CITATION: *Inquest into the death of Jessica Jane* *******[2000] NTMC 37

TITLE OF COURT:	Coroners
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HEARING DATE(s):	2 November 1999
JUDGMENT OF:	Mr Greg Cavanagh

CATCHWORDS:

Coronial Inquest, death of infant, jurisdiction, reportable death, doctor patient relationship, medical practitioner

REPRESENTATION:

Counsel:

Assisting:	Mr Peter Barr
For the Doctor:	Mr David Farquhar
For the Darwin Private Hospital	Ms Anita King

Solicitors:

For the Doctor:	Cridlands
For the Darwin Private Hospital:	Finlaysons

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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. 9815022

IN THE MATTER OF AN INQUEST INTO THE DEATH OF:

JESSICA JANE ***************

FINDINGS

(Delivered 10 APRIL 2000)

Mr CAVANAGH SM:

THE NATURE AND SCOPE OF THE INQUEST

1. Jessica Jane *************** (the "deceased") was born alive at the Darwin Private Hospital on the morning of 14 July 1998 at 0245 hours. The deceased was delivered after an induction procedure had been carried out with the express purpose of terminating the mother's pregnancy by aborting the foetus. However, the delivery of an aborted foetus did not occur and instead a baby girl (the deceased) was born alive. She died at 0405 hours on the same morning after living some 80 minutes. Pursuant to the ***Births, Deaths and Marriages Registration Act***, relevant particulars of the deceased and her parents were provided and a birth certificate issued in due course. The death was reported to my office pursuant to the ***Coroners Act*** ("the Act") by the general manager of the Hospital.

2. Section 14(1) of the ***Coroners Act*** ("the Act") reads:

> "a Coroner has jurisdiction to investigate a death if it appears to the Coroner that the death is or may be a reportable death".

The phrase "reportable death" is defined in Section 12 of the Act to include:

> "(a) a death where
>
> i) the body of a deceased person is in the Territory
>
> ii) the death occurred in the Territory
>
> iii) the cause of death occurred in the Territory
>
> being a death –
>
> iv) that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury."

3. As to the question of jurisdiction, Counsel Assisting me (Mr Peter Barr) and Counsel for the Darwin Private Hospital (Ms Anita King) submitted that I did have jurisdiction to investigate (and hold an Inquest) in relation to the death. Mr David Farquhar, Counsel for the doctor responsible for the induction procedure, submitted that I did not have jurisdiction. He submitted that the death was not "a reportable death" pursuant to the Act. I accept that if the death is not "a reportable death" then I do not have jurisdiction. I have already outlined the statutory definition of "reportable death" and I do not believe that there is any argument that the requirements of Section 12(1)(a)(i-iii) are complied with. The question is whether section 12(1)(a)(iv) is complied with ie, does the death "appear to have been unexpected, unnatural or violent ---". Despite some initial doubts (expressed at the Inquest), in my considered view the death was unexpected. What was expected was the delivery of an aborted foetus, unexpectedly there occurred the delivery of a live baby human being; that being unexpected, her death 80 minutes later was also unexpected. I note in this regard that the evidence revealed that in relation to second trimester

abortions, the induction procedure usually results in an aborted foetus. Apparently this is so because the trauma involved in the delivery process results in death of the foetus as it proceeds down the birth canal and exits the mother.

4. Furthermore, I accept the submission of Counsel for the Hospital (which was similar to that of the submissions of Mr Barr) that the death is also a "reportable death" because it was unnatural. The evidence revealed that the birth and inevitable death of the baby due to prematurity was caused by artificial means. That is to say, the death was contrary to nature.

5. The Inquest is held as a matter of discretion pursuant to the provisions of section 15(2) of the Act. Section 34 of the Act set out the limits of the jurisdiction of the Coroner as follows:

> "Section 34 Coroners' Findings and Comments
>
> (1) A coroner investigating
>
> (a) a death shall, if possible, find
>
> i) the identity of the deceased person;
>
> ii) the time and place of death;
>
> iii) the cause of death;
>
> iv) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act;
>
> v) any relevant circumstances concerning the death.
>
> (2) A coroner may comment on a matter, including public health or safety of the administration of justice, connected with the death …… being investigated.
>
> (3) A coroner shall not, in an investigation, include in a finding or comment, a statement that a person is or may be guilty of an offence.

(4) A coroner shall ensure that the particulars referred to in subsection (1)(a)(iv) are provided to the Registrar, within the meaning of the Births, Deaths and Marriages Registration Act."

6. The public Inquest commenced at Darwin Courthouse on Tuesday 2 November 1999 and concluded by way of written submissions on Friday 12 November 1999. Counsel assisting the coroner was Mr Peter Barr. Ms Anita King sought leave, and was granted leave to appear on behalf of the Darwin Private hospital. Mr David Farquhar sought, and was granted leave, to appear on behalf of Dr Henry Cho.

7. At the commencement of the Inquest I made an order pursuant to section 43(1)(c) of the Act prohibiting publication of the name of the mother and the deceased. I continue this order and extend it to include the name of the father and any details likely to lead to the identification of these three persons. I also continue my order suppressing the publication of addresses of all witnesses including any details likely to lead to the identification of any such address.

FORMAL FINDINGS

i) The identity of the deceased was Jessica Jane **********, a female Caucasian born on 14 July 1998 at the Darwin Private Hospital in the Northern Territory of Australia.

ii) The time and place of death was at the Darwin Private Hospital on 14 July 1998 at about 4.05am.

iii) The cause of death was premature delivery.

iv) The particulars required to register the death are:-

(1) The deceased was a female.

(2) The deceased was of Australian origin.

(3) The death was reported to the Coroner.

(4) The death was confirmed by post-mortem examination.

(5) The cause of death was as per clause (iii) above.

(6) The pathologist (Dr Terence John Sinton) viewed the body after death and carried out the post-mortem examination.

(7) The mother of the deceased was Fiona Louise ********** and the father was Scott Edward **********.

(8) The deceased did not have any usual address and was a baby.

RELEVANT CIRCUMSTANCES CONCERNING THE DEATH INCLUDING COMMENTS, REPORTS AND RECOMMENDATIONS

8. Staff at the Darwin Private Hospital were called at the Inquest. They gave evidence of Dr Henry Cho booking the mother of the deceased into the hospital for a second trimester termination of pregnancy procedure. A term of 19 weeks was apparently mentioned by the doctor. The procedure was necessitated, in the opinion of Dr Cho, by concerns for the mother and not because of any foetal abnormalities.

9. Evidence disclosed some carelessness in relation to consultation notes and hospital admission forms by both the doctor and hospital staff. The former manager of the hospital gave evidence that there were no procedures or protocols in place at the hospital at the time of death concerning the assessment, treatment and care of children who survived a termination procedure. I note that second trimester abortions were not usually done at the Private Hospital and there was evidence that the survival of the deceased was an unusual event for the hospital. Indeed, such an event had never happened at the hospital to the manager's knowledge.

10. Ms Carrie Williams, a registered mid-wife with over a decade of specialized experience in this field gave evidence. On the night of Monday 13 July 1998 she was responsible for the care of the mother of the deceased. The mother had been admitted to the hospital on the morning of 13 July 1998. Dr Cho last saw her on that morning at the hospital to confirm her desire to proceed. He completed a medication chart and left it to the nursing staff to

administer the prescribed drugs and deliver the expected aborted foetus. Nurse Williams attended to the mother during the night as the medication gradually induced, over a number of hours, labour pains leading to the delivery of the deceased. She was present for the delivery of the child; she was the only person present other than the mother. The time was recorded at 0245 hours. Dr Cho had indicated that he would not be in attendance at the hospital during the night for the delivery but would be available by telephone if there were any complications.

11. She gave evidence of being called to the mother's room and finding the mother in the toilet ensuite about to deliver. She immediately obtained some equipment to help with the delivery which proceeded. She placed what she assumed to be the foetus in a kidney dish and took it from the mother's room. She heard the baby cry which shocked her. She realised that the baby was older than the 19 weeks term that she had been advised. Based on her experience the baby appeared to her to be "a lot more" than only a 19 week term baby. The baby although premature, was apparently healthy, had no apparent abnormalities and its vital signs were relatively good. Nurse Williams weighed the baby and its weight was 515 grams. She checked the baby every 10-15 minutes and some crying and movement by the infant was heard and observed. After about an hour her heartbeat and breathing slowed until death at 0405 hours.

12. She said to me that she had been given no indication that the baby might survive the termination procedure. There were no procedures or protocols in place for her to refer to. None of her supervisors were available to help her; she tried to telephone them but to no avail. She said to me, and I quote: (transcript p.82 and p.83)

> "That then left me in a very big moral dilemma. I didn't know what to do.
>
> THE CORONER: Where was the baby during this? --- The baby I had taken into delivery suite, into what we call a clean-

up area and because the baby was making noises I could not just leave it like we do with some, in a kidney dish, and I put it into a warm rug and put a drape over the top of it so at least it was warm. During all this time I'd been back and checked it about every 10, 15 minutes.

and

What did you then do? --- I wasn't sure what to do. I was actually getting quite frustrated. In the meantime I had gone back to Fiona because there was still the problem of delivering the placenta.

and

MR BARR: Could you tell His Worship what happened next, Ms Williams? --- I rang Doctor Cho, who answered the phone fairly quickly and said to him, because I had dealings with him before and he knows me, I said, 'Doctor Cho, this is Carrie at the private hospital. Fiona's delivered. The baby has good Apgars. I told him what the Apgars were.'

Could I just stop you there in the course of that? --- Sure.

Could you tell us what Apgars are? --- Apgars is a scoring that you give babies when they're born at 1, 5 and 10 minutes. There are five categories and each category gets a 2 or a 0 to 2 depending on - - -

On your assessment? --- Exactly.

THE CORONER: These are the vital life signs of a baby? --- Exactly, yes.

MR BARR: So you told Doctor Cho that - - - ? ---- I told him that the baby was alive and that the baby's weight led me to have to register the baby as a birth. He then said to me. 'Was the placenta out?' to which I answered yes. I said, 'Doctor Cho, the baby is alive.' He said to me, his exact words were, 'So? I will see her in the morning' and hung up.

THE CORONER: Did you tell the doctor the baby was a female baby? ---- No.

So who do you understand that he was talking about when he said, "I'll see her in the morning'? ---- The mother.

> MR BARR: Did you specifically ask Doctor Cho for – did you say to him any words to the effect that you wanted his assistance or guidance? ---- No. I assumed that being the doctor in charge of Fiona that he would have given me that direction, especially when I told him what the Apgars were and the fact that the baby was alive."
>
> "THE CORONER: So what was your reaction when he hung up? ---- Not very good. I was very distressed by it. I hung up the phone and actually said a few words out loud."
>
> MR BARR: And did you take any other steps to get some assistance to help you with your problem? --- I did. I re-rang my supervisor who still couldn't offer my any advice. By this stage it was getting on and I had been back to check the baby and I knew it wasn't going to survive. I desperately wanted to do more, but felt my hands were tied.

and

> Did it occur to you that there was any other course open to you other than simply maintaining the child warm and observing it? --- Knowing the gestation of the baby was probably about – on my estimation the baby was probably anything from 22 to 24 weeks. Having seen those gestations before born and not survive in the Territory I didn't think of doing anything. I thought it would have been cruel to try and resuscitate the baby in any form……"

13. I accept Nurse William's evidence generally and that which I have quoted specifically.

14. Dr Henry Cho, is a well-qualified and experienced Medical Practitioner and specialist in the field of Obstetrics and Gynaecology. He told me of his consultations with the mother and of her request for an abortion. He gave evidence that despite the length of the pregnancy he was prepared to carry out her request as he thought that she really would "then be in great psychological trouble if she continued with the pregnancy" (transcript p.16). He appeared to agree (I think with hindsight) that by the time of the actual termination procedure, the term of the pregnancy might have been approaching 22 weeks.

15. The doctor apprehended that he could only lawfully perform the abortion in the Northern Territory at such a late stage if he held the opinion that to allow the pregnancy to continue would present dangers to the mental or physical health of the mother. The doctor usually carried out these kind of abortions at the Darwin Public Hospital, however, the relevant ward at that hospital was full. Accordingly he contacted the Darwin Private Hospital and arranged to conduct such a procedure, (as far as he was concerned for the first time at this hospital). I note that the doctor gave evidence that the termination was "immediately necessary as to continue the pregnancy would be extremely detrimental to her". He decided to induce labour (in the same way as would be an induction for a mother wanting to give birth to a live baby) by prescribing the drug Misoprostol. He told the mother that he would not be in attendance at the time of the delivery of what was expected to be an aborted foetus. He told me that he did tell the mother that it was possible that the baby might be born alive. He did not tell the nursing staff at the Darwin Private Hospital of such a possibility. He told the mother he would be available by telephone if there was any complications like bleeding or retention of the placenta.

16. I note his evidence that there are other medical procedures available (than that which he used eg. Foeticide) to ensure that the foetus would not be born alive. However, it was not his practice to use them.

17. He gave evidence that the nurse in attendance on the mother at the time of delivery telephoned him. This was in the early hours of the morning of the birth. The doctor did not appear to have a good memory of the contents of this telephone conversation. He did say he remembered some mention by the nurse that the baby was breathing, however, he decided that the baby was of a non-viable age and "nothing need be done". (transcript p.21) He agreed that in relation to the birth of the deceased he was the only Medical Officer involved (transcript p.23). He accepted that he gave no instructions about the care of the baby or forewarned the nurses of the possibility of a

live birth. He presumed they knew of such a possibility. The doctor agreed that he completed a death certificate for the baby and noted the cause of death as "extreme prematurity". The doctor thought that the only thing one could have done for the deceased was to keep her warm and wrapped.

18. In response to Counsel for the Private Hospital who asked him about his response to the telephone advice that the baby was alive, he said he couldn't remember if he only said "so".

19. The doctor appeared to be confused when asked who was medically responsible for the deceased: (transcript p.36) and I quote his evidence,

> "So when it results in a live birth, do you consider that you're also responsible for the welfare of that foetus? --- Well, I mean, in these circumstances, no.
>
> And my next question was do you think that you are responsible overall for the foetus that was born alive as a result of the procedure that you performed? --- Well, I don't think resuscitating the patient – the baby - - -
>
> No, I'm not asking about whether you should have resuscitated or – I'm just saying, do you think that you are the person that would be overall responsible? --- Yes."

And then further: (transcript p.38-39)

> "MR BARR: Doctor, just following on from that, we hear a lot about the doctor/patient relationship. Do I take it that you accept that you had a doctor/patient relationship with this new-born child, Baby J? --- No.
>
> You obviously accept that you had the doctor/patient relationship with the child's mother.
>
> THE CORONER: Is that right? --- Yes.
>
> Yes. Doctor, if this patient of yours had continued to full term and produced a healthy viable live birth, would you agree in those circumstances that you would have a doctor/patient relationship with the child? --- Yes.

> So if I could ask you this. What was it about the procedure that was carried out on 14 July that meant that you, in your view anyway, you didn't have a doctor/patient relationship with the infant born as a result of the procedure? --- I don't quite understand your question.
>
> Well, you've told us that you didn't regard yourself as having a doctor/patient relationship with Baby J? --- No.
>
> Right. But if, for example, hypothetically, Baby J's mother had continued on full term and had produced an infant at, say, 36, 38 weeks, whatever, you would have regarded yourself as having a doctor/patient relationship with the baby? --- Yeah, usually I would be there, delivering the baby.
>
> And the baby is your responsibility? --- That's right.
>
> So what I want to ask you is, what was it about the procedure carried our on 14 July that made you think that you didn't have a doctor/patient relationship with Baby J? --- Well, because it's a termination of pregnancy, of the indication that the mother psychiatrically cannot cope with a pregnancy, and because it's a pre-viable age, resuscitation is going to be futile, and also because of circumstances of the mother, I think it's emotionally traumatic for the mother if we try to resuscitate the foetus – or baby.
>
> Doctor, let's just say for example that – and I'm not asking this about you, I'd ask you to look at this as a hypothetical. What if a doctor in a similar position to yours, involving a termination, carried out a procedure that gave rise to the birth of a child which was assessed as having, say, 24 or 25 weeks gestational age, what would the position be in that case between the obstetrician who carried out the termination procedure and that child born as a result of the procedure? --- I can't answer that."

20. The doctor agreed that the documentation in relation to his consultations with the mother and the termination procedure was "sadly lacking". (transcript p.49)

21. Evidence was tendered during the Inquest of the opinion of Professor Ian Jones, Professor of Obstetrics and Gynaecology, University of Queensland that the deceased's gestation was 21 to 22 weeks. His opinion was based on

measurements of the infant's body made at the post-mortem examination. His evidence was to the effect that the deceased was not going to survive due to her prematurity. I accept this.

22. I agree with Mr Peter Barr's written submission that despite the apparent "responsibility vacuum", Nurse Williams did what she could to care humanely for the deceased. She gave the deceased basic nursing care by covering, keeping warm and checking the infant. I commend her efforts.

23. Counsel for the Private Hospital called Ms Ann Cassidy a former Director of Nursing as well as the manager of Darwin Private Hospital who told me of the reaction of the hospital to this death. In my view, the hospital's responses were considered, appropriate and sensible; lines of communication have been improved, and documentation and procedures put into place so that the mother's doctor is expected to be in attendance and responsible for the clinical care of any live baby.

24. Ms Cassidy had made an effort to find out what other Australian hospitals do in similar circumstances to that of the birth of the deceased: She said, and I quote, (transcript p.107):

> "You mentioned earlier that you undertook a search of what other hospital were doing; did you find any policies that indicted what care should be provided to live neonates born post-termination? ---- Not from Australia, no, I was – and remembering that the – I didn't ring every hospital in Australia; I rang those hospitals that I thought would be best placed to be able to provide me with some information and as my background is primarily in Victoria, it was Victorian hospitals that I did access and also any hospital that Healthscope owned that also did obstetrics, and I couldn't gain any of those – any information from them – either the hospitals didn't do mid-trimester terminations; most of them have not had the experiences that we had had, and the only policy I could find was one on the Internet that was American based.
>
> So in Australia, you couldn't find any policies? ---- No."

25. Professor Brian John Trudinger gave evidence; he is the Head of Obstetrics and Gynaecology at the Westmead Hospital in Sydney and also the Professor of Obstetrics and Gynaecology at Sydney University. The Professor's evidence was important and some bears quoting (transcript p.135 – 136):

> "Professor, if I could just ask you to assume now that we have a situation, or a situation at Westmead existed with a presumed gestation age of 21, 22 weeks, a procedure were to take place to terminate the pregnancy but not on account on any foetal abnormality, for example on account of the risk to the health of the mother? ---- Yes.
>
> What procedures would be put in place once the decision to effect such a termination had been made? ---- Generally speaking, the – as far as the medical management of the termination is concerned or as far as the management of the birth of the baby?
>
> In relation to the birth of the baby? ---- Because generally speaking the usual circumstance in the situation is the baby, because the labour – because of the nature of the labour, the baby would usually perish at some point of time in the labour, and I think in think in that early gestation, if the prospect of neonatal survival was – was slender, I would doubt that we could be monitoring the pregnancy so we wouldn't know at what point of time death had occurred, but generally speaking, we would – we would have expected that the foetus would be born – would be stillborn – be born not alive. If – if we had the circumstance where a – a foetus was delivered prematurely and alive, then quite clearly that foetus or a child – infant as it becomes at the time of birth, would be afforded full – full access to neonatal resuscitation if it was considered that the child had any prospect of survival but – but that would be a – a – well, it's not a circumstance that we've been in so it's – it's hypothetical. It – it would be a – an exceptional circumstance at 21,22 weeks."

And p.140 - 141

> "We also received a report, professor, form Professor Ian Jones from the University of Queensland; do you know Doctor Jones? ---- I don't know him personally, no.

He was provided with information and was given the recorded weights and measurements of the baby, the autopsy report, the head circumference, the other lengths and measurements and he assessed the gestation period at between 21 and 22 weeks? ---- Yes.

As Mr Barr said in his letter, he reported that there was no chance of long-term survival for an infant born under 23 weeks. Can I ask you if you agree with that assessment? --- Yes, I – I wouldn't say no chance, but the chances would be extremely small, extremely small and by extremely small I am talking about, you know, less than one or two percent sort of thing, but – but extremely small.

What do you predict as its survivability, what treatment would you give the child ? ---- Yes, I – I – if a – what are we talking during the pregnancy or at the time of delivery?

No, you've been called in after the delivery because it's an unexpected live child? ---- Yes.

You've assessed it? ---- Yes, if – if it's a live child, small and immature but alive, then – then we would, although we don't think that there is a – a prospect for survival, we would provide that child with support.

What support would that be? ---- Ventiltory support, oxygen, and – and then looking at the pattern of behavior and the maturity and – of the child to determine the need for admission to level three nursery and that's as I say, is based on the assessment of the prospect of survival and the maturity beyond that point of time. Now, it is a very difficult – it's a very difficult area, it's a very difficult decision to make clearly because – because it – it's not just the sort of weight or just the length of the child, but it's knowing exactly how – how mature the baby was, in other words how long the pregnancy had continued for because you can't equate weight and – and length of a pregnancy precisely. So those sorts of factors enter into it, so you look at overall at the – the newborn child and – and – and its level of maturity, it's level of behavior, whether the eyes are fused, all these sorts of things help get a guide as to what you thought realistically was a – a prospect for survival.

Coming back to it, though, you've assessed the child as having a gestation period of between 21 and 22 weeks – is it

> going to survive? ---- Truly, at that time, the – the prospects of survival would be – would be poor."

and

> "That presupposes that you agree that there is a possibility of live birth? ---- Yes. Yes. Yes, it does, it's – unless one actively does a procedure to – to change this then that remains a possibility although it's an uncommon possibility; it's an uncommon possibility as I said, because the usual mechanism for – for procuring the early delivery is actually associated with demise during labour. It remains as a possibility, it certainly is something in these sorts of circumstances in our hospital with – with major foetal abnormalities, we still – we still make sure the staff is aware of this, and the parents are aware of it.
>
> Where there is such a live birth in circumstances where the baby is apparently born without abnormalities? ---- Yes.
>
> Would you expect the treating doctor who's told of this to attend in relation to the baby or otherwise give directions as to the baby? ---- Yes, I would.
>
> The treating doctor being the doctor in charge of the termination? --- Yes.
>
> Is our understanding? ---- Yes.
>
> I suppose especially would you expect that in the absence of available specialists and other doctors? ---- Yes, I – there should be in place protocols for this sort of situation.
>
> That's what I'm about to get on? --- Yes.
>
> So you would say that there should be protocols in hospitals around Australia, if they're not around Australia? ---- Yeah.
>
> That are in place such that when there is unexpected deliveries of babies, people aren't caught by surprise in terms of what to do? ---- Yes, I think that should be the case."

26. The doctor said that it was very difficult question as to whether a body such as the deceased could feel pain, however, he did say (transcript p.145):

> "So would you then expect such a baby to at least be able to be affected by stress and discomfort? ---- They – it's certainly affected by stress, yes; the extent, as I say – the extent to which there is discomfort, I don't think that anybody could answer that.
>
> And you would expect that until there's a full assessment done of that baby that there'd be some medical attention at least given to the baby? ---- Yes, I mean, yes, and – and some attention, in other words to – to ensure that there is support for the baby and even just in the basic, you know, warmth and – and handling and so on, but it – but attempt to support the baby, yes.
>
> Whatever was the support, you'd expect a medical practitioner to be there to advise in terms of that? ---- We – to be there in – one would answer that with the rider, where possible, because some times the – the moment of delivery is – is very unpredictable and this is where protocols come into place rather than – rather than having – being able to always to have somebody on the spot because the – the delivery could happen at the end rather precipitously and such that there was no warning for – for anybody sort of thing, apart from the – the staff immediately caring, the nursing staff immediately caring sort of thing, so - - -
>
> I suppose an answer to that question would also depend on how long the baby had lived? ---- Yes."

27. Nurse Williams confirmed that in her experience at the Darwin Private Hospital, no incident had occurred similar to that of the deceased. However, the Nurse had also worked for some years at the adjacent Darwin Public Hospital and gave some evidence of such events happening in the past. I note that Dr Cho gave evidence that with the kind of termination procedure conducted by him, when used in second trimester terminations, it was not uncommon for there to be a live birth. One must therefore be surprised that the witness Ms Cassidy could not find any Australian Hospital which has protocols in place. I accept as truth what she told me in this regard. One

must also be surprised that these kinds of death apparently are rarely reported to the Coroner by medical professionals.

28. I note that this death is the first ever reported to the Northern Territory Coroner's Office. Yet the evidence discloses that such deaths in similar circumstances occur from time to time. I have already stated that such deaths are reportable deaths as defined in the ***Coroners Act***. They must be reported to my office. I am aware of a similar death in New South Wales in August 1998 in which the Deputy State Coroner stated that although she had been made aware that "many terminated foetus live after they are expelled from the mother", to her knowledge this was "the first death of this nature reported to a Coroner".

29. This Deputy State Coroner based at Westmead in Sydney was moved to say about the circumstances concerning that death, and I quote from her findings handed down on 16 April 1999.

> "There is a serious issue which arose as to the way in which the deceased was treated after signs of life were detected. Not the least of these being the non-acceptance by medical staff that they had a duty to treat the situation in a manner different than they did."

30. The New South Wales Coroner went on to recommend as follows:

> Protocols be formulated for medical and nursing staff, and implemented as a matter of urgency, as to the legally correct procedures for dealing with live births which result following termination of pregnancy.
>
> Medical and Nursing staff be advised of their legal duties and obligations when dealing with any person under their care, especially where that person is a new born baby.
>
> Medical and Nursing staff be advised of their legal obligations to advise a coroner of deaths which are at law, reportable.

31. I understand a high level committee in New South Wales which included Professor Trudinger was set up after these particular New South Wales Coronial Findings to advise on the difficult issues involved, including the formulation of protocols. I understand from the Westmead Coroner that these protocols have still not been formulated.

32. In my view Dr Cho was responsible for the treatment and care of the deceased. This was so despite his saying in evidence that he did not have a doctor – patient relationship with the baby. I agree with the submission from Counsel for the hospital that it was this incorrectly held belief by Dr Cho which led to a "responsibility vacuum". In the absence of him taking responsibility, it fell to the mid-wife to do what she could. He should have alerted the nurse of the possibility of a live birth, he should have given her directions in relation to the baby on the telephone, he should have then attended on the baby himself or arranged attendance on the baby by a medical practitioner, he should have assessed the infant not just in regard to viability but in relation to alleviating stress, suffering and other possible problems.

33. In may be that he would have directed the nurse do to no more than what she did. Certainly, I do not find that Dr Cho's inaction had consequences relative to the infant's survival. The infant was not going to live very long and any resuscitation may well have only put off the death. However, this was a decision very much for Dr Cho and not the nurse to make.

RECOMMENDATIONS

34. I accept the submissions of Mr Barr that I make the following recommendations;

    1. I recommend that protocols be put in place in the Northern Territory (by statute, regulation or otherwise) to ensure that children who survive termination procedures are, at the very least, immediately

assessed for gestational age and viability by a medical practitioner. Ideally, this should be done by a paediatrician, but, if that is not possible, the medical practitioner (generally obstetrician/gynaecologist, but not necessarily so) who performs or initiates the termination procedures should assess and document his/her assessment of the child. If that doctor is not present at the birth of the baby, then those in charge of the baby (ie, the hospital staff) should make the necessary arrangements for urgent medical assessment.

2. The management and staff of all hospitals and clinics – public and private – in the Northern Territory and medical practitioners generally should be made aware of their legal obligations towards any children who survive termination procedures, including the obligation to report the deaths of such children to the Coroner.

3. The protocols should apply to all hospitals and clinics – public and private – in the Northern Territory.

CONCLUSIONS

35. In my view the "moral dilemma" faced by Nurse Williams is not just something for medical practitioners and health professional to consider and deal with. The public have a right to be informed and take part in any debate. The coronial process is the means by which they are informed. This is why it is important that these kind of deaths be reported to the Coroner.

36. The evidence established that the deceased was fully born in a living state. In the 80 minutes of her life she had a separate and independent existence to her mother. In my view, it is important to not let semantics confuse the matter. The deceased was not, and should not be described as a "foetus", an "aborted foetus", an "abortus", a "living foetus" or a "living abortus", "non-viable foetus", "live neonate" or anything else that diminishes her status as a

human being. Similarly, the purpose of the induction procedure (which was to abort the delivery of a live baby) should not be allowed to diminish her status as a human being. Her life was unexpected and her death was inevitable. However, the first half of this description could be applied to many of us, and the second half to all of us. The deceased having been born alive deserved all the dignity, respect and value that our society places on human life.

37. In my view, the fact that her birth was unexpected and not the desired outcome of the medical procedure, should not result in her, and babies like her, being perceived as anything less than a complete human being. Similarly, the fact that her death was inevitable should also not have the same result. The old, the infirm, the sick, the terminally ill are all entitled to proper medical and palliative care and attention. In my view, newly born unwanted and premature babies should have the same rights. The fact that her death was inevitable should not effect her entitlement to such care and attention.

Dated this 10TH day of APRIL 2000.

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GREG CAVANAGH
TERRITORY CORONER