JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	SARAH HELEN LINTON, DEPUTY STATE CORONER
HEARD	**:**	24-25 NOVEMBER 2020
DELIVERED	**:**	10 JUNE 2021
FILE NO/S	**:**	CORC 1318 of 2017
DECEASED	**:**	Baby AM

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Ms R Collins assisted the Coroner.
Mr B D Nelson (State Solicitor's Office) appeared for the Department of Health and the Western Australia Country Health Service.
Ms B Burke (ANF) appeared for Ms Mansfield.
Mr E Panetta (Panetta McGrath) appeared for Dr McKenna.
Ms K L Reynolds (Avant Legal) appeared for Dr Du Preez.

Case(s) referred to in decision(s):

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Sarah Helen Linton, Deputy State Coroner, having investigated the death of ***Baby AM****, with an inquest held at the* ***Busselton Courthouse*** *from* ***24 to 25 November 2020****, find that the identity of the deceased person was* ***Baby AM*** *and that death occurred on* ***14 September 2017*** *at* ***Princess Margaret Hospital****, as a result of* ***severe hypoxic ischaemic encephalopathy secondary to uterine rupture****, in the following circumstances:*

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SUPPRESSION ORDER

A suppression order has been made prohibiting from publication the deceased's name and any evidence likely to lead to the deceased's identification. The deceased is to be referred to as Baby AM.

INTRODUCTION

1. In December 2016 Baby AM's mother, Ms M, found out she was pregnant for the second time. When pregnant with her first child, Ms M had hoped for a vaginal birth but after some complications, including cholestasis, she had given birth to her first child by caesarean section on 29 September 2015 in Bunbury Hospital.

2. With this second pregnancy, Ms M again hoped for a vaginal delivery. This meant she would be attempting a vaginal birth after caesarean (often referred to for convenience as a VBAC). There is a small (0.5%) but known risk of uterine rupture occurring during a VBAC. Although the risk is small, when a uterine rupture does occur, it can be life threatening for both the mother and baby. Due to these potentially fatal complications, when it is planned that a VBAC will be attempted, it is generally recommended that the safest way it can be undertaken is under close medical supervision and continuous monitoring in hospital.[1]

3. Ms M initially consulted a GP about the pregnancy. She then decided to continue her antenatal care with an independent midwife, Samantha Mansfield. Ms M said she had planned to have a midwife supervised VBAC delivery in hospital, but after meeting Ms Mansfield and discussing the process involved in giving birth in hospital and at home, she decided with her husband to proceed with a plan for a VBAC at home. Ms M said in a statement provided to police that she and her husband had been open to a hospital birth, if that was advised, but believed from what they were told that it was safe to attempt a home birth for this pregnancy.

4. Ms M was reviewed by a GP Obstetrician on 7 June 2017. It is documented that they discussed VBAC, cholestasis and 'increased risk' but it was unclear from the documentation if the doctor was aware that Ms M and her husband planned a VBAC at home. The extent of this consultation was explored further at the inquest, and it became clear that the risks associated with attempting a VBAC at home had been discussed with Ms M and a suggestion made that she be referred to be assessed at the Bunbury Hospital High Risk Clinic. However, Ms M declined the referral and Ms M did not attend for any further medical follow up. Ms M's pregnancy continued to be monitored and managed by her midwife, Ms Mansfield.

5. On 6 September 2017 Ms M started to experience irregular contractions. Ms Mansfield checked on Ms M on the morning of 8 September 2017, at her request, as Ms M had texted her indicating that she was struggling a bit with painful contractions and had been unable to sleep. Ms Mansfield advised Ms M that she was in the early stages of labour, but labour was not yet established. Ms Mansfield then left to attend to another patient some distance away. Ms Mansfield remained in phone contact with Ms M's husband, who kept Ms Mansfield updated on the progress of the labour.[2]

6. Ms Mansfield returned to the house at about 1.00 pm. By this time, Ms M was having more regular contractions. She was very tired and concerned that she may not

[1] RANZCOG - https://ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical-Obstetrics/Birth-after-previous-Caesarean-Section-(C-Obs-38)Review-March-2019.pdf?ext=.pdf

[2] T 39 – 40.

have the strength to push. When moving from the shower to the bedroom, she appeared to be in pain and had difficulty standing up straight. After assessing her, Ms Mansfield was concerned and recommended immediate transfer to hospital. She called for an ambulance to attend as a priority and notified Busselton hospital that Ms M was being brought in by ambulance. During the transfer from the house to the ambulance her waters broke. Ms M was taken by ambulance to Busselton Hospital.

7. On arrival at the hospital Ms M appeared shocked and was taken straight to the operating theatre. An emergency caesarean section was performed under general anaesthetic. It was found that a large uterine rupture had occurred and Baby AM's head was outside the uterus in the abdomen. Baby AM was delivered at 3.06 pm. He was unresponsive at birth and required aggressive resuscitation. His mother also required emergency treatment for the uterine tear and consequent blood loss.

8. Baby AM was taken to Princess Margaret Hospital for specialist treatment and his mother was taken to Bunbury Hospital for further treatment. Baby M's mother was fortunate to survive and an expert described her case as a "near miss maternal death."[3]

9. An MRI of Baby AM's head on 12 September 2017 showed Baby AM had suffered a severe brain insult, which had resulted in permanent damage to a very large part of his brain. It was considered that if Baby AM survived, he was likely to have very significant physical and intellectual disabilities. After discussion with his parents about his poor prognosis, the decision was made to withdraw active treatment. He was kept comfortable until he died peacefully on 14 September 2017.

10. Initially, a doctor from Princess Margaret Hospital purported to sign a medical certificate in relation to Baby AM's death. However, after the circumstances of his death were considered further, it was determined that his death was reportable to the coroner.

11. Following an initial coronial investigation, which included obtaining an expert opinion from Dr Cliff Neppe, a Specialist Obstetrician and Gynaecologist, I determined that it was desirable to order an inquest into Baby AM's death pursuant to s 22(2) of the *Coroners Act 1996* (WA) as there was evidence to suggest it was a preventable death and also to explore further whether Baby AM's parents were properly informed of the known risks of attempting a VBAC at home.

12. I held an inquest at the Busselton Courthouse on 24 to 25 November 2020. The circumstances of the death were relatively clear. The primary focus was on what information was provided to Baby AM's parents about the risks and, more generally, what relevant information and options are available for other parents in the South West region who wish to consider attempting a planned VBAC.

OBSTETRIC HISTORY

13. Without wishing to invade her privacy, Ms M's obstetric history was a very relevant factor in the events that were to come, so it needs to be set out in some detail.

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

14. During the late stages of her first pregnancy, Ms M developed cholestasis, a liver disorder that can occur in pregnant women. There is increased risk for poor fetal outcomes where this condition is present in pregnancy. The risks include stillbirth. Ms M was referred by her GP, Dr Mostyn Hamdorf, to a specialist obstetrician at Bunbury Hospital. After being reviewed by the obstetrician, it was recommended that Ms M be induced at 38 weeks.[4]

15. Ms M was admitted to Bunbury Hospital on 27 September 2015 for induction of labour. Unfortunately, after two days of trying, labour was not established and the induction was said to have failed. It was recommended that a caesarean section should be performed. Mr M and Ms M's first child, a baby boy, was born by caesarean section on 29 September 2015.[5]

16. Ms M indicated that she and her husband were aware that she was at risk of developing cholestasis again in another pregnancy. She also recalled she was told by her obstetrician after the birth of her first child that her caesarean would not preclude her from attempting a VBAC for another birth at a later date.[6]

THE SECOND PREGNANCY

17. In July 2016 Ms M consulted her General Practitioner Obstetrician, Dr Mostyn Hamdorf, at the Dunsborough medical Centre for pre-conception counselling given her first pregnancy was complicated.[7] Dr Hamdorf explained that the consultation was "multi-faceted."[8] He debriefed Ms M with respect to her birthing experience and talked through the issues surrounding her emergency caesarean section and they also discussed antenatal planning for a second pregnancy, discussing the likelihood that cholestasis might reoccur and blood tests and other things that should be done. He gave evidence that he had discussed with Ms M a referral to the Bunbury Hospital 'High Risk' Antenatal Clinic given her previous birth pregnancy and birth history but he could not recall her response to his suggestion for a referral.[9]

18. Ms M's second pregnancy was confirmed by Dr Hamdorf at a consultation on 3 January 2017. Dr Hamdorf assessed her gestation to be very early (i.e. less than 4 weeks). Ms M and her husband were both clearly delighted with the news that she was pregnant again.[10]

19. Dr Hamdorf described the progress of Ms M's second pregnancy as unremarkable. All her observations were within normal limits and her investigations were normal. Ms M attended Dr Hamdorf's practice on 1, 2 and 28 February 2017 and 19 April 2017. Ms M was troubled by morning sickness in the early stages of the pregnancy and she was prescribed the medication ondansetron on 1 February 2017 with good effect.

[4] Exhibit 1, Tab 4.
[5] Exhibit 1, Tab 4.
[6] Exhibit 1, Tab 4.
[7] Exhibit 1, Tab 13.
[8] T 94.
[9] T 94, 103.
[10] Exhibit 1, Tab 13.

20. The pregnancy was assessed to be low risk for specific chromosomal conditions by First Trimester Screening on 22 February 2017, performed by West Coast Radiology in Busselton. Further, an ultrasound performed at the same place on 10 April 2017 reported an appropriately grown fetus with apparent normal anatomy and cervical length of 39mm.[11]

21. Dr Hamdorf indicated that it was sometime after 19 April 2017 that he was advised by Baby AM's father, Mr M, that after consultation with midwife Samantha Mansfield they had opted to plan for a home birth. Mr M worked as a local pharmacist so they had regular professional contact and knew each other reasonably well. On this occasion they saw each other at a shopping centre and had an informal conversation about the birth plan. Dr Hamdorf indicated it was not an appropriate environment to discuss the matter at length, but he did recall that Mr M said words to the effect of, "I know what you might say, but we're fully aware of the risks."[12]

22. Dr Hamdorf stated it had been his intention to refer Ms M to one of his obstetric colleagues to continue her care as he had ceased intrapartum obstetric care in December 2015 and no longer had admitting rights at the hospital. However, after receiving this information he forwarded all of the relevant information to Ms Mansfield instead. Dr Hamdorf indicated he had a close working relationship with Ms Mansfield, so he knew who she was before being asked to refer on the information.[13] Ms M recalled that she was given Ms Mansfield's contact details by Dr Hamdorf.[14] Dr Hamdorf did not recall this occurring, but accepted that he may have, as he often provided Ms Mansfield's or Ms Worrall's details to prospective mothers at the patient's request.[15]

23. Dr Hamdorf gave evidence that he did not at any stage embark on the process of "risk stratification" with Ms M as she did not consult him for that purpose, and when he did see her later for an iron infusion and influenza vaccination, he assumed those sorts of discussions and planning had already been taken place as part of the usual 'booking in' process with the GPO who was to be the backup clinician for the birth.[16]

24. Ms M had requested all of the usual antenatal investigations, including a Glucose Tolerance test (which was normal) and iron levels, which were performed on 30 May 2017. The iron levels were low so Ms M attended the Dunsborough Medical Centre on 1 June 2017 where she received an intravenous infusion of iron without incident. That was the last occasion Dr Hamdorf saw Ms M during this pregnancy. Dr Hamdorf was, however, kept informed of the results of Ms M's investigations as he was copied them by Ms Mansfield, and he said he felt reassured by the results.[17] Ms Mansfield indicated she did not actually have a discussion with Dr Hamdorf about Ms M's case at any time, and their only contact was through this referral of results.[18]

[11] Exhibit 1, Tab 13.
[12] T 94 – 95.
[13] Exhibit 1, Tab 13.
[14] Exhibit 1, Tab 4 [16].
[15] T 97.
[16] T 96.
[17] Exhibit 1, Tab 13.
[18] T 11.

ENGAGEMENT OF MS MANSFIELD

25. Ms Samantha Mansfield is a registered and endorsed midwife with AHPRA. She generally works as a private midwife in Busselton and the surrounding areas of the south west region, although she also works on occasion as a casual employee with the WA Department of Health. When working as a private midwife, Ms Mansfield is employed directly by the family and the family pay for her services. These private services include home-delivered antenatal and postnatal midwifery care, and also usually involve midwifery care at a planned home birth. Ms Mansfield indicated that home births form the bulk of her work, but occasionally a client will want to plan a birth in hospital or it will become medically necessary during the course of the pregnancy.[19] In the case of a home birth, Ms Mansfield is only insured for her provision of the antenatal care and postnatal care, and not the birth itself, as there is no private professional indemnity insurance for homebirth currently available in Australia.[20]

26. Ms Mansfield has been a practising midwife for about 18 years and has been attending home births for 15 years of that time. She worked in her early year at Bunbury Regional Hospital as a midwife, as well as working as a casual employee sometimes at Busselton Hospital still.[21] Ms Mansfield indicated she has a good working relationship with the staff at Busselton Hospital and the GP Obstetricians who work there. Ms Mansfield was frank that none of those doctors would ever encourage a VBAC homebirth, as it would generally be all doctors' preference for the birth to take place in hospital, but nevertheless she has a good working relationship with the doctors and they are happy to provide advice, referral or consultation where required and she feels well supported.[22]

27. Ms Mansfield provided a detailed statement in relation to her management of Ms M's second pregnancy, and also gave evidence at the inquest. Ms Mansfield recalled that Ms M emailed her on 22 April 2017 and indicated she was thinking of using a private midwife for her pregnancy and Dr Hamdorf had provided Ms Mansfield's name. Ms M told Ms Mansfield she was looking for an independent midwife to care for her through the pregnancy and to help her have a VBAC. Ms M was 21 weeks' pregnant at that time and her estimated date of delivery was 3 September 2017.[23]

28. Ms Mansfield arranged to attend Ms M's house on 2 May 2017. The purpose of the meeting was to discuss the service she could provide as a private midwife. Understandably, Ms Mansfield could not recall all of the details of the first meeting, but she did recall they discussed the general practicalities of using her service and the process involved in giving birth in hospital and at home.

29. They had a specific discussion about Ms M's desire to try for a VBAC. Ms Mansfield had facilitated many VBAC births at home before so it formed part of

[19] T 12 - 14.
[20] T 6 – 8.
[21] T 7, 62.
[22] T 62 - 63.
[23] Exhibit 1, Tab 6 [7] – [10].

her practice. Ms Mansfield gave evidence that in her view the main difference between home and hospital birth with a VBAC is the lack of CTG monitoring or continuous fetal monitoring, which is recommended in VBAC births from the time the woman is in established labour. The other main difference is the potential delay to emergency treatment or caesarean section due to the time getting from home to hospital.[24]

30. Ms Mansfield explained these differences to Ms M and that there was a risk of uterine rupture (which would require emergency treatment), which she put in the order of approximately 1 in 200. Ms M indicated she was already aware of this statistic.[25] Ms Mansfield thought Ms M appeared well informed and it was clear she had done a significant amount of research herself on the subject as Ms M told Ms Mansfield a number of statistics she had identified in her research in relation to the risk of uterine rupture in VBAC.[26] Ms Mansfield formed the impression Ms M had already decided she wanted to attempt a VBAC, but she was still exploring the idea of a home birth.[27] Ms Mansfield recalls that Ms M said words to the effect that, "while she wanted a home birth, she had not yet made up her mind whether she should have one."[28]

31. This was consistent with the accounts Ms M and Mr M gave in their statement, where they indicated that the couple had decided upon a VBAC birth and to have an independent midwife with them through the pregnancy, because Ms M wanted continuity of care, but at the early stage of getting Ms Mansfield's details they had intended to have the baby at hospital with an independent midwife assisting.[29]

32. In terms of why she wanted a VBAC, Ms M indicated to Ms Mansfield she felt quite traumatised after her first birth and it was quite a long process that she wasn't convinced was entirely necessary. She wanted to "avoid any possible unnecessary intervention this time around."[30] She also still felt anxiety about the previous birth and was considering a home birth as she felt that maybe staying out of that previous scenario wherever possible might help her feel more relaxed and at ease with the process.[31]

33. Ms Mansfield agreed that in her experience this was a common reason for women to step outside the hospital system and engage a private midwife to facilitate a home birth VBAC. They often feel the first birth had too much intervention and took some of their control over the situation away.[32]

34. Due to the risk of uterine rupture, Ms Mansfield explained to Ms M that she had a lower threshold for transferring clients from home into hospital when the birth is a VBAC and she would not hesitate to transfer Ms M if she felt she needed to go to hospital. Ms Mansfield explained that she would work in conjunction with a local GP

[24] T 14.
[25] Exhibit 1, Tab 6 [13] – [19].
[26] T 15.
[27] T 16.
[28] Exhibit 1, Tab 6 [21].
[29] Exhibit 1, Tab 4 [16] – [18], [23] and Tab 5 [9] – [10].
[30] T 16.
[31] T 16.
[32] T 16 – 17.

Obstetrician if Ms M was to proceed. Ms Mansfield left Ms M to decide how she wished to proceed.[33]

35. Ms M stated she and her husband "were not determined to have a home birth at any cost."[34] They wanted to safely birth their baby and indicated they were open to a hospital birth if that was advised.[35] Ms M stated that at no point were the couple advised by Ms Mansfield that a VBAC birth was not recommended and they were not provided by Ms Mansfield, or any other medical professional, with the recommendation by the WA Health Department and King Edward Memorial Hospital (KEMH) that home births are not recommended for VBAC patients.[36] Ms Mansfield did, however, go through with them the risks involved with home birth in a general sense.[37]

36. Ms M and Mr M acknowledged that they were aware of the uterine rupture risk, which they recalled Ms Mansfield put at 0.6%.[38] Ms M and her husband considered the increased risk of uterine rupture attempting a VBAC to be "very low and acceptable."[39]

37. Ms Mansfield explained further at the inquest that she generally referred to the risk as "one in 200, or .5"[40] and used to say "it's very rare"[41] and she had never seen it. Even now that she has been in a situation where it has occurred, Ms Mansfield described it as "still a really small chance"[42] noting that what happened in this case "is really rare and unfortunate."[43]

38. Following the meeting with Ms Mansfield, Ms M stated she and her husband "decided to plan for a home birth provided the pregnancy didn't develop any complications and remained low risk."[44] Ms M indicated she made the decision for a home birth as she felt she would be most comfortable birthing at home and had full confidence in Ms Mansfield's ability to provide care during a home birth.[45] Ms M and Mr M stated they believed that between all the medical professionals they consulted and their own research, they felt they made a fully informed decision to proceed with the pregnancy in the way they did.[46]

39. I asked Ms Mansfield at the inquest whether she considered Ms M to be in the category of a 'low risk pregnancy' at this stage, as described by Ms M and Mr M in their statements. Ms Mansfield said that she acknowledged that the previous caesarean definitely counted as a risk factor, but other than the previous caesarean there was nothing medically wrong with the pregnancy and there were no other risk

[33] T 16; Exhibit 1, Tab 6 [21] – [25].
[34] Exhibit 1, Tab 4 [34].
[35] Exhibit 1, Tab 4 [34].
[36] Exhibit 1, Tab 4 [30] – [31].
[37] Exhibit 1, Tab 4 [32] – [36].
[38] Exhibit 1, Tab 4 [32] – [36].
[39] Exhibit 1, Tab 5 [17].
[40] T 22.
[41] T 22.
[42] T 23.
[43] T 23.
[44] Exhibit 1, Tab 4 [28].
[45] Exhibit 1, Tab 4 [28].
[46] Exhibit 1, Tab 4 [41] and Tab 5 [19].

factors that she could see. From what she could tell, Ms M was a healthy young woman and had no other medical complications. I asked if the failed induction counted as a risk factor, and Ms Mansfield agreed "it would factor in, yes, for sure," as well as the potential for the cholestasis to reoccur. Therefore, Ms Mansfield said her "chances of successful VBAC were reduced, … with her history" but it was still possible.[47]

40. I note another midwife, who has a similar practise to Ms Mansfield in the south west, categorised Ms M as falling in a risk category of B, being of medium risk, because she was attempting a VBAC at home. This categorisation is based on the Australian College of Midwives' (ACM) National Midwifery Guidelines for Consultation and Referral.[48]

41. Ms Mansfield gave evidence that she believed both parents understood that VBAC at home was not recommended under the guidelines as she had explained to them the reasons why it was not recommended, in particular because of the inability to provide continuous monitoring at home. She conceded that she had not written down these discussions, and indicated that since these events she has changed her practice and now does document this kind of conversation beyond simply filling in the consent form.[49]

42. Ms M sent Ms Mansfield a text message on 4 May 2017, two days after their meeting, to inform her that she wished Ms Mansfield to care for her during the pregnancy and, it would appear, to plan for a home birth.

43. After receiving the confirmation from Ms M that she and her husband wished to proceed, Ms Mansfield arranged an appointment for 16 May 2017, with both Ms M and her husband. Ms Mansfield had her first antenatal appointment with the couple at their home on 16 May 2017. Ms Mansfield recalled she took a detailed history of Ms M's personal circumstances and obstetric history, which she recorded in the pregnancy and birth record form. The history included the cholestasis, failed induction of labour and delivery by caesarean section for lack of progress. It also included a prior large loop excision procedure in 2009 and gallbladder removal in 2009.[50]

44. In addition, Ms M reported a history of anxiety, for which she had undergone counselling in the past but not been medicated. It appeared to Ms Mansfield that Ms M's anxiety was well-controlled at the time she saw her.[51]

45. Ms M was 24 weeks and 2 days' gestation at that time and had already had her first trimester screen scan and anatomy scan and some blood test results. Ms Mansfield reviewed all the tests results and reports available at that time and added the details into the pregnancy record form.[52]

[47] T 18, 27.
[48] Exhibit 1, Tab 9 [15] – [17].
[49] T 20 – 22.
[50] Exhibit 1, Tab 6 [29] – [40].
[51] Exhibit 1, Tab 6 [40] – [44].
[52] Exhibit 1, Tab 6 [47] – [54].

46. During this first visit, Ms Mansfield also completed the hospital paperwork with Ms M in order to get her booked in at Busselton Hospital, in case hospital transfer was required at any stage. Ms Mansfield explained that this would make any required transfer much more efficient as Ms M would already be in the computer system. Normally the 'booking in' visit takes place at the Busselton Hospital but in this case Ms Mansfield did all the necessary paperwork at Ms M's home. Ms M also declined a tour of Busselton Hospital. Ms Mansfield did provide Ms M with an information 'pack' of pamphlets from the hospital that would have been provided to her if she had seen a midwife there.[53]

47. Ms M informed Ms Mansfield that everything appeared to be going well with her pregnancy and after performing an antenatal examination and a urine test Ms Mansfield found no abnormalities and her impression was that the baby was active with a strong, regular heartbeat.[54]

48. After taking a history and performing an examination, Ms Mansfield and Ms M then discussed her birth plan. Ms M told Ms Mansfield she wanted a home birth, so they discussed VBAC in the home. Ms Mansfield again explained that she had a low threshold for transfer to hospital in such cases and "that if there was too much pain or a prolonged labour, we would then need to transfer her to Busselton Hospital straight away."[55] Ms Mansfield explained at the inquest that she took this position because she "acknowledged it was a more risky scenario"[56] than someone who did not have a prior history of caesarean.

49. Ms Mansfield formed the impression that Ms M would not be comfortable in a hospital setting due to her anxiety, and would be more relaxed at home, but she had full confidence that Ms M would agree to go to hospital if she needed to and would trust Ms Mansfield's judgment in that regard. Ms Mansfield's impression from their conversations was that Ms M was sensible and realistic and open to the fact that a home birth might not work out for her.[57]

50. Ms Mansfield suggested that Ms M see Dr Peter Ginbey, another GP Obstetrician (GPO) practising in the Busselton area, as Dr Hamdorf no longer had admitting rights to Busselton Hospital and Ms M would need to be admitted under a GPO if she was transferred to hospital. Ms Mansfield indicated in her statement she also expected that Ms M would discuss her birth plan with a GPO and, "in effect, get a second opinion."[58] This was also in accordance with the ACM National Midwifery Guidelines, as Ms M was a 'Category B' and required consultation with a medical practitioner due to the previous lower segment caesarean and previous LLETZ procedure.[59]

51. Ms Mansfield believes it was probably at this consultation that she also advised Ms M that the Busselton GPO's preferred all women planning VBAC's to attend the high risk clinic at Bunbury Hospital. Ms Mansfield also indicated she told Ms M

[53] Exhibit 1, Tab 6 [61] – [66], [86] – [90].
[54] Exhibit 1, Tab 6 [67] – [72].
[55] Exhibit 1, Tab 6 [73] – [76].
[56] T 17.
[57] Exhibit 1, Tab 6 [77] – [82].
[58] Exhibit 1, Tab 6 [95].
[59] T 17, 65; Exhibit 1, Tab 6 [96].

"that she did not have to and that no one could force her."[60] Ms M asked what would happen at the appointment and Ms Mansfield explained that she would be assessed by a midwife and then by a consultant obstetrician, and they would advise her of the risks of home birth and of VBAC and make sure she was making an informed decision. Ms Mansfield recalled that Ms M said words to the effect that she did not see the point in attending at Bunbury if she was also attending a GPO in Busselton and "she was already aware of the risks so it would likely not change her mind."[61] Therefore, Ms M indicated she chose not go to Bunbury for review.[62]

52. Ms Mansfield gave evidence she was comfortable with Busselton Hospital as the option for hospital transfer, knowing Busselton Hospital is not suitable for high risk persons, as VBAC's have always been done there and she did not understand VBAC to be considered as a very high risk factor for Busselton Hospital. However, the Busselton GPO's did prefer such patients to have the review at Bunbury Hospital in case Bunbury ultimately needed to be involved.[63]

53. The next antenatal consultation occurred at Ms M's home on 16 June 2017. An antenatal examination was performed which indicated everything was going well and Ms M advised she had had further bloods taken on 30 May 2017, which were suggestive of low iron stores, so Dr Hamdorf had arranged for an iron infusion to take place on 1 June 2017. Ms M advised she had gone to see Dr Ginbey on 7 June 2017 but he was called away to a hospital appointment so she had seen another GP Obstetrician, Dr Ray McKenna, in his place.[64] Ms Mansfield noted in her evidence that at the time she did not confirm the appointment herself, but since then her practice is to email the doctor and provide some history and make it clear in writing that she would appreciate their advice as the mother is seeking a homebirth.[65]

54. Ms Mansfield recalled that Ms M told her Dr McKenna "was very happy and supportive, and had no concerns with her pregnancy or with her birth plan." Ms Mansfield did not recall whether Ms M specifically mentioned that she had discussed VBAC with Dr McKenna but she understood that they would have discussed VBAC as part of Ms M's birth plan.[66]

55. Ms Mansfield clarified in her evidence that she did not imagine at the time that Dr McKenna would have been 'happy' about Ms M's decision to attempt a VBAC at home, as it is not medically recommended, Ms Mansfield made it clear that it was "generally accepted that the GP Obstetricians would always prefer these women to birth in hospital,"[67] so she assumed Dr McKenna would not have encouraged a VBAC at home. However, she did interpret from Ms M's report that Dr McKenna was accepting and supportive of her choice.[68]

[60] Exhibit 1, Tab 6 [102].
[61] Exhibit 1, Tab 6 [106].
[62] T 22.
[63] T 23 - 25.
[64] Exhibit 1, Tab 6 [121].
[65] T 29.
[66] T 31; Exhibit 1, Tab 6 [121] – [127].
[67] T 65.
[68] T 31 – 32, 65.

56. At the end of the antenatal appointment on 16 June 2017, Ms Mansfield arranged for Ms M to sign a consent form regarding her services and Ms M's intention to choose a home birth. Ms Mansfield had no concerns about Ms M's, or the baby's, health at that stage.[69] The consent form is a 'proforma' document and does not specifically address VBAC, although Ms Mansfield indicated that it would be discussed as the form was being filled out.[70]

57. Ms Mansfield gave evidence that she has now changed her practice and writes down more detail about the particular risks discussed, so that the specific conversation is properly documented. For VBAC clients, she provides them with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) booklet printed off the internet and the KEMH pamphlet, as well as documenting in the notes some specifics about the risks and that the client is aware that hospital is an option.[71]

CONSULTATION WITH DR McKENNA

58. Dr Raymond McKenna is a General Practitioner with a specialist interest in obstetrics (generally referred to as a GP Obstetrician - GPO). In addition to his other medical qualifications, he has completed an Advanced Diploma from RANZCOG in February 2017 and a Fellowship from the Royal Australian College of General Practitioners in September 2018.[72]

59. In June 2017 he had been working at a medical centre in Busselton for about six months. Dr Ginbey, who originally was expected to see Ms M in relation to this pregnancy, was Dr McKenna's supervisor at the time.[73]

60. Dr McKenna saw Ms M on 7 June 2017 for a consultation, apparently as Dr Ginbey was not available. Dr McKenna stated that he recalled the consultation particularly well as it was the first time he had consulted a woman planning to VBAC at home.[74] Ms M told Dr McKenna she was 27 weeks and three days into her second pregnancy and was currently under the care of Ms Mansfield, a registered midwife. She explained she was consulting him as it had been recommended by Ms Mansfield that she be assigned to a GPO.[75]

61. Dr McKenna recalled that during the consultation he performed a focused bedside obstetric examination, which was unremarkable. He also asked Ms M about her current and previous pregnancy history, including details of her previous delivery. Ms M advised that during her first pregnancy she did not dilate significantly during the induction and that she had previously undergone a large loop excision (LLETZ) procedure on her cervix. She explained for this pregnancy she intended to attempt a VBAC at home under the care of her midwife.[76]

[69] Exhibit 1, Tab 6 [129] – [133].
[70] T 33 - 34.
[71] T 34 - 35.
[72] Exhibit 1, Tab 14B.
[73] Exhibit 1, Tab 14B.
[74] Exhibit 1, Tab 14B.
[75] Exhibit 1, Tab 14B.
[76] Exhibit 1, Tab 14B.

62. Dr McKenna said he advised Ms M of the risks associated with VBAC generally, including:

- the chance of successful vaginal birth is varied and depends on individual factors;
- if the VBAC failed, emergency caesarean section would be required, which includes an increased risk of morbidity when compared with a planned elective caesarean section;
- uterine rupture, which was the most significant risk. He explained there was a 1 in 200 possibility of that occurring and that it involved a significant risk to the neonate (including hypoxic encephalopathy and death) and the mother (including major haemorrhage, emergency surgery, hysterectomy and death);
- that given she did not dilate significantly in her first pregnancy, there was a risk that a VBAC may not be successful; and
- that her not dilating significantly in her first pregnancy may have been contributed to by the LLETZ procedure.[77]

63. Dr McKenna also discussed with Ms M the particular risks of attempting a VBAC at home. He explained to Ms M that, given the risk of uterine rupture, continuous monitoring (intrapartum cardiotocography – CTG - monitoring) was required in order to look for early signs of uterine scar dehiscence, which cannot be done at home. He told her that without this monitoring, early signs of uterine rupture could be missed.[78]

64. The other risk with attempting a VBAC at home was that, in the event of complication, the emergency escalation and response time would be delayed. In Ms M's case, Dr McKenna had turned his mind to the specific risk of delay, as her home was more than 20 minutes from the Busselton Health Campus. Dr McKenna explained to Ms M that this further increased the risk for her if there was a critical event.[79]

65. Dr McKenna advised Ms M that VBAC at home was not recommended due to these risks that he had outlined. Dr McKenna tried, through providing the relevant information, to discourage Ms M from attempting a homebirth, as he believed hospital was the safest place for her to birth. He suggested that if she delivered at the hospital, she would have support from her midwife in the birth suite.[80]

66. Dr McKenna also discussed other risks of the pregnancy and birth plan with Ms M, including her history of obstetric cholestasis in her previous pregnancy. Dr McKenna told Ms M that there was a high risk of it reoccurring, which might complicate the pregnancy and require further obstetric led management and possibly necessitate delivery at Bunbury Hospital.[81]

[77] Exhibit 1, Tab 14B [16].
[78] T 69; Exhibit 1, Tab 14B [16] – [17].
[79] T 69; Exhibit 1, Tab 14B [16] – [17].
[80] T 70; Exhibit 1, Tab 14B.
[81] Exhibit 1, Tab 14B.

67. Based on her previous history, Dr McKenna stated that he told Ms M she would need a counselling appointment with a specialist obstetrician at Bunbury Hospital's 'High Risk' Obstetric Clinic. He also felt that she would require a similar referral as she was considering a VBAC, but did not raise this with Ms M as it was his expectation Ms Mansfield would do so.[82]

68. Dr McKenna recalled that Ms M appeared "confronted"[83] by the suggestion of Bunbury Hospital involvement, so he wasn't sure that she had been expecting that suggestion until he mentioned it. Ms M replied to his suggestion of a referral to the 'high risk' clinic with words to the effect that she did not want any hospital involvement in the pregnancy. She explained that she didn't want the intervention she had experienced in her previous birth as she felt that her body wasn't ready for it, and she would fear that happening again in a hospital setting. Ms M told Dr McKenna that she had already been informed of the risks by her midwife and she did not raise any additional questions with him.[84]

69. At the end of the discussion, Dr McKenna believed that Ms M understood the risks of VBAC generally, and more specifically VBAC at home, and the fact that VBAC at home was not recommended due to the risks and the availability of safer options. He felt by the end of the consultation she could properly make an informed decision about her pregnancy.[85]

70. Dr McKenna agreed in his evidence that his contemporaneous documentation in the medical notes was a little sparse and could have been more fulsome in relation to the specifics of the discussion about the risks, particularly in relation to homebirth as he did not make mention of this in his notes. However, he also indicated that he was aware that Ms Mansfield was the primary carer so he did not see his role as being to provide formal counselling on the birth plan. It appeared to Dr McKenna that Ms M was already highly motivated to achieve a homebirth, given her previous obstetric experiences, and he didn't feel "she could be particularly swayed on her views at that point."[86] However, he was hoping the factors he had introduced would prompt some extra discussion between Ms M and Ms Mansfield. Dr McKenna was aware Ms M was seeing Ms Mansfield in the next day or two, so he assumed Ms M would be discussing the information he had provided to Ms Mansfield at that time. [87]

71. Dr McKenna offered Ms M follow up care, with the suggestion that at a further consultation they could re-discuss her birthing options, including the possibility of organising delivery at Bunbury Hospital by way of either VBAC or elective caesarean section, but she did not come to see him again after that consultation. He did not have any further contact with Ms M and all relevant correspondence was sent to Dr Ginbey.[88]

[82] Exhibit 1, Tab 14B.
[83] T 69.
[84] T 69, 78; Exhibit 1, Tab 14B.
[85] Exhibit 1, Tab 14A and Tab 14B.
[86] T 78.
[87] T 72 – 75.
[88] Exhibit 1, Tab 14A and Tab 14B.

72. Dr McKenna suggested in his evidence that, in hindsight, he thought it might have been helpful to have called Ms Mansfield ahead of her next appointment with Ms M, just to discuss his concerns and recommendation for a formal medical review at Bunbury Hospital. He suggested it in the context that open communication between caregivers can be beneficial and perhaps prompt more discussion, but he still felt that all the risks were properly conveyed to Ms M and she already appeared to have a good understanding of them from her previous discussions with Ms Mansfield.[89]

73. Dr McKenna also noted that Ms M did not come with any paperwork to the consultation, and indicated that in hindsight it would have been useful to have some kind of written document from Ms Mansfield indicating what she had discussed with Ms M thus far. As noted above, Ms Mansfield gave evidence that she has changed her practice in that regard.[90]

74. Ms Mansfield recalled in her evidence having an informal discussion with Dr McKenna and Dr Ginbey in passing at some stage and she understood they were aware Ms M was planning a home birth, although they did not have a formal discussion about Ms M's case.[91]

CONTINUING ANTENATAL CARE

75. The next antenatal consultation with Ms M took place on 18 July 2017 at her home. Ms M was 32 weeks and 5 days' gestation at that time. Everything still appeared to be going well and the fetal movements were recorded as active. Ms Mansfield collected a blood sample from Ms M to check her iron levels and also to check her liver function, given her previous cholestasis. Ms M had plans to fly to Broome with her family for a wedding and Ms Mansfield had no concerns about her travelling. Based upon her examination findings and the discussion with Ms M, Ms Mansfield's impression was that the pregnancy was normal and proceeding as planned.[92]

76. The next antenatal appointment on 3 August 2017 was also reassuring. Ms M appeared well, and reported feeling well other than some pressure down low at the front of her abdomen and some lower back pain, as well as disrupted sleep and episodes of reflux. Ms Mansfield considered these complaints to be a normal pregnancy complaint, so she was not concerned. Examination findings indicated the baby was still active.[93] Ms Mansfield gave Ms M a pregnancy massage to help with some of her discomfort.

77. Ms Mansfield did not make a record of it, but she believes it was probably during this consultation she repeated to Ms M the fact that the obstetricians at Bunbury Hospital would prefer all planned VBAC's to attend the hospital's high risk clinic. She recalled the conversation was very much a repeat of the earlier conversation on this topic, and Ms M told her that she did not see the benefit of attending the clinic.[94] Ms Mansfield gave evidence that, in her experience, quite a few women decline the

[89] T 74 – 75.
[90] T 77.
[91] T 11 - 12.
[92] Exhibit 1, Tab 6 [134] – [144].
[93] Exhibit 1, Tab 6 [145] – [159].
[94] Exhibit 1, Tab 6 [160] – [164].

offer to go to the Bunbury Clinic for review and it is not compulsory, so she did not take it further. Ms Mansfield commented that she did not think it would have changed anything if Ms M had attended Bunbury for such a review.[95]

78. On 16 August 2017 another antenatal consultation occurred. Ms M was at 37 weeks and 3 days' gestation, so she was at term by this time, although birth would not be expected to be imminent. Again the pregnancy appeared to be going as expected and all the findings were reassuring. Ms M looked well but said she was tired at the end of each day from doing lots of cleaning in preparation for the birth. They had a discussion about the birth pool that Ms Mansfield delivered during the visit. Ms Mansfield had no concerns for Ms M or her baby when she left at the end of the visit.[96]

79. Ms Mansfield visited Ms M again at home on 22 August 2017, when Ms M was 38 weeks and 2 days' gestation. Ms M told Ms Mansfield all was going well and that her baby was active. The baby was showing good growth and was in a good position. Ms Mansfield discussed with Ms M Group B Streptococcal (GBS) screening at this time, which is standard midwifery practice in Australia after 35 weeks' gestation, but Ms M declined. Ms Mansfield stated that in her experience this was not unusual in her clients. The outcome of a positive screen is usually to recommend intravenous antibiotic prophylaxis, which Ms M indicated she would not have wanted to take in any event.[97]

80. On 29 August 2017 Ms Mansfield again visited Ms M at home. Ms M was 39 weeks and 2 days' gestation at this time. Ms M indicated she had felt a lot of Braxton Hicks contractions the previous day, but they had tapered off after she went to bed. She looked and felt well and the baby appeared active, which was reassuring. Ms M indicated everything was ready for the birth.[98]

81. During the last antenatal consultation on 6 September 2017, Ms M was still feeling well and the baby had a normal fetal heart rate. Ms M told Ms Mansfield she had experienced of mild contractions over the previous two days but they had settled down. After her antenatal examination, Ms Mansfield was reassured that the pregnancy was proceeding as expected. Ms M was now a few days overdue (40 weeks and 3 day's gestation) Ms Mansfield discussed the advantages and disadvantages of having a vaginal examination with Ms M, and a possible stretch and sweep, to see if there was any indication of what progress (if any) there had been towards labour commencing. After their discussion Ms M consented to both.[99]

82. Ms Mansfield performed the vaginal examination at 10.45 am and was able to feel that the baby's head was well down and her cervix was 75% effaced and she was 1 cm dilated. Ms Mansfield was able to perform a stretch and sweep of the cervix, which Ms M tolerated well. Ms Mansfield remembered thinking that Ms M looked really favourable for labour and they were both excited about the findings. When

[95] T 30.
[96] Exhibit 1, Tab 6 [165] – [176].
[97] Exhibit 1, Tab 6 [185] – [188].
[98] Exhibit 1, Tab 6 [190] – [200].
[99] Exhibit 1, Tab 6 [201] – [

Ms Mansfield left the house she stated she had no concerns and was feeling positive.[100]

THE ONSET OF LABOUR

83. On or about 6 September 2017, Ms M began to have early signs of labour, mainly irregular contractions.[101]

84. Ms Mansfield received a text message from Ms M at 5.46 am on 8 September 2017 which read,[102]

> *'Another night with no sleep but contractions not getting to 5 minutes apart. I'm struggling a bit to get through them because they are painful. I think I'd like you to come over.'*

85. Ms M was 40 weeks and 5 days' gestation at this time.[103]

86. Ms Mansfield arrived at Ms M's home at approximately 6.30 am, so less than an hour after receiving the message. Ms M's husband opened the door and took her to Ms M, who was sitting on a fitball in the bedroom having a conversation with her sister. Ms M told Ms Mansfield she had been experiencing consistent mild to moderate contractions for the previous two nights and the contractions were now 5 to 10 minutes' apart. She said she had been awake most of the night as a result.[104]

87. Ms M appeared calm and was able to hold a conversation, so she did not look to Ms Mansfield to be in established labour. It was her impression that Ms M was tired but was coping well. Ms Mansfield asked Ms M to lie on the bed and she then palpated Ms M's abdomen and measured the fetal heart rate. With Ms M's consent, she also performed a vaginal examination. Ms Mansfield found there had been some progress since her last examination on 6 September 2017, and Ms M's cervix was now thinner and she was now 2 cm dilated. The baby's head was engaged four-fifths down.[105]

88. Ms Mansfield gave evidence she stayed for over an hour assessing Ms M and timing the contractions, but she only had three contractions in the whole time Ms Mansfield was present. Ms Mansfield felt she was not in active labour and was confident that she could leave.[106]

89. Ms Mansfield told Ms M she was in early labour and to get some rest. She indicated things could stop completely or she might move into established labour. Ms Mansfield explained she had an appointment in Margaret River, although it could be cancelled if needed, so she "needed to be kept in the loop."[107] Ms Mansfield left

[100] Exhibit 1, Tab 6 [215] – [226].
[101] Exhibit 1, Tab 4 [43].
[102] Exhibit 1, Tab 6 [227].
[103] T 39.
[104] Exhibit 1, Tab 6 [227] – [236].
[105] Exhibit 1, Tab 237] – [247].
[106] T 40.
[107] Exhibit 1, Tab 6 [249].

the house at 7.45 am to attend the other appointment.[108] Ms M indicated she already felt tired, due to the previous interrupted nights, and tried to get some rest as suggested.[109]

90. Early in the morning at an unknown time, but presumably not long after Ms Mansfield left the house, Ms Mansfield had a conversation with Loralee Worrall, another midwife who works privately in the south west and who was going to assist Ms Mansfield (as the required back up midwife) with the home birth. Ms Worrall and Ms Mansfield discussed the fact that Ms M had experienced a sleepless night having contractions but she was not yet in established labour. They discussed the possibility Ms M and her uterus could get tired due, and Ms Worrall suggested that Ms Mansfield contact the 'on call' doctor in the next few hours as if Ms M didn't establish into proper labour soon then she should have a caesarean section that afternoon. Ms Mansfield responded that they would see how the next four hours went.[110]

91. At some stage while in the birthing pool, Ms M had a very long contraction, which she estimated to have been 20 minutes of non-stop tightening. She took herself out of the pool and went into the shower to be more comfortable. When the contraction eased, Ms M felt "tender all over like muscle fatigue following a workout."[111]

92. Ms M's husband texted Ms Mansfield at 9.16 am. The message read, *'Amy had a long painful contraction and seems to be in more pain now.'*[112] Ms Mansfield recalled thinking that the labour might be establishing. She telephoned Ms M's husband at 9.27 am to follow up on his message and they had a discussion about Ms M and how her contractions were progressing. Ms Mansfield stated she explained that she had an appointment in Margaret River and wanted to check whether she needed to cancel and come to see Ms M. She heard Ms M say that her contractions appeared to be gaining strength and frequency but Ms M also said there was no pain between contractions and Ms Mansfield believed she was not distressed and was coping well.[113]

93. Importantly, given she was attempting a VBAC, Ms Mansfield and Ms M had a discussion about her caesarean section scar. Ms Mansfield asked Ms M if there was any pain in the area of her scar and Ms M said there was no pain over her scar. Ms Mansfield stated she was reassured that Ms M was not in pain and her labour was progressing and decided she would keep her appointment in Margaret River and then check back in with Ms M.[114]

94. The next communication was a text message sent to Ms Mansfield by Ms M's husband at 10.15 am, which read, '*Last 7 contractions have all been around a 2 minute interval. No outward signs of pain or distress.'*[115]

[108] Exhibit 1, Tab 4 [44] – [46]; Tab 6 [248] – [250].
[109] Exhibit 1, Tab 4 [48].
[110] T 80 - 83; Exhibit 1, Tab 9.
[111] Exhibit 1, Tab 4 [51].
[112] Exhibit 1, Tab 6 [251].
[113] T 40; Exhibit 1, Tab 6 [252] – [261].
[114] T 41; Exhibit 1, Tab 6 [262] – [265].
[115] Exhibit 1, Tab 6 [267].

95. Ms Mansfield responded with a text message thanking him for the information and clarifying whether the contractions were still as strong as before. He responded at 10.20 am with a text message indicating the contractions were the same strength but Ms M seemed to be comfortable enough and was breathing through them, although she wanted to sleep. Ms Mansfield indicated she was reassured from this information that Ms M's contractions had not rapidly increased and she was not distressed.[116]

96. Ms Mansfield received a further text message from him at 12.18 pm indicating that it was '*More of the same*' and she replied shortly after to indicate that she was nearly finished in Margaret River. She called Ms M's husband at 12.52 pm, a couple of minutes after her appointment had finished, and asked whether Ms M wanted her to come over and check on her and see how things were going. He told Ms Mansfield that Ms M would like for her to attend, but at that time Ms Mansfield did not sense any urgency in the request and Ms M's husband did not appear worried.[117]

97. Ms Mansfield called Ms Worrall around this time to advise Ms M might possibly be in early labour and she was going to check on her. Ms Worrall was in Donnybrook but she was nearly finished, so she told Ms Mansfield she would return to Busselton and would be nearby if needed.[118]

RETURN OF MS MANSFIELD

98. Ms Mansfield believes she arrived back at the house about an hour later, at approximately 1.50 pm (noting the drive from Margaret River took at least 45 minutes), although Ms M and her husband believed it was more like 1.00 pm.[119] Ms Mansfield was uncertain about the timing of events, after she arrived at the house, although she was certain of the order in which events occurred. Ms M's husband answered the door and escorted Ms Mansfield inside to where Ms M was sitting on a fit ball in the shower in the bedroom with the shower on. Ms M said she was doing this as a coping strategy for the pain of the contractions.[120] She appeared different to earlier in the day, seeming focussed and quiet, and Ms Mansfield formed the impression Ms M was now in established labour although she still needed to do checks of the cervix and time contractions.[121]

99. Ms M indicated she was feeling very tired and had concerns about being able to push when it came to the pushing stage. Although this was not unusual at this stage of the labour, Ms Mansfield considered Ms M to be a stoic person so she did start to feel concerned that something might be wrong. Ms M said her abdomen was sore to the touch and it also hurt when the baby moved. She described the pain as 'all over' like muscle soreness and did not indicate that the pain was over her scar. Ms Mansfield had begun to think that a successful homebirth was unlikely, given how things were evolving, but she did not have any suspicion of a uterine rupture at that stage. She did consider Ms M might need to go to hospital if the labour was not progressing, as

[116] Exhibit 1, Tab 6 [267] – [270].
[117] T 42.
[118] Exhibit 1, Tab 9.
[119] T 42; Exhibit 1, Tab 4 [53, Tab 5 [27] and Tab 6 [271] – [278].
[120] Exhibit 1, Tab 4 [55].
[121] T 43; Exhibit 1, Tab 6 [279] – [289].

Ms M's fatigue and pain suggested she might require pain relief or assessment.[122] She told Ms M she would need to examine her to see if they needed to transfer to hospital.[123]

100. Ms Mansfield asked Ms M to get out of the shower so she could perform a full assessment. Ms M found it painful and difficult to stand up straight, so Ms Mansfield assisted Ms M to the bed. Just after 2.00 pm Ms M lay down on the bed and Ms Mansfield began the assessment by trying to palpate her abdomen. She was unable to do so due to extreme tenderness. It was clear Ms M was in pain and could not tolerate the examination. Ms Mansfield took Ms M's blood pressure and thought the first reading must be wrong as it was so low. She measured it a second time and the two readings were very similar and abnormally low. As soon as Ms Mansfield saw the blood pressure readings she suspected a uterine rupture as the blood pressure suggested Ms M was bleeding internally.[124]

101. Ms Mansfield also checked the fetal heart rate, which was low at 90 beats per minute. She obtained Ms M's consent to perform a vaginal examination, just in case there was a cord prolapse or the baby was about to be delivered, or there was something else to explain the low fetal heart rate. However, the findings of the vaginal examination were unchanged from the examination she had performed at approximately 7.00 am that morning. Ms M was still only 2 cm dilated and there was nothing else detected that might explain the drop in heart rate.[125]

TRANSFER TO HOSPITAL

102. Ms Mansfield told Ms M and her husband that they needed to go to the hospital immediately. She dialled '000' at 2.11 pm and told the operator Ms M had been attempting a planned home birth but was exhausted and the baby was starting to show signs of distress and so she required urgent transfer to hospital.[126] Ms Mansfield then called the maternity ward at Busselton Hospital at 2.14 pm and notified them of Ms M's impending transfer. She asked the midwife she spoke to for the name of the 'on call' GP obstetrician and was told it was Dr Nicholas Du Preez.[127]

103. Ms Mansfield spoke to Dr Du Preez and told him that Ms M was being transferred to hospital. She explained that Ms M was a planned VBAC home birth and she now had low blood pressure and pain and there was low fetal heart rate. Dr Du Preez recalled that Ms Mansfield told him that she was concerned that there was a possible uterine rupture. Dr Du Preez said he would head to the hospital and get the theatre ready.[128]

104. Ms Mansfield gave evidence that in the ordinary case she would have already notified Busselton Hospital that she had a woman in active labour attempting a VBAC homebirth, just because there is no onsite obstetric theatre team so it would

[122] T 44.
[123] Exhibit 1, Tab 6 [290] – [301].
[124] T 45 - 46; Exhibit 1, Tab 4 [60] and Tab 6 [302] – [324].
[125] T 46; Exhibit 1, Tab 6 [325] – [329].
[126] Exhibit 1, Tab 7, p. 2.
[127] Exhibit 1, Tab 6 [330] – [340].
[128] T 48, 109; Exhibit 1, Tab 6 [341] – [345].

give them some notice in case something went wrong. However, in this case she was still trying to ascertain if Ms M was in active labour when she arrived at the house, and intended to notify the hospital once she had confirmed this was the case. Other events then overtook this usual courtesy call, so that her first call to the hospital was to indicate that there was a potentially urgent medical situation.[129]

105. Ms Mansfield performed a further set of observation while waiting for the ambulance to arrive and noted the fetal heart rate was slightly higher, at 105 beats per minute, and Ms M's blood pressure remained low.[130]

106. The ambulance arrived at 2.26 pm. Ms Mansfield told the ambulance crew that Ms M was not delivering but required urgent transfer to hospital. Around this time Ms M said she felt sick but she did not vomit. Ms Mansfield took a further set of observations at around 2.30 pm, while Ms M was still on the bed, and noted her pulse was 130 beats per minute and her blood oxygen saturation was 97%.[131]

107. Just as Ms M was being transferred from her bed to the ambulance stretcher she said, "I think my waters just broke.' Ms Mansfield checked but did not see any blood loss, liquor or discharge. She measured the fetal heart rate, which had dropped to 65 beats per minute.[132]

108. Dr Du Preez rang Ms Mansfield as the ambulance was departing and told her he was in theatre and they were ready for Ms M's arrival. He had arranged for the operating theatre to be readied and a theatre team, anaesthetist and paediatrician to be in attendance to assist him with an emergency caesarean section.[133] Dr Du Preez directed they bypass the ED and come straight to the operating theatre. Ms Mansfield passed on this information to the ambulance crew along with the information that the baby was very distressed and they needed to get Ms M there urgently. Ms Mansfield offered to travel in the ambulance but the ambulance staff declined.[134] Ms M's husband travelled with her in the ambulance and Ms Mansfield followed behind in her own vehicle.

109. Mr M expressed the opinion the whole process of getting Ms M to hospital, from the time Ms Mansfield returned and formed the view it was necessary, was "very fast and efficient."[135] He believed Ms Mansfield made a very quick decision to arrange the transfer based on the "the first sign she had that things were no longer 'normal'."[136] The ambulance arrived quickly and the driver to hospital was very fast under priority lights and sirens. He described the transfer from ambulance to hospital staff as "instantaneous"[137] as they were already prepared and waiting to conduct the caesarean within minutes of them arriving.

[129] T 61.
[130] Exhibit 1, Tab 6 [346] – [349].
[131] Exhibit 1, Tab 6 [349] – [357].
[132] Exhibit 1, Tab 6 [357] – [362].
[133] Exhibit 1, Tab 15.
[134] Exhibit 1, Tab 6 [363] – [371].
[135] Exhibit 1, Tab 5 [35].
[136] Exhibit 1, Tab 5 [35].
[137] Exhibit 1, Tab 5 [37].

THE BIRTH

110. Ms M stated that by the time they reached Busselton Hospital she was barely conscious. She was aware that she went into theatre but doesn't recall much more of events.[138]

111. Fortunately for Ms M, Dr Du Preez is a very experienced GP Obstetrician with an advanced obstetric diploma, who has experienced a uterine rupture before,[139] so he was able to deal with the emergency in an exemplary manner.

112. Dr Du Preez performed an ultrasound when Ms M arrived, which confirmed that Baby AM was still alive. However, at this time the fetal heart rate was only 60 beats per minute, which was extremely low, so it was obvious that time was of the essence.[140] Ms M was given a general anaesthetic and Dr Du Preez then commenced performing a lower segment caesarean section and got Baby AM out as quickly as he could.[141]

113. At caesarean section, Dr Du Preez found a uterine rupture, with Baby AM located partly in the abdominal cavity. There was bleeding of approximately 2.5 litres in the abdominal cavity. Dr Du Preez delivered baby AM, who was pale and had minimal muscle tone. He handed over the baby's care to the paediatrician. The time between the arrival of the ambulance to delivery of Baby AM was approximately 7 to 10 minutes, and between the administration of the anaesthetic to delivery was about 3 minutes.[142]

114. Ms Mansfield came in around the time Baby M was being delivered and she acted as a scribe for the paediatric team's resuscitation attempts.[143] Baby AM was intubated and ventilated before being transferred to Princess Margaret Hospital via the Newborn and Paediatric Emergency Transport Service.[144]

115. In his initial preparation, Dr Du Preez had requested that Dr Derek Wilson, the Obstetrician and Gynaecologist from Bunbury Hospital, be notified of these events. Dr Du Preez spoke briefly to Dr Wilson before Ms M arrived, and Dr Wilson confirmed that he would attend Busselton Hospital.

116. After delivering Baby AM, Dr Du Preez had focussed his attention on Ms M. He clamped the uterus to stem the bleeding and then had to suture the tears and close the uterus as best as possible given the anatomy was distorted due to the rupture. Dr Du Preez recalled it was a difficult repair that took him a long time to put back together. Dr Wilson arrived in the operating theatre as the suturing was being completed. Dr Wilson allowed Dr Du Preez to complete the abdominal closure. He checked the uterine closure and indicated he was happy with it. The placenta was noted to be healthy.[145]

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[138] Exhibit 1, Tab 4 [66] – [67].
[139] T 112, 115.
[140] T 110.
[141] Exhibit 1, Tab 15.
[142] T 116; Exhibit 1, Tab 15.
[143] Exhibit 1, Tab 6 [383] – [385].
[144] Exhibit 1, Tab 15.
[145] T 116 – 117; Exhibit 1, Tab 11 and Tab 15 and Tab 16.

117. Ms M was transferred to Bunbury Hospital, under the care of Dr Wilson, to continue her recovery. Ms Worrall had responded to a text from Busselton Hospital for midwives to come in and assist, so she had attended and was asked to accompany Ms M to Bunbury Hospital. Ms M and her husband travelled with Ms Worrall in the ambulance together. Ms Worrall recalled during the ambulance ride that Ms M made a passing comment to the effect that "she knew the risks and someone had to be the statistic of uterine rupture."[146]

118. Ms M was subsequently transferred to KEMH to continue her recovery in a location closer to Baby AM. She saw her baby for the first time on 10 September 2017 at PMH. By this time, Ms M and her husband were aware that there had been some damage to Baby AM's brain due to reduced oxygen during his birth. Neurological assessments took place over the next couple of days, which confirmed that his brain damage was extensive and his prognosis was very poor.[147]

CAUSE AND MANNER OF DEATH

119. It seems clear that Ms M's pregnancy had been progressing well and there were no concerning signs prior to Ms M going into labour. Ms Mansfield checked Ms M at what must have been about 7.00 am in the morning, and again, there were no concerning signs. It is clear when Ms Mansfield returned that Ms M's blood pressure was abnormally low and the baby's fetal heart rate had dropped, both indicating that something had changed and flagging the possibility of a uterine rupture. It became apparent the uterus had, indeed, ruptured at the time Dr Du Preez performed the caesarean section.

120. Dr Du Preez gave evidence that it is impossible to tell when the uterine rupture occurred, although he indicated that he would have wanted to start continuous monitoring of the fetal heart rate when Ms M started having painful contractions, which would at least have begun at around 9.00 am after the long painful contraction.[148] Dr Du Preez indicated that he wasn't aware of any clear timeframe between signs of fetal distress being detected and uterine rupture, but he did note that a drop in the woman's blood pressure is a late sign, as they would need to have lost a significant amount of blood beforehand.[149]

121. Dr Du Preez had identified a low fetal heart rate of 60 beats per minute before commencing the caesarean section. Baby AM was unresponsive at birth, with no respiratory effort and had a heart rate of less than 60 bpm. Resuscitation commenced immediately. Apgar score were 1 at 1 minute and 5 at 5 minutes. He was intubated and ventilated at 3.09 pm and cardiac massage was continued until his heart rate was greater than 100 bpm. His cord blood showed significant metabolic acidosis. He was administered adrenaline and intravenous antibiotics. Some seizure activity was noted before he was transported to PMH.[150]

[146] T 85; Exhibit 1, Tab 9 [52].
[147] Exhibit 1, Tab 4 [70] – [75].
[148] T 113.
[149] T 114.
[150] Exhibit 1, Tab 10 and Tab 11.

122. On arrival at PMH Baby AM was noted to have decreased tone, sluggish pupils and seizure activity was noted. He was clinically assessed to have a severe encephalopathy. Baby AM remained intubated and ventilated and showed minimal spontaneous respiration or movement over the following days. An MRI of his head on 12 September 2017 showed a severe central hypoxic ischaemic injury and an EEG was very abnormal. The specialists concurred that Baby AM was likely to have very significant disabilities if he survived. After discussion with his parents, the decision was made to withdraw active treatment and provide comfort measures. He was extubated at 4.15 pm on 13 September 2017. He died peacefully at 3.50 am on 14 September 2017.[151]

123. A Medical Certificate of Cause of Stillbirth or Neonatal Death was issued on 14 September 2017. The cause of death was given as hypoxic ischaemic encephalopathy, secondary to uterine rupture. No post mortem examination was conducted.[152] I accept and adopt the cause of death, as identified on the medical certificate.

124. Given the cause of death, I find that the manner of death was by way of natural causes.

COMMENTS ON THE CARE PROVIDED TO MS M

125. This inquest was directed, in part, because it was initially unclear what advice was given to Ms M and her husband, Mr M, in relation to the risks associated with attempting a VBAC at home. Following on from that, there was an identified need to consider the management of VBAC's by privately practising midwives in the south west, and the appropriateness of the collaborative practices between GP Obstetricians in Busselton with these midwives in facilitating VBAC's at home.

Views of Baby AM's parents

126. Statements were taken, and reports were obtained from relevant witnesses, as well as certain witnesses then being called to give oral evidence at the inquest.

127. Mr M indicated in his statement that he and his wife were happy with the advice and care they received from Ms Mansfield for the duration of the pregnancy and on the day of their son's birth. They believe that at every stage of the pregnancy they made the right decisions at the time and that the circumstances of Baby AM's death were "not the fault of anyone involved."[153] The couple did not feel that there could have been any specific extra amount of information or advice or influence of anyone, prior to the birth, that would have resulted in them making any different decisions.[154] Mr M feels the only way they could have avoided this tragedy would have been to have scheduled an early caesarean section, but there was no indication throughout the pregnancy that this should have been necessary.[155]

[151] Exhibit 1, Tab 4 [75].
[152] Exhibit 1, Tab 2 and Tab 10.
[153] Exhibit 1, Tab 5 [44].
[154] Exhibit 1, Tab 5 [45].
[155] Exhibit 1, Tab 5 [46].

128. While the couple are obviously deeply saddened by the tragic loss of their second child, Mr M expressed the opinion that the haste with which Ms Mansfield came to the decision to recommend they transferred to hospital saved Ms M's life.[156]

129. It seems clear from the available evidence that Ms M and her husband had weighed up the risks of attempting a VBAC homebirth and had made a conscious decision to accept that risk, as they considered it to be small and was weighted against the advantages they felt would flow from a home birth in their particular circumstances. I believe Ms M and Mr M understood that this plan would be unlikely to be recommended by a consultant obstetrician and that is why she chose not to go to Bunbury Hospital for a review, as she felt she had already made an informed decision and their counsel would not alter her choice.

130. Ms Mansfield gave evidence that she believed Ms M was well informed of the pros and cons of attempting a VBAC, knew the risks and made an informed choice. She believes Ms M understood that she was going outside the normal recommended guidelines in attempting a VBAC at home and she understood the greatest risk was that a uterine rupture might occur, in the sense that the risk was small but, if it occurred, potentially catastrophic.[157]

131. The only comment I make, in regard to their understanding of the risks involved, was that they obviously placed reliance on the low statistical odds of a uterine rupture occurring and Ms Mansfield's reassurance that she had never experienced such an event in her years of practice.

132. It was apparent from the evidence that Baby AM's parents bore no ill will towards Ms Mansfield following these events. Mr M indicated in his statement that he and his wife were "happy with the advice and care received from … Samantha Mansfield, for the duration of the pregnancy and on the day of [Baby AM's] birth. Ms Mansfield gave evidence that she had spoken to Mr M and he had made it clear to her that there was no ill feeling or blame and they had been happy with the care and support she had provided. They later went on to have another baby, in hospital as an early elective caesarean section due to the high risk, and rang Ms Mansfield to inform her of the successful birth.[158]

Dr Hamdorf

133. Dr Hamdorf did not comment on Ms M's plan to attempt a home birth in his initial report. He was asked at the inquest if he considered there was a risk associated with attempting a VBAC at home. Dr Hamdorf indicated that there is always a risk with having a VBAC, whether at home or in hospital, and in his view the only extra risk Ms M's case presented was that she had an 'untried pelvis', in that she hadn't had a vaginal delivery beforehand. The risk in such a case is that there is no proof that the pelvis can accommodate the foetal head during the labour process.[159] Dr Hamdorf gave evidence that while he was fully supportive of home births generally, he did have some concerns when he was told by Mr M that the couple had decided to plan

[156] Exhibit 1, Tab 5 [48].
[157] T 52 – 54.
[158] T 65; Exhibit 1, Tab 5 [42].
[159] T 96.

for a VBAC homebirth. However, he drew the conclusion from his brief conversation with Mr M that they were aware of the risks associated with it.[160]

134. Dr Hamdorf was asked about his personal opinion of Ms Mansfield and he indicated that they had enjoyed a close personal and professional relationship for many years, including Dr Hamdorf providing the obstetric backup for Ms Mansfield's own homebirth. He indicated that has confidence in her clinical judgment as a midwife, based upon their many shared clinical experiences.[161]

Opinion of Ms Martin

135. Ms Tracy Martin is also a very experienced nurse and midwife, with over 30 years' experience, including in rural and remote areas. Ms Martin is the Principal Midwifery Adviser for the WA Department of Health and is involved with the privately practising midwives in Western Australia because she holds the database of those registered in WA. However, their conduct is not governed by the Department of Health, as they work privately, so the regulation of their practice falls to the regulatory body, the Nursing and Midwifery Board of Australia.[162]

136. Ms Martin was asked to provide an opinion in relation to the midwifery care provided by Ms Mansfield to Ms M, based upon her experience, current position and extensive knowledge of the relevant ACM guidelines and standards.

137. Ms Martin was critical of the documentation in this case, which did not meet the standards expected by the ACM Birth at Home Midwifery Practice Standards. This criticism also related to the referral to the GP Obstetrician, as there was limited documentation as to what he discussed in his consultation with Ms M and no documented communication between Ms Mansfield and Dr McKenna. A sample of the type of letter that could be sent to a doctor is included in the ACM Guidelines, or alternatively if there was an oral discussion it ought to be documented in the clinical record. Ideally, Ms Martin considers that the midwife, client and doctor should all attend a meeting together, so that they can have a "robust discussion"[163] and provide a balanced view from both parties to the woman, and if the woman declines permission for the midwife to attend, then that should be documented. Ms Martin noted that, with advances in technology, the midwife would not have to be physically at the appointment to participate in a discussion, so there should be no practical impediments to it occurring, if all the parties are willing. Ms Martin expressed the view that this type of joint discussion between the midwife, doctor and woman is vital for informed consent to take place.[164]

138. The ACM Standards require the midwife to document all discussions in the clinical record, including the benefits and risks. The clinical record for Ms M had no documented discussions with Ms M regarding the benefits and risks of VBAC in particular, as well as birth at home. A consent form had been signed by Ms M and Ms Mansfield, but there was no detail in the consent form or corresponding

[160] T 96 – 97.
[161] T 107.
[162] T 163.
[163] T 165.
[164] T 164 – 168; Exhibit 1, Tab 19 and Tab 28.

documentation in regard to what had specifically been discussed. From the clinical record, there was no evidence of the plan of care for the pregnancy or birth plan.[165]

139. Ms Martin also noted that there did not appear to any plan discussed, nor any consultation with the GP Obstetrician, once Ms M's pregnancy had reached 40 weeks' gestation, which is considered post-term. Having reached 40 weeks the risk increased and if Ms M did not go into spontaneous labour the chances of having a successful VBAC decreased. Therefore, from that time it required some planning as to what would happen if she did not go into spontaneous labour, which should have prompted a discussion about planning with the GP Obstetrician.[166]

140. Ms Martin also expressed the opinion that, noting Ms M was in early labour at about 7.00 am and that she was attempting a VBAC at home, it would have been preferable for a physical check of Ms M to have occurred within four hours from that time, in order for the midwife to make her own assessment of whether the labour was progressing and noting there was the known underlying risk factor of a scar on the uterus.[167]

141. Ms Martin noted that abdominal tenderness that causes a woman to question her ability to push is not normal, and should raise a high degree of suspicion for dehiscing scar in a woman with a previous caesarean section. It appears that Ms Mansfield did appreciate this was a possibility once she had returned and had an opportunity to assess Ms M. Ms Mansfield then took immediate action, and Ms Martin expressed the opinion that Ms Mansfield's conduct in arranging an emergency transfer to the nearest hospital was appropriate. Indeed, she expressed the opinion that Ms Mansfield handled the emergency situation "absolutely amazingly."[168]

142. Ms Mansfield gave evidence that she still assists mothers with home births for VBAC's now, but since this experience she has changed her practice to the extent that she now provides written documentation on the risks and the benefits of vaginal birth after caesarean vs repeat elective caesarean and highlights the possibility that uterine rupture may occur, rather than "playing it down."[169] She is also more conscious of documenting the steps generally, as she conceded in this case the written documentation was limited. Ms Mansfield noted that she is generally only involved in two or three VBAC's a year, so it is not a large part of her caseload, and in those cases she is also more conscious of being present during the early stages more, as much to provide reassurance to herself as for everyone else.[170]

143. As the other privately practising midwife in the south-west area, Ms Worrall indicated in her statement that she always has a patient sign a consent form which outlines the risks involved when dealing with a category B birth, such as a VBAC at home. She also refers a person considering a VBAC to the high-risk clinic in

[165] T 165 – 166; Exhibit 1, Tab 28.
[166] T 163; Exhibit 1, Tab 28.
[167] T 172.
[168] T 173; Exhibit 1, Tab 28.
[169] T 54.
[170] T 54.

Bunbury for review.[171] Therefore, she and Ms Mansfield both now follow a similar practice.

144. Dr McKenna also agreed that his documentation was not as fulsome as it ought to have been in relation to the risks that he had discussed with Ms M and his recommendation as to a referral to the Bunbury Hospital High Risk Clinic. He made it very clear he did not support the plan of a VBAC at home, but he believed that further discussion would take place before a final decision was made by Ms M.[172]

Opinion of Dr Neppe

145. Dr Cliff Neppe is a Specialist Obstetrician and Gynaecologist who practises privately at Joondalup Private Hospital. Dr Neppe was requested by the Court to provide an expert opinion on this case. Dr Neppe has not been involved in a homebirth programme, so his opinion was based upon his experience as a specialist working from within a hospital, but with an understanding of what types of services would not be available at a homebirth. His opinion is also given within the framework of the RANZCOG guidelines, which quite properly guide his professional practice.[173]

146. Dr Neppe reviewed all of the relevant materials and provided a comprehensive written report, as well as giving evidence at the inquest. Dr Neppe provided a helpful summary of his opinions at the front of his report, including his opinion that:[174]

- Ms M did not meet the criteria for low risk midwifery led care and home birth consideration;
- The material risks associated with a successful VBAC were overlooked or understated;
- A registered medical practitioner would have a duty of care to discourage a home birth of a patient with a uterine scar;
- A collaborative agreement with Busselton Hospital as a transfer hospital for homebirths of VBAC is inappropriate;
- The intrapartum care of Ms M was substandard;
- Fortuitously the GP on duty at Busselton Hospital was Dr Du Preez, an experienced GP Obstetrician, who was able to save Ms M's life; and
- The death of Baby AM was preventable.

147. Dr Neppe noted that the consideration for homebirth is complex and in order to support a homebirth as a medical professional, he believes, at the very least, two fundamental principles: (a) the patient has no identifiable risk factors (as assessed by an experienced obstetrician) and (b) there is timely access to a suitably supported medical facility.[175] Dr Neppe expressed the opinion that a midwife would not be qualified to make that assessment of risk, but he did consider that a GP Obstetrician would have the capacity to assess the risk and provide that advice.[176]

[171] T 91; Exhibit 1, Tab 9 [22].
[172] T 78.
[173] T 185, 195, 202; Exhibit 1, Tab 12.
[174] Exhibit 1, Tab 12, p. 1.
[175] T 184; Exhibit 1, Tab 12, p. 7.
[176] T 184 – 185.

148. Dr Neppe suggested that the risk assessment is very different for a person who had had a successful VBAC in the past and one who has not. A person who has had a successful vaginal birth has proven capacity of the pelvis, and after a successful VBAC, the uterine scar has been tested and remained intact. In comparison, a person who has not had a successful vaginal birth raises the question, why did the vaginal birth fail?[177]

149. Therefore, Dr Neppe stated,[178]

> *.. if you ask me the question do I think VBAC homebirth is an option, I say possibly in some women who meet the criteria that I've outlined and possibly not for other women.*

150. This opinion was given on the background of an acknowledgment that the RANZCOG does not endorse planned homebirth, even in low risk women, as it is stated to be associated with an unacceptably high rate of adverse events. However, speaking from a personal perspective, and acknowledging that homebirth is a complicated and complex issue, Dr Neppe expressed the view that the important thing is for there to be a good selection process for homebirth candidates, which he believes is currently done well by WA Health.[179]

151. Dr Neppe acknowledged that patient choice is very important and he stated that he supports patient choice and is supportive of VBAC for that reason, but like all medical practitioners, he is most supportive of safe practice. He expressed the opinion that, while obstetricians need to compassionate and empathetic, "at some stage we've got to put emotion to the side"[180] and focus on the facts. It is for this reason that he thinks that the patient should be helped in the decision making process at specialist level by an individualised risk assessment.[181] Dr Neppe accepts that there are personal biases at play amongst consultants in terms of alternative birthing options such as family birth centres and homebirth, but he suggests that as professional people, there should be able to be a collaborative approach to these types of discussions and decisions between consultant obstetricians, GP obstetricians and midwives, taking into account the unique circumstances of each case.[182]

152. In relation to Ms M's specific case, Dr Neppe considered that not only was there the risk factor of a uterine scar, there were also two other specific risk factors with regard to her medical history. In a sense, they both related to the same thing, which was the history of Ms M's failed induction in her first pregnancy. Firstly, Dr Neppe indicated that Ms M's history of a previous LLETZ procedure, in the context of her first induction failing due to failure of cervical dilation, could lead to a suspicion of cervical scarring from the procedure, which can affect or inhibit cervical dilation. Secondly, Ms M's failure to dilate after a prolonged induction effort would alert a clinician that there might be a cervical dilation issue with Ms M.[183] Dr Neppe emphasised that the issue in this case was that where a patient has tried to labour, and

[177] T 186.
[178] T 186.
[179] T 195.
[180] T 187.
[181] T 186 - 187.
[182] T 196, 204.
[183] Exhibit 1, Tab 12, p. 2.

has unsuccessfully laboured, the assessment should be more cautious as the risk of success is lower.[184]

153. Dr Neppe explained that if a uterus ruptures there is a limited amount of time available to be able to deliver the baby to reduce the morbidity to that baby. The evidence supports a timeframe of 17 minutes from uterus rupture to delivery before there are potentially irreversible consequences for the baby, and potentially for the mother too. In that context, Dr Neppe indicated that in the unlikely event that a uterus does rupture, you add additional levels of complexity and risk if the woman is not in a facility that can actually deliver the baby within that requisite amount of time.[185]

154. Dr Neppe stated that once you have experienced a uterine rupture, the consequences can be devastating, and in his opinion managing a ruptured uterus during labour is going to be enormously surgically challenging and is a job for a specialist. He commented that in the hands of a non-specialist obstetrician, such as a GP obstetrician, it would be even more stressful and he believes it is a challenge that would put tremendous stress on the staff to manage that. Dr Neppe framed those comments in the context of the doctor facing a catastrophic injury, not a planned surgical procedure.[186]

155. In this particular case, Ms M had the good fortune to have Dr Du Preez rostered on as the 'on call' GP Obstetrician at Busselton Hospital. Dr Neppe noted that Dr Du Preez has actually completed specialist obstetric training but is not registered as a specialist in Australia by virtue of the fact that he moved countries. Therefore, the level of obstetric and gynaecological training and experience, and specific personal experience, Dr Du Preez could draw upon was much greater than would be available to a medical practitioner who has only completed the general, or even advanced, diploma in obstetrics.[187]

156. As to the monitoring of Ms M during the morning of 8 September 2017, Dr Neppe commented that where there is a patient with a scar on the uterus, the carer must be less "blasé about the latent phase"[188] as the longer the uterus is contracting, albeit even irritably, without the cervix dilating, then the forces of contraction are moving down to the weakest point, that is the scar.[189] Dr Neppe stated that it is, therefore, important to make regular assessment of the mother and baby to ensure they are still comfortable, particularly when they are birthing at home, and to undertake a continued risk assessment to consider whether the woman needs to be transferred to a facility that has got greater capacity for monitoring.[190]

157. In that regard, Dr Neppe referred to the desirability of CTG monitoring to assess fetal wellbeing. Ms Reynold's evidence in relation to the lack of evidence around CTG monitoring was put to Dr Neppe at that stage. Dr Neppe accepted that a CTG is by no means absolute and has its shortcomings, but in his opinion "it would be pretty

[184] T 186.
[185] T 188.
[186] T 189.
[187] T 189.
[188] T 193.
[189] T 193 – 194.
[190] T 192 – 194.

remiss and it would not be standard practise to say patients that have got a scar on the uterus do not need to be monitored with CTG during the course of their labour."[191] Dr Neppe explained further that the benefit of a CTG is that, if it is normal, almost certainly the baby is well oxygenated. If the CTG is abnormal, up to 50% of the time the baby might still be well oxygenated, but it can trigger other assessment tools such as fetal scalp lactate, to help identify if there is a problem. Therefore, Dr Neppe suggested he would rather use an imprecise tool that provides reassurance when things are going well, than no tool at all.[192]

158. Based upon his review of all of the available materials at the time of preparing his report, and allowing for the importance of respecting a woman's choice, Dr Neppe expressed the opinion that Ms Mansfield failed in her duty of care, both in accepting the care of Ms M for a planned VBAC at home, given her previous failed induction and untried pelvis, and by failing to provide oversight of Ms M's labour, which in his view allowed the uterine scar to weaken over time. Given Ms M's failure to dilate in her first pregnancy, her failure to establish labour in this second pregnancy should have triggered a timely transfer to hospital at an earlier stage, rather than being left unmonitored and unsupervised for a prolonged period.[193]

159. Dr Neppe expressed the opinion that all persons involved in the emergency caesarean section should be commended, from the minute the ambulance service got the call until the baby was delivered. However, he also said he wished that the call to the ambulance service had been made a number of hours earlier.[194]

Was the death preventable?

160. I asked Ms Mansfield whether she thought she might have detected a problem earlier, if she had remained with Ms M rather than leaving her that morning. She agreed it was possible, but also commented that it was unclear when the uterine rupture occurred, so it may have not been present for long or could even have occurred when Ms M said that she thought her waters had broken when on the stretcher. I suggested that the low blood pressure and low fetal rate would probably suggest that the uterine rupture had already occurred before Ms Mansfield called for an ambulance, and she agreed that it might at least have suggested that it was a scar dehiscence, rather than a complete rupture. She commented that in the 10 or 15 minutes after she returned to the house, she watched Ms M deteriorate before her eyes, which is why she thought it might have only just occurred around that time.[195]

161. Ms Worrall gave evidence she did not know how this death could have been prevented, noting that even if she had been planning to have her baby in hospital, she might not have presented to hospital before her uterus ruptured. Ms Worrall accepted that the death could, of course, most likely have been prevented if Ms M had followed the usual medical advice and accepted an elective caesarean at 39 weeks,

[191] T 194.
[192] T 206.
[193] Exhibit 1, Tab 12.
[194] T 211.
[195] T 51.

but her answer was given in the context of an understanding that Ms M was committed to the choice of attempting a VBAC, whether in hospital or at home.[196]

162. Ms Reynolds, an experienced midwife who I mention below, similarly suggested that on a review of the materials it appeared likely that Ms M may have been resting forward over the dehiscence when she was on the fitball, so it only fully ruptured and she began to experience the full consequences and rapidly deteriorate when she stood up from the fitball to be assessed by Ms Mansfield.[197]

163. Ms Martin gave evidence that women can compensate very well in hiding any amount of blood loss and they will compensate for hours before they suddenly collapse, which is consistent with the views above.[198] Ms Martin expressed her opinion that even if Baby AM's mother had been in hospital, there was unlikely to have been any difference in the outcome.[199]

164. Dr Neppe, on the other hand, expressed the opinion that Baby AM's death was preventable.[200] Dr Neppe expanded upon his opinion at the inquest, explaining that there were a number of options that may have altered the outcome in this case:[201]

1. If Ms M had undergone an elective caesarean section at 39 weeks;
2. If Ms M had been given a comprehensive risk assessment and then chosen to undertake a VBAC in a hospital setting, Dr Neppe was fairly confident that the duration of a latent phase would have been assessed and Ms M would have been offered a non-elective caesarean section;
3. If Ms M had been labouring in hospital and had declined a caesarean section but had been undergoing CTG monitoring, Dr Neppe believes the fetal distress would likely have been picked up at an earlier stage, prompting more timely advice and possibly an earlier emergency caesarean section; and
4. If Ms M had continued to labour but the uterus had begun to rupture in hospital, it would have allowed the possibility to potentially perform the emergency caesarean section in a shorter timeframe that could have prevented Baby AM suffering a catastrophic hypoxic brain injury.

165. Therefore, Dr Neppe stated there is no doubt in his mind that "the outcome could have been different if [Ms M] had a repeat elective caesarean section or at least undertaken a labour in a facility that could have provided those … risk measurements and assessments"[202] as outlined above.

166. Dr Neppe disagreed with the proposition, suggested by other witnesses, that Ms M would not have been admitted to hospital any earlier, even if the plan had been for a VBAC in hospital, as she was not yet in established labour at the time Ms Mansfield realised there was a complication. Dr Neppe expressed the opinion that, because Ms M was not low risk, he would expect at any hospital in Western Australia Ms M

[196] T 85 - 86.
[197] T 153 – 154.
[198] T 175 – 176.
[199] T 174.
[200] Exhibit 1, Tab 12, p. 1.
[201] T 201.
[202] T 201.

would have been brought in and assessed to determine, face-to-face, whether or not she was suitable to go back to the community to labour or whether she should be admitted. He believes the fact she had a scar on her uterus would have activated a need for assessment by obstetric staff.[203] If she had then been admitted to hospital, the opportunities to intervene earlier in the labour might then have arisen, potentially averting the tragic outcome in this case.

COMMENTS ON PUBLIC HEALTH MATTERS

167. Ms Mansfield has described herself in information material for potential clients as a "passionate supporter of natural birth, water birth and vaginal birth after caesarean."[204] Ms Mansfield indicated at the inquest that her role as a private midwife facilitating homebirths is essentially filling a gap in the type of care that is available to women in the south west area. There is currently no Community Midwifery Service in Busselton (noting that Busselton does not fall into the Bunbury CMS catchment area) and, in any event, Ms M would not have met the criteria for inclusion in that home birth service at that time as she was planning a VBAC. Ms Mansfield indicated she is well aware that she is practising outside the recommended RANZCOG guidelines when assisting a planned VBAC homebirth and she makes sure she obtains informed consent from the mother, as she believes she did in this particular case.[205]

168. Ms Mansfield commented that the choice of a home birth for a VBAC is not simply a choice weighing up medical risk, but is often much more complex for the women who are considering it as an option. She noted that women are individuals and many have complex emotional needs and previous trauma that has to be considered when looking at their requirements. Ultimately, Ms Mansfield expressed the view that it is the woman's choice, not hers, and she is happy to take on that risk with them, provided they are a reasonable person who is well-educated about their choice and they are happy to accept the hospital back-up in case the need arises.[206]

169. Ms Mansfield has worked closely with Ms Worrall to provide this service to women in the south-west for many years. There appears to be strong demand for their services. Ms Mansfield commented that in her view, the collaborative arrangement with Busselton Hospital as a transfer hospital "is a safe option and has been for many years."[207] Ms Mansfield noted that a few years ago they tried to withdraw that service from Busselton and there was a big community outcry. Women from the community fought hard to keep that service in Busselton. Ms Mansfield noted the women want to be close to their community and their home and their families and travelling up to an hour to Bunbury is not the safest option.[208]

170. Ms Mansfield agreed in questioning that there remains a percentage of women in the south-west who would choose the option of unassisted childbirth or 'free birthing' (having a home birth unattended by any medically trained professional) if a private

[203] T 202.
[204] Exhibit 1, Tab 6, Annexure.
[205] T 52 – 53.
[206] T 57.
[207] T 28.
[208] T 28.

midwife was not available to provide the birth of their choice, rather than the alternative of going to hospital. She understands that freebirths occur quite a lot already in the towns where there are no private midwives practising or the family cannot afford the private midwife's fees (which are not covered by Medicare for the birth component of their care).[209]

171. Ms Mansfield also gave evidence that from her experience practising in the Busselton area, if VBAC services were not provided at Busselton Hospital then the only option would be for women in that community to go to Bunbury Hospital, which for some would be acceptable but for others it would not be, increasing the risk that those women will either free birth or labour at home unmonitored for their whole labour, getting to the hospital only at the last possible minute.[210]

172. Similarly, Ms Worrall emphasised that she believes it is "really important to remember that as much as we can give recommendations, it's a woman's right to be able to choose where she births and with whom she births. That's her right as a woman."[211] Ms Worrall sees her role as giving women, many of whom are very damaged from previous birth experiences, the option to make a decision to engage with a private midwife and to opt for a home birth. She believes it is not a decision that is made lightly by the women who engage her.[212]

173. Ms Worrall noted that for women willing to birth at hospital in Bunbury, they may at least have the option of a non-standard management plan even when attempting a VBAC, which could include a water birth, but for women who wish to stay in their community in Busselton they cannot labour in water and must agree to continuous CTG monitoring and having an IV cannula in, if they opt for a planned VBAC at Busselton Hospital. In those circumstances, some women will choose to engage Ms Worrall or Ms Mansfield and bear the financial cost and the acceptance that there is no insurance coverage, in order to have the birth of their choice.[213]

174. Ms Worrall noted that there are only a small number of private midwives practising in Western Australia. Ms Worrall and Ms Mansfield have very busy practices in the south west and it appears there are a handful who practise in Perth and perhaps one in Geraldton, but none in the far north of Western Australia. Ms Worrall believes it is in part due to the inability to obtain professional indemnity insurance for a home birth as a private midwife, as well as the huge responsibility it involves and the large amount of 'on call' work.[214]

175. Like Ms Mansfield, Ms Worrall gave evidence that, as a private midwife, she feels well supported by the GP Obstetricians at Busselton Hospital and believes she and Ms Mansfield have a good working relationship with them. Ms Worrall suggested that it is more often when there is a breakdown in those relationships that women and babies are really at risk.[215]

[209] T 55.
[210] T 60.
[211] T 87.
[212] T 87.
[213] T 87.
[214] T 88.
[215] T 86.

176. Dr Hamdorf has been practising GP obstetrics in the south west since 1988 and although he ceased intrapartum obstetrics in 2015, he still provides antenatal and postnatal support to patients. He therefore has considerable experience in the provision of pregnancy and birth services to women in the south west over many years. Dr Hamdorf agreed with the general evidence that most GP obstetricians would prefer, if given the choice, to see VBAC's take place in hospital. However, he takes the view that where the patient is really passionate about pursuing a VBAC at home, they need to be fully aware of the risks associated with that, and then supported in their choice. Dr Hamdorf commented that "the risk of alienating a patient through concrete fixed counselling and driving them away from clinical support is greater than the other risks that may be associated with VBAC's at home."[216]

177. Dr Hamdorf continued that, in his experience, people who elect to have a home birth will usually do so because they are very passionate about home births. Therefore, it is important for doctors not to simply bury their heads in the sand and pretend it doesn't exist. Dr Hamdorf expressed the view that "the worst thing we can do is restrict support, because it would just drive homebirths underground without any clinical support whatsoever."[217]

178. Dr Hamdorf believes the advantage they have in the south west is that the two private midwives and the GPO's who work in conjunction with them work collaboratively and "share information without fear or favour."[218] Dr Hamdorf also believes that the advantage of a midwife managing the person's antenatal care as well as their labouring at home is that there is a continuity of care that allows the midwife to have a much better sense of how well the patient is progressing and performing in labour, than an assessment by someone who is unknown to them.[219]

179. In addition, Dr Hamdorf noted that the person will usually have one on one contact with a midwife at a much earlier stage in the labour than they would if it was a scheduled vaginal delivery, VBAC or otherwise, in hospital.[220] Dr Hamdorf explained that the infrastructure is stretched at Busselton Hospital, so even with a VBAC the person might not be instructed to come in if they are only contracting, without any other supporting signs of advancing labour.[221]

180. Dr Hamdorf commented that in his experience, uterine rupture is exceedingly rare, and he understands there have been cases where it has begun to occur and the wound has dehisced but there is no clinical catastrophe.[222] He personally has overseen a lot of VBAC's in his time and he considers, overall, that it's a relatively low risk procedure, particularly for those who have a tested pelvis. However, as a doctor, his personal preference would be to see women who are attempting VBAC with an untried pelvis to labour in hospital, as that is obviously the place best equipped to deal with an emergency if it arises.[223] That description would apply to Ms M. In that

[216] T 106.
[217] T 100.
[218] T 98.
[219] T 98 - 99.
[220] T 99.
[221] T 99 - 100.
[222] T 99.
[223] T 100, 106.

sense, he agreed with the opinion of Dr Neppe that a medical practitioner has a duty of care to discourage a home birth for a patient with a uterine scar. However, Dr Hamdorf returned to his earlier statements, whereby he noted that "women who are really enthusiastic about embracing homebirth need to be encouraged and supported, otherwise they're going to be driven underground without any clinical support whatsoever."[224]

181. Dr Hamdorf also noted that the problem for Busselton is that there is too small a population to support an intermediate service, such as a family birthing centre, as is available in Bunbury. He sees this as unfortunate, as he considers this would be a good option for medium-risk patients "that fall between the cracks,"[225] and their only alternative is to either have a birth that is not of their choice or choose a home birth with a private midwife.

182. Dr Hamdorf expressed the opinion that there needs to be more community midwives in the south west region, given its size and the demand, and there needs to be consideration of succession planning both for midwives and GP obstetricians. He otherwise considers that the current system works well as the relationships between the midwives and GP obstetricians relies upon "mutual respect and confidence in people's clinical abilities."[226]

183. Ms Kate Reynolds is the Coordinator of Midwifery for the WA Country Health Service (WACHS). Ms Reynolds provided a comprehensive report to the court dated 5 November 2020 in relation to matters relevant to this inquest,[227] and also spoke to her report at the inquest. Ms Reynolds has been a practising nurse and midwife for more than three decades and over the years has been involved in various management roles within the WA Public Health Service. In her various roles, she has had particular involvement with home birth services, including undertaking a national project investigating options for professional indemnity insurance for privately practicing midwives on behalf of the Australian Health Ministers Advisory Council in 2014 and is the current Co-Lead of the WA Health Women and Newborn Health Network responsible for recent re-publication of the WA Health Mandatory Policy for Public Home Birth programs.[228]

184. Ms Reynolds was also involved in setting up the midwifery group practice at Bunbury Hospital in about 1996, which includes a publicly-funded homebirth program, governed by the Public Home Birth policy. Relevantly to this case, Ms Reynolds noted that in the new version of the Public Home Birth policy, VBAC is no longer an absolute contraindication for homebirth. Instead of past caesarean section being an automatic excluding criterion, it is now on the list of factors that prompts a discussion with a consultant obstetrician to determine their level of risk, based around their individual circumstances. However, Ms Reynolds did accept in questioning that, given the RANZCOG guidelines recommend that a planned VBAC should be conducted in a suitably staffed and equipped delivery suite, it is unlikely

[224] T 101 – 102.
[225] T 108.
[226] T 105.
[227] Exhibit 1, Tab 29.
[228] Exhibit 1, Tab 29.

many consultant obstetricians are going to be giving their approval to a planned VBAC homebirth.[229]

185. Currently, the publicly funded Community Midwifery program is only available in the Perth CBD and in Bunbury. Ms Reynolds indicated that there has been talk about expanding the service to Busselton for many years, but little progress has been made to date. Ms Reynolds noted that they are certainly looking to create a midwifery group practice and, because of the high demand for homebirth services in the south west, it would be a good opportunity to extend that option for women in the Busselton region.[230]

186. Ms Reynolds provided information in her report as to the hospitals in Western Australia that provide VBAC services, which includes Busselton Hospital. A significant number are within the Perth metropolitan area, but regional hospitals (run by WACHS) cover the rest of the State, from as far north as Kununurra all the way down to Albany.[231] Ms Reynolds advised in her report that the overall incidence of women seeking VBAC in WACHS is low at 26%. Of those, 57% achieve vaginal birth, with the remainder having another caesarean for various reasons. Ms Reynolds indicates that there have been 11 instances of women experiencing ruptured uterus during spontaneous labour in WACHS in the past 11 years, and another 9 occurrences were associated with either induction or augmentation of labour. Three of the babies were stillborn and another four were sufficiently unwell to require tertiary hospital transfer. I assume, as it is not mentioned, that there were no maternal deaths.[232]

187. In 2014,[233] two women attempting VBACs experienced uterine ruptures during admission for birth, one at the Bunbury Health Campus and another at the private hospital in Bunbury. The two cases prompted the South West Obstetric Advisory Committee to consider whether VBAC should continue to be offered at Busselton, which does not provide the same level of specialist Obstetric, Anaesthetist and Paediatric services as Bunbury Hospital. The discussion had ramifications for the other regional hospitals in Western Australia that offer a similar service in very remote areas. It was determined by the committee, after taking into account the enormous community demand for the service and the risks in the context of the rest of WACHS, that it would be appropriate to inform women of the differences in clinical service capability between Busselton and Bunbury and that women seeking VBAC at Busselton should be offered an appointment with a consultant obstetrician via the Bunbury Hospital antenatal clinic. A comprehensive brochure was prepared and circulated for comment. Consumer feedback was negative, suggesting the brochure "significantly overstated the risks, was not consumer centred and was more intended to 'protect' the organisation than give unbiased information upon which consumers could make an informed decision."[234] In the end, the WACHS Obstetric Leadership Group decided the recently updated RANZCOG VBAC consumer brochure should be used instead.[235]

[229] T 122, 144 - 145; Exhibit 1, Tab 29.
[230] T 123.
[231] Exhibit 1, Tab 29.
[232] T 129 – 130; Exhibit 1, Tab 29, p. 3, 6.
[233] T 130.
[234] Exhibit 1, Tab 29, p. 5.
[235] T 130 – 131; Exhibit 1, Tab 29.

188. The consumer brochure is now provided to all women on their first visit to an Obstetric doctor or to a maternity hospital. I assume this would capture women who are planning a VBAC home birth, as the evidence of Ms Mansfield and Ms Worrall is that they require their clients to attend a GP Obstetrician on at least one occasion as part of the 'booking in' service.

189. A specific consent form was also developed for VBAC at Busselton Hospital, to be read in conjunction with the RANZCOG VBAC consumer brochure. This consent form does not apply to privately practising midwives in Busselton, only the obstetricians and midwives working at Busselton Hospital. However, Ms Reynolds suggested that it could be used by the private midwives to assist them as part of the documented discussion that they have with a woman around her individual risks for a VBAC at home, something not always done well by the WA Health system.[236] The privately practising midwives are also governed in their general practice by the ACM National Midwifery Guidelines and ACM Birth at Home Midwifery Practice Standards.[237]

190. Ms Reynolds provided some information in her report on the evidence as to why women choose a VBAC homebirth. Ms Reynolds noted that one in three women experience birth trauma.[238] In many cases, a previous traumatic birth experience or traumatic experience of hospital care is a primary factor in their choice to attempt a VBAC at home. Many of these women have researched the circumstances surrounding their first caesarean birth and reached the conclusion that the indication for caesarean section was not evidence based or that they weren't given enough time to achieve vaginal birth. They then feel like they were 'duped' out of experiencing the benefits of vaginal birth. Therefore, they choose a home based attempt at VBAC as they have developed a mistrust of the medical establishment and system and wish to avoid what they consider to be unnecessary, non-evidence based obstetric interventions.[239]

191. Other reasons include:[240]

- access to continuity of midwifery carer, which can have better outcomes for the mother and baby;
- feeling safer at home in a familiar, calming and comfortable environment; and
- an understanding that they are more likely to achieve a vaginal birth at home than in hospital.

192. Ms Reynolds is obviously committed to improving the availability of homebirth as a more mainstream option for women, noting that there is work being done for a Medicare rebate for homebirth (although it can't occur until there is an insurance product for the same). Similar to the evidence of Ms Mansfield and Ms Worrall, Ms Reynolds noted that, without increasing the availability of homebirth for women who wish to choose that option within the health system, there will continue to be cases of women actively avoiding registered obstetric care and opting to free birth,

[236] T 137 – 138.
[237] T 133, 157; Exhibit 1, Tab 19 and Tab 28 and Tab 29.6.
[238] T 128.
[239] Exhibit 1, Tab 29, pp. 4 – 5.
[240] Exhibit 1, Tab 29.

which is actively discouraged by midwives and obstetricians due to the obvious risks involved.[241]

193. Ms Reynolds noted that doctors who have worked in the United Kingdom National Health Service and those coming from New Zealand are far less anxious around homebirths and water births because that has been part of their standard model of care for a long time. She is hopeful that similar progress can be made with obstetricians in Australia.[242]

194. Ms Reynolds also stated her understanding that intervention rates for births in hospital, particularly in private practice, are skyrocketing. She believes it is largely driven by the workload of private obstetricians, because it suits the timing of their workloads rather than clinical needs. This has led to an increase in the primary caesarean rate, which then leads to the issue of VBAC's being required more often. Ms Reynolds suggested that if more work is able to be done by WA Health to reduce the caesarean section rate, that will also help with this complex issue.[243]

195. This is supported by the evidence of Ms Tracy Martin. Ms Martin's master's thesis was the examination of 'Next Birth after Caesarean Section,' so she has a particular interest, and knowledge, in this area.[244] When Ms Martin completed her masters' thesis in 2013, there was already an increasing caesarean section rate in Western Australia, sitting about 35% of births, which is similar to current levels. As noted by Ms Reynolds, it is the high incidence of first-time caesarean section that informs the VBAC issue.[245]

196. Ms Martin was instrumental in creating a 'Next Birth after Caesarean' clinic at KEMH and they talked in the clinic about risk and relative risk. One of the important factors they identified in the process is that interpregnancy interval is really important, as the longer lapse between pregnancies gives the uterine scar a chance to heal to a point that puts the woman at less risk of uterine rupture. As for other risks, there was no risk for a woman planning a VBAC to have her antenatal care with a private midwife in the community, and the only particular risk is intrapartum, where the Department of Health guidelines, consistently with the RANZCOG guidelines, recommend birth in a maternity unit that has the capability for caesarean section in the event that something catastrophic happens.[246]

197. Ms Martin had expressed this position based upon her role with the Department of Health. When asked whether she would express a different position from her personal perspective as a midwife, Ms Martin indicated that from her midwifery perspective she "would still be concerned around vaginal birth after caesarean at home."[247] Ms Martin explained that there is not enough evidence and research into the safety of VBAC at home at this stage for her to feel comfortable with it. Ms Martin noted that Western Australia has struggled to make homebirth normal across the system, and she believes we need to have homebirth more normalised for

[241] T 140.
[242] T 148.
[243] T 142.
[244] T 158 - 159; Exhibit 1, Tab 28.
[245] T 159 – 160.
[246] T 161.
[247] T 175.

low risk births before we move into the grey area of VBAC. Ms Martin commented that we currently have a very medicalised system in Western Australia and it's going to take a long time to change that.[248]

198. However, Ms Martin acknowledged that the AMC guidelines that guide privately practising midwives do not prevent them from assisting a woman with a VBAC at home. Indeed, Ms Martin noted that the principles of midwifery emphasise that a woman should be supported in her choice, so if a woman wants to attempt a VBAC at home, she should be supported in that choice regardless. However, Ms Martin emphasised that it is important to provide all of the information available and ensure that it is well documented, so that there is clear informed choice.[249]

199. Dr Neppe framed his comments around risk and choice by emphasising the importance of the last period of a few hours before the birth of an individual, as the consequences of what occurs in those few hours can be carried by a person for the rest of their life. If a baby is born with hypoxia or anoxia, even if they survive, they can suffer significant impairments in their abilities and might not reach their full potential. As a result, Dr Neppe considers there is a huge responsibility on everyone involved to make collaborative decisions to ensure that the long-term outcome is the best it can be. Dr Neppe suggested there would be merit in putting in place a panel of professionals when a person is planning to undertake a homebirth, to eliminate individual biases from the decision making process. I'm not sure if that is entirely practical, taking into account factors such as distance and likely willingness of the woman to participate in such a panel discussion, but it does align with Ms Martin's evidence that it is very important for the midwife, prospective mother and GP obstetrician to meet together to discuss the risk factors and plan in each case, and ideally also for the midwife to participate in the review by the specialist obstetrician at the Bunbury Hospital clinic.[250]

200. I agree with Dr Neppe's suggestion that there also needs to be a focus, when providing obstetric advice recommending against a homebirth, to consider what other options can be offered to help the woman achieve the best birth experience they can within the hospital environment. Dr Neppe acknowledged that the current system often fails to provide an environment that is safe but also acceptable to women who wish to birth in certain ways.[251]

201. With respect to the planning and decision making, Dr Neppe also emphasised the importance of not placing too much responsibility on GP Obstetricians to deal with emergency situations that are beyond the scope of their training. Dr Neppe is involved in training GP Obstetricians and he expressed the view that they are "absolutely fantastic," but he is mindful that their training program is much shorter, by years, than the specialist training program and they have a completely different skillset, so people should not be expecting the same outcomes when a GP obstetrician is faced with having to perform a lifesaving hysterectomy or other emergency surgery. As Dr Neppe noted in this case, Dr Du Preez has acquired the skillset of a specialist, so he was much better placed than the ordinary GP

[248] T 175.
[249] T 178.
[250] T 196 – 198.
[251] T 198, 205.

obstetrician, when faced with this emergency, but it was still a challenging experience for him and he requested the assistance of a specialist obstetrician from Bunbury Hospital before going into theatre, although the consultant arrived late in the proceedings due to the travel distance.[252] It is for these reasons that Dr Neppe expressed concern about the collaborative agreement with Busselton Hospital as a transfer hospital for VBAC homebirths.

202. Dr Neppe commented that his heart was racing just thinking about the situation faced by Dr Du Preez and the other doctors in this case, and he believes that, as a group, doctors and midwives should be mindful that they have to look after their colleagues and not put them potentially in situations that are outside the ambit of their skill and capability, "because the outcomes live with the patients forever as well as with the practitioners forever."[253]

203. In his evidence, Dr Du Preez commented that, whilst he thinks everyone should have a right to choose, based on all of his obstetric experience, he cannot support VBAC's at home. Dr Du Preez gave evidence that he has never, in his whole career, suggested a VBAC at home to anybody, and "medically [he] won't support it."[254] In his opinion, the risk is too high due to the delay, as time is the critical factor.[255] However, Dr Du Preez also made it clear that he won't necessarily stop looking after a woman if she makes that choice. He just does not think it is a safe choice to make. Dr Du Preez opinion is informed by his previous experiences of uterine rupture, in which he has also seen bad outcomes.[256]

204. Dr Du Preez had stated his belief that it was important for a VBAC to take place in hospital, as there is the opportunity for continuous fetal monitoring, done by CTG, which can pick up fetal distress more quickly. He stated there is also less likelihood of delay if an urgent caesarean is required. Dr Du Preez suggested that in this case, Ms M labouring in hospital might have resulted in delivery half an hour earlier, which could have made all the difference.[257]

205. Ms Reynolds disputed these benefits, on the basis that there can be delays in getting to theatre and having it fully staffed, even if the VBAC is occurring in hospital, and it is known that CTG is not reliable and there is a lack of evidence around CTG monitoring improving outcomes.[258] Ms Reynolds noted that fetal distress is often a late sign of a uterine rupture (similarly to the drop in the mother's blood pressure), so by the time it is detected on CTG, there's no guarantee the poor outcome will be averted.

CTG Monitoring

206. As noted above, there is some conflicting evidence on the benefits of the use of CTG for a VBAC. It is relevant, as one of the reasons given by obstetricians for opposing

[252] T 197 – 198.
[253] T 198.
[254] T 112.
[255] T 111 - 112.
[256] T 112.
[257] T 111.
[258] T 138 – 139.

a home environment to attempt a VBAC is the absence of CTG. Doppler can be done to intermittently check the heart rate of the baby, but is not continuous like CTG, so it might miss changes in the fetal heart rate and also makes it more difficult to detect patterns.

207. In submissions provided on behalf of WACHS, it was clarified that there has been a recent change in the RANZCOG Intrapartum Fetal Surveillance Clinical Guideline. The current Department of Health CTG Monitoring Policy is based on the earlier standard, but the new RANZCOG guideline published in 2019 acknowledges that overall, the literature does not strongly support the use of tools such as computerised CTG assessment.[259] Further the guideline confirms that the few robust randomised controlled trials of continuous CTG that have been conducted have suggested that its use is not associated with statistically significant improvements in long-term neonatal outcomes such as cerebral palsy, but that it is associated with significantly increased rates of (unnecessary) operational delivery.[260]

208. As I've outlined above, Dr Neppe agreed in his evidence that CTG is an imprecise tool, but in his view he would prefer to use an imprecise tool than none at all.

209. I don't consider myself to be suitably qualified to form any conclusion as to whether the benefits of CTG outweigh the risk of unnecessary intervention, although I acknowledge that for an obstetrician, whose primary aim is to deliver a healthy baby and ensure the mother remains safe and well, irrespective of the manner of delivery, it is always going to be an important tool. The relevance of the debate over CTG monitoring, from my perspective, is more to do with the fact that it is not necessarily a strong argument in favour of hospital delivery against home birth.

Reduction of Delay

210. The other argument given by the medical practitioners as to the benefits of undertaking a VBAC in hospital is the availability of emergency caesarean section in a more timely manner.

211. This was disputed by Ms Mansfield, Ms Worrall and Ms Reynolds, and even Dr Hamdorf, who all suggested that it was unlikely Ms M would have been in hospital for monitoring at Busselton Hospital at that early stage of her labour. Dr Neppe and Dr Du Preez obviously took a different view, and I note that at least Dr Du Preez does actually practice at Busselton Hospital so he is well acquainted with the particular practices at that hospital. Certainly the RANZCOG guidelines suggest a woman undergoing planned VBAC should be assessed in early labour, which is supportive of early admission to hospital in such circumstances.

212. I can certainly appreciate the perspectives of Dr Neppe and Dr Du Preez that it would be preferable for them to have the woman in the hospital, rather than at home, when it is apparent something is going wrong, as there is always the likelihood that an ambulance may not be available or there could be road traffic delays or any number of issues that might delay a prompt transfer. However, it is difficult for me to resolve

[259] RANZCOG Intrapartum Fetal Surveillance Clinical Guideline – 4th Edition, 2019, p. 3.
[260] Ibid, p. 4.

the disparity in the evidence about whether, at the stage she had reached in labour, Ms M would have already been admitted to the hospital, based on what is before me.

Monitoring in the Morning

213. The above issue does, however, raise another issue canvassed at the inquest. This was the question whether Ms Mansfield should have remained with Ms M during the morning to monitor her early labour more closely, given the potential risks arising from Ms M undertaking a VBAC on the background of a previous failed induction and with an untried pelvis. Conflicting opinions were given on this issue from the different experts involved, and the matter is further complicated by the fact that it is impossible to predict when the uterine rupture occurred. I note that Baby AM's parents had appeared comfortable with Ms Mansfield leaving them at that stage in the morning and she returned to them when they indicated they would welcome her attendance. When Ms Mansfield first saw Ms M on her return, her appearance was not alarming, but she rapidly deteriorated from that time, resulting in an urgent hospital transfer being arranged.

214. Based on the evidence before me, I am unable to say with any certainty whether there may have been a different outcome if Ms Mansfield had remained with Ms M that morning to monitor her labour. All that can be said is that it certainly would have increased the opportunity for Ms Mansfield to identify any concerning changes in Ms M or the baby, if those changes were occurring. Ms Mansfield herself acknowledged that it was possible, although agreeing that it cannot be put any higher than that.

215. I note Ms Mansfield's evidence that she has changed her practice and now would remain with a client attempting a VBAC at home, as much for her own reassurance as that of the client, given her experience in this case. I am satisfied that this change is appropriate and I make no further comment.

Documentation

216. As is often the case in coronial inquiries, this case highlighted deficiencies in the documentation by a number of the health practitioners involved in her care. The lack of detailed documentation of the conversations with Baby AM's parents, and lack of documentation of the communication between practitioners, made it very difficult to assess the amount of information being provided, and the views expressed by the practitioners involved, based on the paperwork alone. Both Ms Mansfield and Dr McKenna accepted that, in hindsight, their documentation might be described as sparse and could have been more fulsome.

217. Dr McKenna explained that he had not been involved in a similar case before, and he did not understand his consultation with Ms M would be the last he, or any other medical practitioner, would have with her before the birth. He was not Ms M's regular GP and he had only seen her for that appointment as his colleague, Dr Ginbey, was unavailable. Dr McKenna's evidence at the inquest of his discussion with Ms M was not put in dispute, and he made it clear that he told Ms M a VBAC at home was not recommended and she should have a consultation at the Bunbury High Risk Clinic for further medical advice. He believed she understood the risks he had

outlined and could make a properly informed decision about her pregnancy. Dr McKenna gave evidence that since this case, he has definitely improved his communication and documentation. There is, therefore, no need to make any further comment about Dr McKenna's involvement in this case.

218. There was also no dispute in the evidence that Ms Mansfield had the conversations with Baby AM's parents that she described, and that she believed they made a fully informed decision, knowing the risks involved. Although in that sense, she does not consider that any greater amount of documentation would have altered the outcome in this case, she gave evidence that she accepts the need to better document her discussions with clients, to facilitate external review. She indicated she has now changed her practices and both documents communication with clients and other practitioners more comprehensively, and also provides to clients some of the relevant information pamphlets available from WA Health and WACHS. Once again, in those circumstances, I don't consider there is any need to comment further on Ms Mansfield's documentation.

219. The only thing I will add, in support of the evidence of Ms Martin, is that the best way to ensure good communication between midwives, doctors and clients is for everyone to be part of the same conversation. Therefore, where the woman is willing, it is ideal if their midwife ensures she is available to attend any medical consultations with them, whether it be in person or by means of technology, so that a robust conversation can take place that puts forward all points of view and ensures that there is no room for doubt or misunderstanding. This will ensure the woman can make a fully informed choice and the safest plan possible can be agreed to with her consent.

Midwife vs Obstetrician

220. It was noted in submissions provided on behalf of Ms Mansfield that the evidence in this inquest "highlighted a tension between the two separate professions of obstetrics and midwifery, potentially even along gender lines, with what was described as a 'paternalistic' obstetric model and a more 'maternalistic' midwifery model and attitude."[261]

221. I am reluctant to get drawn too far into such a debate, but I think the characterisation of the evidence in this case is not entirely off the mark. It was very clear that all of the specialist and GP obstetricians (who did happen to be men in this case), agreed that it would be preferable for all VBAC's to be attempted in hospital. The midwives (all female), on the whole were more openly supportive of a VBAC at home, other than Ms Martin, who expressed some reservations at this early stage of WA Health engaging with homebirth as an accepted practice.

222. It appeared to me that a primary reason for the difference between the two approaches is their focus. The midwives gave the impression of being focussed on the overall health and wellbeing of the mother, in a holistic sense including both mental and physical health, and with a strong emphasis on respecting the woman's (informed) choice as to where and how she gives birth to her baby. On the other

[261] T 2.

hand, the doctors were primarily focussed on ensuring a well-managed pregnancy and safe delivery with a healthy baby and healthy mother at the end, with a strong preference for the woman to make the 'safe' choice rather than her preferred choice.

223. The difference is borne out in the guidelines and practices of the two professions. The ACM Position Statement on Homebirth Services acknowledges that "some women may choose a planned homebirth when it is not recommended by a health care provider. Women should continue to have access to midwifery care whatever their choice,"[262] although a midwife has a right to decline to continue to provide care based on their clinical judgment, other than in an urgent situation. The RANZCOG guidelines for birth after previous caesarean section, on the other hand, emphasises that a planned VBAC should be conducted "in a suitably staffed and equipped delivery suite" and the RANZCOG policy statement on home birth has, as its opening comment, that the College does not endorse planned home birth for any pregnancies, even those classified as low risk.[263]

224. I am very sympathetic to the position of Dr Neppe and Dr Du Preez, noting that it is these doctors who must deal with the urgent medical crisis that can arise when a homebirth fails. The doctors in this case were left to care for a mother who nearly died, and an otherwise healthy baby who tragically did not survive. None of the medical practitioners involved would walk away unscathed from such an experience. While the rights of the woman to choose must be respected, the rights of the doctors to try to minimise this type of trauma, by ensuring the choice is fully informed based on all the risks, must also be respected. However, there must be some practical acknowledgment on the part of the medical profession that they are creating some of this situation through the increasing primary caesarean rate. Again, this rate may be driven in large part by a focus on safety and minimising risk to mother and child, but it is creating another risk second time around.

225. Information provided on behalf of WACHS indicates that there are around 1,000 women a year in Western Australia opting to attempt a VBAC (many in hospital, not at home), so there is a clear demand for this type of service.

226. Dr Hamdorf, who was the most supportive of the medical practitioners for planned VBAC's, even at home, offered the sage advice (based on many years of practice in south-west region with these particular patients) that it is important for doctors not to simply bury their heads in the sand, as there is a very real danger that restricting medical support will drive homebirths underground.[264] The midwives gave similar evidence, noting there is a very clear demand for this service, in a certain cohort of women who already feel alienated from the medical profession.

227. As a coroner, my focus is on reducing preventable deaths, so I have a tendency to side with the expert medical evidence. This case does not alter that position, when you consider that if Ms M had elected to have a planned caesarean section, it is likely Baby AM would have been born healthy and well. However, like the midwives and doctors, I have an obligation to respect the right of Baby AM's parents, and particularly his mother, to choose how she wishes to labour and deliver her child. I

[262] Exhibit 1, Tab 20, p.2 [9].
[263] Exhibit 1, Tab 12.
[264] T 100.

am satisfied from the evidence in this case that Baby AM's parents did make an informed choice, based on the risks as they understood them to be at that time, namely small. They clearly did not expect to be the 1 in that 1 in 200 risk of uterine rupture. All that I can hope is that this case prompts a better understanding by midwives and expectant mothers of the reality of what occurs when that small risk actually eventuates, as the death of Baby AM was a tragedy for all involved.

228. This case should also prompt all midwives, GP Obstetricians and Specialist Obstetricians to work harder to improve communications between each other, as well as their clients, to ensure that information is provided in a way that is respectful but realistic, with an emphasis on providing women with the safest method to birth their child that still respects their wishes and desire for a birth of their choice. That requires WACHS and the Department of Health to work harder at providing more options to women, to avoid the necessity of having to choose to move outside the public health system.

229. With that in mind, I respect the position of WACHS to continue their current services at Busselton Hospital, noting that without Busselton Hospital providing planned VBAC services and the option to be the transfer hospital for homebirths, there is a strong likelihood more preventable deaths could occur. I also accept the submission that, while desirable, there are not enough births at Busselton Hospital to support the introduction of a consultant obstetrician service at that hospital.

230. However, following line of Ms Reynolds' evidence, I encourage the WACHS to consider what can be done to provide broader community midwifery services and or birthing centre options outside the Bunbury area and moving into the greater south-west, as it is clear the demand for these services is not decreasing, and bringing it within the public health system can only work to ensure a safer system for mothers, babies and health practitioners alike.

CONCLUSION

231. This inquest was held to explore whether Baby AM's parents made a fully informed choice to attempt a VBAC at home, noting the risks of a catastrophic uterine rupture in such cases is well known, although rare. I am satisfied from all of the evidence before me that Baby AM's parents were well informed, both through their own research and through consultation with Ms Mansfield and Dr McKenna, and they made their choice accepting the risks involved and knowing that it was against recommended medical practice. Although the outcome was not what they hoped or expected, in hindsight, they indicated that they did not believe any additional information or advice would have resulted in them making different decisions at that time.

232. I have reflected upon the involvement of the health practitioners in this case, and although there were ways in which their services could have been improved, in particular in relation to communication and documentation, I am satisfied that they did not encourage or unduly influence Baby AM's parents to make their choice, and their conduct was appropriate and in accordance generally with their professional guidelines in the important aspects.

233. This is a very sad case of the potentially preventable death of a baby, but the issues of VBAC and homebirth are complex and should not be glibly brushed aside just because we wish to avoid this tragic situation in the future. While many women choose to be guided by medical advice to take the 'safest' choice for them and their baby from a medical point of view, the safest choice for some women involves many more issues than that, and the desire to feel supported throughout their pregnancy and birth and avoid unnecessary interventions and trauma. The medical profession and midwives need to work together to create a better system for women to support their various needs and create a more individualised service that keeps women and babies safe while respecting the woman's right to choose what is best for her.

S H Linton
Deputy State Coroner
10 June 2021