Failure to appreciate signs indicative of a potentially growth-restricted baby
15HDC00892, 1 December 2017

Midwife ~ Midwifery service ~ District health board ~
Antenatal care ~ Intrauterine growth restriction ~ Right 4(1)

At 35+5 weeks' gestation, a woman was seen by a midwife, who documented the woman's fundal height as measuring 30cm — 4cm less than the previous week — and plotted this on the GROW chart. The midwife noted that the woman was small for dates and referred her for a growth scan.

At 36+4 weeks' gestation, the woman was seen by her lead maternity carer (LMC), who noted that the woman had undergone her growth scan earlier that morning, and documented: "[A]s far as we are aware things are good …" The LMC documented the woman's fundal height as measuring 34cm and plotted this on the GROW chart.

At 37+5 weeks' gestation, the woman was seen by her LMC, who noted: "Active baby. Reviewed scan [from 36+4 weeks'] — shows well grown baby at this stage." The LMC did not measure the woman's fundal height or plot anything on the GROW chart.

At 38+5 weeks' gestation, the woman was again assessed by her LMC. The LMC documented the woman's fundal height as measuring 35cm and plotted this on the GROW chart. The LMC told HDC that she was reassured by her findings at this assessment.

At 39+5 weeks' gestation, the woman was seen by a back-up midwife, who performed an abdominal palpation, documented the woman's fundal height as measuring 35cm (the same as the previous week), and plotted this on the GROW chart. The back-up midwife noted that she measures fundal height lower than her colleagues, and was therefore not concerned that her measurement of fundal height was the same as the LMC's the previous week.

At 40+5 weeks' gestation, the woman saw her LMC, who documented: "5 days post dates now. Lots of movements discussed [induction of labour] [41+4 weeks'] — will book it in." The LMC did not document a fundal height measurement at this assessment.

At 41+3 weeks' gestation, the woman was seen by the back-up midwife for a stretch and sweep, as the woman had been experiencing contractions every 10 to 15 minutes over the previous two nights. The back-up midwife documented that she listened to the fetal heart rate, and discussed whether to perform a CTG. However, as the baby was moving well, it was decided not to. The back-up midwife did not measure the fundal height.

The woman presented to the local public hospital the following afternoon. She went into established labour that evening. The woman was in the birthing pool between 8.35pm and 11.17pm. The LMC monitored the fetal heart rate every 20 minutes during that time, and undertook a CTG when the woman got out of the pool. The LMC stated that she "instantly recognised that this was a very abnormal CTG and would require urgent consultation with an obstetrician".

The LMC consulted the obstetric registrar, and it was arranged for the woman to have a Caesarean section. This commenced at 12.54am and, at 1.07am, the woman's baby was born in poor condition. The baby required resuscitation, and was transferred to the neonatal unit. The baby weighed 2710g and was noted to be intrauterine growth restricted. The baby was transferred to another public hospital for three days before returning to the local public

hospital for ongoing care before being discharged. The LMC provided three weeks of postnatal care to the woman before the woman decided to transfer her care to another midwife.

Findings

The LMC did not measure the woman's fundal height at 40+5 weeks' gestation, and failed to appreciate signs indicative of a potentially growth-restricted baby at her assessments at 38+5 and 40+5 weeks' gestation. In the Commissioner's view, this contributed to the baby being treated as low risk for the remainder of the woman's pregnancy, as well as during labour and birth. Accordingly, the LMC failed to provide services to the woman with reasonable care and skill, in breach of Right 4(1). Adverse comment was also made about the intrapartum and postnatal care that the LMC provided to the woman.

The back-up midwife failed to measure the woman's fundal height at 41+3 weeks' gestation, and it was considered suboptimal that the back-up midwife failed to appreciate signs indicative of a potentially growth-restricted baby at her assessments at 39+5 and 41+3 weeks' gestation. This failure contributed to the baby being treated as low risk during the remainder of the woman's pregnancy, as well as during labour and birth. Accordingly, the back-up midwife failed to provide services to the woman with reasonable care and skill, in breach of Right 4(1).

By failing to have in place any policies to support its staff, particularly in relation to the measurement of fundal height during pregnancy, the midwives' employer did not provide services to the woman with reasonable care and skill, and breached Right 4(1).

Criticism was made of the local district health board regarding the confusion around the woman's transfer to theatre, and that the woman's placenta was not sent for examination.

Recommendations

It was recommended that the LMC and the back-up midwife each provide a written apology to the woman, and that the midwives' employer develop policies regarding measurement of fundal height during pregnancy.

In the provisional opinion, it was recommended that the midwives' employer report back to HDC on the outcome of its intention to arrange training for its staff on the use of GROW charts. The employer arranged this training for its staff, including the LMC and the back-up midwife.