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Media statement

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Health Ombudsman releases report into the safety and quality of maternity services across Central Queensland Hospital and Health Service

Queensland's Health Ombudsman has today released a report into the safety and quality of maternity services across the Central Queensland Hospital and Health Service (CQHHS). The report presents the findings of a systemic investigation that began following several adverse incidents within the region, and the Health Ombudsman said today that CQHHS has made significant progress in improving its maternity service.

"The CQHHS Board has committed to providing safe, high quality maternity services for mothers and babies across Central Queensland," said Health Ombudsman Andrew Brown. "They continue to demonstrate innovation, energy and commitment to a continuous improvement journey and I feel confident that families will receive excellent care at all five maternity services providers in Central Queensland."

The investigation by the Office of the Health Ombudsman (the office) examined the quality and safety of maternity services at Rockhampton, Gladstone, Emerald and Biloela Hospitals and Theodore Multipurpose Health Service between 2015 and 2018, and in the resulting report, the office has made a number of recommendations to CQHHS.

Initially, the investigation focused on complaints received about serious incidents which had occurred at Rockhampton and Gladstone Hospitals, and while investigating, Mr Brown decided to expand the investigation to incorporate the five maternity services and their oversight. Broadening the scope of the investigation allowed the office to address outstanding concerns holistically.

"The investigation was part of my office's responsibility to promote high standards of service delivery by health service organisations and protect the health and safety of the Queensland public and was prompted by a small number of adverse events that had occurred in the region in 2015 and 2016," Mr Brown said.

"A small number of families experienced painful and/or tragic outcomes while receiving maternity care in hospitals in the CQHHS, the human impact of which is not to be diminished or forgotten. Adverse outcomes have an immense effect on all who are involved, including the health practitioners delivering the care," said Mr Brown. "However, the response to these incidents has demonstrated a commitment to continuous improvement to provide the best care for the women of Central Queensland."

With responsibility for the provision of safe and quality healthcare resting with the CQHHS Board and committees, during the investigation it became evident that there were areas in which the CQHHS Board could refine its clinical governance leadership.

The office has made four recommendations in four key areas in relation to the CQHHS's oversight of maternity services, which include development of a midwifery caseload transfer policy, refining their incident escalation procedures, ensuring robust oversight of the safety and quality governance chain, and ensuring clinician engagement in incident response.

“My recommendations made throughout the report are aimed at supporting CQHHS and the individual maternity services in their improvement journey,” said Mr Brown.

Across the CQHHS and five maternity services, the Health Ombudsman’s report makes 11 recommendations to prevent the recurrence of the adverse outcomes as far as practicable.

CQHHS has accepted all recommendations in the report.

“Overall, I am satisfied CQHHS is providing a safe and quality maternity service and one committed to continuous improvement and patient safety,” Mr Brown said.

“CQHHS is clearly rebuilding itself, with a more coordinated and focused strategic vision that aims to provide great care to Central Queenslanders. I am confident that the provision of maternity services across CQHHS, at any level of service, will continue to meet the community’s needs.”

CQHHS Chief Executive Steve Williamson said that the report’s findings were welcomed by CQHHS and reaffirm the actions already begun by the maternity services.

The office will continue to work with CQHHS in monitoring the recommendations through a collaborative approach, which will enable the Office of the Health Ombudsman to be more responsive to the changing nature of the health environment, while retaining an oversight role to ensure that the recommendations are fully and effectively implemented.

The full investigation report is available to download from the OHO website at www.oho.qld.gov.au.

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