

Inquest into the death of Preston Paudel

Preston Paudel, a newborn infant, died at the Mater Mothers Hospital on 13 October 2009 of global hypoxic-ischaemic encephalopathy. Preston had been deprived of oxygen during his birth at the Toowoomba Hospital two days earlier.

Coroner John Lock delivered his findings of inquest on 25 October 2012.

The Queensland Government responds to recommendations directed to government agencies at inquests by informing the community if a recommendation will be implemented or the reason why a recommendation is not supported.

Further information relating the implementation of recommendations can be obtained from the responsible agency named in the response.

Recommendation 1

The cardiotocography (CTG) assessment sticker adopted by Toowoomba Hospital appears to be a comprehensive tool to provide an interpretation of the CTG. Given the issue of a CTG interpretation has arisen in other inquests, I agree with Ms Marten's submission and make a recommendation that Queensland Health consider the implementation of this sticker at all hospitals throughout the state.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

On 21 January 2016 the Minister for Health and Minister for Ambulance Services responded:

The Department of Health implemented the coroner's recommendation by considering the use of the cardiotocography (CTG) sticker, adopted by Toowoomba Hospital, for hospitals around the state.

The Patient Safety Unit issued a patient safety notice to all hospital and health services in November 2014 highlighting incidents involving CTG interpretation. The use of tools such as stamps or stickers, to assist with CTG interpretation and prompt escalation of abnormal results was recommended. Additional recommendations included: education for all midwives, registrars and obstetricians on the clinical guidelines for fetal surveillance; CTG interpretation and graded assertiveness.