IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 005490

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Baby H
Date of birth:	21 September 2022
Date of death:	21 September 2022
Cause of death:	1a: Unascertained
Place of death:	Address known to the Court

INTRODUCTION

1. Baby H[1] was born on 21 September 2022 at a town in Victoria. Baby H's parents have three other children.

2. The family live in a home on a 600-acre property. Other members of Baby H's family also live in homes on the same property.

3. Two of Baby H's siblings were born at home with the assistance of a midwife. Another was born at home with the assistance of a doula. All three births were described as *"smooth"*, despite long labours.

4. Baby H's mother was not seen by any registered medical practitioners during her pregnancy with either Baby H or her youngest sibling, as she did not feel there was a need. With Baby H she felt regular kicks and movements from her baby, and felt it was *"the cruisiest pregnancy she's had"*.

THE CORONIAL INVESTIGATION

5. Baby H's death was reported to the coroner on 22 September 2023. At the time the report was made, it was unclear whether Baby H was alive at birth or was a still-born child[2], which is not a reportable death within the definition in the *Coroners Act 2008* (**the Act**). However, given her parents' assertion that they believed she was moving up until 30 minutes prior to her birth and the equivocal nature of the evidence at autopsy, I took the matter to be reportable.

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

7. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of

[1] This finding has been deidentified to protect the privacy of Baby H's family.
[2] Still-born child is defined in section 3 of the *Births, Deaths and Marriages Registration Act 1996* and means a child of at least 20 weeks' gestation or, if it cannot be reliably established whether the period of gestation is more or less than 20 weeks, with a body mass of at least 400 grams at birth, that exhibits no sign of respiration or heartbeat, or other sign of life, after birth.

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

8. This finding draws on the totality of the coronial investigation into the death of Baby H. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[3]

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

Circumstances in which the death occurred[4]

9. Baby H's mother's waters broke and she went into labour at around 8am on 21 September 2023, at what she believed was 41 weeks gestation.

10. She felt as if everything was going well and told Baby H's father she could feel the baby kicking. They stayed at home while the labour progressed.

11. Around 30 minutes prior to giving birth, Baby H's mother stopped feeling movement from the baby. At approximately 11:25pm, she gave birth to a baby girl. Baby H had a white and blue complexion and showed no signs of life, and the umbilical cord had a prominent blue vein.

12. Baby H's parents attempted to rouse her for around ten minutes, to no avail. They stayed with Baby H overnight and grieved.

13. At around 6am on 22 September 2023, Baby H's parents called their parents to advise of what had happened.

14. At around 9am, they cut the umbilical cord and placed both Baby H, wrapped in a blanket and in a wicker basket, and the cord in the fridge.

15. Later that day, the family contacted Natural Grace Holistic Funeral Care, who contacted emergency services. Police and paramedics attended at the property at around 6pm.

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

[4] As no one else was present during the birth, the circumstances are based on the recount of Baby H's parents.

Identity of the deceased

16. On 22 September 2022, Baby H, born 21 September 2022, was visually identified by her father, who completed a Statement of Identification.

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

Medical cause of death

18. Following discussion and advice received from Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine (**VIFM**), on 23 September 2023 I directed that an autopsy be performed.

19. On 24 September 2024, Coronial Admissions and Enquiries (CAE) at the VIFM received an email from Baby H's parents informing of their objection to autopsy and their request for me to reconsider my direction. They stated:

"Our spiritual beliefs are that our soul travels on to other realms after existing here on Earth. We believe that it is important to honour and respect the body of this soul and return it to Papatūānuku (Mother Earth) without being desecrated. The very fact that the body was taken from us and has been handled by those that are not family and friends has already pushed our boundaries. An autopsy on top of this feels like desecration and would also cause distress to her family and friends."

20. Having received the request for reconsideration, I discussed the matter with Dr Archer who had reviewed the Royal Children's Hospital radiology report, DHHS Report of Child Death, and the witness statement of Baby H's father. She advised that she maintained her medical opinion that autopsy was the most appropriate information and noted that it would not be possible to rule out birth trauma with an external examination only, nor would it be possible to determine an internal anatomical cause for the death.

21. Ultimately, I determined that an autopsy was necessary for the investigation of Baby H's death. Accordingly, I signed a Determination by Coroner Following a Request for Autopsy Direction to be Reconsidered (Form 10).

22. Forensic Pathologist Dr Sarah Parsons from the VIFM conducted an autopsy on the body of Baby H on 29 September 2022 and provided a written report of her findings dated 2 February 2023.

23. Prior to autopsy Dr Parsons had available to her the following materials:

    a) Victoria Police Report of Death (Form 83)

    b) Post mortem computed tomography (**CT**) scan

    c) Ambulance Victoria notes

24. The following materials were provided following autopsy:

    d) Placental histopathology

    e) Metabolic results

    f) DHHS Report of Child Death

    g) RCH radiology report

    h) Statement of Baby H's father

25. A summary of the autopsy findings is as follows:

    a) Intradural haemorrhage tentorium cerebelli

    b) Widespread congestive changes with folial subarachnoid haemorrhage in the posterior fossa

    c) Patent ductus arteriosus

    d) Septum primum atrial septal defect

    e) Adrenal haemorrhage.

    f) Meconium in the lungs

    g) No colloid in the thyroid with ballooning of the cells

    h) Macrosomia.

    i) Weights and measurements in keeping with a > 42 week gestation infant (or late term with increased weights due to macrosomia

26. No significant congenital abnormalities that would have led to death were detected.

27. Dr Parsons commented that Baby H was macrosomic and there were changes in the placenta suggestive of maternal diabetes.

28. The body weight and measurements and organ weights were all greater than or in the band for those of a 42-week gestation infant, meaning Baby H was likely post term or late term with increased weights due to macrosomia. Post term labour is defined as those greater than 42 weeks and is associated with maternal, foetal, and neonatal complications. Many of the complications are sequelae of either excessive foetal growth or uteroplacental insufficiency. Intrauterine infection, uteroplacental insufficiency due to placental aging, and cord compression leading to foetal hypoxia, asphyxia, and meconium aspiration are thought to contribute to the excess perinatal deaths.

29. The placenta showed hypocoiling of the umbilical cord, meconium exposure, chorangiosis and multiple small intervillous thrombi. Chorangiosis has been described to be more common in the setting of poor foetal outcome. It has been associated with maternal diabetes and villous hypoxia. The placenta did not show signs of infection nor prolonged foetal death in utero.

30. There was meconium staining of the placenta, fingernails and lungs. In infants in utero meconium passage is considered a stress-related response. At high concentrations meconium which is present for more than 12 hours can damage the umbilical cord. Infant morbidity from meconium can occur from inhalation due to gasping in utero or at birth or from umbilical vascular damage due to prolonged exposure in utero. In Baby H's case, the cause of the stress leading to meconium passage was not definitively identified.

31. Intradural haemorrhage and focal subarachnoid haemorrhage were identified in the neuropathology examination. Dr Parsons noted that both of these can occur as part of the birth process and do not represent a cause of death.

32. Toxicological analysis of post mortem samples did not identify the presence of any alcohol or other common drugs or poisons.

33. Ultimately, Dr Parsons was unable to determine if Baby H had a separate existence from her mother. Her lungs appeared collapsed with no aeration and there was no air seen on the post mortem CT scan in either the lungs or bowel. However, her remains were not macerated as can be seen in stillborn infants.

34. Dr Parsons provided an opinion that the medical cause of death was 1(a) UNASCERTAINED.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

1. The Coroners Prevention Unit (**CPU**)[5] conducted a search of the Court's surveillance database and identified 34 deaths between 2013 and 2023 that occurred in the context of a home-birth. Four of those deaths occurred without the presence of medical staff or a third-party.

2. Freebirth, or unassisted childbirth, is the conscious decision to give birth without the presence of a registered healthcare professional, such as a midwife or doctor. Freebirth is influenced by a range of complex and deeply personal factors, including past experiences, cultural considerations, access to healthcare and financial or logistical challenges.[6]

3. Safer Care Victoria have published a position statement[7] on freebirth, in which they differentiate freebirth from a planned home birth, *where a woman's health and pregnancy have been assessed by trained AHPRA registered professionals, who use clinical evidence to guide their recommendations and care.*

4. The position statement concludes by stating *SCV and CCOPMM*[8] *strongly encourage women and families to seek care from trained AHPRA registered professionals, who can provide medical support when needed, helping to ensure the safest possible outcomes for mother and baby.*

5. Decisions a parent makes during pregnancy and birth are deeply personal. I accept that it was Baby H's parents desire and intention to have a peaceful home birth with only the two of them present, and that is the reason no medical advice or attention was sought when Baby H's mother's waters broke at around 8am on 21 September 2023.

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[5] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[6] Jackson, M.K., Schmied, V. & Dahlen, H.G. Birthing outside the system: the motivation behind the choice to freebirth or have a homebirth with risk factors in Australia. BMC Pregnancy Childbirth 20, 254 (2020). <https://doi.org/10.1186/s12884-020-02944-6>

[7] Safer Care Victoria, Freebirth – Position statement, <https://www.safercare.vic.gov.au/best-practice-improvement/clinical-guidance/maternity/freebirth-statement>

[8] Consultative Council on Obstetric and Paediatric Mortality.

6. What is more unclear to me is why no medical assistance was sought when her mother noticed that Baby H had stopped moving, or perhaps more obviously, when she was born in such condition and was unable to be roused.

7. While it is not for me to speculate as to whether earlier medical intervention could have changed Baby H's sad outcome, I do note that this Court has investigated other matters where the evidence was that earlier medical intervention may have led to a better outcome.

8. I consider that Baby H's case serves as an important reminder of the risks of freebirth, and I wholeheartedly support the Safer Care Victoria's position statement on the issue. Whilst I ultimately support a person's right to choose how they birth, I would strongly encourage them to seek medical care during pregnancy so that they can make an informed decision on how to birth to ensure the best outcomes for them and their baby.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Baby H, born 21 September 2022;

    b) the death occurred on 21 September 2022 at an address known to the Court;

    c) I accept and adopt the medical cause of death ascribed by Dr Sarah Parsons and I find that Baby H's cause of death is unascertained;

2. AND, having considered the available evidence, including the equivocal nature of the evidence elucidated following autopsy, I am unable to make a finding as to whether Baby H's death could have been prevented. I do, however, find that medical oversight during her mother's pregnancy and the birth would likely have been beneficial and may have increased the likelihood of her survival.

I convey my sincere condolences to Baby H's family for their loss.

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

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

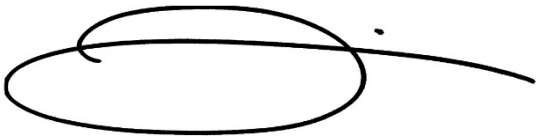
Baby H's parents, Senior Next of Kin

Safer Care Victoria

Consultative Council on Obstetric and Paediatric Mortality

Leading Senior Constable Paul Michell, Coronial Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 12 September 2025

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