OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Talisha Hildebrandt**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Ayr
FILE NO(s):	COR 63/07(0)
DELIVERED ON:	7 October 2009
DELIVERED AT:	Ayr
HEARING DATE(s):	21 August 2009 in Townsville, 5, 6, 7 October 2009 in Ayr
FINDINGS OF:	Coroner Smid
CATCHWORDS:	CORONERS: Inquest – death of baby, meconium aspiration, appropriateness of medical care, policies and procedures

REPRESENTATION:

Counsel Assisting	Mr John Tate, Crown Law
Nurses Helen Cross and Jillian Stanbrook	Ms M. Kochardy i/b Roberts and Kane, Solicitors
Queensland Health	Mr T Gardiner i/b Minter Ellison

These are my findings in relation to the death of Talisha Hildebrandt. The findings seek to explain how the death occurred and consider whether any changes of policy or practices could reduce the likelihood of death occurring in similar circumstances in the future.

The *Coroners Act of 2003* provides that when an inquest is held into a death, the Coroner's findings must be given to the family of the person who died and to each of the persons or organisations granted leave to appear at the inquest. These findings will be distributed in accordance with the requirements of the Act and also placed on the web site of the office of the State Coroner.

The Coroner has jurisdiction to inquire into the cause and circumstances of a reportable death. If possible, he or she is required to find whether the death, in fact, happened, the identity of the deceased, when, where and how the death occurred, and what caused the person to die.

There has been considerable litigation concerning the extent of the Coroner's jurisdiction to inquire into the circumstances of a death and it seems to me to be appropriate that I say something about the general nature of inquests for the benefit of the deceased's family and for completeness.

An inquest is not a trial between opposing parties but an inquiry into a death. In a leading English case it was described in this way,

> *"It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the Prosecutor accuses and the accused defends."*

The function of an inquest is to seek out and report as many of the facts concerning the death that the public interest requires. The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar death. As a result the Act authorises a Coroner to make preventative recommendations concerning public health or safety, the administration of justice or ways to prevent death from happening in similar circumstances in the future. A Coroner must not include in the findings or any comments or recommendations or statements that a person is or may be guilty of an offence or civilly liable for something. However, if as a result of considering the information gathered during an inquest a Coroner reasonably suspects a person may be guilty of a criminal offence, a Coroner must refer the information to the appropriate prosecuting authority.

It is important to note that proceedings in a Coroner's Court are not bound by rules of evidence pursuant to section 37 of the Act. Because section 37 of the Act provides that a Court may inform itself in any way it considers appropriate, that does not mean that any and every piece of information, however unreliable, will be admitted into evidence and acted upon. However, it does give a Coroner a greater scope to receive information that may not be admissible in other proceedings and to have regard to its providence when determining what weight should be given to information.

The flexibility has been explained as a consequence of an inquest being a fact finding exercise rather than a means of apportioning guilt; an inquiry rather than a trial. A Coroner should apply the civil standard of proof, namely the balance of probabilities, to the approach referred to as the Briginshaw sliding

scale is applicable. This means the more significant the issue to be determined, the more serious the allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trial of fact to be sufficiently satisfied that has been proven to the civil standard.

It is also clear that a Coroner is obliged to comply with the rules of natural justice and act judicially. This means that no finding adverse to the interests of any party may be made without that party first being given a right to be heard in opposition to that finding.

On the 7th of January 2007 Annette and Bradley Hildebrandt and their two children presented to the Ayr Hospital following labour contractions Annette experienced earlier that morning. The pregnancy had been uneventful and had been described as low risk and its management according to established practice. No abnormalities had been reported or detected. Her two previous pregnancies had been equally unremarkable. She was admitted into the labour ward and taken care of by Diane McAuliffe, a midwife of 36 years experience with impeccable appropriate credentials. The only CTG monitor in the hospital was administered by Ms McAuliffe with a view to scanning the unborn baby's heartbeat. This process was commenced soon after Annette's admission in hospital and soon after midday on the 7th of January 2007. It showed a fluctuating and then declining heartbeat.

Ms McAuliffe stated in evidence that she had earlier been told the monitor was unreliable and this, she said, had manifested itself during the scanning of Talisha Hildebrandt's heartbeat. Each witness with knowledge and experience of this particular CTG monitor disavowed any notion of its possible malfunction. Be that as it may, the CTG monitor's trace caused Ms McAuliffe such grave concern that on this Sunday she rang Dr Aung at home. Dr Aung was one of the physicians employed by the Ayr Hospital.

Dr Aung, a doctor of ample relevant medical experience, examined the CTG monitor's trace and was alarmed by it. He then carried out a medical examination and performed some manual procedures, one of which was to cause Annette's waters to break.

Upon performing the medical procedures he discovered meconium of a tan colour being present. He quickly formed the view that the baby was in distress and that a Caesarian section was urgently required to be performed. Dr Row, the medical superintendent, was also called at home by Dr Aung and he too, soon after, arrived at the hospital.

Sadly, Talisha was stillborn, in my view. Dr Row, Dr Aung and Dr Ong, all of whom gave evidence, were the medical team performing the Caesarian section. Each of their evidence had a consistent theme.

Resuscitation was attempted for approximately 40 minutes to no avail. A post-mortem by Dr Williams showed that Talisha's cause of death was meconium aspiration. The presence of meconium, we have been told in evidence by Dr McLaren, can be the result of different causes. It can arise spontaneously, by hypoxia, smoking, and flight and fight syndrome, to mention but some of the causes of meconium. As Annette smoked 10 to 15 cigarettes a day during the pregnancy, Dr McLaren considered this as a possible co-factor, though not necessarily the cause of the presence of meconium. This is particularly the case, Dr McLaren said, in second and third pregnancies.

Dr McLaren is an obstetrician, I should say. She was appointed by the court to review the evidence independently and someone of considerable experience in this particular field. She had said in evidence it is not uncommon for meconium to be present but this need not always be fatal. She said, also in evidence that one in 200 to 1,000 babies were stillborn. Dr McLaren gave in evidence that the presence of meconium often goes undetected. Annette would have had no forewarning that anything was amiss except perhaps for the increased movements of the baby on 6 January 2007. This, Dr McLaren concludes, was an indication the baby was then in distress. Given the colour of the meconium, Dr McLaren came to the view that the baby, at least the night before, had started to inhale meconium.

This cross-examination on the part of Mr Hildebrandt was designed to ascertain whether an even quicker response by medical staff on the 7th of January 2007 might have saved the baby. Dr McLaren expressed the view that a medical team's response time was within acceptable boundaries, especially since this was a Sunday and that the medical intervention and supervision had been entirely appropriate. She concluded that neither man nor machine bore any fault in the death of Talisha Hildebrandt.

Even if response times had been quicker, the result, she concluded, would have been the same. Had the same medical procedure been carried out the night before, that is to say on 6 January 2007, Talisha, if she had survived, would have been seriously physically handicapped.

In this inquest few, if any, of the factual issues are in dispute. For that reason I dispense with the usual practice of setting out the evidence received by this court in great detail even though I have considered all of the evidence.

I make the following findings:

I find that Talisha Hildebrandt died at the Ayr Hospital in the afternoon of 7 January 2007.

I further find that Annette had a normal and low risk pregnancy.

Further, that her pregnancy was appropriately and competently managed by medical staff at the Ayr Hospital.

I find that Talisha Hildebrandt's cause of death was meconium aspiration the cause of which was unknown though I have referred earlier on to the evidence of Dr McLaren that perhaps the fact that Annette was a smoker may have been a co-factor.

Meconium was present at least 24 to 48 hours before Talisha's death. There had been no indication of foetal distress other than the increased movement the night before Talisha's death.

I make no finding as to the reliability of the CTG monitor on the basis of Ms McAuliffe's evidence alone. Suffice to say the monitor accurately indicated Talisha's distressed state.

I further find that the medical staff's response time was acceptable and appropriate.

I further find that the medical examinations, procedures, and Caesarian section and resuscitation attempts were competently performed in a timely

fashion.

I find, further, that Talisha's death could not have been prevented.

It follows that I conclude that no one person, medically qualified or otherwise, machine, policy or procedure, or lack thereof was, in any way, responsible or contributed to Talisha's death.

I make the following recommendations:

1. That Queensland Health consider the acquisition of a second CTG scanner for the Ayr Hospital. The provision of a second CTG monitor would provide a critical safety factor and obviate the need for a single machine to be needed for multiple presentations at the one time.

2. That Queensland Health provide recurrent funds to the Ayr Hospital and other rural and primary hospitals such as the Ayr Hospital to enhance the primary health care approach in our antenatal clinics with a particular emphasis on the implementation of screening for smoking, alcohol and drug use to improve access for mothers. In particular, antenatal information provided to expectant mothers should include a warning that a change in foetal movement, be it a decrease or increase in movement, be promptly reported to the doctor.

3. That Queensland Health review the current practice of emergency callout to include codes to clearly signify the degree of urgency. I refer, of course, to the evidence that medical practitioners and nurses had to be called from their home on a Sunday and that the degree of urgency perhaps could be more clearly conveyed to all and sundry if proper coding was in place.

4. That Queensland Health and the Queensland Police Service review any existing Memorandum of Understanding or protocol to ensure the efficacy and timeliness of coronial investigation undertaken by police on behalf of the Coroner. I endorse the recommendation advanced and I refer to Exhibit 24 on the part of Dr Row and Ms Vicary whose respective functions are Director of Medical Services and Director of Nursing at the Ayr Health Service to implement the K2 program for all endorsed midwives and doctors so that a regular CTG implementation updates can be electronically updated and completed.

That completes my recommendations.

I just add the following comments. During the course of this inquest the court visited the Ayr Hospital with particular attention to the labour ward and operating theatre. I had the opportunity to see all this and I'm very grateful I was afforded this opportunity. The very clear impression I received was that of a clean, well laid out hospital whose staff was very professional, motivated and caring. Having carefully listened to the evidence of the hospital's medical and nursing staff, I have come to the inescapable conclusion that the loss of a child by Mr and Mrs Hildebrandt at child birth was at least cushioned by the bountiful compassion and caring of the staff involved towards Mr and Mrs Hildebrandt.

In my view, the community can count itself lucky with such a hospital.

I want to make two more final comments. I thank Mr Tate for his professionalism, for his great assistance to me. Suffice to say without his

assistance I would have had great difficulty getting through this inquest.

I want to say something, too, about Mrs Collins. I commend Mrs Collins who, in response to requests from the court for statements and information, has provided those in a very timely and professional way and she provided a thorough brief of material that has been of great assistance in allowing the court to investigate issues raised in this particular inquest.

As a result of the thoroughness of her investigations and efforts, and the clarity of those statements, I feel that the cross-examination of the inquest was confined to a very narrow range of issues which assisted in the speedy completion of this inquest. I want to thank all of the participants for their courtesy and their involvement.

I close the inquest.

Coroner Smid
7 October 2009