IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 004878

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

INQUEST INTO THE DEATH OF BABY R[1]

Delivered On:	29 May 2026
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank
Hearing Dates:	28 July to 1 August 2025 and 8 September 2025
Findings of:	Coroner Dimitra Dubrow
Keywords:	Obstetric care, midwifery care, privately practising midwives, homebirth

[1] This Finding has been de-identified by order of Coroner Dimitra Dubrow which includes an order to replace the name of the deceased with the pseudonym Baby R and for other persons related to or associated with the deceased, to be referred to by reference to their relationship to Baby R in Court and in any publications.

Counsel Assisting the Coroner:	Ms Anna Martin of Counsel instructed by Dr Declan McGavin, Coroner's Solicitor and Mr Ralph Zeeman, Coroner's Solicitor.
Representation:	
Baby R's parents	Ms Andrea De Souza of Counsel, instructed by Ms Isabelle McCombe, Slater & Gordon.
Ms Elizabeth Murphy	Ms Diana Price of Counsel, instructed by Ms Shannyn Stenner, Gordon Legal.
Ms Marie- Louise Lapeyre	Mr Allan Clayton-Greene of Counsel, instructed by Mr Michael Kotsifas, JK Legal.
Dr Veronica Moule	Mr Sean Cash of Counsel, instructed by Ms Madhavi Ligam, Avant Law.
Bendigo Health	Ms Naomi Hodgson of Counsel, instructed by Ms Lisa Ridd and Ms Lauren Aspley, Minter Ellison.
Royal Women's Hospital	Ms Danielle Corden, in-house lawyer.

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INTRODUCTION

1. Baby R was six days old when he died on 25 August 2022 from perinatal hypoxia. Baby R was the much-loved baby of his parents and younger brother of their first child. He is cherished and lovingly remembered by his family and those who knew him and continues to have a lasting impact on their lives.

2. Baby R was born at Bendigo Health on 19 August 2022 at 39 weeks and 6 days gestation by emergency caesarean section after his mother was transferred from home where she had been in labour as part of a planned homebirth with two privately practising midwives in attendance. Baby R was born in poor condition requiring transfer to the Royal Women's Hospital and died six days later.

3. An inquest was held to examine the management, care and communication provided to Baby R's mother during her pregnancy and labour, the relevant procedures, standards and guidelines relating to homebirth and the suitability of Baby R's mother's pregnancy for homebirth.

THE CORONIAL INVESTIGATION

4. Baby R's death was reported to the coroner as it fell within the definition of a reportable death set out in section 4 of the *Coroners Act 2008* **(the Act)**. Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

5. The jurisdiction of the Coroners Court of Victoria (Coroners Court) is inquisitorial.[2] The role of the coroner is to independently investigate reportable deaths. Section 67 of the Act requires a coroner to make a number of findings including, if possible, the identity of the deceased, the cause of death and the circumstances in which the death occurred.[3]

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[2] *Coroners Act 2008* (Vic) s 89(4)

[3] Section 67 of the Act provides that a coroner need not make findings as to the circumstances if an inquest was not held, the deceased was not in state care and there is no public interest in doing so.

6. It is not the role of the coroner to lay or apportion blame, but to establish the facts. It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

7. The expression 'cause of death' refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

8. For coronial purposes, the phrase 'circumstances in which the death occurred' refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating the death, it is confined to those circumstances which are sufficiently proximate and casually relevant to the death.

9. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the Court's 'prevention' role.

10. Coroners are also empowered to:

    a. report to the Attorney-General on a death;

    b. comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

    c. make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health and safety or the administration of justice.

11. These powers are the vehicle by which the prevention role may be advanced.

12. All coronial findings must be based on proof or relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[4] The effect of this and similar authorities is that coroners

[4] (1938) 60 CLR 336

should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

13. The proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved.[5] Facts should not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony or indirect inferences. Rather, such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[6]

Scope of Inquest

14. On 20 December 2024 and prior to a Directions hearing held on 10 February 2025, a proposed scope of inquest was circulated to the interested parties with the opportunity to make submissions in advance of the inquest. The purpose of setting a scope is to ensure that the parameters of the issues to be examined at an inquest are understood at the outset and limited to those issues that are sufficiently connected with the death.

15. The settled scope of inquest was as follows:

    1. What are the relevant procedures, standards and guidelines in relation to homebirth?

        a. Who has the responsibility for assessing, communicating, and advising in relation to obstetric risk and suitability for homebirth?

        b. Once a mother opts for a homebirth, who has the responsibility for assessing, communicating, and advising in relation to obstetric risk and ongoing care?

[5] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336
[6] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at pp 362-3 per Dixon J

c. Is there consistency across all public maternity services addressing criteria for homebirth and arrangements involving private practice midwife Models of Care?

2. Was Baby R's mother's pregnancy suitable for homebirth given her obstetric history and relevant procedures and guidelines for homebirth?

   a. Were the assessments and communications of the relevant practitioners, including Dr Moule, Elizabeth Murphy and Bendigo Health, reasonable and appropriate?

3. Was the ongoing antenatal care and communication provided by the relevant practitioners, including Dr Moule, Elizabeth Murphy and Bendigo Health, to Baby R's mother reasonable and appropriate?

   a. Why did the 36 week obstetric appointment at the Bendigo Health pregnancy review on 26 July 2022 not occur?

4. Was the midwifery care and communication during the labour reasonable and appropriate?

5. Was Baby R's death preventable?

Pseudonym Order

16. On 12 December 2024, I made a pseudonym and non-publication order pursuant to section 55(2)(e) of the Act ordering that the deceased baby be referred to by the pseudonym Baby R and that his family be referred to by reference to their relationship to Baby R in Court and in any publications.

Evidence at the Inquest

17. The following witnesses gave viva voce evidence at the Inquest:

    a. Dr Veronica Moule, general practitioner with a Diploma in obstetrics from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.
    b. Justine Carr, midwife, Bendigo Health.
    c. Dr Caetlyn Davis, obstetrician and gynaecologist and now Head of Obstetrics and Gynaecology, Bendigo Health.
    d. Dr Nicola Yuen, Clinical Director Women's and Children's Services at Bendigo Health at the time of these events and now Chief Medical Officer at the Royal Women's Hospital.
    e. Marie-Louise Lapeyre, registered midwife at the time of these events and now registered nurse.
    f. Elizabeth Murphy, registered midwife at the time of these events and now registered nurse.
    g. Expert witness, Dr Andrew Woods, obstetrician and gynaecologist, Clinical Lead, Women's Health and Maternity Network, John Hunter Hospital, NSW.
    h. Expert witness, Dr Helen Cooke, registered midwife, NSW.

18. The parents of Baby R did not give evidence at the Inquest but provided a number of statements to the Court.

19. After the conclusion of the inquest, written submissions were provided from Counsel Assisting followed by written submissions from all interested parties.

20. This finding draws on the totality of the material obtained in the Coronial investigation of Baby R's death, the Coronial Brief and further statements obtained, the expert opinions obtained by the court from Dr Woods and Dr Cooke, transcript of the evidence adduced, and the exhibits tendered at the inquest and the closing submissions of counsel.

21. In writing this finding, I do not purport to summarise all the material evidence but refer to it only in such detail as appears warranted by its significance and the interests of

narrative clarity. It should not be inferred from the absence of reference to any aspect of the evidence that it has not been considered.

BACKGROUND

Baby R's Mother's Obstetric History

22. Baby R's parents' first child was born at Bendigo Health via emergency caesarean section in 2019. In that pregnancy, Baby R's mother had considered a homebirth but opted to deliver at Castlemaine Health as "it was a little bit safer in hospital."[7] She was keen to have continuity of care and consulted Dr Veronica Moule for her antenatal care and for the delivery of the baby. Dr Moule is a general practitioner with a Diploma of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and has provided obstetric and birthing care at Castlemaine Health since 1999.[8]

23. Baby R's mother was admitted to Castlemaine Health on the morning of 8 May 2019 at 39 weeks gestation with spontaneous rupture of membranes 48 hours earlier and already in labour. The labour continued over that day and the next. Cervical dilatation progressed to 8 cm by 5pm on 9 May 2019 but plateaued and remained at 8 cm three hours later. As a result of the lack of progress and at Dr Moule's recommendation, Baby R's mother was transferred by ambulance to Bendigo Health.[9]

24. At Bendigo Health, the labour was augmented with syntocinon and an epidural anaesthetic was administered for pain relief.[10] Baby R's mother progressed to full dilatation, but an emergency caesarean section was performed on the morning of 10 May 2019 after an assessment that the labour was obstructed.[11] The baby was found to be in a deflexed occipito posterior position and Baby R's mother suffered a postpartum

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[7] First statement of Baby R's mother dated 3 November 2022, Coronial Brief (**CB**) Volume 1, 27 [18]. All references to CB from here will refer to Vol 1 of the Coronial Brief unless otherwise stated.
[8] Exhibit 2, Profile of Dr Veronica Moule
[9] Castlemaine Health records, CB Vol 2, 943
[10] Bendigo Health records, CB Vol 2, 673; Bendigo Health Obstetric Discharge Summary, CB Vol 2, 656
[11] Bendigo Health Obstetric Discharge Summary, CB Vol 2, 656 – 659

haemorrhage, losing about 800mls of blood.[12] The baby was born healthy and well. His birthweight was 4,896 grams, coming within the definition of macrosomic.[13]

25. Baby R's mother described the birth experience as traumatic. She wanted a vaginal birth but felt like she had gotten to the point where her body seized up. She said she was upset but the takeaway from the hospital debrief the day after was to be happy they had a live baby.[14] Following this experience, she was hesitant to give birth in hospital again and did not want to go back to Bendigo Health.[15]

26. Bendigo Health provided a letter to Baby R's mother, included in the baby's "Green Book", indicating that she was suitable to have a vaginal birth in a future pregnancy, referred to as Vaginal Birth after Caesarean Section (VBAC).[16] This proforma letter has options to be ticked indicating whether the patient is or is not suitable for VBAC.[17] Otherwise, Baby R's mother could not recall a discussion with staff at Bendigo Health about future pregnancies or VBAC.[18]

27. Baby R's mother attended a postnatal six-week appointment with Dr Moule on 24 June 2019. The notes from the consultation refer to the baby's deflexed occipital posterior position and macrosomia, the prolonged second stage of labour and the emergency caesarean section but not to the postpartum haemorrhage.[19] Dr Moule said she usually calls Bendigo Health the day after a transfer to find out what happened. She assumed she followed her usual practice and postpartum haemorrhage was not mentioned in the call and that Baby R's mother did not refer to it during the postnatal appointment.[20] Dr Moule said she otherwise did not receive the Bendigo Health discharge summary about

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[12] Bendigo Health records, Operation Report, CB Vol 2, 690

[13] The RANZCOG Diagnosis and management of suspected fetal macrosomia Clinical Guidance Statement (C-Obs 65), November 2021 refers to the term 'macrosomia' being used interchangeably with 'large for gestational age' to describe a 'big baby' and includes a birthweight greater than 4000 to 4500 grams. Macrosomia is associated with an increased risk of several complications, particularly maternal and/or foetal trauma during birth including shoulder dystocia and neonatal hypoglycaemia and respiratory problems, CB 373

[14] First statement of Baby R's mother, CB 29 [45]

[15] First statement of Baby R's mother, CB 30 [46]

[16] First statement of Baby R's mother, CB 30 [48]; Further statement of Baby R's mother, dated 10 April 2025, CB 477 [5]

[17] Bendigo Health Progress notes, CB Vol 2 666; Bendigo Health template, CB 512

[18] Further statement of Baby R's mother, CB 476 [1] - 477 [5]

[19] Mostyn Street Clinic records, CB Vol 2, 1525

[20] Dr Moule's evidence, T 41. There was no reference to Dr Moule making this call in her records.

the birth (which was addressed to her and included reference to postpartum haemorrhage).[21] She said it varied whether hospital discharge summaries were received and sometimes they were received sometime later.[22]

28. Baby R's mother said that she believed that at the postnatal consultation, there was a discussion about the:

> *... barriers I experienced that meant I was unable to achieve a physiological birth .... [being] a large baby, maternal exhaustion and the baby being in a deflexed occiput posterior position. I believe we also discussed the fact that my obstructed labour and subsequent LUSCS (lower uterine section caesarean section) ruled out a future birth at Castlemaine Health. I think I assumed from that discussion that a homebirth was out of the question if I was not even able to birth at Castlemaine Health.*[23]

29. Castlemaine Health (part of Dhelkaya Health) is a Level 2 maternity service which provides care for low risk pregnancies and works with Bendigo Health to provide for more specialised care needs. VBAC is not available for labour and birth, but midwifery antenatal services are available throughout pregnancy.[24]

30. Baby R's mother said she spoke to private midwife, Elizabeth Murphy, about homebirth while her first baby was still little in May 2020 in a videocall. Baby R's mother was a qualified midwife and had worked at Bendigo Health from 2016 to 2019 in health promotion but had since moved to another role.[25] She said she knew Ms Murphy through her work as a nurse and midwife and first met her during her pregnancy. She said Ms Murphy had a good reputation as a private midwife.[26]

31. During the call, Baby R's mother gave her obstetric history to Ms Murphy and was "pleasantly surprised" when Ms Murphy told her she was suitable for homebirth. She

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[21] Dr Moule's evidence, T 23-24, 78 – 80; Bendigo Health Discharge summary, dated 13 May 2019, CB Vol 2 656.
[22] Dr Moule's evidence, T 24, 41 – 42, 78. Dr Moule said she would not ordinarily contact the hospital to follow up a discharge summary if the mother was able to provide information at an appointment T 24, 81.
[23] Further statement of Baby R's mother, CB 477 [7]
[24] https://dhelkayahealth.org.au/maternity/
[25] First statement of Baby R's mother, CB 26 [9]
[26] Further statement of Baby R's mother, CB 479 [12]

said this was "great news … as I believed this would allow me to have a woman-centred and trauma-informed care that would put me and my baby in the best position to achieve a physiological birth."[27]

32. Baby R's mother said that as a former midwife she had knowledge about homebirths from studies, education events and discussions with colleagues. She recalled seeing a statistic in around late 2020 or early 2021 about VBAC homebirth being more likely to result in a physiological birth, though was uncertain of the source, and said this is what prompted her call to Ms Murphy. She also said that she and Baby R's father had reviewed Safer Care Victoria resources about homebirth as they were exploring the idea of establishing a homebirth space on their property for women who lived further away to use with their chosen private midwife and to be close to Bendigo Health. Baby R's mother said she had been very immersed in researching homebirths for a long time.[28]

33. Baby R's father also referred to accessing the Safer Care Victoria website and said that the statistics indicated homebirth was safe with less intervention resulting in better outcomes and that they considered that the home environment would be most conducive to progressing through labour naturally.[29]

Pregnancy and Antenatal Care

34. Baby R's mother was 35 years old at the time of her second pregnancy. She said as soon as she fell pregnant in late 2021, she contacted Ms Murphy to ensure she could accept her as a patient.[30] She was also referred to Ms Murphy by general practitioner, Dr Aruna Gupta, on 16 December 2021 when she was four weeks pregnant. Dr Gupta's referral letter noted "no previous pregnancy issues."[31] Dr Gupta explained this was

[27] Further statement of Baby R's mother, CB 480 [14]
[28] Further statement of Baby R's mother, CB 480 [13]; 486 [49] - [53]
[29] Statement of Baby R's father dated 3 November 2022, CB 39 [32] - [33]; Further Statement of Baby R's father dated 11 April 2025 CB 489 [14]
[30] Further statement of Baby R's mother, CB 480 [16]
[31] Dr Aruna Gupta, Consultation notes, CB 59; Bendigo Medical Bridge Street records, CB, Vol 2, 1511

based on Baby R's mother telling her that she had not experienced any pregnancy complications.[32]

35. Baby R's mother said she would have told Dr Gupta about the emergency caesarean section and big baby, noting that the pregnancy was uncomplicated. She said they had not made a firm decision about homebirth at that stage and there was no discussion about birthing options with Dr Gupta. In addition to the referral to Ms Murphy, Dr Gupta provided a Bendigo Health "Shared Care Pathway" information sheet.[33] Baby R's mother said Dr Gupta's referral to Ms Murphy led her to believe she was suitable for hospital or homebirth.[34]

36. During her pregnancy, Baby R's mother consulted with Dr Gupta on six occasions including in relation to iron infusions. Dr Gupta did not provide obstetric care or advice.[35]

37. Baby R's mother also attended a consultation with Dr Moule on 8 February 2022 when she was 12 weeks pregnant.[36] Dr Moule said that the consultation was long, lasting 47 minutes and "…covered many issues, including physical, mental health, and planning for the pregnancy - including testing and birth place options."[37] The notes from the consultation include a reference to Baby R's mother experiencing postnatal depression and trauma when she was a teenager. Baby R's mother said she raised the previous trauma with Dr Moule because she believed she may have frozen in the first labour because of it, contributing to the obstructed labour.

38. There was also reference in the notes to thyroiditis, iron deficiency, Baby R's mother being on a gestational diabetes diet, a recommendation for gestational diabetes testing

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[32] Supplementary statement of Dr Gupta dated 14 March 2025, CB 513
[33] Second further statement of Baby R's mother dated 17 June 2025, CB 516 [5]
[34] Further statement of Baby R's mother, CB 479 [11]
[35] Dr Gupta, Consultation notes, CB 59 – 64
[36] Statement of Dr Veronica Moule, dated 23 January 2023, CB 48
[37] Statement of Dr Veronica Moule, dated 23 January 2023, CB 48

given the macrosomia of the first baby, blood tests being performed and that Baby R's mother would not be undergoing chromosomal testing or a 12 week scan.[38]

39. Dr Moule said given the history there was discussion about diet and exercise to reduce the risk of a macrosomic baby and, although not in her notes, it was routine for her to discuss possible uterine rupture with a previous caesarean section at a rate of 1 in 200 labours.[39]

40. Dr Moule provided Baby R's mother with a referral to Ms Murphy for antenatal, intrapartum and postnatal care, unaware that Baby R's mother had already been referred by Dr Gupta.[40] Dr Moule's referral letter reflected her notes from the consultation and additionally included information about Baby R's mother's past obstetric history of an emergency caesarean section at term and the baby's birthweight.[41] There was no reference to the baby's position, the obstructed labour or postpartum haemorrhage. At that time, Dr Moule was still not aware of the postpartum haemorrhage.

41. Baby R's mother did not recall specifically discussing suitability for homebirth with Dr Moule but said that the referral to Ms Murphy led her to believe she was suitable.[42]

42. Ms Murphy said Baby R's mother contacted her when she first found out she was pregnant at around four weeks to discuss homebirth and "…was particularly concerned because she'd had a caesarean section and…I said to her that of itself was not a reason to exclude her from a homebirth."[43]

43. Ms Murphy said that at the time of that discussion, she was not fully aware of the history of the previous pregnancy and birth but became aware of it during the pregnancy.[44]

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[38] Mostyn Street Clinic records, CB Vol 2 1526
[39] Statement of Dr Veronica Moule, dated 23 January 2023, CB 50
[40] Dr Moule's evidence, T 46
[41] Dr Moule's referral letter to Ms Murphy, dated 8 February 2022, CB 88-89
[42] Further statement of Baby R's mother, CB 478
[43] Ms Murphy's evidence, T 297, 289, 312 - 313
[44] Ms Murphy's evidence, T 297

44. Baby R's mother had her first antenatal consultation with Ms Murphy on 11 May 2022 when she was 25 weeks pregnant. The notes refer to the previous delivery and previous trauma impacting this. It was noted that Baby R's mother was working with a number of practitioners including a doula[45] from Queensland called Jess, a Chinese medicine practitioner and a women's physiotherapist and osteopath.[46]

45. Baby R's mother had five further appointments with Ms Murphy, including a birth plan meeting on 22 July 2022. At these appointments, there were checks of the baby's heart rate and movements, the fundal height was measured, and Baby R's mother's blood pressure was checked.[47]

46. Baby R's mother said that in early 2021, she requested the Bendigo Health records from her first pregnancy, which included the records from Castlemaine Health. She reviewed them to understand what occurred during the labour and to inform decision making for the pregnancy.[48] She gave the records to Ms Murphy at one of the antenatal appointments for her to understand her obstetric history.[49] Ms Murphy reviewed the records prior to the birth plan meeting on 22 July 2022 and was aware of the history of transfer from Castlemaine Health after a long labour which failed to progress, the emergency caesarean section, postpartum haemorrhage and large baby.[50]

47. Baby R's mother underwent a number of tests including blood sugar monitoring to screen for gestational diabetes and various other blood tests, including checks of haemoglobin and iron stores. She underwent a 20-week morphology scan on 4 April 2022 on referral from Dr Moule – which was normal – and had an iron transfusion on 20 June 2022.[51]

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[45] A doula is a non-medical support person providing emotional, physical, and informational support before, during, and after birth.
[46] Melbourne Midwifery Collective records, CB 155
[47] Melbourne Midwifery Collective records, CB 154 – 166; Further statement of Baby R's mother, CB 479 - 481
[48] Further statement of Baby R's mother, CB 480 [15]
[49] Further statement of Baby R's mother, CB 481 [23]
[50] Ms Murphy's evidence, T 291 – 293
[51] First statement of Baby R's mother, CB 31 [60] - [62]; Dr Gupta, Consultation notes, CB 63; Bendigo Radiology report CB 147; Melbourne Midwifery Collective, Pathology Results, CB 160 – 165

Birth Plan Meeting

48. In attendance at the birth plan meeting on 22 July 2022 with Baby R's parents and Ms Murphy were, second midwife, Marie-Louise Lapeyre, another midwife who was to potentially be present at the birth and the doula who joined by telephone.

49. The purpose of the birth plan meeting was to cover off preparations for the birth including what supports Baby R's mother wished to have, what to expect, discussion around unexpected outcomes and the potential need to transfer to hospital.[52] Ms Murphy considered that the meeting likely went for two hours as this was the usual duration.[53]

50. The notes from the birth plan meeting included the following entries:

    a. "Happy for NVB (normal vaginal birth) at home accepts may not be possible but pregnancy preparation has been worthwhile anyway."

    b. In relation to what Baby R's mother wanted from helpers "Not much talking. In an emergency would prefer time to process."[54]

    c. In relation to unexpected outcomes/when to transfer "ok to change her mind [mother] aware of slight increase in risks due to VBAC at home. Signs of dehiscence indicate immediate transfer. Meconium liquor can be foetal distress or physiological – will mean closer attention to foetal heart rate and transfer if concerned."[55]

51. Baby R's mother recalled that during the meeting there was reference to unusual pain in labour at the scar site as a warning sign of uterine rupture.[56] Baby R's father said

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[52] Ms Murphy's evidence, T 315
[53] Ms Murphy's evidence, T 410
[54] Ms Murphy's evidence, T 316; Ms Lapeyre's evidence, T 195. Both Ms Murphy and Ms Lapeyre gave evidence that this was a reference to the mother not wanting chatter around her and not that she did not want changes in her presentation discussed with her and that she would want a few minutes to discuss and decide if any urgent action was being recommended.
[55] Birth Plan meeting notes, 22 July 2022, CB 144. The presence of meconium liquor is considered a marker of possible foetal hypoxia.
[56] Further statement of Baby R's mother, 483 [36]; Further statement of Baby R's father, CB 488 [7], 489 [8]

that during the meeting they advised Ms Murphy and Ms Lapeyre that if any major decision needed to be made during the labour, they wanted to take 10 to 15 minutes to discuss, rather than being 'frantic and fear driven' given their previous experience when the consent process felt very rushed.[57]

52. Baby R's father also recalled discussing at some stage how close they lived to the hospital. Baby R's mother also referred to discussing with the father their proximity to the hospital which would mean travelling by car rather than ambulance as was required for the first baby. She said "I had my back-up booking at Bendigo Health for this very reason and also because they knew my obstetric history. I was comfortable to return to Bendigo Health if we needed to."[58]

53. During the inquest, a consent form signed by Baby R's mother dated 22 July 2022 was produced. Ms Murphy said the form was signed by Baby R's mother at or around the time of the birth planning meeting.[59] The form referred to risks associated with a planned birth at home which included not having immediate access to, or having delayed access to, obstetric, anaesthetic and neonatal services and that the risks material to the personal circumstances and preferences (of the mother) had been discussed. Ms Murphy gave evidence that the consent form was usually signed during the meeting with the contents discussed but the risks specific to Baby R's mother would not be noted on the form.[60]

54. The consent form also referred to a collaborative arrangement and included the addition of two handwritten notes, being "Dr Moule" and "Booked at Bendigo Hosp". Ms Murphy gave evidence that she understood that there was a requirement for a collaborative arrangement for homebirth. She said that some midwives had formalised collaborative arrangements with hospitals, but generally, homebirth midwives would

[57] Further statement of Baby R's father, CB 489
[58] Further statement of Baby R's father, CB 489. See also Further statement of Baby R's mother, CB 483
[59] Ms Murphy's evidence, T 365; Exhibit 9 Baby R's Mother's signed Consent Form dated 22 July 2022.
[60] Ms Murphy's evidence, T 365 – 366

perceive a referral from a doctor for homebirth services as fulfilling the requirement for a collaborative arrangement.[61]

Bendigo Health Booking-In Appointment

55. A few days later, on 26 July 2022, upon referral from Ms Murphy, Baby R's mother had a 'booking-in' appointment at Bendigo Health. The appointment took place by phone with midwife, Justine Carr. At this time, Baby R's mother was 36 weeks pregnant.[62]

56. Ms Murphy's referral letter of 4 July 2022 requested a booking-in phone visit for a back-up booking for a planned homebirth and stated that "… [mother] does not need to see an obstetrician for a routine 36 week appointment." There was reference to Baby R's mother's history of emergency caesarean section and that Baby R's mother was healthy with the only relevant history being 'PND', meaning post-natal depression.[63]

57. Ms Carr completed a 'Bendigo Health antenatal booking summary' form,[64] in which she recorded a previous history of prolonged rupture of membranes, long labour, emergency caesarean section, birthweight of 4,896 grams and postpartum haemorrhage of 800 mls. Ms Carr gave evidence that the history she recorded would have been based on her review of the hospital records from the first delivery and Baby R's mother's recollection and information provided.[65]

58. Ms Carr entered her notes in an "Antenatal Visits" form as follows:

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[61] Ms Murphy's evidence, T 366. As at 2022, it was a prerequisite under the *National Health Act 1953* and the *Health Insurance Act 1973* that there be a collaborative arrangement in place between a midwife and a medical practitioner for health services by a midwife to be subsidised by Medicare. This requirement was removed effective 1 November 2024 by the *Health Legislation Amendment (Removal of requirement for a collaborative arrangement) Act 2024.*

[62] Bendigo Health Women's Clinic correspondence to Dr Gupta, date 26 July 2022, CB 57-58; Statement of Justine Carr, dated 21 March 2025, CB 491 [1].

[63] Referral letter from Ms Murphy to Bendigo Health Antenatal Clinic, CB 171

[64] Bendigo Health records, CB Vol 2, 450

[65] Ms Carr's evidence, T 116 - 117

'Planned VBAC at Home. Disc offer of obsc appointment – [mother] will decline this and is aware service is available should she require assessment or advice. Red flags and Service contact details and numbers disc today'.[66]

59. Ms Carr said she told Baby R's mother "…what the scheduled visit with the obstetrician consultant looked like, and that she would need obstetric review to talk about the timing and mode of birth and to counsel her about aiming for a normal birth (NVD) after caesarean section (CS)".[67]

60. Ms Carr said she would have told Baby R's mother what she tells all women at their first appointment (usually at 15 to 17 weeks), that women see an obstetrician at 36 weeks for the safety of mother and baby and to discuss the best time of birth for both. Ms Carr noted that a late gestation booking-in appointment itself was an indication for referral to obstetrics for assessment.[68] Ms Carr said she told Baby R's mother that as this was the first antenatal encounter, and she was presenting at 36 weeks for a backup booking-in appointment and was aiming for a normal vaginal birth after a caesarean section, it was her recommendation that an obstetric appointment be offered.[69] Baby R's mother said she did not recall such a discussion with Ms Carr.[70]

61. Ms Carr stated that, following the appointment, it was her usual practice to print the booking-in documentation and fill out a booking triage form called a "Midwife booking advice to consultant slip". This form is not included in a patient's medical record but is used for administrative purposes (for the obstetric review that would follow). Ms Carr said in completing the form she was confident that she indicated a recommendation for an appointment with an obstetrics consultant as soon as possible even though Baby R's mother had declined the appointment "as the form is meant to include our considered recommendation."[71]

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[66] Bendigo Health records, CB Vol 2, 451
[67] Statement of Ms Carr, CB 492 [3]
[68] Statement of Ms Carr, CB 492 [4]
[69] Statement of Ms Carr, CB 493 [8]
[70] Second further statement of Baby R's mother, CB 515 [4]
[71] Statement of Ms Carr, CB 494 – 495 [12]. An example of the booking triage form was annexed to Ms Carr's statement at CB 497.

62. Dr Caetlyn Davis was the consultant obstetrician who reviewed the medical record that day, as per the Bendigo Health process. She assessed Baby R's mother's pregnancy as high risk due to the circumstances of her previous birth being "an emergency caesarean section at full dilatation of a macrosomic baby" and recommended an appointment for this to be discussed.[72]

63. Dr Davis completed a "Shared Care Form" in which she indicated that Baby R's mother had been triaged as "high risk" (the only alternative box that could be ticked was "low risk") and selected from prepopulated options that, on the basis of this assessment, Baby R's mother was 'NOT suitable for GP shared care and will be seen in the ANC [antenatal clinic] for ongoing care." This form is used for all patients reviewed in the antenatal clinic.[73]

64. Baby R's mother was contacted by an administrative staff member for the purposes of making the recommended obstetric appointment, but she declined. [74]

65. Baby R's mother said that the person who called her said there was an available appointment to see an obstetrician "to make sure your ducks are all lined up". She questioned to herself the need for this given there had been "no change or concerns raised" during her pregnancy and felt like it was a "box ticking exercise". She could not see the relevance of attending and that "[i]f anything, I recall feeling that I could be exposing myself to fearmongering about a VBAC homebirth, and as nothing had changed, I politely declined the appointment."[75]

66. On the 'Shared Care Form' completed by Dr Davis are the words 'declined OBSCON' and 'Home Birth' handwritten diagonally across the form. It is understood that the notation was made by the administrative staff member who made the call to Baby R's mother.[76] The 'Shared Care Form' was sent to Dr Gupta as she was noted as the

[72] Statement of Dr Caetlyn Davis, CB 72; Shared Care Form, CB 57.
[73] Statement of Dr Davis, CB 72; Shared Care Form, CB 57
[74] Statement of Ms Carr, CB 495 [14]
[75] Further statement of Baby R's mother, CB 484 [42]
[76] Statement of Ms Carr, CB 495 [13]

referring doctor in the Bendigo Health records.[77] It was not sent to the actual referring practitioner, being Ms Murphy.[78] Dr Davis gave evidence that her impression at the time was that the form had gone to Ms Murphy as the referring practitioner.[79]

67. The Bendigo Health records include a further entry made by Ms Carr on the following day, 27 July 2022, that Baby R's mother "*declined OBS Con appt review and disc this week at 36/40. She is well aware of WHC [Women's Health Centre] and Birthing Services should she require assistance and assessment*".[80] Ms Carr said she would have written this on learning that the further offer of an appointment had been declined and did not reflect a further discussion between her and Baby R's mother.[81]

Labour and Birth of Baby R

68. Baby R's mother went into labour in the early hours of 19 August 2022, about a day before her due date. She contacted Ms Murphy just before 5am who arrived at approximately 5:10am. There was spontaneous rupture of membranes with clear liquor shortly before Ms Murphy arrived. Ms Lapeyre attended some 15 minutes later. The doula, Jess, who had attended the birth plan meeting, was in phone contact in the morning at around 8:00am and again in the latter part of the labour.[82]

69. During the first stage of labour and up to 10:25am, when a vaginal examination (VE) was performed, Baby R's mother was contracting every 3 to 4 minutes and labour was proceeding normally. The findings of the VE were of a thick anterior lip and cervical dilatation of 7 cm. As Baby R's mother was not yet fully dilated, she was advised not

[77] Bendigo Health Women's Clinic correspondence to Dr Gupta, CB 57-58; Statement of Dr Gupta dated 24 January 2023, CB 55.
[78] Ms Murphy's evidence, T 330
[79] Statement of Dr Davis, CB 72; Dr Davis' evidence, T 141
[80] Exhibit 5, Three pages of Antenatal Visits with Justine Carr, tendered on 29 July 2025; Ms Carr's evidence, T 115
[81] Statement of Ms Carr, CB 495 [14]
[82] A Queensland based doula. First statement of Baby R's mother, CB 33 [90]; Labour and Birth Progress Notes CB 93 – 94; 172, 174; Ms Lapeyre's evidence, T 273

to push, and manoeuvres were carried out to assist with the baby's position in the uterus.[83]

70. During the labour, the baby's heart rate was monitored using intermittent auscultation.[84] A normal foetal heart rate (FHR) is between of 110 to 160 beats per minute (bpm).[85]

71. At 2:46pm, the baby's FHR was 140 bpm and Baby R's mother's contractions were noted to be long and lasting up to two minutes. It was queried whether the baby was in the right occipito posterior position (ROP).[86] The assessment of the position of the baby was based on external assessment using abdominal palpation.[87] It was also noted that Baby R's mother said she feels "like she's stuck like last time and has been thinking of epidural for the past hour."[88] Baby R's mother said she was doing various uncomfortable positions with the guidance of Ms Murphy and Ms Lapeyre to get the baby into a good position.[89]

72. At 3:10pm, as Baby R's mother was walking to the couch and doing long forward inversion, there was a gush of meconium liquor. In a note made after the labour, Ms Murphy wrote "…[mother] recognised that meconium may indicate foetal distress or could be physiological. Midwives said that we will listen more often to the foetal heart to check on baby's well-being."[90]

73. Baby R's mother states that once she saw the meconium liquor, she thought that she would be needing to go to hospital but recalls Ms Lapeyre saying something like *'don't*

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[83] Labour and Progress Notes, CB 93, 173. For discussion about the stages of labour and maternal observations, see Safer Care Victoria, Clinical Guidance, Maternity 'Care during labour and birth', CB 401

[84] Intermittent auscultation is defined in the RANZCOG Intrapartum Fetal Surveillance Clinical Guideline as the auscultation of the foetal heart using a hand-held Doppler at regular intervals and for a pre-defined duration during labour, Exhibit 4 RANZCOG, Intrapartum Fetal Surveillance (4th ed, Clinical Guideline, 2019) 13. This Clinical Guideline has since been updated with a 5th edition in September 2025.

[85] Exhibit 4 RANZCOG, Intrapartum Fetal Surveillance (4th ed, Clinical Guideline, 2019) 29.

[86] An ROP position indicates that the back of the baby's head is towards the mother's back to the right. The ideal position for vaginal delivery is considered to be occipito-anterior (OA) fetus facing spine.

[87] Ms Lapeyre's evidence, T 221 – 222; Ms Murphy's evidence, T 343, 373

[88] Labour and Progress Notes, CB 93, 173

[89] Further statement of Baby R's mother, CB 485 [47(a)]

[90] Labour and Progress Notes, CB 94; Reflections of Ms Murphy, undated and not signed, CB 97

worry, we will just monitor you more closely'.[91] Baby R's father said that Ms Murphy and Ms Lapeyre said '*ok, no problem, we'll just increase monitoring*.'[92] Ms Lapeyre noted in a timeline set out in her statement that at this time the midwives decided to listen to the foetal heart rate every 15 minutes and the plan was to transfer if there were any pathological changes.[93]

74. At 3:37pm the FHR was 157 bpm and the baby's position was noted to be right occipito transverse (ROT).[94] Ms Murphy gave evidence that this change indicated the baby was moving around towards an anterior position.[95]

75. A VE was performed by Ms Murphy at 5:56pm, around 14 hours after labour began, and seven hours after the first VE at 10:25am, indicating that Baby R's mother was fully dilated, the baby's head was at spines with some caput. The position of the baby's head and whether it was in the ROP position was queried.[96]

76. At 6pm, Baby R's mother was in a birth pool. At 6:22pm Baby R's mother was speaking with Jess, the doula. Ms Murphy was resting and Ms Lapeyre recorded a FHR of 119 bpm. The notes refer to the contractions now being 10 to 15 minutes apart and mild and the doula reminding Baby R's mother to trust her body.[97]

77. At 6:55pm, the FHR was 170 bpm and Baby R's mother remained on the phone to the doula. At 7:16pm the FHR was 159 bpm and three minutes later Baby R's mother was noted to have some urge to push.[98]

[91] First statement of Baby R's mother, CB 33 [84] uses the word 'heavily'; Further statement of Baby R's mother, CB 485 [47(c)] uses the word 'closely'.
[92] Statement of Baby R's father, CB 41 [58]
[93] Statement of Ms Lapeyre, CB 69
[94] Labour and Progress Notes, CB 94, 174; ROT indicates that the back of the baby's head is on the side and facing the mother's right side.
[95] Ms Murphy's evidence, T 350
[96] Labour and Progress Notes, CB 94, 174; Caput is an oedematous swelling of the scalp from pressures of the birth canal which can sometimes disguise the true position and station of the foetal head; "At spines" refers to the foetal head being level with the ischial spines, part of the mother's pelvis.
[97] Labour and Progress Notes, CB 94, 174; Ms Lapeyre's evidence, T 271
[98] Labour and Progress Notes, CB 94, 174

78. At 7:43pm, the FHR was noted to be 195 bpm with decelerations.[99] Ms Lapeyre gave evidence that when she detected the heart rate, she woke Ms Murphy who checked and interrupted Baby R's mother's call with the doula.[100]

79. Ms Murphy said the baby was showing signs of distress and a transfer to Bendigo Health was required. Baby R's father requested 15 minutes to consider, consistent with the parents' birth plan. However, Ms Murphy said the transfer had to happen now and called Bendigo Health at 8.05pm while Baby R's parents made their own way to the hospital arriving at 8.25pm. Ms Murphy provided a letter summarising the labour for the parents to hand over to the hospital upon arrival. [101]

80. At the hospital, the cardiotocography (CTG) revealed that Baby R was tachycardiac with a FHR up to 220 bpm, absent variability and with deceleration – meaning the baby's heart rate was beating faster than normal – and dropping during contractions.[102]A category 1 emergency caesarean section was performed with findings of thick meconium liquor and a deflexed occipito-posterior position. Baby R was born at 9:36pm, weighing 4.2kg.[103]

81. Baby R's APGAR scores were low at 3 at 1, 5 and 10 minutes;[104] he had no spontaneous respiratory effort for the first 40 minutes of life, with shallow and irregular breathing noted thereafter; his initial heart rate was low but improved within the first 30 seconds of intermittent positive pressure ventilation. Baby R was intubated and ventilated at 10.09pm. His heart rate remained stable throughout.[105]

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[99] Labour and Progress Notes, CB 94, 174

[100] Ms Lapeyre's evidence, T 270 – 273

[101] Bendigo Health records, Correspondence from Ms Murphy to Bendigo Base Hospital, CB Vol 2, 613

[102] CTG is electronic foetal monitoring (EFM) of the FHR in relation to uterine contractions. CTGs are a widely used technique for assessing foetal wellbeing. A normal CTG has baseline FHR between 110 and 160 bpm, baseline variability of 5-25 bpm and no decelerations. FHR variability is the single most important feature of the CTG trace in determining foetal wellbeing. Normal baseline variability is indicative of adequate foetal oxygenation.

[103] Statement of Dr Andrew McIntyre dated 27 June 2023, CB 74; Bendigo Health Operative Report, CB Vol 2, 208; Bendigo Health Progress Notes CB, Vol 2, 679 ff.

[104] APGAR stands for Appearance, Pulse, Grimace, Activity and Respiration. The APGAR is a standardized way to evaluate a baby's physical wellbeing at birth and its transition from the intrauterine to extrauterine environment using five physical signs measured when the baby is 1, 5 and 10 minutes old. The scores range from 0 to 10, with a lower score indicating poorer outcomes.

[105] Bendigo Health, Obstetric Discharge Summary, CB Vol 2, 652 – 655; Autopsy report of Dr Yeliena Baber, dated 4 May 2023, CB 5-6.

82. Within hours, medical staff noted Baby R had left arm stiffness and possible seizure activity which was treated with medication. At that point, medical staff suspected Baby R had severe hypoxic ischemic encephalopathy – a brain injury resulting from reduced oxygen or blood flow – and was passively cooled.

83. At 4.15am on 20 August 2022, Baby R was transferred to the Royal Women's Hospital in Melbourne via the paediatric infant perinatal emergency retrieval service (PIPER). He was actively resuscitated and stabilised under the direction of PIPER prior to transfer.[106]

84. Baby R was admitted to the Neonatal Intensive Care Unit at the Royal Women's Hospital at 6:35am with diagnoses of newborn encephalopathy and seizures with renal and hepatic dysfunction. He had no gag reflex, response to pain or any spontaneous movement. He had no further seizures but had a very abnormal electroencephalogram (EEG). Magnetic Resonance Imaging (MRI) scans performed in the following days showed severe hypoxic ischemic brain injury.

85. Baby R's prognosis was considered poor. He was unlikely to breathe when extubated and if he survived, he was likely to have a severe disability.

86. Following discussions with Baby R's parents, a decision was made to institute palliative care measures.

87. Baby R died at 11.37pm on 25 August 2022.[107]

IDENTITY OF THE DECEASED

88. On 26 August 2022, Baby R, born 19 August 2022 was identified by his mother.

89. Identity is not in issue and require no further investigation.

[106] Statement of Dr Nicola Yuen, dated 11 November 2022, CB 51 - 52
[107] Statement of Dr Sue Jacobs dated 6 December 2022, CB 66 [8]

BABY R'S CAUSE OF DEATH

90. On 30 August 2022, Dr Yeliena Baber, forensic pathologist at the Victorian Institute of Forensic Medicine performed an autopsy on the body of Baby R.[108]

91. On 5 September 2022, an examination of the brain was undertaken by Forensic Pathologist, Dr Linda Iles. In a neuropathology report of 3 March 2023, Dr Iles set out her finding of hypoxic ischaemic injury.[109]

92. Dr Baber found Baby R's cause of death to be perinatal hypoxia. In her autopsy report of 4 May 2023, [110] Dr Baber also noted the following findings:

    a. several hypoxic features identified on microscopy of the liver, brain and thymus;

    b. meconium and foetal squamous cells deep within the lungs which was in keeping with prolonged exposure to meconium liquor during obstructed labour; and

    c. hypo coiled umbilical cord.

93. There was no evidence of trauma or injury that may have caused or contributed to death.

WHAT IS HOMEBIRTH?

94. Most babies in Australia are born in a hospital setting. Homebirth describes birth occurring at home with the support of usually two midwives where at least one of those midwives has also provided antenatal care.[111]

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[108] The case was reviewed by a second pathologist in accordance with the Victorian Institute of Forensic Medicine protocol.
[109] Neuropathology report of Dr Linda Iles dated 3 March 2023, CB 17
[110] Autopsy Report of Dr Yeliena Baber dated 4 May 2023, CB 13
[111] Safer Care Victoria, Homebirth Clinical Guidance (May 2021), provides that two AHPRA registered health practitioners are required at all homebirths and one must be a midwife and the second must be educated to provide maternal and newborn care, CB 432 - 433; 436. See also Nursing and Midwifery Board, Safety and Quality Guidelines for Privately Practising Midwives (Guidelines, July 2025). Accessible at Safety and Quality Guidelines 2025

95. The number of babies born at home in Australia has fluctuated, impacted by factors such as the availability of midwives to provide antenatal and intrapartum care, the availability of insurance and arrangements with local hospitals should hospital care be required. Generally, there has been an increase in the number of homebirths in Victoria since 2000.[112]

96. There are a number of reasons why some women[113] wish to labour and give birth at home which range from a desire to be at home rather than in a hospital environment, concern around intervention in a hospital setting preventing a physiological birth and previous birth trauma in a hospital setting or other psychosocial reasons.[114]

97. Homebirth is generally considered to be suitable for low risk pregnancies with parameters for assessing and reassessing this throughout a pregnancy.[115]

98. Throughout the Coronial Brief and the evidence in this inquest there have been references to birth trauma and a lack of respect by the medical profession driving women to avoid engagement with hospital systems and towards homebirth and a difference in approach between the medical and midwifery profession.

99. This inquest did not and could not examine these important but complex and wide-ranging issues impacting women's choices about obstetric care. They go beyond the scope of the inquest but are reflected in a shifting landscape which includes the growth of publicly funded homebirth programs, models of care emphasising continuity of midwifery care, a focus on building collaborative relationships between privately practising midwives and maternity services and guidelines expressly recognising women’s autonomy to make informed choices and for their wishes to be respected and supported while mitigating risk to the unborn baby.

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[112] Safer Care Victoria, Homebirth Clinical Guidance (May 2021) refers to 131 homebirths in 2000 increasing to 322 in 2018 in Victoria, CB 426

[113] References to woman and women in this finding refers to the person(s) giving birth.

[114] Safer Care Victoria, Homebirth Clinical Guidance (May 2021), CB 429

[115] Safer Care Victoria, Homebirth Clinical Guidance (May 2021), CB 425, 434

100. I note that in May 2024, the NSW Legislative Council Select Committee on Birth Trauma published its report following an enquiry involving extensive public hearings and submissions which referred to an increasing preference for homebirths. A number of recommendations were made by the Committee including in relation to expanding midwifery continuity of care models.[116]

101. While beyond scope, these themes provide some context for the relevant issues in this investigation and inquest.

HOMEBIRTH OPTIONS IN VICTORIA

102. There are currently five publicly funded hospitals that facilitate homebirth in Victoria.[117] At the time of these events, the Joan Kirner Hospital for Women at Western Health provided a publicly funded homebirth program which commenced in 2010. The Royal Women's Hospital (RWH) commenced its program in 2024. At around the same time, Barwon Health launched its homebirth service through its Midwifery Group Practice. More recently, Casey Hospital, part of Monash Health, and Mercy Hospital for Women, have also commenced offering a homebirth service. Eligibility criteria for acceptance into all the publicly funded homebirth programs is a low risk pregnancy.[118]

103. At the RWH, homebirth care is provided by registered midwives employed by the hospital as part of the caseload model of care. Initial homebirth discussions and consideration of the eligibility criteria occur at around 22 weeks. As part of the program, a homebirth midwife is allocated as the primary point of contact with a view

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[116] NSW Legislative Council Select Committee, Birth Trauma Report (29 May 2024) 71, 82. Accessible from NSW Birth Trauma Report 2024

[117] Safer Care Victoria, Homebirth, Clinical Guidance (May 2021), CB 428. The RANZCOG Clinical Guidance Statement Home Births, version 3, July 2023, refers to there being at least 15 publicly funded home birth programmes where there is collaboration between midwives and hospital services across Australia, CB 344

[118] https://westernhealth.org.au/service/maternity-services/homebirth
https://www.thewomens.org.au/patients-visitors/clinics-and-services/pregnancy-birth/pregnancy-care-options/home-birth;
https://maternity.barwonhealth.org.au/pregnancy/your-pregnancy-care/types-of-pregnancy-care/#midwifery-group-practice-including-homebirths;
https://monashwomens.org/patients/pregnancy-care/support-services/healthy-pregnancy/;
https://health-services.mercyhealth.com.au/home-birth-program-mhw/

to providing care throughout the pregnancy, labour and after the birth. The eligibility criteria include no previous caesarean section, no foetal growth restriction or macrosomia and no history of postpartum haemorrhage of more than 1 litre. The mother is to attend routine antenatal appointments and complete all requested testing and scans and live within a 20-minute drive from the hospital. Where the criteria are not met, the woman is advised with an explanation. If the woman wishes to have a homebirth, their choice is to be respected with advice that RWH homebirth midwives will not be in attendance and an explanation of the risks associated with the decision. The discussions are to be recorded in the medical records.

104. Eligibility checks continue throughout the pregnancy and include a 35-week collaborative assessment by the caseload midwife and a designated homebirth consultant obstetrician. At 36 weeks, a home visit occurs with the homebirth midwife to assess safety and suitability of the home environment. One midwife is to attend at the commencement of labour and a second at the commencement of the second stage. Two hourly updates are provided to hospital 'In-Charge' midwife during the labour.[119]

105. An alternative model at the RWH is the Private Practice Midwife Model of Care where antenatal care is provided in the home by a privately practising midwife, who must also have and maintain employment as a RWH midwife, ensuring familiarity with the Hospital. A contractual agreement allowing the midwife access for admissions and to hospital staff to provide antenatal, intrapartum and postnatal services is also required as part of a collaborative arrangement. Homebirth is not included as part of the Model of Care.[120]

106. Bendigo Health did not and does not have any formal arrangements either for antenatal care in the home or for homebirth. Bendigo Health provides GP shared care for low risk women where most of the care is provided by the GP with a view to the woman birthing at the hospital. Otherwise, the hospital provides midwifery led antenatal care,

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[119] Exhibit 12: Statement of Danielle Corden, 2 September 2025, DPC-1 "Homebirth : RWH publicly funded model"
[120] Exhibit 12: Statement of Danielle Corden, 2 September 2025, DPC-2, "Private Practice Midwife Model of Care at the Women's at Parkville Triage and Booking Criteria-Procedure" and DPC-3 "Private Practice Midwife Model of Care Procedure"

part of which is a program called Mamta where a woman receives continuity of care with the same midwife.[121]

107. Otherwise, there was some evidence at the inquest that Bendigo Health was developing a private midwifery partnership in the community with midwives who also work at Bendigo Health and that work was being undertaken to support credentialling/endorsement for private midwives to have a clinical role in the hospital in a non-employee contract role.

108. Beyond the established publicly funded homebirth programs available at the five public hospitals mentioned above, women in Victoria may consult privately practising midwives throughout their pregnancy and for labour care in the home. The majority, about three-quarters, of homebirths in Victoria occur under such arrangements.[122]

109. It is a requirement, under the Nursing and Midwifery Board's Safety and Quality Guidelines for Privately Practising Midwives, that midwives who provide homebirth services are skilled and current in obstetric and emergency management, adult basic life support and newborn resuscitation.[123] Prior to a planned homebirth, a privately practising midwife must engage a second health practitioner who is similarly qualified to be present as the second health practitioner for the birth of the baby. Compliance with these Safety and Quality Guidelines is mandatory for all privately practising midwives.[124]

110. Prior to the birth of Baby R, in January 2022, Dr Nicola Yuen, then Head of Obstetrics and Gynaecology at Bendigo Health met with Ms Murphy and Ms Lapeyre, as the two registered private midwives providing care for women opting for homebirths in the area at the time. Dr Yuen said that the aim was to engage and seek "…a shared understanding with the locally practicing private midwives on how a collaborative care

[121] Dr Yuen's evidence, T 93 – 94
[122] Safer Care Victoria: Homebirth Clinical Guidance (May 2021), CB 428
[123] Nursing and Midwifery Board, Safety and Quality Guidelines for Privately Practising Midwives (Guidelines, July 2025). Accessible at Safety and Quality Guidelines 2025 This requirement is also in the version of the guidelines effective from 1 January 2017 and applicable at the time of these events.
[124] Nursing and Midwifery Board, Safety and Quality Guidelines for Privately Practising Midwives (Guidelines, July 2025). Accessible at Safety and Quality Guidelines 2025

model should occur."[125] In evidence, she said there was anecdotal experience of a potential tension between homebirth midwives and obstetric staff at the maternity services that they were referring women to and she wanted to ensure that this was not a barrier for Ms Murphy and Ms Lapeyre.[126]

111. It is evident from the email exchanges that followed the meeting that it was well received and positive. Ms Murphy sent an email thanking Dr Yuen for the opportunity to meet and her generous support and said true collaboration will make homebirth even safer. [127] Ms Lapeyre also expressed gratitude noting that mutual cooperation makes birth safe for women and babies.[128]

112. Baby R's mother said that she was told by Ms Murphy and Ms Lapeyre about the meeting and Dr Yuen's gratitude about how they were operating in the homebirth space and arranging transfers to Bendigo Health. Baby R's mother said "... from my experience as a midwife, I was generally of the view that, sadly, there was a lot of tension between obstetricians and midwives and so I was really impressed by this story. It gave me a lot of confidence that I was working with private midwives who were professional and respected."[129]

THE RELEVANT PROCEDURES, STANDARDS AND GUIDELINES IN RELATION TO HOMEBIRTH AND BABY R'S MOTHER'S PREGNANCY

113. At the time of Baby R's mother's pregnancy, there were a number of guidelines, standards and policies that either specifically applied to homebirth or applied more generally to maternity care with implications and relevance for homebirth care. They formed part of the evidence that was examined during the inquest and were the subject of comment by the two experts who gave evidence, obstetrician and gynaecologist, Dr Andrew Woods, and midwife, Dr Helen Cooke.

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[125] Further Statement of Dr Yuen, CB 499 [6]
[126] Dr Yuen's evidence, T 102
[127] Email from Ms Murphy to Ms Yuen, 17 January 2022, CB 503
[128] Email from Ms Lapeyre to Ms Yuen, 27 January 2022, CB 508
[129] Second further statement of Baby R's mother, CB 481 [24(e)]

114. The guidance documents relevant to homebirth were:

a. Australian College of Midwives: National Midwifery Guidelines for Consultation and Referral, 4th ed 2021, (**ACM Guidelines**);

b. The Australian College of Midwives: Position Statement for Planned Birth at Home 4 March 2019, (**ACM Position Statement**);

c. Nursing and Midwifery Board of Australia: Midwife Standards for Practice, 1 October 2018;

d. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) Statement: Home Births, version 2, July 2017; and

e. Safer Care Victoria (SCV): Homebirth Clinical Guidance, May 2021.

115. The **Australian College of Midwives National Midwifery Guidelines for Consultation and Referral (ACM Guidelines)**[130] have been in place for more than 20 years with the current edition dating from 2021. They are referred to as an essential resource for guiding clinical midwifery care, providing clear guidance to midwives across all practice contexts and as applying to all midwives working in all models of care.[131]

116. The ACM Guidelines are structured using a three-level tiered approach to responding to specific conditions or circumstances that may arise during the relevant periods of maternity care to support "…midwives to quickly identify situations that require the input of other health care professionals.[132]

[130] Australian College of Midwives, National Midwifery Guidelines for Consultation and Referral (4th ed, Guidelines,2012), CB 287
[131] Ibid 289, 291
[132] Ibid 295

117. They provide:

4.1 The Levels of Consultation and Referral Explained

When a variance from normal is identified during a woman's care, it is recommended that the midwife use their clinical judgement and the following guidance to determine the appropriate level of consultation and/or referral.

Table 4.1 Levels of consultation and referral

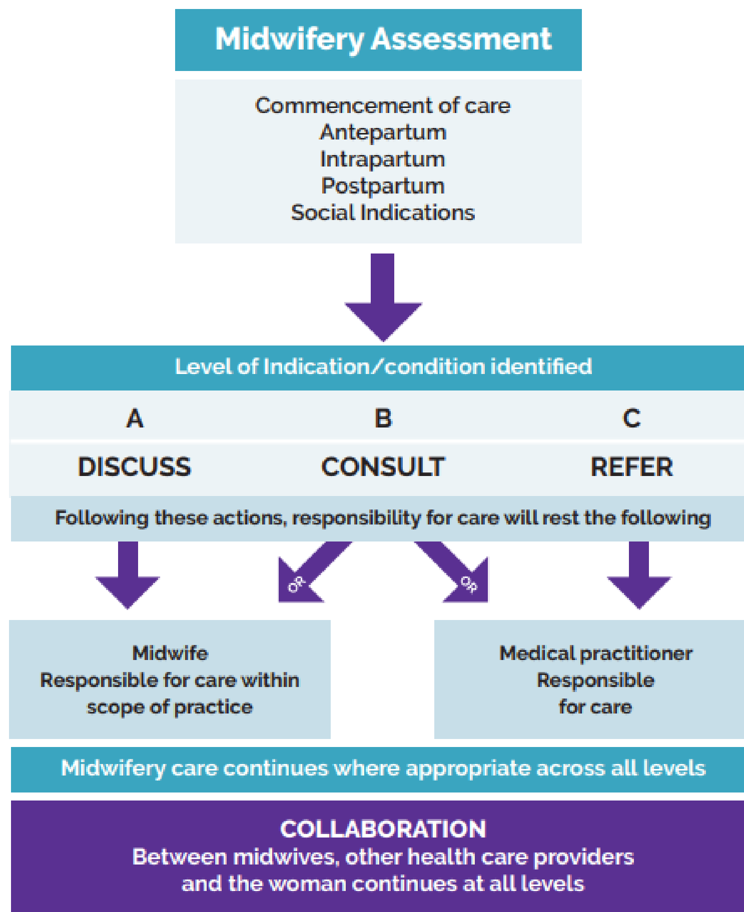
LEVEL	DESCRIPTION	GUIDANCE
A/A*	Discuss	Care is provided by the midwife. (Note: the midwife may discuss clinical situations with a midwifery colleague, medical practitioner, and/or health care provider, but this is not indicated).
B	Consult	Consult with a relevant medical practitioner or other health care provider.
C	Refer	Refer a woman and/or her baby to a relevant medical practitioner or other health care provider.

A: Midwife with endorsement to prescribe scheduled medicines*

118. Variations in severity of a condition may lead to more than one level being recommended, i.e. B and C and "clinical judgement" is to be used to determine the level of consultation and/or referral. Where there are multiple indications, the level of consultation and/or referral is to depend on the clinical judgment of the midwife in consultation with relevant medical practitioners or other health care providers. Multiple indications do not result in a Level C or automatic referral to a medical practitioner, and more than one Level B does not equal a Level C rather "for a woman who presents with multiple indications that are both Level B, the midwife should follow the guidance for a Level B and in collaboration with the medical practitioner (or other health care provider) to determine whether referral is required."[133]

[133] CB 296

119. The following flowchart sets out how the guidelines are to be used[134]:



120. Relevant to the circumstances of Baby R's mother's history or conditions that indicated Level B consultation or Level C referral were:

1. In relation to previous maternity history:[135]

- Macrosomia (more than 4500g) – Level B
- Lower segment caesarean section – Level B
- Minor postpartum haemorrhage of 500 to 1000 mL – Level B/C

[134] CB 299
[135] CB 303 - 304

2. In relation to the intrapartum period:[136]

- Meconium-stained liquor:
  - Non-significant (defined as pale green/yellow thin diluted non-particulate) - Level A/B
  - Significant (defined as dark green or black that is tenacious or containing lumps of meconium) - Level B/C
- Prolonged labour in the active first stage (more than 6cm dilated) where there is no cervical change in 4 hours and cessation or change in strength, duration and frequency of contractions – Level B/C

121. Consultation in the ACM Guidelines is defined as:

The seeking of professional advice from a qualified, competent healthcare provider with the relevant knowledge and skills to make decisions about the woman's care, in collaboration with the woman and midwife. It is dependent on mutual respect, open communication, the sharing of information and recognition of the equally important roles that each care provider has in providing high quality, evidence-based care to women, babies and families.[137]

122. The ACM Guidelines also provide that the consultation be a face-to-face assessment with the woman or between the midwife and medical practitioner or health care provider where the woman is unable or chooses not to attend, with consultation being undertaken by the midwife in such situations on behalf of the woman. If a woman declines a consultation, the midwife is also to complete a Record of Understanding set out in Appendix B which is used when a woman chooses care outside the Guidelines or against the advice of her midwife. [138]

[136] CB 309 - 310
[137] CB 293
[138] CB 297

123. The **Australian College of Midwives: Position Statement for Planned Birth at Home (ACM position statement)**[139] expressly "…supports the choice of planned, midwife attended births at home as a safe option for women with uncomplicated pregnancies"[140] and includes as a key principle the right of women to decide where they would like to give birth and that:

> *It is important that all childbearing women have access to evidence based, unbiased information that includes the potential advantages and disadvantages of birth at home*.[141]

And:

> *Midwives have a responsibility to establish appropriate consultation and referral processes and collaborative networks using the ACM National Midwifery Guidelines for Consultation and Referral.*[142]

124. The **Nursing and Midwifery Board of Australia: Midwife Standards for Practice**[143] lists 7 standards which relevantly include:[144]

- Standard 1: Promotes health and wellbeing through evidence-based midwifery practice, which includes the midwife promoting informed decision-making, participation in care, and self-determination and supporting access to maternity care for the woman.

- Standard 2: Engages in professional relationships both with the woman and other health practitioners and colleagues including participating in and/or leading collaborative practice.

- Standard 3: Demonstrates the capability and accountability for midwifery practice, which includes the midwife understanding their scope of practice, practicing within

[139] CB 268
[140] CB 270
[141] CB 271
[142] CB 271
[143] CB 278
[144] CB 281 - 283

relevant legal parameters and professional standards, codes and guidelines and participating in their own continuing professional development and maintaining the required knowledge and skill base for safe and effective practice and engaging in timely consultation, referral and documentation.

125. The **RANZCOG Statement: Home Births, version 2, July 2017**[145] (since replaced) stated that "… [a]ll women contemplating planned homebirth should receive evidence-based information about the risks and benefits of homebirth…"[146] and relevantly provided the following recommendations at the time of Baby R's death:[147]

- Recommendation 1: RANZCOG supports women having informed choices in maternity care – including the place of birth.

- Recommendation 2: Women contemplating planned home birth must be provided with accurate information free of prejudice and bias.

- Recommendation 3: Even in a pregnancy without complicating factors, the level of risk to mother and baby with homebirth is at a level that is unacceptable to most women. When a pregnancy has any factor that increases maternal or perinatal risk, homebirth is particularly dangerous.

- Recommendation 4: Where a woman remains intent on a planned homebirth, the following is strongly recommended:

  - Health practitioners providing home birth services should be confined to obstetricians (GP or specialist) and/or suitably qualified midwives.

  - Women planning a home birth should meet the eligibility criteria as specified in the guidelines of their local hospital program or in accordance with the National Guidelines for Consultation and Referral (the ACM guidelines).

[145] CB 322
[146] CB 324
[147] CB 324 - 325

- o A midwife practising homebirth must have established professional relationships with an obstetrician(s) for consultation and referral.[148]

126. The **Safer Care Victoria (SCV) Homebirth: Clinical Guidance**[149] states that homebirth is a safe option for some births and provides more choice for women. In assessing suitability for homebirth, the clinical guidance refers to homebirth with a registered midwife as a safe choice for women who are deemed to be at low risk of complications during pregnancy, labour and birth and the postpartum period and as a suitable option for women with all of the following:[150]

- A low risk pregnancy with no pre-existing or occurring medical conditions that may impact on the pregnancy, birth or postpartum period (maternal and foetal)

……

- No previous caesarean section or uterine surgery.

127. Given Baby R's mother's history of previous caesarean section, the following guidance documents also applied in the circumstances:

a. **SCV: Birth after Caesarean**[151] which provides that:

i. During labour, there is to be continuous electronic fetal monitoring and continuous midwifery support with 1:1 care, remaining alert for signs of uterine rupture including prolonged, persistent, profound fetal bradycardia and an abnormal fetal heart rate pattern suggesting fetal compromise;[152] and

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[148] The RANZCOG Clinical Guidance Statement: Home Births (C-Obs 2) (version 3, July 2023) replaced the RANZCOG 2017 statement and specifies that a reference to 'low risk or women without identified risk factors' include women who have had antenatal care and have a singleton, cephalic pregnancy at 37 to 41 weeks gestation, with a normally grown foetus, without previous caesarean births or other uterine scars, and do not have other pre-existing or current conditions affecting the woman or her baby which may increase the risk of adverse outcomes during pregnancy, birth or in the postnatal period. In that respect, RANZCOG refer to the ACM Guidelines as a comprehensive list of conditions that warrant further consultation or referral to a medical practitioner and therefore may change the level of risk, CB 343-344.

[149] Safer Care Victoria, Homebirth (Clinical Guidance, May 2021), CB 435

[150] Ibid 428, 431

[151] Safer Care Victoria, Birth after Caesarean (Clinical Guidance, November 2021) CB 388 – 400

[152] Ibid 390, 395. The risk of uterine rupture for vaginal birth after caesarean (**VBAC**) was noted to be between 0.1-1.9% while the risk of hypoxic ischaemic encephalopathy (**HIE**) for VBAC was 0.08% (CB 393-394).

ii. If planning VBAC, ensure the hospital has capacity to perform emergency caesarean section and manage a uterine rupture.[153]

b. **RANZCOG Best Practice Statement: Birth after Previous Caesarean Section (March 2019)** (since replaced) had a stated objective "[t]o provide women who have previously given birth by caesarean section, their partners, doctors and midwives with information regarding the benefits and risks of their options for delivery, vaginal birth or repeat elective caesarean section'.[154] The target audience was specified to be health professionals providing maternity care.[155] It was recommended that:

   i. women be advised:

      - that a planned vaginal birth after caesarean (VBAC) should be conducted in a suitably staffed and equipped delivery suite, with continuous intrapartum care and monitoring and with available resources for urgent caesarean section and neonatal resuscitation should complications such as scar rupture occur;[156] and

      - to have continuous electronic fetal monitoring following the onset of uterine contractions and for the duration of the planned VBAC.[157]

   ii. a trial of labour mandates vigilant assessment of progress and that two hourly assessments from 7 centimetres dilated can be helpful to detect

[153] Ibid 394
[154] RANZCOG Best Practice Statement: Birth after Previous Caesarean Section (C-Obs 38) (version 2, March 2019), CB 448
[155] Ibid
[156] Ibid 452 [Recommendation 8]
[157] Ibid [Recommendation 10]. The RANZCOG statement also sets out factors reducing the likely success of a VBAC (including previous caesarean section for dystocia and fetal macrosomia of 4kg or more) and a number of risks and benefits of VBAC, with the recommendation that these matters be discussed with the patient and documented in the medical record, CB 451, 454-455. This statement was updated and replaced by RANZCOG Birth After Caesarean (Clinical Guideline, version 4.1, August 2025), Exhibit 13.

secondary arrest of labour. Lack of progress is to trigger clinical reassessment by an experienced obstetrician.[158]

128. Other guidance documents applicable generally to intrapartum care are:

a. **SCV: Care During Labour and Birth Clinical Guidance (Nov 2020)** which recommends offering a VE to assess labour progress every four hours in the first stage of labour, and for fetal surveillance as per the RANZCOG Intrapartum Fetal Surveillance Clinical Guideline (below);[159] and

b. **RANZCOG Intrapartum Fetal Surveillance Clinical Guideline (2019)** which recommends continuous electronic fetal monitoring where there is a uterine scar e.g. previous caesarean section and where there is meconium or blood stained liquor during the intrapartum period.[160]

ANTENATAL CARE AND COMMUNICATION

Expert Evidence as to Suitability for Homebirth and Obstetric Risk

129. In his report, Dr Woods said that pregnancy care and birth planning involves a comprehensive review of a woman's physical, mental and psychosocial health and any previous birth and pregnancy history explored.[161] He said a vital part of pregnancy care and birth planning was identification of maternal and foetal risk factors which should be discussed in the context of individual circumstances ensuring that a collaborative pregnancy care and birth plan is made using the principles of shared decision making.[162] Should any trauma be identified that may impact the care or experience of care, this should be discussed to reduce the likelihood of a resurgence of previous trauma or newly

[158] RANZCOG Best Practice Statement: Birth after Previous Caesarean Section (C-Obs 38) (version 2, March 2019), CB 459 [5.9.7]
[159] Safer Care Victoria, Care During Labour and Birth (Clinical Guidance, November 2020) CB 406, 409.
[160] Exhibit 4 RANZCOG, Intrapartum Fetal Surveillance (4th ed, Clinical Guideline, 2019), 8.
[161] Report of Dr Andrew Woods dated 13 May 2024, CB 238 [75]
[162] Report of Dr Andrew Woods dated 13 May 2024, CB 238 [78]

arising trauma which may impact the woman's health and wellbeing in a pregnancy or into the longer term.[163]

130. Dr Woods noted there were a number of risk factors or health concerns in Baby R's mother's pregnancy including previous caesarean birth, macrosomic baby, postpartum haemorrhage and traumatic birth experience.[164]

131. Given the identified risk factors and the various guidance documents, Dr Woods considered Baby R's mother was not a suitable candidate for homebirth.[165]

132. By reference to the SCV Homebirth: Clinical Guidance, Dr Woods noted Baby R's mother had a caesarean section and did not have a low risk pregnancy with no preexisting or occurring medical conditions that may impact on the pregnancy, birth or postpartum period.[166]

133. In relation to VBAC, Dr Woods said he would base his discussions around the RANZCOG Best Practice Statement: Birth after Caesarean Section and would incorporate the identified risks into the discussion and decision-making process which included the likelihood that the events of the previous labour would occur again and affect the success of a VBAC.[167]

134. Other risks of VBAC as set out in the SCV: Birth After Caesarean included bleeding and need for transfusion and the risks of injury to the mother and the baby. Dr Woods said the potential consequences of a uterine rupture included the need for urgent delivery of the baby,[168] the risk of hysterectomy for the mother and hypoxic injury to the baby and potentially, stillbirth.[169]

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[163] Report of Dr Andrew Woods dated 13 May 2024, CB 238 [79]
[164] Report of Dr Andrew Woods dated 13 May 2024, CB 238 [84]
[165] Report of Dr Andrew Woods dated 13 May 2024, CB 241 [112]
[166] Dr Woods' evidence, T 446
[167] Dr Woods' evidence, T 434
[168] Dr Woods said that uterine rupture would be recognised as a category 1 emergency with the expectation of birth occurring within 30 minutes, T 435 – 436
[169] Dr Woods' evidence, T 434 – 435

135. Dr Woods would recommend birthing in a hospital facility with maternity capabilities for a planned VBAC in accordance with the RANZCOG's Best Practice Statement: Birth after Caesarean.[170] Dr Woods considered this guidance and all the guidance documents applied to all involved in providing maternity care to women and provided a framework around which to build a collaborative care plan involving the woman and the primary practitioner and any practitioner consulted as part of the care.[171]

136. Dr Woods said if, after discussion, the mother made a choice to go outside a recommendation of birthing in a hospital, he would work with her and the wider multi-disciplinary team to build an alternative pathway of care. Dr Woods said he would document the discussion about the specific risks of VBAC at home such as, delay if transfer to hospital was needed which could affect the baby and the mother's outcomes, and that continuous electronic foetal monitoring would not be available as is recommended for pregnancies with risk factors.[172]

137. Dr Woods also considered that Baby R's mother's risk factors of previous caesarean section, macrosomia and postpartum haemorrhage when assessed against the ACM guidelines indicated a consultation with a relevant medical practitioner or other health care provider (Level B indication) during the pregnancy.[173]

138. Dr Woods said the purpose of the consultation would be to provide another balanced opinion around the risk factors to help inform the recommendations around pregnancy care to support a woman's choice.[174] Ideally the consultation would be with both the woman and the midwife benefitting from three perspectives, exhibiting mutual respect to the primary practitioner and having an understanding of an agreed plan of care articulated in clear case documentation and accessible should the woman require transfer.[175]

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[170] Dr Woods' evidence, T 434 – 435. See also Report of Dr Woods, CB 239 [94]
[171] Dr woods' evidence, T 437 – 438
[172] Report of Dr Woods, CB 240 [98]
[173] Report of Dr Woods, CB 240 [103]; Dr Woods' evidence, T 438
[174] Dr Woods' evidence, T 438 – 439
[175] Dr Woods' evidence, T 440

139. Dr Cooke noted that Baby R's mother's obstetric risks going into the pregnancy were of previous caesarean section, macrosomia and postpartum haemorrhage.[176] She considered that it was of relevance that the reason for the previous caesarean section was obstructed labour which was a risk which could happen again and needed to be kept in mind and discussed with Baby R's mother.[177]

140. Dr Cooke did not consider that the pregnancy was unsuitable for homebirth. She said every woman has the right to choose to birth at home and, for each family to make the right decision, it was important to have:

> *…frank and open discussion around the relevant risk factors and how these impact on potential birthing outcomes and safety for both the mother and baby. The information should come from a multidisciplinary team who can provide evidence-based, non-biassed information to assist women in their decision making. Risk factors can often be managed at home if there are clear consultation transfer pathways organised.*[178]

141. Dr Cooke considered that the <u>RANZCOG Best Practice Statement: Birth after Caesarean</u> applied to all who provide obstetric care including privately practising midwives and was about providing women with information around risk and the measures that can be put in place to counteract them.[179]

142. However, Dr Cooke also said that the <u>RANZCOG Best Practice Statement: Birth after Caesarean</u> used language which was 'woman unfriendly' with women being advised without any level of discussion, taking away any form of individuality or scope for alternate decision making and risk stratification.[180]

143. Dr Cooke went on to say:

> *Given the birth trauma inquiry in New South Wales [...] it is time for all clinicians to rethink the advice and support we offer for all women and offering them the opportunity*

[176] Report of Dr Helen Cooke dated 6 June 2024, CB 258
[177] Dr Cooke's evidence, T 506 – 507
[178] Report of Dr Cooke, CB 258
[179] Dr Cooke's evidence, T 523 – 524
[180] Report of Dr Cooke, CB 260

to make choices that best suit them. Home birth with access to good obstetric and hospital support in a timely fashion is suitable for the majority of women regardless of risk. In an ideal world a cohesive, multidisciplinary team should be able to support women with the choices that are best suited for them physically and psychologically.

Unfortunately, the divide between obstetrics and midwifery care is still cavernous in the majority of cases and midwives are unfortunately dubious about asking for help that is often woman unfriendly and critical.[181]

144. For the purposes of the SCV Homebirth Clinical Guidance, Dr Cooke considered that the pregnancy was low risk as Baby R's mother did not have a medical condition impacting her pregnancy such as hypertension or diabetes but acknowledged that the previous history of caesarean section is separately flagged as not being suitable for homebirth.[182]

145. Dr Cooke said Baby R's mother's pregnancy was suitable for an attempted home birth as every pregnancy and labour is different and there was a possibility of achieving normal birth at home and, with the right evidence, this was a decision for Baby R's mother to make.[183]

Dr Moule

146. Dr Moule was familiar with Baby R's mother's obstetric history, having provided care in Baby R's mother's first pregnancy. In this pregnancy, Dr Moule saw Baby R's mother on one occasion, at 12 weeks gestation on 8 February 2022. Dr Moule said it was a long, emotional and intense consult which was mostly debriefing about the previous delivery experience.[184]

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[181] Report of Dr Cooke, CB 260
[182] Dr Cooke's evidence, T 528 – 529
[183] Dr Cooke's evidence, T 529 – 530
[184] Dr Moule's evidence, T 28

147. Given the previous caesarean section, Dr Moule said Baby R's mother could not give birth at Castlemaine Hospital, and her options were to deliver at Bendigo Hospital or have a homebirth.[185]

148. In her statement, Dr Moule noted that for a woman planning a VBAC following a single caesarean section and with a history of macrosomia, consultation with an obstetrician was recommended under the ACM guidelines as Level B indications[186] and that all women choosing homebirth are recommended to have a back-up booking and to see an obstetrician at Bendigo Health.[187]

149. Dr Moule also said that if Baby R's size was estimated to be normal then the risks of homebirth were similar to other women planning a VBAC at home which was the risk of uterine rupture at 1 in 200 and the risk of failing to progress and requiring hospital transfer.[188] In relation to the potential need for transfer, Dr Moule noted that the proximity to Bendigo Health was discussed.[189]

150. Dr Moule said in this context, she considered Baby R's mother had made an informed decision about attempting a VBAC at home and that she was a suitable candidate for homebirth.[190]

151. In evidence, Dr Moule said that she would add the word 'potentially' in relation to Baby R's mother's suitability for homebirth because the size of the baby could not be determined at 12 weeks. She said this needed to be assessed later in the pregnancy and that a recurrence of macrosomia might make Baby R's mother 'ineligible' for homebirth.[191] Dr Moule could not recall whether she explicitly told Baby R's mother that she was potentially suitable for homebirth.[192]

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[185] Dr Moule's evidence, T 46
[186] Statement of Dr Moule, CB 49
[187] Statement of Dr Moule, CB 49
[188] Statement of Dr Moule, CB 49
[189] Statement of Dr Moule, CB 50
[190] Statement of Dr Moule, CB 49
[191] Dr Moule's evidence, T 21 – 22, 72
[192] Dr Moule's evidence, T 22

152. Dr Moule said she saw it as her role and responsibility to have an initial discussion with Baby R's mother about the risks of VBAC, uterine rupture, having another obstructed labour and requiring transfer and considered that she did so.[193] Baby R's mother recalled discussion about the risk of uterine rupture and the size of her first baby.[194]

153. Dr Moule did not recall discussing with Baby R's mother the RANZCOG Best Practice Statement: Birth after Caesarean Section and its recommendation that a planned VBAC be conducted in a suitably staffed and equipped delivery suite. She said the Best Practice Statement read as applying to birthing in hospital and did not reference women who wanted to birth at home.[195] Dr Moule said that, while the Best Practice Statement made clear that VBAC could not be undertaken at Castlemaine Health, which would not be able to provide the recommended monitoring, it did not address homebirth.[196]

154. Dr Moule considered that the RANZCOG Statement: Homebirth was applicable as it specifically referenced homebirth and referred to the ACM guidelines.[197]

155. In her statement, she said that she did not provide Baby R's mother with a referral to an obstetrician but recommended that she have this done with the midwife to whom she was referring Baby R's mother.[198] Dr Moule said it would have been too early for a referral at 12 weeks and was usually done by the midwife.[199]

156. Dr Moule said that she expected Baby R's mother to have a booking-in appointment and consultation with an obstetrician at Bendigo Health at around 36 weeks when it could be determined whether macrosomia was present.[200] She said that if there was a finding of macrosomia in this pregnancy, this would change the category in the ACM guidelines from a Level B to a C requiring referral.[201] Dr Moule said she was expecting that the midwife and the consultant obstetrician would be assessing all the risks

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[193] Dr Moule's evidence, T 25
[194] Further statement of Baby R's mother, CB 478 [8(e)] – [8(f)]
[195] Dr Moule's evidence, T 52 – 53
[196] Dr Moule's evidence, T 84
[197] Dr Moule's evidence, T 26 – 27
[198] Statement of Dr Moule, CB 49
[199] Dr Moule's evidence, T 30 - 31
[200] Dr Moule's evidence, T 58
[201] Dr Moule's evidence, T

together, later in the pregnancy, and it was appropriate for that consultation to be at the maternity centre where Baby R's mother might end up being referred to.[202]

157. Baby R's mother did not recall Dr Moule mentioning a backup booking-in appointment or referral to an obstetrician and did not "…recall consciously rejecting the obstetrician part."[203] Dr Moule said it was possible that she did not recommend seeing an obstetrician or discuss the benefits of seeing one.[204]

158. In relation to homebirth, Dr Moule said in her statement:

With women deciding between home birth and hospital birth, I explain that in hospital we can provide more interventions, including if the baby needs resuscitation a hospital can get more staff and equipment immediately to help. I don't specifically recall whether I had this conversation with [the mother] in her pregnancy with [Baby R] or in her previous pregnancy.[205]

159. Baby R's mother did not recall such an explanation.[206] Dr Moule said in evidence that this is what she usually tells mothers considering homebirth, but it was possible she did say this to Baby R's mother.[207] There is no reference to this in Dr Moule's notes nor indeed to any discussion about suitability for homebirth or VBAC.[208] Dr Moule said more happened in the consultation than what was in her notes and that the notes were not as accurate as she would have liked on everything that was discussed.[209]

160. Dr Moule acknowledged that her referral letter to Ms Murphy did not include a recommendation that Baby R's mother be referred to an obstetrician or reference to any discussion about suitability for homebirth. She said the letter could have been written

[202] Dr Moule's evidence, T 29, 60
[203] Further statement of Baby R's mother, CB 479 [9]
[204] Dr Moule's evidence, T 30 - 31, 62
[205] Statement of Dr Moule, CB 50
[206] Further statement of Baby R's mother, CB 479 [10]
[207] Dr Moule's evidence, T 62
[208] Mostyn Street Clinic records, CB Vol 2 1519
[209] Dr Moule's evidence, T 22, 29

better to include discussion around uterine rupture and reference to the RANZCOG and ACM guidelines.[210]

161. Dr Moule also noted there were time limitations in covering everything in the context of an appointment that involved debriefing and complex issues. She said it might have been of benefit to see Baby R's mother for another appointment, noting that antenatal care is a continual process of risk assessment and reflection.[211] She said that she would usually invite a patient to come back and talk further but it would be up to the woman to decide to make the appointment. She otherwise said that in terms of obstetric care, the usual pathway was the independent midwife and Bendigo Health.[212] She did not see herself as the obstetrician providing Baby R's mother's antenatal care.[213]

162. Dr Moule said that Baby R's mother had a strong desire to have a homebirth and had already spoken with a homebirth midwife by the time of the consultation.[214] Consistent with this, Baby R's mother said that by the time of the appointment with Dr Moule, they had already decided on a homebirth and had spoken with Ms Murphy.[215]

163. Dr Woods noted there was no contemporaneous documentation about discussion of VBAC or suitability for homebirth in Dr Moule's clinical documentation. He considered that Dr Moule's documentation should have more clearly reflected discussion around suitability and included reference to the RANZCOG and ACM positions, Baby R's mother's understanding of risk, model of care, place and mode of birth choices and that she was making an informed choice.[216]

164. Dr Woods did not agree with Dr Moule that Baby R's mother was suitable for homebirth. He said Dr Moule could have suggested that she was not suitable as it was

[210] Dr Moule's evidence, T 35
[211] Dr Moule's evidence, T 32, 63 - 64
[212] Dr Moule's evidence, T 64
[213] Dr Moule's evidence, T 49
[214] Dr Moule's evidence, T 46
[215] Further statement of Baby R's mother, CB 478 [8(c)]
[216] Report of Dr Woods, CB 242 [128] – 243 [129]

outside standard recommended care but supported Baby R's mother's informed choice.[217]

165. Dr Woods said it was difficult to provide an absolute opinion as to the standard of the consultation given the differing recollections but based on Baby R's mother's recollection it was "… of a reasonable but not high standard", [218] and based on Dr Moule's statement and recollection, it was a more comprehensive consultation.[219]

Ms Murphy

166. Ms Murphy said, as the primary midwife, she was responsible for Baby R's mother's pregnancy and labour care with Ms Lapeyre as the second midwife involved at the time of the birth plan meeting on 22 July 2022 and the labour.[220] She also agreed that she had the primary responsibility for assessing and communicating with Baby R's mother about obstetric risk and suitability for home birth.[221] Both Dr Woods and Dr Cooke considered Ms Murphy had this responsibility.[222] Dr Woods referred to her as the primary care provider.[223]

167. Ms Murphy considered that Baby R's mother was suitable for homebirth notwithstanding the risks.[224] When Ms Murphy was first contacted by Baby R's mother she told her she did not consider that her previous caesarean section precluded her from homebirth.[225] Ms Murphy said reviewing the medical records from Baby R's mother's first labour and delivery did not change her initial view about suitability. There was no further conversation specifically about suitability and she provided antenatal care based

[217] Report of Dr Woods, CB 243 [130]
[218] Dr Woods' evidence, T 467
[219] Dr Woods' evidence, T 466 – 467
[220] Ms Murphy's evidence, T 290
[221] Ms Murphy's evidence, T 334 – 335
[222] Dr Woods' evidence, T 448; Dr Cooke's evidence, T 506, 570
[223] Dr Woods' evidence, T 448
[224] Ms Murphy's evidence, T 296
[225] Ms Murphy's evidence, T 297. Ms Murphy said this discussion took place when the mother was four weeks pregnant, but the mother recounted this conversation as taking place before her pregnancy; Further statement of Baby R's mother, CB 480 481 [22]

on an understanding that Baby R's mother was a suitable candidate. Ms Murphy maintained her view in evidence that Baby R's mother was suitable to have the opportunity to try and have a homebirth.[226]

168. Baby R's mother said she did not recall any discussions at the antenatal appointments with Ms Murphy about VBAC or the suitability and risks of homebirth and felt that the decision had already been discussed before the pregnancy and was not raised again in detail. [227] She also noted that after reviewing her medical records, Ms Murphy returned them without discussing them or raising any concerns. [228]

169. Ms Murphy noted that Baby R's mother was aware of the risk of uterine rupture[229] and Baby R's mother said that she understood the main risk of VBAC was uterine rupture.[230]

170. Ms Murphy also said Baby R's mother was aware of the potential for an obstructed labour occurring again and was seeking to minimise the risk with diet, monitoring for signs of a big baby, undertaking manoeuvres and consulting other practitioners such as a pelvic floor practitioner. She said "Baby R's mother was remarkably dedicated to improving her chances of a positive vaginal birth by the amount of preparation that she did..." and these were all things that they discussed. [231] Baby R's mother similarly said that she knew that an obstructed labour could occur again and took measures to address this including daily maternal positioning exercises, seeing a pelvic floor osteopath, a chiropractor and being fastidious with her diet.[232]

171. Ms Murphy considered that the Safer Care Victoria guidance documents applied to midwives including private midwives.[233] She agreed that based on the history of caesarean section, Baby R's mother fell outside of the factors that would make her

[226] Ms Murphy's evidence, T 313
[227] Further statement of Baby R's mother, CB 480 - 481
[228] Further statement of Baby R's mother, CB 481 [23]
[229] Ms Murphy's evidence, T 293
[230] Further statement of Baby R's mother, CB 483 [34]
[231] Ms Murphy's evidence, T 322
[232] Further statement of Baby R's mother, CB 483 [38]
[233] Ms Murphy's evidence, T 381 - 384

suitable for homebirth set out in the SCV: Homebirth Clinical Guidelines. She also agreed that the risks associated with the previous birth were pre-existing conditions that would impact on the pregnancy such that the birth was not low risk by reference to the SCV Guidelines. She acknowledged that she did not discuss these guidelines with Baby R's mother.[234]

172. Ms Murphy said it was her responsibility to ensure Baby R's mother was fully informed about her decision to have a homebirth and she believed that Baby R's mother was fully informed. Additionally, she considered that Baby R's mother knew that an obstetrician would not recommend a homebirth for someone with a previous caesarean section and would have told her this. Further, she noted that Baby R's mother had been a midwife herself "….so she understood the system…".[235]

173. Ms Murphy said she was not required to follow the RANZCOG Best Practice Statement: Birth After Previous Caesarean Section as she was not an obstetrician, though acknowledged it contained useful information.[236] She said she conveyed to Baby R's mother the content of the RANZCOG Best Practice Statement: Birth after Previous Caesarean Section but could not specify when and what was said. She considered she would have said that the RANZCOG guidelines advise against homebirths but that many women have homebirths after a caesarean section. She acknowledged that the RANZCOG advice that VBAC be conducted in a suitably staffed and equipped delivery suite may not have been specifically referred to and that these discussions may not have been documented.[237] Ms Murphy's antenatal notes do not refer to advice being given along the lines of the RANZCOG guidelines.[238]

174. Ms Murphy could not recall whether the discussion during the birth plan meeting about meconium liquor included a reference to colour and thickness and acknowledged that

[234] Ms Murphy's evidence, T 310 - 311
[235] Ms Murphy's evidence, T 323, 325
[236] Ms Murphy's evidence, T 294, 380 - 381
[237] Ms Murphy's evidence, T 308 - 310
[238] Melbourne Midwifery Collective records, CB 154 - 157

she did not discuss the RANZCOG guidelines which recommend continuous heart rate monitoring in the presence of meconium liquor. [239]

175. Ms Murphy also could not recall whether she discussed the ACM guidelines but said in her practice she generally would inform mothers of the guidelines and how they worked. She agreed it was an important discussion to have and acknowledged that there may not have been a note about such a discussion in her records. [240]

176. In any event, Baby R's mother said at some point during her pregnancy, she reviewed the ACM Guidelines and assessed herself as being at a Level B or C in relation to a couple of areas but otherwise that she was trusting her health care providers (including Ms Murphy, Ms Lapeyre, Dr Moule and Dr Gupta) "… that they considered the birth plan to be safe, otherwise they would have said something."[241]

177. For the purposes of a Level B indication in the ACM Guidelines, Ms Murphy considered that consultation with 'a medical practitioner or other health care provider', included a midwifery colleague as midwives are health care providers and did not require consultation with an obstetrician.[242] She said she discussed Baby R's mother with Ms Lapeyre. [243]

178. Ms Murphy distinguished a Level C indication requiring referral. She considered the reference to *health care provider* in this context did not include another midwife as it involved a referral. Ms Murphy did not consider that the postpartum haemorrhage of 800ml in the first delivery was significant[244] and did not consider it required referral but if she was to refer, it would be to Dr Moule or Bendigo Health.[245]

179. In any event, Ms Murphy said she regarded the requirement for consultation for a Level B indication was discharged when Baby R's mother had her appointment with Dr

[239] Ms Murphy's evidence, T 320
[240] Ms Murphy's evidence, T 304
[241] Further statement of Baby R's mother, CB 484 [41]
[242] Ms Murphy's evidence, T 295, 302 - 303
[243] Ms Murphy's evidence, T 299
[244] Ms Murphy's evidence, T 293
[245] Ms Murphy's evidence, T 307

Moule.[246] She said she suggested to Baby R's mother that she see Dr Moule.[247] Baby R's mother did not say she attended Dr Moule upon referral or at the suggestion of Ms Murphy. However, she did say that she told Dr Moule that she had already spoken to Ms Murphy and she knew that Dr Moule and Ms Murphy were known to each other. Baby R's mother also said that Ms Murphy planned to refer her to Dr Moule for clinical oversight.[248]

180. Neither Dr Woods nor Dr Cooke considered the consultation with Dr Moule satisfied the ACM Guidelines. Dr Woods said were that the case, there would be communication from Ms Murphy outlining the expectation and request for consultation with Dr Moule, a documented consultation by Dr Moule and written communication back setting out the consultation, advice and opinion, whereas Dr Moule sent a referral letter.[249]

181. Dr Cooke said that had the appointment with Dr Moule been a consult under the ACM Guidelines, she would expect a letter from Ms Murphy to Dr Moule identifying the risk factors and the advice that she was seeking from Dr Moule. Dr Moule would then respond to the points raised.[250]

182. Ms Murphy said that she understood the ACM Guidelines to mean that consultation should happen rather than Ms Murphy necessarily herself being required to consult.[251] In that respect, the ACM Guidelines provide in respect to Level B consult as follows:

Following a discussion with the woman about the need for consultation and the woman offering informed consent, it is the midwife's responsibility to initiate consultation with a medical practitioner (or other health care provider), as indicated. The midwife must clearly communicate and document the indication(s) that require consultation with the relevant medical practitioner or other health care provider.[252]

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[246] Ms Murphy's evidence, T 299
[247] Ms Murphy's evidence, T 303, 305 - 306
[248] Further statement of Baby R's mother, CB 478 [8(c)]
[249] Dr Woods' evidence, T 441 – 442
[250] Mr Cooke's evidence, T 517
[251] Ms Murphy's evidence, T 376
[252] ACM Guidelines, CB 297

183. Ms Murphy acknowledged that this was the wording of the guideline and that she did not herself have any communication with Dr Moule in relation to Baby R's mother during the pregnancy.[253]

184. Dr Wood considered that for the purposes of the ACM Guidelines, the appropriate practitioner to be consulted about a history of previous caesarean section, macrosomia and postpartum haemorrhage being category Level B/C, was a specialist obstetrician, not another midwife such as Ms Lapeyre.[254]

185. The purpose of the consultation would be to have another balanced view around the benefits and risks of home birth and VBAC at home, to support Baby R's mother in the informed decision-making process and introduce her back to the hospital where she had had a previous traumatic experience.[255] It would also enable obtaining advice and support from the hospital to which transfer and referral might be required.[256]

186. Dr Woods noted that the ACM guidelines also include commentary around using clinical judgement and referring to clinicians who have the consultation required as part of their normal scope of practice.[257] He said while discussion with colleagues is good practice "…it does not replace … consultation or escalation to other practitioners."[258] Given the previous caesarean section was in the scope of practice of a specialist obstetrician and some general practitioner obstetricians, the expectation would be that the consultation would be with someone with that surgical ability.[259]

187. Dr Cooke also considered the appropriate practitioner for a Level B consultation under the ACM Guidelines was a specialist obstetrician so that Baby R's mother "…could receive the necessary information to make her decision"[260] and the "... the highest level of consultation."[261] It was not a consultation with another midwife with the same skills

[253] Ms Muphy's evidence, T 376 – 377
[254] Dr Woods' evidence, T 477 – 478
[255] Dr Woods' evidence, T 444
[256] Dr Woods' evidence, T 439
[257] Dr Woods' evidence, T 439
[258] Dr Woods's evidence, T 439
[259] Dr Woods' evidence, T 477 – 478
[260] Report of Dr Cooke, CB 261
[261] Dr Cooke's evidence, T 513 – 514

but about bringing everyone to the table and obtaining input from an obstetric colleague.[262] Dr Cooke considered that Baby R's mother should have been told that it was recommended and important that she have a discussion with an obstetrician to discuss the past delivery and obstructed labour which could occur again.[263] Ideally, that appointment would be with Ms Murphy[264] and at the hospital as this is where the transfer, if required, would happen and involve the hospital that would be making the clinical decision at the time of transfer and with responsibility for the outcome of the pregnancy.[265]

188. Dr Cooke noted that the appropriate practitioner for a Level B consultation will differ and may give rise to consultation with another health care provider such as a physiotherapist or a dietician depending on the circumstances.[266]

189. Aside from the guidelines, Ms Murphy did not consider that she needed to consult with an obstetrician during the antenatal care of Baby R's mother as the risk factors at the beginning of the pregnancy had remained unchanged and would become more important in labour.[267]

190. Dr Woods considered that Baby R's mother should have had the opportunity to see an obstetrician at some point during the pregnancy but that it was ultimately Baby R's mother's choice.[268] He also noted that Ms Murphy had an opportunity to reach out to Dr Yuen with a more individualised approach, which would not necessarily be the standard 36 weeks consultation.[269]

191. Dr Cooke considered there had been sufficient discussion around some risks such as scar dehiscence,[270] but insufficient information about the possibility of another

[262] Dr Cooke's evidence, T 515
[263] Dr Cooke's evidence, T 568 – 569
[264] Dr Cooke's evidence, T 571
[265] Dr Cooke's evidence, T 596
[266] Dr Cooke's evidence, T 597
[267] Ms Murphy's evidence, T 303, 333
[268] Dr Woods' evidence, T 444
[269] Dr Woods' evidence, T 468
[270] Dr Cooke's evidence, T 535

obstructed labour and management of the labour if it did start to obstruct.[271] Dr Cooke also agreed that Baby R's mother's decision was being made without the view of an obstetrician.[272]

192. Overall, Dr Cooke considered Baby R's mother was in a position to make an informed decision about attempting homebirth.[273] In coming to that view, Dr Cooke acknowledged that she had factored in Baby R's mother having a level of knowledge as a midwife and having an understanding of the system and, as such, she may not have accepted an offer to see an obstetrician. Dr Cooke considered that Baby R's mother probably made assumptions about the conversation that she might have had with an obstetrician and therefore made a decision not to have that conversation because she did not want to have her decision changed.[274]

193. Dr Woods said that as Ms Murphy was Baby R's mother's "…primary maternity care provider, it was… most important for her to ensure comprehensive discussion of any benefits and risks related to [Baby R's] mother's risk factors and care choices was documented to reflect shared decision making and a fully informed choice was being made."[275]

194. In evidence, Dr Woods acknowledged the further materials, including Baby R's mother's signed consent form, which had been provided since his report.[276] Dr Woods considered that the consent form was generic, with commentary around informed decision making, understanding risks and the use of the consultative process. He considered that additional to this, there needed to be individualised decision making and that:

… as part of completing this consent form to make it [a] valid and informed decision making process incorporating Baby R's mother's beliefs, preferences, choices and the benefits and risks of the aspects of her health that she brings into pregnancy, should be

[271] Dr Cooke's evidence, T 533 – 535, 562 – 563
[272] Dr Cooke's evidence, T 579 – 580
[273] Dr Cooke's evidence, T 535
[274] Dr Cooke's evidence, T 505, 510, 535
[275] Report of Dr Woods, CB 243 [136]
[276] Dr Wood' evidence, T 449

clearly documented as well, so that the generic form then becomes an individual form, supported by antenatal record documentation.[277]

195. Dr Woods said there was no documentation of a discussion on the benefits and risks of VBAC homebirth including any agreed alterations to standard recommended care relevant to homebirth. In his opinion, Ms Murphy's documentation did not reflect the quality or quantity of information sharing that would be expected from a maternity clinician when discussing pregnancy care and birth planning in the context of the mother's beliefs and wishes, her risks, VBAC, suitability for homebirth, the benefits and risks of proposed care including mode and place of birth.[278]

196. Dr Woods said the lack of documented evidence of information sharing and shared decision-making, made it difficult to provide an opinion about whether Baby R's mother was making fully informed decisions around the care she received throughout her pregnancy and labour care.[279]

197. Ms Murphy said that she tried not to treat Baby R's mother differently because of her background as a midwife but acknowledged that she may have done so including in relation to the potential for obstructed labour because she knew that Baby R's mother was aware of it and taking steps to avoid it happening again.[280]

198. Dr Cooke considered that Baby R's mother's previous knowledge as a midwife would have made the discussion more challenging and complex for Ms Murphy but the skill was to put it to the side to have a reasonable conversation,[281] and to have a different conversation which might be to ask questions of Baby R's mother about what she considered was going to happen with her labour.[282]

[277] Dr Wood' evidence, T 448
[278] Report of Dr Woods, CB 244 [141]
[279] Report of Dr Woods, CB 238 [74]
[280] Ms Murphy's evidence, T 363 – 364
[281] Dr Cooke's evidence, T 512
[282] Dr Cooke's evidence, T 563 – 564

The 36 Week Appointment

199. Ms Murphy acknowledged that there was a more relevant history which should have been included in the referral letter to Bendigo Health for the 36 weeks booking-in appointment, including postpartum haemorrhage and macrosomic baby. However, she also said that the letter would have prompted the hospital to retrieve the medical history from the records which would include this information.[283]

200. Ms Murphy said in evidence that, rather than putting in the referral letter that Baby R's mother did "…not *need* to see an obstetrician for a routine 36 week appointment", she should have instead said that Baby R's mother did not *want* to see an obstetrician as her memory was that this was the case.[284]

201. She also said that she generally recommended a booking-in appointment and would additionally recommend an obstetric appointment if there was a problem she was concerned about.[285]

202. Ms Murphy said she would have discussed with Baby R's mother that the hospital would want her to meet with an obstetrician and made her aware of the recommendation that women who have had a previous caesarean section are not suitable for homebirth. She did not consider that a consultation with an obstetrician would have changed Baby R's mother's mind as Baby R's mother was already cognisant of the risks but acknowledged that she would have had another opinion.[286]

203. Baby R's mother said that she did not see the relevance of a meeting with an obstetrician.[287]

204. Ms Murphy said she did not believe an obstetric appointment would give any positive contribution to her pregnancy care,[288] and that she "…didn't know what other

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[283] Ms Murphy's evidence, T 327
[284] Ms Murphy's evidence, T 327
[285] Ms Murphy's evidence, T 367
[286] Ms Murphy's evidence, T 328 – 329
[287] Further statement of Baby R's mother, CB 484 [42]
[288] Ms Murphy's evidence, T 330

information they would've provided, except to perhaps reinforce the guidelines are against women having homebirths after caesarean sections. But I believe that Baby R's mother was aware that that was not generally recommended…".[289] Further Ms Murphy was concerned that if Baby R's mother went to Bendigo Hospital, they "... would be unpleasant in their dealing with her, and … it wouldn't be very useful to her."[290]

205. Dr Cooke said a 36 week appointment would have been helpful and it was not for Ms Murphy to determine attendance, rather it was for Baby R's mother to decide based on a discussion about the risks of the birth and the benefits of attending.[291]

206. Dr Cooke said that the referral letter did not outline the risk factors and the reference to the mother not needing to see an obstetrician for a routine 36 week visit would have been a 'red flag' for her. If she received such a letter, she would ignore it and proceed with a referral to an obstetrician, which is what the midwife did, but was open to misinterpretation and could have been accepted by the midwife.[292]

207. Dr Cooke said that the letter should have included information about the previous delivery, even in dot point form, as the ability to access hospital notes is not always there and time constraints might prevent information being accessed.[293]

208. Dr Woods said it was Ms Murphy's role as the primary practitioner to provide Baby R's mother with information about the purpose of the 36 week gestation appointment,[294] but acknowledged that given Baby R's mother's background as a midwife it would be expected that she might know what the purpose of the meeting would be.[295]

[289] Ms Murphy's evidence, T 334
[290] Ms Murphy's evidence, T 367
[291] Dr Cooke's evidence, T 571 – 572
[292] Dr Coke's evidence, T 518
[293] Dr Cooke's evidence, T 595
[294] Dr Wood's evidence, T 469
[295] Dr Wood's evidence, T 483

209. Dr Woods considered the referral letter should have included more information about Baby R's mother's previous and current pregnancy to support triaging of the appointment and the conversations.[296]

210. Ms Murphy confirmed that she did not receive the completed 'Shared Care Form' from Bendigo Health following the booking-in appointment with its reference to Baby R's mother being high risk and not suitable for GP shared care. She said that had she received it, she would have discussed it with Baby R's mother but does not consider it would have changed her own opinion about the value of seeing an obstetrician at the time.[297]

211. Ms Murphy agreed that not attending an appointment with an obstetrician at 36 weeks was a missed opportunity for Baby R's mother to receive more information to make an informed decision about homebirth.[298]

212. Ms Murphy did not consider contacting Dr Yuen herself following on from the discussions around collaboration in January 2022 as she did not consider the situation to be so far out of the normal and she was aware of the risks and was advising Baby R's mother accordingly.[299]

Ms Lapeyre

213. Ms Lapeyre's role in the antenatal period was limited to her attendance at the birth plan meeting on 22 July 2022, and potentially some discussion that she may have had with Ms Murphy during the pregnancy. She said she did not normally make notes of such discussions.[300]

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[296] Dr Woods' evidence, T 443
[297] Ms Murphy's evidence, T 330
[298] Ms Murphy's evidence, T 332
[299] Ms Murphy's evidence, T 333
[300] Ms Lapeyre's evidence, T 176

214. Ms Lapeyre did not recall being involved in any discussions with Baby R's mother about obstetric risk and suitability for homebirth (though she was present at the birth plan meeting where some risks were discussed). She expected those discussions to have occurred between Baby R's mother and Ms Murphy.[301]

215. Ms Lapeyre said that she regarded it the role of the primary midwife to discuss with Baby R's mother suitability for homebirth and obstetric risks and to recommend an appointment with an obstetrician. She said she would have done so, however, if a woman declined the recommendation to see an obstetrician, she would honour that.[302] However, she also said that she would explain the benefits of attending an appointment so that the hospital knows the woman, for the woman to familiarise themselves with the hospital and for the obstetrician to have a frank discussion about the risks they perceive.[303] If a woman did decline, Ms Lapeyre would discuss the reasons to see if any could be addressed.[304]

216. Initially, Ms Lapeyre said that as the second midwife, it was not her role to assess and discuss obstetric risks and suitability for homebirth or for her to consult anyone under the ACM guidelines but later acknowledged that to a different degree she too had this responsibility.[305]

217. Ms Lapeyre accepted that, with the benefit of hindsight, Baby R's mother was not suitable for homebirth.[306]

218. Ms Lapeyre considered that the risks in Baby R's mother's pregnancy that were Level B indications under the ACM guidelines required consultation with an obstetrician and she assumed that Ms Murphy had discussed this with Baby R's mother.[307]

[301] Ms Lapeyre's evidence, T 176
[302] Ms Lapeyre's evidence, T 177 - 178
[303] Ms Lapeyre's evidence, T 210 - 211
[304] Ms Lapeyre's evidence, T 248
[305] Ms Lapeyre's evidence, T 176, 180, 215
[306] Ms Lapeyre's evidence, T 191
[307] Ms Lapeyre's evidence, T 184 – 185

219. She gave evidence that she was not aware that Baby R's mother had experienced postpartum haemorrhage in the first delivery. She agreed that this indicated a Level B consultation/C referral under the ACM guidelines. Even if she had been aware of this, she did not consider it was her role to refer but rather to discuss with Ms Murphy.[308]

220. Ms Lapeyre said that for the purposes of consultation for a Level B indication and referral for a Level C indication, a relevant medical practitioner would include a GP obstetrician like Dr Moule or an obstetrician or a phone call to the delivery suite if arising during labour and that the reference to *other health practitioner* in the ACM Guidelines included other midwives.[309]

221. In relation to the birth plan meeting on 22 July 2022, Ms Lapeyre said this was normally chaired by the primary midwife and that her role as the second midwife was to prompt discussion on things that might have been missed or that needed more in-depth discussion.[310] She said it was partly her responsibility to ensure that Baby R's mother was fully informed about her decision to have a homebirth, but this was limited as she was not present during antenatal visits and so lacked a broad view of the period.[311]

222. Ms Lapeyre said she was not aware that the hospital had assessed the mother as high risk and deemed her unsuitable for shared care which she understood to mean that they would want Ms Murphy and the woman to communicate directly with them.[312]

223. She could not recall any discussion during the birth plan meeting about the various RANZCOG, ACM and Safer Care Victoria Guidelines.[313]

224. Ms Lapeyre also said that she and Ms Murphy often worked together acting as primary or secondary midwife and would express opinions and areas of disagreement with each other and would listen respectfully to each other.[314]

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[308] Ms Lapeyre's evidence, T 186
[309] Ms Lapeyre's evidence, T 273 – 276
[310] Ms Lapeyre's evidence, T 194 – 195
[311] Ms Lapeyre's evidence, T 209
[312] Ms Lapeyre's evidence, T 211
[313] Ms Lapeyre's evidence, T 257 – 258
[314] Ms Lapeyre's evidence, T 266-267

225. When asked about how Baby R's mother's obstetric history would potentially impact the safety of Baby R or Baby R's mother during labour, Ms Lapeyre said that if there was an emergency or a totally adverse event there would be transfer to hospital but unless there is something really definite that would prevent a woman from having a homebirth, "… they can do it, and often prove they that they do."[315]

226. However, Ms Lapeyre also said she was not opposed to intervention or transfer to hospital in both emergency and non-emergency situations and that she had withdrawn from providing care to women in the past.[316]

227. Ms Lapeyre said the RANZCOG Best Practice Statement: Birth after Previous Caesarean Section applied to hospitals 'mainly' and that a "…woman who wants to have a home birth because of trauma will, she steps outside of the guidelines, she steps outside of the hospital system."[317] Later, Ms Lapeyre resiled from this position and said she meant that "the work of obstetric and the work of midwifery is different",[318] and she did not wish to say that the guidelines did not apply to homebirth.[319]

Bendigo Health

228. Bendigo Health's involvement in the ante-natal care of Baby R's mother occurred late, at the time of the 36 weeks backup booking-in appointment.

229. Notwithstanding Ms Murphy's referral letter, Ms Carr obtained the relevant history from the medical records and Baby R's mother and assessed that an appointment with an obstetrician was required.

230. Ms Carr gave evidence that her approach to such appointments was to gain an understanding of the woman's knowledge and that she usually asked whether they were

[315] Ms Lapeyre's evidence, T 170
[316] Ms Lapeyre's evidence, T 279
[317] Ms Lapeyre's evidence, T 257
[318] Ms Lapeyre's evidence, T 258
[319] Ms Lapeyre's evidence, T 266

aware of any risk factors.[320] Ms Carr said she discussed the two risks of presenting for the first hospital antenatal consult at 36 weeks and planning a normal vaginal delivery against a previous history of caesarean section.[321] She said that the note "Disc offer of obsc appointment" indicates that this is what would have been discussed at the time.[322]

231. Further, Ms Carr gave evidence that she would have used the words 'high risk' in relation to the history of caesarean section and presentation at 36 weeks. She said it was her usual practice to write in the notes that she had flagged with the patient that they were 'high risk' but acknowledged that there were no notes in this case.[323]

232. Baby R's mother said she did not recall the discussions Ms Carr said she had with her nor an offer of an appointment with an obstetrician.[324]

233. Ms Carr said it was not within her scope of practice to counsel Baby R's mother on the most suitable mode of birth, and this was a discussion to have with a specialist obstetrician.[325] Dr Cooke agreed and said that the role of the midwife doing the booking-in telephone consult was to obtain the obstetric history and decide whether there are risk factors that needed to be escalated to an obstetrician.[326]

234. Dr Davis said she assessed the pregnancy as high risk and recommended that Baby R's mother be offered an appointment with an obstetrician. [327] She said she was concerned that in stating that Baby R's mother did not need to see an obstetrician for a routine 36 week appointment that the private midwife was practising outside of the ACM guidelines and was concerned about the plan for homebirth given the obstetric risk factors.[328] Dr Davis said it was known that the identified risk factors were associated with a low chance of being able to have a vaginal birth in a subsequent pregnancy so it

[320] Ms Carr's evidence, T 119
[321] Ms Carr's evidence, T 123 – 124
[322] Ms Carr's evidence, T 120, 123
[323] Ms Carr's evidence, T 125 – 126
[324] Second further statement of Baby R's mother, CB 515 [4]
[325] Statement of Ms Carr, CB 493
[326] Dr Cookes' evidence, T 570
[327] Dr Davis said in evidence that she was also aware of the postpartum hemorrhage but considered this the least of the concerning risks that needed to be discussed, T 129
[328] Statement of Dr Davis, CB 73

was highly likely that the patient would need hospital based care.[329] Dr Davis spoke with the clinical head of the unit, Dr Yuen, and from this discussion decided to call Ms Murphy. [330]

235. Dr Yuen gave evidence that Dr Davis showed her the referral letter from Ms Murphy. She described it as "unusual" as it referred to Baby R's mother not needing to see an obstetrician, making this a backup booking only without any referral for consultation. However, as the pregnancy was considered to be high risk, there was agreement that a consultation with an obstetrician was warranted, and they decided to offer an appointment followed by a call to Ms Murphy as they did not want the offer of an appointment to be seen as disrespecting Ms Murphy's letter.[331]

236. Dr Woods described the review as a 'desktop review' which accurately identified Baby R's mother's risk factors and, despite the note from Ms Murphy that Baby R's mother did not need to see an obstetrician, an appointment was offered. With these limitations, Dr Woods considered this was adequate and reasonable and gave Baby R's mother the opportunity to see an obstetrician to discuss pregnancy care, labour and birth plans.[332]

237. Dr Davis gave evidence that she called Ms Murphy on her mobile but was unable to leave a message.[333] Ms Murphy said she did not believe she received a call.[334]

238. Dr Davis said that she did not pursue the contact with Ms Murphy given that there had been a recommendation for Baby R's mother to come in for an appointment.[335] She also said that she did not write to Ms Murphy as, at the time, her impression was that the 'Shared Care Form' had been sent to Ms Murphy as the referring clinician.[336] She said she may have asked for the form be sent to Ms Murphy had she known that it had not. Otherwise, she did not consider she would have attended to any other

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[329] Dr Davis' evidence, T 140 – 141

[330] Dr Davis' evidence, T 128, 141. Dr Davis was a consultant obstetrician at the time of these events and is now the clinical head of Obstetrics, the role that Dr Nicola Yuen was in at the time of these events.

[331] Dr Yuen's evidence, T 99

[332] Report of Dr Woods, CB 243 [132]

[333] Statement of Dr Davis, CB 73; Dr Davis' evidence, T 153

[334] Ms Murphy's evidence, T 417

[335] Statement of Dr Davis, CB 73

[336] Dr Davis' evidence, T 141

correspondence, noting the context that she would be triaging 15 to 20 patients at the time.[337]

239. Dr Yuen said, looking back, written correspondence could have been sent to Ms Murphy referring to risk factors that may require counselling around the choice of homebirth.[338] She said an email to Ms Murphy requesting Baby R's mother be referred to the hospital would then have required Ms Murphy to discuss this with Baby R's mother and for the mother to consent and have an understanding of the referral.[339]

240. Dr Woods said there was an opportunity for the maternity team to communicate in writing back to Ms Muphy around the decision in the desktop review which may have been passed on to Baby R's mother, potentially prompting further discussion about the appointment.[340]

241. As to the option of a midwife calling to recommend the obstetric appointment, Dr Davis said a midwife would call if further information needed to be obtained from Baby R's mother to make a recommendation, but otherwise administrative staff would manage scheduling an appointment.[341] Dr Davis also did not consider the call being made by Ms Carr, the midwife with whom Baby R's mother had attended, would take things further because Ms Carr had already offered an obstetric appointment.[342]

242. Dr Davis was asked whether there was value in the call coming directly from her as the obstetrician, given Baby R's mother had indicated that she would not be accepting an appointment. Dr Davis considered that she did not have Baby R's mother's consent to contact her given the letter from the referring midwife and the information provided by Ms Carr. She also said:

... information needs to be provided to patients in [a] way that it can be heard and calling somebody out of the blue, without notice, is not the way to have a conversation

[337] Dr Davis' evidence, T 141 – 142
[338] Dr Yuen's evidence, T 100
[339] Dr Yuen's evidence, T 102
[340] Dr Wood's evidence, T472
[341] Dr Davis' evidence, T 138
[342] Dr Davis' evidence, T 138 – 139

that is going to affect any change in behaviour and it's just as likely to alienate people and make them feel like they're not welcome to receive care or that their choices are going to be judged and so my decision to not contact the patient directly on that day was informed by her expressed wishes that she didn't want to talk to an obstetrician.[343]

243. Dr Yuen said communicating directly with Baby R's mother about risk was difficult when a relationship had not yet been formed which is why the woman is usually invited in to have that conversation.[344] Dr Yuen said there was a risk of being seen as harassing a patient and that this is how repeated contacts had previously been viewed.[345] Dr Cooke also said direct contact by the obstetrician was an option but might look a bit like the hospital was harassing to the patient.[346]

244. Dr Davis was also asked whether written correspondence could have been provided to Baby R's mother but said it was a "very nuanced conversation that you need to have" and that the available information was not sufficient to advise fully. She said conversations with patients about risks and benefits needed to be individualised and required fact finding about what is motivating the person to make the choices they are making and what is important to them and this is the approach that would have been taken had Baby R's mother attended an appointment with her.[347]

245. In relation to the Shared Care Form, Ms Carr said this is usually sent to the patient's doctor or general practitioner as they are typically the referrer. She was not aware of communication or correspondence being sent directly back to private midwives as a process at Bendigo Health, or elsewhere, even where the general practitioner was not the referring practitioner.[348]

246. After these events, Dr Davis became aware that the Shared Care Form she completed had not been sent to Ms Murphy. She now explicitly writes on the form which practitioners are to receive it. However, Dr Davis was unable to say whether this was a

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343 Dr Davis' evidence, T 131
344 Dr Yuen's evidence, T 100
345 Dr Yuen's evidence, T 101 – 102
346 Dr Cooke's evidence, T 577 – 578
347 Dr Davis' evidence, T 132 – 133
348 Ms Carr's evidence, T 121

common practice across Bendigo Health. She said there was possibly scope to implement a stricter approach as to who receives forms and correspondence back from referrals at Bendigo Health.[349]

247. Dr Yuen said the Shared Care Form should have been sent to Ms Murphy as the referring practitioner as it was important, as part of the communication loop, for the referring practitioner to be aware of decisions made or about other matters.[350]

248. Dr Davis also spoke about changes that had been made to the Shared Care Form since these events,[351] noting the form better reflected the available models of care, was clearer as to whether the patient had been seen and by whom and allowed for the inclusion of additional information if high risk care was indicated.[352]

249. The updated Shared Care Form has a box for the referrer's details which are completed by administrative staff. Dr Davis acknowledged that where the referrer was not a GP, as occurred here, it would still require the consultant completing the form to specifically write on the form for it to be copied to a specific practitioner.[353]

250. Dr Davis was also asked about the letter that Baby R's mother received in the "Green Book" following the first delivery indicating she was suitable for VBAC. Dr Davis noted that the letter aimed to provide information about whether there were any contraindications which would make it dangerous to try for vaginal birth after caesarean section at all.[354]

251. Dr Yuen said that in circumstances such as this, ideally in the antenatal period, there would have been an opportunity to collaborate on the plan for intrapartum care so that it was made ahead of time. It would allow for informed decision making on behalf of the woman and an opportunity to address Baby R's mother's traumatising experience by coming into the hospital so if transfer was needed, the hospital would be in a better

[349] Dr Davis' evidence, T 135 – 136
[350] Dr Yuen's evidence, T 92
[351] Shared Care form, CB 511
[352] Dr Davis' evidence, T 145 – 146
[353] Dr Davis' evidence, T 162
[354] Dr Davis' evidence, T 146 – 147

place to reduce her trauma. Dr Yuen said it would be expected that a care plan would be developed between Baby R's mother and her midwives around what would be the triggers for transfer or when the hospital would be contacted which may have been at the onset of labour with subsequent updates.[355]

CARE AND COMMUNICATION DURING LABOUR

252. In Dr Wood's opinion, the labour care did not accord with the recommendations in the SCV Care during Labour and Birth Clinical Guideline. He said during labour there were newly arising risk factors requiring escalation of care. These risk factors required discussion with Baby R's mother and contact with Bendigo Health to discuss ongoing care and to arrange referral.[356]

253. At the time of the first VE at 10:25am (when Baby R's mother was 7cm dilated), Dr Woods would have expected that there would be documented an ongoing plan anticipating further progress with birth to occur after five hours. This would include further VE being performed after two to four hours to ensure further progress.[357]

254. Dr Cooke noted that at the time of the VE at 10:25am, Baby R's mother had been in labour for 5 to 7 hours. For a second pregnancy the progress was satisfactory though a little slow and the presence of an anterior cervical lip was not reassuring. In evidence, Dr Cooke explained that the presence of the anterior lip is often an indication that the baby is in a posterior position, with the head pressing on one area of the cervix rather than across the whole cervix and slowing the labour as the cervix will not dilate as well. This necessitated closer observation and the option of a recheck of cervical dilation within the next couple of hours.[358]

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[355] Ms Yuen's evidence, T 105
[356] Report of Dr Woods, CB 244 [146]
[357] Report of Dr Woods, CB 244 [149]
[358] Report of Dr Cooke, CB 263; Dr Cooke's evidence, T 539

255. Dr Woods said that a thick anterior lip might indicate malposition and may have been the first sign that what happened in Baby R's mother's first labour may be occurring again.[359] He would recommend discussing the findings with the mother and putting a plan in place, to gauge the mother's thoughts on a further assessment, which would include a VE.[360]

256. Dr Cooke considered a trigger point in the labour was at 2:46pm when it was queried whether the baby was in the occipito posterior position and Baby R's mother said she felt stuck like last time and was considering an epidural. Dr Cooke said it would have been good practice to perform a VE at this time when it would be anticipated that Baby R's mother would be fully dilated and that the baby's head would be starting to progress through the pelvis. It would be expected that Baby R's mother would be having her baby and Baby R's mother's comment about being stuck was not a reassuring sign.[361]

257. Dr Cooke said this was also the time to discuss with Baby R's mother the risks and benefits of staying home or transferring to hospital, noting that a posterior position lengthens labour and places pressure on the anterior cervix, causing the cervical lip and labour dystocia. This was the complicating factor in the first pregnancy.[362]

258. Dr Cooke said exploring what Baby R's mother meant by feeling stuck would allow for conversation and the value of that was giving a woman options including not staying with their first choice. At that point, transfer to hospital did not mean caesarean section but change of environment and potential for pain relief.[363]

259. Ms Murphy said she did not consider another VE was needed within two to five hours of the VE at 10:25am. She said less VEs are performed in homebirths than in a hospital setting and there were other ways to assess labour progress apart from cervical dilation, such as location of the baby's heartbeat lower in the abdomen, the sacrum bulging out and anal dilation.[364] Ms Murphy distinguished the recommendations in the RANZCOG

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[359] Dr Woods' evidence, T 451
[360] Dr Woods' evidence, T 452
[361] Report of Dr Cooke, CB 263; Dr Cooke's evidence, T 540 – 541
[362] Report of Dr Cooke, CB 263 – 264; Dr Cooke's evidence, T 539 – 542
[363] Dr Cooke's evidence, T 542 – 543
[364] Ms Murphy's evidence, T 340

Best Practice Statement: Birth after Caesarean for two-hourly assessments from 7 cm dilation to help detect secondary arrest of labour and for there to be a clinical reassessment by an experienced obstetrician if there is a lack of progress on the basis that these were checks on progress that would occur in hospital. Ms Murphy said, "we recognise that labour can be a varying length of time which is not necessarily indicating obstruction and women are able to labour for longer when they're at home because we don't have the strict guidelines that RANZCOG recommends."[365]

260. However, Ms Murphy acknowledged that the ACM guidelines provide, in relation to prolonged labour in the active first stage of labour (more than 6 cm), for consultation or referral, i.e. Level B/C, when there is no cervical change in four hours. She also acknowledged that as a VE had not been performed within four hours, cervical change could not be assessed.[366]

261. Ms Murphy noted that in response to the circumstances at 2:46pm, different physical movements were tried to help get the baby into an anterior and more favourable position for birth but, in retrospect, she could see that it would have been helpful to undertake a better assessment with a VE.[367]

262. Ms Lapeyre agreed that at 3:46pm, when the notes referred to long contractions lasting one and half to two minutely every five minutes, it could have been useful to perform a VE to assess the progress of labour, with Baby R's mother's consent.[368]

263. The next VE took place at 5:56pm, some seven hours after the first at 10:25am.

264. Other than the two VEs performed at 10:25am and at 5:56pm, Ms Lapeyre did not recall any other VE being offered or refused by Baby R's mother during the labour.[369]

265. Dr Woods considered the presence of fresh meconium liquor at 3:10pm should have alerted Ms Murphy to a change in the baby's condition and probably represented a

[365] Ms Murphy's evidence, T 341
[366] Ms Murphy's evidence, T 342
[367] Ms Murphy's evidence, T 344
[368] Ms Lapeyre's evidence, T 238, 239
[369] Ms Lapeyre's evidence, T 250

foetal physiological response to stress, which was likely to be hypoxic in origin.[370] This should have prompted a discussion with Baby R's mother and a revisiting of the birth plan with consideration for transfer to Hospital.[371] He noted that the RANZCOG Intrapartum Fetal Surveillance Clinical Guideline recommended that there be continuous electronic monitoring in the presence of meconium-stained liquor.[372]

266. Ms Murphy acknowledged that Baby R's mother had not been told about the RANZCOG recommendation for continuous foetal monitoring in the presence of meconium liquor at the birth plan meeting.[373]

267. Dr Cooke considered that a very serious discussion regarding transfer to hospital should have occurred in the presence of meconium liquor as this was an early warning sign of potential foetal distress.[374]

268. Dr Cooke considered a VE was also important at that time to assess how close delivery was, by determining the position and station of the baby's head (whether the baby had entered the pelvic canal). In the context of the baby having passed meconium this information would impact decision making at that point.[375]

269. Dr Woods noted that if the plan at this time was to increase the frequency of the intermittent foetal heart auscultation in the presence of meconium liquor (i.e. listen to the heart rate every 15 minutes as stated by Ms Lapeyre), this did not occur. The auscultation which did occur did not accord with the RANZCOG Intrapartum Fetal Surveillance Clinical Guidelines which provides for auscultation every 15 to 30 minutes in the active phase of the first stage of labour and with each contraction or at least every 5 minutes in the active second stage of labour.[376] Rather, the frequency of auscultation was between 10 to 76 minutes throughout the labour. There was no recognition whether Baby R's mother had entered the active second stage of labour

[370] Report of Dr Woods, CB 245 [151]
[371] Report of Dr Woods, CB 245 [153] – [154]; Dr Woods' evidence, T 455
[372] Report of Dr Woods, CB 245 [152]
[373] Ms Murphy's evidence, T 320
[374] Report of Dr Cooke, CB 264
[375] Dr Cooke's evidence, T 610 – 611
[376] Exhibit 4 RANZCOG, Intrapartum Fetal Surveillance (4th ed, Clinical Guideline, 2019), 13

when full dilatation was noted at 6pm and when increased monitoring would be required. The notes about the auscultations did not refer to timing in relation to contractions nor how long the foetal heart was auscultated for. There was also no differentiation with Baby R's mother's pulse.[377]

270. Ms Murphy acknowledged that after meconium liquor at 3:10pm, closer monitoring of the heart rate meant taking the heart rate around 15 minutes but that this did not happen "…as well as it should have."[378]

271. Dr Woods also noted that the heart rate was lower than what would be expected at 3:20pm and 6pm and higher than expected at 3:37pm. Dr Woods considered this should have led to a recommendation to further evaluate the heart rate with continuous monitoring and for there to be a discussion with Baby R's mother and referral to Hospital.[379]

272. In Dr Woods' opinion, a full assessment of the labour should have been completed by 3:25pm at the latest and certainly earlier when the meconium-stained liquor was apparent.[380] A full assessment would include obtaining the woman's perspective and a VE assessing the position of the baby's head, the presenting part and the station of the head. If the labour was progressing there would be an expectation of descent and rotation of the foetal head as well as dilatation of the cervix. [381]

273. The assessment findings would be discussed with Baby R's mother with a recommendation for transfer to hospital allowing time at the hospital for a full assessment and resulting in birth within an hour of arrival and certainly by 7pm.[382]

274. Similarly, Dr Cooke noted that at 3:30pm, given the labour progress after 12 hours with no signs of the baby being born soon and the previous history, multidisciplinary input was required and the baby would have benefitted from a foetal welfare review with

[377] Report of Dr Woods, CB 245 [157] – [158]
[378] Ms Murphy's evidence, T 319, 348
[379] Report of Dr Woods, CB 245 [161]
[380] Report of Dr Woods, CB 246 [165]
[381] Dr Woods' evidence, T 453
[382] Report of Dr Woods, CB 246 [166] – [168]

EFM or a scalp pH test.[383] Dr Cooke explained that a scalp pH involves taking a blood sample from the baby's head to measure the pH and lactate in the umbilical cord blood providing a more accurate test of foetal welfare than a foetal heart rate pattern.[384] Dr Cooke considered this was the point when Baby R's mother should have been strongly encouraged to transfer to Bendigo Hospital.[385]

275. The meconium liquor was described by Baby R's mother as "yellowy-brown" [386] and by Ms Lapeyre as "thick" and "dark".[387] Both Ms Murphy and Ms Lapeyre agreed that these descriptions fell within the definition of significant meconium stained liquor in the ACM guidelines, being dark green or black that is tenacious or containing lumps of meconium, which is a Level B/C indication for consultation/referral.[388]

276. Both Ms Lapeyre and Ms Murphy acknowledged that there should have been more discussion with Baby R's mother at the time of the meconium liquor and discussion with a relevantly qualified medical practitioner which included Dr Moule, Dr Yuen or a call to the delivery suite of the hospital.[389]

277. Ms Lapeyre said that she deeply regretted not giving Baby R's mother choice when there was meconium liquor and that this went "…against everything that I am as a midwife."[390]

278. Ms Murphy said that the presence of meconium liquor was not discussed properly.[391] Ms Murphy said she had many regrets about not stopping and having a proper conversation at this time and she knew it was not adequate.[392] She acknowledged that

[383] Report of Dr Cooke, CB 264; Dr Cooke's evidence, T 545 – 547
[384] Dr Cooke's evidence, T 544
[385] Report of Dr Cooke, CB 264
[386] First statement of Baby R's mother, CB 33 [83]; Ms Lapeyre's evidence, T 224, 251
[387] Ms Lapeyre's evidence, T 224, 251
[388] Ms Lapeyre's evidence, T 251 – 252; Ms Murphy's evidence, T 345
[389] Ms Lapeyre's evidence, T 225; Ms Murphy's evidence, T 345 – 346, 364
[390] Ms Lapeyre's evidence, T 197
[391] Ms Murphy's evidence, T 364; Ms Murphy acknowledged that the mother being a midwife may have affected this aspect of the care provided.
[392] Ms Murphy's evidence, T 348

a discussion about transfer to hospital did not occur and with the benefit of hindsight should have.[393]

279. The statement from Baby R's mother is consistent with this. She said the first time the possible need for transfer to hospital was raised was in the presence of meconium liquor, though it is not clear who raised this as both Ms Murphy and Ms Lapeyre say transfer was not discussed. Baby R's mother assumed they would be transferring at this point but was told by Ms Lapeyre not to worry and that they would be monitoring more closely.[394]

280. Baby R's mother expressed that she wished she had advocated for herself and asked:

"... "okay, so what does more monitoring look like?" so that I could've discerned whether we were on the same page. If we were not on the same page, I could have decided whether the monitoring was adequate. But I didn't do this and that is very hard to live with."[395]

281. Ms Murphy agreed that by 3:30pm, given the previous posterior position of the baby, Baby R's mother's comments about feeling stuck at 2:46pm and the meconium liquor, there should have been a discussion with Baby R's mother about transfer.[396] Ms Muphy agreed that such a discussion would provide Baby R's mother with time to consider, noting that as part of the birth plan, Baby R's mother had said that in an emergency they would rather have time to process. Ms Murphy agreed that such a discussion would allow for a multidisciplinary team discussion with Bendigo Health to assist in the decision making but also said that once contact was made with the hospital, the expected advice would be to transfer in order to make a proper assessment.[397] Ms Murphy said if she had seriously recommended transfer at that point, Baby R's mother likely would have agreed.[398]

[393] Ms Murphy's evidence, T 346
[394] Further statement of Baby R's mother, CB 485 [47]
[395] Further statement of Baby R's mother, CB 485 [47]
[396] Ms Murphy's evidence, T 350 – 351
[397] Ms Murphy's evidence, T 351 – 352
[398] Ms Murphy's evidence, T 351 – 352

282. Dr Cooke said that at 6:22pm, when the heart rate was 119 bpm, the contractions were 10 to 15 minutes apart and described as mild, this was an indication that Baby R's mother was tired and the labour was slowing. Monitoring the FHR was very important and auscultation of the heart rate every 15 to 30 minutes was insufficient and needed to be done every 5 minutes or after every contraction. Further, plotting the heart rate was important to obtain a trend.[399]

283. Dr Woods said from 6:55pm, the heart rate was high at 170 bpm, and when identified this should have prompted discussion and hospital transfer.[400]

TIMING OF HYPOXIC INJURY

284. Dr Woods addressed the likely timing of the hypoxic injury noting that this was limited by the available information. He explained that a baby can experience hypoxic stress during labour and have enough reserves not to suffer hypoxic injury. However, when exposed to severe or prolonged hypoxic stress even a baby with the highest reserves can suffer hypoxic injury.[401]

285. Dr Woods considered that the baby likely experienced gradually evolving hypoxic stress and noted the following:[402]

- The baby likely entered labour well with adequate reserves notwithstanding the identified risk factors.
- Even when there was meconium liquor, the baby was likely still compensating for any stress and, due to having good reserves, likely continued to do so for some time.

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[399] Dr Cooke's evidence, T 550 – 552, 580 – 581
[400] Report of Dr Woods, CB 246 [163]
[401] Report of Dr Woods, CB 249 [195]
[402] Report of Dr Woods, CB 249 [199] – 250 [215]

- The variations in the heart rate from 3:10pm to 6:00pm probably related to decelerations which would be a further sign of a normal physiological compensatory response.

- The likely cause of the hypoxic stress was umbilical cord compression which would evolve gradually.

- The increase in the foetal heart from 6:00pm likely represented an adrenaline response to the ongoing hypoxic stress caused by repetitive cord compression indicating that while the baby was still compensating, its reserves were depleting with the risk of decompensation and hypoxic injury rising.

- By the time the baby's heart rate reached 195 bpm at 7:43pm and on the basis of the CTG trace following the baby's arrival at the hospital at 8:31pm, signs of decompensation were evident. This likely indicated worsening cord compression, further evolving hypoxia with some form of hypoxic neonatal adverse outcome unavoidable.

- It was likely that the changes occurred over several hours. This was also consistent with the results of the umbilical cord blood sample testing which showed an abnormal arterial pH level indicating significant acidosis at 6.88 but normal venous pH level. This was consistent with significant cord compression.

- The hypo coiled umbilical cord identified at autopsy increased the cord's susceptibility to compression. Therefore, it was possible that the evolution of the cord compression, foetal heart rate changes and transition from compensation to decompensation and hypoxic injury occurred in a shorter time frame.

286. Dr Woods considered that had transfer to Bendigo Health occurred at around 3:25pm on 19 August 2022, the hospital would have had an opportunity to undertake a full assessment, respond to an emerging emergency situation and have discussions with the

parents, with birth occurring at some point after that, and the ultimate outcome being avoided.[403]

CONCLUSION

Suitability for homebirth given Baby R's mother's obstetric history and the relevant guidelines

287. By reference to the relevant and applicable procedures and guidelines at the time, Baby R's mother's pregnancy was outside recommended care for homebirth by reason of the previous caesarean section and the pregnancy not being low risk.

288. In evidence, there were some differing views whether the RANZCOG Best Practice Statement: Birth After Previous Caesarean Section applied to midwives, as opposed to obstetricians, and to homebirth as opposed to a hospital setting.

289. I consider that the RANZCOG Best Practice Statement: Birth After Previous Caesarean Section applied to midwives. The target audience was said to be health professionals providing maternity care. The stated objectives included midwives (along with doctors, women and their partners) as those to whom the statement was to provide information about the benefits and risks of mode of delivery following caesarean section. Both Dr Woods and Dr Cooke considered that the Best Practice Statement applied to midwives and all providing maternity care.

290. The Best Practice Statement did not expressly refer to homebirth. It recommended that a VBAC take place in a suitably staffed and equipped delivery suite with continuous intrapartum care and monitoring and with available resources for urgent caesarean section and neonatal resuscitation should complications such as scar rupture occur. As a result, Level 2 maternity services such as Castlemaine Health were not suitable for VBAC as they were unable to provide the recommended monitoring, urgent caesarean

[403] Dr Woods' evidence, T 455 – 456, 485 – 486

section or neonatal resuscitation. It must therefore follow that the effect of the guideline was that birthing at home was also not recommended.

291. Since these events, the Best Practice Guideline has been replaced by the RANZCOG Birth After Caesarean (C-Obs 38) (Clinical Guideline, version 4.1, August 2025) which no longer advises that VBAC take place in a suitably staffed and equipped delivery suite. Rather, it refers to continuous electronic monitoring being *offered* given that uterine scar is an identified risk factor for foetal compromise in labour. However, the earlier wording was applicable at the relevant time. Furthermore, the current Guideline states that "…birth in any other setting than a secondary or tertiary maternity unit…" is out of scope, implying hospital-based setting for the guidance.[404]

292. In any event, the SCV: Birth after Caesarean provided and continues to provide for continuous EFM during labour for VBAC which can only occur in hospital.

293. Further, the SCV Homebirth: Clinical Guidance specifically states that homebirth is a suitable option for women who have not had a previous caesarean section or uterine surgery and have a low risk pregnancy with no pre-existing or occurring medical conditions that may impact on the pregnancy, birth or postpartum period (maternal and foetal).[405]

294. The RANZCOG Statement: Home Births applicable at the time referred to homebirth being particularly dangerous when a pregnancy has any factor that increases the maternal or perinatal risk, to the importance of women being informed of factors critical to reducing potential adverse outcomes and strongly recommended acting in accordance with the ACM National Guidelines for Consultation and Referral.[406] Read together with the RANZCOG Best Practice Statement: Birth After Caesarean Section, it is evident that VBAC was intended to be excluded from homebirth. It is noted that the current guideline provides an evidence-based statement and suggests that discussion include evidence about maternal and neonatal outcomes associated with planned home

[404] Exhibit 13, RANZCOG Birth After Caesarean (C-Obs 38) (Clinical Guideline, version 4.1, August 2025), 4
[405] CB 431
[406] CB 324 - 325

birth compared to hospital birth, for ‘women without identified risk factors for adverse pregnancy outcomes’.[407]

295. The Australian College of Midwives: Position Statement for planned Birth at Home (ACM Position Statement) refers to supporting the choice of planned, midwife attended births at home as a safe option for women with uncomplicated pregnancies and that midwives have a responsibility to establish appropriate consultation and referral processes and collaborative networks using the ACM National Midwifery Guidelines for Consultation and Referral.

296. Taking into account the relevant procedures, guidelines and recommendations and Dr Woods’ expert opinion, I consider that Baby R’s mother’s pregnancy was not suitable for homebirth.

297. I acknowledge Dr Cooke’s view that Baby R’s mother’s pregnancy was suitable for an attempted homebirth, but this was in the context of and with the benefit of a frank and open discussion with Baby R’s mother around relevant risk factors including how these can impact outcomes for mother and baby and coming from a multidisciplinary team.

298. In that regard, the evidence indicated that the risk factors, and how they might impact Baby R’s mother and baby, were not sufficiently discussed and advice was not provided to Baby R’s mother from a multidisciplinary team and by reference to the guidelines and recommended care to enable her to make a fully informed decision.

299. Further, the Australian College of Midwives: National Midwifery Guidelines for Consultation and Referral (ACM guidelines) which are referred to in both the ACM Position Statement and the RANZCOG Statement: Home Births in turn provided for consultation and referral for variances arising during maternity care which for Baby R’s mother were Level B indications for macrosomia and previous caesarean section and Level B/C indications for consult/referral for a minor postpartum haemorrhage. Applying the ACM guidelines, Baby R’s mother required a consultation and possibly

[407] CB 341, 344

a referral during her pregnancy to a relevant medical practitioner or other health care provider. This did not occur.

300. Ms Murphy considered that a consult with a midwife satisfied this requirement, a midwife being a health care provider. No other witness held this view including the experts, Dr Woods and Dr Cooke, who both gave evidence that the appropriate medical practitioner was a specialist obstetrician or Bendigo Health as the back-up hospital.[408]

301. Given the definition of consultation in the ACM Guidelines as the seeking of professional advice from a qualified, competent health care provider with the relevant knowledge and skills to make decisions about the woman's care*,* it is clear that what is contemplated by a Level B consultation is an *escalation* of care. This is distinguishable from a Level A discussion where the guidance specifies that the midwife may discuss clinical situations with a *midwifery colleague*, medical practitioner or health care provider.

302. It is recognised that the escalation of care may not always involve an obstetrician. Depending on the Level B indication, it may indeed be that another health care provider such as an allied health provider is the appropriate practitioner for consultation. However, given the Level B indications for consultation in this case, I consider that the appropriate practitioner was an obstetrician.

303. As to Ms Murphy's understanding of consultation under the ACM guidelines, there is no evidence that Ms Murphy consulted with Ms Lapeyre or any other midwife for the purposes of a Level B consultation under the ACM Guidelines in respect to any of Baby R's mother's obstetric history or conditions that gave rise to such a consultation.

304. Further, I do not consider that Baby R's mother's attendance on Dr Moule on 8 February 2022 was a consultation in accordance with the ACM guidelines. There was no communication from Ms Murphy and Dr Moule's letter was for referral not a response to any communication. It may well be that Baby R's mother attended Dr

[408] Dr Woods' evidence, T 439, 478 – 479; Statement of Dr Moule, CB 49; Dr Moule's evidence, T 29, 56; Dr Yuen's statement, CB 54; Ms Lapeyre's evidence, T 184; Dr Cooke's evidence, T 513 – 514, 596. Also, Dr Davis' evidence, T 140 – 141

Moule at the suggestion of Ms Murphy or because she was aware that Dr Moule and Ms Murphy were known to each other and any clinical oversight referral would be to Dr Moule and this would explain why, having already obtained a referral to see Ms Murphy from Dr Gupta, Baby R's mother attended Dr Moule. However, this would not satisfy the requirement for consultation in the ACM Guidelines and, if this was the intention, it was certainly without Dr Moule's knowledge and could not achieve the aim of the indicated consultation.

305. Dr Moule was not asked specifically whether she regarded her consultation with Baby R's mother as a consultation under the ACM Guidelines during her evidence, which was given prior to Ms Murphy's evidence. She did say she did not regard herself to be Baby R's mother's obstetrician in terms of providing antenatal management. Given the matters already flagged as to the expectations for such a consult, the content of Dr Moule's notes from the consultation and letter of referral to Ms Murphy for ongoing antenatal care, I am satisfied that Dr Moule's single consultation with Baby R's mother did not satisfy the need for a Level B consultation under the ACM Guidelines.

306. I note that a consultation with a specialist obstetrician, as required under the ACM Guidelines, would have contributed to a multidisciplinary team discussion to ensure that Baby R's mother was fully informed including by having an obstetrician's view about her specific risks, suitability for homebirth and the recommendations set out in the relevant guidance documents.

The antenatal care and the reasonableness of the assessments, care and communication provided by the relevant practitioners

307. The communication with Baby R's mother about future pregnancy started with the proforma letter from Bendigo Hospital following the first birth indicating that she was 'suitable for VBAC'. The purpose of the form was to flag that no specific issues had been identified at the time which definitively precluded VBAC in a future pregnancy.

308. The RANZCOG Best Practice Statement: Birth after Caesarean Section supported discussions about VBAC beginning after the primary caesarean section and ideally with the doctor who performed the caesarean section and the midwife who provided care during labour. Discussions would include the reason for the caesarean section and any unexpected issues during surgery that would affect suitability for VBAC in future pregnancies and advice about increasing the success and safety of a planned VBAC. The guidance also referred to the debrief providing an opportunity to address any emotional needs, particularly for patients who found the experience traumatic.[409]

309. I further note that the current RANZCOG Birth after Caesarean Section (C-Obs 38) (Clinical Guideline, version 4.1, August 2025), similarly provides an evidence-based recommendation 17, suggesting that:

> *"… a birth debrief is offered to women with unplanned caesarean section prior to hospital departure as it may improve the woman's understanding of the reason for their caesarean and the options available to them for their next pregnancy."*[410]

310. Example letter templates to general practitioners and women are provided for at Appendix F which include the reasons for and information about the caesarean section.[411]

311. I highlight the above as the ideal scenario for laying the foundations for future consultation and discussion. However, a debrief after a primary caesarean section could not replace discussions with health care practitioners in the context of a planned or actual pregnancy and individualised advice based on a woman's presentation and wishes.

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[409] RANZCOG Best Practice Statement: Birth after Previous Caesarean Section (C-Obs 38) (version 2, March 2019), CB 453 [5.1.3]

[410] Exhibit 13, RANZCOG Birth After Caesarean (C-Obs 38) (Clinical Guideline, version 4.1, August 2025), 9 [Recommendation 17]

[411] Exhibit 13, RANZCOG Birth After Caesarean (C-Obs 38) (Clinical Guideline, version 4.1, August 2025), 9, 37, 49 – 50

312. As noted, I consider that Baby R's mother was not sufficiently and adequately advised during her pregnancy to enable her to make a fully informed decision in relation to her obstetric risks and suitability for homebirth.

313. However, Baby R's mother's background as a midwife, research into homebirth including reviewing Safer Care Victoria literature and an early assumption that homebirth was out of the question suggests that she likely had an awareness that homebirth was outside recommended care for a VBAC and that at any consultation with an obstetrician, the planned homebirth would be discussed and recommendations made in respect of it. She referred to 'fearmongering about a VBAC homebirth' which suggests she may have been cocooning herself from advice that an obstetrician might provide in relation to the decided course of VBAC at home.

314. This is the context in which the various practitioners were providing antenatal care and advice to Baby R's mother and I accept this made the situation a more complex and challenging one. Notwithstanding this, it was necessary for there to be a fulsome discussion with Baby R's mother about obstetric risk, the impact for potential outcomes in this pregnancy, relevant guidance documents and recommended care and for there to be a consultation under the ACM Guidelines.

315. In that regard, I note that it was submitted on Baby R's parents' behalf that they understood some of the risks involved given Baby R's mother's experience and research, however, ultimately relied on the practitioners involved in Baby R's mother's care.[412]

Dr Gupta's Care

316. While Baby R's mother included Dr Gupta as a health care provider that she trusted and whose referral to Ms Murphy led her to believe that she was suitable for homebirth or hospital birth, I consider that Dr Gupta's role was limited.

[412] Submissions on behalf of Baby R's parents, paragraph 25

317. Dr Gupta said that she was not suitably qualified to give detailed information about childbirth and did not discuss birthing options and obstetric risks with Baby R's mother.[413] Baby R's mother said there were no discussions at any of the consultations with Dr Gupta about VBAC, obstructed labour or the suitability or risks of homebirth.[414] Dr Gupta was not involved in Baby R's mother's antenatal care and the consultations during the pregnancy were limited to issues such as iron deficiency, amongst other things.[415]

318. I consider that any contribution that Dr Gupta's referral had on Baby R's mother's belief that she was suitable for homebirth could only have been marginal given Dr Gupta's limited role and in the context of the consultations, care and advice provided to Baby R's mother following Dr Gupta's referral and throughout the antenatal period. Any misapprehension on Baby R's mother's part could easily have been corrected or clarified by the practitioners she consulted for her antenatal care.

319. It is unfortunate that the Shared Care Form from Bendigo Health was sent to Dr Gupta who, in turn did not act on it or discuss it with Baby R's mother, given her limited involvement in Baby R's mother's antenatal care. This underlies the need for communication to be provided back to referrers to allow for ongoing dialogue in the care of a shared patient.

Dr Moule's Care

320. The outcome of Baby R's mother's single appointment with Dr Moule on 8 February 2022 was the referral to Ms Murphy for ongoing antenatal care. Dr Moule said the appointment covered a number of areas not all of which were included in her consultation notes or her referral letter to Ms Murphy. The evidence supports that there

[413] Statement of Dr Gupta, CB 56
[414] Further statement of Baby R's mother, CB 479 [11(b)]
[415] Statement of Dr Gupta, CB 55; Supplementary statement of Dr Gupta CB 513; Dr Aruna Gupta, Consultation notes, CB 59 – 64

was discussion about the risk of uterine rupture, the potential for another macrosomic baby and the potential need for transfer and proximity to the hospital.

321. It was submitted on Dr Moule's behalf that it was reasonable that she did not base her discussions with Baby R's mother around the RANZCOG Best Practice Statement: Birth after Caesarean Section as she had formed the view that it is was directed to hospital settings with no reference to homebirth.

322. I accept that as a GP obstetrician providing intrapartum care at Castlemaine Health, a category 2 maternity service, Dr Moule understood the application of the RANZCOG Best Practice Statement: Birth after Caesarean Section to exclude VBAC there. However, as already stated, it must then follow, by extension, that a VBAC in a home setting without access to emergency caesarean section would also not be recommended.

323. On Dr Moule's behalf, it was submitted that she understandably took guidance instead from the RANZCOG: Home Birth Guidelines which in turn refer to the ACM guidelines with its different levels of consultation and referral depending upon the extent of any identifiable variances from normal arising.[416]

324. I consider it was reasonable for Dr Moule to expect that the midwife she was referring Baby R's mother to would act in accordance with the ACM Guidelines and advise in relation to recommended care. However, notwithstanding this, as a GP obstetrician, I consider that it was Dr Moule's role to outline and advise in relation to recommendations about VBAC and homebirth in accordance with the RANZCOG and SCV guidance documents.

325. I do acknowledge that Dr Moule said that she recommended to Baby R's mother a 36 week booking-in appointment and to see an obstetrician. However, there was no reference to these discussions in Dr Moule's notes, Baby R's mother did not recall them and Dr Moule accepted that she may not have discussed these matters with Baby R's mother. It is therefore difficult to positively conclude that these matters were discussed.

[416] Submissions on behalf of Dr Moule, page 3

326. I have already addressed that I do not consider that the appointment with Dr Moule satisfied the requirement for a consultation with an obstetrician under the ACM Guidelines.

327. However, Dr Moule was a GP obstetrician well familiar with Baby R's mother's history and had an established relationship with her. She had an important role to play in advising Baby R's mother in relation to risks, including the risk of obstructed labour occurring again, and to contribute to the information available to Baby R's mother to consider and upon which to base her decision, particularly given that there was no expectation or arrangement for a further appointment at which such advice could be provided.

328. Dr Moule had this responsibility even while having a reasonable expectation that Ms Murphy would advise Baby R's mother about such matters and would refer to an obstetrician both for the purposes of a referral under the ACM Guidelines and the usual practice of women seeing an obstetrician at 36 weeks at Bendigo Health.

329. Further, Dr Moule's assessment that Baby R's mother was suitable or potentially suitable for homebirth was not consistent with recommended care and the guidance documents from both RANZCOG and SCV. As a GP obstetrician and a RANZCOG member, she was aware of the two relevant RANZCOG guidelines, the Best Practice Statement: Birth after Caesarean Section and Homebirths Statement which applied to her practice. If Dr Moule held her own views about suitability for homebirth that ran counter to those guidance documents, it remained incumbent upon her to advise Baby R's mother that homebirth in the circumstances fell outside recommended care. This was required regardless of Baby R's mother's actual or assumed knowledge of these matters and regardless of her strong desire to have a homebirth.

330. Dr Moule provided some pertinent information in relation to uterine rupture, the significance of the history of macrosomia for this pregnancy and the potential for hospital transfer. However, there is no reference in the notes to discussion about the expectation of a consultation with an obstetrician under the ACM guidelines or usual practice at 36 weeks and Dr Moule's communication was lacking in relation to obstetric

risk, suitability for homebirth and recommended care including by reference to relevant guidelines.

331. Having not covered all the expected matters during the consultation, Dr Moule also did not flag these matters in her referral letter to Ms Murphy. Dr Moule agreed that her single communication with Ms Murphy could have been better to include more information about her recommendation that an obstetric appointment occur, the risks of uterine rupture, the relevant ACM guidelines and RANZCOG recommendation about VBAC. More comprehensive communication with Ms Murphy may have allowed for collaboration between Dr Moule and Ms Murphy during the pregnancy.

Ms Murphy's Care

332. As primary care provider, I find that Ms Murphy had the primary responsibility to advise and make recommendations to Baby R's mother in accordance with accepted midwifery standards and in line with the applicable guidelines relevant to Baby R's mother's pregnancy, obstetric risk and suitability for homebirth.

333. As her primary carer, Ms Murphy, had an obligation to inform Baby R's mother that a homebirth, given her obstetric history, including previous caesarean section, was against recommended care, and to discuss the basis for this together with a full discussion of the risks of proceeding.

334. Instead, Ms Murphy assured Baby R's mother, at a critical early stage when Baby R's mother was querying whether her history precluded homebirth, that she was suitable. The evidence supports that this discussion had already occurred by the time of the consult with Dr Moule on 8 February 2022.

335. Ms Murphy, as the primary care provider was also responsible for advising Baby R's mother of the relevant guidelines and recommendations and for referring Baby R's mother to an obstetrician in accordance with the ACM guidelines and usual practice.

336. The referral should have been to an obstetrician at Bendigo Health, the maternity hospital where Baby R's mother would be attending for intrapartum care or, if Baby R's mother chose to proceed with a homebirth outside of the recommendations following such a consultation, the hospital where she would be transferred if required during labour.

337. I consider that it was Ms Murphy's responsibility to explain the purpose and importance of such a consultation and to recommend attendance by Baby R's mother.

338. I also consider there was a missed opportunity for Baby R's mother and Ms Murphy to meet with a Bendigo Health obstetrician allowing for collaboration and the development of a trusting and respectful relationship, as envisaged by Dr Woods.

339. Had a consultation with an obstetrician been declined by Baby R's mother after being recommended, it was incumbent on Ms Murphy to attend such a consultation. Not only do the ACM guidelines provide for this, but such a consultation would reflect the collaborative arrangements and multidisciplinary communication that is referred to in many of the guidance documents, recommended by both Drs Woods and Cooke and which Dr Yuen sought to engender when she reached out to Ms Murphy and Ms Lapeyre earlier in the year.

340. By contrast, Ms Murphy not only did not refer for a consultation but confined the referral at 36 weeks to a backup booking-in appointment saying that Baby R's mother did not need an appointment with an obstetrician. Further, Ms Murphy provided a referral letter wholly deficient by omitting relevant aspects of Baby R's mother's obstetric history.

341. Ms Murphy's evidence that she would expect the hospital to retrieve Baby R's mother's history from their records is concerning when one considers it is expected practice that practitioners provide clear communication in referrals. Such an approach created a risk that the full history might not have come to the attention of the Bendigo Health staff member allocated to the booking-in appointment. It was also inconsistent with the Midwife Standards of Practice which provide for engagement in professional

relationships and respectful partnerships and timely consultation, referral and documentation.

342. It is unclear whether Baby R's mother was aware that Ms Murphy's referral letter to Bendigo Health said she did not need to see an obstetrician, but she was aware that the referral was a booking-in referral and not for a consultation with an obstetrician. According to Ms Murphy, Baby R's mother did not want to see an obstetrician, and this is what Ms Murphy said in evidence she should have said in the referral letter. Ms Murphy said Baby R's mother was aware that an obstetrician would advise her that she was unsuitable for homebirth and that an obstetric consult would not have changed her mind because Baby R's mother was already aware of the risks.

343. Indeed, Ms Murphy said she did not see any benefit in Baby R's mother seeing an obstetrician as she was not showing signs of macrosomia and was concerned about the hospital being unpleasant and that it would not be useful for her.

344. I consider this was too narrow a view of the content and purpose of a consultation with an obstetrician and it was not for Ms Murphy to assess the contribution or determine the merits and likely impact of such consultation.

345. Not only did this overlook that a consultation was required under the ACM guidelines and is routine practice at 36 weeks, it also runs counter to the purpose of the consultation which Dr Woods referred to as allowing for a balanced opinion around risk factors to help inform the recommendations around pregnancy care to support a woman's choice and the primary practitioner. Such a consultation would provide an opportunity for a frank and open discussion as referred to by Dr Cooke.

346. It was submitted on Ms Murphy's behalf that a collaborative plan could not have been developed as suggested by Dr Woods because Baby R's mother had been deemed ineligible for the GP shared care program and Ms Murphy, as a privately practising midwife, had no formal arrangements with Bendigo Health and no admission rights. It

was submitted that there may have been contact by Ms Murphy with Dr Yuen, but this would not have had the status of a collaborative plan.[417]

347. The Shared Care Form did indeed indicate that the pregnancy was not suitable for shared care, however, there is every indication that a consultation under the ACM guidelines could and should have taken place and a referral for a consultation with an obstetrician was considered the expected care pathway by all the practitioners who gave evidence at the inquest.

348. Furthermore, Dr Yuen had sought to open avenues of communication for any shared patients earlier in the year. Therefore, I do not consider the absence of a formal arrangement in place between Bendigo Health and privately practising midwives such as Ms Murphy, precluded the development of a collaborative care plan for this pregnancy.

349. Ms Murphy also did not consider this was a situation to contact Dr Yuen about because she did not consider the situation so far out of normal and she was aware of the risks and advising Baby R’s mother accordingly. I consider this was also a missed opportunity to provide collaborative care and communication which may have allowed for the development of a plan going forward. Dr Yuen said such a plan could potentially have included the hospital to be notified when labour commenced and the agreed triggers for transfer to hospital if required.

350. I consider such a plan to have been integral to a collaborative arrangement that prioritised safety for Baby R’s mother and baby, as it may have allowed for arrangements for safe delivery despite the risks.[418] It would have also supported Ms Murphy to continue to provide Baby R’s mother care if, after such a consultation, she made an informed choice to proceed with a homebirth.

351. As it was, until Bendigo Health was alerted by Ms Murphy's phone call at around 8:00pm on 19 August 2022, for what had now become an urgent situation, the hospital

[417] Submissions on behalf of Ms Murphy, paragraph 27

[418] Submissions on behalf of Bendigo Health, page 5, paragraph 14.

had no knowledge of Baby R's mother's labour and no notice of a potential need for input or transfer.

352. On behalf of Ms Murphy, it was highlighted that the RANZCOG Best Practice Statement: Birth after Caesarean Section had been replaced by RANZCOG Birth After Caesarean (C-Obs 38) (Clinical Guideline, version 4.1, August 2025),[419] representing a shift away from a 'dictatorial tone' to evidence-based recommendations. For example, recommendation 1 which states:

It is suggested that women who have had a lower segment caesarean birth are advised that planned vaginal birth may increase the likelihood of some adverse maternal outcomes, while the likelihood of some adverse neonatal outcomes may be reduced.

And recommendation 2 which states that:

It is suggested that a discussion about the likelihood of achieving a vaginal birth after caesarean should include potential complications such as complete uterine rupture and the need for emergency caesarean birth.

353. It was put on behalf of Ms Murphy that the right to make informed choices and the dialogue between women and their healthcare professionals is as contained in the current RANZCOG guidelines and mirrors the expert evidence of Drs Cooke and Woods.[420]

354. I note that Dr Cooke similarly critiqued the tone of the previous RANZCOG Best Practice Statement: Birth after Caesarean for being 'woman unfriendly' and taking away any individuality or ability to make other decisions.

355. The current RANZCOG Clinical Guideline no longer refers to women being advised that a planned VBAC should be conducted in a suitably staffed and equipped delivery suite and expressly states "[a]ll women making decisions about mode of birth have a

[419] Exhibit 13, RANZCOG Birth After Caesarean (C-Obs 38) (Clinical Guideline, version 4.1, August 2025).
[420] Submissions on behalf of Ms Murphy, paragraph 16

right to make informed choices about their care."[421] It also provides an evidence-based recommendation (with a low grade of evidence) stating "Uterine scar is one of the identified risk factors for foetal compromise in labour, and it is recommended that continuous electronic monitoring be offered."[422]

356. While this is a change in language and tone, an *offer* of continuous electronic monitoring to assist in detecting potential foetal compromise, would involve a discussion with the mother about the purpose of monitoring and the levels and types of intrapartum monitoring.

357. In any event, as noted, the SCV guidance, which expressly applies to homebirths, refers to homebirth as being suitable for low risk pregnancy and no previous caesarean section. Therefore, regardless of what the RANZCOG guidance document about birth after caesarean stated and now states, the SCV guidance precludes homebirth for VBAC.

358. Furthermore, the right to make informed choices can only be achieved if women are sufficiently and adequately informed. It is of relevance that Baby R's mother had been a registered midwife, had immersed herself in research about homebirth and both parents had reviewed the Safer Care Victoria literature about homebirth. Baby R's mother was also aware of the ACM guidelines assessing herself as falling into a Level B consult or C referral. There was also considerable evidence that she was aware of the risk of uterine rupture, postpartum haemorrhage and of the potential of another obstructed labour.

359. However, in order for Baby R's mother to be fully informed and make an informed choice including about having a homebirth outside of recommended care, it was relevant what the health care providers responsible for her care were advising including in individualised and documented discussions about obstetric risk and suitability for homebirth by reference to the substance of relevant guidance documents and

[421] Exhibit 13, RANZCOG Birth After Caesarean (C-Obs 38) (Clinical Guideline, version 4.1, August 2025), 13
[422] Exhibit 13, RANZCOG Birth After Caesarean (C-Obs 38) (Clinical Guideline, version 4.1, August 2025), 32

recommended care. To be fully informed, Baby R's mother also required a consultation with an obstetrician in accordance with the ACM guidelines.

360. Ms Murphy was the practitioner that Baby R's mother primarily relied upon for the provision of antenatal care and advice. Baby R's mother reached out to Ms Murphy before her pregnancy and was assured that her history did not preclude her from homebirth. Baby R's mother provided Ms Murphy with the records from her first pregnancy to ensure that her history was understood by her. She engaged with Ms Murphy in relation to plans for the birth including minimising the risk of obstructed labour. She knew Ms Murphy through her work as a midwife and said she had a good reputation. Ms Murphy agreed that Baby R's mother trusted her.

361. I find that Ms Murphy was the primary care provider with the primary responsibility for assessing and advising in relation to obstetric risk, suitability for homebirth and ongoing care. While there was discussion of the risk of uterine rupture, meconium liquor, potential for obstructed labour and need for transfer, this did not encompass all the advice that was required in the circumstances in order for Baby R's mother to make a fully informed decision. I consider that Ms Murphy's assessment and advice about obstetric risks, how these risks might impact the labour and suitability for homebirth did not encompass recommended care and the relevant guidelines and did not accord with reasonable midwifery practice.

362. I also find that Ms Murphy did not act in accordance with the ACM Guidelines, in particular she did not recommend to Baby R's mother attendance at a consultation with a specialist obstetrician and, if declined by Baby R's mother, attending such a consultation as stipulated. Further, Ms Murphy limited the interaction to a backup booking-in appointment with incomplete information about Baby R's mother's obstetric history and positively stated that Baby R's mother did not require an appointment with an obstetrician contrary to the ACM Guidelines and the usual practice of an obstetric consult at 36 weeks. This also did not accord with expected midwifery practice.

Ms Lapeyre's Care

363. I consider that Ms Lapeyre, as the second midwife, shared some of the responsibility of assessing Baby R's mother's obstetric risk and suitability for homebirth and discussing those matters with Ms Murphy.

364. As at the time of the birth plan meeting, Ms Lapeyre was aware of Baby R's mother's history except for the postpartum haemorrhage in the first delivery. The information that was available or available to be gleaned at the time of the birth plan meeting was sufficient for Ms Lapeyre to assess Baby R's mother's obstetric risks and suitability for homebirth including by reference to recommended care and the applicable guidelines. She said she could not recall any discussion with Baby R's mother about suitability for homebirth or obstetric risks (some risks were noted as being discussed at the birth plan meeting such as uterine rupture). She expected those conversations to have occurred between Ms Murphy and Baby R's mother but did not know if they had occurred and did not recall discussing suitability for homebirth and obstetric risks with Ms Murphy. She also did not recall any guidelines being discussed.

365. Ms Lapeyre was not involved in any other antenatal appointments, so her responsibility to assess Baby R's mother's obstetric risks and suitability for homebirth is limited to the birth plan meeting on 22 July 2022 and her attendance to provide labour care on 19 August 2022. However, as noted it would be expected that discussions between Ms Lapeyre and Ms Murphy would have occurred prior to and around the time of the birth plan meeting from which Ms Lapeyre could have informed herself to enable that assessment to occur. I consider that Ms Lapeyre should have discussed obstetric risk and suitability for homebirth with Ms Murphy and the indications for consultation with an obstetrician based on enquiries made at or around the time of the birth plan meeting.

366. I note that under the Nursing and Midwifery Board's Safety and Quality Guidelines for Privately Practising Midwives a privately practising midwife is to engage a second midwife or health care practitioner and ensure that they are present for the birth of the baby. There is no express requirement for them to be involved in the antenatal care. It

was noted that it was Ms Lapeyre's preference to attend birth planning meetings when acting as a second midwife, but arrangements vary.[423] I acknowledge this.

367. Within this context and as part of her engagement as second midwife and attendance at the birth plan meeting, Ms Lapeyre had a responsibility to make enquiries of Ms Murphy which would have allowed for her to arrive at her own independent assessment of obstetric risk and suitability including by reference to the guidelines and recommended care and may have prompted collaboration with Bendigo Health given the contact with Dr Yuen earlier that year and the ACM Guidelines indication for a consultation.

368. Ms Lapeyre otherwise had a responsibility to assess obstetric risk and suitability for homebirth as part of her attendance on Baby R's mother during the labour.

Bendigo Health

369. The lack of referral for a consultation with an obstetrician by Ms Murphy appears to have hamstrung Bendigo Health in its communication and care of Baby R's mother.

370. In her statement, Ms Carr said she offered Baby R's mother a consultation with an obstetrician. There are two entries in the Bendigo Health records reflecting this. While Baby R's mother did not recall a discussion with Ms Carr about seeing an obstetrician, I am satisfied that Ms Carr offered an obstetric consultation as referred to in the notes and consistent with usual practice.

371. There were some discrepancies in Ms Carr's evidence about whether she used the term 'high risk' in her discussion with Baby R's mother (she said she mentioned two things; the late presentation at 36 weeks and the plan for VBAC). There is no reference to 'high risk' in the Bendigo Health notes. I am therefore unable to conclude whether Ms Carr told Baby R's mother she was high risk. However, I do accept that as a midwife it

[423] Submissions on behalf of Ms Lapeyre, page 3, paragraph 8

was not Ms Carr's role to counsel Baby R's mother as to the most suitable mode of delivery. This was for discussion with an obstetrician.

372. A subsequent offer of an appointment with an obstetrician by a hospital administrative staff member was similarly declined by Baby R's mother. It is unclear whether further information about the purpose of an obstetric consultation would have made a difference. On the evidence, this information had not been provided by Ms Murphy and Ms Carr was unable to as it was beyond her role.

373. Given the referral letter from Ms Murphy and the information that Baby R's mother had declined a consultation with an obstetrician, Dr Davis did not consider the hospital had consent to directly communicate with Baby R's mother to outline the purpose of such a consultation.

374. This point was elaborated on further by the hospital in its submission as being contrary to the principle of a patient's autonomy. It was said that for an obstetrician to contact Baby R's mother after she had twice declined and after the midwife had said in her referral letter that she did not need to see an obstetrician would have been "…deemed an inappropriately paternalistic action by the hospital…" and "…while a patient has the right to receive, and medical practitioners have an obligation to provide, information to a patient about their health, assessment and treatment, such information cannot be provided without the patient's consent."[424]

375. However, another view might be to consider that, as a patient with a backup booking at the hospital, Baby R's mother was already a patient of the hospital for the purpose of consenting to the provision of that advice.

376. Having said that, the option of direct contact by an obstetrician, does not overcome the practical difficulty Dr Yuen and Dr Davis properly flagged that reaching out to Baby R's mother without a relationship being formed and who had already declined the offer to see an obstetrician may not have been effective.

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[424] Submissions on behalf of Bendigo Health, page 9, paragraph 30

377. Another available opportunity was for there to have been a joint conversation with Dr Davis, or Dr Yuen, and Ms Carr to satisfy themselves as to the information that had been provided to Baby R's mother by Ms Carr and for Ms Carr to contact Baby R's mother as part of a continuation of the telehealth booking-in appointment to convey that an obstetrician had now reviewed her antenatal paperwork and confirmed the recommendation for an appointment. Contact by the same midwife reaching out may have allowed for a more effective conversation but it is difficult to say.

378. In any event, Baby R's mother said she did not recall any discussion with Ms Carr about seeing an obstetrician. As noted, I am satisfied that Ms Carr offered an obstetric consultation as referred to in the Bendigo Health clinical documentation. Further, in relation to the later call by the administrative staff member Baby R's mother said she could not see any relevance because there were "no changes and no concerns raised". She also indicated a concern that there would be "fearmongering" around VBAC homebirth which suggests an awareness that at any consult with an obstetrician there would be recommendations about VBAC and homebirth. This is consistent with Ms Murphy's evidence that Baby R's mother did not wish to see an obstetrician.

379. Notwithstanding this, communication with Ms Murphy was an avenue which was available to be pursued by Bendigo Health. As the referring practitioner, Ms Murphy should have been sent the Shared Care Form. Bendigo Health acknowledged this should have occurred.[425] While the form has been updated and improved since these events to allow for clearer and additional information, it appears to continue to be sent to the GP entered as the usual referrer of most maternity patients. For it to be sent to an *actual* referrer where they are not the GP, a consultant would need to turn their mind to adding the name of the referrer to the form.

380. Ms Murphy said that had she received the Shared Care Form, she would have discussed it with Baby R's mother but did not think it would have changed her opinion about seeing an obstetrician. While that may be the case, such a discussion may have flagged

[425] Submissions on behalf of Bendigo Health, page 8, paragraph 26

something for Baby R's mother who had said that to that point no concerns had been raised.

381. Further, Bendigo Health could have pursued direct written communication with Ms Murphy flagging risk factors that required counselling and expressly requesting Baby R's mother be referred for consultation. Dr Yuen acknowledged that this was an option.

382. However, I also acknowledge that the hospital was in a difficult position to navigate these communication options in the circumstances after two offers of an appointment with an obstetrician had been declined and in the context of a busy maternity unit. It is also difficult to determine whether such communication would have led to further dialogue or consultation. Nonetheless, it would have set out the hospital's position clearly to Ms Murphy with the expectation of the content being discussed with Baby R's mother.

383. I find that as Ms Murphy did not refer and Baby R's mother declined to attend an appointment with an obstetrician on the basis that she did not see the relevance, Bendigo Health was unable to assess Baby R's mother's pregnancy and provide an obstetrician's view as to obstetric risk and suitability for homebirth to enable Baby R's mother to make a fully informed decision and to develop an individualised care plan in collaboration with her and Ms Murphy for ongoing maternity care, including triggers for communication during labour should Baby R's mother have elected to proceed with homebirth. Communication with Ms Murphy by Bendigo Health presented a potential opportunity for an obstetric consultation to occur but whether this would have eventuated is difficult to determine.

Care and Communication During Labour

384. I consider that the intrapartum care provided by Ms Murphy and Ms Lapeyre was deficient and did not accord with reasonable midwifery care.

385. The deficiencies encompass the lack of a documented plan for further progress of the labour and anticipated birth within a certain time, the assessment of the labour progress, the failure to appreciate or anticipate slowing progress or that the labour may be arresting as occurred in the first labour. There was also a failure to act on potential indicators of foetal stress and to appropriately monitor foetal wellbeing and the FHR.

386. Ms Murphy referred to less interventions by way of VE with alternative methods to assess progress in homebirths and that women are able to labour longer at home. However, these general approaches and comments in relation to homebirth cannot replace timely assessment of progress against the backdrop of this mother's obstetric history and presentation at the time.

387. In that regard, the baby's posterior position and the presence of an anterior lip indicated potential malposition, slowing of labour and a recurrence of the events of the first pregnancy. This necessitated closer observation, discussion with the mother and a plan for further assessment including by way of VE.

388. Another potential indication of obstructed labour was at 2:46pm, when Baby R's mother said that she felt stuck like last time. This required assessment of the labour progress including of dilatation and descent of the baby and for discussion including about transfer to hospital.

389. In any event, there was a consensus view and acknowledgement by both Ms Murphy and Ms Lapeyre that the presence of meconium liquor at 3:10pm, should have prompted discussion with Baby R's mother about its significance. I consider that expected midwifery care and practice required Ms Murphy and Ms Lapeyre to undertake a full assessment with multidisciplinary input and to discuss and recommend hospital transfer to Baby R's parents in the presence of meconium liquor at or around 3:10pm.

390. Further, the presence of meconium liquor should have prompted a consultation under the ACM guidelines which, in this context, required Bendigo Health to be contacted. Had such contact been made, the likely recommendation would have been for transfer to hospital.

391. Instead, labour was allowed to continue. The heart rate was not adequately monitored either in accordance with the stated plan of intermittent auscultation every 15 minutes or in accordance with the RANZCOG Intrapartum Foetal Surveillance Clinical Guidelines which provides for continuous electronic monitoring in the presence of meconium liquor. When transfer did occur, it was the first that the hospital was aware of the labour and time was required for hospital staff to make an assessment of the labour progress and determine next steps.

Was Baby R's Death Preventable?

392. I accept Dr Woods' opinion that Baby R's death would have been prevented had transfer to hospital occurred earlier in the labour. Had transfer to Bendigo Health occurred at around 3:25pm on 19 August 2022, the hospital would have had an opportunity to undertake a full assessment and have discussions with the parents, with birth occurring at some point after that and, on the balance of probabilities, Baby R's death would have been avoided.

393. I accept that Baby R likely entered labour well but experienced evolving hypoxic stress caused by cord compression and that the meconium liquor likely represented a foetal physiological response to stress which was likely to be hypoxic in origin and that the variations in the FHR from 3:10pm to 6:00pm were likely to be decelerations and a further sign of the baby's compensatory response. The increased heart rate after 6:00pm was a sign of depleting reserves. In Dr Woods' opinion, the CTG on arrival at the hospital at 8:31pm showed signs of decompensation with some form of hypoxic neonatal adverse outcome now unavoidable.

394. I am satisfied that had transfer to hospital been recommended by Ms Murphy and Ms Lapeyre at or around 3:30pm, Baby R's parents would have agreed. Even allowing for some time for discussion and consideration, I consider that transfer would have occurred at some stage soon after 3:30pm.

395. I consider that given the references in the birth plan meeting notes to the parents accepting that normal vaginal birth at home may not be possible and the potential reasons for transfer and Baby R’s mother’s assumption that there would be transfer to hospital in the presence of meconium liquor that, with discussion and time, Baby R’s parents would have agreed to a transfer. Further, when that recommendation was ultimately made, Baby R's parents agreed.

396. Also, Ms Murphy said Baby R’s mother trusted her and that if she had seriously recommended transfer to hospital, Baby R’s mother would likely have agreed.

397. It is not possible to say how long assessments of foetal wellbeing at the hospital would have taken nor the timing of responses to any emergency situation and steps to deliver Baby R, bearing in mind the potential for delay, including delay occasioned by competing priorities, the availability of medical and midwifery personnel and operating theatre.

398. Notwithstanding these uncertainties, I am satisfied that had transfer occurred at around or soon after 3:30pm, delivery would have occurred at an earlier time and Baby R’s death would likely have been avoided.

399. It should also be noted that, given my finding that Baby R’s mother’s pregnancy was not suitable for homebirth, had labour occurred in a hospital setting from the outset, continuous foetal heart monitoring would have been recommended or offered, given the previous caesarean section and certainly in the presence of meconium liquor. Continuous foetal heart monitoring would have also been recommended had Baby R’s mother been transferred to hospital earlier. This, together with other intrapartum monitoring and assessments, would likely have provided a clearer picture of foetal wellbeing.

400. As Baby R’s mother was not labouring in a hospital with access to CTG and other assessments, potential signs of distress and decompensation could not be detected and acted upon. Therefore, had Baby R’s mother’s labour occurred in a Level 5 hospital

such as Bendigo Health and not at home, or transfer had occurred at or around 3:30 pm on 19 August 2022, I consider Baby R's death would have been avoided.

FINDINGS UNDER SECTION 67(1) OF THE ACT

401. Pursuant to section 67(1) of the Act I find as follows:

   a. The identity of the deceased is Baby R, born 19 August 2022;

   b. Who died on 25 August 2022 at the Royal Women's Hospital, Victoria, from *1(a) Perinatal hypoxia*; and

   c. The death occurred in the circumstances described above.

COMMENTS

I make the following comments connected with the death under section 67(3) of the Act:

Consistency across Guidance Documents

402. A number of guidelines, standards and procedures from various bodies and relevant to the provision of maternity care in the circumstances were examined during this inquest.

403. It is desirable that guidance is clear, easy to follow, consistent and contained in as few guidance documents as possible to minimise the need for familiarity with multiple potentially applicable guidelines and procedures. Achieving the latter is challenging given the different professional practitioner bodies that provide guidance to members such as RANZCOG and ACM and government issued guidance such as from SCV. Cross referencing of other guidance documents may also create difficulties if the referenced guidance is updated or revised over time and no longer current.

404. However, should there be further opportunities for greater consistency and for cross referencing of guidance documents, I have made a recommendation for consideration by the Royal Australian and New Zealand College of Obstetricians and

Gynaecologists, Safer Care Victoria and the Australian College of Midwives in respect to this. For example, there may be scope for homebirth guidelines to expressly refer to guidelines relating to VBAC when addressing risk factors and suitability and for guidelines relating to VBAC to expressly address risk and recommendations in respect to homebirth.

ACM National Midwifery Guidelines for Consultation and Referral

405. It was submitted that the ACM Guidelines were open to being misinterpreted in so far as they relate to consultation for a Level B indication, in particular, that consultations between supporting midwives were understood to satisfy the requirement to consult with "… a relevant medical practitioner or other health care practitioner".

406. As I have already found, a Level B indication does not include consultation with a midwife as it represents an escalation from a Level A discussion. The definition of consultation states that it is the seeking of professional advice from a qualified and competent health care practitioner with the relevant knowledge and skills to make decisions about the woman's care in collaboration with the woman and midwife.

407. In this case, I have found that the appropriate practitioner was an obstetrician. It is acknowledged that it would not always be the case, depending on the nature of the consultation indicated, and requires the exercise of judgement on the part of the midwife.

408. Dr Woods considered that the ACM Guidelines were clear and provided good advice.[426]

409. However, given the evidence about this issue, including Dr Cooke's acknowledgement that there may be scope for further clarification, I have made a recommendation for the Australian College of Midwives to review the National Midwifery Guidelines with

[426] Dr Woods evidence, T 446

a view to considering any scope to provide clarity in the Guidelines or to otherwise provide training to assist in the understanding and application of the Guidelines.

Documentation and Health Records

410. There were references during the inquest to discussions and advice provided in consultations not being documented and that not all lengthy discussions can be captured in medical notes. While this may be so, some of the gaps in documentation related to advice about risk, recommended care and guidance documents from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Safer Care Victoria and the Australian College of Midwives.

411. What is recorded in or, more pertinently, omitted from health records is a feature in some coronial matters involving health care. The lack of sufficiently clear notes and documented advice can impact patient care and communication between health care providers who are each responsible for the provision of care to that patient. In providing care, practitioners are aided by having the fullest relevant information possible. It is recognised that time constraints can impact the ability to contemporaneously and comprehensively record the content of consultations, however, it is expected that key aspects of treatment, advice, discussion and informed consent would be documented. Health records are required to be kept in a form that can be understood by other practitioners and are to include management plans to enable continuity of care.[427]

[427] See AHPRA and National Boards, Managing Health Records Obligations which provides a summary of health professional's code of conduct and expectations of clinical documentation. Accessible from Health Records Obligations.

Documentation of Discussions between Privately Practising Midwives

412. There was evidence that discussions between Ms Murphy and Ms Lapeyre were generally not documented.[428] Dr Cooke considered this reflected current expectation unless there was disagreement about providing ongoing care.[429]

413. A copy of this finding will be provided to the Nursing and Midwifery Board of Australia to consider whether guidance about documenting discussions between primary and secondary midwives and the matters to be documented should be incorporated in the Safety and Quality guidelines for Privately Practising Midwives or other guidance document.

Charting Labour Progress

414. Charting labour progress during homebirth in a manner akin to a partogram used in hospital settings was raised as a way to help detect trends and deviations from normal and with the handover of information should transfer to hospital be required. Partograms include recordings of the position and station of the baby, the foetal heart rate and cervical dilatation, maternal wellbeing and analgesia during labour.[430] Dr Cooke also raised the benefits of plotting the baby's heart rate in a graphical representation.

415. I do not consider that a recommendation is required in relation to charting labour progress as the current Safety and Quality Guidelines for Privately Practising Midwives already require midwives providing home birthing services to develop comprehensive labour and birth records that contain relevant, complete and up to date information that correctly reflects the event being documented.[431]

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[428] Ms Lapeyre's evidence, T 187
[429] Dr Cooke's evidence, T 559
[430] Ms Lapeyre's evidence, T 245; Dr Woods' evidence, T 491, 496 – 497
[431] Nursing and Midwifery Board, Safety and Quality Guidelines for Privately Practising Midwives (Guidelines, July 2025), 5. Accessible at Safety and Quality Guidelines 2025. The Safety and Quality Guidelines applicable at the time of these events did not include this level detail in relation to expected documentation but referred to 'comprehensive documentation'.

416. However, this finding will be provided to the Nursing and Midwifery Board and the Australian College of Midwives to consider the utility of charting assessment findings in homebirths on a document such as a partogram.

Fatigue

417. In her evidence, Ms Lapeyre said that extreme tiredness may have impaired her decision making while providing intrapartum care.[432] Both she and Ms Murphy had not slept before attending to Baby R's mother as they had been at another birth overnight.[433] She said that they serviced a large area as there were no other privately practising midwives and she had previously experienced fatigue including while driving.[434]

418. I note that the RANZCOG Fatigue Risk Management in Obstetric and Gynaecological Practice Statement expressly recognises the potential impact of fatigue on patient safety and clinician wellbeing and makes recommendations for managing fatigue at a departmental, organisational and individual level.[435]

419. I also note that the Royal Women's Hospital Private Practice Midwife Model of Care Procedure provides for replacement of a private practice midwife after 12 hours and requires midwives to be familiar with the Hospital's Fatigue Management Guideline.[436]

420. Clearly, managing fatigue is integral to the provision of safe patient care and for long term practitioner wellbeing and must be prioritised by all in the health care system.

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[432] Ms Lapeyre's evidence, T 233
[433] Ms Lapeyre's evidence, T 244
[434] Ms Lapeyre's evidence, T 244
[435] RANZCOG Statement WPI - 18 Fatigue Risk Management in Obstetric and Gynaecological Practice (Guideline, November 2015) Accessible from Fatigue-Obstetrician-Gynaecologist.pdf
[436] Exhibit 12: Statement of Danielle Corden, DPC-3 "Private Practice Midwife Model of Care Procedure", page 7

Consistency across Public Maternity Services addressing Criteria for Homebirth and Opportunities for Improved Collaboration

421. One of the scope items for consideration at the inquest was whether there was consistency across all public maternity services addressing criteria for homebirth and arrangements involving privately practising midwife models of care.

422. As noted, a small but growing number of public hospitals have publicly funded home birth programs. The RWH also has formal arrangements with privately practising midwives who are employed by the hospital who provide antenatal care in the home, with birth occurring in hospital.

423. Otherwise, SCV: Homebirths Clinical Guidance encourages maternity services to use the guidance to consider providing homebirth services and directs those wanting to start a public homebirth service to the five current hospitals with programs in place.

424. It is evident that any expansion of publicly funded homebirth programs would include similar eligibility criteria of low risk pregnancy and no previous caesarean section as is the case for the existing programs. It is also evident that Baby R's mother would not come within the criteria for a publicly funded homebirth program.

425. What is not currently available is a model where midwives provide antenatal care in the community, intrapartum care in the home with arrangements to continue providing ongoing care in the hospital should transfer occur. Dr Cooke suggested this would be a perfect situation.[437]

426. I noted that Westmead Hospital in NSW was referred to in the NSW Parliamentary Enquiry into Birth Trauma as the only hospital in NSW where private midwives hold access agreements with formal admitting rights enabling them to transfer to hospital from a homebirth.[438]

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[437] Dr Cooks' evidence, T 546

[438] NSW Legislative Council Select Committee, Birth Trauma Report (29 May 2024) 16, 73. Accessible from NSW Birth Trauma Report 2024

427. Dr Woods commented that there could be stronger recommendations on the need for relationships between private homebirth providers and local public maternity services. He said well-defined relationships between clinicians would foster a culture of collaboration, enhance shared decision-making opportunities, support escalation pathways and multidisciplinary education and learning.[439]

428. During her evidence, Dr Yuen said there was some consistency but no real structure about how collaborative relationships between public maternity services and private midwives should occur.[440]

429. In relation to better supporting women making choices outside of recommended care, Dr Yuen said there were clear frameworks for engagement underpinned by the principles of informed decision making, patient autonomy and trauma informed care but there could be more by way of guidance as to how to do this in practice.[441]

430. Dr Davis said there was an opportunity for greater resources to work through why a patient might be requesting care outside the guidelines or recommended care and to be better at identifying and supporting those who have been through traumatic births.[442]

431. It is evident from these comments that more is needed to address birth trauma in our hospital system, provide trauma informed care and develop and improve collaborative relationships. This finding will be provided to Australian College of Midwives, Safer Care Victoria and the Royal Australian New Zealand College of Obstetricians and Gynaecologists for a consideration of these issues.

[439] Report of Dr Woods, CB 242 [118] – [119]. See also Dr Wood's evidence, T 480
[440] Dr Yuen's evidence, T 95
[441] Dr Yuen's evidence, T 103 - 104
[442] Dr Davis's evidence, T 149

RECOMMENDATIONS

445. In the interests of public health and safety and with the aim of preventing similar deaths, I make the following recommendations connected with the death under section 72(2) of the Act:

Recommendation 1

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Safer Care Victoria and Australian College of Midwives review this finding with a view to consider how guidance documents relating to maternity care can be streamlined, be more consistent and cross referenced to assist in providing clear guidance to all practitioners providing maternity care, women and their families and the public.

Recommendation 2

The Australian College of Midwives review this finding and the National Midwifery Guidelines for Consultation and Referral and consider any revisions to provide clarity to the reference to "relevant medical practitioner or other health care provider" for the purposes of a Level B indication for consultation and/or training in the understanding and application of this aspect of the Guidelines.

I convey my deepest condolences to the parents and family of Baby R for their loss.

ORDERS

Pursuant to section 73(1) of the Act, I order that this finding be published on the internet in accordance with the Rules.

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

Baby R's parents, Senior Next of Kin

Slater & Gordon on behalf of Baby R's parents

Gordon Legal on behalf of Ms Elizabeth Murphy

JK Legal on behalf of Ms Marie-Louise Lapeyre

Avant Law on behalf of Dr Veronica Moule

Minter Ellison on behalf of Bendigo Health

Royal Women's Hospital

Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Australian College of Midwives

Nursing and Midwifery Board

Safer Care Victoria

Signature:

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Coroner Dimitra Dubrow

Date: 29 May 2026

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 inquest. 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.