Inquest into the death of Samara Hoy

On the evening of 8 November 2008, Samara Hoy, a newborn baby, died at the John Flynn Private Hospital from birth asphyxia after a prolonged labour during which the umbilical cord became tightly wrapped around her neck.

Coroner John Hutton delivered his findings of inquest on 5 April 2011.

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

The department 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- access and availability of adequate antenatal information and classes
All women should have access to balanced antenatal information and classes clearly outlining normal and abnormal labour, when intervention may be required and why it may be necessary. The classes should clearly outline:

- the possible risks of the intervention and the possible risks of not utilising the intervention method
- that the parents should be encouraged to raise any issue, discuss and ask any questions they feel an inclination to during the classes, pregnancy and labour
- the circumstance of the attendance of each medical professional during labour so that the parents are more likely to have an understanding of the expectation of the attending medical professional.

The classes should involve both midwife and obstetric facilitation.

Response and action: implementation of the recommendation is in progress.

Responsible agency: Queensland Health

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

Since the establishment of independent hospital and health services on 1 July 2013, each hospital and health service is now principally responsible for providing public health services within their own service areas. The department forwarded this recommendation to all hospitals and health services to consider and to provide advice to the department about the availability of antenatal information and classes in their health service.

Hospital and Health Services continue to report on the progress of their implementation to the Department of Health. An update on implementation will be provided in 2016.

On 10 May 2016 the Minister for Health and Minister for Ambulance Services responded:

The Patient Safety and Quality Improvement Service have reaudited hospital and health services to determine the progress on implementation of access and availability of adequate antenatal information and classes as per the coroner's recommendation.

The outcomes of the audit will be provided in 2016.