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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COVER PAGE

This submission has been prepared of the Standing Committee on Health, Ageing and Community Service's inquiry into Maternity Services in the ACT.

The Committee Secretary
Standing Committee on Health, Ageing and Community Services
Legislative Assembly for the Australian Capital Territory
GPO Box 1020, CANBERRA ACT 2601

Dear Committee Secretary,

RE: Inquiry into the Maternity Services in the ACT

Thank you for extending the submission period for the Inquiry to Maternity Services in the ACT.

My submission addresses the following Terms of Reference (ToR);

ToR A - Models of care for all maternity services offered at the Centenary Hospital for Women and Children (CHWC) and Calvary Public Hospital (CPH), including, but not limited to, the Birth Centre, the Canberra Midwifery Program, and the Home Birth Trial and whether there are any gaps in care.

ToR C - Management of patient flow, including, but not limited to, wait lists, booking services, and capacity constraints.

ToR D - Management of patient birthing preferences, including, but not limited to, professional advice offered to patients, and the practices associated with birthing emergencies.

ToR F - The efficiency and efficacy of maternity services.

ToR H - Patient satisfaction with the services.

ToR I - The impact on staff including, but not limited to, rostering policies and practices, staff-to-patient ratios, optimum staffing levels, and skills mix.

ToR L - Any related matters.

Background

I gave birth to my first child in July 2018 at The Canberra Hospital (TCH) as a part of the Canberra Midwifery Program (CMP) run out of the Birth Centre.

I had a very straightforward and uncomplicated pregnancy. Considered to be in excellent health by my GP before falling pregnant and during my pregnancy.

My experience of the CMP

Overall, I was generally happy with my pre-natal care provided by the CMP, however, now on reflection there were a lot of warning signs that I missed because of giving my continuity midwife (someone, I trusted) and the maternity services system the benefit of the doubt that they had my best interests at heart and would fulfil their duty of care.

The birth (including labour, delivery and post-natal care) of my first child in July 2018 was the most traumatic and worst experience of my life because, of the inadequate care and lack of compassion provided to me by my continuity midwife, the CMP and TCH more broadly. I was failed as a human being, a women and a new mother. I was shown little to no compassion and it reduced me to feeling worthless, invisible and a failure.

I did not submit a complaint at the time to TCH nor offer a submission into this inquiry the first time round because I did not feel ready to wholly confront the entirety of my experience. Now 15 months later, upon reading other submissions and the stories of women, as detailed in media, I feel empowered to tell my story in the hope that I prevent other women from experiencing what I did. So, I thank those who have been brave and told their stories in any capacity.

My continuity midwife was and will be referred to hereon in in as 'my continuity midwife'. I know for the purpose of this submission this name will be redacted but I felt it important to myself and somewhat therapeutic to name this person for my own healing moving forward.

My birth story

40 + 0: Tuesday

As previously mentioned, I had an uncomplicated pregnancy, until I attended my 40 week appointment (exactly at 40 weeks gestation). Baby had never engaged at this point.

My continuity midwife did her routine checks at the appointment. My blood pressure was elevated (134/86) and had been consistent throughout my pregnancy (118/70). I had previously mentioned my concerns about my fluid retention, which were shrugged off. She did a urine test which came back positive for protein. She sent me home and booked me an appointment at the Birth Centre in 2 days' time (40 +2).

40 + 1: Wednesday

My membranes ruptured at 4:30am the following morning (40+1). No contractions and I went back to bed, called my midwife at 8:30 in the morning and was told to make our way into the Birth Centre. She performed an internal swab to confirm amniotic fluid and I was hooked up to a monitor so baby could be monitored. My blood pressure was still elevated. She explained the hospitals policy on Premature Rupture of Membranes (PRoM), gave us an information sheet, explained that it was standard procedure for a Doctor to come and discuss my PRoM with us and quipped that they would recommend I be induced immediately. I continued to be monitored, baby was 'happy'.

Midwife decided that she wanted to check baby's position, she was unable to distinguish baby's head from bottom. She asked another midwife to palpate, she was also unable to confirm baby's position. A bedside scan was ordered and confirmed that baby was head down (not engaged). I was promptly sent home, no doctor had come to discuss an induction due to PRoM. An appointment was booked at the Birth Centre the following day, in the event that I did not go into labour overnight.

40+2: Thursday

I did not go into labour overnight and attended my appointment at the Birth Centre. My continuity midwife was in theatre, so I was seen by another midwife on duty at the Birth Centre. She took my blood pressure and it was still elevated. We broached the subject of being induced and she passively

and indirectly advised against doing so. She did a urine test and was again positive for protein. She went and discussed this with a doctor and came back and said 'I've talked them around, you can go home' and we went home.

Later that night my contractions started and picked up quickly. We arrived at TCH at 11:30pm and were admitted. An internal examination (which I consented to) was performed and I was just 1cm dilated. Given my membranes had been ruptured for over close to 20 hours I was put on an antibiotic drip and transferred to the Birthing Suite for an induction via a syntocinon drip.

I will note that the attending midwife when we arrived at was my continuity midwife's alternative.

<u>40+3: Friday</u>

The sequence of events from my induction to my child's birth over the following 24 hours are as follows:

- Induction was started via drip
- Blood pressure continued to rise, was medicated. This was repeated as medication wore off.
- Baby was constantly monitored throughout.
- With every contraction Baby's heart rate was lowering dramatically. Later learned that the contractions were compressing baby on the umbilical cord. This was not communicated to us during my labour.
- Internal examination after 'labouring' for over 12 hours. Had not yet reached 3cm. Confirmed that I had ruptured my hind waters not my forewaters, so they were broken with the hook.
- Continued to labour for a few hours, internally examined again (which I'm positive consent wasn't sought), confirmed I was 3.5 cm dilated and officially 'in labour'.
- Midwife shift change occurred.
- Midwife discussed considering an epidural because I still had 'a long way to go'.
- I decided that I wanted an epidural and requested it.
- Epidural was given and had to be adjusted as wasn't working correctly. Confirmed that I had a 'window'. Throughout labour I went through two epidurals.
- Laboured and dilated to 10cm at about 10:30pm (still 40+3).
- Began pushing at 10:30pm

<u>40+4: Saturday (baby born)</u>

- Pushed for the 'allowed' 2 hours
- Due to exhaustion I was unable to deliver my baby
- Doctors entered the room and explained that I need an assisted delivery. At no point was any permission sort from me or my husband for the delivery to go ahead.
- Baby was delivered using Wrigley's forceps and a 'large' episiotomy.
- I haemorrhaged > 500mls
- I don't really remember my baby being born or the first time I held or fed them. I passed out and my husband had to hold baby to my breast to feed.
- I was left in a pool of my own blood and transferred to an overflow ward within an hour of birthing.
- I was left on the overflow ward and forgotten about.

Post-natal day 1: Sunday

- Still on overflow ward
- No contact from anyone in CMP
- My blood pressure continued to rise, was medicated over an over medication, wore off and blood pressure rose again
- Required an iron transfusion but was unable to have one on the overflow ward because not enough staff available to monitor due to my blood pressure. Was told I had to wait until a bed was available on the post-natal ward
- Milk had not come in and my baby was getting increasingly hungrier.

Post-natal day 2: Monday

- Still on overflow ward
- My continuity midwife texted me to see what time she could come and visit me at home. Explained that I was still on the ward and I needed someone to come see me and was given a reply of 'I can't, I am busy today doing visits'.
- Asked again about having an iron transfusion. Reply 'we are too busy down here to monitor you'
- Milk had not come in and my baby was getting increasingly hungrier. Was now being delayed to my low iron levels.
- Baby screamed on and off all night.
- Medication wore off and my blood pressure rose again.

Post-natal day 3: Tuesday

- Still on overflow ward with no contact from CMP
- Milk still had not come in
- Blood pressure medication worn off (again)
- Questioned when I would be getting an iron infusion. Was told that as well as not having enough staff to monitor my blood pressure and no midwifes on shift knew how to cannulate.
- By this point I was very distressed, extremely tired and felt very unwell.
- One of the midwives on shift took the initiative and suggested that she was happy to take on the responsibility of monitoring me and attempt to cannulate with a doctor supervising. This went ahead.
- Within the first 10 minutes of my transfusion my blood pressure rose dramatically. I was then taken upstairs to the postnatal ward for monitoring throughout the remainder of the transfusion
- I broke down when we got there, I was exhausted and felt like I had been invisible to anyone the moment my baby was born. I aired how I felt to the doctor on shift and she went and spoke to her superior (apparently).
- I will note the care for the remainder of my stay in the post-natal ward could not be faulted. Midwifes helped me pump so my milk would come in and took my baby so I could have a rest. They were encouraging and showed me compassion and care.

Post-natal day 4: Wednesday

- CMP midwives popped in to see me, which I got the impression they were told to do. Was chastised for referring to my baby as a 'big baby' (born 4.13kg).
- Was discharged on the condition that my continuity midwife monitored my blood pressure (medication controlled) on my community visits.

- I was discharged.

Post-natal day 5: Thursday

- Continuity midwife came to our house for first follow up visit. Was there for 10 minutes if that.
- Showed no interest in me at all only my baby. I tried to raise the subject of the birth with her, to which she replied 'XXXXXXX' was there you can call her to talk about what happened.
- I or my husband were never debriefed about the birth and what happened and why.
- She left with-out checking my blood pressure. My husband reminded me that she was supposed to check when he got home, I had forgotten. I sent her a text to say it was supposed to be checked to which she replied 'ok'.

From this point my continuity midwife made one more visit to my house a couple of days later, weighed my baby and left saying 'One more visit and you'll be discharged'. She (midwife) fell sick and again I was forgotten about, no alternative was arranged to visit me. During this time I had finished my blood pressure medication. I chased them a couple of times to see if anyone was coming to see me only to be asked who I was when I called to follow up.

An alternative was eventually arranged and when she arrived before even stepping through the door or examining me or my baby she was stating that 'we are discharging you today'.

When she took my blood pressure it was high again. She called the hospital and they advised not to discharge me and agreed that a visit would be arranged for the following day.

The next day (14 days post birth) I passed a very sizable blood clot. Contacted my continuity midwives alternative (diverted to her). She advised I come into the birth centre for monitoring and I did.

We spent all day at the hospital (with a newborn baby) to see a doctor. Was also told that my placenta and cord was tested and I did end up with an infection from my PRoM. I would not have known this had I not been back at the hospital. Doctor did a bed side scan, the doctor and midwife then performed an internal examination *without* asking me for consent. On reflection the examination was highly uncalled for given I had only given birth 14 days previously and had a lot of stiches still. Upon hearing stories in the media about internal examinations being undertaken without consent at TCH, I now know that I they should have asked if they could examine me. If I was asked I would have said no.

The doctor advised that I would need a proper ultrasound with the FMU first thing on Monday. She sent a referral and explicitly asked the midwife present to ensure that when my continuity midwife was back in on Monday for her to facilitate my appointment ASAP. I was sent home with some misoprostol and antibiotics (because my inflammation markers were high).

Monday came and my continuity midwife called to say that she got the message and I was to call FMU, it wasn't her responsibility and she was discharging me from the CMP program that day.
I called FMU and there was a lot of confusion about my referral and was told to 'ask my GP for another' and that I 'might' be able to get an appointment in a fortnights time. I felt so defeated and abandoned. I heard nothing else that day, however, following morning I was called by the FMU and asked to come in ASAP for an appointment that day.

We went back in and as soon as the sonographer placed the doppler on my stomach you could instantly see matter still in my uterus. She asked who was looking after me and I again broken down and said 'no-one, the CMP discharged me yesterday knowing this hadn't been resolved and I still was having medical issues'.

The sonographer went up to the birth centre and asked that someone prepare for me coming up. I arrived, they took bloods and I waited all day (again) to see a doctor. The doctor came, reviewed my scan and bloods. Sent me home with a note for my GP to monitor my blood pressure and follow up with a pelvic ultrasound at 6 weeks postpartum to check if my body had broken down the remaining clot.

The moment that I left the hospital and realised that I didn't have to go back there and deal with them and the system, was probably the happiest moment of the preceding two weeks.

Reflections

- We have a very happy, healthy and thriving 15 month old, who is the light of our lives and is the best thing that has ever happened to us, but it has been at a mental and physical cost to myself because the lack of duty of care provided to me by ACT maternity services. All of what happened affected me bonding with my baby and my fear of having another baby.

- I acknowledge that there are some aspects of my birth story that were out of the control of the hospital and would have occurred wherever I chose to give birth (i.e. size of baby and blood pressure issues). However, I strongly believe that if my post-natal care was adequate I would have not had experienced the mental stress that I did. If I was supported and acknowledged I could have had a very different experience. There is little to no focus on the mother post birth. In my case, I was disregarded because my baby was 'healthy'.

- I felt invisible once my baby was born, I felt lost in the system, like no one who should have cared about me did. I was made to feel like a burden because I was still having complications 14 days post-partum. I even apologised to CMP staff for still being with them post 10 days. I felt that my continuity midwife was washing her hands of me to meet her 10 day metrics and because I was too 'complicated' for the birth centre.

- We were never debriefed about what occurred. This account has been put together from the very limited medical notes I was given on discharged and us piecing together what we can recall. Does not appear to be a routine practice at all.

- I feel like the birth centre ideology was more important than my medical needs during my birth. I feel like they pushed for a vaginal birth at all costs. I was told later on as well, that my pelvis was very small and babies head was big so it was always going to end the way it did. I felt this could have been avoided with more routine scans etc. my last was 20 weeks because I was 'low risk' and measuring cm for week. There are obviously systemic flaws in the 'low risk' births are monitored and defined in my opinion.

- Because of how I was treated, I felt ashamed of how I'd given birth, I felt I had failed because of all of the interventions I had. I feel this stemmed from no acknowledgement of how I felt

after my baby was born and no debrief and explanation of what occurred and why. I wouldn't let anyone see a picture of my baby until the forceps marks had disappeared and I would not let anyone know her weight. I felt I had failed because I didn't have a 'birth centre' birth.

- Birthing education classes run out of the birth centre passively demonised any kind of intervention and pain relief. I believe this fuelled my feelings of failure. I believe the CMP set me up to feel the way I did about my experience.

- There is an obvious a tension and power struggle between doctor and midwife led care in the ACT maternity system.

- Clearly there are understaffing issues in Canberra Hospitals that are impacting on the level of care being provided.

- The individual actions of my continuity midwife had such a profound and negative impact on my experience, I would as go as close to say her behaviour ruined my experience of having my first child. What should have been a momentous occasion in my life, that I thought about so much throughout my pregnancy, turned out to be the worst experience of my life. I was robbed of the moment I met my child, bonding with them afterwards and acknowledge that mu body had done such a wonderful thing of growing and birthing my baby.

- I would suggest a review of attitudinal related self-development activities of staff in the ACT maternity system. While aptitude is no doubt an important aspect of the roles undertaken, what's the point if you are oblivious to the impact you have on people's experiences.

My experience has really made me question whether I want to have another child. When the subject is broached with love ones, they ask if I would go through the Canberra system again to birth, and my answer is resoundingly, no.

If I did not have the support of my husband through all of this, I don't know if I would have survived it.

Reading other submissions made in this enquiry has greatly saddened me, to know that others have suffered. While my experience and outcomes are not as horrendous and truly heartbreaking as some, it is my experience and I will carry the impacts of it for the rest of my life. I wish others all the best on their journey to healing and understanding.

I thank the committee for the opportunity to provide this submission.

Regards,