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At least 13 babies have died following so-called freebirths in Victoria over the past five years, while a further 11 have suffered potential lifelong brain injuries

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The Costs of Freebirth

In September 2025 a Melbourne influencer died during a freebirth – at home attended by a non-midwifery-trained birth attendant Ms Emily Lal (“the Authentic Birthkeeper”). The Coronial inquiry which followed heard that the deceased aged 30, had no prenatal care while pregnant, except for one visit to a GP for an initial blood test. The birth keeper has since been the subject of an Interim Prohibition Order based on information received by the Health Complaints Commissioner alleging that Ms Lal is facilitating and/or participating in homebirths which may put both mothers and babies at risk.

A “freebirth” is when a woman makes a conscious decision to give birth without the support of a registered health professional, such as a midwife or doctor registered with the Australian Health Practitioners Regulation Agency (AHPRA). An alternative term is “sovereign birth”

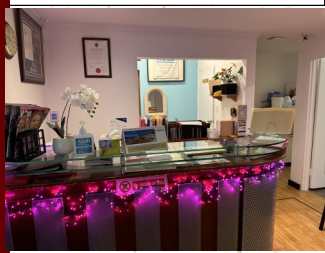
A “wildbirth” is where a mother eschews any antenatal care including routine blood tests, microbiological tests and ultrasounds which are wrongly considered to be the cause of miscarriage or fetal limb defects.

Not infrequently wildbirth or ‘sovereign birth’ may be followed by freebirth. Individuals choosing a “wild pregnancy” (no prenatal check-ups) frequently choose to continue that philosophy into birth, resulting in a freebirth where potential risks—such as breech presentation, twins or placenta praevia—are not detected beforehand. The reasons for freebirth choice include excessive costs or inability to recruit a private homebirth midwife; previous traumatic birth in hospital; limited in-hospital options for the mode of delivery with breech birth, twin birth or previous Caesarean section or the desire for autonomy during pregnancy and birth.

Traditional Birth Attendants are commonplace especially in the developing world. The WHO defines a TBA as a person who assists the mother during childbirth and initially acquired her skills by delivering babies herself or through apprenticeship to other traditional birth attendants. Their role was not limited to birthing but included antenatal care including the diagnosis of pregnancy, the use of herbal remedies for pregnancy related nausea and vomiting, determining malpositions of the fetus and to identify multiple pregnancies as well as to provide emotional support and elementary care in labour and the puerperium. The latter included support for breastfeeding. In Indonesia a Dutch nun, Jeanette Barten, adapted the traditional birth attendant model to include the provision of basic antenatal care and to act as a conduit to regional obstetricians when antenatal or intrapartum complications arose.

Maternal mortality in Australia in the early 1900’s was 600 deaths per 100,000 deliveries but that fell to 450/100,000 by 1937 due to advances in the use of ergometrine, blood transfusions, and antibiotics; better training; better anaesthesia; improved organization of obstetric services; less interference in normal labors; and the decline in virulence of the *streptococcus*.

Sulfonamides were introduced into clinical practice in 1939 and penicillin in the 1940’s & much of the initial rapid decline in maternal deaths is attributed to their use. Ergometrine was introduced in 1935 to prevent primary postpartum haemorrhage and the use of prophylactic oxytocin in the third stage of labour reduces the risk of PPH by 50%. Postnatal administration of vitamin K can virtually eradicate haemorrhagic disease of the newborn (VKDB). It is rare in developed regions due to routine prophylaxis, with an incidence of classic VKDB at 0.01%–0.44%. Without prophylaxis, the incidence rises to 0.25%–1.7%. Late-onset VKDB, often causing intracranial hemorrhage, affects 1 in 15,000–25,000 infants, primarily those exclusively breastfed who did not receive vitamin K.



The first reports of freebirth appeared in the late 1950s in the USA, at a time of high medicalization of childbirth and lack of maternity care choices. The latter included strict regulation of private homebirth midwifery care; inequitable access to independent homebirth midwives and restricted access to midwife-led care for women with risk factors. Disrespectful care is a well-known factor leading to avoidance of wanted care. During the Covid-19 pandemic beginning in March 2019 and continuing until May 2023 the imposed restrictions on movement led to a significant increase in demand for homebirth. For example, in the US there was a 20% increase in community births from 2019 to 2020. The high cost of homebirth midwives particularly in Australia where private homebirth fees can range from \$5,000 to over \$8,000 out-of-pocket pushed some parturients to choose freebirth with no professional birth attendants. Edwards, 1973 surveyed 18 US primiparous freebirthing women and found that 11 of those women eventually needed to be delivered in hospital. Maternal and newborn deaths are highest where access to quality, basic health services is obstructed due to a lack of infrastructure, health professionals, geographical challenges and transport, and displacement of people due to war or environmental disasters.

An insight into the consequences of a total lack of professional obstetric or midwifery care in labour in developed countries is found in the Indiana Faith Assembly mortality statistics: the maternal mortality rate was 872/100,000 live births for church members residing in the 2 counties vs. 9/100,000 for Indiana: a ninety-two-fold higher rate. However, in the US it is the birth location (home vs hospital) and not the birth attendant which determines neonatal mortality.

In Australia it is not illegal to arrange a homebirth without any qualified birth attendants. There is no law that makes it illegal for a woman to choose to birth at home alone, with her partner, or with friends/family, provided no one acts as a paid or professional birth attendant without proper qualifications. In some states, such as South Australia (s123A *Health Practitioner Regulation National Law (South Australia) Act 2010*) it has been an offence for anyone other than a registered midwife or medical practitioner to perform clinical tasks during childbirth, such as checking a baby's heart rate, doing vaginal exams, or managing the third stage of labour, unless the person is rendering assistance to a woman who is in labour or giving birth to a child, or who has given birth to a child, where the assistance is provided in an emergency. In Western Australia. Under the *Health Practitioner Regulation National Law (WA) Act 2010* (specifically section 123A), it is unlawful for an unregistered person to manage any of the three stages of labour or birth.

In NSW even unregistered health carers are subject to the provisions of the Public Health Act 1991 (NSW) which includes guidelines to ensure such persons practise in a safe and ethical manner, avoiding unwarranted claims to cure serious disease or illness, freely permitting consultation with registered medical practitioners, respecting the informed choices of their clients, avoiding financial exploitation of clients, avoiding misinformation of clients, respecting privacy of clients and maintaining contemporary records of client encounters.

Further Reading:

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- Rigg, Elizabeth & Schmied, Virginia & Peters, Kath & Dahlen, Hannah. (2017). The role, practice and training of unregulated birth-workers in Australia: A mixed methods study. *Women and Birth*. 30. 15. 10.1016/j.wombi.2017.08.038.
- Angela Gallo. "Freebirth movement called out for extremism as mothers share traumatic experiences" *ABC News* . 14 June 2025
<https://www.abc.net.au/news/2026-02-24/the-difference-between-a-homebirth-and-a-freebirth/106348232>
- RANZCOG "RANZCOG & ACM Call on Health Ministers to End Freebirth Deaths) November 3,2025
<https://ranzcof.edu.au/news/ranzcof-acm-call-on-health-ministers-to-end-freebirth-deaths/>