OFFICE OF THE HEALTH OMBUDSMAN

Health service investigation—snapshot report

Investigation focus: Maternity and neonatal resuscitation care following the death of a baby - September 2023.

Wider learnings and recommendations for service improvements

The findings from this investigation highlight broader lessons for enhancing maternity and neonatal care, such as:

- **Importance of systematic oversight:** Robust oversight mechanisms are essential to ensure compliance with safety protocols, particularly in high-risk areas such as neonatal resuscitation.
- **Team-based training:** Effective teamwork and clear communication are critical during high-pressure situations. Training programs should prioritise these skills to improve outcomes.
- **Documentation as a quality foundation:** Comprehensive, accurate and timely clinical documentation is fundamental for reconstructing events, ensuring accountability, and driving quality improvement.
- **Equipment traceability:** Maintaining clear records of equipment checks and functionality is vital for ensuring readiness and compliance with safety standards.

Background

The Office of the Health Ombudsman (OHO) commenced a systemic investigation following a complaint about maternity services provided to a mother and a newborn baby. The investigation was conducted in the context of a baby's death, and the OHO acknowledges the significant loss experienced by the family.

Issues investigated

The investigation examined key areas, including:

- Staffing levels at the time of induction of labour and resuscitation
- Neonatal resuscitation
- Resuscitation equipment
- Clinical documentation.

Key findings

The key findings from the investigation were as follows:

Strengths and areas of compliance

- Maternity staffing levels during the relevant period complied with rostering practices, the hospital's business planning framework, and the Clinical Services Capability Framework (CSCF).
- Clinical support needs were appropriately recognised and escalated, with paediatric and senior clinical staff present or arriving within expected timeframes in line with clinical guidelines and frameworks.
- All personnel involved in the birth and resuscitation were appropriately trained according to organisation policies and guidelines.

- Equipment used during labour was in working condition, with no reported faults, and any functionality issues with resuscitation equipment were promptly identified and managed.

Opportunities for Improvement

- Enhanced team-based resuscitation training is required, with a focus on communication under pressure, and family support during critical incidents.
- Neonatal resuscitation equipment checks were not consistently completed in line with best practice, despite processes being in place.
- Gaps in clinical documentation were identified, limiting the ability to fully reconstruct events and confirm adherence to clinical guidelines.

Recommendations

The investigation identified several opportunities for systemic improvements that support continuous quality improvement. Key recommendations included:

- **Neonatal resuscitation equipment:** Ensure checking procedures align with state guidelines, are clearly defined in policy, consistently documented, and supported by appropriate oversight mechanisms.
- **Resuscitation training:** Review and enhance resuscitation training programs to reinforce teamwork, communication, and family support during critical incidents.
- **Clinical documentation:** Strengthen clinical documentation practices to ensure accurate, timely, and comprehensive recording of clinical assessments, interventions, and equipment checks.
- **Equipment traceability:** Improve the traceability of clinical equipment and associated equipment checks to provide assurance of compliance with safety protocols.

These recommendations aim to address identified gaps, mitigate risks, enhance accountability, and strengthen clinical governance.

Implementation and ongoing monitoring

It was also noted that the health service has since implemented actions to address the recommendations arising from both its internal review and the OHO investigation. Governance processes have been strengthened to monitor progress and support ongoing improvements in the delivery of safe and high-quality care.