IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 003046

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner David Ryan
Deceased:	Baby R
Date of birth:	9 June 2021
Date of death:	12 June 2021
Cause of death:	1(a) Unascertained
Place of death:	Royal Children's Hospital Melbourne, 50 Flemington Road, Parkville, Victoria, 3052
Keywords:	Baby, sudden unexpected death in infants, SUDI, SIDS, home birth, doula.

INTRODUCTION

1. On 9 June 2021, Baby R was born at home, where he lived with his mother RYF and father EHV in an inner northern suburb of Melbourne. Baby R later died at the Royal Children's Hospital (**RCH**) on 12 June 2021 when he was three days old.

BACKGROUND

Initial referral to the Western Health Midwifery Group Practice

2. On 20 July 2020, RYF sought fertility treatment from her general practitioner (**GP**), Dr Radhika Sheorey of East Brunswick Medical Centre. Dr Sheorey referred her to a fertility specialist, and she became pregnant a short time later with her first child, with an estimated due date of 25 June 2021. RYF was subsequently referred to The Royal Women's Hospital on 24 December 2020.[1]

3. On 19 February 2021, when RYF was approximately 24 weeks pregnant, she requested a referral from Dr Sheorey to a hospital-supported home birth program.[2] Her care was subsequently transferred to the Midwifery Group Practice program at Joan Kirner Women's and Children's Hospital, which was operated by Western Health.[3] RYF and EHV were eager to avoid a hospital birth as they had suffered several recent losses in hospital settings.

4. On 9 March 2021, RYF attended an initial appointment with Western Health, at which time she provided her medical, family and obstetric history.[4] Her pregnancy was allocated to a green (low risk) pathway of care, and she was referred to the home birth program.

Ongoing suitability assessment for the home birth program

5. On 29 March 2021, at around 27 weeks, RYF met with her primary midwife, Lynnelle Moran, and they discussed the specifics of the home birth program, the eligibility criteria for inclusion in the program, perinatal mental health supports, and pre- and post-natal symptoms that would warrant a transfer to hospital. After reviewing RYF's pathology and radiology, she recommended iron supplements and an iron-rich diet. In her statement to police, Ms Moran recalled that RYF's fundal height indicated her baby's growth rate was normal.[5]

---

1 Statement of Dr Radhika Sheorey dated 22 December 2021; Medical records from East Brunswick Medical Centre.
2 Statement of Dr Radhika Sheorey dated 22 December 2021; Medical records from East Brunswick Medical Centre.
3 Statement of Lynnelle Moran dated 16 November 2021.
4 Statement of Lynnelle Moran dated 16 November 2021.
5 Statement of Lynnelle Moran dated 16 November 2021.

6. Ms Moran was employed in a job share arrangement for the fulltime role of a clinical midwife specialist with her colleague, Katherine O'Driscoll. In her statement to police, Ms O'Driscoll explained that together they cared for four women each month and they each assumed the role of primary care practitioner for two of those women. Ms Moran and Ms O'Driscoll each referred to the recent losses suffered by RYF and EHV, and its effect on the parents' stress levels throughout the pregnancy.[6]

7. At a subsequent appointment with Ms Moran on 19 April 2021, at around 30 weeks, RYF's fundal height again indicated a normal growth rate. According to Ms Moran, RYF advised she had engaged a doula[7] and Ms Moran clarified the role of a doula as distinct from a midwife.[8]

8. On 11 May 2021, at around 34 weeks, RYF met with Ms O'Driscoll, who recorded her fundal height as within normal ranges. They discussed breastfeeding and preparations for labour and birth, and RYF appeared "*excited and prepared for labour and birth*". She expressed some hesitation surrounding the postnatal period and Ms O'Driscoll recommended some further reading and additional supports.[9]

Exclusion from the home birth program and engagement of doula

9. On 26 May 2021, RYF and EHV met with Senior Obstetrician Dr Emily Olive, who was accompanied by a medical student, and midwife Ann Hallett, who attended in Ms Moran's absence. The purpose of the consultation was to assess whether RYF met the criteria for a hospital-supported home birth.[10] RYF's fundal height was measured, and Dr Olive performed a bedside ultrasound, which revealed her baby was "*concerningly small*"[11] at approximately 2280 grams, or on the 5th to 10th centile for growth. Notwithstanding the baby's small size, Dr Olive recorded normal Dopplers, normal amniotic fluid index and good foetal movements.[12]

---

[6] Statement of Katherine O'Driscoll dated 16 November 2021.
[7] A doula is a person who offers non-medical, physical and emotional support to women before, during and after birth and also provide support and information to spouses and other family members.
[8] Statement of Lynnelle Moran dated 16 November 2021.
[9] Statement of Katherine O'Driscoll dated 16 November 2021; Statement of Lynnelle Moran dated 16 November 2021.
[10] Western Health, In-Depth Case Review, p 2.
[11] Statement of Lynnelle Moran dated 16 November 2021.
[12] Western Health, In-Depth Case Review, p 2.

10. On 1 June 2021, at approximately 36 weeks, RYF underwent a formal growth ultrasound scan which corroborated the results of the bedside ultrasound, namely that the baby's weight was on the 10th centile.[13]

11. On 2 June 2021, RYF and EHV met with Ms Moran and consultant obstetrician Dr Rebecca Mitchell, who examined RYF, took several observations, and measured her fundal height. Dr Mitchell advised that, as the baby was small-for-gestational age (**SGA**), RYF would not be suitable for the home birth program. She also explained the risks associated with SGA babies, including increased risk of stillbirth and death, low birth weight, hypoxia, hypothermia and hypoglycaemia.[14]

12. RYF expressed concerns that given her ethnicity, a growth chart based on Malaysian measurements should be used, as those adopted by Western Health growth charts were only based on Caucasian standards. Dr Mitchell was reluctant to approve RYF for a hospital-supported home birth but advised that she would consult the Head of Obstetrics, Dr Elske Posma. After the appointment, Ms Moran showed RYF and EHV the birthing suites and they indicated "*they were feeling more comfortable and open to the possibility of hospital birth*."[15]

13. Further, Ms Moran requested that Dr Mitchell also discuss with Dr Posma the need for continuous foetal monitoring during labour (which was not the parents' preference), in the context of RYF's request for a water birth in the hospital setting.[16]

14. Later that day, Dr Posma advised Dr Mitchell that she considered a water birth without foetal monitoring was appropriate. However, she agreed with Dr Mitchell's assessment that RYF did not satisfy the criteria for a hospital-supported home birth, due to the increased risk and their inability to ascertain appropriate foetal growth by ultrasound or physical examination after 37 weeks. Dr Mitchell tried to contact RYF that evening to confirm her exclusion from the home birth program, however she did not respond.[17]

[13] Statement of Lynnelle Moran dated 16 November 2021; Western Health, In-Depth Case Review, p 2.
[14] Statement of Dr Elske Posma dated 15 November 2021; Statement of Lynnelle Moran dated 16 November 2021; Statement of Dr Rebecca Mitchell dated 25 November 2021.
[15] Statement of Dr Elske Posma dated 15 November 2021; Statement of Lynnelle Moran dated 16 November 2021.
[16] Statement of Lynnelle Moran dated 16 November 2021.
[17] Statement of Dr Elske Posma dated 15 November 2021; Statement of Lynnelle Moran dated 16 November 2021.

15. On 4 June 2021, Ms Moran spoke with RYF over the phone and reiterated the advice of Dr Posma. In her statement to police, Ms Moran recalled explaining that the program's "*low threshold for deviations from normal*" operated to protect mother and baby, the midwives providing care, and the publicly funded program. RYF elected to take some time to decide whether she would transfer her care to a privately practising midwife, or whether she would remain with Western Health for a hospital birth.[18]

16. At approximately 5.30pm, Dr Mitchell also spoke with RYF over the phone, at which time RYF raised 'free birth' or unassisted home birth as a further alternative. According to Ms Moran, RYF had not previously raised the possibility of choosing a free birth. Dr Mitchell strongly advised against a free birth and reiterated the risks, including the challenges of managing a small baby at home if resuscitation was required. Dr Mitchell also emphasised that they would be able to facilitate a water birth at the hospital and that RYF was welcome to present to Western Health for antenatal, intrapartum and postpartum care. Dr Mitchell scheduled a review appointment for one week's time and advised RYF to attend the hospital in the event of spontaneous rupture of membranes, bleeding or any other concerns.[19]

17. On 7 June 2021, RYF emailed her birth plan to Ms Moran, which referred to an intended hospital birth. Ms Moran forwarded the email to Ms O'Driscoll.[20] At approximately 7.00pm, RYF called Ms O'Driscoll to express concerns regarding a possible rupture of membranes. RYF had earlier advised her doula, Jo Askham and sent several photographs. Ms O'Driscoll reviewed the photographs, as RYF remained under the care of Western Health, but was unable to assess whether her membranes had spontaneously ruptured. She encouraged RYF to attend for further examination, however RYF declined and advised that she would monitor her discharge and contact them if she had any further concerns.[21]

18. On 8 June 2021, Ms Moran asked her manager, Maree Dell, if she could remain on call for RYF's labour.[22] At approximately 6.32pm, Ms O'Driscoll emailed RYF to advise that her most recent blood tests were normal. She also encouraged her to contact Western Health if she engaged an independent midwife so that her records could be copied and transferred. Ms O'Driscoll then finished her shift and did not see RYF's response at 8.34pm, in which she advised that Ms Askham had arranged a "*back up Doula*" by the name of Kylie Wallace. RYF

[18] Statement of Lynnelle Moran dated 16 November 2021; Statement of Dr Rebecca Mitchell dated 25 November 2021.
[19] Statement of Dr Elske Posma dated 15 November 2021; Statement of Lynnelle Moran dated 16 November 2021; Statement of Dr Rebecca Mitchell dated 25 November 2021; Western Health, In-Depth Case Review, p 2.
[20] Statement of Lynnelle Moran dated 16 November 2021.
[21] Statement of Katherine O'Driscoll dated 16 November 2021.
[22] Statement of Lynnelle Moran dated 16 November 2021.

also advised that she observed further mucous following a walk and had experienced Braxton Hicks contractions that day.[23]

19. In her statement to police, Ms Wallace explained that she trained as a midwife in England before moving to Australia in 2005 and working as a private midwife. She ceased working as a midwife in 2010 and retired in 2013. Ms Wallace clarified that she was covering for Ms Askham for one night as she had exam revision and she was "*not really a doula*", nor was she acting in the role of midwife.[24]

20. On 6 June 2021, Ms Wallace visited RYF and EHV at home and discussed their birth plan. According to Ms Wallace, they were "*resigned to having a hospital birth*", having been excluded from the home birth program, and she expected to support them at the hospital for the birth.[25]

Onset of labour and subsequent free birth

21. On the evening of 8 June 2021, Ms Wallace received a text message from Ms Askham to remind her to be available that evening in the event RYF went into labour. Ms Askham advised she would be unavailable until after 6.00pm on 9 June 2021.[26]

22. At approximately 12.00am on 9 June 2021, EHV called Ms Wallace to warn her that they thought RYF was going into labour.[27]

23. Between approximately 2.30am and 2.45am, EHV called Ms Wallace and asked her to come over as RYF was in labour. In her statement to police, Ms Wallace advised that she could not recall discussing hospital, but assumed RYF was in early labour and that they would "*hang out a bit and then go to hospital later*".[28]

24. Ms Wallace arrived at the home at approximately 3.30am. Ms Wallace recalled that the bathroom was dark, but she observed RYF on all fours in the bathtub with the overhead shower running. Baby R was born at approximately 3.45am, at which time Ms Wallace picked him

[23] Statement of Katherine O'Driscoll dated 16 November 2021.
[24] Statement of Kylie Wallace, undated; Statement of Detective Senior Constable Thomas Gall dated 11 August 2021.
[25] Statement of Kylie Wallace, undated; Statement of Detective Senior Constable Thomas Gall dated 11 August 2021.
[26] Statement of Kylie Wallace, undated; Statement of Detective Senior Constable Thomas Gall dated 11 August 2021.
[27] Statement of Kylie Wallace, undated; Statement of Detective Senior Constable Thomas Gall dated 11 August 2021.
[28] Statement of Kylie Wallace, undated; Statement of Detective Senior Constable Thomas Gall dated 11 August 2021.

up from the bathtub base and handed him to RYF. EHV then cut the cord and they placed the placenta in a bowl in the fridge.[29]

25. At approximately 11.22am on 9 June 2021, EHV sent a text message to Ms O'Driscoll to advise that RYF had given birth at home that morning, and that both mother and baby were well. He also advised that Baby R arrived in the amniotic sac.[30]

26. Although not rostered on to work, Ms O'Driscoll alerted Louise Saunders, a Western Health Assistant Midwifery Unit Manager. She also responded to EHV with congratulations and advised that he and RYF could continue with the Western Health program for birth registration and postnatal care if they presented to hospital within 24 hours of the birth. RYF later indicated via text message that they understood and would "*make a plan*" that night, and that they would let her know if they were going to hospital for an assessment.[31]

27. According to Ms Wallace, Baby R was awake and breastfed throughout the morning. Although she recalled them asking how they could weigh Baby R, Ms Wallace did not recall any specific discussion of his birth weight. Ms Wallace remained at the home until lunchtime and returned between approximately 7.00pm and 8.00pm with Ms Askham. Ms Wallace brought a set of scales and recorded Baby R's weight as approximately 2.2 kilograms. RYF reportedly commented that her mother also gave birth to smaller babies.[32]

28. Ms Askham enquired of the parents whether they had spoken with the hospital. Ms Wallace suspected that they may have been confused as they reportedly responded that they would be unable to receive any hospital care if they did not attend within 24 hours.[33]

29. On the morning of 10 June 2021, Ms O'Driscoll commenced her shift and noted that RYF had not presented to the hospital. Throughout the morning, she and RYF exchanged several text messages regarding their inability to attend the hospital as they were "*too delirious to drive*".[34] RYF advised she would visit her treating GP, but accepted Ms O'Driscoll's offer to visit 'off the record' later that day.[35]

---

[29] Statement of Kylie Wallace, undated; Statement of Detective Senior Constable Thomas Gall dated 11 August 2021.
[30] Statement of Katherine O'Driscoll dated 16 November 2021.
[31] Statement of Katherine O'Driscoll dated 16 November 2021; Western Health, In-Depth Case Review, p 3.
[32] Statement of Kylie Wallace, undated; Statement of Detective Senior Constable Thomas Gall dated 11 August 2021.
[33] Statement of Kylie Wallace, undated; Statement of Detective Senior Constable Thomas Gall dated 11 August 2021; Medical records from Western Health, Notes of text message exchange between RYF and Ms O'Driscoll.
[34] Medical records from Western Health, Notes of text message exchange between RYF and Ms O'Driscoll.
[35] Statement of Katherine O'Driscoll dated 16 November 2021; Statement of Lynnelle Moran dated 16 November 2021; Victoria Police, Sudden Unexpected Death of an Infant Checklist, Free narrative, p 116.

30. Growing concerned, Ms O'Driscoll spoke to Ms Dell, and expressed her concerns regarding RYF's home birth and Baby R's low birth weight. Ms Dell reiterated that as RYF and EHV had not presented to hospital within 24 hours, they had elected not to continue treatment with Western Health and Ms O'Driscoll and Ms Moran were not permitted to visit the family at home.[36]

31. At approximately 1.00pm, Ms Wallace reattended at Ms Askham's request. She stayed for several hours and observed that RYF and EHV were tired but otherwise well, and Baby R was feeding. Ms Wallace could not recall a discussion about attending hospital.[37]

32. RYF and EHV later reported to RCH clinicians that in the day following the birth, Baby R "*appeared well…with 'lots of little feeds' at the breast. He passed urine and stool*."[38]

THE CORONIAL INVESTIGATION

33. Baby R's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

34. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

35. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

36. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Baby R's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

[36] Statement of Katherine O'Driscoll dated 16 November 2021; Statement of Lynnelle Moran dated 16 November 2021.
[37] Statement of Kylie Wallace, undated; Statement of Detective Senior Constable Thomas Gall dated 11 August 2021.
[38] Statement of Dr Amanda Moody, undated.

37. This finding draws on the totality of the coronial investigation into the death of Baby R including evidence contained in the coronial brief, maternal health records from Western Health, medical records from RCH and East Brunswick Medical Centre, and a report of an in-depth case review conducted by Western Health. While I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[39]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

38. On the morning of 11 June 2021, Ms Wallace returned and observed that the parents were growing increasingly tired as Baby R had been feeding and restless overnight. She offered to bring donated breastmilk as she recalled RYF's milk had not yet come in. Ms Wallace left at around midday and later that day, she received a phone call from EHV in which he sounded "*a bit stressed and worried about being a tired, vulnerable father*". She returned later that day with the donated breastmilk and was met at the door by EHV, who expressed concerns that "*he felt like something was happening to* [Baby R] *like when his Dad died.*"[40]

39. As Ms Wallace entered the home, RYF handed Baby R to her. In her statement to police, Ms Wallace recalled that Baby R's face was "*drained of colour*" and she could not detect a pulse, nor see his chest moving. Ms Wallace commenced cardiopulmonary resuscitation (**CPR**) while EHV contacted emergency services.[41]

40. Responding paramedics and members from Fire Rescue Victoria arrived at approximately 3.08pm and continued CPR. According to several accounts of Ambulance Victoria paramedics, on arrival they observed a woman who identified themselves as a 'friend' conducting CPR. The woman, presumably Ms Wallace, advised that "*'they' were trying to feed the baby, and then the baby stopped breathing*". Throughout this time, friends and family arrived at the home.[42]

---

[39] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[40] Statement of Kylie Wallace, undated; Statement of Detective Senior Constable Thomas Gall dated 11 August 2021.

[41] Statement of Kylie Wallace, undated; Statement of Detective Senior Constable Thomas Gall dated 11 August 2021.

[42] Statement of Katherine Spicer dated 15 July 2021.

41. Responding paramedics also obtained collateral information from EHV, who reportedly advised that Baby R had been "*feeding poorly since birth*". He advised that they attempted to feed him via a syringe that day when he experienced breathing difficulties and became unresponsive.[43] Ms Moran provided a similar account in her statement to police, which was relayed to her by RYF in the days that followed, namely that the parents invited Ms Wallace back to their home that afternoon as they grew concerned for Baby R's condition.[44]

42. Paramedics assessed Baby R's airway and did not observe any obstructions but noted his breathing was laboured and ineffective. They also noted that Baby R appeared "*unwell and undersized*", and his abdomen was distended. Though they were able to hear a heartbeat and detect a pulse, Baby R's breathing difficulties persisted despite suction and mechanical ventilation. His condition continued to deteriorate, and paramedics continued CPR on route to the RCH.[45]

43. On arrival to the emergency department at approximately 3.48pm, clinicians administered four doses of adrenaline before they achieved return of spontaneous circulation. By this time, approximately 40 minutes had passed since Baby R first became unresponsive. Intravenous antibiotics were also administered, and Baby R was intubated before being transferred to the Neonatal Intensive Care Unit (**NICU**).[46]

44. According to RCH neonatologist Dr Amanda Moody, Baby R's parents advised that earlier in the day, he "*fed frequently (every 1-3 hours) and was sleepy 'at times'*". EHV reported that between approximately 2.00pm and 3.00pm, Baby R was given 1.5mL of breastmilk by syringe over the course of 20 minutes before he became weak. This appeared to resolve, and Baby R was "*moving and kicking strongly*", but he then turned yellow in colour and became unresponsive.[47]

45. Despite several investigations, treating clinicians were unable to identify the cause of Baby R's condition and he continued to deteriorate. Clinicians observed that his pupils were fixed and dilated, and a computed tomography (**CT**) scan revealed a hypoxic brain injury. Discussions took place between treating clinicians and Baby R's parents and a decision was

[43] Ambulance Victoria Patient Care Record dated 11 June 2021.
[44] Statement of Lynnelle Moran dated 16 November 2021.
[45] Statement of Matthew Riddle dated 24 June 2021; Statement of Julian Staffieri dated 13 July 2021; Statement of Katherine Spicer dated 15 July 2021; Ambulance Victoria Patient Care Record dated 11 June 2021.
[46] Medical records from The Royal Children's Hospital Melbourne, Progress Notes and ED Clinician Notes dated 11 June 2021.
[47] Statement of Dr Amanda Moody, undated; Coronial brief, Notes titled 'Percy's first days', p 98.

made to commence him on a palliative pathway. He was extubated at 11.55pm and subsequently pronounced deceased at 12.04am on 12 June 2021.[48]

Identity of the deceased

46. On 12 June 2021, Baby R, born 9 June 2021, was visually identified by his grandmother.

47. Identity is not in dispute and requires no further investigation.

Medical cause of death

48. Forensic Pathology Fellow Dr Chong Zhou, supervised by Forensic Pathologist Dr Sarah Parsons from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 16 June 2021 and provided a written report of her findings dated 24 February 2022.

49. Dr Zhou commented that Baby R's weight was around the 5th percentile for 38 weeks gestation, with other external measures between the 5th and 95th percentile.

50. Dr Zhou observed external signs of jaundice and at autopsy, identified evidence of aspiration pneumonia, congestion of the liver, mild inflammation of the uvula, soft palate, larynx and trachea. Dr Zhou identified a seccundum atrial septal defect but did not identify any lethal congenital abnormalities, nor any natural disease that would have caused or contributed to death.

51. A subsequent neuropathological examination revealed histological and macroscopic changes associated with hypoxic ischaemic injury and jaundice. The neuropathological examination did not identify any underlying morphological abnormalities.

52. Dr Zhou reviewed the findings of a placental examination, which revealed patchy high grade chronic villitis with associated avascular villi and features of maternal vascular malperfusion. The cause of the inflammatory condition was unknown, however the anatomical pathologist who conducted the placental examination considered these findings were associated with adverse foetal outcomes and likely restricted Baby R's growth.

53. Toxicological analysis of ante-mortem samples from the RCH identified mildly elevated acetone levels and medications consistent with the care Baby R received in hospital. No alcohol or illicit drugs were detected.

[48] Statement of Dr Amanda Moody, undated.

54. Further biochemical and metabolic analyses of blood and urine samples confirmed hypoglycaemia and hyperammonaemia. While these were atypical findings for a newborn, Dr Zhou commented that they did not indicate a disorder of the urea cycle, fatty acid oxidation, or organic acid metabolism. Dr Zhou added that these findings can be caused by metabolic abnormalities which may not be detected by newborn metabolic screening (of which Baby R's was negative). Given the uncertainty surrounding the cause of Baby R's high ammonia levels, Dr Zhou recommended a family referral for clinical genetic testing.

55. The results of post-mortem bacteriology and virology were otherwise non-contributory. There was also no evidence of unexpected skeletal trauma, non-accidental injury or metabolic bone disease on skeletal survey.

56. Dr Zhou advised that the exact cause of Baby R's death remained unascertained following a comprehensive examination and ancillary tests and formulated the medical cause of his death as 1(a) Unascertained. Notwithstanding that Dr Zhou was unable to definitively determine the cause of Baby R's death, she considered his death was due to natural causes.

57. I accept Dr Zhou's opinion.

CONCERNS EXPRESSED BY THE PARENTS

58. During a compassionate visit conducted by Ms Moran on 13 June 2021, and in their later discussions with Victoria Police, RYF and EHV expressed several concerns regarding their engagement with Western Health and the services provided by Ms Wallace.

59. With respect to Western Health, RYF expressed concerns to Victoria Police that the review appointments—which she described as a strategy to rebuild their trust with the hospital after their exclusion from the home birth program—"*were not happening soon enough*".[49] The parents denied having been advised the pregnancy was 'high risk' and allege they were instead advised the baby's small size was 'borderline' with respect to the threshold and that this placed their pregnancy in a 'grey area'.[50]

60. RYF reported that they subsequently came around to the idea of a hospital birth and at the time she went into labour, they had packed their hospital bag. Since her exclusion from the home birth program, RYF had practised walking around with a blindfold in anticipation of a

[49] Transcript of recorded conversation between RYF, EHV and Victoria Police, undated, p 148.
[50] Transcript of recorded conversation between RYF, EHV and Victoria Police, undated, p 218 and 221.

hospital birth in order to avoid "*getting retraumatised from* [her] *other experiences there*."[51] However, RYF explained that this was the extent of their preparations for a hospital birth and were they were better prepared for a home birth prior to their exclusion from the program. She asserted that they were not given sufficient information on who to contact or what to do at the time of labour in order to give birth in hospital.[52]

61. The parents also advised Victoria Police that following RYF's text message exchange with Ms O'Driscoll on 10 June 2021, they were uncertain whether her reference to an 'off the record' visit would constitute medical care.[53]

62. In their discussions with Victoria Police, the parents explained that they initially engaged a doula when RYF was around 25 weeks, and they acknowledged their awareness that a doula is "*mostly just there for emotional support*".[54]

63. Although there were no abnormalities or complications detected throughout the pregnancy, the parents reported increased anxiety in large part due to their recent grief.[55] They alleged that they voiced concerns to Ms Wallace following the birth regarding Baby R's small size, but their concerns were apparently met with reassurance.[56] They further alleged that Ms Wallace did not encourage them to take Baby R to hospital, and at times allegedly dissuaded them, and that they "*just took her advice and trusted her as someone who has a level of expertise*". They were also similarly critical of Ms Askham.[57]

IN-DEPTH CASE REVIEW CONDUCTED BY WESTERN HEALTH

64. Following Baby R's death, Western Health conducted a review of the care provided to RYF and EHV, including their engagement with and subsequent exclusion from the home birth program, and attempts to engage with the parents for postnatal care.

65. The review panel noted that the transfer of RYF's care to Western Health occurred at a late stage, which impacted the time available to clinicians to build a relationship of trust with the parents.[58] Notwithstanding the limited time available, the review panel was satisfied that the

[51] Transcript of recorded conversation between RYF, EHV and Victoria Police, undated, p 134.
[52] Transcript of recorded conversation between RYF, EHV and Victoria Police, undated, p 138.
[53] Victoria Police, Sudden Unexpected Death of an Infant Checklist, Free narrative, p 116.
[54] Transcript of recorded conversation between RYF, EHV and Victoria Police, undated, p 154 and 207.
[55] Victoria Police, Sudden Unexpected Death of an Infant Checklist, Free narrative, p 116.
[56] Statement of Lynnelle Moran dated 16 November 2021; Victoria Police, Sudden Unexpected Death of an Infant Checklist, Free narrative, p 116.
[57] Transcript of recorded conversation between RYF, EHV and Victoria Police, undated, p 144 and 167.
[58] Western Health, In-Depth Case Review, p 1.

midwives and obstetricians who met with RYF and EHV were clear in their communication regarding the risks associated with home birth and the reasons for their exclusion from the home birth program. The panel was also satisfied that the parents received appropriate follow-up after their exclusion, namely counselling and other available supports. The use of text messaging by midwives following the birth was deemed appropriate as other forms of communication were found to be ineffective.[59]

66. The internal review did not identify any issues relating to Western Health policies, systems and structures within its remit; however, the review identified broader issues relating to public health services more generally. For example, the review panel considered that a different outcome may have been achieved if Baby R was reviewed at home by a "*skilled practitioner*" shortly following the free birth.

67. The panel identified a gap in provision of public health services with respect to postnatal review following freebirth if a family is unwilling to present to hospital. The panel considered that the responsibility to access care ultimately lay with the parents, but that these gaps in service provision arose in the context of available pathways for unassisted births.

68. The pathways for postnatal care in Victoria rely on health service referrals, both internal and external, and Maternal and Child Health (**MCH**) services are reliant on these referrals to conduct home visit risk assessments for women in the postnatal period. The review panel noted that while it is also open to families to engage with their treating GP for postnatal care when a birth occurs outside the hospital system, RYF's GP was not notified of her withdrawal from Western Health care. Ms Moran expressed a similar sentiment in her statement to police, wherein she expressed her disappointment at being unable to provide routine post-natal midwifery care to RYF and EHV, but that she had raised with the internal review the need for "*continuing care options in instances where families disengage from the home birth program*".[60]

69. The review panel noted that the practices employed by Western Health in its home birth program are consistent with those employed by the Monash Health program, namely the practice of not conducting postnatal home visits for free births. It also identified the inherent risks of conducting such visits, namely risks associated with clinicians entering an unknown environment without a risk assessment and absent the knowledge of any birth complications.

[59] Western Health, In-Depth Case Review, p 3.
[60] Statement of Lynnelle Moran dated 16 November 2021.

The review identified that conducting postnatal visits following an unassisted home birth may have the unintended flow-on effect of increasing the incidence of free births.

CONCLUSION

70. With respect to the family having engaged the services of a doula, I have considered the evidence of Ms Wallace regarding her communication with the parents following Baby R's birth. Her recollection of events is largely consistent with other witnesses, including the parents; however, it is difficult to reconcile the competing account of the parents in relation to their apparent desire to attend hospital following the birth.

71. Putting to one side their allegations of reassurances provided by Ms Wallace, the evidence is clear that RYF and EHV were eager to avoid a hospital environment which, on reflection by Western Health clinicians, presented an element of confirmation bias. In communication with Western Health clinicians shortly after the birth, the parents clearly indicated that they did not wish to leave home to attend the hospital.

72. Consideration must be given to the limitations of the role of unregulated personnel, such as doulas, in the provision of maternity care. In circumstances where doulas are not subject to qualification or registration requirements, the extent and expectations of their involvement in the birthing process is restricted to providing non-medical support and reassurance to parents. While the services provided by doulas are a valuable resource for parents during a particularly emotional time, it is important that parents have a firm understanding of the limitations of their role well before the birth so that informed decisions can be made at critical and stressful times with sufficient clarity and preparation.

73. An expectant mother's right to bodily autonomy necessarily extends to making decisions in relation to her birthing plan and medical care. Having considered the available evidence, I am satisfied that RYF was provided with sufficient information regarding the risks posed by Baby R's small size and risks associated with a free birth.

74. The evidence is also clear that at the time of labour, the parents elected to contact and request the presence of their doula, rather than, or in addition to, seeking medical attention. The first instance of specialist contact following the birth was a text message by EHV to Ms O'Driscoll, some seven hours after the birth, at which time Ms O'Driscoll appropriately encouraged the parents to attend the hospital.

75. I acknowledge that both parents were particularly vulnerable, given their recent trauma associated with the hospital setting, and that this may have impacted their capacity to adequately process information provided by treating clinicians before and after the birth following their exclusion from the home birth program. This fact was acknowledged by EHV while speaking with Victoria Police, namely that had he and RYF been "*in a bit more of a clearer headspace*", they would have been able to sufficiently filter advice they received before and after the birth.

76. Returning to the risks associated with conducting postnatal home visits following an unassisted home birth, I accept the findings of the Western Health in-depth review with respect to ways in which these risks could be addressed.

77. I direct that a copy of this finding be provided to Safer Care Victoria and the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (**CCOPMM**) for consideration of these broader issues raised by the circumstances of Baby R's death.

FINDINGS

78. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Baby R, born 9 June 2021;

    b) the death occurred on 12 June 2021 at RCH Melbourne, 50 Flemington Road, Parkville, Victoria, 3052, from unascertained causes; and

    c) the death occurred in the circumstances described above.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

I direct that a copy of this finding be provided to the following:

Consultative Council on Obstetric and Paediatric Mortality and Morbidity

Royal Children's Hospital

Safer Care Victoria

Constable Grace McLaren, Coroner's Investigator

Signature:

Coroner David Ryan

Date : 04 October 2022

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.