By Rebecca Tidswell

HOME BIRTHS IN AUSTRALIA
A CHANGING LEGAL LANDSCAPE

Home birth in Australia has come under scrutiny following the deaths of a number of infants born at home. Coronial inquests and associated police investigations considering criminal charges have opened up the debate on the legal issues touching on pregnancy and the rights of the unborn child.

PREGNANT WOMEN, AUTONOMY AND THE LAW

Patient autonomy and the rights of an individual to make decisions about their own healthcare are recognised by law in Australia. This includes the right to refuse treatment and a right to make a choice which is contrary to a care provider's preference or advice.

Right to refuse treatment

Competent patients have the right to refuse treatment,[1] even if this refusal will result in death.[2] However, in practice there appear to be limits to this right, which are invoked by the perceived need to protect third parties: the cases where a right to refusal has been recognised have resulted in 'harm' to that individual only. This raises the question: does a pregnant woman have the right to refuse treatment, even if it harms her unborn child?

Only one Australian case has apparently dealt with this question specifically.[3] In this unreported judgment, the court approved the forcible treatment of a pregnant prisoner (with an intellectual impairment) if she were to unreasonably

Maternity care providers have a poor understanding of women's autonomy and legal rights during pregnancy, and of their own legal accountability for adverse outcomes.

refuse treatment. Similarly, in a number of international cases, the courts have made orders for a pregnant woman to undergo treatment or be detained in hospital, in order to protect the interests of an unborn child.

In *Re S (Adult: Refusal of Treatment)* [1993] Fam 123, a UK court made a declaration that a caesarean section could be performed on a woman who was refusing to undergo the procedure (for religious reasons) when it was advised that the life of the woman and unborn child were at risk.

In *St George's Healthcare NHS Trust v S* [1998] 3 All ER 673, hospital staff detained a woman under mental health legislation when she refused a caesarean section after being diagnosed with pre-eclampsia (a condition that threatens the life of an unborn child). The court subsequently authorised the caesarean.

There have also been cases in which the pregnant woman's autonomous right has been upheld. When reviewing the decision in *St George's Healthcare NHS Trust v S* [1998] 3 All ER 673, the Court of Appeal held that a pregnant woman's express and competent refusal of treatment cannot be overridden by an unborn child's need for medical attention. The Court went a step further by saying that even if the 'treatment' is a minor intervention and not 'invasive', the treatment will not be sanctioned as it undermines the principle of patient autonomy.

In re Baby Boy Doe 632 NE 2d 326 (1994), a pregnant woman was said to retain her rights to refuse treatment and the potential impact on the foetus was not relevant (Appellate Court of Illinois).

Despite the fact that both legal and medical principles support a patient's right to refuse medical treatment, the case law here and internationally is contradictory, and some courts have overridden a pregnant woman's decision to refuse treatment.

In an Australian case, *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, a pregnant woman, injured in a car accident, refused a blood transfusion (for religious reasons) but agreed to a caesarean section. Lord Donaldson MR stated that a temporary 'disturbance of mental functioning' could erode a person's capacity to make a medical decision, and that pain, fatigue, and being under the influence of drugs (medicinal) were among the things that could affect capacity.[4] This judgment potentially gives rise to the argument that a woman in labour is suffering a temporary disturbance of mental functioning, such that she may be deemed 'incompetent' and therefore unable to exercise autonomy and refuse treatment.

This is exactly what occurred In *Re MB* [1997] 8 Med LR 217, where the Court of Appeal in England found that a fear of needles made a woman temporarily incompetent and therefore a caesarean section could be performed despite her non-consent to the anaesthetic.

CONSENT AND THE DECISION-MAKING PROCESS

A patient providing consent is patient autonomy at its simplest. Consent is a process that respects the active participation of the patient in decision-making.[5] But decision-making in medicine must be considered within its social and cultural context, as some decisions are not based upon weighing up pros and cons, burdens and benefits, but are intuitive and based on emotions and personal beliefs.

Health professionals cannot help but bring their own values and beliefs to bear when providing information and advice to patients, whose decisions they can easily influence due to the nature of the doctor:patient relationship.[6]

Genuinely informed decision-making can occur only when there is careful disclosure of all relevant information by the care provider to the patient, and in an unbiased manner.

A study that specifically considered conversations between pregnant women and maternity care providers found that informed decision-making was problematic for pregnant women and their care providers.[7] Obstacles included the provision of inadequate information and the power imbalance (between a woman and doctor/medical specialist), which made it difficult for women to advocate for their own preferences. How does this affect home births?

MATERNITY CARE PROVIDERS' PERCEPTIONS OF THE LEGAL RIGHTS OF THE WOMAN AND THE UNBORN CHILD

In the home birth context, when a woman's decision may lead to an increased risk to the safety of the baby, maternity care providers may misunderstand their legal responsibilities to the mother and the unborn child.

A recent study revealed that maternity care providers had a poor understanding of women's autonomy and legal rights when it comes to decision-making during pregnancy, and poorly informed beliefs regarding their own legal accountability for adverse outcomes.[8]

Specifically, maternity care providers' support and recognition of a woman's right to autonomous decision-making during pregnancy changed when the 'safety of the baby' came into the equation. The interests of the baby were perceived to override the mothers' rights to autonomous decision-making, despite the fact that the law is clear on this issue (the unborn child is not a legal person).[9]

The study concluded that both midwives and doctors were inconsistent in their attitudes towards women's rights to choose their care. Previous research has suggested that maternity care providers would often support the woman's decision only if it was one with which they agreed.[10]

These findings have significant repercussions for a collaborative approach to maternity care and decision-making, which is a key feature of successful home births.

Clear guidelines and policies are needed to clarify the legal principles applying to maternity care and home births. The current confusion effectively undermines a woman's ability to exercise her autonomous decision-making rights.

THE REGULATIONS, POLICIES, GUIDELINES AND CLINICAL FRAMEWORKS

A variety of government and regulatory bodies offer guidelines and policies to assist maternity care providers on how best to treat their pregnant patients. Unfortunately, there is no single set of guidelines concerning home births. Furthermore, those available offer contradictory and conflicting information, and some do not appear to accurately reflect the legal rights of the pregnant woman.

Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)

The very first sentence of its Statement on Home Births (the Statement) makes it clear that RANZCOG does not endorse planned home birth:[11]

> 'while supportive of the principle of personal autonomy in decision-making, RANZCOG cannot support the practice of planned home birth due to its inherent risk and the ready availability of safer options for labour and delivery in Australia and New Zealand'.[12]

The Statement outlines support for a collaborative model of care between a midwife and an obstetrician in a hospital as being the 'best model of maternity care'.[13] It describes 'Alternative Birth Centre and Law Intervention Models of Care' that can be used to provide women with a more home-like setting for birth, explaining that the close proximity to the hospital reduces any risks.[14]

While clearly concerned that women make an informed choice about where their child is born, the Statement tends to highlight the risk factors excluding home birth as an option:

> 'A decision to give birth at home must be taken in the knowledge that there are relatively few resources available for the management of sudden unexpected complications that may affect any pregnancy or birth – even those without any acknowledged obstetric risk factors. Women contemplating planned home birth need accurate information about these risks.'[15]

The RANZCOG Standards of Maternity Care in Australia and New Zealand (the Standards) highlight the importance of informed choice for women in the very first section.[16] They emphasise the need for obstetricians to help women with decision-making and specify the importance of conducting a risk/benefit assessment of the available choices.[17] However, whether this is how women actually make decisions about their maternity care is questionable. According to an evaluation of the Victorian Homebirthing Pilot program, the main reasons why women chose home birth include having a natural birth, comfortable surroundings and greater control over the birth experience.[18]

The Standards also address documentation and confidentiality generally, but do not specifically address the importance of documenting discussions concerning the decision-making process or the issues that arise during considerations around treatment, such as location of birth or risks surrounding home birth.[19]

Australian College of Midwives

The attitude towards home birth of the bodies representing and regulating midwives is very different from that of the main organisation representing obstetricians and gynaecologists (RANZCOG). The Australian College of Midwives (ACM) has published three significant documents in this area: The *National Midwifery Guidelines for Consultation and Referral* (the ACM Guidelines) the *Position Statement on Homebirth Services* (the Position Statement), and the *Guidance for Midwives Regarding Homebirth Services* (the Guidance).[20]

The ACM Guidelines are the overarching principles governing the provision of public and private maternity services by midwives in Australia for all pregnant women in all models of maternity care, not just those choosing home birth. In Appendix A, the Guidelines set out specific requirements for maintaining contemporaneous records that document advice, assessments and decisions to act or not to act, as well as for documenting and reporting when a woman refuses advice.

The Position Statement, which is specific to home births, advises that 'The Australian College of Midwives supports the choice of midwife-attended home birth as a safe option for women with uncomplicated pregnancies.'[21] It lists ten key principles for safe home births, which appear to recognise the importance of the pregnant woman's treatment decisions. Key principle 1 specifies that midwifery care is woman-centred, and key principle 4 notes that:

> 'Women have a right to decide where they wish to give birth to their baby. It is important that all childbearing women have access to evidence-based, unbiased information that includes the potential advantages and disadvantages of birth at home.'[22]

Key principle 7 explains midwives' responsibility to ensure that decisions, recommendations and options are focused on the needs and safety of the woman and her baby, and key principle 8 emphasises that:

> 'Informed decision-making, informed consent, and right of refusal are accepted legal principles in Australia. Each and every woman has the right to make informed decisions, including consent or refusal of any aspect of her care. Women must be respected in the choices that they make.'[23]

The Guidance is also specific to home births and provides practice points for the midwives to follow; an explanation of professional accountability and responsibility; and the type and scope of information that should be provided to women choosing a home birth. Usefully, there is also a list of 'relevant guiding documents' for providing maternity services and a flowchart, 'Decision-making for midwives providing home birth services'.[24]

The main thrust of the Guidance is clearly stated on p3:

> 'Midwives have a responsibility to provide women with access to comprehensive, unbiased, up-to-date and evidence-based information to enable them to make informed decisions about all aspects of their care,

including place of birth. Informed decisions may include issues of consent, the right of refusal of a recommended course of care; and the right to refuse care.'[25]

The emphasis of the ACM is clearly on the midwife providing information that enables the woman to make an informed choice, while maintaining her right to autonomy.

Nursing and Midwifery Board of Australia (NMBA)

The NMBA is the principal regulatory and disciplinary body for the midwifery profession, and has published the *Safety and Quality Framework for Privately Practising Midwives Attending Home Births* (the Framework).[26] The Framework is intended to exempt privately practising midwives (PPMs) from requiring professional indemnity insurance for providing home births, by establishing requirements that comply with the National Law.[27]

A key principle of the Framework is to ensure that the services provided by the PPMs allow women to 'make informed and timely choices regarding their maternity care and to feel in control of their birthing experience'.[28]

PPMs must adhere to the ACM Guidelines and implement processes that demonstrate their compliance. For example, PPMs should provide balanced and up-to-date advice to ensure informed decisions and then document this clearly, together with plans and referral pathways.

South Australia

The *Policy for Planned Birth at Home in South Australia* (the Policy) was developed by the government of SA to guide maternity care providers when caring for women who have made the decision to home birth.[29] The Policy doubles as an information brochure to be handed to women, and allows them to give signed informed consent for a planned home birth. Three appendices to the Policy provide practical guidance for practitioners. Appendix C provides an extensive checklist for completion by 'qualified practitioners'; the 'Information in Pregnancy' section requires the Policy to be given to the mother and the practitioner to perform an assessment of the woman's suitability for home birth. The 'Actions in Pregnancy' section requires the informed consent (signed in duplicate) and for the woman's suitability for home birth to be monitored and documented regularly.

Maternity care providers are reminded that a pregnant woman's autonomy is legally protected and that the United Nations states that 'the human rights of women include their right to have control over, and to decide freely and responsibly on, all matters related to their sexual and reproductive health'.[30]

However, the Policy preamble qualifies this, stating that 'A woman can be supported to give birth at home only if she fits the criteria for a low-risk, singleton pregnancy at term, and the qualified practitioners are confident and competent to assist.'[31] There is a list of contraindications for home birth, and VBAC (vaginal birth after caesarean), twin and breech births are not supported.[32]

The Policy requires clear and adequate documentation regarding discussions and decisions about giving birth at home, and consent (it does not specify discussions about risk).[33] It also requires the notification and documentation of women (within their clinical record) who decide to continue with plans for a home birth contrary to the maternity care providers' advice.[34]

RECENT CASES

In a number of recent cases, maternity care providers have been caught up in the complex and often contradictory legal and regulatory landscape surrounding home births.

Inquest into the death of Thomas Freemantle[35]

Thomas was born at home, a family farm approx 25 kilometres from Bendigo, on 19 October 2010. He died two days later. His mother had had a previous home birth during which the baby suffered a fractured clavicle (after the shoulders were reportedly stuck for 10 minutes, a condition called shoulder dystocia) and required emergency transfer to hospital due to neonatal respiratory distress.[36]

Claire Hall, a qualified midwife, was involved in the home birth. She had declined to act as the midwife for Thomas's delivery, but attended the birth after she learnt that the mother intended to birth at home without support; Ms Hall advised the court that she attended the birth as a friend, not a midwife.[37] However, during the birth she performed some midwifery tasks, including rupturing the membranes and performing a vaginal examination. The expert in the case said that Ms Hall's conduct did not meet the expected professional standards of a midwife and was critical of her dual role as a 'friend and midwife in emergency only'.[38]

During her pregnancy, the mother was warned of the enhanced risk of cephalo pelvic disproportion (given the prior history of shoulder dystocia), the associated impact on both mother and baby, and advised of concerns with the proposed home birth.

The parents agreed that they had discussed the risks of home birth, but stated that the maternity care providers were not sufficiently firm in their advice that a hospital birth was appropriate in the circumstances.

The coroner found that the risks of home birth had been advised, but that the ongoing care by Ms Hall may have influenced the parents' view that it was safe. He recommended that all women planning a home birth should undergo a comprehensive and clearly documented risk assessment.[39]

Inquest into the death of Joseph Thurgood-Gates[40]

Ms Thurgood planned a home birth, but was rushed to the Monash Medical Centre where Joseph was born. Joseph had sustained a severe hypoxic brain injury and life support measures were discontinued.

Ms Thurgood had had two previous pregnancies (one with twins) which both resulted in caesarean section deliveries. During both pregnancies, she had been diagnosed with gestational diabetes.

Having regard to this previous history, the obstetrician at the Monash Medical Centre advised her that a caesarean delivery would be the safest option, due to the risks of uterine rupture (among other things).[41]

Contrary to this advice, Ms Thurgood engaged a private midwife to undertake a home birth. She was of the view that the purpose of the doctor's advice of the risk of uterine rupture was to 'scare her' into a hospital delivery. Ms Thurgood even went so far as to ask the doctor at the medical centre to make a note that she did not want to be advised of the risk of uterine rupture.[42] The coroner was clear in his view that, despite the clear advice of clinicians concerning the risks to the pregnancy, Ms Thurgood had formed her own opinion.[43]

At two weeks post-term (42 weeks' gestation), Ms Thurgood experienced an ante-partum bleed and was admitted to the Monash Medical Centre. During that admission, an obstetrician recommended a hospital delivery by caesarean section, further explaining the risk of uterine rupture and hypoxic injury to the baby. Ms Thurgood agreed to return to the hospital when her labour began. Her private midwife, Ms Hallinan, was present and gave evidence at the inquest that her support for a home birth stopped at this point. However, the evidence did not demonstrate that this information was conveyed to Ms Thurgood. The midwife continued being involved in her care and Ms Thurgood developed the view that she supported the decision to birth at home.

When Ms Thurgood's labour began, she contacted Ms Hallinan, who attended the family home. Despite the agreement with the hospital obstetrician, Ms Thurgood did not go to the hospital.[44] Ms Hallinan did not advise her to go to the hospital, but commenced assisting in the labour.

The expert evidence identified that home birth posed significant risks in this pregnancy and that the labour was mismanaged. The coroner found that it was the 'absolute duty' of the midwife to ensure that her views were clearly and precisely conveyed and documented.[45]

The Thurgood family criticised the hospital staff, stating that they had indirectly contributed to Joseph's death 'because they were not minded to accommodate the mother's wishes or to properly communicate with her as to her needs'. The coroner did not support this submission, stating that the hospital staff 'went to great lengths to attempt to engage with Ms Thurgood and her midwife, in an attempt to understand how they (the hospital) may be able to convince her to accept the safest option for delivery of the baby'.

Coroner Parkinson found that Joseph's death was preventable and specifically criticised the midwife for failing to provide clear advice to Ms Thurgood of the risks associated with home birth.[46] He concluded that 'There appears to be an absence of legislative standards and practical supervision and regulation of private midwifery practice and home birthing in particular.'[47]

Inquest into the deaths of Tate Spencer-Koch, Jahli Jean Hobbs & Tully Oliver Kavanagh[48]

This inquest was conducted by SA Deputy State Coroner Anthony Schapel over a number of days in 2010, 2011 and 2012. He found that all of the deaths had arisen in circumstances involving planned home births with readily identifiable risks. Had the births been managed in the appropriate setting, the deaths could and should have been prevented.[49]

The coroner was careful to emphasise that the inquest was in no way about the desirability, appropriateness or otherwise of home births in low-risk pregnancies. It was instead focused on whether the choices made by each pregnant woman were fully informed choices, where the risks involved were fully understood.[50]

Baby Tate Spencer-Koch died in July 2007 as a result of intrapartum hypoxia. The mother had previously had an obstructed labour due to shoulder dystocia, resulting in a caesarean section due to foetal distress and slow progress. The details of this previous pregnancy placed Tate's delivery at risk of complication (there was a risk the mother may not dilate to the necessary degree, and a risk of uterine rupture because of the previous caesarean). In addition, Tate was a macrosomic (heavy) baby, so at a higher risk of shoulder dystocia. Despite this, midwife Lisa Barrett did not consider that the baby was at an increased risk and proceeded with a home birth. This course of action was heavily criticised by the expert who gave evidence at the inquest that the safest course was an elective caesarean section, due to the risk factors.

Baby Jahli Jean Hobbs died in April 2009 as a result of intrapartum hypoxia. The family lived on a remote island with limited access to a hospital. The mother had had a previous child born by caesarean section due to foetal distress and slow progress. It was known during the pregnancy that baby Jahli was going to be a breech birth. The expert at the inquest advised that continuous foetal monitoring is an essential safeguard against an unknown adverse event in breech births, as it would allow the practitioner to expedite delivery if necessary.[51]

Ms Barrett provided evidence that despite a breech birth the baby was at no bigger risk if born in the home than in the hospital, even with continuous monitoring. There was evidence that she had advised the mother that a breech birth was 'just a variation of normal' and therefore the mother felt reassured and didn't think it was a risk.[52] Another midwife who had been involved during the pregnancy gave evidence that no detailed discussion took place with the mother about risks associated with breech delivery.[53]

Specific guidelines deal with breech births but Lisa Barrett admitted in her evidence that she had not drawn the mother's attention to the ACM Guidelines, as she was of the view that the mother had made her choice and already knew of the risks involved.[54]

Baby Tully Oliver Kavanagh died in October 2011 as a result of hypoxic ischaemic encephalopathy. Tully was the second born of twins. His mother suffered a placental separation during labour. Twin births are excluded from home births as they are high risk.[55]

All three home births involved Lisa Barrett, a registered midwife who commenced her own private home birth practice in 2005. The practice was often accessed online by expectant mothers seeking a home birth practitioner and/or information. During the inquest, the coroner was critical of Ms Barrett's approach to private home births and her

philosophy of maternity care:

> 'An opposing philosophy involves the notion that although no person wants to see their unborn child die, the mother has a complete and unfettered choice of venue of birth and may place the at term unborn infant at risk regardless of the type and magnitude of the known risk to the baby, and regardless of the fact that the risk might be ameliorated by the delivery taking place in hospital. The same philosophy holds that the unborn child at term has no rights in this regard.'[56]

Partway through the inquest, Lisa Barrett voluntarily relinquished her registration as a midwife, describing her ongoing practice as a 'birth advocate'. She said it was because the new regime prevented women from making choices. The coroner rejected that evidence, finding that the requirement to practise within the Framework and the ACM Guidelines 'would act as a hindrance to her home birthing practice in respect of high-risk home births'. He recommended legislation rendering it an offence for anyone other than a registered midwife or medical practitioner to engage in the delivery of midwifery services, explaining that this would bring all home births by PPMs within the purview of s284 of the National Law and the requirements to follow the Framework and ACM Guidelines.[57]

Nursing and Midwifery Board of Australia v Lisa Barrett

Lisa Barrett was brought before the Health Practitioners Tribunal of South Australia following complaints of professional misconduct concerning the treatment she provided to a number of other women during their pregnancies and home births.[58]

The expert obstetricians and midwives agreed that the women were not candidates for home birth due to previous pregnancy history (including VBAC, shoulder dystocia, twin pregnancies and breech presentations).

The experts indicated that it was difficult to ascertain whether an informed decision had been made by each mother due to the lack of documentation of discussions, education or management planning of the proposed home births. Tate's mother 'went to a number of seminars and an information night about natural births...her position was that she satisfied herself that she could have a natural birth and contacted the Midwives Association and in turn the Association recommended the respondent.'

Jahli's mother had carried out some research on the internet and found the respondent, who had agreed to undertake the home birth. 'Thereafter she did not see an obstetrician or her general practitioner. She indicated that her general practitioner was not aware that she was going to attempt a home birth. She said she had received no medical advice in relation to the advantages and disadvantages of home births.' She obtained information about home birth mainly from the internet but indicated that she did not read any literature about home births or the risks associated with them, or with regard to breech births.

The experts were highly critical, indicating that there was a 'total absence of any written documentation of risks and explanations that home birth was utterly contraindicated'.[59]

One of the specialist obstetricians, Professor Dekker, commented:

> 'The concerns regarding the care provided by Lisa Barrett are clearly of a repetitive nature – unwillingness to follow standard protocol, ignoring advice, not providing proper written information regarding risks, not have a second midwife as a back up at time of birth and a gross over-estimation of her own professional skills.'[60]

The tribunal was satisfied that the respondent's conduct constituted professional misconduct.

On 28 November 2013, Steve Tully, then Health and Community Services Complaints Commissioner, made a formal order prohibiting Lisa Barrett from 'providing specified health services in South Australia pursuant to section 56C (2) of the *Health and Community Services Complaints Act* 2004'.[61] He noted that she had failed to adhere to previous recommendations (made in October 2012) and that both AHPRA and the NMBA had conducted investigations into her midwifery practices.[62] Noting the findings of the coronial inquest conducted by Deputy State Coroner Anthony Schapel, he further indicated that the expert evidence obtained during those investigations and the inquest exposed practice that was unsafe, dangerous and not in accordance with accepted obstetric and midwifery standards. Barrett was fined $20,000. There was no criminal penalty (although a police investigation opened in July 2014 is ongoing).

As a postscript, five months after Lisa Barrett surrendered her midwifery registration, she was involved as a 'birth advocate' in the delivery of a baby in Western Australia. An inquest into that baby's death was held in 2014.[63]

THE CURRENT LANDSCAPE

Uncertainty in the law and regulatory framework

Confusion and a lack of consistency regarding the legal and regulatory landscape within which they are operating means that maternity care providers are currently navigating a minefield when trying to help women to make informed choices about their care.

Informed choice, risk assessment and appropriate selection

Proper communication of risk to mothers, careful and clear risk assessments and shared decisions between providers and patients are clearly essential to safe and successful home births. These discussions and considerations need to be carefully documented so as to obviate concerns that maternity care providers are not fulfilling their obligations to facilitate informed choice. In the cases described above, the risks of home birth had not been properly communicated or documented. If they had, the mothers may well have made different decisions.

In addition to informed decisions, the appropriate selection of individuals for home birth, based on comprehensive risk assessments, is also essential. The SA policy for planned birth at home indicates that home births can be achieved safely when conducted within appropriate guidelines. Adverse outcomes tend to occur when women are

inappropriately 'selected' for home birth, or when there is a failure of the maternity care provider to respond adequately to risks arising.[64]

THE WAY FORWARD

Maternity care providers need to be aware that they are not legally responsible for adverse outcomes if they transfer responsibility to the mother by proper communication and documented informed consent.

Pregnant women have an unambiguous legal right to make autonomous decisions about their medical care, even when their decisions may result in an increased risk of harm to them or their unborn babies. But, at present, their autonomy is being compromised by the absence of informed decision-making processes, and a lack of clarity and consistency in medical guidelines and regulations.

Professional medical education should focus on a clear and accurate reflection of the law concerning patient autonomy, the interests of the unborn child, and the need to share decision-making so as to ensure the communication of desires and beliefs as well as the correct and unbiased disclosure of risk. Ensuring properly informed decision-making by pregnant women will result in safe and healthy child birth practices that can continue to include home birth. ■

Notes: **1** *Smith v Auckland Hospital* [1965] NZLR 191. **2** *Brightwater Care Group Inc v Rossiter* [2009] WASC 229 heard from a quadriplegic man who refused feeding and hydration through a PEG tube; *Re PVM* [2000] QGAAT 1 involved the refusal of artificial ventilation. **3** *Queensland v D* (unreported, de Jersey CJ, 28 August 2002). **4** *Re T (Adult: Refusal of Treatment)* [1993] Fam 95 [27]. **5** Charles Lidz, Paul Appelbaum and Alan Meisel, 'Two models of implementing informed consent' [1988] 148(6) *Arch Intern Med* 1385-1389. doi:10.1001/archinte.1988.00380060149027. **6** Dan Brock, 'The Ideal of Shared Decision-Making between Physicians and Patients' [1991] 1(1) *Kennedy Institute of Ethics Journal* 28-47. **7** Michael Klein, 'Many women and providers are unprepared for an evidence-based, educated conversation about birth' (2011) 20(4) *Journal of Perinatal Education* 185. **8** Sue Kruske, Kate Young, Bec Jenkinson and Ann Catchlove, 'Maternity care providers' perceptions of women's autonomy and the law' (2013) 13 *BMC Pregnancy and Childbirth* 84, accessed online at http://www.biomedcentral.com/1471-2393/13/84 on 3 October 2014. **9** The foetus is considered to be human but not a legal person with legal rights until it is born alive. See *R v Hutty* [1953] VLR 338. **10** TS Eri, A Blystad, E Gjengedal and G Blaaka, 'Stay home for as long as possible: Midwives' priorities and strategies in communicating with first time mothers in early labour' (2011) 27(6) *Midwifery* 286-92. H Stapleton, M Kirkham and G Thomas, 'Qualitative study of evidence-based leaflets in maternity care' (2002) 324 (7338) *BMJ (Clinical Research Edition)* 639-43. **11** The Royal Australian and New Zealand College of Obstetricians and Gynaecologists Statement on Home Births dated July 2014, available at http://www.ranzcog.edu.au/college-statements-guidelines/c-obs-2-home-births.html. **12** *Ibid,* p2. **13** *Ibid,* p3. **14** In that same paragraph, RANZCOG also identifies a trend towards higher perinatal death in these environments when compared with 'conventional hospital birth'. **15** *Ibid,* p3. **16** The Royal Australian and New Zealand College of Obstetricians and Gynaecologists Standards of Maternity Care in Australia and New Zealand (dated March 2014) available at http://www.ranzcog.edu.au/college-statements-guidelines.html, p6. **17** *Ibid,* p6, Standard 1.1: 'Any discussions of choice in maternity care must ensure the woman and her family have an understanding of the concept of risk management and how this underpins obstetric interventions'. **18** The La Trobe University's Mother and Child Health Research conducted the evaluation and an evaluation summary report was prepared by the Department of Health for the State Government of Victoria in 2012 –http://docs.health.vic.gov.au/docs/doc, accessed 16 October 2014 via 'The Victorian homebirthing pilot summary'. **19** Above n16, p14, Standards 8.1 to 8.9. **20** The National Midwifery Guidelines for Consultation and Referral (2013) (3rd edn) accessed at http://www.midwives.org.au/scripts/cgiip.exe/WService=MIDW/ccms.r?PageId=10196 on 18 October 2014. **21** Australian College of Midwives – Position Statement on Homebirth Services, 8 November 2011, p1. **22** *Ibid,* p1, Key Principle 4. **23** *Ibid,* p1, Key Principle 8. **24** Australian College of Midwives – Guidance for Midwives Regarding Homebirth Services, 8 November 2011, pp4 and 5. **25** *Ibid.* **26** Nursing and Midwifery Board of Australia – Safety and Quality Framework for Privately Practising Midwives Attending Homebirth. **27** Specifically, s284 of the National Law. **28** Above n26, Attachment 1. **29** Policy for Planned Birth at Home in South Australia dated 4 July 2007, Government of South Australia. Department of Health. **30** *Ibid,* p3. **31** *Ibid.* **32** *Ibid,* para 6, pp7 and 8. **33** *Ibid,* para 12, pp15 and 16. **34** *Ibid,* paras 7.11 and 8.12, pp9 and 10. **35** Coroners Court of Victoria – Inquest into the death of Thomas Freemantle (ref 2010/4201), findings delivered on 8 April 2014. Accessed at www.coronerscourt.vic.gov.au on 28 October 2014. **36** *Ibid* at [8]. **37** *Ibid* at [36]. **38** *Ibid,* expert Catherine Adams, at [41]. **39** *Ibid* at [9], [11], [44] and [15]. **40** Coroners Court of Victoria – Inquest into the death of Joseph Thurgood-Gates (ref 2010/4851), findings delivered on 10 May 2013 accessed at www.coronerscourt.vic.gov.au on 28 October 2014. **41** *Ibid* at [15] and [16]. **42** *Ibid* at [30]. The doctor declined, reiterating that it was the obligation of the medical practitioners to advise of the risks. **43** *Ibid* at [139]. **44** *Ibid* at [34], [41], [39]. 'At no stage did Ms Hallinan provide clear and precise advice that the birth should not occur at home, that birth should occur at hospital or that it would be dangerous in any circumstance in this pregnancy to proceed to attempt to birth at home', [163]. 'By her actions and inactions, she gave sustenance to the firmly held views of the mother that it was safe, [165]. In her evidence, Ms Thurgood said that she had intended to mislead the hospital when she undertook to return at the commencement of labour as she wanted to protect her midwife from the requirements of the ACM Guidelines, [142]. **45** *Ibid* at [172]. **46** *Ibid* at [203], [205] and [224]. The midwife was also criticised for sustaining the misguided views of the mother, as this was thought to have contributed to her level of confidence in the home birth and decision to disregard the advice of the hospital clinicians. **47** *Ibid* at [231]. **48** Coroners Court of South Australia – Inquest into the deaths of Tate Spencer-Koch, Jahli Jean Hobbs and Tully Oliver Kavanagh (ref 17/2010 (0984/2007, 0703/2009) & 45/2011 (1628/2011), findings delivered on 6 June 2012, accessed at www.courts.sa.gov.au on 28 October 2014. **49** *Ibid* at [3.1]. **50** *Ibid* at [3.1] and [3.9]. **51** *Ibid* at [7.9] and Professor Pepperell at [7.6], [7.20]. **52** *Ibid* at [7.23] referring to Transcript p587; [7.28] referring to exhibit C39b, p8; and p9: 'I never felt as though it was unsafe thing, never'. **53** *Ibid* at [7.30] referring to Transcript p469, the evidence of Ms Rosemary Vaher. **54** *Ibid* at [7.33] referring to Transcript, p979 and evidence of Ms Lisa Barrett. **55** *Ibid.* An 'absolute no' according to the expert Professor Pepperell, at [7.48] referring to Transcript p899. **56** *Ibid* at [3.5] referring to the evidence of Ms Lisa Barrett, Transcript pp579-80, 650-1 and 991. **57** *Ibid* at [9.16], referring to Transcript p989; and [13.10]. **58** *Nursing and Midwifery Board of Australia v Lisa Barrett* [2014] SAHPT 1. The births of baby Tate, Jahli and Tully from the inquest described above were included in the complaint, along with the 'WA' twins (one breech), 'W' twins (one breech) and breech baby 'KH'. **59** *Ibid* at [27], [70], [71], [75] and Professor Dekker, obstetrician at [93]. **60** *Ibid* at [52]. **61** Statement for Public Release, HCSCC reference 011122, accessed at http://www.hcscc.sa.gov.au on 28 October 2014. **62** AHPRA is the Australian Health Practitioner Regulation Agency and NMBA is the Nursing and Midwifery Board of Australia. **63** Sonia Kohlbager, 'Coroner has questions as former midwife linked to home birth death', *The Australian,* 1 October 2014. **64** Above n29, pp4-5.

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