IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 007447

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Catherine Fitzgerald
Deceased:	Baby E
Date of birth:	28 December 2022
Date of death:	29 December 2022
Cause of death:	1(a) Neonatal pneumonia, meconium aspiration and chorioamnionitis 1(b) Prolonged labour in a home birthing pool
Place of death:	Victoria
Keywords:	Home birth, water birth, 'free birth'

INTRODUCTION

1. On 28 December 2022, Baby E was born at the home of her parents, Ms E and Mr E. Baby E died the following day on 29 December 2022, whilst at home with her parents.

THE CORONIAL INVESTIGATION

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

3. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and the circumstances in which the death occurred. The 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.

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

5. This finding draws on the totality of the coronial investigation into the death of Baby E. 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.[1]

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

Circumstances in which the death occurred

6. Ms E was 41 years old when she fell pregnant with Baby E in March 2022, with an estimated due date of 12 December 2022. She stated that during her pregnancy, "*everything was normal, [she] felt fantastic, [she] had no scans and no check-ups*". She did not see a general

[1] 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.

practitioner (**GP**) or obstetrician for regular antenatal tests and scans, and she planned to birth at home in a birthing pool.

7. On 23 November 2022, Ms E presented to a GP, Dr Peter Lucas, at about 36 weeks' gestation. This was her first and only consultation with Dr Lucas; prior to this she had not seen Dr Lucas for general medical management as an adult.

8. Dr Lucas discussed Ms E's health and proposed management after birth. Examination of the abdomen showed the size and position of the baby was normal and the heartbeat was regular on doppler examination. Dr Lucas offered to arrange a blood screen and ultrasound for late pregnancy, however Ms E declined. According to Dr Lucas, Ms E explained that her blood tests were normal and that she "*had had enough investigations over the course of the pregnancy*". She also reported that she had a "*team*" organising her birth for her, but she was "*undecided about her birth team*". Dr Lucas expected Ms E to return for an appointment after the baby was born.

9. According to Ms E, the purpose of the GP visit was to ascertain whether there was one heartbeat, or two. She recalled her blood pressure was normal, and that she told Dr Lucas that she had not had any blood tests. It is apparent that she did not seek any further involvement by Dr Lucas in the management of her pregnancy or birth, and did not inform him how she planned to give birth. Ms E described the remainder of her pregnancy as "*smooth and uneventful*" and she did not notice anything out of the ordinary.

10. Medicare and Pharmaceutical Benefits Scheme checks for the period of 29 December 2021 to 29 December 2022 confirm this single medical appointment with Dr Lucas was the only medical consultation which occurred during the pregnancy, and there was only one prescription for antibiotics dispensed to Ms E in March 2022 (which was prescribed by a dentist). There is no record of any pathology or other testing during that period. Therefore, it does not appear that Ms E had any antenatal tests or screening during her pregnancy.

11. Ms E reported that during her pregnancy she saw a post on Instagram from the page "The Authentic Birthkeeper", run by Emily Lal, who was advertising birthing pools for hire. Ms E contacted Ms Lal directly and organised the hire of a birthing pool, which was delivered at the end of November 2022. She states that she remained in contact with Ms Lal "*socially*" but says she "*sought no other service or advice*" from her. Although she did ask if she could contact Ms Lal following the birth to "*conduct a post-partum visit*".

12. On the afternoon of 26 December 2022, Ms E reported that she felt a "*light tightening in [her] abdomen*". At about 4.00am on 27 December 2022, Ms E felt a contraction. She experienced a few further contractions throughout the morning, although they were far apart.

13. At about 7.30am that morning, Ms E asked her partner, Mr E, to fill up the birthing pool that she had hired from Ms Lal. Ms E spent that entire day and night in the birthing pool.

14. At some time between 7.00am and 9.00am on 28 December 2022, Ms E left the pool so that her partner could empty it and refill it with clean water. Ms E estimated it took Mr E about an hour to empty and refill the pool. Once the pool was refilled, Ms E entered the pool again and stayed there for the remainder of 28 December 2022. She occasionally exited the pool to use the bathroom. According to the statement of Ms E, this was the only occasion when the pool water was emptied and refilled.

15. Ms E stated that her contractions became more intense around dinnertime on 28 December 2022. At about 10.00pm, she told Mr E to enter the pool with her, as she felt like it was time for the baby to be born. Mr E estimated that Ms E commenced active pushing and continued for about 30 minutes, and Baby E was born at about 10.30pm. Ms E did not deliver the placenta, and the cord was not cut.

16. Mr E and Ms E then went to sleep in their bed, with Baby E in Ms E's arms. At an unknown time during the morning of 29 December 2022, Ms E awoke and attempted to deliver the placenta but was unsuccessful.

17. At times during the morning of 29 December 2022, Ms E states that she checked on Baby E to ensure she was still breathing. At the time, she thought she felt her heartbeat, but upon reflection, she believes she was feeling her own heartbeat through her fingers.

18. Ms E and Mr E noted that there appeared to be something wrong with Baby E sometime between 6.30am and 7.50am.[2] Ms E recalls that she sent a message to Ms Lal, and Ms Lal reportedly viewed Baby E via FaceTime and then told Ms E to call 000 for an ambulance.

19. However, according to a response provided by Ms Lal to the Court, the only occasions when she spoke to Ms E was to arrange the pool hire, and when she attended the home after emergency services arrived to attend to Baby E. Ms Lal's response did not include reference to the FaceTime video call that Ms E reported. Ms Lal stated that Ms E contacted her following

[2] According to Ambulance Victoria records, statement of Ms E and the notes from Sgt Joanna Jamieson.

the birth to ask her to come visit her and the baby, which she was happy to do as she had to collect the pool.[3]

20. Further information about the contact between Ms Lal and Ms E is contained in a record of a conversation between Ms Lal and a staff member at the Mercy Hospital. According to that record, Ms Lal recalled that she received a text message at 10.50pm on 29 December 2022 from Ms E saying, "I did it", which was about half an hour after the baby's birth, estimated to have been at 10.20pm. She received a further message from Ms E just before 8.00am on 30 December stating "we can't wake her, we aren't sure if she's breathing" and a picture was sent at 8.10am in which the baby's face was blue. Ms Lal didn't see the messages for 25 minutes. She then made a Facetime call and saw the baby, which she believed to be deceased, and she told the parents to call an ambulance. Ms Lal also spoke with police at the home following the birth, and the version of events she provided mostly correlates with this record from Mercy Hospital, and it included the text message and FaceTime contact with Ms E.

21. Ambulance Victoria records show that at 8.20am on 29 December 2022, Ms E called 000 and requested ambulance assistance. Mr E attempted to perform cardiopulmonary resuscitation (**CPR**) prior to the arrival of paramedics. Paramedics arrived on scene at 8.34am and immediately commenced CPR. Baby E was noted by paramedics to be in asystole, and warm to the touch. CPR continued for 30 minutes but was unsuccessful, and Baby E was declared deceased at the scene. Whilst at the scene, paramedics observed that Ms E needed medical care, and she was transported to the Mercy Women's Hospital for further treatment.

22. Police attended the scene and spoke to persons present including Mr E and Ms Lal, who arrived after the paramedics. The interactions were captured on body worn camera footage and police members made handwritten notes. Police determined that there were no suspicious circumstances.

Identity of the deceased

23. On 29 December 2022, Baby E, born 28 December 2022, was visually identified by her father, Mr E.

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

[3] Email from Ms Lal to the Coroners Court.

Medical cause of death

25. Forensic Pathologist Dr Yeliena Baber, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 30 December 2022 and provided a written report of her findings dated 9 August 2023.

26. Dr Baber noted that there was no estimated date of delivery (**EDD**), based on the limited information available to her at the time of completing her report. This was later identified to have been 12 December 2022. Dr Baber noted that the appearances of the skin were typical of those seen in post-date babies and can also be seen because of prolonged meconium exposure. The weights and measurement were indicative of a gestation of at least 40 weeks. Based on the reported EDD of 12 December 2022, Baby E was more than 42 weeks gestation at the time of birth.

27. Dr Baber stated that there was minimal antenatal care, and therefore, the suitability of a birthing pool, pursuant to Safer Care Victoria guidelines (applicable for healthcare facilities) as a choice for delivery, had not been determined.

28. Ms E's Group B Streptococcus (**GBS**) status was unknown, and therefore the risk of ascending infection was also unknown. The timing of membrane rupture was also unknown due to the extended amount of time spent in the birthing pool. As such, the need for intravenous antibiotics during labour as a precaution to prevent neonatal infection was also unknown.

29. Examination of the placenta determined that there was necrotising chorioamnionitis,[4] umbilical phlebitis[5] and chorionic vasculitis[6]. This meant there was a maternal inflammatory response stage III, grade 2 and foetal inflammatory response stage I, grade 1. In addition, there was evidence of meconium exposure, and a recent marginal haemorrhage. These are all risk factors for a poor neonatal outcome.

30. Examination of the lungs showed that there had been deep inhalation of meconium and squamous cells; many small airways being tightly packed. Acute inflammatory cells were present within multiple airways and within some alveoli.

31. Swabs and tissue samples taken at autopsy revealed the presence of *Rhizobium radiobacter* in the right lung swab and both middle ear swabs. Bacteria from the genus *Rhizobium* (formerly *Agrobacterium*) are plant pathogens. Genus *Rhizobium* contains five species out of which

[4] Bacterial infection.
[5] Inflammation of the umbilical vein.
[6] Placental inflammation, specifically affecting the blood vessels of the chorion.

Rhizobium radiobacter has been recognised as the most common opportunistic human pathogen. Infections due to *R. radiobacter* are strongly related to the presence of foreign plastic materials. Most commonly, human infections are community acquired. Pneumonia and sepsis are amongst the clinical conditions caused by this bacterium. Dr Baber opined that these findings also raised the issue of whether appropriate guidelines were followed with respect to the use of the plastic birthing pool.

32. Other adjuvant tests (toxicology, metabolic tests) were non-contributory. Electrolytes could not be assessed due to the paucity of vitreous humour.

33. Toxicological analysis of post-mortem blood samples did not identify the presence of alcohol or any commonly encountered drugs or poisons.

34. Dr Baber provided an opinion that the medical cause of death was "*1(a) Neonatal pneumonia, meconium aspiration and chorioamnionitis*" secondary to "*1(b) Prolonged labour in a home birthing pool*".

35. I accept Dr Baber's opinion.

FURTHER INVESTIGATIONS

36. Following receipt of Dr Baber's report, I sought further information from her about Baby E's death and whether there were any opportunities for prevention. Additionally, I requested further information from Ms Lal regarding her involvement, and from the Department of Health and RANZCOG, regarding the use of birthing pools.

Further information from Dr Baber

Chorioamnionitis

37. Dr Baber explained that chorioamnionitis is a maternal infection that is transmitted vaginally and this is the reason that pregnant women undergo antenatal GBS testing. A GBS positive status, if treated with antibiotics, is not a serious issue for the neonate. However, if left untreated, the baby may inhale the bacterium and develop neonatal pneumonia or an eye infection.

38. Dr Baber was unable to conclusively determine if the chorioamnionitis was the result of Ms E being in the birthing pool for an extended period of time, or she if was GBS positive prior to entering the pool. However, she noted that the finding of necrotising chorioamnionitis indicated it had been present for some time.

Meconium exposure

39. Dr Baber explained that there was deep inhalation of meconium which was extensively present throughout Baby E's lungs. Inhalation of meconium often occurs following prolonged labour, however this is not always the case and can occur even during a short labour. Its presence does not always mean the baby was in distress, however, given the extent of its presence in Baby E's lungs and likely length of time on her skin, Dr Baber estimated that Baby E was likely in distress for some time and was exposed to meconium for many hours.

40. Meconium exposure is not necessarily serious, if medically treated promptly and appropriately. In a clinical setting, Baby E would have likely received antibiotics and/or respiratory support and therapy and is unlikely to have suffered any long-term consequences.

Presence of Rhizobium radiobacter

41. Dr Baber explained that the presence of *R. radiobacter* was unusual, as it usually tends to colonise in catheters and intravenous lines. However, given that Baby E and Ms E were not intubated and did not receive any intravenous treatment, the only remaining source of the bacteria was the plastic birthing pool.

Preventability of Baby E's death

42. Dr Baber explained that Baby E did not have any congenital abnormalities and was well-formed; Ms E's placenta was appropriately located, her amniotic fluid levels were normal, and she did not have gestational diabetes.

43. Dr Baber opined that if Ms E had presented to hospital, a cardiotocography (**CTG**) would have picked up foetal distress and clinicians would have observed the prolonged labour, leading to an expedited delivery via forceps, caesarean section and/or vacuum. Furthermore, if Ms E had presented to hospital, her GBS positive status would have been identified and she would have received antibiotics accordingly. Even if Baby E's condition was poor at the time of her birth, if she had been born at hospital, she would have received immediate resuscitation from trained neonatologists, improving her likelihood of survival.

44. Dr Baber concluded that if Baby E was born in hospital and Ms E had received appropriate antenatal care it is highly unlikely that Baby E would have died, as she was a healthy baby and her death was caused by the prolonged delivery in a home birthing pool. Similarly, if a trained midwife had been present at the home birth for Ms E's prolonged labour, it would be

expected that that they would escalate care to a hospital if it was clear that the baby was in distress.

45. I accept Dr Baber's opinion.

Responses from the Department of Health and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)

46. The Department of Health (**DOH**) noted that there are no regulations specifically applicable to the provision of birthing pools in Victoria or Australia.[7]

47. The position of DOH is that mandatory regulation of the sale/hire of birthing pools is not recommended as it would have limited effect. DOH instead recommended an "*educative approach which encompasses broader access to relevant information"*. DOH proposed that "*this would include updating websites such as the Better Health Channel with Safer Care Victoria's* Guidance: Water for labour and birth' *and RANZCOG's best practice statement* Water immersion during labour and birth*"*.

48. DOH pointed to information available on its own website, as well as the Better Health Channel, Safer Care Victoria, the Royal Women's Hospital and the RANZCOG websites regarding home birth. It noted that Safer Care Victoria's '*Guidance: Water for labour and birth*' and RANZCOG's best practice statement, '*Water immersion during labour and birth*' are publicly available documents which could guide GP care and advice to women they are seeing for pregnancy care. DOH noted the role that GPs play in education, referrals, and guidance during pregnancy.

49. DOH also directed attention to the Australian Government '*Pregnancy, Birth and Baby*' website, which includes a publicly accessible information page on water birth. That information refers to water births at home. It is recommended that two midwives and an additional support person be present for a water birth as part of a home birth, and a safe inflatable birth pool be chosen that can be easily removed if there is a complication. The website also provides more general information about planning a home birth and issues for expectant parents to consider, including risks and avenues for further information if needed. The importance of speaking to a midwife or doctor is noted for both home births and water births. A home birth is distinguished from a '*freebirth*', which is when someone chooses to

[7] DOH referred to standard safety and consumer laws that apply to inflatable pools, as with other consumer goods, regulated by the Australian Consumer and Competition Commission (**ACCC**). I note that the ACCC laws are not relevant to the facts of this case.

birth their baby without medical or midwifery assistance. I note that DOH also drew the distinction between a 'homebirth', and a 'freebirth', such as occurred in this case.

50. The publicly available information regarding water birth, including the Safer Care Victoria and RANZCOG guidelines, is clearly directed to health practitioners and birthing facilities, and for the general information of women considering water birthing options with medical care either in a hospital or a planned home birth. They are not directed at women intending to birth at home with no medical assistance or antenatal medical management. It is difficult to see how these guidelines could be of practical use in a freebirth where no one with appropriate medical training is involved.

51. I note that DOH supports inclusion of the Safer Care Victoria and RANZCOG guidelines regarding water birth on the publicly available *Better Health Channel.* Whilst these guidelines have no direct application to freebirths, this at least has the potential to increase access to relevant information for medical practitioners involved in managing birth and pregnancy, as well as for prospective parents who are considering birthing choices. Any approach which leads to broader public access to relevant birthing information is worth pursuing. As such, I have made a recommendation to that effect.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Baby E, born 28 December 2022;

    b) the death occurred on 29 December 2022 at [redacted] Victoria, [redacted] from neonatal pneumonia, meconium aspiration and chorioamnionitis secondary to prolonged labour in a home birthing pool; and

    c) the death occurred in the circumstances described above.

53. Having regard to all the available evidence, and particularly the evidence of Dr Baber, I am satisfied that the circumstances of the birth occurring in the birthing pool contributed to the death. I am also satisfied that the death of Baby E was preventable. It was unlikely to have occurred if the birth occurred in a hospital setting, and it may also have been avoided if the birth was a planned homebirth with appropriate midwife support.

54. The birth of Baby E was a planned freebirth with an absence of antenatal medical management. The single consultation with Dr Lucas late in the pregnancy provided no real

opportunity for education to be given regarding birth options, noting that Ms E did not attend to ask for management of her pregnancy and did not disclose her birth plan at that time. Having regard to the circumstances of the case, I have not identified any specific prevention opportunities.

RECOMMENDATION

Pursuant to section 72(2) of the Act, I make the following recommendation relating to public health and safety:

1. That the Department of Health update relevant websites, including the Better Health Channel, with Safer Care Victoria's 'Guidance: Water for labour and birth' and RANZCOG's best practice statement 'Water immersion during labour and birth'.

ORDERS

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:

Ms E and Mr E, Senior Next of Kin

Jenny Atta PSM, Secretary to the Department of Health

Leading Senior Constable Peter Hanson, Victoria Police, Notifying Member

Signature:

Coroner Catherine Fitzgerald

Date: 04 August 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.