Inquest into the death of Baby M

Baby M died a few hours after birth at the Gladstone Base Hospital on 11 February 2016. Baby M was born in poorly condition with sepsis and suffered an injury when a nurse fell whilst carrying to her to another birthing suite.

Coroner David O'Connell delivered his findings of inquest on 21 September 2018.

The departments named in this response will provide implementation updates until the recommendation is delivered. Further information relating the implementation of recommendations can be obtained from the responsible minister named in the response.

Recommendation 1
Resuscitation tables never use an adapter, and that proprietary brand resuscitation masks only be used on that brand's resuscitation table.

Response and action: the recommendation is agreed in part and implementation is in progress.

Responsible agency: Queensland Health.

On 2 June 2019 the Minister for Health and Minister for Ambulance Services responded:

Queensland Health is considering the coroner's recommendation as it relates to current and future resuscitation medical equipment supplies. A working group comprised of clinicians from Queensland neonatal services advisory group was established to assess potential implementation issues for hospital and health services.

Queensland Health is currently progressing new tender arrangements for infant and maternity care equipment, this includes resuscitation tables and specific resuscitation equipment. The tender specifications will clearly stipulate that offers for resuscitation tables must be accompanied by offers to supply fully compatible accessories and consumables without the use of an adaptor. The Strategic Procurement Branch will coordinate and manage the request for offer process and evaluate tender submissions for the supply of resuscitation tables.

The working group will identify issues and develop advice on the use of adapters in hospital and health services.

On 11 December 2019 the Minister for Health and Minister for Ambulance Services responded:

Queensland Health will seek to eliminate the use of circuit adapters with the introduction of revised procurement specifications embedded in a new standard operating requirement.

The infant and maternity care equipment specification documents for the request for offer, including the supply of infant resuscitation systems, was prepared and was advertised for tender during the second half of 2019. The specification documentation clearly stipulated that all mobile and fixed wall-mounted resuscitation tables must be accompanied by offers to supply original equipment manufacturer options/accessories and proprietary consumables and that compatibility must be demonstrated by the suppliers at the time of evaluation and/or via trials prior to consideration for award.

Until equipment supplies are replaced, existing infant resuscitation systems may rely on the use of an adapter due to the broad range of different proprietary brand equipment in use. To ensure the safe use of equipment,

a patient safety communique is currently in development and will request that two-piece tubing and 'T' piece adapter are not used and are replaced with a closed-circuit system. The communique will be circulated across all Queensland Health hospital and health services.

The Queensland Neonatal Services Advisory Group is considering the application of a standardised neonatal resuscitation equipment checklist that would provide a tool for confirming the required neonatal resuscitation equipment is available and operational for each birth. The checklist will include the identification of adaptors and enable potential risks associated with their use to be mitigated.

Queensland Health will finalise of the tender process and supply of resuscitation tables with fully compatible accessories and consumables. Queensland Health will develop and distribute standardised equipment checklist to support the safe and correct operation of resuscitation equipment prior to each birth.

On 3 June 2020 the Deputy Premier and Minister for Health and Minister for Ambulance Services responded:

Queensland Health Strategic Procurement introduced revised specifications to the Infant and Maternity Care Standing Offer Arrangement (SOA). It is now a requirement of the equipment offered that accessories and consumables are to be original equipment manufacturer proprietary products.

The change to resuscitation equipment available via the SOA ensures that hospital and health services (HHSs) have a mechanism to purchase proprietary brand airway circuits, thereby removing the need to have spare outlet adapters in stock.

Queensland Health distributed the Patient Safety Communique – *Coronial recommendations to reduce the risk of resuscitation equipment incompatibility* across all HHSs in December 2019. The communique outlined multiple actions for HHSs to undertake to ensure the coroner's recommendation and findings are fully considered, including:

- perform audit of resuscitation airway equipment to identify the use of two-piece tubing and outlet adapter setup, and implement appropriate risk mitigation strategies including replacing two-piece tubing and adapter setup with a closed-circuit ventilation system
- perform audit of the routine practice of checking resuscitation equipment to identify compliance with checking schedule (each shift, daily, weekly) and implement corrective action where audit results indicate opportunity for improvement
- report clinical incidents and 'near misses' where resuscitation equipment is unavailable, incomplete, malfunctioning or not fit for purpose.

The Queensland Neonatal Services Advisory Group is developing a statewide standardised neonatal resuscitation equipment checklist that will complement the implementation of routine quality and safety processes.

On 2 October 2020 the Deputy Premier and Minister for Health and Minister for Ambulance Services responded:

The Queensland Neonatal Services Advisory Group has developed the statewide standardised neonatal resuscitation equipment checklist and is currently consulting with neonatal retrieval and education services to arrange publication of the checklist.

Recommendation 2
A bassinet and trolley be available in each birthing suite, and the baby is only to be transported from a room by the use of a bassinet and trolley.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

On 2 June 2019 the Minister for Health and Minister for Ambulance Services responded:

Queensland Health established a working group comprised of clinicians from Queensland neonatal services advisory group to determine an appropriate response to the recommendation.

Queensland Health will develop and distribute a communique to all hospital and health services recommending safe transporting practices of neonates.

On 11 December 2019 the Minister for Health and Minister for Ambulance Services responded:

The patient safety communique – Safe handling and transport of a baby/neonate/infant – was developed and circulated across all Queensland Health hospital and health services. The communique reinforces the requirement to transport a baby in an infant cot or Resuscitaire and ensure equipment is available in areas where a transfer may be required, such as an emergency department, birth suite and operating theatre.

Recommendation 3
Expectant mothers be informed about the incidence and issues relating to group B streptococcal disease, and encouraged to have screening conducted, if they choose.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

On 2 June 2019 the Minister for Health and Minister for Ambulance Services responded:

Queensland Health developed and published in 2015 the *Queensland clinical guideline on early onset group B streptococcal disease* (EOGBSD) and parent information on group B streptococcus (GBS) in pregnancy. All hospital and health services were notified at the time of publication.

The Queensland clinical guideline supports the coroner's recommendation to inform pregnant women about GBS and EOGBSD as evidenced by the following recommendations contained within the guideline (Section 1.3 clinical standards):

- discuss EOGBSD and intrapartum antibiotic prophylaxis (IAP) with women during the antenatal period in a manner that supports informed decision making
- document the discussion and decisions about IAP in the healthcare records (including handheld pregnancy health record)
- confirm decision prior to any healthcare intervention as per routine practice
- routinely provide written information about GBS and EOGBSD to women during the antenatal period—refer to Queensland clinical guidelines parent information about EOGBSD.

The Queensland clinical guideline parent information on GBS provides information about the transmission of GBS, the incidence in Queensland, the approach recommended in Queensland (risk factor approach) and prevention strategies.

The parent information and clinical guideline are freely available to download and/or print from the Queensland Clinical Guidelines website.

The minister recognises that the risk factor approach for the management of EOGBSD (as opposed to the universal screening approach) was endorsed as the preferred recommendation for women in Queensland after extensive review of the evidence and statewide consultation:

- Increased compliance to a single approach is likely to achieve a greater reduction in the incidence of EOGBSD than either using both approaches together or changing the approach. Therefore, the risk factor approach should continue to be preferentially recommended to women in Queensland.
- Recent evidence supports the effectiveness of the risk factor approach in Queensland (Chen J, et al. 2018. *Early-onset group B streptococcal disease in a risk factor-based prevention setting: A 15-year population-based study*, ANZJOG;1–8. DOI: 10.1111/ajo.12891).
- The guideline recognises that screening may be preferred by some women and supports informed choice, stating 'If requested, GBS screening at 35–37 weeks gestation may be appropriate for individual women—offer information about the implications of the GBS screening test'.