QUEENSLAND COURTS

# OFFICE OF THE STATE CORONER

# FINDINGS OF INQUEST

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| CITATION: | **Inquest into the death of Baby M** |
| TITLE OF COURT: | Coroners Court |
| JURISDICTION: | Brisbane |
| FILE NO(s): | 2008/176 |
| DELIVERED ON: | 29 June 2012 |
| DELIVERED AT: | Brisbane |
| HEARING DATE(s): | 25 – 27 June 2012 |
| FINDINGS OF: | J Lock, Brisbane Coroner |
| CATCHWORDS: | Coroners: inquest, child birth at home, unknown pregnancy |

REPRESENTATION:

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| Counsel Assisting: | Ms A Martens, Office of State Coroner |

# CORONER'S FINDINGS AND DECISION

1. Baby M was born on 27 November 2008 in tragic and unusual circumstances. He was delivered by his mother into a toilet bowl at her home. She had told Ambulance and Police personnel she was not aware she was pregnant.

2. Although it was initially thought Baby M was deceased, paramedics were able to resuscitate him. He was taken to hospital but it was diagnosed he had suffered irreversible brain damage and after life support was withdrawn he passed away on 29 November 2008.

3. As there was uncertainty concerning the circumstances leading up to Baby M's death, in accordance with section 28 of the Coroners Act 2003 ('the Act'), I decided to hold an inquest into Baby M's death.

4. On 5 April 2012, a pre-inquest conference was held. The issues identified at the pre-inquest conference to be explored at the inquest were:

    - The findings required by section 45 (2) of the *Coroners Act 2003* ("the Act"), namely the identity of the deceased, when, where and how he died and what caused his death;
    - Whether Ms J was aware she was pregnant prior to 27 November 2008;
    - The identity of Baby M's biological father;
    - The exact time of Baby M's birth and how long he was in the toilet bowl before being removed; and
    - An examination of the quality of the QPS investigation including the substantial delay in finalising the investigation.

5. At the commencement of the inquest, I made an order that the names and any identifying features of the civilian witnesses be de-identified due to the very personal nature of matters to be investigated at the inquest. For completeness, my findings de-identify all witnesses who gave evidence or provided statements in the proceedings other than QPS and QAS personnel and medical staff.

## *The scope of the Coroner's inquiry and findings*

6. A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible he/she is required 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.

7. There has been considerable litigation concerning the extent of a coroner's jurisdiction to inquire into the circumstances of a death. The

authorities clearly establish that the scope of an inquest goes beyond merely establishing the medical cause of death.

8. An inquest is not a trial between opposing parties but an inquiry into the 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 record as many of the facts concerning the death as the public interest requires."* [1]

9. 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 deaths. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.2 However, a coroner must not include in the findings or any comments or recommendations, statements that a person is or maybe guilty of an offence or is or maybe civilly liable for something.3

**The Admissibility of Evidence and the Standard of Proof**

10. Proceedings in a coroner's court are not bound by the rules of evidence because the Act provides that the court "*may inform itself in any way it considers appropriate."*[4] 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 greater scope to receive information that may not be admissible in other proceedings and to have regard to its origin or source when determining what weight should be given to the information.

11. This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt. As already stated, it is an inquiry rather than a trial. If a witness refuses to give oral evidence at an inquest because the evidence would tend to incriminate the person, the coroner may require the witness to give evidence that would tend to incriminate the witness if satisfied it is in the public interest to do so. The evidence, when given, and any derivative evidence is not admissible against the witness in any other proceeding, other than a proceeding for perjury.[5]

12. A coroner should apply the civil standard of proof, namely the balance of probabilities but the approach referred to as the *Briginshaw* sliding scale is applicable.[6] This means that the more significant the issue to be

[1] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[2] Section 46 of the Act
[3] Sections 45(5) and 46(3) of the Act
[4] Section 37(1) of the Act
[5] Section 39 of the Act
[6] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J

determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[7]

13. It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[8] This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[9] makes clear that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

14. If, from information obtained at an inquest or during the investigation, a coroner reasonably suspects a person has committed a criminal offence, the coroner must give the information to the Director of Public Prosecutions in the case of an indictable offence, and to the chief executive of the department which administers legislation creating an offence which is not indictable.[10]

# Introduction

15. Baby M was born on 27 November 2008 and died on 29 November 2008. His mother was Ms J was aged 19 (DOB: 04/11/1989) and his maternal grandparents were Mr R J and Mrs E J.

16. Ms J delivered Baby M into a toilet bowl on the morning of 27 November 2008.

17. Ms J claimed she was unaware she was pregnant.

18. Baby M was initially thought to be dead. However, paramedics were able to find a heartbeat and immediately attempted resuscitation.

19. Baby M was transported to the Gold Coast Hospital ("GCH") were he was placed on life support. He was later transferred to the Mater Mother's Hospital. Testing revealed that Baby M had suffered irreversible brain damage.

20. Life support was removed on 28 November 2008 and Baby M passed away on the morning of 29 November 2008.

21. From the post-mortem examination, it was determined that Baby M demonstrated anthropometrical measurements in keeping with a

[7] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[8] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13
[9] (1990) 65 ALJR 167 at 168
[10] Section 48(2) of the Act

gestational age between 35 – 38 weeks. This would mean he was conceived between late January and late February 2008.

22. The police report containing all the material was not provided to me until March 2012, hence the identified concern with respect to a delay in finalisng the investigation.

23. In between the pre-inquest conference and the inquest, the Police have taken steps to investigate this issue internally and conducted a review with the relevant police officers in relation to the delay. The Police have taken action in relation to the relevant officers and I am satisfied that this issue is unlikely to arise again. In those circumstances, this issue has resolved and was not examined any further at the inquest.

24. Enquiries with the Department of Communities – Child Safety (Queensland) and the Department of Family and Community Service (NSW) revealed that apart from the notification of Baby M's birth, neither organisation had any previous history of child notifications for Ms J or her family.

## *The Evidence*

### Did Ms J know she was pregnant prior to 27 November 2008?

25. Ms J was involved in a relationship with Mr S D from January 2004. According to Ms J she had been using the contraceptive pill which her mother initially purchased for most of the period of the relationship. Whilst on the pill, Ms J did not have cramps or period pain with her menstrual period.

26. In November 2007, the J family moved to the Gold Coast, and Mr D lived with the J family. Mr D at first came up with Mr J, with whom he was working and Ms J and her mother came up some months later after Ms J finished her schooling.

27. Ms J says when she started working she was expected to pay for the pill. Ms J broke her foot in March 2007 and dislocated her knee in August 2007 and given she was not working she decided the pill was something she could go without. After ceasing using the pill, she says she used condoms with Mr D. She says she also used condoms with her next sexual partner, Mr J B.

28. Mrs J recalls discussing with Ms J that she had stopped taking the pill because it was making the migraines Ms J suffered worse. Mr D confirmed Ms J suffered from headaches but he was not told she stopped taking the pill for this reason.

29. Mrs J stated she had told Ms J that she hoped Ms J was using appropriate birth control. Ms J stated "they" were using condoms.

30. Mr D recalls with some particularity the history of Ms J's contraceptive medication over the years and how it affected her menstrual cycle. Ms J gave conflicting evidence, indicating her menstrual cycle, irrespective of taking the pill, was always regular and light.

31. In November 2007, when they moved to the Gold Coast, Mr D believes Ms J was on the pill but he could not remember how it affected her menstrual cycle.

32. Mr D believes that at some stage between November 2007 and January 2008, Ms J stopped taking the pill as her mother Mrs J stopped paying for the prescription. Mr D and Ms J continued to have intercourse and did not use any method to prevent pregnancy. Ms J stated in evidence they were using condoms but there had been a couple of times when they did not and used the withdrawal method of contraception.

33. Around January to March 2008, Mr D says Ms J told him she had missed her period. He thinks she told him that she had missed two of her periods. They purchased a home pregnancy kit and took the pregnancy test. Mr D describes in relative detail the pharmacy where the test was purchased and how the test was purchased. They initially viewed the pregnancy test too early and it revealed it was negative. The pregnancy kit was thrown in the bin in Ms J's bedroom. They then read the box of instructions which indicated they had not waited the correct period of time and so Ms J retrieved the pregnancy test from the rubbish bin and it revealed Ms J was pregnant.

34. Ms J began to cry and Mr D was shocked. They both decided it would be better if Ms J had an abortion.

35. Ms J denied there was any time she thought she was pregnant and denied that at any time she and Mr D had purchased a pregnancy kit or the test was positive.

36. Mr D told his mother and his friends B C and L Sm that Ms J was pregnant. Ms J can offer no explanation as to why he would have spoken to his friends about this subject.

37. B C, a friend of Mr D, recalls that Mr D contacted him in the first three months of 2008. During the phone call, Mr D disclosed that he and Ms J had been fighting and that Ms J was pregnant. Mr D stated that Ms J would have an abortion. Mr C did not have any subsequent discussions with Mr D and Mr C assumed that Ms J had the abortion.

38. Mr L Sm, a friend of Mr D recalls Mr D contacting him in 2007 not long after Ms J and Mr D had moved to the Gold Coast to advise that Ms J was pregnant. They discussed whether or not Mr D and Ms J were going to keep the baby and Mr D indicated there were talking about getting an abortion. They discussed the matter in other phone calls and Mr D indicated Ms J would be getting an abortion.

39. Mr D does not believe Ms J told her parents she was pregnant. He is unsure whether she disclosed her pregnancy to her friends or sister, although he said she was close to her sister.

40. Mr D and Ms J did not really discuss the pregnancy. When they did speak, Mr D would encourage Ms J to see a doctor or specialist to confirm the pregnancy and if Ms J was going to organise an abortion. Ms J would say she would go to see a doctor but Mr D formed the view that Ms J was avoiding the topic.

41. In March or April 2008, Mr D was asked by Mrs J to move out as Ms J needed her own space. Mrs J believes Mr D and Ms J broke up in May or June 2008. Mr J confirms this version of events.

42. Mr M St became closer friends to Ms J and Mr D following his 18th birthday which was on 14 May 2008. Ms J, Mr D and Mr St attended various social events over this time.

43. Approximately a week or two after Mr St's birthday, Mr St, Ms J and Mr D went to the Casino. At some point, Ms J left for work at the Surfers Paradise RSL and Mr D disclosed to Mr St that Ms J might be pregnant.

44. Following that conversation, Mr St did not speak to either Mr D or Ms J about the possibility of her being pregnant.

45. On a Friday in May or June, Ms J contacted Mr St via text message. He recalls it was the day Ms J and Mr D broke up. These text messages were sexual in nature and arrangements were made for them to have sexual intercourse that afternoon.

46. According to Mr St, they met up and began kissing and fondling and were naked however as Mr St did not have any condoms, they did not have sexual intercourse. Ms J confirmed that she had met with Mr St and kissed him in a romantic way, whilst she was still dating Mr D.

47. Later, after picking up an intoxicated Mr D, Ms J and Mr D had a fight outside Mr St's residence and they broke up.

48. That evening Mr D sent threatening text messages to Mr St. These text messages did not concern Mr St as he believed Mr D was drunk and mouthing off.

49. Following the breakup, Mr St started spending more time with Ms J. Although they kissed and flirted, they did not have sexual intercourse. Eventually they stopped spending time with each other. After that, they did not have much contact other than friendly text messaging. During his time with Ms J, Mr St observed that Ms J's breasts and stomach had been getting bigger and whilst he thought Ms J had a bit of weight around her stomach area he did not think that she looked pregnant.

50. Mr St exchanged text messages with Ms J on 14 November 2008 and 26 November 2008 by way of catching up. There was no reference to Ms J being pregnant.

51. Ms J says that she and Mr D broke up on 23 May 2008 after they had a fight. She said she recalls the date as it was one of significance for her given they had been together for 4 years. Following the break up, Ms J had minimal contact with Mr D via MSN, as he had moved back to Sydney fairly soon after the break up. Ms J says that the first phone contact she had with Mr D was after Baby M's birth when she contacted Mr B C to obtain Mr D's phone number.

52. A few days after Mr D returned home to Sydney he contacted Ms J on the telephone. Ms J stated she was not pregnant.

53. Mr D says that Ms J returned to NSW to visit her sister and Ms J met with Mr D and they had sexual intercourse. This took place sometime during the June to August 2008 period. Ms J agrees this encounter took place. Mr D did not observe any physical changes to Ms J's body so it did not occur to him that Ms J was pregnant.

54. Approximately 3 months prior to Baby M's birth, Ms J says she started to experience cramping when she got her period. She had never previously before experienced pain when she was menstruating. Despite having ceased taking the pill many months prior, she believed this was because she had ceased taking the pill. Mrs J recalls Ms J indicating she was experiencing painful periods.

55. Approximately 3 – 4 weeks prior to Baby M's birth, Mr J had seen Ms J in tight clothes and a bit of a full stomach. He joked "when's the baby due?" However, neither Mrs J nor Ms J found this to be funny.

56. Ms J has indicated that did not believe she was pregnant as she did not have morning sickness, she got her period every month (her last period was in October before her surgery on 30 October) and she only had light periods lasting 2 to 3 days, she did not feel the baby move, she was using a condom and although she had gained 6 kilograms she believed this was due to having a knee operation and ceasing physical activity.

57. Ms J also indicated that her belly button had popped out but she thought it was as a result of an infection from her belly button piercing being ripped out. Ms J did not observe any differences with her breasts and was still wearing the same bra size.

58. Ms J says that if she had known she was pregnant she would have sought medical attention.

59. Mrs J was aware of Ms J's weight gain but believed it to be due to a healthy appetite and lack of physical activity. There were no other signs

she observed that indicated Ms J was pregnant. Ms J continued to wear the same clothes and Mrs J had in the days prior to Baby M's birth, observed Ms J in a bikini.

60. Ms J had a good relationship with her sister and believes she would have disclosed a pregnancy to her family. She believed they would have been shocked and angry initially but would have been supportive. Mrs J also indicated she would have supported Ms J and the baby.

61. Following Baby M's birth, Ms J contacted Mr D. Ms J told him that she had gone to the toilet as she had been in a lot of pain and gave birth to a baby. Mr D said to Ms J "Well I thought you weren't pregnant" and Ms J said "I would prefer it if you didn't tell anyone about that." Ms J denies this conversation took place.

62. Mr C recalls receiving a phone call from Mr D in July or August 2008 but obviously it was later. Mr D told Mr C that Ms J had delivered a baby into the toilet. Mr C stated that he thought Ms J had had an abortion and enquired if Mr D had been present during the abortion. Mr D stated he had not been present. Mr D also stated to Mr C that Ms J did not know she was pregnant.

63. Ms J conceived Baby M in the period of late January to late February 2008. Sometime between January and March 2008 Mr D recalls that she had been late in a menstrual period as a result they purchased a pregnancy test which turned out to be positive. Ms J denies this test ever took place and denies ever stating to Mr D that she was concerned she was pregnant. She agrees she would remember taking a pregnancy test. She claims that the reason why Mr D would give Police this information is because they had a difficult breakup and his intention was to make trouble for her.

64. The difficulty is that I have heard compelling evidence from Mr D about the pregnancy test which I consider to be truthful. Not only does it have a ring of truth about it, the version fits with the actual clinical circumstances and the timing of Baby M's birth given his gestational age. Ms J was in fact in early pregnancy at this time. With all respect to Mr D, I did not get the impression from his evidence he would be sophisticated enough to work out a timing of events which would suit this version being a lie and a reprisal.

65. Even if Mr D could have worked back on the timing of the events at the time of giving his statement to police in April 2009 (which was clearly after they had broken up) it is important to note that prior to them breaking up he had conversations with Mr C, Mr Sm and Mr St about concerns that Ms J was pregnant. On any calculation those conversations took place prior to the breakup. There would be no reason for Mr D making up the story and telling his friends if it was not what he believed.

66. There is no obvious motive or reason for Mr C, Mr Sm and Mr St to make up those stories and to then repeat them under oath in court.

67. Ms J was given a number of opportunities to explain a number of the discrepancies in this case. Unfortunately, faced with what I considered to be the compelling evidence of Mr D and his friends, evidence which is supported by the fact she must have been pregnant at this time, Ms J continued to deny any possibility she may have some knowledge that she was pregnant.

68. The fact I consider she was being untruthful on this issue, does not mean it necessarily follows she necessarily knew she was pregnant in the months leading up to Baby M's birth.

69. One possible conclusion is that notwithstanding the positive pregnancy test, as she continued to have what appeared to be light menstrual periods up until the birth she may have thought that the pregnancy test was wrong or she had miscarried early in the pregnancy. Given there was only moderate weight gain for which there was a possible explanation due to the immobility after her knee operation, it may very well be that she genuinely did not know she was pregnant at the time of the birth.

70. The events which are described later in this decision around the circumstances of the birth also reveal she was apparently in a genuine state of shock.

71. Unfortunately Ms J's failure to be truthful on that issue and her lack of candidness in offering an explanation as to who was the father of the child, given the DNA results (see below), leaves me unable to make a conclusion on the balance of probabilities as to whether or not she knew she was pregnant at the time of the birth and therefore this is an issue which remains open.

## Who is Baby M's father?

72. Following the initial involvement of the QPS, DNA samples were obtained from Ms J, Mr D, Mr St and Mr B to determine if any of them were Baby M's biological parents.

73. DNA testing revealed that Ms J was Baby M's biological mother, however Mr D, Mr St and Mr B are excluded as a potential biological father of Baby M. The DNA testing results are peer reviewed by another scientist within the DNA laboratory of Forensic and Scientific Services and not likely to be wrong.

74. As far as Mr D was concerned, whilst they were together Ms J did not have a sexual relationship with anyone other than himself during their relationship. He now says he has been told by friends that she was seeing a third person at the time before they broke up but he is not aware who he is.

75. Ms J contacted Mr D on 29 November 2008 to advise him that she had his baby. Ms J disclosed the circumstances of the delivery; that she believed she had had food poisoning, she had not felt the baby move and that the baby had died. Ms J told Mr D he was Baby M's father and that she needed him to sign documentation for either Baby M's birth or death registration.

76. Ms J told Police she believed Mr D was the father of Baby M as he was the only person she had sex with up until 23 May 2008. Ms J denies she had any other sexual relationship with any other person at this time. She is unable to explain the DNA results.

77. At the time of completing her statement, Ms J was in a relationship with Mr B. She did not commence having sex with him until the middle of July 2008.

78. Ms J completed an application for Baby M's birth registration which was received by the Registry of Births, Deaths and Marriages on 3 December 2008. This document and Baby M's birth certificate (which was issued as a result of this application) do not list Baby M's biological father.

79. The death registration application does not list Baby M's biological mother or father however, there is no section for this information to be inserted.

80. Baby M's death certificate lists Ms J as his mother and Mr D as his father. Mr D told the court he had signed some paperwork to that effect.

81. Mr B told the Court he had been seeing Ms J firstly in a mainly sexual relationship until after the birth when he started dating her. They lived together for a period of time before she went back to NSW to her family. As far as he was concerned she had always maintained he was the father and she explained the child had been born very early. He was surprised when he saw photographs which showed the baby was much bigger and he had thought the father was Mr D. Ms J consistently maintained to Mr B she did not know she was pregnant.

82. Mr B was not aware if Ms J saw anyone else when he was involved with her. He was himself in another relationship at the same time when he initially commenced a sexual relationship with Ms J. He said he had since been told by other third hand sources Ms J was having some form of relationship with two persons who he named to the court. He did not know if the information was true. Ms J knows the persons named but denies such relationships included a sexual one.

83. Ms J denied that she had always maintained Mr B was the father however conceded she may have allowed him to continue with that assumption while they were together in the selfish belief he would feel obligated to stay in a relationship with her.

84. The evidence clearly supports a finding the father is not Mr D or Mr B. It is unknown who the father is and Ms J, for reasons only known to her, is unable to say, but evidently there was one other sexual partner in the January/February 2008 period.

85. For completeness, I will be writing to Birth Deaths and Marriages supplying them with this decision and suggesting the record note Mr D is not the father and he be removed from the Certificate of Death.

## Telephone records

86. Following Baby M's death, the police conducted a forensic analysis of Ms J's mobile telephone and the people she contacted in the period leading up to Baby M's birth through to after Baby M's death.

87. On 23 November 2008, Ms J received a text message from "Nathan". Mr D confirmed Ms J had been friends with a "Nathan" but did not think they had been in a sexual relationship. Ms J says this is N S and she was not in a sexual relationship with this person.

88. On 26 November 2008, Ms J was in contact with her sister Janine and Mr B. Despite telling QPS she did not have a contact number for Mr St when she provided her statement, his contact details were saved in her mobile phone as "Black Matt" and she was in contact with him on 26 November 2008 between 8.58pm to 9.02pm. These text messages appear to be of a general nature. Ms J agrees his details were in her mobile phone and she does not know why she told Police she did not have the number.

89. On 27 November 2008, 4 and 5 December 2008, Ms J received text messages from "Shaun". Ms J says this is Shaun M who was in NSW.

90. On 29 November 2008, Ms J received a text message from "Daniel". Ms J thinks it is Daniel C, the brother of Mr B C. In her evidence she indicated she may have contacted Daniel for Mr D's telephone number following Baby M's birth.

91. Mr B sent a text message on 1 December 2009 that this involved him as much as it did Ms J and that he would not be able to front up to Mr and Mrs J for a little while. This is consistent with Mr B's version that he was told and he believed he was Baby M's father. Ms J does not know what this referred to.

92. On 3 December 2008, Mr B sends a text message to Ms J asking if the baby was stillborn and why did Ms J lie. Neither Mr B nor Ms J were able to clarify what the reference to lying was about.

## Medical history and previous surgery

93. Ms J saw a GP on 11 January 2008 for upper respiratory tract infection, earache and sore throat. She saw a GP on 3 March 2008 complaining of a sore chest and cough.

94. Ms J was seen by a GP on 12 and 14 April 2008 due to chest pain. The notes of these attendances reveal that Ms J's x-rays were normal and there were no notations on the file regarding birth control or pregnancy.

95. On 1 September 2008, Ms J presented to a GP in relation to a dislocation-relocation injury to the right patella. Ms J had previously fractured her patella 7 years prior. Ms J was referred to orthopaedic surgeon, Dr Christopher Vertullo.

96. Dr Vertullo reviewed Ms J on 3 and 13 October 2008. Ms J was diagnosed with right chronic patellofemoral instability. On 30 October 2008, Ms J underwent a right patellofemoral stabilisation at Pindara Hospital.

97. Prior to Ms J's knee surgery and for the MRI, CT and x-ray investigations, she completed forms stating she was not pregnant.

98. On 30 October 2008, a patient admission form for Pindara Private Hospital was completed by RN Bull. This document contained the question "could you be pregnant?" which was answered in the negative. The pre-operative checklist again contained the question "could the patient be pregnant?" which was again answered in the negative.

99. The surgery was uncomplicated. Ms J was reviewed by Dr Vertullo on 21 November 2008 and she was doing well with a standard postoperative recovery.

## The version of events of 27 November 2009 provided by the J family

### *Version of Ms J*

100. On 26 November 2008, Ms J went out to lunch with her mother and consumed a large burger. She was too full from lunch to have dinner. However, she had a couple of bites from her father's dinner.

101. Afterwards Ms J felt nauseous. She went to bed at 9pm.

102. Ms J awoke and went to the toilet to throw up which made her feel a little better. When she lay down on bed her stomach really hurt like period pain and she could feel the pain in her lower stomach area.

103. Ms J got up later with diarrhoea and returned to bed with pain that was almost unbearable. Ms J felt nauseous and went to vomit but only dry retched.

104. Ms J went to the kitchen to get a hot water bottle and saw that it was 2.30am on 27 November 2008. She went to use the computer in the study. However, she got a sharp pain in her lower stomach so closed the program down and went to the toilet.

105. Ms J went to the toilet for 10 – 15 minutes, believing her bowels needed to open however nothing occurred.

106. Ms J believes she attempted to call Mr B at 2.45am however she did not reach him. Ms J's phone records indicate this call occurred at 3.52am.

107. Ms J then spent a period of time in the toilet as the pain was unbearable.

108. At 4.45am she tried call out to her parents but the door was closed. She believes she may have then tried to call her mother's phone. This is confirmed by Ms J's mobile phone records, which indicate the call was made at 4.46am. Her mother did not answer the phone. Ms J stayed on the toilet.

109. Eventually the pain eased so Ms J went to her parent's bedroom. Ms J told her parents she had a really sore stomach, was vomiting and had diarrhoea.

110. Her parents assisted her into bed and got her a hot water bottle. Mr J commented on Ms J's stomach being either swollen or bloated.

111. Mrs J told Ms J she would go the chemist when it opened. Ms J believed her pain and the vomiting and diarrhoea was as a result of food poisoning.

112. At around 5am, Ms J went to the toilet. The pain was far worse than what it had been earlier. Ms J then discovered she was bleeding. Ms J believed she had got her period and the pain would now cease.

113. Ms J attempted to go and get something to eat when the sensation to push become overwhelming. Ms J sat down on the toilet and saw clear liquid and specks of blood. Ms J believed this was urine however she was told at GCH this was likely her waters breaking.

114. Ms J felt her body pushing and because it was pushing she was pushing to get something out of her bowel. Ms J then felt something come out of her vagina and a lot of fluid came out as well. Ms J observed a piece of string coming from her vagina out into the toilet bowl. Ms J was not sure what this was so she called out to her mother.

115. Ms J then told her mother she thought something had come out of her and it was a baby. Ms J did not know why she said this. Ms J was attempting to put her underwear on when she felt something else come out of her vagina. She then started to bleed heavily.

116. Both Mr and Mrs J thought that Ms J had had a miscarriage.

### *Version of Mr and Mrs J*

117. In her interview with the police on the day of Baby M's birth, Mrs J told the police that Ms J had come in at 5.30am complaining of vomiting and diarrhea. Mrs J got up and Ms J returned to the toilet. Mrs J got a hot water bottle for Ms J and told her they would go to the chemist when it opened. Mrs J then made a cup of tea and toast for herself and Mr J. Whilst they were consuming this in their bedroom they were watching Sunrise on Channel 7. Immediately after 'Kochie' told a bad joke, they heard Michelle call out.

118. In her statement Mrs J changed her version slightly, indicating Ms J had initially attended their bedroom at 5am and that after obtaining the hot water bottle for her daughter she returned to bed however she was not able to really fall asleep.

119. Mr J believes Ms J came into their bedroom at approximately 5am. After being told Ms J's symptoms they considered whether she needed to go to Hospital however her symptoms did not appear to be appendicitis so they thought Ms J would have to tough it out.

120. Mr J believes it was at approximately 7am when he was watching Sunrise and Kochie had just told the joke of the day when Ms J called out.

121. The QPS confirmed with Channel 7 that David Koch delivered his joke of the day at 6.53am, Queensland time.

122. All of the J family indicated that her parents went to assist her immediately after she had called out.

123. Mr and Mrs J entered the toilet. They both observed a lot of blood and Mrs J took Ms J off the toilet. Mrs J saw the blood and a mass or blob in the toilet. She only looked for a split second and did not realise it was a baby.

124. Mrs J retrieved a phone to call 000 and Ms J was placed in the bath in the bathroom.

125. Mr J telephoned 000 as Mrs J was unable to. Mrs J stayed with Ms J.

126. At some point, Mr J went to the toilet bowl and observed congealed lumps of blood and large lumps of tissue or foetal matter.

127. Mr J intended to clean up the toilet area and he starting scooping the blood clots and foetal matter into a bucket as he did not think he would be able to flush the toilet with this matter still in the toilet. The foetal matter turned out to be Baby M's back. When Mr J placed both hands in

the bowl he realised there was something more solid in the bowl and he removed Baby M.

128. Mr J is unsure whether this occurred before, during or after the 000 call.

129. Mr J observed that Baby M was larger than what he had expected. Baby M was pinkish in colour and warm with no breathing or movement. Mr J assumed the child was deceased. He said in his statement if there were signs of life he would have tried to resuscitate Baby M.

130. Mr J initially placed Baby M in the bucket with the placenta and then decided that was not the best place for Baby M. He wrapped Baby M up in a towel, similar to how you wrap a baby, with his face uncovered and left him on the toilet floor.

131. Mr J went to check on his wife and daughter but went back to Baby M about a minute later to check he was not alive and breathing as he was concerned Baby M was pink and warm but lifeless.

132. Mr J checked Baby M's mouth to see if there was anything blocking his airway. Mr J put his finger into Baby M's mouth and felt around but there was nothing in his mouth.

133. Mr J told police in his interview with them that Baby M had been in the toilet for between 5 and 10 minutes before Baby M was removed.

134. In her interview with police, Mrs J stated that she asked what was in the toilet and Mr J replied "a baby". Mr J wrapped the baby in a towel or blanket. Later in her interview she stated that Mr J had stated that the baby was pink. Even later in her interview, Mrs J stated that Mr J had advised that the baby was 5 – 6 months old.

135. In her statement, Mrs J only says that Mr J advised them that there was a baby in the toilet bowl and that he had wrapped the baby in a towel.

136. Mrs J states that she believes that Mr J had presumed the baby was not alive because of the distress she observed him to be in when the paramedics announced that they could detect a heartbeat.

137. Given the circumstances, Mr and Mrs J's reaction was appropriate and it is understandable that Mr J assumed Baby M was deceased.

## The 000 call, the QAS response and Hospital treatment

138. Mr J telephoned 000 at 6.58am on 27 November 2008. During the phone call, Mr J stated that it looked like Ms J had had a miscarriage and she did not know she was pregnant. Mr J told the 000 operator that the baby had come out and was in the toilet. The 000 operator asked if Mr J could retrieve the baby from the toilet and he agreed to do so. Mr J indicated to the ambulance officer that the baby appeared to be four or five months old. The rest of the conversation focused on the well-being

of Ms J. There was no discussion about checking Baby M's vital signs and/or whether CPR should be commenced.

139. At 7.00am, an ambulance unit was assigned to attend the J's residence to assist. This was the unit containing Advanced Care Paramedics (ACP's) King and Pattemore. They were on route to the residence at 7.01am and arrived at the residence at 7.08am.

140. Prior to arriving at the scene, ACP King recalls being advised that a baby had been born and was located in the toilet. ACP Pattemore recalls they were advised that Ms J was unsure if she was pregnant. They were not provided with any information on whether the baby was breathing or conscious. They had some difficulty entering the house, and did not gain entry to the residence until 7.10am.

141. The officers had the impression Mr and Mrs J appeared to be more concerned with Ms J's well-being than Baby M who was on the floor of the toilet. ACP King had a feeling, without this being verbalised, that this was in the context that Mr J thought the baby was dead.

142. Ms J was initially located in the bath in the bathroom. Ms J was extremely distressed and Mrs J appeared to be distressed for her daughter.

143. ACP King assessed Ms J and ACP Pattemore went to the toilet to assess Baby M.

144. Ms J told ACP King that she had no idea she was pregnant and she had still being having her period, although it had been lighter than normal. Ms J told ACP King she had had a recent knee operation. She also stated she awoke with stomach cramps and needed to open her bowels and this was when she had the baby.

145. Ms J told ACP King she gave birth to Baby M head first. ACP King assessed that Ms J was not bleeding excessively and had vital signs that were not considered to be life threatening.

146. ACP King believed Ms J was in distress as a result of the delivery and in shock. This was what he would have expected in the situation. Ms J was able to understand what ACP King was saying. However, her responses were slower and she was visibly upset. Ms J was assessed as having a Glasgow coma score of 15.

147. ACP Pattemore entered the toilet and observed approximately 500ml of blood in the toilet and on the floor. ACP Pattemore observed a blue bucket that contained the placenta with the umbilical cord running out of it to a white towel. ACP Pattemore initially could not see any part of Baby M as he was completely covered by the towel.

148. ACP Pattemore felt Baby M and found him to be warm in temperature and could feel a heart beat. ACP Pattemore obtained a stethoscope and confirmed a heart rate of 60 beats per minute.

149. Baby M appeared to be centrally and peripherally cyanosed. By this, Baby M's skin was purple/blue in his limbs and his head and body were the same colour. ACP Pattemore assessed Baby M's APGAR score as 1.

150. ACP Pattemore advised ACP King of his findings and requested ACP King's assistance. ACP Pattemore heard a female voice sob and cry when he said Baby M had a heart beat but was not breathing. ACP King heard someone wail. The stress in the room became greater as a result.

151. ACP Pattemore also contacted QAS communications for another emergency crew and intensive care crew code 1 at 7.15am. ACP's King and Pattemore then focused their attention on Baby M given his life threatening condition and as Ms J was in a stable condition. There was no complaint given by Ms J or her parents that Baby M was to be given priority.

152. ACP King recalls either himself or ACP Pattemore asking how long was the baby in the toilet for. Mr J replied "about ten to fifteen minutes after the birth". Mr J confirmed that Ms J did not know she was pregnant and no treatment had been provided to Baby M prior to the arrival of QAS.

153. ACP King and Pattemore then proceeded to the ambulance with Baby M, continuing CPR. They departed at around 7.20. Whilst ACP's King and Pattemore were departing ACP Haw and Student Paramedic ("SP") Wright arrived.

154. ACP Haw recalls both Ms J and her parents were all crying and appeared to be in a state of shock and disbelief when she went to assess Ms J. Ms J did appear to understand directions given to her by ACP Haw and followed these.

155. SP Wright recalls ACP Haw assessing Ms J. ACP Haw asked a number of standard questions like what medications Ms J had been taking etc. SP Wright believed Ms J to be upset and in shock. SP Wright left the bathroom to organise a stretcher for Ms J.

156. ACP Haw asked Ms J how many weeks pregnant she thought she was. Ms J stated she did not know because she did not know she was pregnant.

157. Ms J stated she had got up that morning with tummy pain and when she went to the toilet the delivery occurred. Ms J stated she had had abdominal pain for a few days.

158. ACP Haw asked Ms J if she had missed any periods. Ms J stated her periods were normally irregular so she had thought nothing of it as she could go some time without having a period normally.

159. Mrs J advised ACP Haw that Ms J had had a knee reconstruction 4 weeks earlier at Pindara Hospital under general anaesthetic and they were concerned about the effect the anaesthetic may have had on Baby M.

160. Initially Mr and Mrs J were advised Ms J would be taken to Pindara Hospital. However, SP Wright and ACP Haw altered this decision, knowing that Baby M had already been taken to GCH. When SP Wright advised Mr J of the change in destination, he observed Mr J to be teary, upset and in complete shock.

161. Ms J was transported to GCH. On route, Ms J was quiet and only responded to direct questions from ACP Haw. ACP Haw believed Ms J was in a state of shock and disbelief and was very tearful.

162. During the journey Mrs J was very supportive and said things to Ms J like not to worry about it and they would get through it and sort it out.

163. Baby M's condition remained critical on the way to GCH with no improvements to his vital signs. Further advanced procedures were conducted on route to GCH.

164. By the time the ambulance arrived at GCH at 7.30am, Baby M's skin colour had changed from cyanosed (a blue or grey colour) to pink though his heart rate and GCS/APGAR remained unchanged. Baby M was handed over to GCH at 7.31am.

165. On Baby M's arrival at the GCH, his heart rate was 40 with no output, no respirations and he was cold. He was intubated and cardiac compressions and ventilations were continued and advanced life support measures were put in place. He was transferred to the Special Care Nursery. All tests indicated Baby M had been severely hypoxic and acidotic for a reasonable period of time.

166. Staff at the GCH assessed Baby M at being approximately 36 weeks in gestation. As the GCH does not have a Neonatal Intensive Care Unit, arrangements were made to transfer Baby M to the Mater Mother's Hospital.

167. At the Mater, Baby M was unresponsive while receiving mechanical ventilation with decreased muscle tone in both his upper and lower limbs. Baby M's EEG monitoring revealed a "flat trace".

168. Dr Zankl, a consultant neonatologist assessed Baby M. She formed the view that Baby M had endured a major brain injury and the prognosis for

him was very poor. Baby M's family made the decision to withdraw intensive care and he passed away at 6.45am on 29 November 2008.

169. The evidence of Ms J and that of her parents concerning be events of that morning is reasonably consistent. Any variation in the versions is minor and simply indicative of differing recollections. The evidence would support Baby M remained in the toilet bowl for a period of between five and 10 min and more probably closer to the five-minute mark.

170. There is no evidence which would suggest that Mr or Mrs J had any reason to suspect their daughter was pregnant or that this was anything but an early term miscarriage. The ambulance officers all give evidence of the obvious distress and shock of all three. Their distress heightened when they realised Baby M was a more mature baby and had signs of life.

## *Autopsy report*

171. A full external and internal autopsy was completed by Dr Urankar on 1 December 2008.

172. From the post-mortem examination, it was determined that Baby M demonstrated anthropometrical measurements in keeping with a gestational age between 35 – 38 weeks. Radiology and neuropathology examinations confirmed the gestational age to be around 36 weeks.

173. The autopsy examination did not demonstrate any evidence of an underlying congenital abnormality which could account for Baby M's premature delivery or death. The heart was normal in size and appearance but for a patent ductus arteriosus. This is not an uncommon finding in infants at birth and would not be contributory to his death. The kidneys, liver, spleen and gastrointestinal tract were normal.

174. The lungs were observed to float in water at autopsy. This is an observation made in cases of infants who have breathed after delivery. Microscopic examination confirmed patchy expansion of the airways (alveoli). This, however, does not necessarily indicate spontaneous breathing and could simply reflect ventilation by medical staff. There was some subpleural expansion of airspaces, an observation often made in cases of drowning however this is not a specific finding.

175. The lungs also demonstrated evidence of acute bronchopneumonia throughout all lung lobes. This could have developed as a consequence of the aspiration of water from the toilet bowl following a live delivery. It could also have developed following admission to the intensive care unit with a depressed conscious level and inadequate lung ventilation. It is unlikely to have preceded delivery.

176. Lung samples were sent for microbiological testing. These showed growth for the fungus Candida albicans and some bacteria considered to

be post-mortem contaminants. A swab from the trachea was positive for Delftia acidovorans, an environmental gram negative bacillus which can be found in waste water. Other tissues samples were also sent for microbiological testing (heart, liver, brain). Again, some were positive for Delftia acidovorans as well as other post-mortem contaminants. No viruses were detected.

177. The placenta had been previously examined by a hospital pathologist. This had a histological appearance in keeping with the third trimester. The presence of large numbers of syncytial knots and areas of infarction would be unremarkable in a 36+ week placenta but in a younger gestation it could lead to premature delivery.

178. Blood tests did not demonstrate any evidence of an underlying metaboloic disorder.

179. Full toxicological analysis was performed on samples of blood taken at the time of autopsy. These were in keeping anti-seizure and a palliative infusion of drugs administered by medical staff. No alcohol or illicit drugs were detected.

180. The brain was examined by specialist neuropathologists. This showed a swollen and enlarged brain. These changes were a consequence of widespread (global) deprivation of vital oxygen from the brain tissue (hypoxic-ischaemic encephalopathy). The consequent damage and death of brain cells would have been irreversible and would have led to death without ongoing respiratory and cardiovascular support. They would also have led to the development of seizures as was noted clinically.

181. Dr Urankar was of the opinion, based on the history and circumstances in conjunction with the autopsy and investigation findings, that Baby M's death was the consequence of deprivation of vital oxygen to the brain (hypoxic-ischaemic encephalopathy).

182. She believed the hostile environment following delivery into the toilet bowl could have led to the aspiration of water during attempts at breathing by the live born infant leading to hypoxia. Other reasons for deprivation of oxygen could be considered including hypoxia during pregnancy or delivery leading to stillbirth although this was unlikely given the detection of a heart beat by ambulance officers at the scene.

183. There were no findings which would suggest Baby M would not have survived delivery under other supervised circumstances.

184. The consequent development of pneumonia would have contributed to respiratory failure and the hypoxic state. While it does not ultimately relate to the brain injury, it would have contributed to death when life support was withdrawn.

## Conclusions on the issues

185. I have been unable to come to a conclusion one way or the other as to whether Ms J knew she was pregnant at the time that she gave birth to Baby M. There is clinical evidence that at some stage in late January to late February 2008 Baby M was conceived. I accept that sometime in the next month or so she delivered a positive pregnancy test, which was accurate because she was pregnant.

186. There is good evidence in the months leading up to the birth that she was not noticeably pregnant, and she was having what seemed to be menstrual periods, albeit lighter than usual. She saw a number of doctors over this period and no mention was made as to her being pregnant. Those closest to her including her family and boyfriend had no suspicions she was pregnant. Her moderate weight gain could be explained by her immobility after a knee operation.

187. The evidence of all those present at and soon after the birth indicated Ms J and her parents were shocked and distressed with the events, again supporting a conclusion that Ms J did not think she was pregnant, at least at the time of Baby M's birth.

188. Unfortunately her evidence concerning the pregnancy testing and lack of explanation as to who the father is have left me unable to make a conclusion on what is the most likely scenario.

189. The DNA testing clearly supports a finding that neither Mr D nor Mr B is Baby M's biological father. I am unable to come to a conclusion as to whom the father is.

190. The evidence supports a finding Baby M was born at close to 6.53 am on 27 November 2008 into the toilet bowl where he tragically remained for a period of around 5 minutes but not more than 10 minutes. Any CPR or resuscitation efforts would not have commenced until around 7.12 am. This was sufficient to cause hypoxic ischaemia which was irreversible despite intensive resuscitation measures and Hospital care. The autopsy examination opines that Baby M most likely would have survived if he had not been delivered into the toilet bowl and remained there for that period of 5 minutes or more.

# Findings required by section 45

**Identity of the deceased** – Baby M

**How he died** – Baby M was born on 27 November 2008 into a toilet bowl at a house shared by his mother and her parents. It is unclear as to whether she was aware she was pregnant at the time although the evidence supports a finding her parents were not aware. Baby M remained in the toilet bowl for a period of between 5 and

10 minutes. Resuscitation did not occur until approximately between 15 and 20 minutes after his delivery. The time in the toilet bowl and between commencement in resuscitation was sufficient to cause hypoxic ischaemia and brain damage which despite advance resuscitation treatment was irreversible and after withdrawal of life support he died.

**Place of death** – Mater Mother's Hospital, Stanley Street, South Brisbane, 4101

**Date of death**– 29 November 2008

**Cause of death** – 1(a) Hypoxic-ischaemic encephalopathy

Other significant conditions:

2 Bronchopneumonia.

I close the inquest.

J Lock
Brisbane Coroner
BRISBANE
29 June 2012