Hon Nick Goiran MLC

Member for the South Metropolitan Region

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19 September 2018

Coroner's Court of Western Australia
Central Law Courts
Level 10, 501 Hay Street
PERTH WA 6000

By email: coroner@justice.wa.gov.au

Dear Coroner,

REPORTING OF THE UNNATURAL DEATHS OF 27 WESTERN AUSTRALIANS

I am writing to report the unnatural deaths of 27 infants in Western Australia during the period of July 1999 to December 2016.

Yesterday the Government informed the Legislative Council that the deaths of 27 babies born alive following an abortion procedure between July 1999 and December 2016 have not been reported to your office. The Minister confirmed that, pursuant to advice from the State Solicitor's Office, these deaths are reportable as defined under the Coroners Act. The Minister further informed the House that nothing prevents me from reporting these deaths to you in the ongoing absence of the Department of Health doing so.

On 15 June 2017 Parliament was told that there had been 27 cases of abortion procedures resulting in a live birth between July 1999 and December 2016. Disturbingly, it was also disclosed that there was no record of medical intervention provided in any of these cases of live births and that these 27 babies subsequently died.

21 of these cases were revealed to be of babies born at 20 weeks gestation or later. From further information provided to Parliament on 10 April 2018 it was revealed that 15 of these births were at the gestational age of between 20-25 weeks, and 6 were at 26 weeks or later with 1 being 34 weeks or later.

In 2000 in a similar case in the Northern Territory, the instance of a baby born alive following an abortion who subsequently died was reported to the Coroner and a Coroner's Inquest was carried out. In the findings, the Coroner made the point in relation to the case that "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." The Coroner also stressed the point that "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."

The Northern Territory Coroner recommended that protocols be put in place to ensure that babies who survive termination procedures are subject to urgent medical assessments. It was also recommended that all hospital and clinic staff are made aware of their legal obligations to report deaths of this nature.

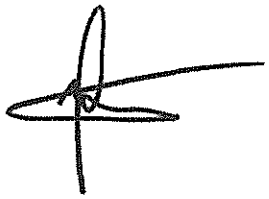
I respectfully urge you to undertake an Inquiry into the deaths of these 27 Western Australian babies who despite being entitled to medical attention did not receive any and subsequently died. It is disturbing that these deaths, despite being clearly reportable, have not been reported. Medical staff should be aware of their obligations under the law to provide medical attention to these babies regardless of the circumstance of their birth and their obligations under the Coroner's Act to report any unexpected deaths.

I have attached the following relevant documents for your reference:

1. Parliament of WA Hansard Extract – 18 September 2018;
2. Question On Notice No. 5 asked in the Legislative Council on 11 May 2017 by Hon Nick Goiran MLC;
3. Question On Notice No. 651 asked in the Legislative Council on 13 March 2018 by Hon Nick Goiran MLC; and
4. Northern Territory Coronial Inquiry Findings – 10 April 2000.

I would be grateful if you could acknowledge receipt of my correspondence and update me as to the progress of this matter.

Yours sincerely,



Hon Nick Goiran MLC
Member for the South Metropolitan Region
Shadow Minister for Child Protection; Prevention of Family and Domestic Violence
Secretary to the State Parliamentary Liberal Party

The purpose of my amendment, if moved, is to insert an additional definition to ensure that a reportable death in Western Australia, amongst all the other things that it includes, would also include the death —

> of an infant who was born alive that occurs during, within 28 days after, or as a result of, the performance on the infant's mother of an abortion, within the meaning of the Health (Miscellaneous Provisions) Act 1911 section 334(1);

<028> I/C

The shorthand for all that is simply to say that for any baby who survives an abortion and is born alive in Western Australia and subsequently dies, at least within 28 days, that would be a reportable death. That would be the purpose of the amendment. It has been put to me that that amendment is unnecessary, and I understand that that is the position of the government because it is already captured as a reportable death in Western Australia. I want to make sure that we get this absolutely crystal clear, not only for the benefit of further work that needs to be done but also to ascertain whether it is necessary to move the amendment on the supplementary notice paper; it may prove not to be necessary. My question to the minister is: is the death of an infant who was born alive that occurs during, within 28 days after, or as a result of the performance on the infant's mother of an abortion, a reportable death in Western Australia?

Hon SUE ELLERY: The answer to that is yes. I already did this in my reply to the second reading debate, and I think I have done it already, but I will do it again. I will start off by making this point: I do not speak on behalf of the Department of Health, so in respect of the debate that we are having now, it is in respect of the powers that exist within the State Coroner's office. The advice provided is that section 3 of the Coroner's Act defines "reportable death". Section 8 of the act prescribes the functions of the State Coroner, and includes at paragraph (c) —

> to ensure that all reportable deaths reported to a coroner are investigated;

Paragraph (a) of the definition of "reportable death" defines a Western Australian death and states —

> that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from injury;

The government's advice from the State Solicitor's Office confirms that the circumstances of the death of such an infant as described in the member's proposed amendment—that is, an infant born alive that occurs during, within 28 days after, or as a result of the performance on the infant's mother of an abortion within the meaning of the Health (Miscellaneous Provisions) Act 1911, section 334(1)—would come within the definition of "reportable death" in the Coroners Act 1996 at paragraph (a), unnatural, or directly or indirectly from injury, and therefore already comes within the definition of "reportable death".

Hon NICK GOIRAN: I thank the minister for that very clear response. If that is the case, I want to ask why these have not been reported. However, in light of the minister's earlier remarks indicating that she cannot speak for the Department of Health, she is not going to be able to tell me why these deaths have not been reported, despite the fact that it is clear from tonight's proceedings that that is the law in Western Australia. These deaths are reportable deaths, but the minister will not be able to tell me why they have not been reported. That is no criticism; that is just the situation we find ourselves in. Can I ask the minister, however: has the Coroner's office received reports of any such deaths?

Hon SUE ELLERY: No. The member might recall that in my second reading reply I referred to the jurisdictional issue raised with the State Coroner when she gave evidence to the Community Development and Justice Standing Committee in October 2016. The State Coroner advised that none had been reported to her since her appointment and I am advised that, subsequent to that, it is still the case that none has been reported. She undertook to seek information and did so, and I am advised that the Department of Health advised the Coroner that medical practitioners had been unaware of their obligations to report such deaths and would do so in the future.

Hon NICK GOIRAN: But, minister, this cannot possibly be correct because during my second reading contribution I quoted in this chamber letters that had been penned by the State Coroner of Western Australia in 2012, acknowledging that these types of deaths had been reported to the Coroner's office. It was the conclusion of that particular coroner, the former coroner, and I quote from the letter of 14 August 2012, in the penultimate paragraph —

> In the above circumstances it appears that the deaths were not reportable and I have no jurisdiction to take the matter further.

That is a statement we now know, from tonight, was incorrect, but it is actually the fact that some of these deaths have been reported to the Coroner's office, so it does not sound correct to me to say that these have never been reported. This particular correspondence from 2012 was the reporting of the deaths of 14 infants. On what basis can we maintain that these had never been reported to the Coroner's office?

Hon SUE ELLERY: I just advised the house that the current State Coroner—I cannot speak on behalf of the previous coroner—at that committee hearing in 2016 was asked how many of those deaths were reported to the office of the State Coroner. She advised that none had been reported since her appointment. She undertook to seek information, and she did so. I then said that the Department of Health advised the State Coroner that medical practitioners had been unaware of their obligation. The honourable member may be right; I do not know if he is or is not. He may be right.

The advice that I am being given is from the current coroner and that advice is the answer she gave to a committee hearing in 2016. Between then and now, I am advised, none of the deaths that the member describes has been reported to the existing coroner.

Hon NICK GOIRAN: The minister has just indicated to the house that the Department of Health advised the State Coroner that medical practitioners had been unaware of their obligation under the Coroners Act to report such deaths and would do so in the future. Are we able to tell the house when that advice came to the State Coroner's office from the Department of Health?

Hon SUE ELLERY: No. We do not have that information here.

Hon NICK GOIRAN: But since that time, whenever that time was that the Department of Health advised the State Coroner that it was unaware of its obligation and it would report in future, the evidence in the chamber tonight is that since that time, it still has never happened. Even though the Department of Health now knows that it needs to report them, it still has never reported.

Hon SUE ELLERY: Correct.

Hon NICK GOIRAN: Has the Coroner's office ever gone back to the Department of Health to say to them, "This is highly irregular; this is highly unusual. We know that these deaths do occur in Western Australia and you said to us that you were unaware of your obligation. You now know that you have this obligation and you said you would do so in the future. We, the Coroner's office, find it very strange that we are not catching any of these reports from you." Has there been any conversation like that between the Coroner's office and the Department of Health?

Hon SUE ELLERY: I am advised not.

Hon MICHAEL MISCHIN: Hon Nick Goiran said that it was highly irregular. I is actually a little more than that, because section 17(3) of the Coroners Act 1996 states —

> A doctor who is present at or soon after the death of a person must report the death immediately to a coroner if —
>
> (a) the death is or may be a reportable death; or
>
> (b) the doctor is unable to determine the cause of death; or
>
> (c) in the opinion of the doctor, the death has occurred under any suspicious circumstances.
>
> Penalty: $1 000

Derisory as a penalty of $1 000 may be nowadays, it goes beyond simply a difference of opinion or uncertainty on the part of the Department of Health, its officers and its medical practitioners as to whether or not it is a reportable death; it says "is or may be a reportable death". There is a positive obligation, backed by criminal sanction, against doctors who fail to report these matters.

<029> A/4

Whatever one may think of the merits of the idea that these sorts of deaths ought to be investigated and the like—I will not get into that—it is not up to medical practitioners to decide that they will or will not comply with the Coroners Act; or, if they have any doubt about the matter, take an interpretation that suits themselves. The minister has told us the State Coroner has informed the Department of Health. Is the minister able to assure us, or is the State Coroner able to assure us through the minister and her advisers, that the Department of Health is aware of its responsibilities; and, if these offences are being committed, they will be reported and dealt with? It seems to me unsatisfactory that although the Department of Health has a positive obligation, and there is a history, patently, of these sorts of deaths occurring and not being reported, that all of a sudden none of these deaths are being reported at all. Either things have improved enormously, or the Department of Health and its medical practitioners are not complying with their obligations.

I want to go back to the point I made in my earlier questioning about the ability of medical practitioners to kill their patients, in the noblest of causes, of course, and the coroner not being able to find out about that. I also go back to the point about whether the provisions that are being introduced in this bill, which would expedite cases, but would rely entirely on the opinion of a pathologist, without going through some of the detailed investigation that may be unnecessary but is gone through now, will allow more of those sorts of cases to occur. Is the State Coroner satisfied that medical practitioners—doctors—are complying with their obligations, at least within the state health system, and do not require further reminders?

Hon SUE ELLERY: Chair, I ask for some assistance here. In my second reading reply, and in response to questions asked by Hon Nick Goiran, I have addressed this issue. I put a caveat on my second reading reply. I understand Hon Nick Goiran's issue well. There are actually two agencies that manage the information that Hon Nick Goiran is interested in. I cannot speak on behalf of the Department of Health here tonight. That is not who the advisers are. This is not their bill. This is a coroner's bill. Therefore, the advice that I can give, and have given in good faith and as much as I am able to, comes from the coroner's perspective. However, we did seek advice, and I have provided it to the

chamber I think five times now, that the coroner undertook to the committee back in 2016 that she would raise that issue with the Department of Health, and she did. What the Department of Health advised the coroner, and what I have been advised—which the member can choose to believe or not—is that medical practitioners were not aware of their obligations. Beyond that, I am not able to provide any further information. I have provided as much information to Hon Nick Goiran as I possibly can. I am not in a position to go further than what I have already said a number of times.

Hon NICK GOIRAN: Minister, I understand this is exasperating, and that the minister has said she has said certain things five times. That may well be the case, and we can go back to *Hansard* and count how many times that has happened. However, I have been pursuing this matter since 2011, which is more years than the number of times the minister has said it tonight. So, minister, please understand if we do take a few moments to make sure that we get this absolutely right. Given that we now know that these deaths are reportable deaths and that they have not been reported to the coroner's office, is there anything that would prevent me from writing to the State Coroner tomorrow to report to her those 27 deaths, and is there anything that would prevent the coroner from investigating those deaths?

Hon SUE ELLERY: There is absolutely nothing that would prevent the member from writing to the coroner in the terms he has just described. What detailed advice the coroner might require from the member in order to respond to the letter remains to be seen, but there is nothing to stop him from writing that letter.

Hon NICK GOIRAN: I take it from the earlier advice the minister has given to the chamber that, of course, albeit that these types of deaths are reportable, an inquest is not mandated by the coroner, and it remains discretionary should she want to investigate these matters, should she receive a letter from me.

Hon SUE ELLERY: That is correct. When we came back into the chamber at 7.30 pm, that is the bit that I set out. I outlined which provisions in paragraphs (a) to (j) are mandatory.

Hon NICK GOIRAN: The minister's evidence to the chamber, on the basis of the expert advisers whom the minister has before her at the moment, is that there is no provision in this bill before the chamber that will change any of that. It will remain the case, as it is now, that babies who are born alive, survive an abortion and subsequently die are reportable deaths today and will be reportable deaths even if this bill passes in its current form.

Hon SUE ELLERY: I would not describe what I am doing as giving evidence, but I am providing the chamber with advice and trying to respond to the questions the member has asked. I am doing that based on the advice I am given. Yes, what the member has described is correct. The advice I am given is that there is nothing in the legislation as it exists now, and there is nothing in the bill, that would preclude the deaths that the member has described from being reported. That is the view of the current coroner.

Hon NICK GOIRAN: It is customary when we are considering clause 1 of a bill to range over the bill and the various clauses, and also the supplementary notice paper. As I indicated earlier to members, I have a proposed amendment on the supplementary notice paper. On the basis of the information that has been given to the chamber by the minister, on the basis of the expert advice that is available to her, it is not my intention to move that amendment this evening. I am persuaded, on the basis of the information to the chamber, that it is unnecessary to do so. I indicate and underscore for the benefit of members that we have been told tonight that the 27 Western Australian babies born alive and left to die are reportable deaths, and they were always reportable deaths. It is, therefore, open to me to write to the coroner's office as early as tomorrow, and it is then at the discretion of the coroner to determine whether that investigation will take place. That would be the case irrespective of the content of this bill that is before the chamber and would be the same whether that amendment was moved or not. For those reasons, I am persuaded that it is not necessary to move the amendment, because the advice that has been provided to the government from the State Solicitor's Office confirms that the circumstances of the death of such an infant born alive would come within the definition of "reportable death" as set out in the act, specifically paragraph (a), which reads a Western Australian death —

> that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from injury.

I will have a further set of questions when we get to clause 4, but otherwise I am minded to support clause 1.

Hon MARTIN ALDRIDGE: Minister, I have a couple of questions. I do not think it will detain the chamber very long. During the course of the briefings that we received on this matter, which goes back a number of months, so I am testing my memory, we received advice from the Attorney General's office about some government amendments that would be introduced to this bill. It appears from the supplementary notice paper that no notice has been given of any such government amendments. Can the minister confirm for me the government's intention with respect to amendments to this bill?

<030> D/4

Hon SUE ELLERY: There are not any.

Hon MARTIN ALDRIDGE: If I read from the advice that we received from the Attorney General's office, it might assist the minister in providing a response. We received an email on 21 August 2018 following, I think, a briefing from the Attorney General's office by an adviser by the name of Leesa Markussen. The email says —

Question On Notice No. 5 asked in the **Legislative Council** on **11 May 2017** by **Hon Nick Goiran**

Question Directed to the: **Parliamentary Secretary representing the Minister for Health**
Minister responding: **Hon R.H. Cook**
Parliament: **40** Session: **1**

Question

(1) For the calendar year, from 1 January 2016 to 31 December 2016, what was the number of:
(a) induced abortions;
(b) induced abortions over 12 weeks gestation;
(c) induced abortions for women under the age of 20;
(d) approvals given by the Ministerial Panel for abortions at 20 weeks gestation or later; and
(e) induced abortions at 20 weeks gestation or later?
(2) I refer to the cases of babies who show signs of life after an abortion procedure, and I ask:
(a) what is the total number of these cases between 20 May 1998 and 31 December 2016;
(b) how many of these cases were induced abortions at 20 weeks gestation or later;
(c) how many of these cases were induced abortions at 23 weeks gestation or later; and
(d) in how many of these cases was medical intervention or resuscitation provided?
(3) I refer to the Tabbott foundation which prescribes the RU486 abortion drug over the phone, and I ask:
(a) what data does the Department of Health maintain on the use of this service; and
(b) what oversight mechanisms is the Department of Health involved in or aware of for this service?
(4) I refer to question on notice No. 4219 answered on 7 September 2016, which advised of changes in documentation processes and I ask, what were those changes?
(5) How many abortions were approved at 20 weeks gestation or later with the justification for the abortion given as "Trisomy 21" between 1 January 2015 and 31 December 2016?
(6) I refer to question on notice No. 4216 answered on 7 September 2016 and I ask, what method or methods of feticide were used?
(7) In the 2016 calendar year, how many hospital admissions were there for conditions related to post medical abortion complications?
(8) How many facilities perform medical abortions in Western Australia?
(9) I refer to supplementary information No. A5, provided by the Department of Health to the Standing Committee on Estimates and Financial Operations, arising from the 2014-15 Annual Report Hearings, and I ask:
(a) when was the second annual report submitted by the Executive Director, Public Health in 2016; and
(b) when will the Minister table this report?

Answered on 15 June 2017

The Department of Health advises:
From 1 January 2016 to 31 December 2016:

(1)(a) 7839;

(1)(b) 664;

(1)(c) 631;

(1)(d) 81; and

(1)(e) 78.

(2)(a) As at 19 May 2017, a total of 27 cases of abortion procedures resulting in a live birth have been reported between July 1999 and December 2016.

(2)(b) Of the cases in (2)(a), 21 were at 20 weeks gestation or later.

(2)(c) Data not available.

(2)(d) In Department of Health routine data collections, there is no record of medical intervention or resuscitation in these cases.

(3)(a) The Abortion Notification Form requires the name and address of the doctor performing the abortion.

(3)(b) The Department of Health oversight mechanism is via the legislated data collections. Other oversight mechanisms are provided by Australian Health Practitioner Regulation Agency, and professional bodies.

(4) The records documenting approval for abortion now include relevant clinical information.

(5) Less than five. *

(6) The Chair of the Panel does not keep documentation on the methods of feticide when panel approval is given. This is determined clinically by the specialists involved in the care of the woman. The usual method is ultrasound guided injection of potassium chloride into the fetal circulation. The other method, used in selective reduction of monochorionic twin pregnancy only, is fetoscopically directed cord occlusion.

(7) In 2016, there were 99 hospital separations with post abortion complications.

(8) There are 33 facilities that provide abortion services.

(9)(a) The confidential report 'Notification of induced abortions, 2014/15, Gestation 20 weeks or more' was provided by the Executive Director Public Health to the Minister for Health in August 2016, and a revised version was provided in November 2016.

(9)(b) The report is confidential, contains medical information on 'Reason for Abortion', and will therefore not be tabled.

*Note due to patient confidentiality the response provided did not report figures less than five, in line with the Department of Health's Guidelines for the Release of Data.

Question On Notice No. 651 asked in the **Legislative Council** on **13 March 2018** by **Hon Nick Goiran**

Question Directed to the: **Parliamentary Secretary representing the Minister for Health**
Minister responding: **Hon R.H. Cook**
Parliament: **40** Session: **1**

Question

I refer to the cases of babies who show signs of life after an abortion procedure, and I ask:

(a) what is the total number of these cases between July 1999 and December 2017;
(b) how many of these cases were induced abortions assigned the code for gestation range 20-25 weeks;
(c) how many of these cases were induced abortions assigned the code for gestation range 26-33 weeks; and
(d) how many of these cases were induced abortions at 26 weeks gestation or later?

Answered on 10 April 2018

I am advised that:

(a) The answer to this question has been suppressed for patient confidentiality. Provision of this figure would reveal a number less than 5 for the number of cases in 2017 when compared with the answer to Question on Notice 5, part 2(a) (11 May 2017): "As at 19 May 2017, a total of 27 cases of abortion procedures resulting in the live birth of a child have been reported between July 1999 and December 2016."

(b) The answer to this question has been suppressed for patient confidentiality. Provision of this figure would reveal a number less than 5 for the number of cases in 2017 when compared with the answer to Question on Notice 308, part (a) (23 August 2017): "As at 24 August 2017, between 1 July 1999 and 31 December 2016, there were 15 induced abortions assigned the code for gestation range 20-25 weeks."

(c) The answer to this question has been suppressed for patient confidentiality. Provision of this figure would reveal a number less than 5 for 34 weeks gestation or later for the period July 1999 to December 2017.

(d) There were 6 induced abortions at 26 weeks gestation or later in the period July 1999 to December 2017 who showed signs of life.

IDENTIFICATION SUPPRESSION ORDER

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

TITLE OF COURT:	Coroners
JURISDICTION:	Coronial
FILE NO(s):	9815022 101/98
DELIVERED ON:	10 April 2000
DELIVERED AT:	Darwin
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

Judgment category classification:	B
Judgment ID number:	[2000] NTMC 37
Number of paragraphs:	37
Number of pages:	20

IDENTIFICATION SUPPRESSION ORDER

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.

GREG CAVANAGH
TERRITORY CORONER