The ‘born alive’ rule revisited

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Abstract
The common law ‘born alive’ rule has a significant meaning with respect to a number of legal issues. When there is the death of a newborn, the issue is whether the child has been born alive for the purposes of the law. A Coroner does not have jurisdiction to hold an inquest into the death of a stillborn child. The observable signs of life that have been held to be indicia of life in a newborn have traditionally included a cry, a gasp, respiratory effort, heartbeat and/or movement, albeit transitory and insufficient to sustain life. The rule was established in law at a time of high perinatal mortality when medical knowledge of the foetus was limited and in the absence of medical technology for determining and supporting life. An issue that has just recently arisen is whether medical technology which can indicate pulseless electrical activity (PEA) in a newborn, in the absence of other observable indicia, can be regarded as an indication of live birth so as to trigger the jurisdiction of a Coroner to hold an inquest into the child’s death.

Keywords (MeSH): Legal Cases; Midwifery; Home Childbirth; Stillbirth: Brain Death.
Supplementary Terms: Born Alive Rule; Pulseless Electrical Activity (PEA)

Introduction
In June 1990, the Australian Medical Record Journal published an article by me under the heading Wig & Pen, entitled ‘The “born alive” rule’ (Mair 1990). It described how the common law regards the status of the foetus with respect to various legal issues. Generally, a child must be born alive in order for the law to regard the child as a ‘person’ having legally enforceable rights. In order to be declared as having been born alive, the child must have been fully extruded from the mother’s body and have shown some indicia of life such as a gasp, movement, respiratory effort and/or heartbeat. The born alive rule has been in existence for centuries and dates back to a time when medical knowledge regarding foetal life was limited and the foetus was regarded as a part of a woman's body like her internal organs. It was also developed at a time when contemporary technology for determining and supporting life did not exist. In the above article, I canvassed issues regarding homicide of an unborn child. The common law has always held that in order for a charge of murder or manslaughter to be laid for the death of a newborn child, the child must be fully extruded from its mother’s body, and have exhibited some sign of having lived albeit briefly before dying.

For example, the Crimes Act (NSW) Section 20 provides that: ‘On the trial of a person for the murder of a child, such child shall be held to have been born alive if it has breathed, and has been wholly born into the world whether it has had an independent circulation or not’.

Other than murder or manslaughter, there are alternative offences where an unborn has not survived the birth process. For example, Section 42 of the Crimes Act (NSW) provides that: ‘Whosoever, during or after the delivery of a child, intentionally or recklessly inflicts on such child, whether then wholly born or not, any grievous bodily harm shall be liable to imprisonment for fourteen years’.

In civil law, the ‘born alive’ rule operates to bar a claim for damages for injuries caused to the unborn through an alleged negligent act or omission unless the child is born alive. The mother can recover for injuries to herself if she can prove assault or negligence, including nervous shock, but not for injuries to the stillborn child. If any changes to the definition are to be made it is a matter for the Parliament. Other areas of civil law in which the born alive rule may be significant includes family law, succession and wills. I also referred to the fact that a Coroner has no jurisdiction to inquire into the death of a newborn unless the child had first been born alive. The role of a Coroner is to establish the identity of the deceased, the cause of death and the time and place of death. If the Coroner forms the view that there is a prima facie case of criminal involvement of someone with respect to the death of a ‘person’, the Coroner is required to cease the Coronial Inquest and forward the matter on to the Director of Public Prosecution to consider criminal prosecution. When it is determined that the newly born is a stillbirth, a Coroner is precluded from holding an inquiry into the death.
Recently, there has been a further clarification with respect to this born alive rule. In June 2010, a South Australian Deputy State Coroner ruled that he had jurisdiction to hold an inquest into the death of a child delivered during a homebirth attended by a midwife. The midwife sought judicial review of the Deputy State Coroner’s findings to the South Australian Supreme Court, Barrett v Coroner’s Court of South Australia [2010] SASCFC 70. The Full Court dismissed the case. The High Court of Australia refused leave to appeal the matter; Barrett v The Coroner’s Court of South Australia & Anor [2011] HCA Trans 165. The South Australian Deputy State Coroner then went on to hold an inquest into the death of the child, Tate Spencer-Koch, and two others.

The facts and the law summarised and reported herein are drawn from the two findings of the South Australian Coroners Court, the judgment handed down by Supreme Court of South Australia Full Court, and from the High Court of Australia Transcripts.

The Facts: 1st Coronial hearing 4 June 2010 and 2nd hearing 6 June 2012
Tate Spencer-Koch died during the process of childbirth. The delivery took place at her parent’s home assisted by a registered midwife, Ms Lisa Barrett. Also present was a trainee midwife as a support person who ended up assisting in an emergency at the final stage of the delivery [2nd Inquest 10.5]. The time of delivery was approximately 5.40 am on 16 July 2010 [1.1]. The pregnancy was at term and had been uncomplicated throughout. Mrs Spencer had a history of a previous emergency caesarean section due to foetal distress and slow progress. The live born baby weighed 3950 at birth. In addition, Mrs Spencer had a history of a previous emergency caesarean section due to foetal distress and slow progress. The live born baby weighed 3950 at birth. In addition, Mrs Spencer was obese with a BMI of 37 at the time of Tate’s birth [2nd Inquest 7.2]. Tate weighed 4790 grams at birth [1.2]. The Deputy State Coroner commented that this recorded weight ‘is considerably in excess of the mean birth weight’. No respirations were detected at birth and Tate was considered to be stillborn. An ambulance was called and when they arrived the ambulance crew examined the child and elicited signs of electrical activity in the child’s heart. They unsuccessfully attempted to resuscitate her [1.3]. Ms Barrett had kept a record of the progress of labour and assessed the foetal heart rate using a Doppler machine. At all times up until the birth, the foetal heart rate remained within normal limits. At 5.10 am, the head crowned and the foetal heart rate of 120 bpm was last recorded at this time [1.4]. The head was delivered at 5.30 am but the delivery was delayed due to shoulder dystocia. Ms Barrett tried a number of manoeuvres to overcome the dystocia; however, full delivery did not take place until 20 minutes later. The circumstances of the delivery and the time it took to complete the delivery of the child exposed her to significant hypoxia [1.5]. After the delivery had been completed, Ms Barrett stated that she had tried to detect a heartbeat by palpating the child’s chest and detected no heartbeat whatsoever. She did not look for a pulse manually or use a stethoscope. There was no evidence of a heartbeat or pulse at any time after delivery [1.19].

According to the evidence, two relevant phone calls were made to the South Australian Ambulance Service (SAAS) sometime between 5.36 am and 5.44 am. The Women’s and Children’s Hospital was also called in anticipation of the child requiring transfer to hospital [2nd Inquest 10.11]. The ambulance crew arrived at the home at about 5.48 am One of the ambulance crew, who was an intensive care paramedic, applied a machine to the child, which registered pulseless electrical activity (PEA) in her heart of about 15 bpm. The heart was not actually beating nor were there any respirations. Resuscitation efforts, which had been commenced prior to the arrival of the ambulance officers was taken over by them using intubation, ventilation and the administration of adrenaline [1.19]. Tate could not be resuscitated [1.21]. The PEA ultimately ceased and Tate was declared deceased at the Women’s and Children’s Hospital at North Adelaide at 6.37 am [2nd Inquest 1.3].

The Law
The Relevant provisions of the Coroners Act 2003 (SA) referred to by the Deputy State Coroner ‘stipulate that the jurisdiction to conduct an inquest in the Coroners Court is enlivened when there has been the reportable death of a person’. Whether a living entity is a ‘person’ under the Act is referred by the Deputy State Coroner ‘is a matter of law and fact’. The proof required is the civil standard of ‘on the balance of probabilities’. The Coroner applies the common law definition of what is a ‘person’ in the eyes of the law. To be regarded as a ‘person’ a foetus must be shown to have completely left its mother’s body and to have been alive at, or after its birth. According to the Deputy State Coroner:

*It will be seen from those two requirements that a child who dies in the womb prior to its complete removal from the mother and who therefore exhibits no sign of life following that full delivery will not be regarded as having existed as a person in the eyes of the law, notwithstanding that the evidence clearly establishes that at some point in time, even very close to the child’s delivery, it had existed as a healthy and viable foetus.* [1.6]

The Coroner went on to consider a decision in a previous Coroner’s case in 2002 regarding Matthew McPhil Osborne in which he had found that the evidence had been insufficient to show that the child had taken a breath after delivery, had established a heartbeat or exhibited any other signs of life. There was no evidence that there had been any residual electrical activity. Therefore, Matthew was not a ‘person’ in the eyes of the law and the Coroner had no jurisdiction to hold an inquest into the cause of his death. He was of the opinion that the Death (Definition) Act 1983 (SA) modified the common law definition of death in South Australia by introducing the requirement of brain activity as an alternative to circulation of blood within the body. After considering precedent from a NSW Court of Appeal case, the Coroner stated that the statutory definition of death
does not alter the requirements of the common law rule he was obliged to apply as a Coroner. Additionally: ‘[T]here is no jurisdictional requirement that there was some function of the brain or circulation of blood within Tate before I can regard the Court as being vested with jurisdiction to investigate her death’ [1.12]. The Deputy State Coroner went on to refer to the New South Wales Court of Appeal case of R v Iby (2005) 63 NSWLR 278, and opined that the Coroner Court should follow and apply all aspects of the decision in that case even though it was not binding on the Court in South Australia. In R v Iby, the defendant was convicted of the manslaughter of a newly born child who was born and died after a motor vehicle accident. He appealed against his conviction to the New South Wales Court of Appeal. The facts were that the appellant had been driving erratically at an excessive speed when his car collided head-on with a car which was driven by a woman who was then 38 weeks pregnant. Following an emergency caesarean section performed after the woman was admitted to hospital, the child was born in a poor state and died two hours after his birth whilst on life support. There was a spontaneous heartbeat present but the question which arose was whether the heartbeat was being supported by the artificial ventilation. Although the heartbeat fluctuated and the child’s blood pressure was low these factors indicated that there was circulation of blood occurring. The child never breathed spontaneously. One hour after birth an electroencephalogram was used to measure brain activity and it indicated a flat trace. There was no evidence that the child had ever had any brain activity following delivery. Despite the history as described above, the NSW Court held that the heartbeat was of itself sufficient to be regarded as a sign of life and child had been born alive even though the sign of life was non life sustaining. The Court held that but for the trauma caused by the motor vehicle accident, the child could have been born as a healthy living person [1.16].

The NSW Court adopted the view that it was now possible to determine the viability of a foetus in ways which were not in contemplation when the born alive rule was adopted. In their view the born alive rule should be applied with contemporary conditions such that any sign of life after delivery is sufficient [1.16]. Thus the fact that the child had been on life support from birth until its death did not preclude a finding that the child had been born alive. The fact that the NSW government had introduced a statutory definition of death, namely ‘brain death’ in its organ transplant legislation was not held to affect the existing common law born alive rule to be applied. With regard to the facts as before the Deputy State Coroner in the case before him, he stated: ‘There is no evidence that Tate Spencer-Koch was anything other than a viable and healthy foetus right up to the point of crowning of her head during the course of the delivery process’ [1.17]. He went on to state that the failure to be delivered due to the shoulder caused a fatal period of hypoxia before full delivery which would, if left unchecked lead inevitably to death [1.18].

The issue to be decided by the Deputy State Coroner was whether the PEA detected in Tate’s heart by the paramedic approximately 10 minutes after her birth was a sign of life sufficient to satisfy the born alive rule. If yes, the Coroners Court had jurisdiction to hold an inquest into her death [1.22]. A medical witness, Dr Gavin Wheaton, was called to give expert witness testimony. Dr Wheaton explained that PEA is one of four cardiac arrest rhythms. In Tate’s case he opined that the PEA was in effect a pre-asystolic state, immediately before the heart ceased exhibiting any activity whatsoever [1.23]. In Dr Wheaton’s opinion, the PEA in Tate’s case should not be regarded as a sign of life. Although the Deputy State Coroner took into account Dr Wheaton’s views, he stated that whether the PEA in the case before him was a sign of life was a matter for him to decide as a matter of law and fact. He went on to state: ‘That said, it is evident to me that what the medical profession might regard as a sign of life might well differ from what a sign of life might be when considered in the context of the criminal law or the law relating to the jurisdiction of a court’ [1.24]. After extensive analysis of the expert evidence, the Coroner formed the view that the PEA of 15 bpm detected 10 minutes after Tate’s birth was a sign of life for the purposes of the law. He opined that all facets of the born alive rule had been satisfied in the case. He made a finding that Tate was a person in the eyes of the law and this satisfied the jurisdictional requirement of the Coroners Act 2003 (SA) [1.28]. He declared that Tate was alive at the time of her birth and that she then died [1.29].

The Supreme Court of South Australia
Full Court decision: 9 December 2010

Ms Barrett sought judicial review of the Deputy State Coroner’s findings. The grounds for seeking a judicial review put forward were that the Coroner lacked jurisdiction to hold such an inquest, as Tate Spencer-Koch was not born alive. Her case was dismissed. The Court followed the decision of the NSW Court of Criminal Appeal case of R v Iby. According to the Court, ‘The Deputy State Coroner was correct in his delineation of the test to be applied, namely that it is the ‘born alive’ test as formulated by the Court of Criminal Appeal in R v Iby (77) that is determinative and that ‘any sign’ (in the sense of ‘any evidence’) of life will satisfy that test [78], [146]. The Court held that the born alive rule is satisfied by any sign of independent life, thus the presence of pulseless electrical activity (PEA) was sufficient to be regarded as a sign of life in the case before them. From this case it can be concluded that indicia of life are not limited to those which have been applied in previous cases such as heartbeat, movement, or respiratory effort.
The High Court of Australia case: 10 June 2011
Ms Barrett proceeded to seek leave to appeal to the High Court of Australia. Her counsel posed to the court that the case raised fundamental issues in relation to the commencement of life. He stated that he wished to put an argument before the Court that the ‘sign of life’ required to satisfy the born alive rule to date has been changed by incorporation within it ‘pulseless electrical activity’. He argued that the common law concept of the born alive rule is a settled, stable and sound one and had recognised five examples of signs of life for in excess of 200 years. PEA is significantly at variance to the other five and would add a sixth sign of life. The High Court refused the application for special leave to appeal. According to the Court (French CJ and Kiefel J) they did not consider that the concept of ‘born alive’ had been extended.

The Coroners Court of South Australia findings: 6 June 2010
The inquest into the causes and circumstances of Tate’s death was conducted concurrently with two other infant deaths as all three births had been planned homebirths in South Australia and Ms Barrett had been present at all three. One of these deaths was a known breech delivery and the other a twin birth at which the second twin died. The Coroner also received evidence gathered regarding the death of an infant who was the second of twins born in the course of a planned home delivery that had taken place in Western Australia where Ms Barrett was present. This report deals only with that part of the inquest into the death of Tate.

Ms Barrett trained as a nurse and midwife in Wales. Post training she practised as a nurse and as a midwife in the United Kingdom. She migrated to Australia in 2003, worked as a hospital midwife then in 2005 commenced a homebirthing practice as a privately practising midwife. In early 2011 Ms Barrett relinquished her registration as a midwife following the implementation of changes to registration and insurance requirements. She commenced practice as a ‘birth advocate’ working privately within the homebirth industry, providing services and charging for those. Although Ms Barrett denied that she was working as a midwife, the Deputy State Coroner held that she continued to perform the clinical tasks and clinical responsibilities of a midwife with respect to the intrapartum component of a homebirth, which followed on from the changes to the National Law services [3.8]. In her evidence to the Inquest, Ms Barrett admitted that she had handed in her registration in response to changes in the law. She was in fact still a registered midwife as at the date of Tate’s birth [9.14] but not at the time of the birth of the second of twins in South Australia on 7 October 2011, nor the second of twins born in Western Australia on 3 July 2011 [11.9]. The Deputy State Coroner expressed the view that he was not concerned in any of these inquests, viewed either separately or collectively, with the issue generally as to the desirability or otherwise, or appropriateness or otherwise, of homebirthing in cases involving low risk of an adverse outcome occurring in respect of the mother or the infant.

He was concerned that all three homebirths involved an enhanced degree of risk to the unborn infant which had been identified well before the deliveries took place. As such they ‘ought to have been manageable in a more appropriate clinical setting’ [3.2]. The Deputy State Coroner in fact went on to consider the evidence of a range of experts regarding the risks of homebirths and the philosophies espoused by both sides of the homebirth debate and to make some recommendations to official parties regarding the practice. After a consideration of the evidence, the Deputy State Coroner found ‘that Tate Spencer Koch’s cause of death was intrapartum hypoxia’ [4.2]. Some of the evidence relied upon in forming this conclusion was the evidence give by Dr Khong who conducted the autopsy. Dr Khong reported that ‘Tate was macrosomic with shoulder dystocia during delivery, that Tate had experienced peripartum asphyxia as evidenced by petechial haemorrhages on thymus, visceral pleura, pericardium and epicardium’ and also cites a finding of occipital osteodiastasis. He opined that macrosomic neonates are at risk for shoulder dystocia and birth trauma and that the risk increases substantially when the birth weight exceeds 4500g [4.4]. He recorded Tate’s birth weight as 4790g [4.5].

Although the cause of Tate’s death was essentially undetermined other than the risk factor associated with her large size [4.6], Dr Khong acknowledged ‘that the clinical circumstances associated with the child’s birth suggested that the asphyxia that was experienced was peripartum’. Furthermore, there were no abnormalities detected in the placenta or umbilical cord that may have resulted in the deprivation of oxygen during delivery. In his statement to the police, Dr Khong stated that from a clinical and pathological point of view the cause of death was ‘asphyxia ... caused by the hold up in the baby’s delivery through the birth canal’. This evidence as to the cause of death was accepted by the Deputy State Coroner [4.7]. Dr Khong also reported that at the post-mortem examination he found separation of the base of the skull and the top of the spine which he suggested could have happened during manoeuvres taken to overcome the shoulder dystocia [4.10]. The Coroner also accepted the evidence of a medical expert witness, Professor Pepperell, that ‘Tate died due to intrapartum hypoxia associated with the prolonged time interval between delivery of the head and delivery of the remainder of the baby’. This had been brought about by the infant being trapped within the birth canal due to a being a macrosomic baby with shoulder dystocia [4.9].

Conclusion
From the above series of cases it is now settled law in Australia that the born alive rule is satisfied whenever there are any indicia of life even when such sign indicates...
that the child is incapable of sustained life. Indicia of life may even be determined by pulseless electrical activity and when a child’s life has been sustained by mechanical ventilation. It can now be accepted that advances in medical science can be used to determine signs of independent life not possible at the time the rule was formulated. It is a matter of time as to whether different factual circumstances will come before the courts to determine whether medical technology has developed to indicate signs of life other than those involved in the above cases. A question could also be raised in those cases where there are not any traditional signs of life present at birth but there is no means or opportunity to test for pulseless electrical activity which may in fact be present.

The Deputy State Coroner did not find prima facie evidence of criminal activity with respect to the deaths of the three newborns. However, Coroners in all states are empowered by their respective legislations to make recommendations that they consider might prevent or reduce the likelihood of a recurrence of a similar event to the event that was the subject of the Inquest. As a result of the 2nd Inquest, the Deputy State Coroner made a number of recommendations regarding the issues raised in the case. The Deputy State Coroner was concerned inter alia that unregistered practicing midwives providing care for women having planned homebirths are essentially beyond the reach of the law [13.4]. It was his opinion that

…the practice of midwifery should be permissible only in the case of midwives registered under the National Law and that it ought to be regarded as an offence, punishable by law, for midwives to practice midwifery without registration with the Nursing and Midwifery Board of Australia pursuant to the National Law [13.8].

As a corollary to the above, the Deputy State Coroner recommended changes to legislation rendering ‘it an offence for a person who is not a midwife or registered medical practitioner to engage in the delivery of midwifery services, regardless of the venue’ [13.10]. There were other recommendations made to the authorities regarding the provision of homebirthing services in South Australia.

Education of the public was also an issue. According to the Deputy State Coroner:

there is a need for education of the general public in respect of the risks associated with certain types of childbirth within the home and in order to dispel what appear to be widely held myths concerning the circumstances in which these births are managed in hospital [13.13].

There were also concerns throughout the Inquest as to the extent that women contemplating homebirth were fully informed regarding the risks involved, particularly those in a higher risk category.

Each of the cases make extensive but interesting reading. The summary set out in this report provides just an overview of the progress of the cases and the outcomes. Each has a substantial analysis of the facts and of the law. Readers who are interested are encouraged to locate the relevant cases in full in order to appreciate the complexity of the issues to be resolved and how legal minds tackle medical issues that come before them.

References

