LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH, AGEING AND COMMUNITY SERVICES
Ms Bec Cody MLA (Chair), Mrs Vicki Dunne MLA (Deputy Chair)
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Submission Cover Sheet

Inquiry into Maternity Services in the ACT

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Gemma SMYTH

[redacted]

Committee Secretary, Standing Committee on Health, Ageing and Community Services

Legislative Assembly for the ACT
GPO Box 1020, Canberra ACT 2601

Dear Committee Members

Please find attached my written submission to your *Inquiry into Maternity Services in the ACT*.

Thank you for considering my submission and I would be happy to appear before the Committee when hearings commence.

Regards

Gemma SMYTH

In December 2016 I gave birth to my son prematurely (32 weeks gestation). This was an unplanned and unforeseen premature birth, I had had a very healthy pregnancy leading up to that point. I was a private patient of [redacted] who delivered outstanding care during my pregnancy. I had planned to give birth at Calvary John James Hospital but due to my gestation had to be admitted to Canberra Hospital.

My submissions relates primarily to the efficiency and efficacy of maternity services (which from my experience I consider to be poor), patient satisfaction with the services and the practices associated with birthing emergencies.

I arrived at Canberra Hospital at approximately 12.30am on [redacted] 2016 at 32 weeks gestation. My waters had broken at home just three hours earlier, I was seen by [redacted] at John James and was informed that I had to go to Canberra Hospital given I was only at 32 weeks. Contractions commenced on my drive from John James to Canberra Hospital.

When I arrived at Canberra Hospital I advised the midwife that since leaving John James 10 minutes earlier contractions had started and were already approximately 6 minutes apart. I felt this information was immediately dismissed as though I wouldn't know what I was talking about.

The midwife felt my stomach and commented that there was a lot of movement and that the head wasn't engaged. I told her that was contrary to recent (less than a fortnight before) scans and other advice I'd received from my obstetrician who had said that the head was well down and engaged. The midwife didn't respond in any way to my comment, again I felt as though I was being dismissed.

At no point in the entire time I was at Canberra Hospital before my son was born was I physically examined to see if I was dilated, this was my first child so hadn't birthed before but found this odd. My mother (who has had five children naturally) who was with me and my sister both also thought this was unusual. It was at this stage I began to be concerned about the experience of the midwife, I felt she wasn't sure about what to do most of the time she was with me.

It was over an hour after arrival that I was cannulated in the back of my left hand. When I was cannulated I told the midwife I didn't think that is was in properly and that I had felt a 'pop'. The midwife wasn't able to flush the cannula or draw blood from it but left it in anyway.

It would be another hour before another midwife was called in to try and take bloods from me. The midwife couldn't use the existing cannula so the blood was taken from my arm. I was having significant contractions by then and taking blood was challenging as I wasn't get any reprieve from the contractions.

I advised the first midwife a number of times that I was in pain and that the pressure was intense. I explained I'd been an elite athlete and was used to pain and pushing past pain and had a high pain threshold but again I felt ignored. I very much felt like she didn't believe me or that I was making things a bigger deal than they were. It was just before 3am that I told her again that I couldn't really cope with the pain and that the pressure in my lower back was now very intense. I kept asking her what I should do as I hadn't given birth before. I asked her what the plan was and never got a response.

My mother and my sister also asked the midwife what the plan was given the midwife didn't seem to think birth was imminent, they too were starting to get concerned about a lack of engagement from the midwife and were also staring to question the experience of the midwife. Just after 3am I told the midwife I felt different and that I had to push, I asked her again what I should do.

She, only at that time, reluctantly examined me and appeared to panic when she said she could see my son's head. I told her I couldn't hold on and had to push, she asked me not to push so she could prepare for his birth. I had to push and literally pushed once and he was born.

At no point prior to my son's birth was the room prepared for his arrival, the bed/crib on the wall wasn't even unfolded until she saw his head.

The midwife later came in to apologise to me about the lack of care through labour and admitted she was a new graduate midwife and hadn't anticipated what was going to happen. I still question why, at 32 weeks pregnant, I was assigned a graduate midwife when I was in active labour. She clearly wasn't supported by other (senior) midwives and didn't appear to have an understanding of general processes or procedures. She didn't know for instance that she had to call my obstetrician to let him know that I was in labour. As a result I didn't have my obstetrician or any doctor there for the birth of my premature baby who has taken straight to the Neonatal Intensive Care Unit.

I felt chastised by the maternity staff that I didn't have a hospital bag ready with the necessary items like maternity sanitary pads. The midwife said the hospital didn't have any for me to use so my mother had to wait until the shops opened to go and buy some for me. I was left to bleed freely until that occurred, this was embarrassing and uncomfortable.

Post birth I was moved to a room on the antenatal ward at approximately 7.30am, I walked down there with my mother and sister.

Once in my room on the antenatal ward I was told that the tea room was down the corridor if I wanted a cup of tea. At no point from that time to discharge at 3.30pm that same day was I offered food or water. I had to walk to the hospital's café to buy my own lunch.

I was then told in the afternoon that the midwife had spoken to my obstetrician and that my obstetrician had said that he was happy for me to be discharged. My obstetrician later informed me he was told I'd asked to be discharged so he'd agreed. I felt, in effect, that both sides (myself and my obstetrician) had been played off against each other to get the room back. It was made quite clear to me that the staff wanted the room back, at no point was I asked if I wanted to even stay the night to be with near my son in the NICU. It was known I was a single mother and that this was my first child. I felt disempowered and vulnerable.

I was then encouraged to pack up my room and was discharged at 3.30pm, 12 hours after giving birth to a premature baby who was in the NICU and would remain there for some time. From the time I arrived on the antenatal ward (post birth) to when I discharged my observations were taken once (just blood pressure and temperature) and I was not physically examined at all prior to my discharge as I'd required stitches after birth. No one spoke to me about wound care or examined me.

My interactions with the NICU team were nothing but positive, their level of care for me and my child was exceptional. They also appeared to be very surprised at the speed of my discharge.

My obstetrician was also very unhappy with the lack of care I'd received and made formal enquiries of the Clinical Director as to why he wasn't notified of my active labour and why the medications he'd chartered were not administered. He also questioned the management and level of my care pre and post-delivery. The response from the Clinical Director was far from satisfactory, included factual errors and pushed back to the responsibility to my obstetrician. As my obstetrician said at the time he'd have been happy to manage my care but was notified by the hospital I was in labour.

My discharge notes from Canberra Hospital also included factual errors which led me to believe they'd drawn from the notes of a different patient or had recorded my notes incorrectly at the time. Errors included a recording 'this pregnancy was complicated by prolonged rupture of membranes for 4 days' and 'antibiotics were given before delivery'. My membranes ruptured a few hours before delivery and I was not administered antibiotics, which the Clinical Director acknowledge when I questioned this. The clinical director acknowledged my lack of care was due to a lack of resources but this is not satisfactory.

In summary I was very dissatisfied with my treatment generally and the specific care, or lack of, that I received at Canberra Hospital. If I were to have another child I would do everything I could to avoid birthing there again. I have many associations with the medical fraternity including a grandmother who was awarded an Order of Australia for her services to nursing in Canberra and fully appreciate the stresses of working within the environment but this does not diminish my view that there are fundamental flaws in the processes, procedures and quality of care.

I think everyone involved in my situation is exceptionally lucky that my son survived birth and has since thrived but **luck** should not be a fundamental part of the management of patient care and maternity services in Canberra.