BABY B (NAME SUPPRESSED)

Baby B died as a newborn following a home birth assisted by the Community Midwifery Program (CMP). Baby B was born floppy and not breathing. Following transfer to Princess Margaret Hospital and several days of review and testing with very poor prognosis, Baby B was palliated at home. The coroner reviewed the dissonance between obstetric advice recommending hospital birth, and events leading to the CMP supporting a home-birth.

The Department of Health's Coronial Review Committee reviewed these findings and directed the recommendation to the appropriate stakeholders for review and response.

The Women and Newborn Health Service has reported that a number of changes have been undertaken since the death of Baby B. Effective 1 July 2015; the Community Midwifery Program (CMP) has been realigned and now comes under the governance of the Obstetrics and Gynaecology Clinical Care Unit of KEMH. The mandatory obstetric review is documented in the patient record and is signed by the obstetrician reviewing the mother. A new 'Non-standard Management Plan' sticker alerts staff when a woman has declined to accept the management plan recommended by the obstetrician – this is signed by both the woman and the obstetrician.

Further strategies to improve practices, governance and evaluation of services have also been implemented, including: a review of the CMP inclusion criteria; review of the home to hospital transfer guidelines; role of the support midwife has been clarified; introduction of formal policy about recording and handling of correspondence; scope of practice included in orientation, education and performance appraisal program; improvements to the CMP orientation program; neonatal resuscitation education requirements; and, improvements to ongoing audits and monitoring of CMP inclusion against the criteria, referral forms and the clinical handover process.

The coroner's recommendation has now been reviewed and actioned appropriately and marked as complete.