QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of Lucy Campbell**
TITLE OF COURT:	Coroners Court
JURISDICTION:	CAIRNS
DATE:	7 May 2026
FILE NO(s):	2024/1021
FINDINGS OF:	Stephanie Gallagher, Deputy State Coroner
CATCHWORDS:	CORONERS: Appropriateness of perinatal care of mother and child, fetal compromise, complicated assisted vaginal birth in rural and metropolitan hospitals.

Contents

Introduction

1. Lucy Margaret Campbell was born on 16 February 2024 and died on 24 February 2024 at the Townsville University Hospital (TUH).

2. Lucy's death was reported to the coroner because her death was subsequent to receiving health care and was investigated as possibly health care related, within the definition of a reportable death under the *Coroners Act 2003*.

3. The role of a coroner is to investigate reportable deaths to establish, as far as is possible, the identity of the person who died, how, when and where they died and what caused the death. The purpose of a coronial investigation is to establish the facts, not to make findings of criminal or civil liability nor to attribute blame or punish any person.

Circumstances of the death

4. Alexandra Meehan (Alex) was 33 years old and 6 weeks pregnant when she was referred by her GP into the Midwife Group Practice (MGP) at Ingham Hospital (IH) for management of her first pregnancy. Alex was assessed as being in a low-risk pregnancy. She was a primigravida and had a normal height and body mass index at the time of booking. She underwent combined first trimester screening and non-invasive pre-natal testing. Both tests were normal. Her Rhesus type was negative and she was counselled about the need for Anti D prophylaxis.

5. On 28 September 2023, when Alex had a morphology scan, the detail visible was obscured by the fetus' position. A further morphology scan was performed on 26 October 2023 and a possible ventricular septal defect (VSD) was identified in Lucy's heart. A further scan was arranged at the Maternal Fetal Medicine unit at TUH for specialist review. This was done, and the scan result suggested that there may be 2 small muscular VSDs. They were sufficiently small such that birth at IH which is a level 3 maternity service, would still be possible. When Alex was about 26 weeks, a birth plan was discussed, though what was discussed was not comprehensively recorded.

6. Alex's antenatal blood tests showed normal results. She was seen regularly through her final trimester. Lucy grew well throughout. Alex was seen at different times by MGP Registered Midwives (RM), Clinical Midwives (CM) and the Rural Generalist Senior Medical Officer (RGSMO) obstetricians who were on the staff of IH. The Pregnancy Health Record that each practitioner filled out at antenatal visits recorded that staff at different times discussed 'birth' with no records of the details of those discussions.

7. Alex's membranes ruptured while at home on 12 February 2024. On 13 February 2024 she attended a routine appointment with IH MGP RM. She was assessed and her ruptured membranes were confirmed. There were no concerning features in that examination, with a screening swab for Group B Streptococcus (GBS) taken during assessment. Induction of labour was offered for that day and Alex expressed a preference that she await labour at home, avoiding the need for induction. The RGSMO determined that this plan was appropriate. Alex was to present to the IH each day until the onset of labour. She was provided with education regarding the risks associated with term prelabour rupture of membranes (PROM) and she was advised to monitor for change in fetal movements and to check her temperature every 4-hours, escalating to the MGP if it was not between 36.5 and 37.5 degrees Celsius.

8. Alex returned on 14 February 2024, as planned and a cardiotocography (CTG) trace assessment was completed and reviewed by RM and CM with no concerns identified. Her observations were normal. She returned home to continue to await labour and was to present the next day at 0630 hours for an induction, which would be about 36 hours after her membranes ruptured.

9. On 15 February 2024, Alex was admitted to IH for induction of labour. Her forewaters were ruptured and the changes in her cervix amounted to a Bishop score of 7, indicating induction would likely work. To provide the opportunity of spontaneous labour, consistent with Alex's preferences, her labour was induced two hours later at 1045 hours with an infusion of Syntocinon, administered intravenously and increased incrementally until she was having regular strong uterine contractions. This clinical course was in accordance with current guidelines.

10. Alex was assessed as being in active labour by about 1300 hours. Continuous electronic fetal monitoring was instituted, using a CTG. By 1600 hours, she underwent a vaginal examination to assess her progress. Her cervix was 5 cm dilated and full effaced, with Lucy's head at station -1 with a +of moulding and ++ of caput. A fetal scalp electrode was attached to the fetal scalp to facilitate CTG monitoring. The use of a fetal scalp electrode improved the quality of the CTG trace initially.

11. By 2015 hours, labour had progressed and Alex was found to have a cervical dilatation of 9 cm with the fetal head at station +1. Between 2000-2100 hours, the CTG trace was difficult to interpret and the midwives reverted from the fetal scalp electrode to an external transducer to conduct fetal monitoring with the CTG.

12. From 2100-2300 hours, the CTG started to deteriorate. The quality of the trace at times was poor, making interpretation of the trace more difficult.

13. At 2340 hours, Alex was found to have achieved full cervical dilatation. The fetal head was at station +1 with '++' of caput and '++' of moulding. A decision was made to conduct an operative vaginal birth as Alex was exhausted and not progressing well. There were no concerns documented about fetal well-being.

14. An attempt at vacuum extraction was made, commencing at 0006 hours on 16 February 2024. The CTG seems to record fetal heart till about 2356 hours and on review by expert Prof Weaver, the trace looked suspicious for maternal heart trace, rather than fetal heart. It is thus impossible to know what the fetal heart rate was during this time.

15. The first doctor utilised 6 pulls on the vacuum extractor with descent of Lucy's head to the perineum with 3 associated 'pop offs'. Despite an episiotomy and further unassisted maternal pushing, Lucy remained undelivered. A RGSMO colleague was notified and attended and after one further application of the ventouse cup and one pull, delivery was effected at 0138 hours.

16. Lucy was in poor condition at birth with an initial APGAR score of 4 at one minute. This was improved to 7 at 5 minutes and 10 minutes following initial resuscitation.

17. Cord blood gases obtained from an umbilical vessels at birth were highly suggestive of Lucy having developed a significant metabolic acidosis, likely to cause significant harm. To mitigate this harm, especially to her central nervous system and other organs, the Lucy was likely to need therapeutic cooling in a larger hospital facility.

18. After initial resuscitation and consultation with neonatal staff in Brisbane and Townsville, Lucy was retrieved from IH to the Neonatal ICU at TUH and was admitted at 0650 hours on 16 February 2024, with Alex following her down there later that day.

19. On admission, seizures were noted, which required sedation and intubation. A number of potential diagnoses were considered by the treating team, including possible GBS infection with meningitis, hypoxic ischaemic encephalopathy (HIE) and meconium aspiration. Further investigations were done according to the guidelines for HIE and Neonatal seizures and genetic bloods looking for epilepsy syndromes presenting in the neonatal period were all found to be negative.

20. GBS positive results from the specimen collected from Alex on 13 February 2024 were not available until 15 February 2024 at 1323 hours, once induced labour had commenced. Alex had appropriately received the antibiotics (benzylpenicillin) during labour and prior to Lucy's blood cultures. A further lumber puncture on Lucy was not carried out due to a lack of clinical indications, however consequently, a positive GBS status for Lucy cannot be ruled out.

21. On 20 February 2024, an MRI showed extensive hypoxic injury throughout most of Lucy's brain. Specialist opinion was that similar blood patterns are seen around a brain after a difficult delivery, although small bleeds are sometimes seen after uneventful deliveries.

22. After discussion with family about Lucy's poor long-term prognosis, Lucy was palliated and died on 24 February 2024.

23. Consistent with family preferences, a coronial autopsy was not conducted. The placenta was not sent for histology. A Form 9 Cause of Death certificate was initially drafted by a TUH clinician. A Form 30A Coronial Certificate was subsequently issued by Forensic Physician Dr Amy Weber and accepted by the Coronial Registrar on 1 March 2024.

24. The cause of death was recorded as:
    1(a). Severe hypoxic ischemic encephalopathy
    1(b). Brain injury
    1(c). Complicated assisted vaginal birth.

Expert opinion

25. Expert opinion was provided by Professor Edward Weaver on 10 June 2025. Prof Weaver has over 35 years' experience in the discipline of Obstetrics and Gynaecology (O&G) and is enrolled on the Expert Witness register of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). He is currently part time Senior Medical Officer in the Department of O&G at Sunshine Coast University Hospital, practising antenatal obstetrics and management of complex pregnancies. He is a Professor within the Department of O&G at Griffith University of Queensland and an Associate Professor in O&G at the University of Qld.

26. Prof Weaver was provided with coronial documents Forms 1A and 30A, medical records for both Lucy and Alex from IH, TUH and Retrieval Services Queensland, statements from hospital staff, including doctors and midwives as well as Townsville Hospital and Health Service (THHS) Case Review report, Records of Open Disclosure, Morbidity and Mortality meeting summary of recommendations, and Riskman report.

27. Prof Weaver considered the chronology and background of the case as outlined in the Case Review Report document that was compiled by the Patient Safety Officers at THHS. Prof Weaver was comfortable accepting it as correct and did not identify any inconsistencies that raised concern. Given this independent review, I accept the same background and chronology.

28. Prof Weaver specifically referenced the statement of the RGSMO who conducted the delivery and confirmed that he has no reason to disbelieve it. In Prof Weaver's opinion they seem to have thought carefully about the options and tried to deliver Lucy safely and counselled Lucy well beforehand.

29. Prof Weaver was of the opinion that Alex's antenatal care was of a good standard. He identified some aspects of the care provided to Lucy and Alex that would benefit from further review by THHS.

30. He observed that given resource constraints, especially after hours in small hospitals, it is essential that staff involved in acute care are proactive, recognise emerging risks and early clinical deterioration and act decisively.

31. Prof Weaver is of the opinion that medical staff should have been called at the latest about 2230 to review Alex and the CTG results. Specifically:

    a. "If the deterioration in the CTG had been recognised earlier, it would have allowed for earlier escalation of the problem to the medical staff. Following their review, it may have been determined that the mother needed to be delivered earlier than she was at 0138.

    b. If this had happened, it is possible that the baby would have been born in better condition and the ultimate outcome for the baby may have been different. It is difficult to be definitive about this as the mother grew Group B streptococcus (GBS) from swabs taken at the time when she ruptured her membranes. It is possible that infection with Group B streptococcus was a factor in the baby's condition at birth. As the baby did not undergo an internal autopsy it is impossible to know the answer definitively about any effects of the GBS."

32. Prof Weaver noted that given there were some indications that this birth was going to be difficult, it would have been reasonable to have mobilised the on-call operating team to have them present on site at IH and it would have been reasonable to conduct Lucy's delivery in the operating theatre with easy recourse to Caesarean Section should the birth attempt failed. However, Prof Weaver recognised that Caesarean Section at full dilation can also be a hazardous procedure.

33. Prof Weaver's report was provided to THHS for consideration on 24 September 2024.

34. THHS identified the following key issues raised by Prof Weaver:

    a. "The clinicians did not recognise fetal compromise on the cardiotocography (CTG) and escalate this earlier during the mother's labour.

    b. Fetal scalp lactate, if available, may have led to earlier intervention and possibly an improved the outcome.

c. The expert was unable to ascertain what discussion the clinicians had with the mother about communicating the risk of birthing in a smaller regional hospital / Clinical Capability Services Framework (CSCF) level 3 facility."

Townsville Hospital and Health Service Response

35. Following receipt of Prof Weaver's report, THHS advised in correspondence dated 21 January 2026 that a Case Review Report was completed, identifying 5 recommendations as well as additional training for clinicians which were each implemented in the following ways:

36. ***"Recommendation 1:*** *The Women's and Children's service group will collaborate with the Rural Hospitals Service Group to establish a formal process that supports clinicians at THHS Rural facilities to obtain TUH tertiary obstetric and midwifery opinion, allowing for peer-review, earlier escalation for assistance and support with decision making for rural obstetric care and birthing.*

    Summary of the Status of the Recommendation:
    The Women's and Children's Service Group (WCSG) and Rural Hospitals Service Group (RHSG) have updated the THHSCLI181264v3 Clinical Concern Escalation procedure in Rural Facilities and published the THHSCLI251671v1 THHS Rural Maternity Service Fetal Cardiotocography Management procedure.

    The THHS Rural Maternity Service Fetal Cardiotocography Management procedure includes available pathways for a second clinician review. This includes the during business hours pathway (to an on-site midwife or senior medical officer, Rural Clinical Midwifery Consultant (CMC) or TUH CMC) and the after-hours pathway (to a Retrieval Services Queensland Senior Midwifery Advisor, TUH on call obstetrics registrar, Duty Shift Coordinator TUH Birth Suite, second on call midwife or an on call senior medical officer).

37. ***Recommendation 2:*** *The application of the alarms listed on the assisted vaginal birth (AVB) clinical pathway form will be considered within the context of a Rural facility, and the pathway form will be made accessible in Rural birth rooms to support contemporaneous use as a decision support tool.*

    Summary of the Status of the Recommendation:
    The Ingham rural maternity team have received simulation training for the assisted vaginal birth. The Assisted Vaginal Birth Pathway form has been made available in the Ingham birth room. This form has been reviewed and is currently being reviewed at a Statewide level by the Queensland Maternity and Neonatal Statewide Clinical Network.

38. ***Recommendation 3:*** *The Ingham Health Service Maternity Service which includes RHSG Rural Generalist (Obstetric) and Ingham Midwifery Group Practice (Ingham MGP) Midwives will engage in mandatory, annual simulated (SIM) training covering the following topics: CTG interpretation, continuous monitoring during oxytocin use, the use of intrapartum ultrasound, the use of the AVB pathway as a clinical decision tool, management of complex AVB, and use of Fetalink.*

    Summary of the Status of the Recommendation:

Annual simulation training has been made a role-specific mandatory training in the THHS Mandatory and Role-required Training policy.

39. ***Recommendation 4:*** *Once Fetalink is established at the Ingham Hospital Service, RHSG and WCSG will ensure that it is incorporated into formal escalation processes to ensure opportunity for peer review of CTG monitoring and support clinicians with complex and/or difficult CTG traces.*

    Summary of the Status of the Recommendation:
    Fetalink is not in place at Ingham Hospital Service yet as there is an infrastructure issue at a Statewide level that has delayed the implementation. At a Statewide level, THHS has been advised that Queensland Health will be supporting the roll out to rural facilities. As of 05/01/2026, our acting Nursing Director Digital Services advises that the project is expected to commence in the first half of 2026. In THHS, this will be rolled out to Ingham Hospital, Ayr Hospital and Charters Towers Hospital. Progress regarding the implementation of Fetalink will be monitored through the Patient Safety Committee, with updates provided by the Nursing Director Digital Services.

    Fetalink has been incorporated into the THHS Rural Maternity Service Fetal Cardiotocography Management procedure (please refer to the Recommendation 1 summary of status above).

    For context, Fetalink is a maternity and fetal monitoring system that integrates with the integrated electronic medical record (ieMR) PowerChart to capture, display, and analyse real-time Cardiotocography (CTG) data (fetal heart rate, contractions, maternal vitals) directly into the electronic health record. It offers clinicians remote viewing via the Fetalink / ieMR PowerChart, improving decision-making, coordination, and reducing manual documentation by centralising waveforms, annotations, and patient data for improved safety during labour and delivery.

40. ***Recommendation 5:*** *The Ingham Health Service Maternity Service which includes RHSG Obstetric Medical Officers and Ingham Midwifery Group Practice (Ingham MGP) Midwives will become aware of how to identify, self-assess and appropriately escalate concerns regarding fatigue.*

    Summary of the Status of the Recommendation:
    Ingham Health Service has provided an in-service on Fatigue Management training to RHSG Obstetric Medical Officers and Ingham MGP Midwives. Staff have been asked to complete online Fatigue Management training. Fatigue management has been incorporated into the Ingham Obstetric Senior Medical Officer Orientation book and the MGP Orientation book.

    If fatigue issues are identified in on-site midwives and rural generalist obstetricians, Ingham Hospital can request Maternity Bypass, which results in moving from CSCF 3 (birthing) to CSCF 2 (non-birthing).

b) Use of Fetal Scalp Lactate

41. *As Dr Weaver notes in his opinion, fetal scalp lactate estimation is not always available at smaller hospitals. I can confirm it was not available at Ingham Hospital during the relevant period.*

42. *[Redacted] has provided the following advice: "The cited Queensland Health Intrapartum Fetal Surveillance guideline (February 2025) states 'there is limited evidence to establish firm recommendations for the use of fetal blood sampling' and explicitly provides for expediting birth 'where CTG indicates further assessment required and FBS unavailable, contraindicated or declined.'*

43. *The absence of fetal scalp lactate facilities at Ingham Hospital, a Level 3 maternity service, is consistent with peer practice across comparable Australian obstetric services, where low case volume prevents safe maintenance of procedural competency for a test with limited supporting evidence. The Queensland guideline provides explicit alternative pathways within its clinical algorithm for management of abnormal CTG when fetal blood sampling is unavailable, including management of reversible causes, fetal scalp stimulation, and clear criteria for expediting birth. These pathways represent accepted clinical practice independent of fetal blood sampling availability."*

c) Communication of Risk of Birthing at Ingham Hospital

44. *THHS thanks the expert for feedback querying how our clinicians communicate risk of birthing in a CSCF level 3 facility to the mother. This feedback has been provided to the Medical Director of the Women and Children's Service Group (WCSG) for consideration. We can confirm that the risks of birthing at each facility are discussed with the patients from the booking-in stage. WCSG and RHSG will consider options to communicate this information to pregnant women who are considering engaging with the Ingham Hospital birthing service.*

d) Other

45. *THHS had a change in the organisational structure for the Ingham Midwifery Group Practice in the months prior to Lucy's delivery. This midwifery team's reporting line changed from the Nurse Unit Manager of the ward and the Director of Nursing at the facility to reporting to the Midwifery Unit Manager of the Midwifery Group Practices at THHS. The escalation process for concerns during delivery was less well-defined at this time. Since Lucy's delivery, THHS has implemented an escalation process, as discussed in part a) of this response under Recommendation 1.*

46. *Two of the clinicians involved in Lucy's delivery have advised that the Ingham Hospital midwifery staff and rural generalist obstetrics staff have received additional training since her birth. They have attended the following courses:*
    - *Safety Intervention Essentials: This is a 1 day course (4 hour refresher) focussed on preventing and/or intervening in a crisis situation.*
    - *Maternity Emergency Program – Advanced: This is a 1 day simulation workshop for medical and midwifery staff that covers scenarios about pregnancy-related issues, intrapartum complexities and postnatal complications.*
    - *NeoResus – Advanced Resuscitation: This is an annual 8 hour online course that teaches health care professionals attending the birth of a baby the theoretical and practical aspects of neonatal resuscitation.*
    - *Fetal Surveillance Education Program: This is a 7 hour course on CTG interpretation.*

47. *These clinicians have advised that this has helped them be better prepared during complex birthing scenarios.*

48. I take this opportunity to offer my condolences to Lucy's family and friends. On behalf of THHS, I thank you for the opportunity to respond to Professor Weaver's opinion."

49. The procedure documents referred to were also provided to me for consideration.

Conclusion and findings

50. After considering the material obtained during the coronial investigation, I consider that I have sufficient information to make the necessary findings required by s 45(2) *Coroners Act 2003* in relation to Lucy's death.

51. I acknowledge the significant impact that Lucy's death has had on her family and loved ones.

52. I find that Lucy Margaret Campbell died on 24 February 2024 at the Townsville University Hospital, Queensland from severe hypoxic ischemic encephalopathy, the result of brain injury as a consequence of a complicated assisted vaginal birth.

53. After considering the available evidence about the level of risk associated with Alex's pregnancy, I can be satisfied that it was reasonable to plan for birth to occur at Ingham Hospital. While earlier recognition and escalation of fetal compromise on CTG was possible during Alex's labour at Ingham Hospital, on the information available to me I am not able to be satisfied to the requisite standard that earlier recognition would have likely changed the outcome for Lucy.

54. I am satisfied that the combined effect of the strategies recommended and implemented by THHS will prevent similar events from occurring again in the future.

55. An inquest will not be held into Lucy's death as I am not satisfied that it is in the public interest because the investigation has revealed sufficient information to enable me to make findings about the death. There are no factual disputes or suspicious circumstances that have not been resolved and there does not appear to be any prospect of recommendations not already identified that would reduce the likelihood of similar deaths occurring in the future.

Findings required by s.45 Coroners Act 2003

Identity of the deceased –	Lucy Campbell
How she died –	Lucy Margaret Campbell died on 24 February 2024 at the Townsville University Hospital, Queensland from severe hypoxic ischemic encephalopathy, the result of brain injury as a consequence of a complicated assisted vaginal birth.
Place of death –	Townsville University Hospital DOUGLAS QLD 4814 AUSTRALIA
Date of death–	24/02/2024

Cause of death –

1(a). Severe hypoxic ischemic encephalopathy
1(b). Brain injury
1(c). Complicated assisted vaginal birth.

56. I close the investigations.

Stephanie Gallagher
Deputy State Coroner
CORONERS COURT OF QUEENSLAND - BRISBANE OFFICE
7 May 2026