CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Serena Lee
Hearing dates:	24 November – 4 December 2025[1]
Date of findings:	17 March 2026
Place of findings:	Coroners Court of New South Wales at Lidcombe
Findings of:	Deputy State Coroner, Magistrate Hosking
Catchwords:	CORONIAL LAW - Midwifery Support Program; early discharge of babies; consultation as between doctors and midwives on neonatal wards; hypoglycaemia; intrauterine growth restriction; head sparing growth patterns; small for gestational age.
File number:	2021/310546
Representation:	Mr Matthew Robinson, Counsel Assisting, instructed by Ms L Shepherd and Ms Z Carter (Crown Solicitor's Office) Serena's parents, Mary-Grace Alger and Xcent Zan Lee (unrepresented) Mr Patrick Rooney, instructed by McCabes, for South Western Sydney Local Health District and Dr Danesh Hewa-Gamage Mr Neale Dawson, NEW Law, instructed by New South Wales Nurses and Midwives' Association, for

[1] This inquest was heard concurrently with the Inquest into the death of Gia Lam. The common issue was that Gia Lam and her baby were also discharged onto the Midwifery Support Program operating within the South Western Sydney Local Health District.

registered midwives Catherine Faulds and Fay Marshall

Statutory findings:

Identity of deceased: Serena Lee

Date of death: 1 November 2021

Place of death: Campbelltown Hospital, Campbelltown in New South Wales

Cause of death: Serena died from obstructive sleep apnoea occurring in the context of significant, unrecognised hypoglycaemia associated with intrauterine growth restriction.

Manner of death: Serena's death was preventable. She died following her premature discharge from Campbelltown Hospital onto the Midwifery Support Program in circumstances where her discharge was contrary to hospital policy and she was inappropriately identified as low risk. Those responsible for her discharge failed to identify or take into account that she was small for gestational age, that she had intrauterine growth restriction with a head-sparing growth pattern and that she was at risk of hypoglycaemia.

Recommendations:

To the South Western Sydney Local Health District (**SWSLHD**):

1 That the SWSLHD conduct an audit to ensure that the equipment identified in the Midwifery Support Program (**MSP**) Policy as available to midwives on the MSP is available, working and properly calibrated, and that staff are trained in the use of it.

2 That the SWSLHD immediately ensures that material relied on by MSP midwives and handed out or shown to new parents is up-to-date and consistent with current best practice.

3 That the SWSLHD consider further amendment to the MSP policy to provide guidance as to the circumstances in which a neonate's blood glucose level should be monitored, inclusive of consideration of requiring or recommending monitoring where there have been two successive feeds missed.

4 That the SWSLHD consider undertaking a review of the MSP Policy including seeking input from midwives currently working in the MSP with a view to amending the MSP Policy to exclude patients which, from the perspective of the midwives, are not considered to be low risk.

To the President of the Medical Council of NSW:

1 I recommend that consideration be given to the Medical Council of NSW reviewing and/or investigating Dr Danesh Hewa-Gamage's care of Serena, and his decision to discharge her.

I direct that a copy of the brief of evidence and transcript of the coronial inquest be forwarded to the President of the Medical Council of NSW.

Introduction

1 These are the findings of an inquest into the circumstances of the death of Serena Lee, the much loved and welcomed first baby of her parents, Zan and Grace.[2]

2 While Serena had been Zan and Grace's daughter for her months in utero, she was born on 31 October 2021 and died, tragically, at approximately 2pm on 1 November 2021, at Campbelltown Hospital, Campbelltown.

The role of the coroner

3 The role of the coroner is to make findings as to the identity of the nominated person and in relation to the place and date of their death. The coroner is also to address issues concerning the manner (circumstances) and cause of the person's death.[3] A coroner may make recommendations, arising from the evidence, in relation to matters that have the capacity to improve public health and safety in the future.[4]

4 This inquest was held because of uncertainty surrounding Serena's cause of death and concerns surrounding the care and treatment provided to Serena and her mother from the period of her birth to her tragic death.

The issues examined in the inquest

5 The issues identified in the coronial investigation to be examined at the inquest are outlined below.

(1) Findings required pursuant to section 81 of the *Coroners Act* 2009 (NSW).[5]

[2] Serena's parents' names are Xcent Zan and Mary-Grace. They are known as Zan and Grace.
[3] s 81 of the *Coroners Act 2009* (NSW) (**the Act**).
[4] s 82 of the Act.
[5] While it was clear before the inquest that the person who died was baby Serena and that she died on 1 November 2021 at Campbelltown Hospital, the inquest explored more broadly the cause and manner of her death.

(2) Whether the SWSLHD policies in relation to early discharge following birth and the monitoring of glucose levels and assessment of hypoglycaemia in newborns were adequate and adhered to.

(3) Whether the early discharge of Serena was appropriate.

(4) Whether Serena had any diagnosable signs or symptoms of illness which could or should have been detected during the period of her hospitalisation following birth.

(5) The reasonableness of the MSP review conducted by registered midwives Catherine Faulds and Fay Marshall, including:

    (a) whether Serena should have been referred to hospital?

    (b) whether Serena's blood glucose level should have been measured during the review?

    (c) whether any of Grace's pre-existing health conditions caused or contributed to Serena's death.[6]

(6) Whether RM Faulds and/or Marshall were shown any videos of Serena in respiratory distress and, if so, whether action should have been taken in response to those videos.[7]

(7) Whether it is necessary or desirable to make any recommendations in relation to any matter connected with Serena's death.

[6] The coronial investigation did not reveal any evidence that suggested that any pre-existing condition of Grace's (and in particular her multiple sclerosis) contributed to Serena's death. It was made clear during the opening given by Counsel Assisting that this was not an issue that was to be explored in the course of the inquest as it had been 'ruled out' in the investigation stage.

[7] While Zan said in his statement that the footage was shown to the attending midwife/s, Faulds and Marshall denied seeing it. I did not require Zan to give evidence at the inquest and therefore his evidence is untested and I am unable to make a finding as to whether the footage was shown to the midwives. The footage was available to the experts in their analysis.

The evidence

6 A four-volume brief of evidence was tendered to the Court. I was also provided with a statement of 'Agreed Facts' in relation to Serena's background and death. I accept that this document accurately summarises much of the important evidence before me. I adopt its content and have incorporated it into my written reasons.

7 Oral evidence was adduced at the inquest from:

(1) Julie McConachie, clinical nursing unit manager, Campbelltown Hospital

(2) Dr Denesh Hewa-Gamage, Paediatric Resident Medical Officer Campbelltown Hospital

(3) Catherine Faulds, RM,[8] MSP

(4) Fay Marshall, RM, MSP

(5) Kate Pigott, Clinical Midwifery Consultant, Royal North Shore/Ryde Hospitals

(6) Dr Andrew McPhee, senior consultant neonatologist (retired)

(7) Scott McDonnell, Director of Nursing and Midwifery at Camden and Campbelltown Hospitals.

Findings and recommendations

8 Having reviewed all of the evidence and submissions in this inquest, my findings follow.

(1) I find that Serena died on 1 November 2021 at Campbelltown Hospital from Obstructive Sleep Apnoea (**OSA**) occurring in the context of

[8] Registered Midwife.

significant, unrecognised hypoglycaemia associated with intrauterine growth restriction (**IUGR**).

(2) Serena's death was preventable if she had remained in hospital, been appropriately monitored and treated for hypoglycaemia in accordance with the SWSLHD Neonatal Hypoglycaemia Management Guidelines[9] (**NHM Guidelines**).

(3) I find that Serena should have been identified as an infant at risk, requiring glucose monitoring and further observation, who accordingly was not suitable for discharge. Clear policy triggers for glucose monitoring were missed; and Serena's death was preventable with timely and appropriate neonatal care.

(4) I find that Faulds and Marshall ought to have recognised that Serena had fed poorly and ought to have considered that she may therefore have been at risk of hypoglycaemia.

(5) I find that had Serena's blood glucose level been tested, she would have been found to be hypoglycaemic. However, contrary to the MSP policy then in force, MSP midwives did not have access to glucometers at the time as they did not become available within the program until about a year after Serena's death.

(6) I find that Faulds and Marshall demonstrated substantial insight into the shortcomings in their assessment of Serena. It was very clear that Serena's death has had a significant impact on them both.

(7) It is not clear whether a prompt and accurate assessment of Serena's risk of hypoglycaemia by Faulds or Marshall arriving at 10am on 1 November 2021 could have prevented Serena's death. There was, however, a missed opportunity to improve her prospects of survival.

[9] October 2020.

9 Having reviewed all of the evidence and submissions in this inquest, I make the recommendations that follow.

To the SWSLHD:

(1) That the SWSLHD conduct an audit to ensure that the equipment identified in the Midwife Support Program (**MSP**) Policy as available to midwives on the MSP is available, working and properly calibrated, and that staff are trained in the use of it.

(2) That the SWSLHD immediately ensures that material relied on by MSP Midwives and handed out or shown to new parents is up-to-date and consistent with current best practice.

(3) That the SWSLHD consider further amendment to the MSP policy to provide guidance as to the circumstances in which a neonate's blood glucose level should be monitored, inclusive of consideration of requiring or recommending monitoring where there have been two successive feeds missed.

(4) That the SWSLHD consider undertaking a review of the MSP Policy including seeking input from midwives currently working in the MSP with a view to amending the MSP Policy to exclude patients which, from the perspective of the midwives, are not considered to be low risk.

To the President of the Medical Council of NSW:

(1) I recommend that consideration be given to the Medical Council of NSW reviewing and/or investigating Dr Danesh Hewa-Gamage's care of Serena, and his decision to discharge her.

I direct that a copy of the brief of evidence and transcript of the coronial inquest be forwarded to the President of the Medical Council of NSW.

Background

Grace's pregnancy

10 Grace fell pregnant with Serena in February 2021 with an expected date of confinement of 11 November 2021.

11 Grace took a pregnancy multivitamin (Elevit) from the beginning of her pregnancy, vitamin D in the second trimester, and an iron supplement at the end of the second or beginning of the third trimester.

12 Grace attended appointments for fetal ultrasound at Gregory Hills Medical Centre and antenatal appointments at Campbelltown Hospital. There were no abnormalities detected during antenatal imaging and Serena was considered to be developing normally. The antenatal course was unremarkable. A low vaginal swab for Group B Streptococcus (GBS) was requested at the time of an antenatal visit at circa 35 weeks' gestation, with a negative result documented at the time of an antenatal visit at 37 weeks' gestation.

13 In the third trimester, Serena exhibited faltering intrauterine growth, with serial ultrasound estimates and birthweight indicating a downward trajectory across centiles:

(1) an obstetric ultrasound performed on 3 September 2021, at 30 weeks' gestation, reported an estimated fetal weight (EFW) of 1600 gm (53rd centile for 30 weeks' gestation); and

(2) an obstetric ultrasound performed on 6 October 2021, at 35 weeks' gestation, reported an EFW of 2460 gm (38th centile for 35 weeks' gestation).

14 On 30 October 2021, Grace experienced mild contractions which she believed to be Braxton Hicks contractions.

31 October 2021

15 Grace's membranes spontaneously ruptured at 1am on 31 October 2021. Zan called Campbelltown Hospital and was advised to monitor the frequency of contractions. At around 2am Zan contacted the Hospital again as the time between contractions had reduced and he was advised to present with Grace to Campbelltown Hospital. Grace and Zan arrived at the Hospital at approximately 2.15am.

16 Shortly after their arrival, CTG[10] was commenced. Deceleration of the fetal heartbeat was noted. On examination Grace was fully dilated 'with presenting part at spines'.[11] Grace was transferred to a birthing suite. A fetal scalp electrode was placed. Further decelerations were observed which were found to be deeper than the first. The fetal heart rate was taking longer than anticipated to recover following the decelerations. The decision was made to expedite delivery. Grace was instructed to push.

17 Serena was born vaginally at 3.23am. APGARs of 9 at 1 minute and 9 at 5 minutes were recorded. Serena cried at birth. The placenta, with complete membranes, was delivered. There was an estimated blood loss of 300 ml. Serena was noted not to have passed meconium or urine.

18 Serena's birthweight was 2485 grams, which is between the 5th and 10th centile for 38 weeks' gestation and below the 10th centile on the personalised GROW chart[12] used at Campbelltown Hospital.

19 Based on the WHO/Fenton growth charts, Serena's birthweight plots on circa 5th centile, length (47.5 cm) on the 25-50th centile and head circumference (34 cm) on the 50th centile for a gestational age of 38+3 weeks.

20 Overall, Serena's birthweight plots below the 10th centile, being small for gestational age (**SGA**). Her growth centiles demonstrate discordant or

[10] Cardiotocography, monitoring of the baby's heartbeat.
[11] Often referred to as the baby being 'engaged'.
[12] Personalised for ethnic background, BMI and parity.

asymmetric growth, also referred to as 'head sparing'[13] growth restriction, with weight centile well below centiles for length and head circumference. The results suggest significant IUGR, with an element of progressive placental dysfunction being the likely mediator. The reduced subcutaneous fat layer (2 mm) as described at the time of the autopsy further supports this assessment.

21 Observations of Serena at 4am included respiratory rate of 44 breaths per minute, oxygen saturations of 100% on room air, heart rate of 150 beats per minute, and temperature of 36.6˚ C.

22 A newborn risk assessment at 4.55am by RM Julie Mitford identified no risk factors in respect of Serena, nor any signs of clinical deterioration.

23 In relation to Serena's condition at the time of transfer from the Birth Unit to the Post Natal Ward within Campbelltown Hospital, of note:

(1) hearing test passed in both ears

(2) she was breastfeeding at the time of discharge

(3) she was born 10 days early

(4) she had hyper-flexed feet bilaterally.

24 At 5am an assessment of maternal risk factors was undertaken by RM Tyare Hampton. The progress note reflects that there were no risks identified.

25 At 5.06am, Grace was noted to be breastfeeding Serena, and a suck code of 6 was recorded, suggesting Serena latched well with rhythmical sucking for greater than 15 minutes. Serena breast fed well from both breasts for a period of more than one hour.

[13] Where the head circumference and length of a baby are considered normal but their weight is disproportionately low by comparison.

26 At 6.44am, RM Hampton recorded that prior to transferring Grace to the Postnatal Ward, Grace expressed a desire to be discharged home. A discussion with both Grace and Zan followed, and they both confirmed they wanted to be discharged home directly from the Birthing Unit. To be clear, while this desire was expressed, there was no evidence or suggestion that Grace and Zan would have pressed to be discharged if they were advised that it was inappropriate or unsafe.

27 At 7.36am, Dr Denesh Hewa-Gamage conducted a 'blue book check'[14] and completed a newborn discharge summary. He identified no issues in respect of Serena.

28 At 10.15am on 31 October 2021, just under 7 hours from Serena's birth, Grace and Serena were discharged home.

29 Aside from the events of the delivery, Dr Denesh Hewa-Gamage's review was the only occasion on which a medical practitioner reviewed Serena following her birth. Importantly, Serena was not reviewed by a consultant paediatrician prior to her discharge from hospital.

30 At discharge, Serena was not suspected to be suffering from IUGR.

31 The MSP Guidelines[15] has a neonatal birthweight criterion of '2300-2499 grams suitable for MSP with medical consultation'.

32 The NHM Guidelines lists both SGA and IUGR as criteria for glucose monitoring. The NHM Guidelines also state that neonates weighing less than 2300 grams were at risk of developing hypoglycaemia, requiring glucose monitoring. It is the evidence of Hampton and Mitford that they reviewed the NHM Guidelines and determined that Serena did not require glucose monitoring

[14] Newborn examination.
[15] 11 September 2020.

as her birth weight exceeded 2300 grams. There is no evidence that IUGR or Serena being SGA were considered.

33 The ‘My Baby’s Feed Chart’ records that babies of weight less than 2.8 kg require a feeding plan, that babies should feed at least 3 hourly and that if baby does not feed then expressed milk should be offered by cup or finger feed. Aside from this recorded information, there is no record of Grace or Zan being verbally informed of such a feeding plan or what to do if Serena failed to feed over a protracted period.

34 Grace had difficulty feeding Serena once at home. Grace and Zan attempted to feed Serena throughout the day, though Serena appeared tired and did not latch on. The only successful feed was at about 9pm and finished at between 10.30pm and 11pm.

35 Grace recorded two videos of Serena’s breathing on 31 October 2021. Video #7511 recorded at 5.56pm lasts for 24 seconds and shows Serena swaddled and lying on her back facing upwards. Serena took 6 breaths in the 24 seconds of the video (respiratory rate 15 breaths per minute). The second video #8696, recorded at 6.02pm, is more of a close up and lasts for 34 seconds; it shows a similar pattern of breathing with a respiratory rate of 15 breaths per minute.

1 November 2021

36 Grace woke Serena at 2am on 1 November 2021 and attempted to breastfeed her. Serena opened her eyes for the first time. Serena appeared to Grace to be distracted and wanting to look around. Grace persisted with attempting to feed Serena for about an hour without success. At about 03:30am Serena woke. She was not interested in feeding and licked a few drops of colostrum that Grace had expressed. Grace woke Zan and asked him to look after Serena while she got some sleep. Zan put Serena down to sleep at about 4am. Serena slept for about three and a half hours, waking at 7.30am.

37 Grace thought Serena sounded like she had mucus in her nose whilst sleeping and was making a slight wheezing noise.

38 After Serena woke, Grace spent 30 minutes attempting to get Serena to feed without success as Serena would not latch. Grace attempted to feed Serena again an hour later, which was about eight and a half hours since Serena had last fed. At about 9am, Grace unsuccessfully attempted to feed Serena.

39 Grace took photos of Serena in the early hours of 1 November 2021, which show Serena to be awake, alert, pink and in no obvious distress.

MSP

40 The MSP is designed for well women and babies who are assessed as being suitable for early discharge by either the midwife on the ward, the obstetrics team, and/or the paediatrics team at the hospital. If found to be suitable for early discharge, mother and baby can leave the birthing unit within four to six hours of birth, the postnatal ward within 48 hours for a normal vaginal birth, or within 96 hours for a caesarean section. Under the MSP, the mother and baby receive follow up care at home. Medical staff are able to decline women seeking early discharge if there is a concern as to risk. No such declinature occurred in Grace and Serena's case.

41 Grace and Serena were scheduled to be seen by the MSP on 1 November 2021.

42 By reason of Serena being SGA, and in hindsight due to likely IUGR, she was at risk of hypoglycaemia and therefore she ought to have remained admitted to hospital until three consecutive normal blood glucose levels (BGLs) were achieved. She was therefore not suitable for discharge to the MSP until that had occurred.

43 On 1 November 2021, there were 18 women and babies, including Serena and Grace, to be seen or contacted by the MSP, comprising of three midwives that day. The maximum number of visits a midwife can conduct per day is five. Faulds observed that three women were to be telephoned but not visited. Faulds was working with Marshall. It was Marshall's first day with the MSP though she was an experienced midwife.

44 It was Faulds' view that it was necessary to see Grace and Serena early in the day as it was Grace's first child, she had been discharged within six hours after birth, and Serena was smaller than average (less than tenth centile). Between 9.55am and 10am Faulds and Marshall attended Zan and Grace's home and stayed for about an hour. On arrival, they found Grace attempting, unsuccessfully, to feed Serena. Faulds recalls Grace stated that Serena was latching but not sucking.

45 Faulds examined Serena, conducting an APGAR assessment. She unwrapped Serena and performed a full body visual assessment of her, finding she appeared pink and therefore well oxygenated, and had a flex posture indicating good tone. Faulds provided guidance to Grace on breastfeeding. Following this, Serena came to the breast though had her hands in the way; she sucked a few times then stopped.

46 Faulds recalled that when Serena was removed from the breast she cried, so a further attempt to breastfeed was made. Again, Serena latched but did not suck. Faulds regarded Serena's behaviour as not unusual and introduced a feeding plan. She advised Grace that if Serena did not feed, she may need to go back to hospital. Zan and Grace agreed with the feeding plan.

47 While the feeding plan was being discussed in further detail by Marshall with Zan downstairs, Faulds conducted a physical examination of Grace upstairs. Marshall told Zan to go to the shops as soon as the midwives left to purchase formula as it was important that Serena fed as soon as possible.

48 Faulds and Marshall noted the following matters:

(1) Serena had fed twice in the first 24 hours and Grace described good nutritive feeds

(2) Serena had woken herself at 3.30am but was not interested in feeding, suggesting she was not overly lethargic

(3) Grace reported that Serena had licked a few drops of colostrum that Grace had expressed

(4) Zan reported that Serena did not cry when removed from the breast by Zan, and was alert and looking around

(5) Serena had been put back to bed at about 4am and awoke at 7am, again indicating she was not overly lethargic, and was noted to be alert but not distressed

(6) Serena had displayed some feeding cues

(7) Serena had passed urine and meconium overnight, consistent with normal output from a newborn

(8) Serena was not crying excessively

(9) Serena was mucousy, which provided a reasonable explanation for her failure to feed. Faulds observed in her statement, 'A term baby in the first 24hrs can be sleepy and be mucousy and only feed twice. This is normal if it has had its first breastfeed at birth with good nutritive sucking observed'.[16]

49 A TcB[17] reading was attended which was 'about 99'. Faulds recorded that this reading was 'well under the treatment range'.

50 Zan recalls showing video #7511 to one of the midwifes when they attended their home. Faulds and Marshall deny having seen the video.

[16] Faulds considered that a baby having been fed twice in 24 hours accorded with the guidelines published by the Royal Hospital for Women for term babies. This issue is discussed in more detail below.
[17] Transcutaneous bilirubinometer.

51 Faulds had, in her experience, observed mucousy babies display the opposite behaviour in the night on day two, breastfeeding non-stop. Grace was informed of what to do should that occur.

52 Faulds informed Grace and Zan that they should take their phones off silent because she would call later in the day to see how Serena's feeding was progressing. Faulds intended to return to their home to assess Serena again later that day.

53 The midwives provided Grace and Zan guidelines for breastfeeding babies in the first 7 days which explains number of feeds and output. They discussed SIDS (sudden infant death syndrome) guidelines and provided the leaflet. Grace took photos of the formula preparation, expressing and storage of breastmilk, signs of newborn infection information. Information about newborn infection and the safe sleeping guidelines for baby were also discussed.

54 The midwives left around 11am, and Serena was asleep. She was placed in the bassinet in the downstairs loungeroom at about that time. Zan went to Woolworths for fifteen to twenty minutes to get formula and Grace attempted to express colostrum. Zan arrived home around 11.30am. Around that time, Serena made a little cry or yelp. Grace picked her up and changed her in the upstairs nursery, noticing both stool and urine in her nappy. Grace tried to play with her, stating that she got some 'half reactions' but that Serena seemed 'half asleep'. Grace took Serena downstairs and laid her in the bassinet.

55 About 10 minutes later, Zan prepared a bottle of formula and asked Grace to pick Serena up. Grace noticed that Serena's chest was not rising as normal and it appeared that she was not breathing. Grace attempted to play with Serena but received no response or reaction. Grace did not notice anything unusual about Serena's skin colour but did notice that she felt slightly cold. Serena was wearing a long sleeve onesie with short legs and was wrapped in a swaddle with her arms across her chest. Grace informed Zan that she did not think Serena was breathing and handed her to him. Zan put Serena up to his face and could not feel her breathing. Grace called triple zero at 12.10pm and

the operator gave instructions to perform CPR by laying Serena on the ground and using two fingers to perform chest compressions. Serena and Zan followed the operator's instructions with respect to the performance of CPR.

Paramedic attendance

56 Paramedic Rosemary Levack and paramedic trainee Ivan Koudashev responded to an emergency call relating to Serena at 12.12pm, arriving at the home at 12.21pm. Upon arrival they confirmed that Serena was not breathing and had no pulse. The paramedics took over CPR. David Kynaston, intensive care paramedic, arrived in a second ambulance.

57 The paramedics placed an airway delivering oxygen via the Bag Valve Mask and began 3:1 compressions to ventilations. Serena was conveyed to Campbelltown Hospital with a Code 3 pre-notification to the emergency department (**ED**). CPR continued throughout. Paramedics attempted unsuccessfully to gain intraosseous vascular access in the ambulance. Paramedics noticed that Serena was centrally cyanosed.[18]

Campbelltown Hospital

58 Serena arrived in the ED at 12.45pm. Grace and Zan sat with Serena whilst resuscitation attempts occurred.

59 Dr Catriona Maclean, ED physician, noted that upon arrival, Serena had very low blood sugar on her gas. Her level was consistent with hypoglycaemia. Dr Maclean was of the view that Serena arrived at the hospital in full arrest and at no point recovered to a point that survival was possible.

60 Based on an x-ray taken after insertion of the umbilical catheter, the catheter was noted to be in the right umbilical artery, and therefore the blood tests done were arterial rather than venous in nature.

[18] Blueish purple discolouration of the skin.

61 The biochemistry performed on Serena upon arrival showed elevated levels of creatinine (189 micromole/L NR 10-100) and urea (9.5 millimole/L – NR 3.0-7.0). Serena had a very low bicarbonate level and an elevated potassium level (9.9 – NR 3.5-6.5 millimole/L), consistent with a severe acidosis.

62 The blood film showed a normal white cell count, with borderline low haemoglobin (112 g/L – NR 135-215) and platelets (99 x 109/L – NR 200-500). Coagulation studies showed evidence of a severe coagulopathy – PT 111 sec (NR < 15), APPT 145 sec (NR < 50), fibrinogen 0.4 g/L (NR 2.0-4.3) and d-dimers > 20 (NR < 0.5).

63 A repeat blood gas, performed at 1.38pm showed a severe metabolic acidosis - pH= < 6.80 with lactate = 17.8 mmol/L; a repeat glucose level was 0.9 mmol/L (NR 3.5-550 5.4).

64 A blood culture drawn at the time of insertion of the umbilical catheter returned a growth of a coagulase negative Staphylococcus, a common skin contaminant and not a plausible pathogen in the clinical context. A throat swab for respiratory viral pathogens was negative.

65 Grace and Zan were told that Serena's prognosis was extremely poor. It was agreed by all doctors present, and Grace and Zan, that resuscitation efforts should not continue. Resuscitation was ceased at around 2pm, with Serena's death confirmed soon after.

66 Faulds contacted Grace at 1pm as part of the planned telephone follow up. There was no answer. A further telephone call was made at 1.05pm, and there was no answer. A telephone call was made to Zan at 1.08pm. He advised that he was in the ED and unable to speak.

Post-mortem

67 A coronial post-mortem examination was conducted by Dr Isabel Brouwer, forensic pathologist, on 3 November 2021. In her post-mortem report of 22 March 2023, Dr Brouwer recorded that Serena was a small for gestational age

neonate with decreased subcutaneous body fat; no signs of congenital abnormalities or dysmorphic features were found and there was no evidence of injuries.

68 Dr Brouwer reported that the following findings raise the suspicion of early sepsis:

(1) placental abnormalities noted in the biopsy report

(2) reported history of Grace being on antibiotics

(3) raised APTT[19] INR and D-dimer in antemortem blood

(4) raised urea and creatinine in antemortem blood suggestive of renal failure.

69 Ultimately, Dr Brouwer concluded that the cause of Serena's death was 'unascertained.'

Dr Andrew McPhee, neonatologist, report dated 26 June 2025

70 Dr McPhee reported that Serena was born after an uneventful pregnancy, she was well at birth and although small she fed well within 2-3 hour of delivery.

71 Following her discharge, Serena's feeding deteriorated having only one successful feed at around 9pm on 31 October 2021. Her parents noted breathing difficulties. Dr McPhee benefited from viewing the videos taken by Serena's parents and in his view, they showed evidence of severe airway obstruction during sleep.

72 Dr McPhee opined that Serena died as a complication of OSA with hypoglycaemia related to IUGR very likely compounding the problem.

[19] Activated Partial Thromboplastin Time.

73 Dr McPhee considered it unlikely that neonatal sepsis contributed to Serena's death.

74 In his oral evidence Dr McPhee stated that:

(1) looking at Serena, her smaller, leaner body and larger head was noticeable and should have been apparent to the doctor considering her for early discharge. He considered that if her SGA status was appropriately identified, the tragic outcome of Serena's death could have been avoided as she should have remained in hospital for ongoing monitoring

(2) Serena's breathing patterns shown in the videos were very unusual

(3) hypoglycaemia was probably the underlying issue and her smaller birth weight was a risk factor

(4) it appeared Serena was an otherwise healthy child that suffered from obstructive breathing problems because of her hypoglycaemia

(5) while the NHM Guidelines may be a useful document for first time mothers, the reference to two feeds in 24 hours may be problematic as that is not 'never a sign of a problem'

(6) in Serena's case, by 11am on 1 November she was showing signs of 'poor feeding'

(7) if an ambulance had been called by 10am 1 November 2021 and Serena been transferred to hospital, her collapse would have been avoided and even at 11am it may have been avoided.

75 In Dr McPhee's view, Serena should not have been discharged early onto the MSP.

Analysis of the issues

76 As the evidence was adduced, the issues developed into the following themes:

(1) Serena's cause of death

(2) was the decision to discharge Serena appropriate and in accordance with the SWSLHD's policies and procedures?

(3) was the MSP review appropriate?

(4) whether it is necessary or desirable to make recommendations.

Serena's cause of death

77 I accept the unchallenged evidence of Dr McPhee which enables a finding that Serena died from OSA occurring in the context of significant, unrecognised hypoglycaemia associated with IUGR.

78 Serena's death was preventable if she had remained in hospital, been appropriately monitored and treated for hypoglycaemia in accordance with the NHM Guideline.

Was the decision to discharge Serena appropriate and in accordance with the SWSLHD's policies and procedures?

79 In the third trimester, Serena exhibited faltering intrauterine growth. At birth, Serena's weight placed her well below the 10th centile on the personalised GROW chart used at Campbelltown Hospital. This represented a significant decline from the 53rd centile at 30 weeks and the 38th centile at 35 weeks.

80 Dr McPhee observed, this trajectory 'clearly suggested suboptimal growth through the third trimester'.

81 The NHM Guidelines relevantly provided:

3…

(c) Early and regular feeding of neonates along with keeping the neonate normothermic is the most effective way of preventing hypoglycaemia…
(d) Any neonate that is unwell or has signs that cannot readily be explained should have a BGL[20] performed.

…

4.1.3 Neonates at Risk of Developing Hypoglycaemia

The following neonates require BGL monitoring in BU and PNW

…

(c) Birth weight, 2300 grams (see pg 6 for preterm/SGA babies 2300-2800 grams)

…

(e) Intrauterine Growth Restriction (IUGR)
(f) Small for Gestational Age (SGA)

…

(k) Inadequate feeding.

4.1.4 Clinical signs of hypoglycaemia

Any neonate that is unwell or has signs that cannot be readily explained should have a BGL attended.
…Apnoea…Poor feeding

4.2 Birthing Unit and Postnatal Ward Management

Neonates who do not require admission to a Neonatal Unit will be managed according to the following guidelines:

…

Encourage 3 to 4 hour feeds… (i) Continue BGL before feeds (AC) until the baby has 3 consecutive readings >2.6 mmol/L…

4.4 Preterm and Small for Gestational Age (SGA) Neonates

…SGA neonates weigh less than the 10th centile for their gestation.

82 At 4.55am on 31 October 2021, a newborn risk assessment was conducted on Serena by a registered midwife who documented no immediate clinical concerns. Serena's length was 47.5 cm, head circumference 34 cm, and weight 2,485 grams. She was not identified to be SGA (despite fitting with the definition in the NHM Guidelines), and she was not managed in accordance with the NHM Guidelines.

83 At 5.06am Grace was breastfeeding Serena with a suck code of 6, indicating effective nutritive sucking. Plans were made to transfer Grace and Serena to

[20] Blood Glucose Level

the postnatal ward but, at 6.44am, RM Hampton recorded that Grace expressed interest in early discharge if it was clinically safe.

84 Shortly thereafter, Dr Hewa-Gamage performed the newborn examination, completed the Blue Book check, and signed the newborn discharge summary. He determined that there were no barriers to discharge and authorised Serena's early discharge home. In his assessment, he did not take into account or determine that Serena was SGA. In his oral evidence he indicated that his understanding of the relevant policy was that a neonate weighing less than 2300 grams required medical review and possible nursery admission and anything above that 'didn't necessarily need care'.

85 To his mind, given Serena exceeded the baseline of 2300 grams, he did not consider that she was precluded from early discharge or that she needed more 'sugars' done. His evidence was that if a baby were excluded from early discharge then they wouldn't be presented to him for discharge. It was not his practice to consult policies – he was, 'oriented to the flavour of policies.' He knew which weight was precluded from early discharge and which weight range was allowed.

86 Dr Hewa-Gamage acknowledged that he did not recognise Serena's IUGR. When asked about head sparing growth patterns, Dr Hewa-Gamage said he did not give much weight to head circumference measurements as these are often inaccurate.

87 With the benefit of hindsight Dr Hewa-Gamage said he would now diagnose Serena as SGA and having IUGR.

88 In his oral evidence, Dr Hewa-Gamage described a high volume of patients, an erosion of the quality of checks and a 'discharge culture' within Campbelltown Hospital. He indicated that at the time he, as a junior doctor, was not necessarily a 'decision maker.' Given the physically and emotionally exhausting job, he considered there is not necessarily the capacity to raise issues with midwives.[21]

[21] Though he clarified later that he didn't mean midwives per se but a pressure by systemic factors.

He considered himself to be disempowered. He was of the view that a request by him for further testing (including BGL) would have been met with irritation or discontent when what he was being asked to do was to discharge. He did concede that a midwife is not responsible for diagnosing IUGR.

89 At no time was it suggested to Grace and Zan that their discharge was early, or premature, not were any health risks to which Serena was exposed explained or identified. That might be, in part, because at no point was Serena identified as SGA, as having IUGR, or as exhibiting a head-sparing growth pattern. Nor was she recognised as being at risk of hypoglycaemia. No glucose monitoring was undertaken, and Serena's blood glucose level was never measured during her admission.

90 Serena's discharge was contraindicated in circumstances where:

(1) **Serena was small for gestational age**. Her birthweight placed her at approximately the 5th centile. All relevant witnesses, including Dr Hewa-Gamage, accepted that a weight below the 10th centile constitutes SGA. The NHM Guidelines expressly required glucose monitoring for all SGA infants.

(2) **Serena had IUGR**. The downward trend in antenatal centiles, from more than the 50th centile to 35th centile, to 5th centile at birth, reflected classic IUGR. Under the NHM Guidelines, IUGR was independently a criterion mandating glucose monitoring. While Dr Hewa-Gamage suggested that estimating fetal weight in utero can be unreliable, Dr McPhee observed that the safe and appropriate course is to assume the correctness of any estimated fetal weight. Dr McPhee's evidence was to the effect that a reasonable clinician would have accepted the estimated fetal weight on ultrasound and identified IUGR.

(3) **Serena had head-sparing growth**. Dr McPhee explained, Serena displayed an asymmetrical pattern, normal head circumference and length, but strikingly low weight, consistent with 'head-sparing' growth.

While not expressly listed in the policy, the unchallenged expert evidence was that such a pattern significantly increases the risk of neonatal hypoglycaemia and militates strongly against early discharge.

91 The clinical features of SGA, IUGR, and head-sparing growth, should have alerted the discharging paediatric clinician to the need for inpatient monitoring and represented, individually and cumulatively, a basis on which to decline discharge.

92 Serena's SGA status, her IUGR, and her head-sparing pattern were not identified by Dr Hewa-Gamage. While it should be acknowledged that he was at the time a junior doctor,[22] these were matters which the evidence indicates ought to have been capable of diagnosis by a paediatric resident.

93 In his evidence, Dr Hewa-Gamage asserted that he believed the NHM Guidelines operated on the basis that a threshold of 2300 grams applied, such that babies above that weight could be discharged if they otherwise appeared well. He was unaware that SGA and IUGR were independently listed criteria in the NHM Guidelines requiring glucose monitoring. Ultimately, he accepted his understanding was wrong. He also conceded that the guidelines were readily available on the intranet.

94 In his oral evidence, Dr Hewa-Gamage was defensive, evasive at points, and demonstrated limited insight into the nature and seriousness of his errors. He appeared unwilling to engage meaningfully with the central proposition that Serena's size and growth trajectory represented a contraindication to discharge. He attempted to characterise discharge decision-making as 'collaborative' failing to recognise that discharge is a medical decision for which the reviewing doctor bears ultimate responsibility.

95 Dr Hewa-Gamage suggested that midwives bore responsibility for identifying policy barriers to discharge. The evidence does not support that contention. Midwives are not trained to diagnose IUGR, nor to interpret growth trajectories

[22] He was three years post-graduation and in his first year of paediatric training.

in the way required here. The responsibility for assessing Serena's suitability for discharge rested on the clinician performing the newborn examination.

96 In his written submissions, Dr Hewa-Gamage acknowledged that he had valid clinical and policy grounds not to discharge Serena and that he should not have discharged Serena. He also apologised that his evidence came across as defensive indicating that his distress and nerves manifested in this way while he was giving evidence.

97 RM Pigott's evidence was that the diagnosis of SGA, as opposed to IUGR and head-sparing growth – is within the ambit of a midwife's practice. Midwifery staff in the birthing unit also failed to identify Serena as SGA and therefore did not initiate glucose monitoring from birth in accordance with the NHM Guidelines.

Findings

98 I find that Serena should have been identified as an infant at risk, requiring glucose monitoring and further observation, who accordingly was not suitable for discharge. Clear policy triggers for glucose monitoring were missed; and Serena's death was preventable with timely and appropriate neonatal care.

Was the MSP review appropriate?

99 Marshall and Faulds attended on Grace, Zan and Serena between 9.55 and 10am on 1 November 2021. On arrival, they found Grace attempting to breastfeed Serena. They observed that Serena was latching but not sucking effectively. By that point, Serena had not properly fed for around 12 hours.

100 Faulds undertook an examination of Serena which was reportedly normal. Later in the MSP review, further attempts at breastfeeding were made. Serena latched but again did not sustain sucking. While Faulds considered such behaviour not unusual for day one or two, Serena's small size and the midwives' inability to return later in the day prompted her to institute a feeding plan. She advised that if Serena did not feed from the bottle by the time of her later planned call, hospital readmission might be required.

101 In their statements, the midwives identified a number of features they found reassuring: that Serena had fed twice in the first 24 hours; that she had passed urine and meconium overnight; that she had roused at 3:30 am; that she was not excessively crying; that she displayed some feeding cues; and that she was mucousy, which they considered could account for feeding difficulty.

102 The MSP is designed for low-risk mothers and newborns. Serena was not a low-risk newborn, and, properly, she should never have been discharged into an MSP pathway. To that extent, the midwives were entitled to assume that the hospital's earlier decision to discharge her signified that she was low risk.

103 Ms Pigott, in both her report and oral evidence, identified the potential for cognitive bias: that is, that the midwives' assessment was coloured by their belief, reasonable in context, that they were seeing a low risk baby who had been appropriately discharged. In addition, both midwives explained that they were influenced by a 2012 Royal Hospital for Women document titled 'Breastfeeding in the First Week,' which indicated that two feeds in the first 24 hours may be adequate. The evidence suggests that document was not intended as clinical guidance for midwives but as general guidance for new mothers.

Findings

104 I find that Faulds and Marshall ought to have recognised that Serena had fed poorly and ought to have considered that she may therefore have been at risk of hypoglycaemia.

105 The unchallenged expert evidence of Dr McPhee was unequivocally to the effect that had BGL testing been undertaken, Serena would have been found to be hypoglycaemic. Dr McPhee suggested the likely reading would have been below 1.5 and Ms Pigott's evidence was that a glucose reading below 2 would have warranted a call to Triple Zero.

106 However, the unchallenged evidence was that contrary to the MSP policy then in force, MSP midwives did not have access to glucometers at the time as they

did not become available within the program until about a year after Serena's death.

107 I find that Faulds and Marshall demonstrated substantial insight into the shortcomings in their assessment of Serena. It was very clear that Serena's death has had a significant impact on them both.

108 On the evidence of Dr McPhee, it is not clear whether a prompt and accurate assessment of Serena's risk of hypoglycaemia by Faulds or Marshall arriving at 10am could have prevented Serena's death. There was, however, a missed opportunity to improve her prospects of survival.

Whether it is necessary or desirable to make recommendations.

Policy changes since Serena's death

109 A number of changes have been implemented by the SWSLHD since Serena's death as outlined below.

(1) Discharge information packs are now available in the Birthing Unit for women who are discharged early. These include specific guidance for families of smaller newborns, providing advice on feeding, normal newborn behaviour, and signs that require prompt review.

(2) The MSP policy has also been revised to ensure that babies under 2,500 grams are recognised as being at increased risk of hypoglycaemia and are not eligible for discharge within 24 hours.

(3) The current equivalent of the NHM Guideline has been amended to reflect these policy changes.

(4) Initiatives such as the 'Jelly Baby' project have been introduced to support earlier recognition of babies at risk of hypoglycaemia through clearer prompts for clinicians and parents.

(5) Further education has been delivered to midwifery staff on newborn risk assessment, feeding documentation, and the need for vital sign observations, including blood glucose monitoring and pulse oximetry, for small or poorly feeding newborns.

(6) The electronic Newborn Risk Assessment has also been audited and reinforced to ensure consistent identification of risk, and the MSP policy has been updated to clarify expectations regarding discharge observations and the monitoring to occur at early home visits.

110 While these improvements are welcomed, they do not address the following matters identified in this inquest:

(1) the failure to comply with the NHM Guidelines in assessing Serena for early discharge into the MSP

(2) that Faulds and Marshall were relying on a 2012 Royal Hospital for Women document titled 'Breastfeeding in the First Week, which was not intended as clinical guidance for midwives but as general guidance for new mothers

(3) the absence of equipment available to MSP midwives to appropriately and adequately perform their duties

(4) the lack of guidance as to the circumstances in which a neonate's blood glucose level should be monitored noting that Dr McPhee indicated that further guidance would be appropriate and that the contemporary view is that glucose monitoring is required where there have been two missed feeds

(5) the evidence from Marshall that babies who are plainly not low risk continue to be discharged into the MSP, and that, in her experience, this is occurring with greater frequency now than in 2021

(6) that, according to Marshall, in the earlier stages of the MSP, midwives working within the MSP had a right of veto in relation to patients they deemed to be unsuitable. Then she said, as the program developed, the ability of MSP midwives to refuse to accept patients was removed – or patients that were declined by MSP midwives were simply re-presented the next day.

Recommendations to the SWSLHD

111 In light of all of the evidence and submissions I make the following recommendations to the SWSLHD.

(1) That the SWSLHD conduct an audit to ensure that the equipment identified in the MSP Policy as available to midwives on the MSP is available, working and properly calibrated, and that staff are trained in the use of it.

(2) That the SWSLHD immediately ensures that material relied on by MSP Midwives and handed out or shown to new parents is up-to-date and consistent with current best practice.

(3) That the SWSLHD consider further amendment to the MSP policy to provide guidance as to the circumstances in which a neonate's blood glucose level should be monitored, inclusive of consideration of requiring or recommending monitoring where there have been two successive feeds missed.

(4) That the SWSLHD consider undertaking a review of the MSP Policy including seeking input from midwives currently working in the MSP with a view to amending the MSP Policy to exclude patients which, from the perspective of the midwives, are not considered to be low risk.

112 Helpfully, the SWLHD indicated in their submissions that recommendations (1) to (3) above were not opposed.

113 The wording of recommendation (4) followed careful consideration of submissions from the SWSLHD. The earlier proposal circulated by Counsel assisting provided for consideration being given to consultation with the MSP midwives prior to discharge. I accept, as highlighted in the SWSLHD's submissions, that this could involve additional pressures on these midwives including requiring them to review medical records prior to a patient being released onto the MSP. That said, the evidence of the MSP midwives as to patients inappropriately being discharged into their care was compelling. In response to that, my recommendation aims to empower the MSP midwives to have input into the MSP Policy which is then to be administered by the relevant hospital.

Referral of Dr Hewa-Gamage

114 Counsel assisting submitted that I may consider a recommendation pursuant to s 82(2)(b) of the Act, that the Medical Council of Australia investigate Dr Danesh Hewa-Gamage's care of Serena, and his decision to discharge.

115 Section 82(2)(b) provides that:

> (1) A coroner (whether or not there is a jury) or a jury may make such recommendations as the coroner or jury considers necessary or desirable to make in relation to any matter connected with the death, suspected death, fire or explosion with which an inquest or inquiry is concerned.
>
> (2) Without limiting subsection (1), the following are matters that can be the subject of a recommendation—
>
> (a) public health and safety,
>
> (b) that a matter be investigated or reviewed by a specified person or body.

116 At the time of Serena's death, Dr Hewa-Gamage was a junior doctor, 3 years post-graduation and in his first year of paediatric training.

117 Dr Hewa-Gamage's care of Serena was lacking in the ways described below.

(1) Dr Hewa-Gamage failed to diagnose or assess Serena as SGA, having IUGR or as exhibiting head-sparing growth pattern. In his evidence he said that estimating fetal weight can be unreliable. Dr McPhee indicated that the appropriate course is to assume the correctness of estimated fetal weight, rather it appears Dr Hewa-Gamage failed to take it into account in his assessment of Serena for discharge.

(2) Dr Hewa-Gamage failed to recognise Serena's risk of hypoglycaemia.

(3) Dr Hewa-Gamage failed to adequately familiarise himself with the hospital's policies including the NHM Guideline. He was operating under the misapprehension that 2300 grams was a 'threshold' which, if met, allowed for discharge if a baby appeared otherwise healthy. Despite the passage of time, it appears this error in understanding of the policy was not identified by him until he was giving evidence.

(4) Dr Hewa-Gamage was a poor witness. He was defensive, evasive at points, and demonstrated limited insight into the nature and seriousness of his errors. He appeared unwilling to engage meaningfully with the central proposition that Serena's size and growth trajectory represented a contraindication to discharge. That said, I accept that in his written submissions Dr Hewa-Gamage has made further concessions and explained that his anxiety and distress were contributing to his presentation while giving oral evidence.

(5) Dr Hewa-Gamage attempted to characterise discharge decision-making as a 'collaborative' between medical officers and midwives. This did not properly reflect the evidence as to the respective roles and responsibilities of each practitioner, nor the reality that discharge is a medical decision for which the reviewing doctor bears ultimate responsibility. He reluctantly accepted in the course of his evidence that he as the medical officer was responsible for determining whether Serena was safe for discharge

(6) Dr Hewa-Gamage also suggested that midwives bore responsibility for identifying policy barriers to discharge. The evidence does not support that contention. Midwives are not trained to diagnose IUGR, nor to interpret growth trajectories. The responsibility for assessing Serena's suitability for discharge rested squarely on the clinician performing the newborn examination.

(7) A reasonable paediatric doctor, junior or otherwise, should have recognised Serena as an infant at risk, requiring glucose monitoring and further observation, who was not suitable for discharge.

118 Dr Hewa-Gamage did express a level of contrition, offered an apology and did identify changes to his practice since Serena's death. However, those changes appeared more to reflect that his current environment is not as high pressured as it was when he was working within the SWSLHD.

119 In his written submissions, Dr Hewa-Gamage expressed that it would not be appropriate for a referral for investigation to be made in circumstances where:

(1) there is no suggestion he is not currently competent to practice

(2) it was not put to him in cross examination that there is a continued gap in his knowledge or training

(3) he has embraced the opportunity to learn from a review of Serena's care and treatment.

120 There are limitations to the evidence which can be adduced at an inquest. The inquest did not explore in detail, Dr Hewa-Gamage's current practices. His presentation in his oral evidence was not indicative of someone who has fully embraced the opportunity to learn from a review of Serena's care and treatment. I accept it may well be that Dr Hewa-Gamage's failings are attributable to his lack of experience at the time of Serena's death. That is a

matter which can be given due consideration by the Medical Council of Australia in any investigation they undertake.

121 The inadequacy of the care provided by Dr Hewa-Gamage to Serena combined with his overall lack of insight into his failings support the recommendation being made that the Medical Council of Australia investigate Dr Danesh Hewa-Gamage's care of Serena, and his decision to discharge.

122 In light of the evidence adduced at the inquest, I consider it necessary and desirable that the following recommendation be made to the President of the Medical Council of NSW be made:

(1) I recommend that consideration be given to the Medical Council of NSW reviewing and/or investigating Dr Danesh Hewa-Gamage's care of Serena, and his decision to discharge her.

I direct that a copy of the brief of evidence and the transcript of the coronial inquest be forwarded to the President of the Medical Council of NSW.

Concluding remarks

123 I will close by conveying to Serena's family and their community, my sympathy for the tragic loss of their beautiful baby girl. Zan and Grace's love of Serena was tangible and the loss they have suffered indescribable.

124 I thank the Assisting team for their outstanding support in the conduct of this very difficult inquest.

125 I thank the officer in charge, Detective Senior Constable Mark Gibbs, for his work in conducting the investigation and compiling the brief of evidence which was supplemented by the Assisting team.

Statutory findings required by s 81(1)

126 As a result of considering all the documentary and the oral evidence heard at the inquest, I make the following findings:

Identity

The person who has died is Serena Lee

Place of death

Campbelltown Hospital, Campbelltown, in New South Wales

Date of death

1 November 2021

Cause of death

Serena died from obstructive sleep apnoea occurring in the context of significant, unrecognised hypoglycaemia associated with IUGR.

Manner of death

Serena's death was preventable. She died following her premature discharge from Campbelltown Hospital onto the Midwifery Support Program in circumstances where her discharge was contrary to hospital policy and she was inappropriately identified as low risk. Those responsible for her discharge failed to identify or take into account that she was small for gestational age, that she had intrauterine growth restriction and a head-sparing growth pattern and she was at risk of hypoglycaemia.

I close this inquest.

Magistrate R Hosking
Deputy State Coroner
Lidcombe

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