Recommendations from the coroner

Board: Nursing and Midwifery Board of Australia (NMBA).

Finding Date: 24 March 2016

Details: Coronial inquest into the death of Ms Caroline Lovell, the State Coroner of Victoria.

Media release: http://www.ahpra.gov.au/News/2016-03-24-media-statement.aspx

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From time to time, a state coroner may refer a finding of an inquest to AHPRA or the Board to bring to the attention of the profession. AHPRA will publish a case summary of each referral from the coroner on its website, naming the deceased person, with the coroner's recommendations in full. A link will also be provided to the coroner's website. Practitioners are encouraged to access the AHPRA website at www.ahpra.gov.au to keep up to date with these cases and the coroner's recommendations.

When the Board decides that a referral from the coroner has wide-reaching implications for practitioners, it may publish a summary of the case, and highlight particular issues relevant to the profession.

Summary

Caroline Lovell died following the home birth of her second child on 24 January 2012. It was found that she died from a global ischaemic injury following cardio respiratory arrest in the immediate post-partum period and post-partum haemorrhage.

Introduction and background

Caroline Lovell was generally well during her pregnancy and had been monitored by her GP for anaemia. She had experience post-partum bleeding following the birth of her first child and considered at risk of this reoccurrence with subsequent pregnancies.

Her home birth was attended by practising midwives Gaye Demanuele and Melody Bourne. A healthy baby girl was born at 8.52am in a home birthing pool in at the Lovell residence. The girl was noted to have blood on her head indicating a possible tear during the delivery. This was later found in autopsy to be a 5cm tear to the vaginal wall and perineum which would have caused considerable bleeding.

An hour after the birth Caroline went to leave the pool having complained of feeling faint she lost consciousness. It is believed that she had bled out by this time, which later led to her cardiac arrest. Photographs of mother and baby indicate an increase in blood in the water of the pool after the birth. It wasn't until being taken out of the pool and losing consciousness a second time and ambulance was called.

It was found the lead midwife Gaye Demanuele's personal feelings towards medical intervention led to a failure to conduct or direct a full examination of Caroline, including a vaginal examination which was inconsistent with midwife protocols. Instead a focus was placed on seeing the mother and baby connect uninterrupted. Failure to maintain appropriate blood pressure and vital sign monitoring in the hour following the birth was wholly inappropriate and caused or substantially contributed to her death.

Caroline's heart stopped, likely as a result of the post-partum haemorrhage, 5 minutes after the ambulance was called. Despite resuscitation and interventions to stem the bleeding at the hospital, the cardiac arrest, and subsequent brain damage led to her death at 12.30am on January 24, 2012.

Coroner's recommendations

The coronial inquest into the death of Ms Caroline Lovell has made a number of recommendations for AHPRA and the Nursing and Midwifery Board of Australia (NMBA), Department of Health and Human Services, and the Director of Public Prosecutions.

Recommendations as follows:

- Department of Health and Human Services, in conjunction with AHPRA, examines the adequacy of the regulatory system currently in place and develops a specific framework for privately contracted midwives, working in the setting of a home
- NMBA develops specific guidelines to define mandatory clinical competency and clinical experience standards, for privately contracted midwives, working in the setting of a home
- the Department of Health and Human Services provides ongoing training for registered midwives specifically engaged with providing home birth services. For the protection of all concerned, participation in such ongoing training should be mandatory
- additionally it is recommended that the Department of Health and Human Services undertakes a public campaign designed to provide education for women and for their partners who may be considering home birth, to seek to inform as to how safe and otherwise reasonable decisions on this matter should be reached
- NMBA develops a system of monitoring mandatory clinical competency and clinical experience standards, for privately contracted midwives, working in the setting of a home
- Department of Health and Human Services, in conjunction with AHPRA, examines the question of whether there is a need to create a regulatory offence that would prohibit the receipt either directly or indirectly of a financial commission of any type for attending at a place of birth while being an unregistered midwife (or medical practitioner), and
- the Director of Public Prosecutions examines the evidence collected in this investigation and takes such action against Gaye Demanuele as he may deem to be appropriate.

The full findings of the Coroner's Court and its recommendations, which were delivered on 24 March 2016, are on the Coroner's Court of Victoria website.

Download a PDF of the Media statement - Coroner's Court recommendations - 24 March 2016 (308 KB,PDF)