation had been continued for a further 20 minutes, Dr Tung rang the Paediatric Consultant, Dr Patel. They discussed whether resuscitation efforts should be continued given the prolonged duration of resuscitation efforts. Dr Patel indicated that the likely outcome for Baby P would be "very poor."[34] At Dr Patel's suggestion, Dr Tung then spoke to the Senior Registrar of the Newborn Emergency Transfer Service (NETS), who advised that resuscitation should be ceased.

29. Following this advice, Dr Tung asked the Emergency Department staff to pause in their resuscitation attempts in order for her to perform a final assessment on Baby P. This was approximately 13 to 14 minutes after the final dose of adrenaline had been administered. It was at this point that Dr Tung detected, on auscultation, a slow, faint heartbeat of around 20 beats per minute. There were no other signs of life present. This observation prompted Dr Tung to telephone Dr Patel again to discuss this finding while the ED staff recommenced cardiopulmonary resuscitation. Dr Patel advised that they should cease all

[31] Exhibit 6, Tab 4.
[32] Exhibit 6, Tab 4, Tab 5; Tab 6, Fremantle Hospital Emergency Department Clinical Record 3/7/11.
[33] Exhibit 6, Tab 3; Exhibit 6, Tab 6, Integrated Progress Noes, entry 3/7/11 by S. Tung.
[34] Exhibit 6, Tab 6, Integrated Progress Noes, entry 03/07/11 by S. Tung.

resuscitation despite the detected heart rate, following on from her earlier observation that the outcome for Baby P was likely to be very poor if he was resuscitated at that late stage.[35]

30. An entry in the Neurological Observation Sheet by Nurse Canard also records an auscultated heart beat at 4.12 am of 70, which then dropped to 30.[36]

31. Resuscitation was stopped at 4.21 am (approximately 1 hour and 6 minutes after delivery) and Baby P was certified life extinct by Dr Todd.

Post Mortem Evidence

32. The Chief Forensic Pathologist, Dr Clive Cooke, and a Perinatal/Paediatric Pathologist, Dr Jevon, conducted together an external examination (with plain X-rays) of the body of Baby P and the umbilical cords and part of the placenta. No internal examination was conducted.[37] Because it was only an external examination, the cause of death couldn't be determined, but relevantly no abnormalities were detected and the medical history provided suggested that the likely mechanism for Baby P's death was as a result of intra-partum asphyxia due to the detachment of the placenta.[38]

33. Dr Cooke and Dr Jevon also noted that the medical information provided to them suggested that Baby P may have partly responded to resuscitation attempts.[39] Dr Cooke clarified in oral evidence that even if an internal examination had been performed, it is unlikely that the results of the examination would have been able to determine conclusively if this were so, given the effect of prolonged resuscitation efforts.[40]

[35] Exhibit 6, Tab 3; Exhibit 6, Tab 6, Integrated Progress Noes, entry 3/7/11 by S. Tung.
[36] Exhibit 6, Tab 6, Neurological Observation Sheet, 2.
[37] T 101.
[38] T 101 – 105.
[39] Exhibit 5, Tab 21.
[40] T 109.

Expert evidence of Dr Minutillo

34. Dr Corrado Minutillo is a Consultant Neonatologist at Princess Margaret Hospital for Children. He regularly conducts formal training for other medical staff in neonatal resuscitation protocols, and has been doing so for 15 years.[41] Dr Minutillo gave expert evidence at the inquest, both by way of a written report and orally, in relation to the significance of the PEA and the auscultated heartbeat recorded at Fremantle Hospital.[42]

35. Dr Minutillo considered the evidence available from the various witness accounts and noted that "the first time PEA was used was after intubation and 2 doses of adrenaline," [43] the purpose of the adrenaline being specifically to stimulate the heart into action.[44] Dr Minutillo concluded that Baby P's heart "only responded after adrenaline, endo-tracheal ventilation and a fluid bolus at [Fremantle Hospital] but unfortunately this was far too late."[45]

36. During the inquest, Dr Minutillo described the response obtained from Baby P's heart after stimulus as "a flicker…of a heartbeat so that there was some kind of minor response to that resuscitation before it was decided to stop the process.'[46] Dr Minutillo confirmed that, by this, he meant an actual beating of Baby P's heart of its own accord.[47]

37. In Dr Minutillo's opinion, if Baby P's heart responded "in some weak way to appropriate neonatal resuscitation at about 55 minutes of age, it is at least possible he may have rapidly responded to this same resuscitation protocol, if he had been born in a hospital able to provide this emergency care at his birth."[48] This was within the context of Dr Minutillo considering the resuscitation that was offered

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[41] T 213.
[42] T 199 -232; Exhibit 6, Tab 5.
[43] Exhibit 6, Tab 5, 4.
[44] T 213 - 214.
[45] Exhibit 6, Tab 5, 4.
[46] T 211.
[47] T 211.
[48] Exhibit 6, Tab 5, 4 - 5.

to Baby P, at least in the home by the midwives, was "less than ideal,"[49] and certainly not optimal.

38. Part of the difficulty in forming an opinion as to whether the outcome may have been different in those circumstances is the timing of the placental abruption, which is unknown, and when Baby P's heart stopped beating. In Dr Minutillo's experience, if a baby is born pulseless after an acute one-off event, resuscitation is possible and the outcome is usually very good.[50] It is for this reason that he talked, at the inquest, of a hospital birth providing Baby P with "[a]t least the possibility of a better outcome."[51] However, Dr Minutillo accepted that there were no guarantees that this would have been so.[52]

39. Dr Minutillo also clarified in his evidence that his use of the word "if" in relation to the hospital treatment being able to generate a "weak response" from Baby P's heart, was included in the context of the heart rate indicating an inadequate output from his heart, such that it could not provide adequate oxygenation for Baby P to survive.[53]

Conclusion on Jurisdictional Question

40. The evidence tendered and heard at the inquest all supported the conclusion that Baby P was considered to be a healthy, viable foetus during the pregnancy.[54] The evidence of the midwives was that during the delivery they were checking the heartrate of both twins and there were no concerning features.[55] According to the evidence of the midwives, at approximately 5 minutes before the delivery of Baby P, they checked his heartbeat (which they were both firm in their evidence was not his mother's heartbeat)[56] and it was still normal, estimated at between 130 and 145 beats per minute.[57]

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[49] T 217.
[50] T 223.
[51] T 219.
[52] T 226.
[53] T 230.
[54] For example, T 417.
[55] T 486 – 487, 535.
[56] T 487 – 489, 543.
[57] T 543.

41. I am satisfied from the above evidence that, due to a hypoxic event during delivery, Baby P was deprived of oxygen before his birth. The evidence strongly supports the conclusion that this event occurred close in time to his delivery, due to placental abruption. As a result, he was born pulseless and not breathing.

42. As no electronic monitoring was available in the home, I am unable to say with any certainty whether Baby P displayed PEA at the time he was born. Dr Minutillo stated that he is "certain it is likely to be present in some babies born with no auscultated or palpated heartbeat"[58] but it is speculation as to whether it was present in the case of Baby P at that time. What is certain is that he did not display any PEA at the time he was hooked up to the ECG monitor in the ambulance, approximately 20 minutes after he was delivered.

43. He continued to exhibit no sign of life until he had been intubated and given fluid and adrenaline boluses.

44. At that time, after optimal resuscitation had been provided, Baby P's heart responded to the resuscitation provided. At first PEA, and then an auscultated heartrate of 20 beats per minute, were observed by medical staff. Either of these observations individually can constitute a sign of life for the purpose of determining whether Baby P was "born alive," although I accept that the evidence of the PEA so far established in this case, when considered in isolation, would be a weak foundation to ground a sign of life. That is due to the lack of information about the number of beats per minute of the PEA. However, the same cannot be said of the heart rate auscultated by Dr Tung.

45. When considered within the context of Dr Minutillo's opinion that those observations signify:

    a. that the resuscitation had, to a limited extent, been effective; and

[58] Exhibit 6, Tab 5, 4.

b. there was a possibility that Baby P might have been resuscitated more successfully if optimal resuscitation had been provided at a much earlier stage,[59]

I am further pointed in the direction of a conclusion that Baby P exhibited signs of life at Fremantle Hospital.

46. I accept that the signs of life detected were, as Dr Todd expressed it from a medical point of view, not compatible with life and indicated that Baby P would have had a very poor outcome if further resuscitation had been attempted and succeeded.[60] However, as noted above in paragraph [15], the life sustaining qualities of the heart beat or the PEA are not relevant to whether or not they are signs of life for the purposes of enlivening my jurisdiction.

47. In my opinion the PEA and auscultated heart rate that were detected in Baby P between 4.02 am and 4.21 am, when resuscitation efforts were ceased, were signs that Baby P's heart had been stimulated into a response by the optimal medical resuscitation efforts. As such, they were signs of life that existed after Baby P had been fully delivered from his mother.

48. Focussing particularly on the heart rate of 20 beats per minute auscultated by Dr Tung, which prompted her second telephone call to Dr Patel, I find that this heart rate was a sign of life for the purposes of the law.

49. In reaching that conclusion, I do not accept the submission made on behalf of the family that this has the effect of expanding the previously accepted jurisdiction of the Coroner's Court.[61] Rather, I am simply applying the existing legal principles relating to the concept of "born alive" to the primary facts in this particular case.

50. In my opinion, all facets of the born alive rule have been satisfied in this case and I find that, at the time Baby P

[59] See Barrett [106] (Peek J) as to the importance of the possibility of resuscitation.
[60] T 5541 Exhibit 6, Tab 2 [32], [35].
[61] Outline of Submissions on behalf of Family P dated 31 October 2014, [47] – [48].

was certified life extinct at 4.21 am, this constituted a death for the purposes of the *Coroner's Act*.

51. Accordingly, I conclude that I have jurisdiction to continue to make findings and comments in relation to Baby P's death, pursuant to s 25(1) of the *Coroner's Act*. I now turn to a consideration of the facts for those purposes, which will inevitably involve some duplication of the facts set out above.

BABY P'S MOTHER'S OBSTETRIC HISTORY

52. As a couple, Baby P's parents appear to have similar characteristics to many of the people who choose to home birth in Australia; namely older, tertiary educated and proactive in doing a lot of research before making their decision.[62]

53. Baby P's mother is a journalist with a particular interest in natural birth and birth choice.[63] She is from Canada, where home birth is more common. Baby P's mother described it in evidence as "a country where women's rights to choose where and with whom they want to give birth is recognised."[64] Baby P's mother also regards homebirths as part of her culture from a more personal perspective, as there have been many homebirths in her family.[65]

54. Her husband, who is the father of her children, is a registered nurse.

55. When Baby P's mother became pregnant with their first child, Baby P's mother and father researched birth options in Western Australia to find the best fit for them.[66] Baby P's mother became aware of the Community Midwifery Program (CMP), which was highly recommended

[62] T 647.
[63] T 722; Exhibit 5, Tab 6 [1]
[64] T 346.
[65] T 346.
[66] T 346, 358.

to her by a midwife friend.[67] She was attracted to the program as it was free (as opposed to a cost of approximately $3000 for a private midwife) and they offered services that were very important to her, including continuity of care and water birth.[68]

56. 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.[69] The model aims to ensure clients are offered continuity of care throughout the pregnancy continuum.[70] 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.[71]

57. The CMP inclusion criteria is limited to women deemed to have 'low risk' pregnancies, based on the Australian College of Midwifes' (ACM's) National Midwifery Guidelines for Consultation and Referral (National Midwifery Guidelines).[72] The CMP Midwifery Protocol sets out a number of criteria, any of which, if met, will exclude a pregnant woman from being accepted on to the CMP on the basis of the increased level of risk.[73]

58. Baby P's mother applied to the CMP. She was assessed as having a 'low risk' pregnancy and was accepted onto the CMP. It was an uncomplicated pregnancy and delivery, apart from some maternal blood loss, and she gave birth to her first child at home with the support of two CMP midwives. The child was healthy at birth. The birth was described in the notes by one of the midwives as a "beautiful water birth" and Baby P's father described it as

[67] Exhibit 10.
[68] T 346.
[69] Exhibit 2, Tab 13, 2 - 3.
[70] Exhibit 2, Tab 13, 3.
[71] Exhibit 2, Tab 13, 3 - 4.
[72] Exhibit 2, Tab 13.1 & 13.2.
[73] Exhibit 2, Tab 13.1 & 13.2.

a "wonderful experience."[74] The birth appears to be a good example of how home births in appropriate cases can be a positive experience for all involved.[75]

ACCEPTANCE ON TO THE CMP THIS PREGNANCY

59. When Baby P's mother became pregnant again three years later, she went straight to the CMP and applied to be accepted again onto the program for her second pregnancy.[76] Baby P's parents were hopeful they could repeat their positive first birth experience.[77]

60. Baby P's mother saw a general practitioner, who confirmed that at that stage of the pregnancy, 8 weeks' gestation, she appeared to be a suitable candidate for another home birth.[78]

61. As she was assessed at that time as having a 'low risk pregnancy', Baby P's mother was accepted onto the CMP again. She was allocated a CMP midwife, Marilyn Allen, as her primary caregiver. Ms Allen met with Baby P's mother on 25 January 2011, when she was 16 weeks pregnant. Baby P's mother signed the CMP Terms of Care that day.[79] At that meeting she declined to have an ultrasound scan – the Pregnancy Health Record progress note indicates that Baby P's mother was undecided about having an ultrasound at that time.[80]

62. On 7 March 2011, Ms Allen had another antenatal visit with Baby P's mother. At that time Baby P's mother again declined to have an ultrasound.[81]

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[74] T 358.
[75] T 346; Exhibit 10.
[76] T 346.
[77] T 358.
[78] Exhibit 10, Letter dated 29.11.2010 from Dr S Hawkins.
[79] Exhibit 10; Letter to Coroner from Marilyn Allen dated 14.10.2014 (provided after the inquest).
[80] Exhibit
[81] Exhibit 10, Letter to Coroner from Marilyn Allen dated 14.10.2013.

DISCOVERY OF TWIN PREGNANCY

63. The next antenatal visit was conducted at the CMP clinic just over a month later by a different CMP midwife, Sarah Davis, as Ms Allen was on leave. During this visit, it became apparent during the examination that there was a strong possibility that Baby P's mother was pregnant with more than one baby. At this stage, Baby P's mother was at approximately 27 weeks' gestation. The progress notes record that a discussion took place between the midwife and Baby P's mother around multiple births and homebirth. Baby P's mother understood that, in accordance with the CMP terms of care, she would be unable to homebirth twins on the CMP, as a twin pregnancy is classified as a 'high risk' pregnancy. The note indicates that Baby P's mother wanted to discuss the findings with Ms Allen when she returned from leave which Baby P's mother confirmed.[82] Baby P's mother indicates that this was because Ms Davis had suggested that it would be up to the hospital and Ms Allen to decide whether Ms Allen could accompany her to hospital.[83]

64. Ms Davis' note also records that Baby P's mother indicated that she was happy to arrange for an independent midwife to support a twin homebirth, if necessary.[84]

65. On 13 April 2011, Baby P's mother telephoned Ms Davis and asked her to arrange for an urgent ultrasound as she had decided not to wait for Ms Allen's return from leave, but instead "wanted to get on with deciding on a birth plan."[85] Ms Davis arranged an appointment for an ultrasound at the Maternal Fetal Assessment Unit (MFAU) at KEMH for that afternoon.[86]

66. Baby P's mother attended the MFAU for an ultrasound, which confirmed a twin pregnancy.[87] The twins apparently showed good growth and no apparent abnormalities on the

[82] Letter to Coroner from Baby P's mother dated 30.10.2014 (provided after the inquest).
[83] Letter to Coroner from Baby P's mother dated 30.10.2014.
[84] Exhibit 10, Pregnancy Health Record Progress Note 11.4.2011.
[85] Exhibit 10, Pregnancy Health Record Progress Note 13.4.2011.
[86] Exhibit 10, Pregnancy Health Record Progress Note 13.4.2011.
[87] Exhibit 10, Pregnancy Health Record Progress Note 13.4.2011 – 18.15 time entry.

scan.[88] The hospital antenatal record shows there was a discussion between the Registrar and Baby P's mother about twin deliveries and usual hospital recommendations in those circumstances.[89] The plan was for Baby P's mother to see her CMP midwife again and also to have another ultrasound at KEMH.[90]

67. The progress notes record that Baby P's mother telephoned Ms Davis that night following the ultrasound. She told Ms Davis that she was very happy to be having twins but was not happy with the proposed investigations and not happy to birth in hospital. Instead, she wanted to pursue a home birth with an independent midwife. She was going to contact Jill Bellingham, who was the back-up midwife at her first birth with the CMP and was now a privately practising midwife,[91] and Theresa Clifford, another privately practising midwife.[92]

MOVE TO 'SHARED CARE' ARRANGEMENT

68. As noted above, the CMP inclusion criteria is directed towards providing services only for women who are assessed as having 'low risk' pregnancies. When CMP clients sign the standard terms of care, they acknowledge that that they may be referred to a hospital if the level of risk is determined as unsafe for a home birth.[93]

69. Twin pregnancies are recognised by obstetricians and midwives as 'high risk' pregnancies. They are more likely to have complications than a singleton pregnancy, and they present both antenatal and intrapartum challenges. Of particular relevance to this case is the known higher perinatal morbidity and mortality of second-born twins, as compared to first-born twins, due to the mechanics of what can happen in the course of delivery. This may give rise to the need for manipulation of the second twin inside

[88] Exhibit 10, Pregnancy Health Record Progress Note 13.4.2011 – 17.40 time entry.
[89] Exhibit 6, Antenatal Record, Entry 13.4.2011.
[90] Exhibit 10, Pregnancy Health Record Progress Note 13.4.2011 – 1815 and 1830 time entries.
[91] T 350.
[92] Exhibit 10, Pregnancy Health Record Progress Note 13.4.2011 – 1830 time entries.
[93] Exhibit 10, CMP Terms of Care, signed by Baby P's mother 25.1.2011.

the uterus, instrumental delivery and, on occasion, emergency caesarean section. There is also an increased risk of post-partum haemorrhage.[94]

70. Because of the inherent risks involved in twin labour and delivery in general, as well as the particular risks for the second twin during delivery, the CMP inclusion criteria is limited to singleton pregnancies.[95]

71. On 28 April 2011, the Clinical Midwifery Consultant of the CMP, Ms Dawn Hudd, emailed Dr Karczub, the Director of Obstetrics at KEMH, in relation to Baby P's mother. Ms Hudd outlined the history of the pregnancy and advised that Baby P's mother was distressed by the fact that she was unable to continue with her plan to birth at home. Ms Hudd indicated that Baby P's mother had contacted the CMP to request that she remain on the CMP with Ms Allen as her midwife, in order to maintain continuity of care throughout the antenatal, labour and postnatal period. Given Baby P's mother's request, Ms Hudd asked whether Dr Karczub would support a 'shared care' option with the CMP (contrary to the normal CMP practice for early diagnosed twin pregnancies to continue care solely with the hospital), on the understanding that under no circumstances would CMP midwives attend the home whilst Baby P's mother was in labour.[96]

72. Dr Karczub responded that day by email and indicated that Baby P's mother would require frequent scanning in the hospital clinic but, all other things being equal, there was no reason why the CMP midwife could not perform the blood pressure checks and some of the additional antenatal visits.[97]

73. On 4 May 2011, Baby P's mother saw Dr Saunders, an obstetrician at KEMH, at the antenatal clinic. Dr Saunders discussed with Baby P's mother potential problems with twins and twin delivery. On that day the

[94] T 417 – 418.
[95] T 418; Exhibit 9B, Tab 2.
[96] Exhibit 10, Email from Dawn Hudd to Dr Karczub dated 28.4.2011.
[97] Exhibit 10, Email from Dr Karczub to Dawn Hudd dated 28.4.2011.

scan showed 'twin 1' was still in the transverse lie position (sideways across the uterus) and Baby P's mother understood that there was no option for delivery other than a caesarean if 'twin 1' remained in that position.[98] It was explained during the inquest that this was because there is no mechanism for the baby to come out if the first twin is in this position.[99] Baby P's mother recalled that Dr Saunders told her that she would most likely have a caesarean section.[100]

74. After returning from her holidays, Ms Allen saw Baby P's mother on 9 May 2011. Ms Allen recalls that they discussed the CMP guidelines and Baby P's mother indicated she would like care to be continued by the CMP but understood that it would be in consultation with KEMH and she would give birth in hospital.[101]

75. Baby P's mother recalls that during the conversation she asked Ms Allen whether it was possible for Ms Allen to be her primary midwife in the hospital. Ms Allen indicated that she could attend the hospital as her support person only, and Baby P's mother would need to ask Dr Karzcub about who would perform vaginal examinations and manage the labour and birth.[102] Baby P's mother's recollection is that when she later discussed this issue with Dr Karczub, she indicated that the vaginal examinations could not be done by Ms Allen, but it was possible to try to arrange for one person only to do the vaginal examinations, although Dr Karzcub couldn't make any promises in that regard at that stage.[103]

76. On 13 May 2011, a letter was sent by Dawn Hudd to Baby P's mother and copied to Ms Allen and Dr Saunders clarifying the roles and responsibilities of the CMP and Dr Saunders in regards to her care during the remainder of the pregnancy.[104] It was described as a 'shared care' arrangement with Ms Allen providing continuity of

[98] Exhibit 5, Tab 17 [4] – [5].Exhibit 6, Letter to Marilyn Allen from Dr Saunders dated 4.5.2011.
[99] T 433 – 434.
[100] Letter to Coroner from Baby P's mother dated 30.10.2014.
[101] Exhibit 10, Pregnancy Record entry 9.5.2011; Letter to Coroner from Marilyn Allen dated 14.10.2013.
[102] Letter to Coroner from Baby P's mother dated 30.10.2014.
[103] Letter to Coroner from Baby P's mother dated 30.10.2014.
[104] Exhibit 10, Letter to Baby P's mother from Dawn Hudd dated 13.5.011.

midwifery care in collaboration with Dr Saunders.[105] In the letter, Ms Hudd reiterated that Ms Allen could not attend Baby P's mother at home if an emergency situation arose, and she should immediately go to hospital.[106] Ms Allen would meet her at the hospital and support her during the birth.[107]

77. Ms Allen saw Baby P's mother for another antenatal visit on 17 May 2011 and everything seemed to be going well.[108]

78. It appears Baby P's mother continued to attend KEMH for regular scans over this period.[109] Baby P's mother had another ultrasound at KEMH on 23 May 2011, and at that time 'twin 1' had moved from a transverse to a breech (bottom down) position.[110]

79. On 1 June 2011, at 34 weeks, 5 days' gestation, Baby P's mother saw Dr Karczub at KEMH for an ultrasound and antenatal visit. Notably, this was the first appointment Baby P's mother had with Dr Karczub.[111] Until then, her care had been managed by Dr Saunders.

80. At the time of that appointment, Dr Karczub was aware that 'twin 1' was now in a breech position.[112] This was a positive step towards Baby P's mother's hopes for a vaginal delivery as, unlike with a transverse lie position, a vaginal delivery was possible with 'twin 1' in a breech position as there is a mechanism for a vaginal delivery in those circumstances.[113]

81. However, Dr Karczub explained that even with a singleton vaginal delivery, a breech position carries an inherent risk above and beyond the risk presented by a cephalic (head down) position. As a result, the perinatal mortality and morbidity of a breech presentation is substantially

[105] Exhibit 10, Letter to Baby P's mother from Dawn Hudd dated 13.5.011.
[106] Exhibit 10, Letter to Baby P's mother from Dawn Hudd dated 13.5.011.
[107] Exhibit 10, Letter to Baby P's mother from Dawn Hudd dated 13.5.011.
[108] Exhibit 10; Letter to Coroner from Marilyn Allen dated 14.10.2014.
[109] Exhibit 10.
[110] Exhibit 5, Tab 17 [6].
[111] T 413.
[112] T 419.
[113] T 434.

increased.[114] This has led to a divergence of opinion amongst consultant obstetricians, both in general and more particularly at KEMH, as to the safety of vaginal breech deliveries in singleton births and whether the risks can be appropriately ameliorated by taking certain steps.[115] As a result, while vaginal breech delivery in a singleton pregnancy is offered at KEMH as a standard management, there are some consultants there who would be less happy to do so as they inherently believe it is a less safe mode of delivery than caesarean section in such circumstances.[116]

82. In the case of a twin delivery, which is inherently high risk even when the first baby is cephalic, the risk is increased again if the first baby presents as breech. It presents as a combination of two high-risk obstetric deliveries: a breech and twins.[117] Dr Karczub indicated that she, personally, is comfortable with delivering a woman who has 'twin 1' presenting as a breech provided that she is a healthy woman having a healthy pregnancy, and that they can do adequate monitoring of the babies.[118] However, because of the combination of risk factors, Dr Karczub indicated that the majority of her colleagues, both at KEMH and elsewhere, would recommend a caesarean section for such a delivery.[119] Another witness at the inquest agreed that this was likely, due to the general trend in practice at that time for clinicians to have little experience with breech deliveries.[120]

83. Whilst many of Dr Karczub's colleagues would not *support* a vaginal delivery in such circumstances, in the sense of recommending it, she explained that the medical staff at KEMH has a duty of care to provide that service if the woman maintains her desire to pursue that birth plan.[121]

[114] T 421-423.
[115] T 423.
[116] T 423 – 424.
[117] T 424.
[118] T 424.
[119] T 424.
[120] T 635.
[121] T 422, 424 - 425.

84. In circumstances where the clinician does not recommend the proposed birth plan, there is a document available at KEMH to record the interactions between the clinician and the woman. It is known as the Non-Standard Management Plan, and is a sticker that can be placed in the woman's antenatal record. It records the non-standard components of the birth plan and documents that a discussion has been had between the clinician and the woman. It also confirms that the woman understands that her plan is not recommended by the clinician and the plan is not supported by evidence-based KEMH guidelines. It demonstrates that informed consent has been given by the woman to pursue that course of action nevertheless.[122] Dr Karczub described it as a tool "to demonstrate that a difference of opinion has been explored and that the woman's wishes are documented, but that it is clear that the clinician/institution does not…condone…or agree…with those decisions."[123] The plan not only satisfies the medico-legal obligations of the medical staff, but the primary purpose of the plan is to inform the labour ward team, so that they are clear of the woman's plan going into labour.[124]

85. Dr Karczub acknowledged that in such circumstances it is likely the obstetrician would re-discuss the birth plan with a woman, even if she had signed a non-standard management plan, to reiterate the risk and confirm the woman's choice.[125] However, the plan is there to reduce anxieties and confrontation in the labour ward. If the woman maintains her position in line with the non-standard management plan, the obstetrician would be required to comply with it, as the KEMH staff cannot compel women to do something they do not wish to do or to accept care.[126]

86. In the case of Baby P's mother, as well as wanting to attempt a vaginal delivery of twins with the first twin in the breech position, she did not want to agree to some of the

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[122] T 415 – 416.
[123] T 416.
[124] T 442, 459.
[125] T 416, 425, 459.
[126] T 416.

standard managements that Dr Karczub recommended, such as cardiotocograph (CTG) monitoring, if she was going to attempt a vaginal twin delivery. Accordingly, Dr Karczub created a non-standard management plan form for both herself and Baby P's mother to sign. The form, which is contained in the KEMH antenatal record, indicates that Baby P's mother did not want continuous monitoring and wished to labour in a shower or bath for a time.[127]

87. Dr Karczub's evidence was that, apart from the bath which was not available for use by Baby P's mother due to hospital policy because of the level of risk involved in her pregnancy,[128] Baby P's mother's other conditions could have been accommodated at KEMH, as they had been for other women.[129]

88. Baby P's mother's recollection, on the other hand, was that Dr Karczub refused to forego constant monitoring and refused to allow her to labour in water.[130] The non-standard management plan does not support her recollection, although I accept Baby P's mother's reference to "water" may have meant a bath rather than a shower, which could not be accommodated.

89. Baby P's mother was also concerned that her CMP midwife would only be allowed to attend the birth in hospital as a support person, rather than as the midwife, which was important in relation to vaginal examinations amongst other things.[131] She was also opposed to the siting of an epidural as a precautionary measure.[132]

90. Dr Karczub agreed that she raised the possibility of a caesarean section with Baby P's mother, as that was the standard recommended option in the circumstances. Dr Karczub cannot recall whether she discussed caesarean section with her in detail, and accepts she may not have

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[127] T 416; Exhibit 6, 2nd Pregnancy Antenatal Record, Non-Standard Management Plan dated 1.6.2011.
[128] T 417, 443 - 444.
[129] T 422.
[130] T 348.
[131] T 348.
[132] T 388, 446.

done so to the level she would have done if she had been asking her to sign a caesarean section consent form.[133] Because Dr Karczub formed a very strong impression that Baby P's mother was very keen to have a vaginal delivery, she believes much of the discussion was centred on that option.[134]

91. Dr Karczub also agreed that she recommended an epidural, but reiterated that it was within Baby P's mother's right to decline to have one sited and it did not require a non-standard management plan.[135] Dr Karczub could not recall arranging an appointment for Baby P's mother to see an anaesthetist at KEMH, but agreed that it was possible, as she commonly does recommend an appointment with an anaesthetist to give the woman an opportunity to have a discussion with the relevant expert, the anaesthetist, about the epidural and her concerns.[136]

92. Baby P's mother saw Dr Karczub one more time at the KEMH antenatal clinic on 15 June 2011. They discussed again the options of elective caesarean versus vaginal delivery and the risks involved in each. There are brief notes in the pregnancy health record that indicate some of what was discussed, including the 2001 Term Breech Trial and the rare risk of a 'locked twin' when a breech twin vaginal delivery is attempted.[137] Dr Karczub still believed that Baby P's mother strongly wanted to have a vaginal delivery, but she also thought it was important to give Baby P's mother time to consider both options. By this means, she could be certain Baby P's mother was giving informed consent.[138]

93. Dr Karczub's recollection was that Baby P's mother was going to go away and consider her options and telephone Dr Karczub with her decision. If she was to choose the option of an elective caesarean, it could be booked within the 37 to 38 week gestation period, the following week.

[133] T 425 – 426.
[134] T 425, 427.
[135] T 447, 451 - 452.
[136] T 447.
[137] Exhibit 10, Pregnancy Health Record, entry 15.6.2011.
[138] T 448 - 449.

Dr Karczub was going on leave in a few days' time so the next appointment was made with Dr Saunders for the 22 June 2011.[139]

94. Baby P's mother's evidence was that she recalls being told that Dr Karczub was going on leave and that Dr Karczub also told her that she was one of the few doctors at KEMH who would support her to have a trial of labour if 'twin 1' was in the breech position.[140] She took that to mean that she would be forced to have a caesarean section if Dr Karczub was not available at the time she went into labour.[141] Baby P's mother's evidence was that she felt dread, when "…thinking about going to the hospital and agreeing to a major surgery without a trial of labour."[142] As a result, she began to look into other options.

95. Dr Karczub did not accept that she intentionally conveyed to Baby P's mother that she would be forced to have a caesarean section in Dr Karczub's absence. She indicated that if Baby P's mother had communicated her clear decision to pursue a vaginal delivery to Dr Saunders (or another KEMH doctor), "he would have had no choice but to accommodate it."[143]

96. Ms Allen saw Baby P's mother the following day and her note in the pregnancy record confirms that Dr Karczub had suggested Baby P's mother consider having an elective caesarean section. Ms Allen's note indicates Baby P's mother felt that she wanted to wait until term and when she went into labour, she could attend the hospital and have the babies' position checked and make a decision as to whether she would attempt a vaginal delivery or have a caesarean at that time.[144] Ms Allen then called Dr Karczub during the visit and they had a three-way conversation about Baby P's mother's decision. Ms Allen's note records a conversation about putting an epidural in place, not topped up but ready to be used if required, and also the

[139] T 430.
[140] Letter to Coroner from Baby P's mother dated 30.10.2014.
[141] T 349; Letter to Coroner from Baby P's mother dated 30.10.2014.
[142] T 355.
[143] T 435.
[144] Letter to Coroner from Ms Allen dated 14.10.2014; Exhibit 10, Pregnancy Health Record, Progress Note 16.6.2011.

question of continuous monitoring.[145] Baby P's mother recalls she told them that she did not want an epidural or continuous monitoring because she wanted to try and manage the labour pain with water, either in a shower or bath. Dr Karczub indicated that Baby P's mother would need to update her non-standard management plan with Dr Saunders at the visit the following week.[146]

97. Baby P's mother did not attend her appointment with Dr Saunders on 22 June 2011 to sign the non-standard management plan.

END OF CMP/KEMH INVOLVEMENT

98. Baby P's mother's evidence at the inquest was that when she found out she was having twins she requested to stay on the CMP and to have continuity of care with the CMP and to go to the hospital to give birth.[147] She maintained that she continued with this plan until shortly before she ceased her use of their service approximately four weeks prior to the birth.[148] She stated that she had not considered opting out of the CMP and having a home birth until after she realised that Dr Karczub would be on leave[149] and she was told that Dr Karczub had made an appointment for her to see an anaesthetist.[150]

99. Although Baby P's mother had discussed with Dr Karczub the possibility or requiring an anaesthetist in case of an emergency caesarean section,[151] she took the fact that an appointment had been made for her to see the anaesthetist beforehand as a sign of bad faith by Dr Karczub and an indicator that none of her birth plan requests would be respected.[152]

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[145] Exhibit 10, Pregnancy Health Record, Progress Note 16.6.2011.
[146] Letter to Coroner from Ms Allen dated 14.10.2014; Exhibit 10, Pregnancy Health Record, Progress Note 16.6.2011; Letter to Coroner from Baby P's mother dated 30.10.2014.
[147] T 348.
[148] T 348.
[149] T 350.
[150] T 348.
[151] T 348.
[152] T 348, 350.

100. Baby P's mother's evidence at the inquest was that it was then that she began trying to find other obstetricians outside KEMH who might be willing to allow her to try to deliver her twins vaginally but she was told that, given her unwillingness to have an epidural and continuous monitoring, she would be sent to KEMH.[153] She then made enquiries with independent midwives.

101. The timing of events given by Baby P's mother in her statement back in July 2011 was somewhat different. There she stated that she stayed on the CMP, knowing they would not assist her with a home birth, while she attempted to find a private midwife in Western Australia to assist her with a home birth. This is consistent with the CMP midwife entries around 13 April 2011, which noted that Baby P's mother was going to approach Ms Bellingham and Ms Clifford.

102. Baby P's mother acknowledged in her evidence that she reached an agreement with Jill Bellingham to act as her private midwife,[154] but after a couple of weeks, Ms Bellingham told her that she was concerned about "the climate around homebirth in Western Australia"[155] and was worried that she might be reported if she assisted at the birth. Therefore, she withdrew her offer to assist at the birth, when Baby P's mother was at approximately 37 weeks' gestation.[156] Baby P's mother's evidence was that after Ms Bellingham withdrew, she then approached a private midwifery clinic in Fremantle and spoke to Theresa Clifford. Ms Clifford declined to act as her primary midwife as she was moving towards retirement and didn't want to take on the responsibility of being the primary midwife, but she agreed to act as her back-up midwife.[157] Although Ms Clifford gave evidence that home births of twins was not generally part of her practice as a midwife, she did not put this forward as a reason why she did not want to be the primary midwife at the birth.[158]

[153] T 350.
[154] T 350 - 351.
[155] T 360.
[156] T 351, 360.
[157] T 351.
[158] T 545 – 546.

103. Baby P's mother then broadened her search beyond Western Australia and eventually found a person in South Australia, Lisa Barrett, who would come to Perth and assist her.

104. Ms Clifford recalled that she was initially approached by Baby P's parents approximately 10 weeks prior to the birth, at the time they found out they were having twins and were not able to remain on the CMP.[159] She declined to be the primary midwife but agreed to act as a secondary support person or 'back-up' midwife if required, and to provide post-natal care.[160] She was initially asked to be Jill Bellingham's back-up but that later changed to Lisa Barrett.[161]

105. Lisa Barrett indicated in her statement that she was first contacted by Baby P's parents about two months before the birth of Baby P.[162] After several telephone conversations and negotiations as to what arrangements could be made, she eventually arrived in Perth on 22 June 2011.

106. I note that the second meeting with Dr Karczub took place on 15 June 2011, when Baby P's mother was 36 weeks and 5 days' gestation.[163]

107. Looking at the various dates given above, in terms of timing of events, there is an obvious difficulty in reconciling Baby P's mother's evidence at the inquest as to when she began to again consider pursuing a homebirth, rather than a hospital birth, with the other evidence available. Her account in her statement is more consistent with the other evidence.

108. Baby P's father's oral evidence at the inquest represents something of a midway point between Baby P's mother's two versions. His evidence was that a homebirth was

[159] Exhibit 5, Tab 9 [11] – [16].
[160] T 524 – 529.
[161] T 526 – 527.
[162] Exhibit 5, Tab 8 [6].
[163] Exhibit 10, Pregnancy Health Record, Progress Note entry 15.6.2011.

always an option in their minds,[164] but they "were not hell-bent on having a home birth" and were prepared to consider birth in hospital.[165] He believed they were "leaning a little bit towards, or at least being open as an option, to having the babies in hospital"[166] until they met with Dr Karczub late in the pregnancy and were told that she was going on holidays and it was unlikely any other obstetrician at KEMH would support a vaginal twin delivery with 'twin 1' in the breech position.[167] However, I note in Baby P's father's statement, which he signed on 4 July 2011, he placed much greater weight on their continuing plans to have a home birth, although they wanted to keep their options open to the end.[168]

109. I find that the evidence overall establishes that at the time Baby P's mother found out she was having twins and was not eligible to have a home birth on the CMP, Baby P's mother continued a strong preference towards a vaginal birth at home. However, knowing that she did not have the support of the CMP, she had to find someone else willing to assist her. She also had to wait to see if 'twin 1' moved from a transverse position, making a vaginal birth possible. Therefore, she needed to continue her relationship with the hospital, as it might be her only realistic option.

110. By late May 2011, 'twin 1' had moved to a breech position and she had found Ms Bellingham to assist her, with Ms Clifford as a back-up, although Ms Bellingham later withdrew. She then began discussions with Ms Barrett.

111. Therefore, at the time of the first meeting with Dr Karczub on 1 June 2011, Baby P's mother was still exploring her birth options, but with the knowledge that a vaginal delivery was now possible and she might have someone to assist her to attempt it at home. The fact that Dr Karczub was willing to facilitate a vaginal delivery, even though 'twin 1' was breech, may have encouraged her and her

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164 T 359.
165 T 360.
166 T 360.
167 T 359 - 360.
168 Exhibit 5, Tab 7 [26].

partner to consider the option of a hospital birth. However, I find that they were still actively pursuing the home birth option as a strong preference.

112. Around the time Baby P's mother was firming up an arrangement with Lisa Barrett, she also found out that Dr Karczub would be on leave. Although I am satisfied Baby P's mother could still have insisted upon her choice of attempting a vaginal twin delivery with another obstetrician, I also accept that she understood the other obstetricians at KEMH were unlikely to be supportive of her choice and she might face some attempts to change her mind. Some of her other requirements, such as a bath and her CMP midwife doing the vaginal examinations, were also not going to be available to her.

113. It was in those circumstances that Baby P's parents made the final decision to engage Lisa Barrett's services and have a home birth.

114. Therefore, I do not accept Baby P's mother's evidence that she only began to consider the option of a home birth, without CMP assistance, after her meeting with Dr Karczub on 15 June 2011, due to her loss of trust in Dr Karczub.[169] I am prepared to accept that she did give some consideration to having a hospital birth and only made the final decision to definitely attempt a home birth at that time, knowing that Ms Barrett and Ms Clifford would be there to assist her. This decision was made within the context of Baby P's mother considering the home birth option with independent midwives from the moment she found out she was no longer eligible to have a CMP-assisted home birth.

115. I also find that Baby P's mother understood that she could still be provided with support by Ms Allen, as part of the CMP, during her labour at KEMH, but she was unhappy with the limitations placed upon the role Ms Allen would be able to provide to her in that context.

[169] T 350.

116. Baby P's mother had an appointment to attend KEMH to see Dr Saunders on the same day Lisa Barrett arrived in Perth. Baby P's mother did not attend the appointment and KEMH staff were informed that she would attend the following Friday instead.[170]

117. The following day, on 23 June 2011, Ms Allen saw Baby P's mother for an antenatal visit. At that time Baby P's mother told Ms Allen she was not going to continue with the CMP and was going to make other arrangements for support.[171] Ms Allen understood at the end of that visit that Baby P's mother would still attend her next appointment with Dr Saunders at KEMH on the Friday.[172]

118. A letter was sent to Baby P's mother by Ms Hudd from the CMP that same day confirming her decision to withdraw from the CMP and Ms Hudd's understanding that Baby P's mother would continue to have her care managed by KEMH.[173]

119. Baby P's mother did not attend the next scheduled KEMH appointment on 24 June 2011.[174] Dr Saunders telephoned her on 27 June 2011 and left a message for her to attend an appointment on 29 June 2011.[175]

120. On 29 June 2011, an entry in the hospital notes records that a midwife from KEMH telephoned Baby P's mother and offered her a new antenatal clinic appointment for that day. Baby P's mother declined and indicated that she had changed carers and did not want to come to KEMH. The entry indicates that Baby P's mother told the staff member she was in discussions with another maternity hospital, Kaleeya Hospital, to attend there. Baby P's mother was encouraged to attend KEMH at any time if she changed her mind.[176]

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[170] Exhibit 5, Tab 17 [10]; Exhibit 6, Tab 2nd Pregnancy, Antenatal Record entry 22.6.2011.
[171] Exhibit 10, Pregnancy Health, Record Progress Note 23.6.2011.
[172] Exhibit 10, Letter to Coroner from Marilyn Allen dated 14.10.2013.
[173] Exhibit 10, Letter from CMP Clinical Midwifery Consultant Ms D Hudd to Baby P's mother hand dated 23.6.2011.
[174] Exhibit 5, Tab 17 [11] – [12]; Exhibit 6, Tab 2nd Pregnancy, Antenatal Record entry 27.6.2011.
[175] Exhibit 5, Tab 17 [13].
[176] Exhibit 5, Tab 17 [14] – [15]; Exhibit 6, Tab 2nd Pregnancy, Antenatal Record entry 29.6.2011.

121. Baby P's mother's evidence was that she simply told the KEMH midwife that she had found "new caregivers, health caregivers" and that she was ceasing her relationship with KEMH. She said that the midwife then asked her if she was going with Kaleeya, and Baby P's mother replied, "I don't know. Something like that."[177]

122. Irrespective of which of those versions is correct, it is clear that Baby P's mother had made the final decision to have a home birth with the assistance of Ms Barrett but she chose not to inform the hospital staff of that decision.

123. Baby P's father had understood that his wife had told Dr Karczub earlier that she was still looking at homebirth as an option. However, Dr Karczub's evidence was that there was never any question in her mind that Baby P's mother would be birthing in hospital, until she found out after the birth that they had chosen to have a home birth.[178] I accept Dr Karczub's evidence on this point, which is consistent with her response at KEMH after 3 July 2011, when she became aware that the twins had been born at home.

MIDWIFE, BIRTH ADVOCATE & DOULA

124. When Baby P's parents were unable to find a midwife in Western Australia who would take on the responsibility of being the primary midwife for their homebirth, they did not take this as a final indicator (added to the information about the risks in a twin delivery that they had been told by KEMH staff) that the risks were too great to attempt a homebirth for their twins. Instead, Baby P's mother simply looked to other avenues for someone who would support her decision to have a homebirth.

125. Baby P's mother researched other options and, at some stage, apparently found a link between the CMP website and the blog website of Lisa Barrett.[179] The website is

[177] T 397.
[178] T 421 – 422.
[179] T 351.

named "Homebirth: Midwife Mutiny in South Australia."[180] On the website, Ms Barrett promoted the philosophy that birth at home "is truly the miracle of life and not a traumatic medical situation,"[181] and her belief that anyone who believes they want a birth at home should be entitled to get it.[182] At that time, the deaths of two babies during home births in South Australia, both in the presence of Ms Barrett, were being investigated by the South Australian Deputy State Coroner. Nevertheless, when Baby P's mother spoke to other people (unidentified) they apparently recommended Ms Barrett to her.[183] Baby P's mother described Ms Barrett as her "last option."[184]

126. Baby P's mother telephoned Ms Barrett and discussed her circumstances with Ms Barrett.[185] Baby P's mother told Ms Barrett she wanted to birth her twins naturally, and Ms Barrett understood Baby P's mother had been told she could not do so in hospital because 'twin 1' was breech.[186] Accordingly, Baby P's mother was planning to have a home birth. Ms Barrett advised she had previously been a midwife at twin deliveries at home, including cases where 'twin 1' was in a breech position.[187] Her past experience as a midwife delivering children in the breech position appears to have strongly influenced Baby P's parents' decision to pursue their home birth plan.[188]

127. Both of Baby P's parents were aware that Ms Barrett was a qualified midwife but was not registered as a midwife at that time.[189] Baby P's mother said she understood that Ms Barrett hadn't renewed her registration, within the context of midwives generally talking about "how their registration was…keeping them from helping women that truly needed support."[190] That is consistent with Ms Barrett's account at the inquest, namely that the

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[180] Exhibit 5, Tab 2.
[181] Exhibit 5, Tab 2.
[182] Exhibit 5, Tab 2.
[183] T 351, 353; Exhibit 5, Tab 6 [23] – [27].
[184] T 353.
[185] T 351; Exhibit 5, Tab 6 [23] – [27].
[186] T 476, 500 - 501.
[187] T 477 – 478, Exhibit 5, Tab 7 [33] – [34].
[188] Exhibit 5, Tab 7 [50] and video.
[189] T 352, 361, 373.
[190] T 352.

culture for midwives was changing and limiting the circumstances under which midwives could support women so she came off the register so that she "could support women in their choices when there wasn't an available practitioner."[191] Ms Barrett denied that she had given up her registration to avoid scrutiny by the Nursing and Midwifery Board of Australia (NMBA).[192]

128. Baby P's parents did understand that there was controversy in the medical community surrounding Ms Barrett, as Baby P's mother explained at the inquest that she did not consider the possibility of Ms Barrett supporting her in a planned hospital birth as,[193]

> *Lisa Barrett being Lisa Barrett, I don't think people would welcome her as a support person in a hospital.*

129. Ms Barrett described her role as being a "birth advocate."[194] She described at the inquest the services a midwife would provide as being "care for a woman who is pregnant, giving birth, and in the postnatal period for up to six weeks."[195] She denied that she was working as a midwife at that time, but said she was doing "anything that a common person could do."[196] However, she also accepted that she did bring her midwifery experience along with her[197] and did provide a "health care service."[198] What she said she specifically could not do was to give an injection or catheterise a client, given she wasn't a registered midwife.[199]

130. The term "birth advocate" seems to have been adopted by Ms Barrett in order to avoid contravening the prohibition in the *Health Practitioner Regulation National Law (WA) Act 2010* (WA) (National Law) against use of the title "midwife" or "midwife practitioner" by a person who is not registered

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[191] T 467.
[192] T 475.
[193] T 354.
[194] T 467, 478.
[195] T 468.
[196] T 475.
[197] T 479.
[198] T 496.
[199] T 485.

under the National Law.[200] There is currently no corresponding prohibition against engaging in the practice of midwifery and undertaking the clinical responsibilities of a midwife,[201] so provided Ms Barrett did not use the title of midwife or give the impression she was registered, she did not contravene the National Law. Ms Barrett's evidence that Baby P's mother "knew that I wasn't registered and in that capacity I *couldn't be seen* as her midwife" [italics added],[202] lends support to that conclusion.

131. The question of whether Ms Barrett was performing clinical duties and responsibilities of a midwife after ceasing to be registered was considered by the Deputy State Coroner of South Australia in an inquest into the death of a baby who died following a home birth attended by Ms Barrett.[203] Deputy State Coroner Schapel also considered the evidence available at that time as to the role played by Ms Barrett in Baby P's birth. His Honour concluded that Ms Barrett was performing the clinical duties and responsibilities of a midwife, and was not merely present as a birth advocate.[204]

132. Taking into account all of the additional evidence available to me, I respectfully agree with his Honour's conclusion in that regard and find specifically in this case that Ms Barrett was engaged to perform midwifery services during the birth, including monitoring foetal heart rates and giving Baby P's mother direction to assist her in labour. It is clear that Ms Barrett intended to fulfil the role of the primary or lead midwife in all but name.

133. After discussing the various options and the associated risks during several telephone conversations,[205] Baby P's mother and Ms Barrett eventually reached an arrangement that Ms Barrett would come to Perth and be the primary

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[200] See sections 113 and 116 of the National Law.
[201] T 763.
[202] T 479.
[203] Inquest into the death of Tully Kavanagh by South Australian Deputy State Coroner A.E. Schapel – delivered 6 June 2012.
[204] Inquest into the death of Tully Kavanagh by South Australian Deputy State Coroner A.E. Schapel – delivered 6 June 2012 [11.9] – [11.10].
[205] Exhibit 5, Tab 8 [9].

caregiver for Baby P's mother during a home birth. Ms Barrett was to be paid $3000 for her services in addition to her travel costs.[206]

134. Ms Clifford, who was a midwife with extensive experience and working as a registered independent practising midwife in Perth at the time, was also to continue her arrangement with Baby Ps mother.[207] Ms Clifford understood that Lisa Barrett had been engaged and she knew Lisa Barrett was not registered as a midwife at that time. She also knew something of Ms Barrett's general reputation and was not concerned by anything she had heard.[208]

135. Baby P's father booked Ms Barrett's flight and a few days later, on 22 June 2011, Ms Barrett flew to Perth.[209] She was accommodated in a cottage located at Ms Clifford's property and Ms Clifford also offered her the use of a car and her midwifery equipment.[210]

136. Following her arrival in Perth, Ms Barrett began seeing Baby P's mother and father almost every day.[211] There is some debate as to how many of the meetings were attended by Ms Clifford. There is a suggestion from Baby P's parents that she attended most of them,[212] but Ms Barrett and Ms Clifford's evidence is that she only attended once.[213] No notes have been provided to the court in relation to the antenatal meetings so it is difficult to be certain about what occurred.

137. In any event, the witnesses agreed that there was at least one meeting attended by Baby P's parents, Ms Barrett, Ms Clifford and Danielle Senini, a friend of Baby P's parents who is also a doula.[214] It was established at the meeting that Ms Barrett's role was to be the 'birth

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[206] T 503 - 504.
[207] Exhibit 5, Tab 9 [18] – [19].
[208] T 527, 547.
[209] Exhibit 5, Tab 6 [28].
[210] T 481; Exhibit 5, Tab 9 [20] – [25].
[211] T 390, 480; Exhibit 5, Tab 7 [37] – [38].
[212] T 362, 390.
[213] T 480, 529, 547.
[214] T 529.

advocate' and primary carer, although I note Baby P's father, who is a registered nurse, referred to her as the "primary midwife."[215]

138. Ms Senini's role was to be a friend and provide doula-type services, involving providing physical comforts such as hot packs and massage, as well as looking after Baby P's parents' other child.[216]

139. What was to be Ms Clifford's role is the matter of some debate. Ms Barrett said she understood that the arrangement between Baby P's mother and Ms Clifford was that Ms Clifford was a currently registered midwife and she was prepared to "back up" at the birth if required.[217] Although she initially referred to Ms Clifford as the "back-up"[218] in her evidence, she later seemed reluctant to accept the description of Ms Clifford as the 'back up midwife' but gave descriptions such as "[s]he has a midwifery qualification, so she was coming as an assistant with a midwifery qualification."[219] In the end, she used a similar phrase of an "experienced pair of hands"[220] or a "second pair of hands."[221]

140. Baby P's mother, who engaged Ms Clifford's services, said that she understood that Ms Clifford was a very experienced midwife so she asked Ms Clifford "if she would attend the birth of my twins."[222] She understood Ms Clifford was not prepared to take on the responsibility of being the primary midwife as she was intending to retire soon but that Ms Clifford agreed to be "the second midwife" or "support midwife" at the birth.[223]

141. Baby P's father also explained he understood Ms Clifford was an experienced registered midwife and she would be attending as their "back-up midwife."[224] Thus while

[215] T 362, 484, 530.
[216] T 390, 529, 663.
[217] T 466, 481, 483.
[218] T 466.
[219] T 483.
[220] T 481.
[221] T 484.
[222] T 351.
[223] T 351.
[224] T 362.

Ms Barrett would be the primary caregiver, Ms Clifford would act in a supportive role.[225] He understood that they would "essentially work in partnership," partly based upon how he saw them interact together.[226]

142. In oral evidence Ms Clifford denied that she was engaged to play a primary midwifery role at the birth.[227] Ms Clifford accepted that she had agreed to act as the back-up midwife for Ms Bellingham.[228] However, she did not accept that she intentionally conveyed to Baby P's mother that she would be the back-up midwife for Ms Barrett,[229] following Ms Bellingham's withdrawal. Nevertheless, Ms Clifford accepted that when she became aware that new arrangements had been made for Ms Barrett to attend the birth, she didn't want to withdraw her support.[230]

143. Ms Clifford knew that Ms Barrett was qualified as a midwife but unregistered, and she understood that Ms Barrett would be the primary carer at the birth.[231] Ms Clifford placed emphasis on her role in the arrangement as the postnatal midwife, as Ms Barrett would have to return home after the birth.[232] Ms Clifford conceded that she said that she would attend the birth if she was called,[233] she thought she probably would be called at some stage during the labour,[234] and indeed she hoped that she would be called.[235] Ms Clifford offered no reason for why she wouldn't be called to attend, other than if the births happened quickly.[236] In the event Ms Clifford was called to attend, she described her role to be "an extra pair of hands"[237] in those circumstances and maintained she was not to be paid any extra money if she attended the birth.[238]

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[225] T 362.
[226] T 363.
[227] T 530.
[228] T 526.
[229] T 528.
[230] T 531.
[231] T 527 - 531.
[232] T 528, 547.
[233] T 527.
[234] T 529.
[235] T 529, 535, 547.
[236] T 548.
[237] T 548; Exhibit 5, Tab 9 [25].
[238] T 528.

144. Ms Clifford also voluntarily provided midwifery equipment for use at the birth,[239] accommodated Ms Barrett at her home and provided a vehicle for her use.[240]

145. I am satisfied the evidence establishes that Ms Clifford understood prior to being telephoned to attend on 2 July 2011 that, if called (which was most likely), she would be attending the planned birth at home of twins and that the primary caregiver in attendance, Ms Barrett, was not registered as a midwife. In agreeing to attend, Ms Clifford was aware that she would be expected to use her skills as a registered midwife to assist Ms Barrett in the delivery of the twins at home.

THE LABOUR AND DELIVERY

146. On Saturday, 2 July 2011 at about 2.30 pm, Baby P's mother was at the acupuncturist in Fremantle when her waters broke.[241] She went home and was joined at about 7.00 pm by Ms Barrett and Ms Senini. At that time, her contractions were approximately 5 minutes apart.[242] Ms Clifford also arrived around this time, having been rung by Ms Barrett, who requested she attend.[243]

147. Once Ms Clifford arrived at the home, she appears to have taken an active role in the monitoring of both Baby P's mother and the babies.

148. Unusually, no birth record appears to have been kept by Ms Barrett and/or Ms Clifford.[244] This is contrary to the National Competency Standards for midwives, which indicates the importance of contemporaneous and comprehensive documentation.[245] Dr Griffin was critical of this failure to document events, referring to the "poverty of content of contemporaneous record keeping."[246]

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239 T 531; Exhibit 5, Tab 9 [30].
240 Exhibit 5, Tab 9 [21] – [23].
241 Exhibit 5, Tab 6 [32], Tab 7 [55].
242 Exhibit 5, Tab 6 [34].
243 T 533.
244 T 486.
245 Exhibit 7, Tab 10, Exhibit 8, Tab 7, Element 1.3.
246 Exhibit 5, Tab 26 [6].

149. The closest information in time is a retrospective progress note made by a registered midwife, Lauren Bell, at KEMH at 7.30 pm on the day of the birth, documenting her discussions with Baby P's mother, father and Ms Barrett (referred to as a doula in the note).[247] Other than that note, I am left with only the witness accounts as to what occurred during the birth, by way of their statements and oral evidence and some limited video evidence.

150. Ms Barrett and Ms Clifford's evidence was that they were initially checking the babies' heartbeats approximately every half an hour, each lady having a Doppler to use.[248]

151. As the contractions got closer together and the birth of the first twin was imminent, it changed to after every contraction or approximately every 5 minutes.[249]

152. Ms Clifford checked the heart rates using her Doppler and was certain she heard both babies' hearts, which were distinguishable from their mother's.[250]

153. Baby P's mother started pushing at 2.00 am and gave birth to the first twin at 2.37 am on 3 July 2011.[251] As identified during the pregnancy, he came out from a breech position (bottom first)[252] and cried spontaneously.[253] His Apgar scores were 8 and 10, so he was in good health at birth.[254]

154. After the first twin was born, Ms Barrett checked for the heart rate of the second twin and confirmed there was still a heartbeat.[255] Ms Clifford could also hear it.[256]

155. Baby P's mother then continued labouring with the second twin, Baby P, in the birthing pool.

[247] Exhibit 6, Tab 2nd Pregnancy, Progress Note 3.7.2011 at 19.30.
[248] T 535.
[249] T 535 - 536.
[250] Exhibit 5, Tab 9 [33].
[251] Exhibit 5, Tab 6 [39]; Exhibit 6, Tab 2nd Pregnancy, Progress Note 3.7.2011 at 19.30.
[252] Exhibit 5, Tab 6 [40], Tab 8 [23]; Exhibit 6, Tab 2nd Pregnancy, Progress Note 3.7.2011 at 19.30.
[253] Exhibit 5, Tab 9 [33]; Exhibit 6, Tab 2nd Pregnancy, Progress Note 3.7.2011 at 19.30.
[254] Exhibit 6, Tab 2nd Pregnancy, Progress Note 3.7.2011 at 19.30.
[255] Exhibit 5, Tab 8 [24].
[256] Exhibit 5, Tab 9 [34].

156. Ms Clifford continued to monitor Baby P's heartrate with a Doppler and check Baby P's mother's pulse and she seems to have taken the primary role in this regard at this time.[257] Ms Clifford recalls Baby P's heart rate was between 130 and 145, which was normal.[258] Ms Barrett gave a broader range of 120 to 160, but said that was also within normal limits.[259]

157. Ms Clifford checked Baby P's heartrate for the last time approximately 5 minutes before Baby P was born.[260] There was nothing about his heartrate that caused either Ms Clifford or Ms Barrett any concern.[261]

158. Just prior to Baby P being delivered, Ms Barrett observed what appeared to be a blood clot coming out of the birth canal, which was suspected to be placenta.[262] This immediately prompted Ms Barrett to tell Baby P's mother that she needed to push the baby out immediately, which she did.[263] Baby P was delivered, head first, into the birthing pool along with the placenta.[264] He was lifted up by his mother and it was apparent to all those present that he was not breathing and very floppy.

159. Baby P's mother named him and she said Ms Barrett told her to blow in his mouth, which she attempted to do.[265] This cannot be seen on the video but on the video, Ms Barrett can be seen attempting to blow breaths into Baby P's mouth while he is held in his mother's arms, and Ms Clifford appears to be moving his legs. There is no immediate attempt to take the baby out of the pool and away from his mother to perform optimal cardiopulmonary resuscitation. An oxygen mask is shown being put on the floor, but it is not put on Baby P at that stage.

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[257] T 394.
[258] T 543.
[259] T 488.
[260] T 507, 536.
[261] T 507.
[262] T 507; Exhibit 5, Tab 8 [26].
[263] T 507.
[264] T 508; Exhibit 6, Tab 2nd Pregnancy, Progress Note 3.7.2011 at 19.30.
[265] T 393.

160. While it is not shown on the video, as Ms Senini stopped the video when it became apparent to her that something was wrong, Ms Barrett's evidence was she then took Baby P out of the pool and put him on the floor and she and Ms Clifford began to attempt to resuscitate him, while Baby P's father called to request an ambulance.

161. Ms Barrett did a couple of breaths to clear Baby P's airway then Ms Clifford administered oxygen with a mask while Ms Barrett performed chest compressions.[266] They apparently checked Baby P's heart rate with a Doppler during the resuscitation and found no evidence of a heart rate.[267]

162. Considerable evidence was led at the inquest about the resuscitative equipment that was brought to the home in preparation for the births and the resuscitation efforts of Ms Clifford and Ms Barrett prior to the ambulance officers arriving and taking over the care of Baby P. Ms Barrett and Ms Clifford's evidence was that they performed the resuscitation of Baby P on the floor.[268] Baby P's father remembers them being on the floor and also on the couch and at some stage "in arms".[269] As noted above, Baby P's mother remembers them at least starting on the floor.[270] As noted below, an ambulance officer thought the baby was being resuscitated while held in arms.

163. The evidence about how the resuscitation was performed was conflicting and there was some suggestion by Dr Minutillo it may not have been optimal based on the information provided to him.[271] I accept that Ms Barrett and Ms Clifford did their best to provide resuscitation to Baby P. My main concern is that they did not do so immediately, but at first left Baby P in his mother's arms and tried to perform some sort of resuscitation with him being held in her arms. This was clearly not optimal and displayed a surprising lack of urgency, given what they

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[266] T 537.
[267] T 540.
[268] T 499.
[269] T 366 - 367.
[270] T 393.
[271] T 219 - 220.

knew about the possible placental abruption and the state of the baby on delivery.

164. The evidence also indicates that there was sufficient equipment and people available to attempt resuscitation of one child, as occurred here, but not if the mother and both children required resuscitation.[272] I accept Ms Clifford's evidence that this was an unlikely scenario and it would be anticipated that an ambulance would arrive to assist.[273] However, it underscores why hospital was the appropriate venue for this delivery, where the resuscitative measures (including equipment and skilled staff) available will naturally be superior in the event a complication arises.

165. According to the St John Ambulance Patient Care Record, the first ambulance arrived at 3.33 am.[274] The first ambulance officer to enter the house was Grant Pursey. In his statement he recalls entering the house and seeing Baby P being resuscitated in the arms of one woman who was doing compressions while another woman was doing the bag valve mask.[275] He describes a woman who matches the description of Ms Barrett as identifying herself as the midwife.[276] Mr Pursey took Baby P and did 2 finger compressions while he walked to the van, which he estimates took approximately 10 seconds.[277] A few seconds later, he was given a bag valve mask and starting bagging while another ambulance officer did compressions.[278] Mr Pursey then suctioned Baby P's airways and the ambulance transported them to Fremantle Hospital while resuscitation continued.[279]

166. At the house and during the drive, they checked several times for signs of life physically and on the monitor. Baby P was not breathing, had no pulse and his heart

[272] T 825 – 826.
[273] T 826.
[274] Exhibit 5, Tab 22.
[275] Exhibit 5, Tab 11 [14].
[276] Exhibit 5, Tab 11 [15].
[277] Exhibit 5, Tab 11 [19].
[278] Exhibit 5, Tab 11 [25].
[279] Exhibit 5, Tab 11 [28] – [34].

rhythm was asystole, showing no cardiac electrical activity.[280] He was also very pale.[281]

FREMANTLE HOSPITAL

167. The ambulance arrived at Fremantle Hospital at 3.47 am and entered the hospital at 3.50 am.[282] The hospital had received notification that they were coming so they had already assigned roles to staff, which were put into effect upon Baby P's arrival.[283] Baby P was taken by the paramedics to the resuscitation area and put on a resuscitator, which is a specialised device for resuscitating babies.[284]

168. Baby P was observed to be blue, with no respiratory rate, no motor tone and his pupils were fixed and dilated. He had no palpable pulse at the umbilicus base.[285] His heart rate was recorded as less than 60 beats per minute, which was entered by a Registrar, Dr Hendrickson, to convey that there was no palpable pulse in a neonate and could represent any actual number from 0 to 69.[286] One of the other Registrars, Dr Todd, intubated Baby P as CPR and ventilation were continued.[287]

169. Dr Todd said in evidence that he recalls there was evidence of PEA.[288] This is an electrical rhythm of the heart that is not translated into an actual effective pumping action of the heart leading to an observable pulse.[289]

170. Because Baby P was showing PEA, he was given four doses of adrenaline, as the resuscitation guidelines suggest that adrenaline doses should be given to try to restart the heart.[290] The last dose was given at 4.06 am.[291]

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[280] T 514; Exhibit 5, Tab 11 [36], Tab 13 [12].
[281] Exhibit 5, Tab 13 [12].
[282] Exhibit 5, Tab 22; Exhibit 6, Tab 2 [11].
[283] T 552.
[284] T 552.
[285] Exhibit 6, Tab 4.
[286] Exhibit 6, Tab 4; Tab 5.
[287] T 553.
[288] T 553.
[289] T 211 – 212.
[290] T 554; Exhibit 6, Tab 2 [22].

171. An entry by Registered Nurse Canard two minutes after the second dose of adrenaline at 4.00 am records "Rhythm check PEA" (as compared to an earlier entry, which reads "asystole").[292]

172. Dr Todd does not recall any auscultated heartbeat, although he accepted it was possible that another doctor auscultated a heart rate of 20 beats per minute at some stage.[293] He observed that such a low heart rate was not a promising sign and would not have changed the outcome.[294]

173. The Paediatric Registrar, Dr Tung, had been called to the Emergency Department to assist with the resuscitation. When she arrived, Dr Todd was about to intubate and she observed Baby P to be grey and cool to the touch, with no heart rate detectable on auscultation and no spontaneous respiratory effort.[295] Dr Tung discussed the case with the Paediatric Consultant, Dr Patel, who advised that, given the duration of the resuscitation, the outcome was likely to be very poor but suggested that she speak to a member of the Newborn Emergency Transport Service (NETS) before ceasing CPR. Dr Tung spoke to a doctor from NETS who advised that they should stop all resuscitation attempts.

174. Dr Tung asked the Emergency Department staff to pause in their resuscitation attempts in order for her to perform a final assessment of Baby P. It was at this point that Dr Tung noted a very faint heart beat on auscultation, at around 20 beats per minute. There were no other signs of life present.[296] An entry by Nurse Canard at 4.12 am, which presumably relates to the time Dr Tung did her auscultation, records a rhythm check with a heartbeat auscultated at a rate of 70 then dropping to 30.[297] Resuscitation attempts were recommenced while Dr Tung discussed this finding with Dr Patel.

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[291] Exhibit 6, Tab 3.
[292] Exhibit 6, Tab 6, Paediatric Triage Assessment Form.
[293] T 554 – 555.
[294] T 554 – 555.
[295] Exhibit 6, Tab 6 – Stillborn, Integrated Progress Note 3.7.2011, 04.35.
[296] Exhibit 6, Tab 3.
[297] Exhibit 6, Tab 6, Paediatric Triage Assessment Form.

175. Dr Patel advised that they should still cease all resuscitation attempts, so resuscitation of Baby P was ceased at 4.21 am and Dr Todd confirmed there were no signs of life.[298] Dr Todd telephoned a staff member of the Coroner's Court and, following their discussion, Dr Todd issued a death certificate, giving the cause of death as "stillborn,"[299] and another certificate in relation to a stillborn or neonate death with the cause of death as "unknown."[300]

176. The death was later reported again to the Coroner by Dr Karczub on 4 July 2011.

OPINION OF DR MINUTILLO

177. Dr Corrado Minutillo, a Consultant Neonatologist at Princess Margaret Hospital, was asked to provide a report based on the information provided in the brief of evidence and by Dr Todd, Dr Hendrickson and Dr Tung in relation to the significance of the PEA and the auscultated heartbeat recorded.

178. Dr Minutillo observed that there was limited information as to the foetal heart rate prior to the birth, as neither Ms Clifford nor Ms Barrett was able to provide any details of actual rates or variations in heart rates.[301] However, the account of a strong heartbeat in utero approximately 5 minutes before birth, and the delivery of the placenta before Baby P strongly suggested that the placenta had separated from the uterus in the last 5 minutes before the birth.[302] From the moment of placental separation, Baby P did not have an oxygen supply in the birth canal during the last stage of labour.[303] That would have been reflected in Baby P's heartbeat if he had been on continuous monitoring.[304]

[298] Exhibit 6, Tab 2 [28].
[299] Exhibit 6, Tab 6, Tab - Other.
[300] Exhibit 6, Tab 6, Tab - Stillborn.
[301] T 217, 228; Exhibit 6, Tab 5.
[302] T 219, 222.
[303] T 217; Exhibit 6, Tab 5.
[304] T 219.

179. Baby P was observed to have been born limp, pale and lifeless at birth. Resuscitation was then provided, first by Ms Barrett and Ms Clifford and then by the paramedics. At least at the point in time when Baby P was in the ambulance, Dr Minutillo observes that it is clear that the absence of a heartbeat/pulse was not associated with PEA.[305] However, on arrival in hospital, the monitor pads were removed, although Dr Minutillo assumes it is likely that electrical monitoring was started again soon after.[306]

180. Dr Minutillo notes that Baby P's heart did start after adrenaline, endo-tracheal ventilation and a fluid bolus at Fremantle Hospital. Dr Minutillo described it as a "flicker of a heartbeat,",[307] but an actual beating of his heart nonetheless. Unfortunately this was far too late.[308] His heart rate at that stage was inadequate for him to survive and have any quality of life.[309]

181. Dr Minutillo speculated that, given Baby P's weak response to appropriate neonatal resuscitation at about 55 minutes of age, he may have rapidly responded to this same resuscitation protocol if he had been born in a hospital and was provided with this emergency care at the time of his birth.[310] For that reason, in Dr Minutillo's opinion, it is certainly possible that the outcome might have been better if Baby P had been born in hospital, where optimal resuscitation was available.[311]

182. This opinion is given within the context that birth asphyxia is a relatively common event, and often unpredictable, but most babies can be resuscitated without developing any signs of encephalopathy.[312]

183. Dr Minutillo accepted that, depending on the timing of events, there were no guarantees that even in a hospital

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[305] Exhibit 6, Tab 5.
[306] Exhibit 6, Tab 5.
[307] T 211.
[308] Exhibit 6, Tab 5.
[309] T 230.
[310] Exhibit 6, Tab 5.
[311] T 217 – 219.
[312] T 200 – 201, 223.

setting Baby P could have been saved, but in his words "you've got a chance."[313]

CAUSE AND MANNER OF DEATH

184. Dr Jevon, a Perinatal/Paediatric Pathologist, and Dr Cooke, the Chief Forensic Pathologist, made an external examination of the body of Baby P on 6 July 2011 and of a placenta and umbilical cords on 7 July 2011. They did not do an internal examination as one was not authorised by the State Coroner, due to the request of the family of Baby P that an internal examination not be performed.[314]

185. The external examination and x-rays showed apparently normal development with no externally evident dysmorphic features (meaning no abnormalities)[315] and no skeletal abnormalities. Other than a small area of grazing to the skin of the back, no other externally evident injuries were observed. There was a small amount of possible meconium, or faecal material, staining to the skin around the anus and right armpit. This is consistent with Baby P experiencing intra-uterine or intra-partum physiological stress.

186. As there was no internal examination, the possibility of abnormalities of the body organs could not be ruled out.[316]

187. Dr Jevon and Dr Cooke also examined the placenta and umbilical cords that were provided to them. The material they were able to examine did not show any apparent abnormalities. If there was a placental abruption, it is sometimes possible to observe a placental blood clot on the maternal surface, but no obvious blood clots were attached to the placenta they examined.[317]

188. However, it was apparent from the other evidence at the inquest that Dr Jevon and Dr Cooke were not given all of

[313] T 226.
[314] T 109.
[315] T 101.
[316] T 102; Exhibit 5, Tab 21.
[317] T 103.

the placental material to examine. A clinical midwife at KEMH, Jacinta Allan, had been given the placenta to examine by Baby P's parents on 3 July 2011. In total, the placenta Ms Allan examined weighed 998 grams.[318] Ms Allan observed it was a twin placenta with two distinct segments on a joined mass of tissue. The right side was smaller and the cord red and jelly-like, suggesting that the blood flow had stopped to that side of the placenta,[319] which would seem to be consistent with the history of placental separation. The left side, on the other hand, appeared normal.[320] Ms Allan drew a diagram of what she observed.[321]

189. After examining the placenta, Ms Allan returned it to Baby P's mother's hospital room.[322] Baby P's mother then consumed some of the placenta while in the hospital.[323] The following day, the remainder of the placenta was apparently taken home by Ms Barrett[324] and was later seized by police.[325] It seems that it was this portion of the placenta that was examined by Dr Cooke and Dr Jevon.

190. At the inquest, Dr Cooke confirmed that the placental material he and Dr Jevon examined weighed only around 300 grams[326] and was not consistent with Ms Allan's diagram, suggesting that they only saw half of the placenta.[327] This obviously limited the scope of their examination.

191. At the end of the external examination and investigations, the pathologists formed the opinion that the cause of death was undetermined.[328] However, based upon the information available from other sources, Dr Cooke and Dr Jevon concluded that it was likely that the deceased died as a result of intra-partum hypoxia, possibly due to

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318 Exhibit 5, Tab 16 [24].
319 Exhibit 5, Tab 16 [19] – [20].
320 Exhibit 5, Tab 16 [21].
321 Exhibit 5, Tab 23.
322 Exhibit 5, Tab 16 [25].
323 Exhibit 5, Tab 6 [55].
324 Exhibit 5, Tab 16.
325 Exhibit 5, Report of Det. S/C Albuquerque, 7 - 8.
326 T 108.
327 T 107.
328 Exhibit 5, Tab 21.

premature separation of the placenta from inside the womb.[329] They also observed that the medical evidence was conflicting as to whether Baby P partly responded to resuscitation attempts before his death was certified at 4.21 am.[330]

192. Even if an internal examination had been authorised and performed, Dr Cooke indicated that it is unlikely that it would have shed any light on whether Baby P had taken a breath or had a heartbeat or shown any sign of life after birth.[331]

Conclusion as to Cause of Death

193. Given the limitations of the external examination, Dr Cooke and Dr Jevon were unable to form an opinion as to the cause of death. However, in their opinion, based on the evidence available, the most likely cause of death was intrapartum asphyxia, due to placental abruption. Dr Minutillo agreed with the pathologists line of reasoning and their conclusion as to the likely cause of death.

194. Relying upon the expert opinions noted above, and taking into account the evidence of the midwives of an acceptable foetal heart rate approximately five minutes before the birth, and then the clear evidence of the placental abruption, I am satisfied the cause of death was intrapartum hypoxia due to placental abruption.

Conclusion as to Manner of Death

195. Given my conclusion as to the cause of death, it follows that I find that the death occurred by way of natural causes.

[329] T 105; Exhibit 5, Tab 21.
[330] Exhibit 5, Tab 21.
[331] T 109.

KNOWN RISKS OF TWIN BIRTH

196. There was no dispute amongst the experts who gave evidence at the inquest that a twin birth carries inherently higher risks of morbidity and mortality (foetal and maternal) than a singleton pregnancy.[332] Even Ms Barrett told Baby P's mother, "two babies, double the risk."[333] Complications involving the birth of the second twin are particularly common, with up to 50% of second twins requiring an emergency caesarean section delivery.[334] Placental separation is one of those risks.[335]

197. Dr Griffin observed that "the reduction in risk for the death of a second twin in the 21st century is solely due to the availability of methods to effect immediate delivery of the baby with skilled staff present to resuscitate the newborn baby."[336]

198. Twin pregnancies are, therefore, appropriately categorised as 'high risk' pregnancies that require expert obstetric care.[337] Dr Catling and Professor Homer note that the National Midwifery Guidelines, which form part of the professional, legal and regulatory framework for midwifery practice in Australia,[338] indicate that a multiple pregnancy falls into Category C, which requires a definite referral to secondary or tertiary care as the woman needs obstetric care.[339] The CMP eligibility criteria reflect these guidelines, precluding women identified as having a multiple pregnancy from the CMP.[340]

199. The inherent risk of a twin pregnancy was amplified in this case because of the identified position of the first twin in the breech position.[341]

[332] T 797 - 798.
[333] T 355.
[334] T 797; Exhibit 5, Tab 26, 3.
[335] T 797.
[336] Exhibit 5, Tab 26, 3.
[337] T 799.
[338] Exhibit 8, Tab 1, 4.
[339] T 609, 638; Exhibit 5, Tab 25, 16; Exhibit 8, Tab 10.
[340] Exhibit 2, Tab 13.1 & 13.2.
[341] T 799; Exhibit 5, Tab 25, 17.

200. In addition, with twin 1 identified as breech and twin 2 as cephalic, there was an additional (although rare) risk that the twins would become locked during delivery. This is a life-threatening complication.[342] It was because of the risk of this occurring that Dr Griffin indicated that he would have recommended an attempted vaginal birth in this case be done in theatre, with constant monitoring of twin 2 and additional skilled staff on hand, so that a caesarean section could be performed in a very rapid manner, if required.[343]

201. Due to the known risks in this case, none of the experts considered that it was ever a safe option for Baby P's mother to have a home birth once it was identified that she was pregnant with twins.[344]

WOULD A HOSPITAL BIRTH HAVE RESULTED IN A DIFFERENT OUTCOME?

202. It cannot be said with certainty that Baby P would have lived if he had been born in hospital on 3 July 2011 rather than at home. However, the evidence points to him being healthy and viable in the period immediately preceding the labour and birth, which suggests that it was the events during the delivery that were the significant factor in his death.

203. How likely it was that a different outcome could have been achieved for Baby P depends, to a large extent, upon what recommendations as to obstetric care Baby P's mother was prepared to accept, as well as when the hypoxic event occurred.

204. If Baby P's mother had agreed to a caesarean section, the weight of the general expert evidence pointed to Baby P being born healthy and well. This puts to one side any maternal risks associated with caesarean section, as

[342] T 797, 803; Exhibit 5, Tab 25, 17.
[343] T 803.
[344] Exhibit 5, Tab 25, 17; Tab 26, 3.

explained in detail by Dr Griffin.[345] I accept Dr Griffin's general evidence that those risks were statistically small and not of the scale suggested by Ms Barrett.[346]

205. If Baby P's mother had agreed to the standard recommended management for a twin birth, which includes an epidural in situ in case manipulation or an emergency caesarean was required, and continuous CTG monitoring of the foetal heart rate to detect any foetal distress, the general obstetric opinion was that Baby P would very likely have survived, even in the event placental separation had occurred.[347]

206. If Baby P's mother had maintained her position and declined continuous monitoring and an epidural in situ, then to some extent the answer as to whether there might have been a different outcome depends on when the hypoxic event occurred.

207. Dr Karczub gave evidence that placental separation can happen over varying periods of time, from minutes to hours.[348] There were no signs to suggest in this case that the placental abruption occurred before labour commenced or in the first stage of labour.[349] In the second stage of labour, it is difficult to pinpoint exactly when the abruption occurred, although it can be said that it commonly occurs after the birth of the first twin and the timeframe for the greatest concern begins after more than 30 minutes has elapsed from the first birth.[350]

208. In those circumstances, it was considered that delivery in hospital would have provided the best facilities and skilled staff to expedite the birth and provide optimal resuscitation. This would have increased the likelihood that Baby P could have been resuscitated quickly with a better outcome.[351] The final outcome depended upon how long prior to his delivery the hypoxic event had occurred,

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[345] T 800 – 801.
[346] T 505.
[347] T 431 – 432, 801, 803.
[348] T 436 - 437.
[349] T 452 - 453.
[350] T 223, 228, 453, 457.
[351] T 218 - 219, 435 – 436.

how quickly the obstetrician could get Baby P out and what condition Baby P was in by that time.[352] However, what can be said conclusively is that Baby P's best chance of survival was in hospital.

CONDUCT OF KEMH STAFF

209. It is apparent from the evidence I have outlined above that Baby P's parents strong preference was for a home birth managed by a midwife from the CMP, like they had for their first child. When Baby P's mother was unable to continue her plan to have a home birth with the CMP, she reluctantly began contact with KEMH, in the hope that another alternative might be found. At the same time, I accept that she and Baby P's father continued to engage with KEMH staff to see what birth options could be offered that might meet their needs.

210. Baby P's mother placed considerable emphasis upon her desire for a water birth. At that time, and even today, there are limits to how that request could be accommodated, given the risk factors associated with her birth. There was evidence given during the inquest that Baby P's mother's request for access to water during the birth was acknowledged by Dr Karczub and recorded in the Non-Standard Management Plan,[353] although it could only have been provided by way of a shower due to the complications associated with her pregnancy.[354]

211. The plan also recorded her intention not to consent to continuous monitoring, which was recommended.[355]

212. Dr Karczub explained that the Non-Standard Management Plan was developed out of a realisation that there are a group of women who will have preferences for their delivery that are contrary to evidence-based guidelines, but they are firm in what they want and their wishes need to be

[352] T 223 - 226.
[353] Exhibit 6, 2nd Pregnancy Antenatal Record, Non-Standard Management Plan dated 1.6.2011.
[354] T 416 – 417.
[355] Exhibit 6, 2nd Pregnancy Antenatal Record, Non-Standard Management Plan dated 1.6.2011.

respected.[356] The role of the Non-Standard Management Plan is to reduce anxieties and confrontation in the labour ward by recording the mother's wishes and an acknowledgement that she is aware of the risks associated with pursuing that plan and has made a clear and informed choice.[357] It continues to be used at KEMH in cases such as this, where a woman has an unanticipated pregnancy complication and will not accept the recommended care based on evidence-based guidelines.[358]

213. Baby P's mother had signed one Non-Standard Management Plan with Dr Karczub and it was likely she would need to sign another Non-Standard Management Form on her next appointment with Dr Saunders in relation to her choice not to have a caesarean section and not to have an epidural sited.[359] However, there was no suggestion that she would be forced to have an epidural, continuous monitoring or a caesarean section against her will.

214. I accept that from the perspective of Baby P's parents, what they were being offered did not match their expectations for the birth of their twins. Although they could make choices not to accept the medical advice and attempt a vaginal delivery with no epidural in place, and intermittent monitoring only, their choice was not supported and they were concerned they might experience pressure to change their choices at some stage.

215. They also were not offered other things important to them such as Baby P's mother's choice of midwife to perform vaginal examinations and water immersion in a bath during the delivery. This is less than ideal and I fully accept it would have been distressing for Baby P's parents, given they had hoped to replicate the positive experience they had with the birth of their first child at home. Dr Karczub herself acknowledged how distressing it can be for a couple to have their plans and dreams for their

[356] T 441 - 442.
[357] T 459 - 460.
[358] T 441.
[359] T 414, 447.

delivery taken away because of unexpected complications arising during the pregnancy.[360]

216. However, the reason this arose is because of the higher risks associated with Baby P's mother's pregnancy on this occasion. I cannot criticise the hospital for putting the safety of the woman and babies above the birth environment or birth experience. As Dr Karczub explained, "[t]ry as we might, we are not going to recreate the ambiance of a birth centre or the ambiance of being at home, and the nature of why that patient may be in our tertiary hospital labour ward is because she had a complication which does not make her a normal low risk delivery and that in itself brings certain pressures and recommendations which the woman…clearly would have preferred not to have."[361] Dr Griffin also spoke of the difficulty matching expectations, and the problem with having to hide hard-faced scientific objectivity about care with the much more subjective feelings of people.[362]

217. Dr Griffin, who was asked to assess the care provided, expressed the opinion that within the constraints of the risks of the pregnancy, the hospital staff attempted to offer Baby P's parents "the best possible scenario for the birth."[363] I accept that this was the case.

218. Dr Catling, on the other hand, thought that there ought to have been more flexibility from the hospital's perspective to try to understand and accommodate the requests of Baby P's parents.[364] Dr Catling's comment appears to be based on the view that it would have been a safer situation for Baby P's mother to birth in hospital, on any terms she requested, even if they were contrary to obstetric advice, than to have a home birth.[365] I agree that is most likely correct, but I also consider that this was what the staff at KEMH attempted to do within the constraints of the facilities and protocols they had at the time.

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[360] T 440 – 441.
[361] T 460.
[362] T 722,724.
[363] T 724.
[364] T 651, 655.
[365] T 655 - 656.

219. Baby P's mother categorised herself as a woman that was "let down by the hospitals."[366] She said that she wanted to go to the hospital and her first decision was to go to hospital, but when she presented her birth plan to the obstetricians, it was not well received and she felt she was going to be pushed towards a caesarean section.[367] As noted earlier in this finding, I do not accept that Baby P's mother's preference was to have a hospital birth. Rather, I find she was prepared to accept that a hospital birth might be inevitable and was willing to consider it if her preferences for her care during labour could be accommodated. I do accept that she felt that her birth choices weren't being respected and supported, although as noted above, I also find that she was aware that she could insist upon her choices.

220. Baby P's father expressed his disappointment at what he considered to be the "not-negotiable attitude that we got from the hospital staff, and the judgmentalism and the pressure."[368] At the time, they felt that the kind of birth they wanted was not possible anywhere else than at home and he hopes that changes may be made to give women some options about their care.[369] They were concerned that if they stayed with the hospital they would be led down the path of intervention towards a caesarean section.[370]

221. Baby P's father provided to the Court copies of two papers. One is an article by A/Prof Michael Nicholl entitled *"Jumped or pushed?"* in relation to insights he gained from the homebirth review he conducted in Western Australia with Professor Homer in 2008.[371] The other is a statement from the World Health Organization (WHO) entitled *"The prevention and elimination of disrespect and abuse during facility-based childbirth"* released in 2014.[372]

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[366] T 352.
[367] T 353.
[368] T 378.
[369] T 378 – 379.
[370] T 380.
[371] Exhibit 5, Tab 7, *Jumped or Pushed?* A/Prof Michael Nicholl, O&G Magazine, V13 (4) 2011, 34.
[372] Exhibit 5, Tab 7. WHO statement.

222. The World Health Organization statement is directed towards eliminating disrespectful, abusive or neglectful treatment during childbirth in facilities.[373] There is currently no international consensus on how disrespect and abuse should be scientifically defined and measured, so it is to some extent a subjective matter as to whether it has occurred in a particular case.[374] I do not categorise any of the conduct of the CMP or KEMH staff in this case as disrespectful or abusive, noting it is very different to the kinds of examples of conduct given in the WHO statement.

223. Baby P's father placed emphasis on the right of every woman to information, informed consent and refusal and respect for her choices and preferences during maternity care.[375] I do, of course, agree with this statement and would expect most health care professionals in Western Australia would also. However, in providing information to a woman, there is the possibility that the information will conflict with her choices and this may well come across as the health professional being disrespectful. Nevertheless, the obstetrician or other health professional is obligated to provide that information, and their medical opinion, where they consider the safety of the woman or baby may be affected. That is part of informed choice, even though it may have the consequence of negatively affecting the relationship between the woman and her obstetrician.

224. The other issue in this case follows on from what Dr Catling observed about a need for greater flexibility by the hospital, and this same issue is addressed in A/Professor Nicholl's article.[376] It is suggested that individualised clinical risk management rather than a hospital policy of pure risk avoidance would prevent people such as Baby P's parents from feeling the need to seek alternatives to hospital care.[377] In this case, as I have noted above, I find that Baby P's mother's strong preference was always for a home birth, if she could find someone to assist her. However, I do accept that she

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[373] Exhibit 5, Tab 7, WHO statement, 1.
[374] Exhibit 5, Tab 7, WHO statement, 2.
[375] T 379, Exhibit 5, Tab 7, WHO statement.
[376] Exhibit 5, Tab 7, *Jumped or Pushed?*, A/Prof Michael Nicholl, O&G Magazine, V 13(4) 2011.
[377] Exhibit 5, Tab 7, *Jumped or Pushed?*, A/Prof Michael Nicholl, O&G Magazine, V 13(4) 2011, 35.

might not have gone to the lengths of engaging Ms Barrett if she had felt that her birth choices were more able to be accommodated and supported in hospital.

225. That is not, however, a criticism of KEMH or its staff as the risks present in Baby P's mother's case were very real (and sadly realised here) and had to be managed appropriately within the framework they had available.

CONDUCT OF MS BARRETT AND MS CLIFFORD IN ASSISTING A HOME BIRTH

226. As noted above, the National Midwifery Guidelines indicate that a multiple pregnancy requires referral to a hospital for obstetric care. The National Midwifery Guidelines are designed "to offer pregnant women the highest standard of safe and collaborative maternity care."[378] The Guidelines are intended for midwives to follow to assist a woman in making informed choice about her place of birth. As part of that process of informed choice, the Guidelines indicate that where a woman exercises a choice that is contrary to professional advice or the Guidelines, the midwife should carefully document the woman's concerns and decision and the advice and information that the midwife provided.[379]

227. In this case, Baby P's mother's decision to attempt a home birth was clearly deviating from the standard obstetric advice and the path recommended in the National Midwifery Guidelines for her care. However, no documentation was provided by either Ms Barrett or Ms Clifford in relation to any conversations had with Baby P's mother about her decision.

228. Baby P's mother recalls Ms Barrett talking to her about the higher risks involved in the birth of two babies, and she asked whether Baby P's parents were "willing to take that

[378] Exhibit 8, Tab 10, 3.
[379] Exhibit 8, Tab 10.

risk." She apparently said to them "two babies, double the risk."[380]

229. Ms Barrett stated that she gave advice on the risks and advantages of birthing in hospital and home birthing in the context of knowing Baby P's mother was pregnant with twins.[381] Ms Barrett appears to have placed considerable emphasis on the risks associated with caesarean section, which she described as "long-term liability risks."[382] She did not, on the other hand, emphasise the positive aspect of a planned caesarean section, in terms of the safety of the babies.[383]

230. Ms Barrett was adamant that it was not her place to tell Baby P's mother "what she should or should not do" but merely to provide information and it is apparent that she did not counsel Baby P's parents against their preference for a home birth, other than to explain to them that if they chose to birth at home and there was a complication and a baby died, there would most likely be a police investigation.[384]

231. Baby P's father recalled from discussions with Ms Barrett that they were led to believe that they were not taking on any more risk than if they were giving birth in hospital.[385]

232. Baby P's mother also described Ms Clifford as being "supportive" in her discussions about her decision to remove herself from the CMP and hospital care.[386]

233. Baby P's father had a specific recollection of Ms Clifford discussing with them the risks involved in having twins at home. He recalled they were led to believe by Ms Clifford that they were not taking on any more risk than they would have been if they had the babies in hospital.[387]

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[380] T 355.
[381] T 475, 477, 504 - 505; Exhibit 5, Tab 8 [8] – [9].
[382] T 505.
[383] T 506.
[384] T 477, 504 - 505.
[385] T 363.
[386] T 352.
[387] T 363.

234. Baby P's father understood that there were higher risks involved in a twin birth but, as he put it, he understood from both Ms Barrett and Ms Clifford that "there were no guarantees," irrespective of whether the births took place in hospital or at home.[388] I accept the expert evidence heard at the inquest that this was absolutely not the case.

235. Baby P's father also said in evidence that they chose Ms Barrett and Ms Clifford as they "supported what we wanted, but also were able to – and willing – to tell us if we were doing something that was unreasonable in our choices of where we wanted to give birth."[389] He observed that they,[390]

> *were the only ones that seemed to come forward and…step up say, "Yes. We can help you to have the kind of birth that you desire."*

236. It is apparent from the evidence that Baby P's parents formed a false sense of confidence in the abilities of Ms Barrett and Ms Clifford to manage the delivery of the twins safely at home. The reality was that this was never a safe choice.

237. Dr Griffin described the birth plan as "the most unobjective management plan as I have seen for such a complex case"[391] and noted that the methods adopted in planning for the birth were "most certainly not supported by any other professionally regulated bodies in Australia."[392]

238. I accept that Baby P's mother was fixed in her intention to have a home birth, at least from late June 2011, and was unlikely to be dissuaded by any advice by Ms Barrett or Ms Clifford. When asked during the inquest what she would have done if Ms Barrett had not agreed to assist her at the birth, Baby P's mother replied that she would have

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[388] T 363 – 364.
[389] T 373 - 374.
[390] T 374.
[391] Exhibit 5, Tab 26, 5 and see T 805.
[392] Exhibit 5, Tab 26, 5.

found someone else.[393] If not, she would have stayed home as long as she could.[394]

239. The fact that Baby P's mother felt certain in her choice did not, however, exempt Ms Barrett and Ms Clifford from warning Baby P's mother in strong terms of the serious risk to the health of her babies and herself, if she pursued her preferred place of birth. The situation called for a discussion with Baby P's parents, documentation of that discussion and consultation with other midwives and staff at KEMH.[395]

240. Ms Clifford in particular, being registered as a midwife at that time, had an obligation to follow the National professional standards for midwives.[396] Ms Clifford acknowledged that in her own practice she had arranged for twin deliveries to be managed in hospital when such arrangements had been available, and it was not at all part of her practice to manage twin births at home.[397] This birth was, then, outside the scope of her normal practice and for good reason, given the recommended pathway is for referral to an obstetrician. The National Competency Standards for the Midwife indicate collaboration with other health care providers in those circumstances,[398] which is consistent with Dr Griffin's view that the hospital staff should have been contacted and discussions encouraged.[399]

241. It was put to Dr Griffin by counsel appearing on behalf of Ms Clifford that if the lead midwife was providing antenatal care, it was for the lead midwife to have communications with the hospital.[400] Dr Griffin accepted that proposition, on the basis that the primary caregiver was, in fact, a midwife. As Ms Barrett was not registered, she could not, in fact, be categorised as the lead midwife.[401] Ms Barrett,

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[393] T 395.
[394] T 395.
[395] Exhibit 5, Tab 26, 5.
[396] Exhibit 8, Tab 1, 1.12.
[397] T 545.
[398] Exhibit 8, Tab 1.17.
[399] T 804; Exhibit 5, Tab 26, 5.
[400] T 807 – 808.
[401] Ms Martin gave evidence that the term "midwife" is a protected title under the National Law relating to health professionals, and can only be used by a qualified

who was operating as a self-described 'birth advocate,' was not subject to the scrutiny of the Nurses and Midwives Board of Australia nor bound to follow the professional practice standards required for a midwife to be registered. The ethical obligation therefore fell to Ms Clifford.

242. In those circumstances, in Dr Griffin's opinion it would be appropriate for Ms Clifford to act as the primary carer and midwife, not the back-up midwife, and to take on the responsibilities of that role. The National Midwifery Guidelines suggest that in those circumstances, she should be documenting all discussions and decisions, engaging the staff at KEMH to see if she could facilitate a resolution to Baby P's mother's concerns about a hospital birth and also planning for the management of an emergency.[402]

243. Dr Catling also noted that she had never before heard of a registered midwife backing-up a person who was not registered as a midwife and she would not consider that to be best practice.[403] Similarly to Dr Griffin, Dr Catling indicated that in those circumstances the registered midwife should be the lead carer.[404]

244. In Dr Griffin's view, the alternative choice for Ms Clifford, when she became aware that the primary carer was not a currently registered midwife, was to decline to continue her role as the support person and "walk", as Dr Griffin put it.[405] He did not accept the proposition put to him that best practice would be to continue her role, in those circumstances.[406] This opinion appears consistent with the approach outlined in the National Midwifery Guidelines.[407]

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midwife who is currently registered. Hence there is no such thing as an 'unregistered midwife'. However, the practice of midwifery is not currently protected under the National Law – T 763; Exhibit 8, Tab 1.

[402] Exhibit 5, Tab 7 (as it applied in 2011), 44 – 45; Exhibit 8, Tab 10, 71 - 72.

[403] T 642 – 643.

[404] T 644.

[405] T 808.

[406] T 809.

[407] Exhibit 5, Tab 7 (as it applied in 2011), 45 - 46; Exhibit 8, Tab 10, 72 – 73.

245. I accept that the National Midwifery Guidelines indicate a midwife should not discontinue care at the last minute.[408] That is more consistent with the scenario that was put to Dr Catling by Ms Clifford's counsel, who asked Dr Catling about whether Ms Clifford should have stayed if those circumstances became known "at the time of birth."[409] Dr Catling agreed with that proposition. As I noted to counsel at the conclusion of the inquest, it was never clarified with Dr Catling whether she would have given a similar answer if the birth was not imminent.

246. In this case, the engagement of Ms Barrett as the primary carer was known to Ms Clifford well before the delivery date, so she had ample opportunity to reconsider her position and inform Baby P's mother. I accept Dr Griffin's opinion that Ms Clifford had a professional obligation to withdraw from any involvement in the birth plan once it became clear that Ms Barrett was to be the primary carer, unless Ms Clifford was prepared to take on that role and Baby P's mother agreed.

247. To the extent that I must assume that Dr Catling's response that Ms Clifford should stay included if she had a period of time to withdraw, I note that Dr Catling's evidence was that there was a difficult choice faced by both Ms Barrett and Ms Clifford, given Baby P's mother may have decided to free birth if she couldn't find someone to assist her.[410] It is obviously better, from a safety perspective, to have experienced and qualified people at the birth than for a woman to be on her own,[411] and that seemed to be a significant factor Dr Catling took into account. I accept that is the case. Ms Clifford's counsel emphasised that this was a primary factor in Ms Clifford's willingness to remain involved, and I accept that. Unlike Ms Barrett, Ms Clifford was not in the habit of facilitating the birth at home of twins.

[408] Exhibit 5, Tab 7 (as it applied in 2011), 46; Exhibit 8, Tab 10, 73.
[409] T 645.
[410] T 643.
[411] T 221, 643.

248. However, Ms Clifford acknowledged that when Baby P's mother came to see her, she was seeking reassurance.[412] Although I accept that Ms Clifford played no role in putting Baby P's mother in contact with Ms Barret, as I have noted earlier in this finding, Baby P's mother and father recalled discussions with Ms Clifford after Ms Barrett was engaged, where she was supportive of their decision and minimised the risk involved. Her behaviour in volunteering to provide accommodation, a vehicle and equipment to Ms Barrett would also have lent implicit support to Baby P's parent's view that she did not disapprove of Ms Barrett's anticipated role in the birth and the birth plan itself.

249. Ms Clifford did give evidence that she was concerned for the safety of the mother and baby, and so she wanted her equipment at the house in case she was called, to put her mind at rest that some safety equipment was there.[413] However, Ms Clifford does not appear to have conveyed those concerns to Baby P's parents and Ms Barrett.

250. There is a difference between:

    a. being willing to attend and assist at a birth where it has become clear that, despite the person's best efforts to provide guidance and advice cautioning against an unsafe choice of place of birth, a woman intends to pursue her wish to attempt a home birth; and

    b. encouraging that choice and providing reassurance that the choice is a safe one.

    In my view, Ms Barrett's, and, to a lesser extent, Ms Clifford's conduct fell into the latter category.

251. It is apparent from material available on Ms Barrett's website that her encouragement stemmed from a strongly held belief that there is nothing concerning about a woman choosing to give birth to twins at home.[414] There is nothing to suggest her views changed following this death,

[412] T 541.
[413] T 534.
[414] Exhibit 5, Tab 2 and the website.

as she was involved in another home birth of twins in South Australia later that year, where again the second twin died following placental abruption.[415]

252. Ms Clifford's counsel, Mr Cuomo, submitted that Ms Clifford, on the other hand, was faced with a determined mother who had made decisions that were unlikely to be changed by advice from Ms Clifford. In those circumstances, Ms Clifford provided support out of the "best of motives",[416] wanting to help and, in effect, to ensure that the birth that had been chosen took place in as safe an environment as was possible in the circumstances. I am prepared to accept that Ms Clifford did provide her support in those circumstances, but it does not alter the fact that it was incumbent upon her to strongly express her own view that the choice being made was not a safe one.

253. Ms Barrett's conduct while a registered midwife was the subject of a hearing before the Health Practitioners Tribunal of South Australia in December 2013. The Tribunal also took into account Ms Barrett's conduct in providing midwifery services after she surrendered her registration, including her involvement in Baby P's birth. The Tribunal decided Ms Barrett's conduct was professional misconduct and on 11 March 2014 the Tribunal determined to reprimand Ms Barrett in the strongest terms, impose a fine of $20,000 and permanently prohibit Ms Barrett from providing health services associated with the practice of midwifery pursuant to s 196(4) of the National Law.[417]

254. Ms Barrett gave evidence at the inquest that she is no longer involved "in the midwifery world or in the birth world."[418]

255. Ms Clifford is also no longer registered as a midwife, having surrendered her registration on 30 July 2011. At

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[415] Inquest into the death of Tully Oliver Kavanagh by South Australian Deputy State Coroner A.E. Schapel – delivered 6 June 2012.
[416] T 858.
[417] *Nursing and Midwifery Board of Australia v Barrett* [2014] SAHPT 1.
[418] T 472.

that time, she had been reprimanded for working outside the scope of practice for a midwife in the homebirth environment and restrictions had been placed on her practice by the Australian Health Practitioner Regulation Agency (AHPRA) precluding her from providing services as a midwife at home births. As she was winding down her practice in any event, she elected not to continue to be registered.[419] She indicated that she is no longer attending births at home now, other than as a supporter for a couple of friends, with a registered midwife in attendance.[420]

256. In the circumstances, there is little purpose in my making a reference to AHPRA pursuant to s 50 of the *Coroner's Act.*

COMMENTS ON PUBLIC HEALTH

257. The evidence heard in this inquest, and the other two inquests heard at the same time, highlighted some of the complex issues surrounding home birth in Australia. Many of the same issues have been considered in a number of other recent coronial inquests into the deaths of infants born during home births.[421]

258. From a statistical point of view, the numbers of women having home births in Australia is relatively small. For example, in Western Australia the rate is about 0.8%.[422] Dr Minutillo suggested the figures are something like 200 births a year in Western Australia, out of approximately 30,000 deliveries.[423]

259. However small the numbers, it is acknowledged that the home birth debate is a fervent one, with strong views held by interested parties both for and against the practice of

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[419] T 56; Exhibit 8, Tab 1A, Letter from AHPRA dated 26 September 2014.
[420] T 57.
[421] For example: Inquest into the deaths of Tate Spencer-Koch, Jahli Jean Hobbs and Tully Oliver Kavanagh by South Australian Deputy State Coroner A.E. Schapel – delivered 6 June 2012; Inquest into the death of Joseph Thurgood-Gates by Victorian Coroner K.M.W. Parkinson – delivered 10 May 2013, Inquest into the death of Bodhi Eastlake-McClure by NSW Deputy State Coroner H.C.B. Dillon – delivered 7 August 2014.
[422] T 765; Exhibit 7, Tab 3, Tab 6.
[423] T 228. Of those deliveries that are planned, very few would involve the birth of twins. Dr Minutillo suggested it would be "particularly unusual."

birthing at home. The two underlying philosophies are on the one hand, the purpose of the exercise is to have a baby and it does not really matter how it is born as long as it is safe, versus the philosophy that childbirth is more than just the physical experience and the process is as important as the outcome.[424]

260. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists' (RANZCOG's) statement on Home Births, most recently reviewed in July 2014, states that the College does not endorse planned homebirth being offered as a model of care. RANZCOG supports collaborative care between midwives and obstetricians in a hospital setting as the best model of maternity care.[425] The focus of RANZCOG in adopting that position is, understandably, the safety of the woman and baby and the desire to limit adverse outcomes. It is fair to say that the emphasis is upon the best physical outcome, rather than any emotional or psychological impact of the birth process.

261. RANZCOG's emphasis on the outcome, rather than the process, was reflected in many of the comments made by the experts who gave evidence in this case. Dr Karczub acknowledged that the primary objective of an obstetrician is to "have a healthy mum and a healthy baby."[426] Similarly, Dr Minutillo spoke from the perspective of a neonatologist, that if intervention is sometimes required as a precautionary measure, the priority is to know the baby is safe and well and to have a live child at the end.[427]

262. In those circumstances, we are not only talking about a live child, but a child who is not faced with a future of long-term disability. In another inquest, Deputy State Coroner Dillon drew attention to an article by British medical ethicists, Professors Lachlan de Crespigny and Julian Savulescu, who argue that choices as to place of

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[424] Exhibit 7, Tab 6, 24.
[425] https://www.ranzcog.edu.au – College Statement on Home Births, first endorsed March 1987 and current July 2014.
[426] T 457.
[427] T 226.

birth should not expose the future child to an unreasonable increased risk of avoidable disability.[428]

263. On the other hand, there are women who place significant emphasis on the birth experience and have a strong desire to avoid institutional intervention in their birth. They feel that birth is a normal, family-oriented event, not a medical event. They want an intimate, personal experience at home amongst people they know, rather than strangers.[429] As Dr Catling explained, for these women "their perception of risk is very low" as they have great faith in their bodies to give birth without medical intervention.[430] When their expectations are not met, and they do require medical intervention, the emotional and psychological impact on these women can be significant.[431] For many of these women, they can lose what little trust they had in hospitals in the first place.[432]

264. In another category are the women Dr Catling described whose choice to birth at home is less to do with a preference for birthing in a home environment and more to do with things they want during their labour, such as birthing in water, which can't always be accommodated in hospital, depending upon what facilities are available and the hospital's protocols. This can push those women into choosing to birth at home.[433] The authors of the 2008 *Review of homebirths in Western Australia* similarly concluded that some women were choosing homebirth, as their options in relation to access to midwifery continuity of care, water birth, support for vaginal birth after caesarean section and access to birth centre environments were limited.[434]

265. In an article titled *"Jumped or pushed?,"* A/Professor Nicholl reiterated these findings and emphasised that, in a

[428] Inquest into the death of Bodhi Eastlake-McClure by Deputy State Coroner H.C.B. Dillon – delivered 7 August 2014 referring to Lachlan de Crespigny & Julian Savulescu, 'Home Birth and the Future Child' (Abstract) *J Med Ethics* doi:10.1136/medethics-2012-101258 published 22 January 2014.
[429] T 646 – 647.
[430] T 647.
[431] T 647 – 648.
[432] T 647 – 648.
[433] T 647.
[434] Exhibit 7, Tab 6, *Review of homebirths in Western Australia*, undertaken for the Department of Health WA, August 2008, Professor Caroline Homer and Dr Michael Nicholl, 5.

lot of cases, the lack of flexibility in what the hospital can offer leads to a perception that women are being 'pushed' away from hospital care, rather than 'jumping' for homebirth.[435] A/Professor Nicholl observed that the inability of care providers to 'negotiate' some issues contributes to some women opting out of hospital-based care.[436]

266. From the point of view of the Western Australian Department of Health, it is fair to say that the Department has implemented a more flexible approach than the position adopted and maintained by RANZCOG, although it does not go as far as some would like. Information distributed by the Department of Health WA acknowledges that home births are associated with preventable stillbirths and infant deaths. However, a review of the evidence available suggests that for women determined to be at low risk of pregnancy complications by established screening criteria, planned home birth with a qualified home birth practitioner is still a safe alternative to birth in hospital.[437]

267. The review of the evidence also indicates that home birth is **not** a safe alternative for women who are determined not to be at low risk or, conversely, determined to be at high risk, of complications, particularly at the onset of labour, where the evidence suggests that there appears to be an excess neonatal morbidity and mortality associated with homebirth in those circumstances.[438]

268. Consistently with this evidence, the Department of Health WA supports home birth only for pregnancies deemed to be low risk. Ms Tracy Martin, the Principal Midwifery Advisor in the Nursing and Midwifery Office at the Department of Health WA, indicated that Western Australia has the longest-running publicly funded homebirth program of all the jurisdictions in Australia and, perhaps as a result, has the highest percentage of

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[435] Exhibit 5, Tab 7, *Jumped or pushed?*, A/Prof Michael Nicholl, O&G Magazine, V 13(4) Summer 2011, 34.
[436] Ibid, 34.
[437] Home Birth Policy and Guidance for Health Professionals, Health Services and Consumers, Perth, Health Networks Branch, Dept of Health, WA; February 2012, 11.
[438] Home Birth Policy and Guidance for Health Professionals, Health Services and Consumers, Perth, Health Networks Branch, Dept of Health, WA; February 2012, 11.

homebirths per capita as well, in the region of 0.8% of all births for the last 5 to 10 years.[439] Ms Martin described home birth as "well entrenched" in Western Australia.[440] The main difficulty is that the current community midwifery group practices funded by the Department of Health WA, including the CMP and group practices in Bunbury and Broome, cannot meet the demand for women seeking their services, despite new practices being established in Bunbury and Broome in recent years.[441]

269. A new group practice is currently being set up at the Family Birth Centre at KEMH, providing continuity of care only at the centre and an ability for the midwives to follow their patients to KEMH in the event of a change of risk. This will increase the number of services available for low risk women in the Perth area.[442]

270. The fact that the current demand outstrips supply shows a significant number of women want this model, which is primarily about continuity of care. Continuity of care is when a midwife cares for a woman throughout the pregnancy, the labour and the postnatal period.[443] A Cochrane review concluded that women cared for in this way are less likely to require interventions, such as a caesarean section, and the outcomes for the mother and baby are better. The long term outcomes are also very good.[444] They are also considered to be cost-effective, given they shift care from hospital to the community, after the initial set-up costs have been recouped.[445]

271. However, there is a difficulty in engaging sufficient midwives to enter into this model, with the need to address some negative perceptions as to what group practice or continuity of care can mean for a midwife in terms of working hours and stress.[446] The present aim is to

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[439] T 765.
[440] T 765.
[441] T 765 – 766.
[442] T 460, 758.
[443] T 651 – 652.
[444] T 651 – 652, 766.
[445] T 651 – 652, 766 – 767 – Ms Martin's evidence was that it takes approximately 5 years for this to happen.
[446] T 766 – 767.

educate midwives that continuity of care is the gold standard and the future of midwifery.[447] According to Dr Catling, that is so not just because women want it, but because the outcomes are so much better than having fragmented care within a hospital.[448]

272. The continuity of care model is not solely limited to births in the home. The model allows for collaboration of care with an obstetrician if a low risk woman develops risk factors.[449] Ideally, the model will permit the same midwife to continue to provide her midwifery services to the woman, even if her birth is managed in hospital, thus enabling continuity of care.[450] Steps have been taken in Western Australia in recent times to ensure that, where possible, this occurs, so that the midwife can remain the primary carer. The changes to the system appear to be reasonably successful for publicly funded, community-based midwives, but there are still steps to go in making similar continuity of care arrangements for the private patients of Privately Practising Midwives.[451]

273. The changes also do not go as far as the recommendation in the 2008 Department of Health WA's Review of homebirths for development of models of care that provide midwifery continuity of care for women of *all* risk factors (emphasis added), in part to avoid women choosing homebirth only as a means to access continuity of care.[452]

274. For women falling into the high risk category at an early stage in the pregnancy, requiring specialised obstetric care, their options for continuity of care are limited. The WA public hospital system does not currently appear to be designed to cater for a request for continuity of care in those cases.

275. There are also still restrictions on what sorts of birth environment and birthing facilities can be offered to these

[447] T 652, 767.
[448] T 652.
[449] T 652.
[450] T 652 – 653.
[451] T 751 – 757; Exhibit 8, Tab 1.19, 1.22 & 1.23.
[452] Exhibit 7, Tab 6, Recommendation 24.

women within the hospital. Although the Department of Health WA does not necessarily advocate water birth, it has endorsed the WA Women's and Newborns' Health Network's clinical guidelines for women requesting immersion in water for pain management during labour and/or birth to ensure it is done as safely as possible.[453] This appears to be a response to the recommendation of the 2008 homebirth review to recognise that there is a demand from women to use water during labour.[454] However, with safety in mind, the criteria effectively limits its use to low risk pregnancies.

276. Thus, those women categorised as 'high risk' who prioritise continuity of care and other facilities such as water birth may still choose to go with a Privately Practising Midwife and a home birth, in the same manner as Baby P's mother.

277. It is fair to state then, as a general proposition, that the WA Department of Health has demonstrated that it is open to exploring ways to accommodate women's choices in terms of birth both at home and in hospital, even if they are not mainstream choices in terms of evidence-based guidelines.

278. The enthusiasm for communication between health professionals and flexibility in birth choices expressed by a senior Consultant Obstetrician such as Dr Griffin, who currently works at KEMH, is also indicative of the individual willingness of obstetricians to embrace a more flexible approach to birth than perhaps was evident in the past. Dr Griffin's glowing endorsement of the current CMP is also encouraging in demonstrating the alternative options being offered are of a high standard.[455]

279. However, what can be offered by the public health system to women who are having an uncomplicated pregnancy with no risk factors is different to what can be offered to women whose pregnancies are more complicated. The

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[453] Department of Health WA Operational Directive 0417/13 issued 30 January 2013, *Women's & Newborns Health Network Clinical guidelines for women requesting immersion in water for pain management during labour and/or birth*, updated October 2012.
[454] Exhibit 7, Tab 6, Recommendation 22.
[455] T 681 – 682.

need to prioritise the safety of the woman and baby or babies creates those limitations.

280. Having said that, what has been demonstrated by the implementation of the Non-Standard Management Plan is that the WA Department of Health understands that women have the right to have their informed choices respected. It is important that pregnant women are encouraged to consult with midwives and doctors and communicate freely about their fears and hopes for their delivery, with the expectation that they will be treated with consideration and their choices respected.

281. The question is whether the Department of Health WA should go further in accommodating the birth choices of high risk women. As noted above, some experts such as Dr Catling and A/Professor Nicholl consider greater flexibility and negotiation as to options should be offered, as to refuse to do so runs the risk that these women will seek alternatives that are even less safe. Dr Catling referred to research conducted into women who have chosen to birth unassisted, or 'free birth', in those circumstances.[456]

282. It is apparent from the evidence that there exists a small percentage of women in Australia who appear unwilling to accept the medical assessment of risk when their pregnancy presents with complications. In those circumstances, their concerns about what they consider to be unnecessary medical intervention or a less than ideal birth environment outweigh the possibility that that risk will be realised in their case.

283. Following an inquest into the death of a baby during a home birth in Victoria, Coroner Parkinson observed that "there appears to have been lost to the community an appreciation that childbirth has inherent and unpredictable risk and the debate is currently largely directed towards denial of the risk, particularly in the

[456] T 653.

context of home birth."[457] Coroner Parkinson theorised that the public consciousness of the inherent risk may have fallen because of the relative rarity of neonatal and maternal deaths due to the development of obstetric knowledge, monitoring and interventions over the last century.[458]

284. That might well apply in this case, where the risks to the second born twin may have appeared to Baby P's parents far less significant due to the small number of deaths of second born twins today, without the recognition that the reduction in the risk of death for the second twin has been brought about due to the availability of methods to effect immediate delivery of the baby with skilled staff present to resuscitate the newborn baby in a hospital.[459] Ms Barrett also unhelpfully encouraged that view.

285. Looking back on what occurred, Baby P's mother accepted responsibility for the decision to attempt a natural birth at home. She said that she considered risk, including what she considered to be the risks of a hospital birth, and she was not willing to 'take the risk' of a hospital birth.[460] She understood what she was doing at the time and made an informed choice.

286. Baby P's mother referred to her grief at losing Baby P, but also emphasised that she and her firstborn twin were alive and well.[461] She referred to what occurred as a "natural disaster," rather than a "man-made disaster."[462]

287. The experience has not deterred her from contemplating home birth again. Looking to the future, Baby P's mother indicated that if she were to become pregnant again, she would look internationally to have the child because she believes that in other countries, such as New Zealand,

[457] Inquest into the death of Joseph Thurgood-Gates by Victorian Coroner K.M.W. Parkinson – delivered 10 May 2013, [226].
[458] Inquest into the death of Joseph Thurgood-Gates by Victorian Coroner K.M.W. Parkinson – delivered 10 May 2013, [227].
[459] Exhibit 5, Tab 26, 3.
[460] T 355.
[461] T 410 - 411.
[462] T 410 - 411.

"women's opinion in childbirth...are valued and respected."[463]

288. Based on the evidence I have heard in this inquest and the others that were heard jointly, I believe that the public health system in Western Australia is actually taking great steps towards more 'woman-centred' maternity care, based on a recognition that a significant number of women want a level of more personalised care, in a less medicalised environment, than is currently on offer. However, those changes are focussed on the general 'low risk' pregnancy, rather than cases where complications arise.

289. In many of those cases, the woman will accept the medical recommendations that follow her change in risk status.[464] However, the question arises as to what can be done for the small percentage of women who wish to keep some of their options, at least at the start of the delivery. In those cases, more needs to be done to encourage these women, such as Baby P's mother, to remain engaged with the hospital system, as there is no doubt the safest place for them to give birth is in hospital, even subject to the limitations on what medical interventions they are willing to accept.

290. How this can be done, whilst still ensuring a safe working environment for hospital staff, bearing in mind the psychological stress that may well arise from their attending a birth in such circumstances, and ensuring that no liability is attached to the medical staff and the hospital, is not easily answered. I think Dr Griffin is right that a lot of the change will come from improved communication between health professionals and the women they serve, so that informed choice will come from an understanding of both points of view and hopefully within the context of a mutually respectful relationship.

291. It is also important, in that regard, to limit the ability of women such as Ms Barrett to actively operate outside the system to provide midwifery services without scrutiny by

[463] T 410.
[464] T 441.

the wider health system of their conduct. As Professor Homer and Dr Nicholl noted in their 2008 review, there is a need to "protect the homebirth model" by cautious and conservative decision making, in order to build community confidence in this model of care.[465] That cannot be done when women such as Ms Barrett are permitted to provide midwifery services simply by adopting a title other than "midwife".

292. Ms Martin gave evidence that there is a move in Western Australia to introduce similar legislation to that recently enacted in South Australia to restrict birthing practices. It is known as the Restricted Birthing Practices Bill and is intended to prevent unqualified and unregistered people from providing planned homebirth services. It would limit the ability to provide clinical midwifery services to a registered midwife or medical practitioner.[466] That is a positive and important step towards improving the safety of homebirths in Western Australia, and I can only hope the legislation is passed expeditiously.

CONCLUSION

293. Baby P was born on 3 July 2011 and died approximately an hour later, having shown only the briefest signs of life. Prior to his birth, he suffered a hypoxic event, which I find was caused by placental abruption occurring sometime between the birth of Baby P's brother and his own delivery. Such an event was predictable, and the outcome most likely preventable, if he had been born in hospital and in accordance with medical advice.

294. The focus of this inquest has been upon the reasons why his parents were led to believe that it was safe to have his birth at home, when medical advice said it was not. The evidence at the inquest supports the finding that the decision was made on the background of a strong preference on the part of Baby P's parents for a home birth, with a particular emphasis on a natural birth in

[465] Exhibit 7, Tab 6, 4.
[466] T 764.

water and with continuity of caregiver. This all appeared achievable, with the full support of the publicly funded health system, when it was thought to be a singleton pregnancy, but changed when it was discovered that Baby P's mother was pregnant with twins.

295. Due to the known medical risks associated with such a delivery, many of the options Baby P's mother wished to utilise for her birth were not available to her in the public health system. While negotiation was attempted by both the CMP staff and the KEMH medical staff in the hope of finding an acceptable compromise, the end result of the discussions was that Baby P's parents felt their birth choices were not supported and they chose to birth at home, with the assistance of a birth advocate who was working outside the regulated health system and the support of a midwife. Sadly, in those circumstances, when one of the known risks of twin delivery occurred, the opportunity to resuscitate Baby P in optimal circumstances was missed and he died.

296. While deeply saddened by the loss of their baby, Baby P's parents maintain that their choice was forced upon them by the inflexibility of the current public health system in Western Australia.

297. While I respect the beliefs of Baby P's parents and acknowledge that they have dealt with their sad loss in a positive and meaningful way for them, I would encourage other parents faced with a similar situation to engage with the health professionals at KEMH and the other maternity units in hospitals in Western Australia, as I am satisfied that there is a genuine desire by obstetricians and midwives in the public system to accommodate as best they can the wishes of women for their birth while remaining focussed on the safest outcome for the women and their babies.

298. Although I acknowledge the importance of the rights of women to make informed choices in their births, as Coroner I also advocate for the deceased, who has lost his chance of life. It must not be forgotten that it is only with

the amazing improvements in medical skills and facilities that childbirth has ceased to be the life-threatening event for women and babies that it used to be in developed countries, such as Australia, not that long ago. The same cannot be said in developing countries, which do not have the same access to health services, where the number of preventable maternal and perinatal deaths remains unacceptably high.[467]

299. In making decisions about the place of birth, future parents should give significant weight to the medical opinion as to the risks of avoidable disability or death of their baby. As is seen in this case, once the choices are made and the consequences flow, they cannot easily be undone.

S H Linton
Coroner
8 June 2015

[467] http://www.who.int/mediacentre/factsheets/fs348/en;http://www.who.int/bulletin/volumes/91/5/12-111021/en.