



LEGISLATIVE ASSEMBLY

FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH, AGEING AND COMMUNITY SERVICES

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Submission Cover Sheet

Inquiry into Maternity Services in the ACT

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To whom it may concern,

My experience with Canberra maternity services has been an extremely messy, frustrating and devastating one. Although I have had some beautiful nurses, for the most part my experience has been horrible and negative. I have had two pregnancies, one was with twins who are now almost 22 months old and my other pregnancy was with a baby boy in May this year, who passed away when I gave birth to him at 22 weeks. My first pregnancy was an IVF pregnancy and I was under the care of Private obstetrician Dr . My second pregnancy I went through the public system at Calvary.

Experience with Dr

I was under Dr care throughout my twin pregnancy 2017/2018. My twins were born extremely premature at 27 weeks. Dr was negligent and failed to give myself and my twins the care that we needed. My referral and early ultrasounds from Dr (my fertility specialist) clearly showed and stated that my twins were MCDA (one placenta). These scans were taken at 7 weeks and 4 days and then again at 9 weeks and 5 days. At my second appointment with Dr (after my 8-week scan with Dr , when we found out we were having twins) I told Dr that they were identical, and he just laughed at me and said, "how do you know". This was very condescending. I did not push further as he was my Dr that apparently specializes in twins, so I trusted him. At the time I had no idea that identical twins were considered a high-risk pregnancy and that I should have been having fortnightly appointments and ultrasounds. I have since learnt that there was a typo on Dr scans but that the imaging was correct and 'clearly shows MCDA twins'. I do not know why Dr never contacted Dr or spoke to me about this.

After making an official complaint, in regards to my scan, Dr has replied "I had also received an ultrasound from CFAC on 12/10/17, this report stated that the pregnancy was a Monochorionic Diamniotic Twins pregnancy, which would require more frequent monitoring, however in the content of the report, the placenta for Twin 1 was in the anterior position and Twin 2 was stated to have a posterior placenta position. This indicated that there may be 2 separate placentas. I sent an SMS to Dr asking him to clarify. Dr subsequently called me back after reviewing the images again. He informed me there had been a typographical error and that the ultrasound showed a Dichorionic Diamniotic twins' pregnancy." This is absolutely ridiculous. First of all, why didn't either Dr not look back at the first scan at this point? And also, why was I not communicated any of this? This is extremely upsetting to just now be learning. Furthermore, why was the report not updated and explained to me? Finally, how can communication through a text and phone-call (if this actually did ever occur) be considered appropriate or professional and overwrite the official report? These are all questions that I am still waiting for Dr to answer through mediation.

In my first trimester Risk assessment through the Canberra Fetal Assessment center on 13th October 2017, it is also clearly stated that I had an MCDA pregnancy. However, in the second trimester ultrasound on 27th November 2017, it is indicated that my twins were DCDA and again on my Growth scan on 8th January 2018 my twins are indicated as DCDA. So, Dr

never gave us a classification of twin type and it was not until after my twelve-week scan that he told us there were two placentas. Yet before this time, I never received fortnightly scans and I was never referred on as a high-risk pregnancy at FMU.

Furthermore, on the 10th January 2018 for some reason Dr [redacted] reviewed my images and told Dr [redacted] that his findings were consistent with MCDA (identical and one placenta) twin pregnancy and not DCDA twin pregnancy. Yet I heard nothing from Dr [redacted] and was hospitalized on the 16th January with my twins arriving via emergency Cesarean on 21st January. Dr [redacted] was on holidays. He needs to have something in place while he is away to ensure high-risk pregnancies like mine do not slip through the cracks. While I was in hospital, Dr [redacted] came and saw me (before the birth) and giggled as he told me that there was actually one placenta and I learnt that the early scans are actually the clearest to identify the placenta/s.

And then it gets even messier. Now I have also learnt the following "...however on the microscopic examination, it confirmed the twins in fact did have Dichorionic Diamniotic Placentas." I have absolutely no confidence in this apparent finding of my placenta because there have been so many mistakes in the care of the pregnancy and this has never before been communicated to me. Dr [redacted] also claimed that in the end as this is the finding, his 'care was appropriate'. This absolutely blows my mind: Using this final examination to condone his mistakes. From the very beginning my pregnancy presented as one placenta and therefore that was the care I should have been given. It even looked like one placenta after birth. Just because they cut it open and apparently discovered that it was two, does not mean that Dr [redacted] surveillance and care was appropriate.

In my last scan with his sonographer (who by the way always made us feel like we were such an inconvenience, taking up so much of her time with a twin scan), my cervix was not checked. I asked Dr [redacted] to look back on my scans at my post-natal appointment to check as I thought maybe I have an issue with my cervix. He went into the ultrasound room to have a look with the sonographer while I waited in the waiting room. He then came out and said that it all looked fine. However, now since filing my official complaint, Dr [redacted] states "I went and discussed this with the sonographer who was just next door at the time. We reviewed the ultrasound images together and it appeared that cervical length was not measured on her last ultrasound on 21/12/2017. It was measured on her previous ultrasound on 23/11/2017 and was normal. I returned to the room and informed Mrs [redacted] of this information." I remember this day very well and this is not the truth. Dr [redacted] did not tell me that the cervical length was not measured on my last pre-birth appointment at his clinic on 21/12/2017. I am extremely upset learning now that on that day, Dr [redacted] lied to me and I am awaiting to discuss this further with him through mediation.

My twins could have developed TTS and may not be here today due to Dr [redacted] negligence. Luckily my twins did not develop TTS, however they were born extremely premature and fortnightly scans and appointments could have very likely picked something up and prevented their traumatic start to life. I could have prevented three scary months in hospital, (Twin 1) major illnesses in NICU and their now compromised immune systems with

already being admitted to hospital with pneumonia (RSV). My last scan with Dr [redacted] was at 22+6 weeks. The next one wasn't planned until 27 weeks. I should have been having fortnightly scans. This could have prevented the traumatic experience that was my birth and the horrible start to life that my girls had.

As my private obstetrician, it was Dr [redacted] job to provide me with the information that I needed for my twin pregnancy and for future pregnancies. These are the things he needed to communicate with me and failed to do:

- He needed to inform me about the different types of twins and the risks associated with them
- He needed to inform me of the type of twins I was having
- He needed to speak to me about the possibility of preterm birth. This is a huge one. I actually asked him about making a birth plan at my last appointment before the girls were born and he giggled at me and told me it was too early. I strongly believe that Dr [redacted] needs to discuss premature birth with twin parents before 24 weeks. Especially if he and/or his patient will be going away during this time. At my last appointment with Dr [redacted] before the birth of my twins, he knew he would not see me until 27 weeks. He missed his opportunity to talk about it with me because he left it too late.
- He needed to give me information about NICU and Special Care
- He needed to inform me that I could actually have my ultrasounds done for free at Canberra hospital rather than paying through the nose at his practice.
- After the twin's birth, he verbally told me that any future pregnancies would be high risk. He needed to tell me what being a 'high-risk' pregnancy means. He needed to inform me about FMU and tell me that I would need a referral there if I was to fall pregnant again. He also needed to provide me with something in writing, because me verbally telling Drs that I am high risk was not enough. For my recent pregnancy, I had to push my GP to write that Dr [redacted] said I was a risk-risk pregnancy, but this was overlooked by Calvary. I should have been at FMU with this recent pregnancy, but I wasn't. As a result, I didn't get the high-risk care that I should have. I lost my baby boy at 22 weeks.
- He needed disclose important information about the extreme premature birth of the twins (1. infection in placenta-which may have been why one of my babies got so sick, 2. reasons why people dilate early 3. reasons why membranes bulge early and waters rupture or break). He did not give me any of the answers.

Experience with Calvary

I have recently lost my baby boy at 22 weeks. I should have gone straight to FMU with my pregnancy, but I didn't know about FMU, so I had a high-risk referral from my GP and went to Calvary. Here, they did not take my high-risk referral seriously, my voice was not heard, and I was not cared for as high-risk nor was I referred on to FMU.

The hospital did not liaise with me as a high-risk pregnancy and when I voiced in my midwife appointment about the fact that I should be considered a high risk pregnancy, I was told that

I would discuss this at my Drs appointment (which would be after my 20 week scan). At the time I didn't know any better, so I listened and followed these instructions.

I gave birth to my son on Tuesday 28th May at 22 weeks, he was born with a heartbeat and soon after passed away on my chest. I experienced a little bleeding the Monday night before, and after calling the hospital they suggested I came in to be checked. Soon I would find out that I had dilated and had bulging membrane and also evidence of a possible infection. The only form of prevention for labour and birth for us was now progesterone pessaries. These did not work and after my water breaking on the Tuesday morning, I went into labor that afternoon and my son was born. This was extremely traumatic, but the nurses were so lovely.

After his birth in May I was not contacted by Calvary for a follow up appointment. My psychotherapist suggested I make one, so I did. The hospital has since apologized that I slipped through the cracks and that they did not contact me. I met with Dr and team twice and it was an extremely awful experience. Dr has since apologized for his huffing and puffing and rolling of eyes as I tried to express my frustration at the whole situation through a cloud of immense grief. I am in the process of replying to his genuine apology, however Doctors as well as nurses need to learn how to appropriately communicate with bereaved parents.

At my appointments with Dr it was admitted that they should have liaised with me earlier but would not say that I should have been referred to FMU. Not having an earlier appointment or not being referred on to FMU meant that I was not provided with extremely important information about my pregnancy nor with the care I needed. It also meant that my medical records and medical history were not considered.

I have since attended a pre-pregnancy planning appointment at FMU (to look at this pregnancy and possible future pregnancies). In this appointment I learnt more about what my care should have looked like for this pregnancy. I also confirmed that I should have been cared for by the FMU. I was completely unaware of FMU and their high-risk program until the day before my son died (when a Dr told me that next pregnancy that is where I will be). When I asked this FMU doctor if I had been referred, how the care would have been different, I was told that I would have been given progesterone pessaries from 16 weeks. This could have saved my baby boy. Further to this, I would have had regular check-ins with one-to-one care and fortnightly ultrasounds. Dr and his team denied me of this care and therefore denied me of having the best chance of giving birth to at a much safer gestation. If I was treated as a high-risk pregnancy my baby boy may still be alive.

I was also provided with misinformation in the last appointment with Calvary. There was a mistake in the original post-mortem, and I was told that it had now been discovered that actually had pneumonia and that he would have had it for a while (a few days or more). I was told that he was sick, and he would not have survived. However, at my appointment at FMU it was explained to me that the infection which had was very new and that it would have occurred the day he was born-he got sick because I got sick. After making a complaint, Calvary still stand by the information they gave me, so this is extremely frustrating and simply not good enough. Information needs to be consistent and correct.

Finally, to no fault of the Doctors or nurses, the wait time when I first arrived at the hospital was not good enough. My symptoms made me an emergency, but I had to wait over an hour to see a Dr and in these situations, time is of the essence. What would be more of an emergency than a baby? I then had to wait a long time to begin my antibiotics through cannula and the pessaries did not arrive until almost 10pm at night (I arrived around 5).

Experience with Canberra Hospital

In January 2018 my twins were born through emergency caesarian at TCH. The Drs and nurses were amazing. Most nurses were professional, kind, caring and nurturing. I felt so safe and at ease even in such a scary situation.

In the NICU most nurses were amazing. They were so good at what they did and helped make the days easier. They were also always very welcoming and accommodating. The Drs were kind and quite thorough, although I do wish that they used and explained the exact terms, even though the information is scary, it is important that parents receive it.

The equipment (along with the staff of course) saved our baby girls' lives. Amazing.

Thank you for reading my submission. I hope it is clear and succinct as it can be. It has been a mammoth task going to meetings and gathering all the information I could about my pregnancies since the death of my baby boy . I have tried to include information from my complaint process. It really was/is an absolute mess and I still do not have answers for some things. I think the common thread throughout this all, is that Drs need to communicate so much better (with each other and with their patients). So many mistakes have surfaced in my two pregnancies and it's just not good enough.