# Coroner's Inquest in West Sussex Reveals Oversight in Hyponatraemia Awareness Led to Newborn's Tragic Death



In West Sussex, England, a coronial inquest raised significant concerns about healthcare professionals' awareness of the condition hyponatraemia, which led to the death of a newborn named Orlando. The inquest, led by Senior Coroner Penelope Schofield, found that the midwives and medical team failed to recognize the abnormal low sodium level condition in Robyn Davis, a trained midwife, during her home birth labor on September 10, 2021. This oversight caused Davis to undergo an emergency C-section at Worthing Hospital after she suffered seizures. The baby was born with no heartbeat and brain damage due to oxygen deprivation and passed away in intensive care at the Royal Sussex County Hospital in Brighton 14 days later.

The coroner's subsequent report criticized the care team for their handling of the situation, including their failure to monitor fluid intake and output adequately during Davis' labor. It highlighted a "gross failure to provide basic medical attention," with the midwives encouraging Davis to consume excessive amounts of fluid without recognizing the risks of hyponatraemia. The report emphasized that such neglect contributed to Orlando's death and called for preventive measures to enhance medical understanding and response to hyponatraemia, particularly in maternal care settings.

Following the tragic event and the inquest, Schofield has communicated with the Nursing and Midwifery Council and the Royal College of Obstetricians and Gynaecologists, urging them to improve training and protocols related to the condition. The healthcare bodies have been given a 56-day period to respond to the coroner’s recommendations aimed at preventing future similar occurrences.