These findings have been amended on 7 April 2011 to remove the reference to Healthscope in recommendation 19 and insert Ramsay Health Care. The Office of the State Coroner apologises for this error.

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Samara Lea Hoy**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Southport
FILE NO(s):	COR 2008/647
DELIVERED ON:	5 April 2011
DELIVERED AT:	Southport
HEARING DATE(s):	10 February, 7 May, 21 – 29 June 2010
FINDINGS OF:	John Hutton, Coroner
CATCHWORDS:	CORONERS: Inquest – death of baby, tight umbilical cord around neck, meconium aspiration, appropriateness of medical care, policies and procedures

REPRESENTATION:

Counsel assisting	Gavin Handran
Parents	Ms Patricia Feeney
John Flynn Private Hospital	Ms J Rosengren (Minter Ellison)
Doctor Doolabh	Mr A Luchich (Flower & Hart)
Doctor McMasters & Doctor Trueman	Ms S Gallagher (Blake Dawson)

Samara Lea Hoy (**baby Samara**) was born at 2.01am on the 8th November 2008, at John Flynn Private Hospital. She was delivered by Ventouse extraction after a prolonged second stage labour. She died shortly after birth.

An autopsy examination concluded that baby Samara died at birth of asphyxia caused by a tight umbilical cord around her neck.

Jurisdiction

The coronial jurisdiction is enlivened because baby Samara died in Queensland and her death was a result of a health procedure; as such it constituted a 'reportable death' under the Act.

The Coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible, s45 of the Coroner's Act requires the Coroner to find:

a. whether a death in fact happened;
b. the identity of the deceased;
c. when, where and how the death occurred; and
d. what caused the person to die.

The following additional questions were also examined at the inquest:

- The adequacy of the birth process employed at the hospital;
- The extent of any inadequacies in the birth process employed at the hospital during the birth process;
- The adequacy of the care and the management provided by the hospital during the birth process;
- The adequacy of policies and procedures in place at the hospital addressing the birth process and the care and management to be offered during the birth process; and
- The adequacy of the training of staff at the hospital in these policies and procedures;

In addition to the above issues the following specific issues were examined:

a. whether the admission cardiotocography (**CTG**) monitoring was adequate and/or in accordance with existing policies;
b. whether the FHR monitoring conducted during labour was adequate and/or in accordance with existing policies;
c. whether there was any delay in calling the obstetrician;
d. if there was delay in calling the obstetrician, what was responsible for the delay;
e. the adequacy of the obstetrician's response; and
f. was there a causal connection between the obstetric response and the death of baby Samara.

The process of an inquest is inquisitorial and the focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability.

Section 46 of the Coroner's Act allows a Coroner to comment on anything connected with a death which relates to public health or safety, the administration of justice, or ways to prevent deaths from happening in similar circumstances in the future.

Admissibility of evidence and the standard of proof

A Coroner's Court proceeding is not bound by the rules of evidence. Section 37 of the Act provides that the court "may inform itself in any way it considers appropriate." However, not every piece of information, however unreliable, will be admitted into evidence and, even if admitted, necessarily relied upon. A Coroner can receive information which may not be admissible in other proceedings and have regard to its provenance (and inherent reliability) when determining what weight should be given to such information.

This is because an inquest is more of a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial. It is not an adversarial proceeding.

A Coroner must apply the civil standard of proof; that is "proof on the balance of probabilities." This is referred to as "The *Briginshaw* sliding scale." This means that the more significant the issue to be determined; or the more serious an allegation; or the more inherently unlikely an occurrence; then in those cases the clearer and more persuasive the evidence should be in order for the court to be sufficiently satisfied that it has been proven to the civil standard.

A Coroner is obliged to comply with the rules of natural justice and act judicially. This means that no findings may be made adverse to the interest of any person who has leave to appear unless that person is given a right to be heard. *Annetts v McCann* makes this clear; this also includes a person or organisation being given an opportunity to make submissions against findings which might be damaging to the reputation of that person or organisation.

If a Coroner reasonably believes, from information obtained at an inquest or during the investigation, that such information may cause a disciplinary body for a person's profession or trade to inquire into, or take steps in relation to, the person's conduct, the Coroner may give that information to such a body.

The Evidence

During the inquest it became apparent that medical records had been altered. As there was no opportunity for Dr Doolabh to do this, the only other party with a real interest in altering the records was midwife Fankhauser. She had both motivation and opportunity to so do, and during the inquest and subsequent to the inquest she has admitted altering the records. For this reason, the medical records needed to be examined carefully before relying upon them specifically in relation to that area covered by midwife Fankhauser. It is alarming that the second stage labour notes were commenced when Mrs Hoy was **NOT** in the second stage of labour. However, when Mrs Hoy was in the second stage of labour the records of the foetal heart rate were not recorded in five minute intervals, as required. The obstetrician, Dr Doolabh, did not make any records until after the baby was delivered. This is despite having attended earlier and subsequently sitting around and waiting for some time when he returned after

midnight. It is noted that the medical records did not record Mrs Hoy's request for the CTG monitoring to cease, nor did they record interaction between herself and Dr Doolabh when she allegedly refused his offers of assisted labour.

Events during pregnancy

Prior to Mrs Hoy presenting at the hospital on the 7th November, she had been attended by Dr Trueman and her pregnancy was considered low risk. In October Mrs Hoy was seen by Associate Professor Pincotter for a suspected foetal arrhythmia. This was fully investigated and the question of arrhythmia was settled. Professor Pincotter described the condition as a series of ectopic beats and concluded that the matter was of no concern, unless there were runs of brachycardia or tachycardia. Mrs Hoy did not discuss with Dr Trueman the question of assisted birth or intervention.

In order to facilitate time off, the obstetricians, doctors Trueman, Doolabh and Tan, had an arrangement to cover each other every third weekend, and as this arrangement would have it, Dr Trueman's weekend off commenced on the 7th November 2008, so according to the arrangement, Dr Trueman was covered by Dr Doolabh. Prior to the 7th November 2008 Dr Doolabh had never met Mrs Hoy.

Antenatal classes

John Flynn Private Hospital ran antenatal classes facilitated by midwife Fennell. These classes were held over a period of five weeks and were mainly focused on a normal delivery. Natural birth was emphasised as the preferred method of delivery. Mrs Hoy was told that the CTG monitor was used to both monitor the foetal heart rate and the mother's contractions, but the necessity for use of CTG monitoring was never fully explained to her. Mrs Hoy was led to believe the labour would be managed by the midwife, and if necessary an obstetrician would take over.

The classes did not fully explain when and how interventions may be necessary. Nor did the classes explain the reason for an urgent intervention. It was explained that when intervention was needed a midwife and an obstetrician would use the required method necessary to suit the situation. The question of timely interventions was never properly addressed in the classes, nor was the urgency of such emphasised. Overall Mrs Hoy got the impression from the classes that drugs were for pain relief and interventions were not ideal.

During the classes there was a noted lack of input from the obstetricians. Given the obstetrician is important in the case of intervention, and given that the birth process is a team effort, the antenatal classes should reflect the cooperation and interaction of the obstetrician and midwives and how they operate when an intervention is necessary.

During the inquest Diane Sapwell, the Director of Clinical Services, provided the Court with an update of the hospital's antenatal booklet, which was user friendly and positive. Whilst this booklet is of some assistance, more emphasis needs to be given to the intervention process. It is vital that mothers fully understand how a timely intervention is necessary for the welfare of the mother and child.
Birth plans need to be revised so that an expectant mother is aware that a birth plan must be flexible enough to urgently change to do whatever is necessary to

deliver the baby safely by intervention. This takes into account the paramount concern for the welfare of the child together with the mother's health.

Admission CTG

When Mrs Hoy was received into the hospital at 6:15pm on the 7th November 2008, the labour ward was busy. Mrs Hoy was having contractions which commenced at 3:00pm that day and she was in established labour. At the time the hospital had a policy of "Assessment and Management of First Stage of Labour". This practice called for a minimum standard of a ten minute duration CTG. The policy also required the midwife to obtain baseline observations for blood pressure, pulse, temperature and communication.

During the inquest, both midwives Fennell and Peller accepted that a period of 20 minutes or more is required to obtain a good trace on a CTG. Midwife Peller went so far as to say that 20 to 30 minutes was ideal. In this case a CTG trace of less than five minutes was obtained by midwife Fennell. This was far too short. There is some dispute between the evidence of midwife Fennell and Mrs Hoy as to whether any encouragement was given to continue with the CTG, but midwife Fennell has no actual recollection nor written record of providing any such encouragement, nor offering Mrs Hoy any explanation for the use of the CTG. Mrs Hoy said in her evidence that she was not encouraged to continue with the CTG. I am prepared to accept Mrs Hoy's evidence that she was not told the CTG was necessary for the welfare of the baby. Midwife Fennell failed to record Mrs Hoy's refusal to continue with the CTG.

I find that if it had been explained to Mrs Hoy that a CTG was necessary to assess the on going welfare of her baby, she would have had no hesitation of accepting any discomfort of the CTG and adopted the procedure.

At the time, midwife Fennell was mainly preoccupied in getting Mrs Hoy into the spa to start pushing, because a vaginal examination by midwife Fennell caused midwife Fennell to believe Mrs Hoy was almost fully dilated.

Midwife Fennell failed to complete the birth record. This was contrary to the admission policy. Midwife Fennell was an experienced midwife and was well aware of hospital policy on admission of a patient such as Mrs Hoy. Any dereliction by her to follow this policy could not be attributed to ignorance on her part. She did not follow the admission procedures of the hospital, nor did she take steps to comply with them.

It became evident during the hearing that midwife Peller was also unaware of hospital policy. In her evidence she said that an admission CTG was only undertaken if the patient was a high risk. This is completely contrary to hospital policy. Given that midwife Peller was the midwife in charge that evening, it is evident that the policies and systems of the hospital were not followed nor understood by the midwives. This matter needs to be addressed urgently.

Foetal heart monitoring during labour

The hospital policy followed The Royal Australian and New Zealand College of Gynaecologists (RANZCOG) clinical guidelines. These clinical guidelines required CTG monitoring to be undertaken in the presence of certain risk factors,

one of which was the presence of meconium or blood stained licor which by itself triggers the requirement for a continuous CTG. Both midwife Peller and Fankhauser accepted the tachycardia was also a trigger for continuous CTG. In the absence of an identifiable risk, as mentioned above, foetal monitoring by use of a Dopler is acceptable at intervals of 30 minutes during the first stage, and, in the absence of a CTG, after each contraction and no less than five minutes during the second stage. The policy required the foetal heart rate findings to be recorded in the medical file.

The second stage of labour in the policy document reiterated the necessary intervals for recording the foetal heart rate.

In this case, midwife Peller commenced recording the second stage labour at 7:00pm. She said she did this because of what she had been told by midwife Fennell, namely that Mrs Hoy was fully dilated. It was not until 7:30pm that midwife Peller realised Mrs Hoy was not fully dilated. Although Mrs Hoy was not in the second stage, as believed by Peller, the foetal heart rate monitoring was not done in five minute intervals as required for a second stage monitoring, but in 15 and 30 minute intervals, completely contrary to hospital policy. Notwithstanding midwife Peller discovering at 7:30pm that Mrs Hoy was not in the second stage of labour, she continued to record information in the second stage document after 7:30pm, when she was aware that Mrs Hoy was not fully dilated and therefore not in the second stage of labour.

There was some dispute in evidence between midwife Peller and the Hoys as to the frequency of monitoring. Mr and Mrs Hoy maintained that midwife Peller left them alone for extended periods of time, whereas midwife Peller said she was out of the birth suite on a number of occasions, but only one occasion was she out of the suite for an extended period of time of 20 minutes or so. The other occasions lasted only minutes.

The partigram, as completed by midwife Peller, clearly indicated a rising base line in baby Samara's foetal heart rate from the time of Mrs Hoy's admission. The rise in base line of the foetal heart rate of 125 beats per minute (bpm) at 6:30pm to 140 bpm at 9:30pm and 150 bpm at 10:00pm is clearly an acceleration in the foetal heart rate, as defined by the RANCOG clinical guidelines, which should have been sufficient to trigger the continuous use of the CTG monitoring between 9:30pm and 10:00pm. There was no reason why this could not be done, as the CTG was present laying idle at all times in the birth suite.

It is apparent that both the policy in place at the time and the new policy, as adopted by the hospital since the death, are deficient, in that they fail to draw attention to matters of concern whether witnessed during a continuous CTG or Dopler. An acceleration to decelerations should be identified as a risk factor sufficient to warrant the commencement of continuous CTG monitoring.

At 10:30pm Midwife Fankhauser took over the care of Mrs Hoy, when midwife Peller's shift finished. It is noted that there were no foetal heart rate monitoring records kept between 10:00pm and 10:30pm. This was a fundamental breach of hospital policy.

From the time midwife Fankhauser took over the care of Mrs Hoy, Mrs Hoy was fully dilated and had an urge to push. Midwife Fankhauser is aware that Mrs Hoy was in the second stage of labour. At 10:30pm she noted the foetal heart rate was 170 bpm. This clearly indicated that baby Samara was tacycardic. Midwife Fankhauser noted this on the second stage document, however she charted the foetal heart rate at less than 145 on the partigram. No other foetal heart rate recordings were charted, despite the policy requiring this be done. Again, the policy was not adhered to.

The foetal heart rate, as recorded by midwife Fankhauser at 10:30pm, when noted against the rising base line on the partigram graph, indicated a clear need to undertake continuous CTG monitoring and to inform the obstetrician. This was not done.

The assessment and management of second stage labour policy required a continuous CTG to be undertaken in cases of foetal heart rate recordings above 160 bpm. Midwife Fankhauser failed to do this and was in breach of policy. Midwife Fankhauser failed to follow the normal labour/use of partigram policy. She failed to accurately record the foetal heart rate recordings taken at 10:30pm or thereafter record the foetal heart rate measurements, as required.

Midwife Fennell said she recorded the foetal heart rate measurements on a piece of paper which she kept in her pocket and which she said she later lost. She did not record foetal heart rate records between 11:45pm and 1:30am, on the second stage document, or in the labour notes. This is another fundamental breach of policy. The keeping of medical notes on a piece of paper kept in her pocket or elsewhere and then losing them is totally unacceptable.

Midwife Fankhauser's monitoring of the foetal heart rate between 10:30pm and 11:30pm did not comply with hospital policy which required continuous monitoring.

Another cause for concern was Mrs Hoy's slow progress. This gave another reason for continuous CTG. Given the fact that Mrs Hoy had no sign of progress after one hour in the second stage, and the policy of the hospital dictated that the obstetrician should be called in in such cases; given the rising foetal heart rate trend as recorded on the partigram and witnessed by Fankhauser, there could be no other conclusion that a continuous CTG monitoring should have been undertaken at 11:30pm or prior. The above facts cause me to conclude that midwife Fankhauser was derelict in her duty as a midwife.

At about midnight, midwife Fankhauser noted the presence of meconium. This is a sign of foetal distress, and again warranted the use of a continuous CTG in accordance with the hospital policy. Again, midwife Fankhauser failed to comply with the policy of the hospital. There was a systemic break down in the managing of Mrs Hoy's labour. It was apparent there had been a rise in the foetal heart rate base line since 6:30pm. The increase is graphically recorded on the partigram and becomes more graphic from 9:30pm on. Failure to adequately monitor the foetal heart rate was more than likely a cause of death for baby Samara. Had CTG monitoring been utilised and the partigram completed, as

required, in all probability intervention may have resulted in the safe delivery of Samara.

The delay in calling the obstetrician

At the change over between 10:00pm and 10:30pm, midwife Peller stated that midwife Fankhauser told her she would call Dr Doolabh. Notwithstanding the fact that she had told midwife Peller she would call Dr Doolabh, she did not call him. Midwife Fankhauser failed to call Dr Doolabh at 10:30 when both the circumstances of the birth, as dictated by hospital policy, at that stage and her assurance to midwife Peller indicated that she should so do. I find that the accelerated baseline pattern of the foetal heart rate clearly indicated that Dr Doolabh should have been called at least at 10:30pm, when signs of tachycardia were present. Dr Doolabh's evidence is that he should have been called at 10:30pm is in agreement with this. Counsel on behalf of the hospital submitted Dr Doolabh's evidence that he should have been called at 10:30 is self serving and an abuse of hindsight and misguided. I disagree entirely with these submissions. The overwhelming evidence is that Dr Doolabh should have been called no later than 10:30pm. He was relying on midwives to monitor Mrs Hoy's progress and inform him accordingly. Dr Doolabh's evidence is that had he been called at 10:30pm he would have undertaken an emergency caesarean upon arrival due to an obstructed labour. Unfortunately, midwife Fankhauser failed to call Dr Doolabh at 10:30pm and the call was delayed until midnight. In these circumstances the foetal heart rate was in an elevated state between 10:30pm and midnight and 12:30pm, which was indicative of tachycardia and decelerations.

Mrs Hoy said in evidence that midwife Fankhauser told her she would wait until the baby's head showed before calling Dr Doolabh. Midwife Fankhauser admitted this was accepted practice but she denied saying it to Mrs Hoy. Given the fact that this was Mrs Hoy's first labour, and given the fact that midwife Fankhauser said this was normal practice, I accept Mrs Hoy as the more credible witness in this case, and that this was in fact stated by midwife Fankhauser, namely that she would wait for baby's head to show before calling Dr Doolabh. Dr Doolabh was not called until 12:11pm and he arrived at 12:30pm. By then it was too late. Had Dr Doolabh been called at 10:30, in accordance with hospital policy and also in accordance with what midwife Fankhauser told midwife Peller, baby Samara may have been delivered alive and well by way of caesarean section which could have been done by 11:30pm, which in turn coincides with the time that Dr Williams (the pathologist) estimates that baby Samara commenced to aspirate meconium, and the slow tragedy of her death had begun.

Dr Doolabh

Dr Doolabh was the obstetrician who attended Mrs Hoy during the birth. He first saw Mrs Hoy at 7:00pm when she was in the first stage of labour. Dr Doolabh briefly read Mrs Hoy's medical notes, introduced himself to Mrs Hoy while she was in the spa and then left for home. Dr Doolabh was called shortly after midnight and told Mrs Hoy had been pushing for one-and-a-half hours without any sign of the baby's head. He was also informed of tachycardia and meconium.

As previously mentioned, the presence of tachycardia and meconium are warning signs to any obstetrician. Dr Doolabh said as a result of the information told to him by midwife Fankhauser, he was coming in to do a Ventrouse extraction because of the meconium and because at this time she had been pushing for one-and-a-half hours and the head is not visible.

This was disputed by midwife Fankhauser. She said she was not directed by Dr Doolabh to have the Ventrouse extraction, vacuum, prepared. In fact, when Dr Doolabh arrived at 12:30pm Mrs Hoy was exhausted as she had been in the second stage of labour for some two hours, and although Mrs Hoy had been pushing for two hours, there was still no head of the baby visible. When Dr Doolabh did arrive, the sense of urgency seemed to dissipate as he settled on the window edge at the bottom of the bed and remained there for some time. Midwife Fankhauser meanwhile said she performed a catheter on Mrs Hoy to remove any possible obstruction caused by a full bladder. This was done just prior to Dr Doolabh arriving. There was some dispute as to how long Dr Doolabh remained on the window edge at the bottom of the bed. Midwife Fankhauser said he remained on the ledge for approximately 30 minutes. Dr Doolabh initially said he sat on the window ledge for 15 minutes and later said he sat there for about one hour. Dr Doolabh then said he sat on the window ledge about three times between five and ten minutes each.

Finally, Dr Doolabh accepted that he sat on the window ledge for approximately 30 minutes. Whether Dr Doolabh sat on the window ledge for 30 minutes or one hour, observing Mrs Hoy, any sense of urgency seems to have dissipated by assuming his position at the end of the bed, waiting and watching. All this time the CTG was sitting, unused beside the bed. It did not occur to Dr Doolabh to commence a continuous CTG, despite the evidence of a rising foetal heart rate and tachycardia as recorded on the medical file. Dr Doolabh did not even undertake a vaginal examination; he just sat at the end of the bed on the window sill between one and one half an hour, ignoring the urgency of the situation.

The evidence of Dr McLaren (an expert obstetrician called to assist the court) is that Dr Doolabh should have done a vaginal examination so as to ascertain the position and station of the baby's head. This would have enabled an experienced obstetrician to understand why the baby had not been delivered. Dr McLaren, an experienced obstetrician, later by way of letter dated 5th August 2010, stated that the position of the baby's head to a Ventrouse extraction was important and could only be ascertained by way of a vaginal examination. This was not carried out by Dr Doolabh when he arrived and waited on the window sill at the foot of the bed between one hour and one half an hour. Given Dr Doolabh's brief reaction on entering the birth suite, and the dispute between Dr Doolabh and midwife Fankhauser, I am inclined to accept that Dr Doolabh did not tell midwife Fankhauser he was coming in to do a Ventrouse extraction, because if he did tell her this, his behaviour upon entering the birth suite would have been completely different to that which he displayed.

Dr Doolabh did not seem to take control of the situation and when queried by Mrs Hoy on two occasions, he only offered options as to how labour could progress including Ventrouse extraction. He did not impress her with the urgency of the situation, nor was he firm and direct in explaining how intervention was used and

why it should be used. In fact, his advice was of no assistance to Mrs Hoy. This was Mrs Hoy's first pregnancy and she needed some direction and help. By giving her a series of options, Dr Doolabh was putting the ball more into her inexperienced court rather than taking control of the situation himself. Given that Dr Doolabh said he told midwife Fankhauser he was coming in to do a Ventrouse extraction, it seems rather alarming and amazing that he took so long to raise this procedure with Mrs Hoy. He says he raised it with her at 1:00am.

Dr Doolabh accepted the Ventrouse extraction was employed in cases of foetal distress and maternal exhaustion. These signs were clearly present on his arrival. He however delayed and could not provide any explanation for his delay. Given that his evidence is that he told midwife Fankhauser on the telephone he was coming in to do a Ventrouse extraction, there seems no explanation as to why he then waited until after 1:00am to attempt a Ventrouse extraction. Indeed, although Mrs Hoy was exhausted, and the signs of foetal distress were there for one hour after he arrived, he did not attempt a Ventrouse extraction until 1:30am, by which time Mrs Hoy was well and truly exhausted.

Dr Doolabh put a series of options to Mrs Hoy in her exhausted state. The situation did not call for options, but for assertive leadership and direction. Dr Doolabh did not provide this to Mrs Hoy. Mrs Hoy attempted to get advice from a relative in the USA. All this demonstrates is the lack of leadership and professional direction Mrs Hoy was given. It also is a measure of the desperation Mrs Hoy had reached. Mrs Hoy was however unable to get this advice from her relative. Out of frustration Mrs Hoy agreed to a Ventrouse extraction. When the Ventrouse extraction was commenced, midwife Martin was summoned to attend. She assumed she was there because of foetal distress, and the medical records at 1:40am record "difficulty hearing; fh vacuum applied two x midwives present". The Ventrouse extraction commenced at 1:45am and, despite a number of attempts by Ventrouse extraction, Dr Doolabh was unsuccessful as the cup kept slipping from the baby's head. Eventually, the use of an older style cup succeeded in successfully extracting the baby. It was during this procedure that the foetal heart rate was undetectable.

Dr Doolabh failed to call or arrange for a paediatrician to be called when hospital policy dictated that in this case a paediatrician needed to be present at the birth. Given that there was sufficient foetal distress recorded, Dr McMaster, a paediatrician on call, should have been present at the birth. In his evidence Dr McMaster said if called he would have attended. He lived 20 minutes from the hospital. Even Dr McMaster was unaware of the policy of the required paediatrician to be present for a Ventrouse delivery.

If, as Dr Doolabh claimed he had said to midwife Fankhauser, that he was coming in shortly after 12:00, midnight, to do a Ventrouse extraction, Dr McMaster should have been called to be present in accordance with hospital policy. He was not called, as required.

Upon being born, the umbilical cord was wrapped tightly around baby Samara's neck and she was covered with thick meconium. She was pale and hypotonic. Her foetal heart rate had dropped to 40 bpm and she had no spontaneous respiration. The baby was placed on Mrs Hoy's stomach and the cord was cut,

after which she was taken immediately to the resuscitation trolley. She did not have spontaneous respiration. Upon being placed on the resuscitation table, baby Samara's heart rate was about 40 to 50.

Midwife Fankhauser assisted with the resuscitation and at this stage midwife Fankhauser arranged for Dr McMaster, the paediatrician, to come in immediately. In the meantime, Dr Cavanagh, an Intensive Care Unit Registrar, arrived to assist. Baby Samara was intubated and given two doses of adrenaline together with oxygen. At 2:30am Dr McMaster arrived and resuscitation continued in vain.

In relation to Dr Doolabh's first attendance to the birth suite at 7:00pm, it was submitted on his behalf that even if Dr Doolabh attained a longer CTG trace, according to Dr McLaren, it would have been normal and reassuring. In respect to this, Dr McLaren said in evidence: "It's too short to really comment on all the parameters that we comment on. You need a significant length, usually 15 to 20 minutes, to comment on where is the baseline. It is impossible to say where the baseline is, because it looks like it starts at 120. It actually goes up to 145-150 when it's taken off. So, it's impossible to determine the baseline on the short strip that we've got, but the heart rate is within the normal range." I note, notwithstanding, what has been put on behalf of Dr Doolabh, he agreed that ideally a longer CTG ought to have been carried out and that he ought to have had Mrs Hoy exit the spa and taken a longer CTG trace. This did take place in this initial introduction to Mrs Hoy. Dr Doolabh's evidence was that he received some comfort, having reviewed this CTG. This, according to Dr McLaren, was impossible to determine.

It is submitted on behalf of Dr Doolabh that when he returned to the hospital on the second occasion "he was advocating delivery of baby Samara" and that he recommended that Mrs Hoy proceed with the vacuum extraction. I do not accept that Dr Doolabh recognised the urgency of the situation. He only offered a series of options to Mrs Hoy. It would appear that Mrs Hoy had the option to either proceed with the pushing and deliver by natural means. The other option was to do an assisted delivery. Given the urgency of the situation, Dr Doolabh should have recognised that there was no "option" but that it was necessary to deliver the baby as soon as he arrived. In fact, Dr Doolabh did not proceed to use the Ventrouse extraction immediately after he arrived. If Dr Doolabh instructed midwife Fankhauser to prepare for a Ventrouse extraction upon his arrival, then one is left wondering why he waited 30 minutes, sitting at the bottom of the bed before he commenced the extraction.

Midwife Fankhauser said she inserted a catheter into Mrs Hoy at the time to relieve the pressure of her bladder, not as instructed by Dr Doolabh to prepare for an urgent Ventrouse extraction. Dr Doolabh's actions on attending the hospital on the second occasion do not bespeak the urgency of the situation.

It is submitted on Dr Doolabh's account that there is something inherently illogical to suggest that at 12:30am in the morning Dr Doolabh would be coming to the hospital to wait around and observe Mrs Hoy to continue to push, and that he would want to intervene immediately to deliver the baby is more likely inconsistent with the intention that he formed when called. This is completely contrary to what he did.

Notwithstanding the fact that Dr Doolabh sat at the bottom of the bed for some time, he did not make any contemporaneous notes of any conversation he had with Mrs Hoy. He did not venture to explain to her the urgency of the situation and the urgency of an intervention. His only explanation was by way of a series of options. His communication to Mrs Hoy was woeful. He did not in any way adequately explain the risks, if the "options" were not followed. In short, Dr Doolabh's behaviour can only be described as substandard.

Dr Trueman

Dr Trueman was initially Mrs Hoy's obstetrician. Dr Trueman did not give evidence as an independent expert, but given the fact that he had managed Mrs Hoy's pregnancy, he was well placed to comment on the care and management Mrs Hoy received during her labour.

Dr Trueman described the care and management of Mrs Hoy's labour as substandard, both from an obstetric and midwifery standard. In summary, Dr Trueman said the following matters needed to be addressed in relation to Mrs Hoy's care and management:

a) A longer admission CTG trace;
b) The CTG to be re-applied, certainly when meconium was first noted at midnight;
c) Dr Doolabh to be called after one hour of pushing (ie 11.30pm);
d) Delivery of the baby when Dr Doolabh arrived (ie 12.30pm);
e) Strong recommendations being given with an explanation of the risks when discussing assisted delivery.

I accept Dr Trueman's summary and, as I have previously said, I also find the care and management of Mrs Hoy substandard.

Dr McLaren

Dr McLaren was an expert appointed by the court to assist the court. She provided three reports and Dr McLaren reviewed the evidence independently and presented as an expert witness in the field, notwithstanding the fact that Dr McLaren was cross-examined, her evidence and opinions were unshaken.

In her initial report, Dr McLaren stated that:

a) Labour was not monitored appropriately. The CTG should have been applied for longer on admission and when meconium was present. It should have been explained to Mrs Hoy as to why CTG monitoring was important given the history of irregular heart beat and the presence of meconium;

b) Labour was not appropriately managed:-

    i. The medical file was incomplete and inadequately maintained. Mrs Hoy's blood pressure and pulse were not recorded, for instance;

ii. The second stage document starts at 7:00pm when the cervix was not fully dilated until 10:30pm;
iii. The exact time that second stage commenced is not clearly indicated

c) The second stage was protracted and the progress was slow. Syntoncinon should have been considered. The second stage was not normal and was allowed to go too long before Dr Doolabh was called. The second stage then continued for too long after Dr Doolabh arrived – it was allowed to continue for a further one hour and 10 minutes. Dr Doolabh should have been more insistent to expedite delivery. The paediatrician should have been called given the loss of the foetal heart rate during the vacuum extraction.

d) Dr Doolabh should have been called at 10:30pm when tachycardia was noted, or failing that at 11:00pm, or failing that at midnight;

e) If a CTG was done earlier there would most likely have been a non-reassuring trace and delivery could have been expedited much earlier than 1:40am. This may have reduced the amount of meconium aspirated.

In her evidence, Dr McLaren went further and said:

a) Had the admission CTG been undertaken for 10 to 15 minutes, it would most likely have produced a reassuring trace,
b) It is possible that the changes noted in the cervix were an indication that the cervix was oedematous,
c) Between 9:00pm and 10:00pm, before the cervix was fully dilated, would have been the ideal time for baby Samara to be delivered,
d) Had the CTG been used from early on, it is likely that it would have shown a non-reassuring trace,
e) The CTG should have been applied before 10:30pm,
f) Most likely, if the CTG was applied at 10:30pm it would have showed tachycardia and Dr Doolabh would have been called within five to 10 minutes,
g) Even though it is not documented, the FHR was probably higher than 170bpm before 10:30pm. If this was picked up, that would have been further reason to undertake CTG monitoring,
h) Based on the information conveyed to Dr Doolabh over the telephone, he should have undertaken a vaginal examination upon arrival and made a strong recommendation for a vacuum delivery,
i) Adequately monitored with CTG, the baby should have been delivered by caesarean section at about 10:20pm,
j) Had intervention occurred earlier, it is most likely that baby Samara would have survived,
k) The FHR does not accelerate in second stage – it decelerates,
l) The rising baseline of the FHR in this case was likely due to baby Samara developing hypoxia and that the hypoxia probably started before 10:00pm to 10:30pm,

m) The baby's expose to the hypoxia and resulting acidosis is critical. The earlier the baby is delivered before exposure to acidosis and hypoxia the better the outcome,

n) Had CTG monitoring showed a non-reassuring trace and a caesarean section been undertaken at about 10:30pm, it is more likely than not that baby Samara would have been born alive,

o) The meconium was probably aspirated at least from 11:00pm,

p) Had Dr Doolabh undertaken a trial of vacuum upon his arrival at12:30am baby Samara would likely have been born at 1:30am. By then baby Samara would have been severely hypoxic and acidodic, putting her in such a state that she was either incompatible with life or presenting with a very high chance of severe hypoxic ischaemic encephalopathy or cerebral palsy.

Dr McLaren said in evidence it is not uncommon for meconium to be present but this need not always be fatal. It is present in about 20-30% of deliveries and meconium aspiration occurred in 5% of all deliveries with meconium stained fluid. Of those infants, only 12% die.

Dr McLaren also said that, given the autopsy findings, it was most likely that there was intrapartum hypoxia. That is consistent with Dr Williams' assessment. Dr McLaren identified the window of opportunity as being between three to four hours.

Following the hearing, Dr McLaren produced a supplementary report. It helpfully summarises her opinion on matters of causation and provides two proposed recommendations. Dr McLaren was of the opinion that the care and management of Mrs Hoy's labour was substandard in numerous aspects which contributed to the death of baby Samara.

Dr Rebecca Williams, the forensic pathologist

A forensic pathologist, Dr Rebecca Williams, performed an autopsy and notes the cause of death as:

1 (a) Main disease or condition in infant: Tight umbilical cord around neck.
1 (b) Other disease or conditions in infant: Meconium aspiration.
1 (c) Main maternal disease or condition affecting infant: Prolonged second stage of labour.
1 (d) Other maternal diseases or conditions affecting infant: Nil

Underlying cause of death
2. Birth asphyxia

During evidence, Dr Williams pointed out the significance of the findings of the histological examination of the lungs. They showed signs of meconium aspiration but there was no evidence of inflammation. Dr Williams said that, usually, meconium needs to be present for between four to six hours to cause an inflammation reaction. Dr Williams therefore concluded that the longest baby Samara was distressed was four to six hours. That places the out timeframe of distress between 8:00pm to 10:00pm.

Dr Williams then explained the significance of meconium being found in the placenta. She identified that this generally takes about two hours and therefore concluded that the presence of meconium at midnight was consistent with the meconium found in the placenta. This therefore places the shortest timeframe for distress at 12:00pm.

Dr Williams' evidence therefore establishes a probable timeframe for the onset of foetal distress in a range of two to six hours, being between 8:00pm and 10:00pm, and midnight.

Significantly, Dr Williams confirmed that the meconium aspiration was a result of the tight umbilical cord around the neck and the prolonged second stage of labour.

Dr Williams agreed that "though the brain (of baby Samara) appeared normal on autopsy, there was interference with functions like breathing and those sorts of things (heart rate) which actually led to the baby's death." Dr Williams stated that "although the brain is normal, certainly, the cells may not have been functioning normally if they were subject to hypoxia….when the cells don't receive enough oxygen supply, they can become irritable and that can sort of lead onto the sequence of events in which the brain's usual function, which includes controlling your heart rate and breathing rate, can be interfered with." Adding that "(she would) expect the brain to be normal, as it was in this case, because usually we need about between 12 and 24 hours to pass from the time of the insult of hypoxia before we can actually see changes that can be appreciated under a microscope."

There was still a mark around the neck of the baby at autopsy and this showed to Dr Williams that "even one's (babies) who may have died, having had a cord around their neck, often there's not one single mark on the neck at autopsy. So, in this case, the fact that we do have the mark around the baby's neck tells us that it played a very significant part in this baby's death."

Dr Williams agreed that it showed that the cord tightened during the process of delivery. The cord around the neck raises two limbs of concern. Firstly, it interferes with the flow of nutrients from the mother to the foetus and waste removal from the foetus. Secondly, it interferes with the blood supply and drainage from the head of the baby.

Dr Williams also surmised that it is likely that because of the signs of distress "it sort of carries on for two hours", that there was some blood flow "getting to this baby's head."

Section 45 Findings

Pursuant to Section 45 of the Coroner's Act, I make the following findings:

1) The identity of the deceased person was baby Samara Lea Hoy.
2) Baby Samara died as a result of birth asphyxia.
3) Place of death - baby Samara died at the John Flynn Hospital, Tugun, in Queensland.
4) Date of death - baby Samara died on the 8th November 2008.

5) Cause of death - a tight umbilical cord around her neck.

In addition to the above findings, pursuant to Section 46 of the Coroner's Act, I find as follows:

The admission CTG was too short and breached hospital policy.

Mrs Hoy was not adequately monitored during labour. In particular, the failure to commence a continuous CTG monitoring prior to 10:30pm and the failure to monitor the foetal heart rate at all during the period of 10:00pm and 10:30pm more than likely contributed to the death of baby Samara.

Had the CTG monitoring been commenced from 10:00pm, it would have produced a non-reassuring trace which would have caused Dr Doolabh to be called in immediately and the baby Samara delivered urgently by no later than 11:30pm, and perhaps as early as 10:30pm.

I find that the maintenance of medical records was woefully inadequate during the process. Information which was required to be recorded was not recorded. Recordings of the foetal heart rate were not made as required. Recordings of the foetal heart rate were not made according to hospital policy. Had proper records been undertaken, they would have, more than likely, produced a non-reassuring trace on the partigram and the second stage document, which would have led to Dr Doolabh being called in much earlier, and baby Samara being delivered urgently.

I find that there was a delay in calling Dr Doolabh. He should have been called at 10:30pm at the latest, but by the time Dr Doolabh was called baby Samara had been exposed to meconium for about two hours.

I find that the delay in calling Dr Doolabh when signs of foetal distress were present and when a delivery around 11:30pm would have been made, in fact this delay did contribute to the death of baby Samara.

I also find that Dr Doolabh's response when he was called was inadequate, and, as said by his own peers, substandard. When he was called, and attended, Dr Doolabh appeared oblivious to the urgency of the situation as it presented. He showed no leadership. Instead, he chose to sit at the bottom of the bed and watch and wait. All the signs that presented indicated that the situation was urgent and dire.

As I have already said, the medical note and the maintenance of medical records, and altering medical records, was of itself substandard. During the inquest it was discovered that alterations were made to the medical records. These alterations occurred after the coronial investigation commenced. Midwife Fankhauser admitted during the inquest that she had altered the notes and that she had subsequent to the inquest also admitted doing so. This is totally unacceptable behaviour of a midwife.

I note that midwives Fennell, Peller and Fankhauser prepared contemporaneous notes of the events after the death of baby Samara. These notes were not

placed on the medical file and were only produced later. It was inappropriate that these notes were not included in the medical records and handed to the Coroner's Office when the records were requested. Midwife Fennell did not fill in the medical file, as required, and stated so in her evidence. Some sections of the partigram were subsequently filled in by another person, possibly midwife Peller. This was inappropriate.

Midwife Peller did not complete the medical documentation, as required, and created her own record of her dealings with Mrs Hoy.

Midwife Fankhauser acknowledged that her record keeping was poor and less than satisfactory. She, too, kept her individual notes which did not become part of Mrs Hoy's medical records.

The behaviour of keeping separate medical records seems to be endemic. The fact that these records were not available when requested by the Coroner's Office is unsatisfactory. Midwife's Fankhauser's keeping of foetal heart records on a scrap of paper in her pocket which she subsequently lost, is in itself unsatisfactory.

Hospital policies on the whole were not adhered to, and nor were staff aware of them. For example, doctors using the hospital were not aware of the requirement for a paediatrician to be called for a birth in an instrument delivery. The fact that an instrument delivery alone was sufficient to cause a paediatrician to have been present seems to have been forgotten by both the obstetrician and paediatrician giving evidence. To this end, the hospital needs to ensure that all staff are aware of the relevant policies. This needs to be urgently addressed by the hospital.

During evidence three of the specialists called to give evidence were unaware of hospital policy. It is not worthwhile having policies if even the specialists are unaware of them.

Section 46 of the Coroner's Act provides that a Coroner may comment on anything connected with a death that relates to public health and safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future. Accordingly, I make the following recommendations:

Recommendation 1

All women should have access to balanced antenatal information and classes clearly outlining normal and abnormal labour, when intervention may be required and why it may be necessary.

The classes should clearly outline:

- The possible risks of the intervention and the possible risks of not utilising the intervention method;

- The parents should be encouraged to raise any issue, discuss and ask any questions they feel an inclination to so during the classes, pregnancy and labour;

- The circumstance of the attendance of each medical professional during labour so that the parents are more likely to have an understanding of the expectation of the attending medical professionals; and

- Should involve both midwife and obstetric facilitation.

Recommendation 2

Women should have an opportunity to discuss their labour antenatally with their midwife and obstetrician and address the issue of when and why intervention may be required.

Recommendation 3

The underlying guiding principle of maternity care is to achieve the outcome of a healthy mother and infant.

- If a couple choose to have a "birth plan", they should write their preferences down so their wishes are clearly communicated to the staff caring for them during labour. The plan should recognise that intervention may be required if necessary.
- Couples should be made aware that it is not realistic to have a birth plan for "natural childbirth" at all cost as natural childbirth is not always normal and intervention may be required under certain circumstances to give the best possible outcome.

Recommendation 4

Intervention when required should be carefully explained by the attending midwife and obstetrician to ensure patients understand

a. Why the intervention is necessary;
b. The scientific evidence behind the need to intervene; and
c. The appropriate risks and benefits of intervention in accordance with the duty to provide fully informed consent.

Recommendation 5

A mother refusing intervention despite recommendations by an obstetrician to use an intervention method is very serious and it should be clearly outlined in antenatal classes and discussed, both risks of using the intervention and not using the intervention, with the woman antenatally by her obstetrician and midwife. Any refusal should be carefully documented both at the time of discussion and during labour.

Recommendation 6

All midwives and obstetricians should

- Be familiar with RANZCOG CTG foetal surveillance guidelines and implement these CTG guidelines in their clinical practice;
- Attend regular CTG courses as part of their continuing professional development; and
- Attend regular CTG review meetings to review and improve outcomes in the maternity unit.

Midwives must be trained to recognise abnormal FHR patterns.

Recommendation 7

All maternity units should encourage their midwifery obstetric staff to attend

- Obstetric emergency courses such as ALLSO/MaCRM/MOET to encourage and optimise professional teamwork and collaborative practice in the maternity unity between midwives and obstetricians; and,
- Neonatal resuscitation workshops.

Recommendation 8

Ongoing professional development for midwives to ensure they are

- Competent in distinguishing and documenting abnormal from normal progress in pregnancy and labour;
- Refer to obstetricians in a timely and appropriate manner for ongoing care when pregnancy and labour become abnormal; and
- Follow evidenced based guidelines and scientific evidence in their clinical practice.

Recommendation 9

All maternity units should ensure there are clear guidelines and instructions for midwives as to when to refer obstetricians.

Recommendation 10

All maternity units should have a paediatrician or staff member capable of intubating a baby available to be present

- At all deliveries through meconium;
- Where there is evidence of foetal distress in labour; or
- Any instrument delivery or caesarean section.

Recommendation 11

All maternity units should schedule paid time for all staff and attending medical professionals to familiarise themselves with all policies, procedures and guidelines in place at the unit and for any changes to same. Understanding of the policies and guidelines should be formally assessed at least annually.

Recommendation 12

The Admission Policy should contain a direction that the necessity of CTG monitoring be explained to the mother and encouragement to persevere with the CTG should be encouraged in all cases where the mother requests the CTG be removed.

Recommendation 13

That all the hospital policies addressing monitoring include a plain language direction that draws attention to abnormal FHR patterns as outlined by RANZCOG, irrespective of whether a Doppler or CTG is being used. The policies should also contain a plain language direction for specialists to be consulted if there is evidence of, or any concern about whether, an abnormal FHR pattern.

Recommendation 14

Regular ongoing professional development for all medical professionals dealing with patients on communication in stressful situations should be required by their respective professional bodies to maintain registrations and licensing.

Recommendation 15

John Flynn Hospital should assess current medical forms and similar documents that are to be maintained by midwives and make them much more user friendly in both number and readability. Facilities should be provided to allow the midwife to have the medical forms much closer to the patient so they can be maintained far more readily. Forms should be consolidated to the extent possible to elevate the need to complete multiple records of the same information.

The keeping of a separate record of a patient to be later transferred to the official medical records by all medical staff should be avoided. If however the need arises to do this all separate, notes written by medical staff should be considered a part of the medical records of the patient and included in the patient's medical file. The separate record should not leave the hospital or similar medical facility. This is a matter of privacy, a patient's right to be able to access all of their records as well as other bodies, including a Coroner's Court, having full access to all of a person's medical records where appropriate. Removal of any notes made on a patient should be seen as both unethical (whether intentional or unintentional) and illegal.

Recommendation 16

The issue of birth plans needs to be re-cast. Patients and staff need to be reinforced that a birth plan is a guide only and does not dictate the only method of delivery; nor did it mean that the patient is not open to assisted labour if the need arose, with suitable explanation. Expecting mothers need to be told that birth plans are important, but are only a guide and that all concerned need to be flexible and prepared to swiftly change the birth plan and do whatever is required to deliver the baby safely.

Recommendation 17

Dr Doolabh undertake re-training in Ventouse vacuum extraction, ethics and communication skills.

Recommendation 18

Midwife Fankhauser undertake re-training in CTG use – including when it should be used, communication skills, ethics and documentation.

Recommendation 19

That Ramsay Health Care and John Flynn Hospital implement the Open Disclosure National Standard.

Recommendation 20

The hospital implement a plain language policy on amendments to medical files in terms of the "practice" alluded to by Ms Sapwell.

Recommendation 21

The hospital implement a system so that approval be required from a senior hospital administrator or appropriately appointed person before a person can access medical files, once stored, and furthermore so that any party accessing medical records cannot do so without records being taken as to the date, time and identification of the person.

Referral pursuant to Section 48

Section 48 of the Coroner's Act requires a Coroner, who as a result of information obtained while investigating a death, "reasonably suspects a person has committed an offence" to give the information to the appropriate prosecuting authority.

Subsection 2 refers to a suspicion, as opposed to a belief or knowledge of the commission of an offence. In Queensland Bacon Pty Ltd v Rees (1966) 115 CLR 266 at 303 (CLR) Kitto J said: "A suspicion that something exists is more than a mere idle wondering whether it exists or not; it is a positive feeling of actual apprehension or mistrust, amounting to 'a slight opinion, but without sufficient evidence', as Chambers Dictionary expresses it. Consequently, a reason to suspect that a fact exists is more that a reason to consider or look into the possibility of its existence (it is) something which in all the circumstances would create in the mind of a reasonable person in the position of the payee an actual apprehension or fear."

Subsection 4 of Section 48 enables a Coroner who reasonably believes information might cause an inquiry, to give such information to a disciplinary body of the person's profession or trade. This is a different test. The test for reasonable belief, not suspicion, is said to be "facts that can reasonably ground a suspicion may be substantially be less than that which would be required to ground a belief…" (George v Rockett 1990) 170 CLR 104 at (115).

Taken together, those subsections allow me to consider whether the medical care given to Mrs Hoy was of an appropriate standard, and if not, whether it was such that it should be referred to the appropriate professional body for consideration in relation to disciplinary action.

In relation to the alteration to the medical file, and thereby providing false information to the Court, I find that midwife Fankhauser altered the medical records, in that she altered the labour progress notes in a medical record of the observations at 10:30pm to make it appear as though those observations were taken at 11:30pm.

The alteration could not be said to correct an inaccurate recording made earlier, and therefore offer an innocent explanation. The events recorded at 10:30pm include that midwife Fankhauser "received care of Simone." It naturally follows that the matters written at that time must have been recorded when midwife Fankhauser took over the care of Mrs Hoy.

The attempt to delay these observations may be readily found to be an attempt to mislead a reader of the medical file. Midwife Fankhauser said that alteration was made at 8:00am on the 8th November 2008, some six hours after the death. She

accepted that when she made the alteration she was aware that amendments were only to be made to the medical file in a clear manner so as to alert a subsequent reader of the medical notes that a correction had been made. She did not, however, accept that at the time she made the amendment she was aware of a coronial investigation. She nevertheless said that she knew later in the day of the 8th November that a coronial investigation was underway.

This evidence needs to be considered to ascertain whether there is sufficient evidence upon which a jury could be satisfied that midwife Fankhauser committed an offence in that she attempted to pervert the course of justice, pursuant to Section 140 of the Criminal Code. Accordingly, the matter should be referred to the Director of Public Prosecutions for consideration.

Midwife Fankhauser gave a statement on the 14th June 2009 in which she sought to explain time entries which she made in the labour progress notes on the 7th November 2008. In a subsequent statement she made on the 15th May 2010, she sought to correct one of the entries which she made on those notes.

At the time she did not have access to the original medical file. There is no reason to suspect that she did. She says that she did not recall making any corrections to the file. A statement from the investigating police officer reveals that she, the police officer, retrieved the original file on the 10th November 2008 and provided records to Queensland Health Forensic and Scientific Services (QHFSS).

A statement from one Karyn Loughran, an administrative officer in the employ of QHFSS, reveals that the hospital charts for Mrs Hoy and baby Samara were submitted to QHFSS and kept in a secure cabinet for the forensic pathologist until they were returned at the end of the investigation by registered post. The medical records were returned to the hospital by registered mail on or about the 12th November 2008.

A copy of the medical file was subsequently produced by the hospital to the Coroner's Office on the 3rd December 2008. A copy of that has the last entry in the labour progress notes as an entry by midwife Peller on the 9th November 2008. In that version, the observation at 10:30pm is not altered. It is impossible to say when the copy was taken, but it must have been taken after the entry was made on the 9th of November 2008. Miss Sapwell indicated that the copy was taken on the 10th November 2008.

Dr McMaster stated that he copied the file on the morning of the 8th November 2008. That version of the records was given to Dr Trueman, who produced a copy to the Court. A study of that version reveals that at the time Dr McMaster copied the records the file was not altered. He does not have the entry of the 9th November 2008, which is consistent with when Dr McMaster said he copied the file.

Miss Sapwell gave evidence that the accepted practice at the hospital was to identify any amendments made to a medical file by crossing out the error. She also identified that medical files are not generally accessible and are kept at the Health Information Service, which is locked after hours and staffed at other times.

The only people with a key are the Health Service Coordinator, the Clerical Coordinator, and that is in the case of emergencies only.

The original medical file was received at the Coroner's office at around 24th April 2009. It would appear that the original file was most likely altered at some time between the 12th November 2008, by which time midwife Fankhauser well knew that a coronial investigation was underway, and the 24th April 2009. It needs to be decided whether the alteration of records in the face of a coronial investigation was in itself an attempt to pervert the course of justice.

In order to establish an offence under Section 140 of the Criminal Code (attempt to pervert the course of justice) a prosecution must prove:

a. That midwife Fankhauser did the alleged conduct;
b. The alleged conduct had the tendency to pervert the course of justice, that is turn it aside from its proper course. The prosecution need not prove that the course of justice was in fact perverted, or would have been perverted. It is sufficient to establish that there was a real risk that an injustice might result.
c. That midwife Fankhauser intended to pervert the course of justice by her actions.

Midwife Fankhauser admitted, maintaining privilege, that she made the alteration. This admission may not be used against her, except in the case of perjury, but there is, looking at the totality of the evidence, evidence upon which a jury could infer that midwife Fankhauser made the amendments in circumstances and altered the file in a restricted area.

It could be said that midwife Fankhauser's act was calculated to mislead the police during an investigation and may amount to an attempt to pervert the course of justice, in that it was action taken before the tribunal proceedings commenced, which would have the tendency to frustrate or deflect the course of curial or tribunal proceedings which are imminent, or even possible. (R v Rogerson 1991, 1992 174 CLR 268, as per Mason CJ at 277).

Accordingly, it is possible that the altering of records in the face of a coronial investigation or police investigation may amount to an attempt to pervert the course of justice if "proceedings are imminent, probable or even possible."

In this case, given the circumstances of the death of baby Samara and the multitude of failures in managing Mrs Hoy's labour, a jury could infer that the records were altered at a time when curial proceedings, in the form of disciplinary, coronial and perhaps criminal, were imminent, probable or possible in that the amendment of the records seeks to record a different timing of events and to represent a false version of events and an untruthful story.

In this case, the coronial investigation began when I, as the Coroner, received a Form 1A from Dr Doolabh and ordered that the proposed death certificate was not to be issued. It was at this point a jury could find that a coronial investigation was underway in which time the medical file was accessed and altered.

Accordingly, I refer material gathered during these proceedings to the Director of Public Prosecutions for consideration, pursuant to Section 48 of the Coroner's Act.

Adequacy of medical treatment

Dr McLaren made three particular criticisms of Dr Doolabh's management of Mrs Hoy's labour after he arrived at 12:30pm. His communication of the interventions necessary at that time was poor. He needed to be assertive and offer adequate explanations for the necessary intervention. His lack of assertive action and subsequent inaction, led to the second stage being left to go on for far too long in circumstances where there were apparent signs of foetal distress. Dr McLaren's unchallenged expert opinion was that the only reasonable course of action was for a Ventouse extraction to be undertaken immediately upon his arrival at 12:30pm.

Dr McLaren was also critical of the evidence given by Dr Doolabh on the use of the vacuum. In particular, Dr Doolabh said that the positioning of the head was not critical, and it did not matter if the baby was in the LOA, LOT or LOP position. He also said that he could perform a vacuum extraction, even though he did not examine the patient himself and the midwife when the last examination had been undertaken by a midwife two hours before. Dr Doolabh also said that the positioning of the head was important for a forceps delivery, but with a Ventouse it is not critical to get the cap in the occiput.

The evidence shows that Dr Doolabh had multiple pulls with two different vacuum instruments to effect delivery of baby Samara, and that he placed the cap over the parietal region. This suggests that the placement of the cap was not optimum and probably contributed to the need for seven pulls and reason why the first vacuum instrument was not successful. That sufficiently demonstrates a lack of competency in respect of a necessary intervention method for labour.

Dr McLaren also stated that Dr Doolabh failed to undertake CTG monitoring when there were compelling signs it was required. Dr Doolabh recognised the existence of these signs during cross examination and offered no adequate explanation for not using CTG.

I find that there is sufficient evidence to warrant Dr Doolabh's management of the labour being reviewed by his professional body. There is a body of evidence which might cause a disciplinary body to conclude that Dr Doolabh failed to provide Mrs Hoy with an adequate standard of care. Accordingly, I direct that the material gathered during the inquest be provided to the Medical Board of Australia for its consideration.

Midwife Fankhauser's management of Mrs Hoy's labour was inadequate for the reasons discussed above. There is a sufficient body of evidence to warrant her conduct to be reviewed by a disciplinary body. There is a body of evidence which might cause a disciplinary body to conclude that she failed to provide Mrs Hoy with an adequate standard of care. The disciplinary board could also conclude that any attempt by midwife Fankhauser to deliberately alter the records and in turn mislead the Court, indicates that she is not a fit and proper person to be registered. Accordingly, I direct that the material gathered during

these proceedings be referred to the Nursing and Midwifery Board of Australia for its consideration.

Further reasons to refer midwife Fankhauser to the DPP

After the inquest it was submitted on behalf of midwife Fankhauser by her counsel that privilege against self incrimination had not been waived and applied to midwife Fankhauser's letter of confession she subsequently sent to the Board.

I note that privilege was not claimed by midwife Fankhauser in her letter to the Board, nor was privilege claimed by her counsel when the letter to the Board was included in submissions made by her counsel and forwarded to me, the Coroner.

It was one thing for midwife Fankhauser to claim privilege during the hearing and then answer questions against her interest when so directed. In this case statutory privilege clearly applies. It is a different matter entirely when midwife Fankhauser, acting on her own volition independently and not directed by me, the Coroner, chooses to write a confession to the Board. It was her decision to so do; she was not acting under any coronial direction to refer herself to the Board, in fact I was totally unaware midwife Fankhauser had referred herself by way of a confession to the Board, so it could not be argued that her confession to the Board was derivative evidence because it was not made as a direct or indirect result of evidence given by midwife Fankhauser at the inquest.

I therefore find that the confession by midwife Fankhauser to the Board is not subject to privilege against self incrimination. In fact, during the inquest midwife Fankhauser claimed privilege and was directed to answer, thereby benefiting from the statutory protection afforded by s39 of the Coroner's Act.

Her subsequent confession to the Board has nothing whatsoever to do with the inquest. As I have said, her behaviour in referring herself to the Board was unilateral on her part voluntary, and not in anyway directed by me, the Coroner.

The question remains however, is that, if privilege applies to midwife Fankhauser's evidence, was it waived by her subsequent dealings with the Board, independent of any direction or even knowledge of me, the Coroner.

Whilst it is accepted law that privilege is not waived by the mere presence of a privileged document in the hands of a third party, in this case there was no attempt to obtain the letter to the Board containing her confession. Midwife Fankhauser voluntarily through her counsel disclosed it to the Court and the Board.

It was contended on behalf of midwife Fankhauser that, in accord with Mann v Carnell (1999) 168 ALR 86 at (28) per Gleeson CJ, Gauldron, Gummo & Callinan JJ, and Spotless Group Pty Ltd (2006) 16 VRI, that her waiver of privilege is not established by voluntary disclosure to a third party for a specific and limited purpose.

In Mann v Carnell the Court held that privilege was not waived because the advice was provided to a member of the Legislative Assembly on a confidential

basis for his consideration only, and therefore disclosure was consistent with maintenance of privilege.

In this case the disclosure was not made on a confidential basis. It was open, voluntary and tendered to the Court without reservation.

In Spotless Group Pty Ltd it was held that a limited disclosure to a third party for a specific purpose did not constitute a waiver of privilege.

In this case there was no such regulated or limited disclosure. It was made to the Board and to the Court without reservation.

It is clear to me that by her disclosure midwife Fankhauser has by her confession admitted, without reservation, her outrageous behaviour to the Board. It would be a nonsense to suggest that a midwife, having confessed her behaviour to the Board responsible for disciplining her, is then protected by some privilege. This practice does not prevail in the criminal jurisdiction, whereby an offender proffers an open confession to the police and then attempts to limit it by some claim of privilege.

I therefore find for the above reasons that the confession to the Board was made voluntarily and not procured by any compulsion and therefore can not be classed as privileged against self incrimination. It was made to a regulatory body without reservation, and even if a privilege attaches to the confession there is still sufficient evidence to satisfy a referral to the DPP, and accordingly I refer midwife Fankhauser's behaviour to the DPP.

John Hutton
Coroner
5 April 2011