Antenatal care of woman carrying fetus small for dates (09HDC01581, 31January 2012)

Obstetrician ~ Midwife ~ Public hospital ~ DHB ~ Antenatal clinic assessments ~ Antenatal systems ~ Maternal fetal medicine ~ Intrauterine growth restriction ~ Pre-eclampsia ~ Rights 4(1), 4(4)

A 21-year-old woman who was pregnant for the first time was referred to the fetal medicine service at a DHB for investigation and monitoring of her fetus' early onset intrauterine growth restriction. The woman was first seen at the clinic when she was in the 21st week of her pregnancy by a clinician who was an obstetrician and gynaecologist specialising in maternal-fetal medicine. The obstetrician performed an initial assessment and arranged to see the woman again two weeks later.

When the woman was seen in the 23rd and 24th weeks of her pregnancy, her routine antenatal screening assessments were conducted and recorded. The tests showed that she had a trace of protein in her urine, but were otherwise normal. The obstetrician tried to persuade the woman to have an amniocentesis to establish the cause of the baby's growth restriction but the woman refused.

When the woman attended the hospital maternal fetal medicine antenatal clinic in the 25th week of her pregnancy, she was accompanied by her mother who was concerned that her daughter had swollen hands and feet, and says she told the obstetrician she was concerned that her daughter might be developing toxaemia. The obstetrician denies being advised of these concerns and again tried to persuade the woman to consent to amniocentesis.

At this appointment, the clinic midwife, who was responsible for conducting routine assessments (blood pressure, urinalysis and weight) of the women attending the clinic had noted the woman's attendance but the woman's routine antenatal assessments were not checked. The obstetrician signed off the woman's record, which included blanks for the uncompleted blood pressure and urinalysis tests but did not follow up the absence of the assessments.

The next week the woman again attended the clinic. This time she was accompanied by her partner. She had a severe headache, blurred vision and swollen hands and these symptoms were communicated to the obstetrician. The absence of the previous week's antenatal assessments was noted, but again no routine antenatal assessments were performed. Later that night, the woman returned to the hospital by ambulance, was admitted and underwent an urgent Caesarean section. The baby was transferred to a neonatal intensive care unit but died a few days later.

It was held that the obstetrician breached Right 4(1) for twice failing to adequately assess the woman or follow up the absence of blood pressure recordings and urinalysis results. This was part of the expected assessment of the woman and should have been carried out as part of the consultations.

The midwife assigned to the clinic, who was not established to have seen the woman on the two relevant visits, failed to take steps to ensure that the woman's routine recordings were taken or to ensure the woman was advised not to leave before the observations were taken. However, she was not found to have breached the Code.

By not ensuring the fetal medicine clinic had appropriate systems in place, that roles at the clinic were clearly defined, and that the clinic midwife was able to undertake the necessary observations on all patients, the DHB breached Rights 4(1) and 4(4).

It was recommended that the obstetrician enter into an appropriate mentoring relationship. She was also referred her to the Director of Proceedings. Recommendations to the DHB included ensuring the implementation of clear pathways for the care of patients attending the clinic.