Monitoring of fundal height during pregnancy
(15HDC00673, 20 May 2016)

Community-based midwife ~ Antenatal monitoring ~ Fundal height ~ IUGR ~ Fetal movements ~ Right 4(1)

A 19-year-old woman, pregnant with her first child, engaged a community-based midwife as her Lead Maternity Carer (LMC). At 29+4 weeks' gestation, during a routine antenatal appointment, the midwife commenced fundal height measurements and noted that the fundal height measured 27cm and the woman's weight was 60.2kg. The midwife arranged to see the woman again in four weeks' time.

The midwife saw the woman again at 33+4 weeks' gestation. During this appointment the woman reported a change in fetal movements. The midwife questioned the woman about the fetal movements, noting that they had changed from being violent to more "swoosh like". The midwife considered that this change in the feel of the fetal movements was expected due to the baby getting bigger. The midwife recorded the fundal height as 29cm and the woman's weight as 65.5kg. The midwife planned to see the woman again in two weeks' time.

The midwife saw the woman again at 35+4 weeks' gestation. She documented that the woman was reporting good fetal movements, and that her fundal height was 31cm and her weight was 66.2kg.

The midwife saw the woman two weeks later. She noted that the woman was reporting good fetal movements, and that her fundal height was 32.5cm and her weight remained static at 66.2kg. The midwife arranged an ultrasound growth scan. The scan was scheduled for six days later. The midwife planned to see the woman on the day following the scan.

The following day the woman reported having decreased fetal movements all day. The midwife requested that the woman lie down on her left side with her hands on her abdomen and pay attention to the fetal movements, and to call back in 30 minutes. The woman called back advising that there had been no improvement in the fetal movements. The midwife immediately arranged for the woman to be assessed by her colleague, a registered midwife, at their clinic rooms.

The second midwife assessed the woman and carried out a cardiotocograph, which was documented as "not reassuring enough to leave for scan … ". The second midwife contacted the on-call obstetrician at the hospital and arranged for the woman to be assessed in the Birthing and Assessment Unit. Following assessment the baby was found to have severe intrauterine growth restriction (IUGR), and a decision was made to induce labour the following morning. The following day the baby was born via forceps delivery. He was treated for severe IUGR. He is now well and has met all his developmental milestones.

By not commencing fundal height measurements until 29+4 weeks' gestation, and by failing to identify and respond to the clinical features of IUGR, the midwife failed to provide services with reasonable care and skill. Accordingly, the midwife breached Right 4(1). Criticism was made of the midwife's failure to fully document details of her decision-making and discussions with the woman.

The Commissioner recommended that the midwife attend further training in relation to the use of customised growth charts and antenatal assessment. The Commissioner also recommended that the Midwifery Council of New Zealand consider whether a review of the midwife's competence is warranted.