Failure to refer newborn for specialist review (14HDC00088, 8 December 2015)

Community-based midwife ~ Newborn baby ~ Referral ~ Blood sugar level ~ Dehydration ~ Weight loss ~ Referral guidelines ~ Right 4(1)

A baby who was born in good condition experienced unstable blood sugar levels in the immediate post natal period. His levels stabilised, and he was discharged home under the care of a midwife, who worked as part of a larger group of midwives.

On the third day home the midwife weighed the baby and identified a 770g weight loss since birth (16.7%). The midwife noted that this weight loss was "excessive" and assessed the baby, but did not identify any other issues of concern. The midwife put in place a plan for regular feeding and to re-weigh the baby in three to four days' time. The midwife then contacted her colleague, a senior midwife, who agreed with the plan. The midwife then went away on planned leave.

Three days later the first midwife contacted her back-up midwife to ask her to reweigh the baby that day. However, the back-up midwife was still on leave so the midwife contacted the senior midwife and asked her to re-weigh the baby in the backup midwife's absence. The senior midwife telephoned the mother and asked her how the baby was doing. The midwife was reassured that the baby was well, and made a plan for the back-up midwife to visit later in the week.

Two days later the senior midwife provided a handover to the back-up midwife advising that the baby was well and needed a visit in the next two days. The back-up midwife subsequently arranged to see the mother and baby in one day. However, that evening the mother contacted the back-up midwife expressing concern that the baby was lethargic and difficult to feed. The back-up midwife contacted the on-call paediatrician and arranged for the baby to be assessed at the hospital.

The baby was later assessed by the on-call paediatrician and noted to be 3.5kg (a 22% weight loss since birth). The baby was admitted to the neonatal intensive care unit (NICU) and found to have severe dehydration, hypernatraemia, and intracranial haemorrhage. Sadly, he died.

It was held that by failing to recommend a consultation with a specialist when the baby was noted to have had a greater than 10% weight loss, and putting in place an inadequate plan to manage and re-check him, the first midwife failed to provide services with reasonable care and skill and, accordingly, breached Right 4(1).

It was also held that by failing to assess the baby in person and re-weigh him, relying instead on the information provided by the mother over the telephone, and by failing to provide timely handover to the back-up midwife, the senior midwife failed to provide services with reasonable care and skill and, accordingly, breached Right 4(1).

Criticism is made of the back-up midwife's failure to follow up with the mother in a timely manner. Criticism is also made of the DHB's failure to ensure that staff were aware of the recommended management for a newborn with unstable blood sugar levels.