

Headline **Baby mix-up raises many questions**  
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# Baby mix-up raises many questions

Lena H. Sun

THE DAY after her first child was born in January at Virginia Hospital Centre in Arlington, Suzanne Libby discovered that he was missing from the hospital nursery. Searching frantically, she found Spencer in his hospital bassinet — in another woman's room. Standing next to him was a hospital aide, a stricken look on her face.

The relief that Libby felt at finding her son was later replaced by fresh anxiety: The woman, it turned out, had breast-fed her newborn.

More than two hours passed before hospital officials told Libby, 34, and her husband, Reed, 36, how the mix-up had happened: The aide had neglected to match Spencer's ID bands with the other woman's. The next day, hospital officials told the couple that results of blood tests run on the woman showed she did not have HIV or hepatitis B or C, diseases that can be passed to a baby through breast milk.

It's impossible to know how often breast-feeding mix-ups happen, because many states do not require hospitals to report them unless there is serious harm.

But Ruth Lawrence, a breast-feeding expert at the American Academy of Paediatrics, says that she hears about them occasionally. At least eight other mix-ups have occurred in recent years, including two at other Washington area hospitals where babies were given to the wrong mothers but not breast-fed.

Although some experts say the potential for harm to infants is minimal, federal authorities say the possible exposure to HIV or other infectious diseases should be treated just like an accidental exposure to other body fluids.

The incidents also point to a larger problem of accurate patient identification — a major cause of health-care errors. That is a particular risk with newborns, and experts say sleep-deprived mothers are sometimes confused: It can be hard to recognise a swaddled infant brought by the nursing staff for feeding in the middle of the night.

In June, the hospital's risk-management officer, Susan Richardson, sent a lawyer hired by the Libbys a two-sentence letter that expressed regret and said: "Please know that after looking into the matter the Virginia Hospital Centre has no knowledge of anything indicating that the woman who breast-fed Spencer Libby on Jan 31, 2010, exposed him to any disease, toxin or other harmful substance."

Virginia Hospital Centre said in a statement July 14 that one employee was fired after she "failed to follow standard protocol." The hospital also said that it had "conducted comprehensive laboratory tests and has no knowledge of anything indicating that the woman who mistakenly breast-fed the infant exposed the infant to any harm" and that it had "taken the necessary steps to ensure that this situation does not happen again."

Hospital officials declined to elaborate, citing patient confidentiality.

"It was the worst moment of my entire life," Libby said, when she realised her son was missing and nurses didn't know where he was. "On top of that, to find that another mother breast-fed him, without my knowledge, without my consent, was horrid."

Hospitals use information on a newborn's and mother's ID bands to try to prevent such errors. Security has

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increased since two baby girls in Virginia were discovered 15 years ago to have been switched at birth. Many hospitals say mothers are asked to say their name and their baby's name as an additional check before nurses hand over a baby.

US states typically don't require hospitals to report breast-feeding mix-ups unless a patient is harmed. But the Virginia Department of Health is investigating the Virginia Hospital Centre incident after receiving a complaint, said Chris Durrer, who oversees hospital licensure and certification. The Libbys said they filed the complaint.

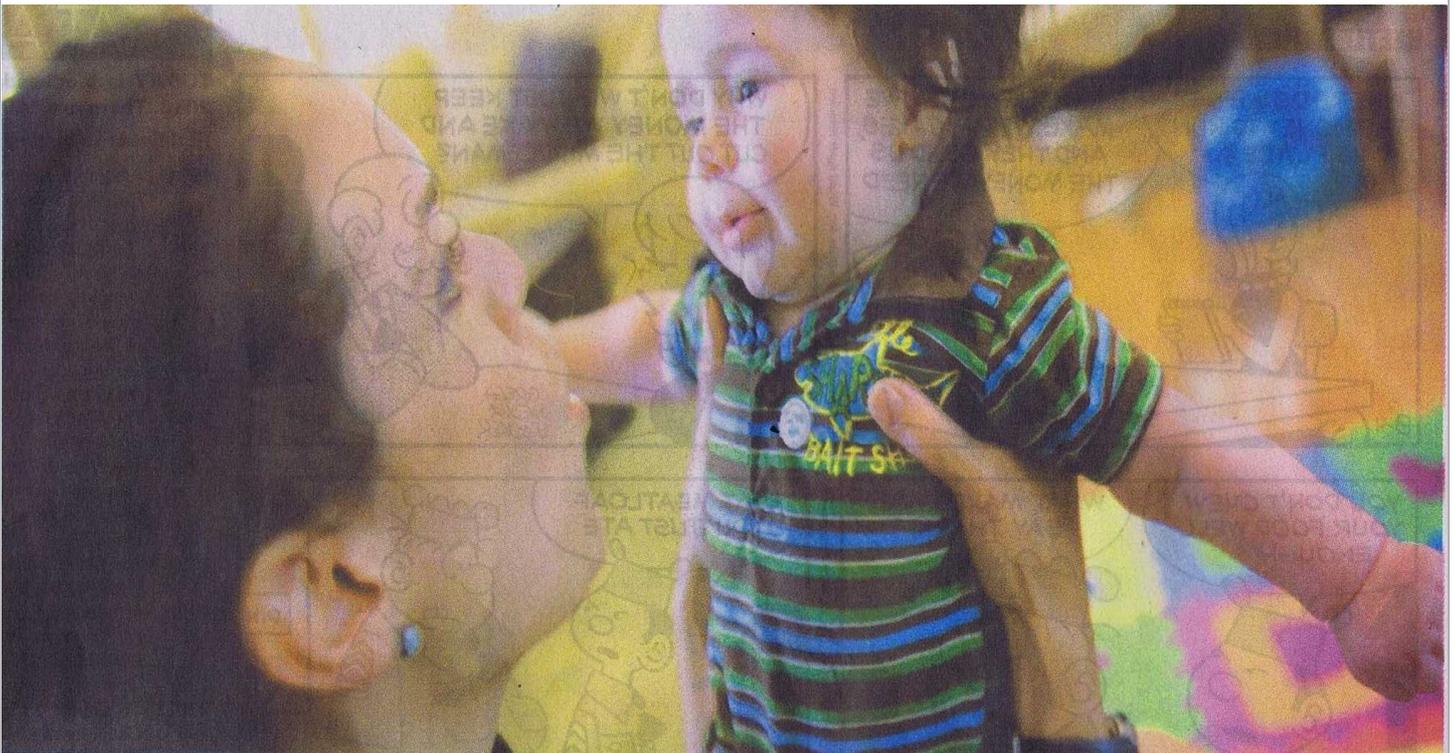
Lawrence, the breast-feeding expert, played down the possible harm to infants, citing the use of wet nurses in many cultures.

But others disagree. "HIV can be found in breast milk, as well as many drugs," said Paul Hain, associate chief of staff at Monroe Carell Jr. Children's Hospital in Nashville.

The larger issue concerns errors in identifying patients, he said. In an initial audit, Hain found that 20 percent of his hospital's patients had wristband ID errors, including illegible and inaccurate data. Such errors could result in the wrong treatment. — WP-Bloomberg

The hospital had conducted 'comprehensive laboratory tests' and has no knowledge of anything indicating that the woman who mistakenly breast-fed the infant exposed the infant to any harm.

Virginia Hospital Centre statement



BREASTFEEDING MIX-UP: Suzanne Libby plays with her son, Spencer, at their Arlington home. In January, the day after he was born, the baby was breast-fed by another woman. — Washington Post photo