QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Findings in the death of Baby M**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2024/5056
DELIVERED ON:	20 July 2026
DELIVERED AT:	BRISBANE
FINDINGS OF:	Stephanie Gallagher, Deputy State Coroner
CATCHWORDS:	vaginal birth at home, free birth after caesarean (with a history of rupture of membranes a day prior to labour and was meconium stained), meconium aspiration syndrome, likely preventable death

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Introduction

Baby M was born on 20 October 2024 and died on 21 October 2024 at Sunshine Coast University Hospital.

Queensland Police Service (Police) reported Baby M's death to the Coroner, because the death appeared to be possible health care related death and fell within the definition of a reportable death in the Coroners Act 2003.

The role of a Coroner is to investigate reportable deaths to establish, if possible, the cause of death and how the person died. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

Identification of the Deceased

Baby M was identified by one of the clinicians treating her at SCUH. That identification was accepted by me.

Circumstances[1]

Baby M was her mother's second ongoing pregnancy. She had previously had 2 miscarriages at 4 and 10 weeks after their first child was born.

Their first child was delivered by an emergency caesarean section on 5/5/2021 at 42+4 weeks. The indication was an abnormal CTG. Thick meconium liquor was noted in the operative notes from Maitland Hospital. Their first child had APGAR scores of 8 and 9 at 1 and 5 minutes respectively. Baby M's mother and first child were discharged 2 days following the caesarean section.

Baby M's mother was wanting vaginal birth after caesarean section at home.

In her pregnancy with Baby M, at 16 weeks' gestation, Baby M's mother engaged a private midwife (PM). Baby M's mother reportedly felt traumatised after her first birth and planned to deliver Baby M at home with a midwife present.

The PM supported Baby M's mother 's request for vaginal birth after caesarean section at home. Baby M's mother had 5 antenatal visits from 17+5 to 29 weeks of gestation. Baby M's mother had declined ultrasound scans and glucose tolerance test as recommended by her midwife. She discontinued with the PM around 30 weeks of gestation due to financial reasons and was planning free birth after caesarean section at home with her partner.

The estimated date of delivery by Baby M's mother was 8/10/2024. Baby M's mother commenced labour at 42 weeks around 15:30 hours on 20/10/2024. Baby M's mother 's friend K was contacted by Baby M's father around 5pm to

[1] Adopted from the report of A/Prof Sekar FRANZCOG CMFM dated 16 April 2026

come over and be with their first child while Baby M's father supported Baby M's mother. K also contacted A, a friend to come over to support and help. There was no midwife or doula present.

Baby M was born that day at reportedly 23:40 hours, and noted to be hypotonic, pale with nil spontaneous limb movements nor attempts at crying as seen in the video. A friend of the family, B who was an off-duty paramedic, was asked for assistance. He arrived with a neonatal valve bag mask and an oxygen cylinder and commenced resuscitation. Baby M had apparently regained a heartbeat during resuscitation.

Queensland Ambulance Services (QAS) was called at 23:45 hours and arrived on scene at 00:13 hours. A heartbeat (>100 bpm) was confirmed but there was no respiratory effort. The first APGAR was assessed to be 2. Resuscitation was continued. It was recorded that a large amount of meconium was suctioned from the airway.

Once Baby M was stabilised, she was transported to SCUH, and it was recorded that she was meconium stained. Oxygen saturation was around 85 to 90%. The heart rate around 100 bpm. She was cyanosed with no spontaneous movement. Temperature could not be recorded (hypothermia). The working diagnosis was birth asphyxia with meconium aspiration. Subsequent laboratory test on blood antibody test was suggestive of maternal/neonate blood ABO incompatibility.

Baby M's condition did not improve despite continuous support. In consultation with her parents, a decision was made to cease resuscitation, and Baby M was declared life extinct at 02:42 hours on 21 October 2024. The placenta was delivered at SCUH, and the histology showed following features:

- Presence of decidual arteriopathy which was consistent with material preeclampsia toxaemia.
- Peripheral villous infarction. These indicated maternal vascular malperfusion (with presence of decidual arteriopathy.
- Presence of chronic villitis likely due to VUE (villitis of unknown aetiology).
- Evidence of prolonged meconium exposure (focal meconium-associated myonecrosis of chorionic plate vessels).
- Thin umbilical cord (measured between 8 to 10mm).

Autopsy

An autopsy was ordered and performed. It comprised an external and internal examination (to the extent an internal examination was required to determine the cause of death), imaging, document review and toxicology studies.

The opinion of the forensic pathologist as to the cause of death is based on consideration of the circumstances of death and an autopsy including associated imaging and testing.

The forensic pathologist summarised the findings at autopsy as follows:

- Female neonate with normal growth parameters.
  No remnant meconium staining on the body apart from anus (likely due to opened bowel). Meconium staining was described as prominent at time of delivery.
  Presence of caput (cephalohaematoma) in keeping with vaginal delivery.
- Confirmation of meconium aspiration syndrome with early inflammatory cell response.
- Changes suggestive of early hypoxic-ischaemic injury to the brain (neuropathology report).
- Absence of any additional pathology that could cause or contribute to death.
- Placental pathology showed features suggestive of maternal PET. In addition, there were additional feature of a condition known as villitis of unknown aetiology. Meconium staining was present indicating prolonged period of exposure.
- Further hospital tests showed the following:
- Microbiology: No bacterial or virus (blood, trachea, brain, lungs, heart and liver tissue).
- Metabolic test: Results compatible with post-mortem changes.
- Karyotype (molecular tests): Normal.
- Vitreous humour biochemistry: Testing not possible due to inadequate sample.
- Post-mortem CT scan (report by paediatric radiologist) showed the following:
- Right hydropneumothorax. This could be due to meconium aspiration.
- Opacification of lungs.
- Small amount of subdural haemorrhage in brain and spinal cord.
- Small focus of haemorrhage in left adrenal gland.
- Negative toxicology tests.

The forensic pathologist commented that following issues were noted:

- Foetal distress as shown by presence of meconium in the amniotic fluid. It was present for at least a day (as derived from the history).
- Birth asphyxia, which was confirmed from the neuropathology examination (early hypoxic-ischaemic change). It was caused by the foetal distress and meconium aspiration syndrome.
- Meconium in the lungs, a condition known as meconium aspiration syndrome. This is a major pathology which could potentially be the cause of death.
- Maternal preeclampsia toxemia (PET) – derived from medical history of mother and placental findings.
- Placental pathology including that caused by PET, villitus of unknown aetiology and thin umbilical cord, resulting in the placenta being inadequate to support the neonate.

- Maternal/neonate blood ABO incompatibility. It usually caused minor clinical presentation (jaundice and/or anaemia) which could add to the foetal distress.
- Possible cord prolapse. It could not be confirmed and hence, not reflected in the cause of death.

In the opinion of the forensic pathologist, the cause of death was:

1(a). Main disease or condition in foetus or neonate: Meconium aspiration syndrome
1(b). Other diseases or conditions in foetus and neonate: Birth asphyxia, maternal-neonate ABO incompatibility
1(c). Main maternal disease or condition affecting foetus or neonate: Preeclampsia toxaemia
1(d). Other maternal diseases or conditions affecting foetus or neonate: Villitus of unknown aetiology.
2. Other relevant circumstances: Home birth

Underlying cause of death: Meconium aspiration syndrome.

Independent Expert Opinion

An independent opinion was obtained in relation to the appropriateness of the care of Baby M and her mother. A/Prof Renuka Sekar provided that opinion. She is registered with the Medical Board of Australia as FRANZCOG, CMFM, and has no restrictions placed upon her practice in Obstetrics and Maternal Fetal Medicine. She is in active Obstetric and Maternal Fetal Medicine (MFM) practice, currently working as a Senior Medical Officer in the Department of Obstetrics and Gynaecology (O&G) at Royal Brisbane and Women's Hospital, with her role requiring her to practise and teach obstetrics and management of complex pregnancies. She is an Associate Professor in O&G at the University of Queensland.

A/Prof Sekar has over 30 years' experience in Obstetrics. She is the Chair of the Congenital Anomalies Subcommittee which is part of the Queensland Maternal and Perinatal Quality Council which oversees and evaluates the quality of maternal and perinatal care in Qld and reports to the Queensland Government.

A/Prof Sekar was asked to provide her opinion, as follows:

1. *The appropriateness of care afforded to Baby M's mother or Baby M at SCUH or by RM*

   Baby M's mother received appropriate care by the PM. The PM had done a debrief surrounding the delivery of her first child and Baby M's mother wishes for home birth after caesarean section. The PM had discussed appropriate blood tests and scans. It appears that plans were put in place for both Baby M's mother's health and preparation for birth.

At SCUH, Baby M's mother received appropriate care and support especially when Baby M's condition deteriorated. Baby M's mother was seen by a multidisciplinary team involving the ED at SCUH, Neonatal Specialist, Registrar, PHO and Nurse, and Obstetric Team. Decision to withdraw care involved the parents with informed choices and support.

Baby M received appropriate care by a multidisciplinary team of specialists who received the baby in the Emergency Department in a very grave condition.

2. *Did any aspect of the care afforded Baby M at SCUH or by RM cause or hasten the death?*

   Baby M's mother saw the PM who outlined and provided care during the antenatal visits till 29 weeks of gestation. The PM, enquired about fetal movements at every antenatal visit. This did not cause or hasten Baby M's death.

   Baby M was brought to SCUH in a very critical condition with no sign of spontaneous breathing, and the care provided to Baby M did not cause or hasten Baby M's death.

3. *Did any failure to provide care to Baby M at SCUH or by RM cause or hasten the death?*

   Care provided to Baby M was appropriate for the situation when Baby M was seen and treated at SCUH or by the PM.

4. *The concerns of the family (in so far as they fall within your specialty).*

   From reviewing the documents provided, it appears that Baby M's parents wanted home birth with a doula for their first pregnancy. The pregnancy went postdates and at 42+4 weeks ended in an emergency caesarean section for fetal distress. Baby M's mother had apparently had a traumatic experience in the public system and chose not to engage with the public system for this pregnancy.

   Birth trauma for women and their families is real, as exemplified by the NSW Birth Trauma enquiry held in 2024. Maternity care staff need to take this seriously and when providing care, be mindful of the woman's past birth history, her wishes for the current pregnancy and provide comprehensive care for women that is respectful of their choices. It is essential that hospitals provide care that is acutely sensitive to a woman's needs and partner with the woman to enfranchise her choices where possible to avoid her disengaging with conventional care.

   The family following the loss of their daughter, Baby M would go through grief. Appropriate care and emotional and psychological support are beneficial.

I am not sure if the family were invited to discuss both the autopsy and placental histology findings and its implications for future pregnancy and encourage shared decision making. This may help Baby M's mother with her decision making in her future pregnancy.

5. *Comment on any aspect of care afforded the deceased which falls within your specialty, as you see fit, which may inform the Deputy State Coroner's consideration of the circumstances of the death of the deceased.*

   I would like to give some background clinical references to meconium-stained amniotic fluid (MSAF) and meconium aspiration syndrome (MAS).

   Meconium is a black-greenish, sterile, odourless, dense, sticky and viscous material consisting of water, skin and intestinal desquamation cells, gastrointestinal secretions, bile, mucus, lanugo, vernix, blood glycoproteins and amniotic fluid.

   MSAF is found in 4–22% of all births and up to 23–52% in those beyond 42 weeks' gestation. Only 3–12% of the babies born through MSAF develop MAS. Among them, 20% are non-vigorous at birth, about one third require intubation and mechanical ventilation and 5–12% die. Overall, MAS explains about 10% of neonatal respiratory failure.

   Meconium aspiration syndrome is when a baby inhales the meconium before, during or after labour. It can cause respiratory problems as serious as pneumonia, and although it rarely happens, it can be fatal.

   The presence of meconium during labour can be (but not always) a sign that the baby is becoming distressed. The labour will be observed closely, and a paediatrician will be available at the birth, in case specialised care is required.

   Meconium aspiration can happen for several reasons, but stress is the most common. The stress could be due to infection or low oxygen levels. Stress makes the baby take strong, deep gasps and this forceful gasp causes them to inhale amniotic fluid deep into their lungs. If the amniotic fluid contains meconium, the aspirated meconium fills their airways making it hard to breathe.

   We cannot prevent a baby from aspirating meconium. The best thing is for healthcare providers to monitor amniotic fluid for meconium and watch for fetal distress. Detecting aspiration early and quickly can prevent severe aspiration.

   Some risk factors for MAS include:
   - Post term pregnancy (42 weeks)
   - Diabetes or high blood pressure

- Prolonged or difficult labour
- Fetal growth restriction and decreased oxygen to the fetus in pregnancy.

As noted above, although meconium staining is not uncommon especially with some risk factors which Baby M's mother had, mortality due to MAS is still low when appropriate monitoring and early and timely neonatal management is available to prevent severe aspiration and death.

The placental histology showed villitis of unknown etiology, which is an inflammatory response and can result in babies with smaller size and reduced oxygen thereby increasing chance of fetal distress or stress during labour. It was noted that the umbilical cord was thin, and the baby appeared growth restricted when examined at SCUH. Although the size of the baby was normal, the baby may not have reached its full growth potential.

Baby M's mother had history of rupture of membranes a day prior to labour and was meconium stained. If she had delivered with the support of skilled personnel, an earlier identification of fetal distress and timely delivery with appropriate neonatal care and support would likely have prevented severe asphyxia resulting in neonatal death due to meconium aspiration syndrome. (emphasis added)

Findings required by s. 45

Identity of the deceased – Baby M

How she died – Baby M died as a consequence of a free birth at home, after caesarean section, with severe asphyxia resulting in her death due to meconium aspiration syndrome.

Place of death – Sunshine Coast University Hospital BIRTINYA QLD 4575 AUSTRALIA

Date of death– 21/10/2024

Cause of death – 1(a). Main disease or condition in foetus or neonate: Meconium aspiration syndrome
1(b). Other diseases or conditions in foetus and neonate: Birth asphyxia, maternal-neonate ABO incompatibility
1(c). Main maternal disease or condition affecting foetus or neonate: Preeclampsia toxaemia

1(d). Other maternal diseases or conditions affecting foetus or neonate: Villitus of unknown aetiology.
2. Other relevant circumstances: Home birth

Comments

After considering the material obtained during the coronial investigation, I consider that I have sufficient information to make the necessary findings in relation to Baby M's death. I am not satisfied that it is in the public interest to hold an Inquest as, I am of the view that drawing attention to the circumstances of this death is unlikely to prevent deaths in similar circumstances happening in the future. There is also no uncertainty or conflict of evidence as to justify the use of the judicial forensic process and no suspicious circumstances that have not been resolved or resulted in criminal charges. On that basis I have determined that an Inquest is not required.

I extend my condolences to Baby M's family for their loss.

Stephanie Gallagher
Deputy State Coroner
BRISBANE