OFFICE OF THE HEALTH OMBUDSMAN

Health service investigation—snapshot report

Investigation focus: Maternity care, neonatal resuscitation and family support following the death of a baby (November 2025)

Wider learnings and recommendations for service improvements

The investigation found the antenatal, intrapartum, and delivery care provided was consistent with relevant guidelines and standards.

The investigation highlighted the importance of a trauma informed and person-centred approach towards consumers and identified opportunities for improvement by proposing recommendations relating to:

- Targeted training initiatives with particular focus on providing trauma informed care and bereavement care.
- Strengthening bereavement support with emphasis on improved, timely communication including follow up with grieving families.
- Management of clinical incidents and adverse outcomes, with enhanced open disclosure processes, ensuring proactive engagement with the consumer and their family.

The investigation also identified the importance of services collaborating closely with affected families to develop improved clinical care guidelines that address identified gaps, and highlights the importance of listening to consumers to understand their priorities and perspectives when responding to a consumer's circumstances.

Background

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

Issues investigated

The investigation reviewed aspects of clinical care provided as well as relevant elements of the Hospital and Health Service's (HHS) clinical incident management and open disclosure processes in response to the adverse event, including:

- Care and treatment provided by maternity services during pregancy, delivery and post natal period.
- Neonatal resuscitation of the baby.
- The adequacy of incident management and open disclosure processes in responding to the adverse event.

The systemic investigation did not seek to address or determine the cause of the baby's death, as this responsibility falls within the coroner's remit.

Key findings

The key findings from the investigation were as follows:

- Clinical Care
  - The investigation reviewed the antenatal, intrapartum, and delivery care provided, finding it to be consistent with relevant guidelines and standards.

  - Some variances from standard protocols were identified, along with several issues requiring the service's attention.
  - The investigation also noted the development of statewide guidelines on prolonged/obstructed labour to address issues identified by the family and the service in this matter.
  - The attempts to resuscitate the baby were unsuccessful, with unavoidable delays due to difficulties obtaining vascular access which is a recognised challenge in neonatal care. The investigation found that the neonatal resuscitation was managed according to the applicable guidelines.
- Clinical Incident Management and Open Disclosure
  - Whilst it was acknowledged that HHS staff had made attempts to contact the family prior to an open disclosure process, the family's loss was compounded by their experience during the immediate post-natal period, and at the time of discharge, where they felt that more proactive offers of counselling and clearer communication about the next steps would have been beneficial.
  - The HHS followed procedural requirements for incident investigation and open disclosure. However, the family's experience and feedback identified important ways to improve trust, transparency, and communication with affected families by adopting a more trauma-informed and supportive approach.

Recommendations

The investigation findings highlight areas for the health service to make systemic improvements to enhance confidence in the service for expectant families, contribute to a more effective and compassionate response to clinical incidents in the future and to support continuous quality improvement, including:

- Targeted training – addressing documentation requirements, maternity specific clinical guidelines, compliance with mandatory training, trauma-informed care, bereavement care, and coronial processes.
- Strengthening responses to bereavement and the care provided to consumers following loss through enhanced communication, timely provision of information, establishing consistent follow-up procedures to offer ongoing support and resources to grieving families.
- Enhancing clinical incident management and open disclosure processes to improve trust, support and communication through improving documentation and communication pathways, and establishing a more structured approach to patient and family engagement, including pro-active follow up and support.

These recommendations aim to enhance staff capability, strengthen communication, and ensure clearer processes, enabling the health service to foster greater transparency, trust and consistency in its interactions with patients and families.

These improvements will support improved patient outcomes, a more compassionate bereavement response, and a more effective incident management process.