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)
Ms Caroline Le Couteur MLA

# Submission Cover Sheet

## Inquiry into Maternity Services in the ACT

**Submission Number:** 65

**Date Authorised for Publication:** 30.10.19

Friday, 7 September 2012

The Canberra Hospital
GPO Box 825
Canberra City ACT 2601

To whom it may concern,

I am sending you this email purely due to haste however I have also sent a hard copy in the mail for your records.

I am writing to you to as I believe you should be aware of the inadequate treatment and resulting traumatic experience I have undergone at Canberra Hospital this past week.

As background during my second pregnancy we found out that our daughter had Trisomy 18 and massive hole in her heart and was not expected to survive the pregnancy or post birth. Acting on the advice of the staff of the FMU my husband and I made the difficult decision to interrupt the pregnancy, this had to be timed for when I would have his support as he is in the ADF and undergoing pre-deployment training.

On the 31st of August I received a phone call as planned from from the FMU asking if I was ready to proceed on Monday 03/09/12 at 0900 as previously organised and I stated that I had mentally and emotionally prepared myself since the Thursday and was ready to go ahead with the procedure. At 0850 on the 03/09/12 my husband, mother (who had travelled from interstate to be there for me) and I arrived at the Birthing Suit to be told by Dr the obstetrician and nurse that there was no bed available for me and could I come back tomorrow to deliver my baby. While I understand that these administration mistakes happen this was a major shock and unacceptable as I had spent quite some time preparing myself for this moment and this was very distressing for me.

from FMU persuaded them to find me a bed so the procedure could start and then move me to the Birthing suit when a bed became available. The room in which they put me had a broken thermostat and was freezing completely inadequate for any birthing woman. said she would get it fixed and reported it as urgent however this wasn't rectified until 1650 again contributing to my ongoing traumatic experience. When being told I was being admitted at 0900 I expected to have the procedure well and truly under way by 1000. If this isn't the timeframe expected by the hospital any communication would have been appreciated as it could have saved further emotional turmoil.

the registrar finally came and saw me at 1150 and made a throw away comment that "You could've started without me" to which the midwife replied "we needed your approval for the medication to be administered". This was an already extremely distressing time for me and I found the level of unprofessionalism surprising and uncalled for particularly with regard to the conduct of the midwife and doctor as this made me feel quite vulnerable.

Of particular concern was the fact that our STUDENT MIDWIFE was expected to perform the required hourly observations and when she finally went home for some well-earned sleep the hourly observations stopped and I was not seen again until 0530 the following morning. Our student midwife whom I specifically asked to be there for me was questioned as to the proprietary of her

presence much to my distress. With the ongoing complications and mistakes of the day I really needed all the support I could get at this point.

There was a lot of confusion about my understanding of the progression of this procedure as I was told by three different midwives on three separate occasions three very differing accounts of how I should progress over the next 24 hours. One midwife gave her own opinion of how I should progress and even suggested that I have a sleeping tablet and try again tomorrow. Realising how upsetting this was to me as I was so far into the process she did return and apologise. When a Doctor finally came and saw me at 2120 it was the first time I had the process clarified to me. I found the staff to be very patronising and certainly not sympathetic to the situation that I and my family were undergoing. Again professionalism of the staff comes into question when I am not being monitored hourly and my mother saw them chatting and mucking around at the nurses desk.

Concerning to me is that the doses of misoprostol were not administered consistently every 3 hours or with water as previously told was most effective even when was prompted by student midwife to do so and this resulted in what I feel was an ineffective dose and further distress.

I was finally moved to the birthing suit at 1715 on the 03/09/12 and by this point I was in quite a bit of pain and much to my relief I was told before I moved that the PCA would be prepared and ready for me when I got there however it was a further hour before it was administered.

My Husband and mother decided to go home at 0310 on 04/09/12 as nothing seemed to be happening and they were exhausted. I told them I would call them before things progressed further as we live in Amaroo which is quite a distance from the hospital. I tried to rest but found I couldn't do so. Again I was not monitored during this period and it was not until 0530 that came to observe me. I asked her to do an internal observation to see if the drug had actually worked. No mention was made that this could cause things to go faster and I was told " I can fit a finger and a bit but it is unlikely anything will happen in the next 2 hours". I texted this to my husband and mother but then found at 0612 that I was having strong twinges when on my side as opposed to on my back like I had previously found.

At 0621 I called my husband and told him to get here as I felt I was ready to push and at 0622 I called my student midwife to come in as well. I buzzed as there was no one in the room with me and I could feel her coming. Sue popped her head in and asked what was up and I told her that she was coming now to which she said shit and grabbed a random midwife from the corridor to help her. At 0625 I birthed my daughter very alone and upset.

The entire process was incredibly distressing, unprofessional and disrespectful to my needs and wishes. I find this not as upsetting as the treatment of my daughter.

After was born we had photos taken with the family and she was weighed and measured as well as having her foot and hand prints taken. After we bathed and dressed her we discovered her hands were beginning to deteriorate and as we were going to have them cast that afternoon it was suggested to us to put her in the fridge to preserve her however I could see her at any time.

When I went in to recover her for the casting session I was disgusted and distraught at finding her wrapped completely in a towel with a sticky label on it, especially as there were no other children in the fridge and the fridge itself was sealed in another room and there was no need for this to occur. I

don't know if this is procedure or not but it would have been preferable to be warned that this was the condition I would find her in.

When my husband and I decided to leave I asked the midwives at least three times if I needed to do anything or sign any papers and was told no everything was fine and that nothing was required. According to The Canberra Hospital's Inpatient Guide to Canberra Hospital and Health Services (February 2012) "Patients are required to sign the discharge form as they leave the hospital" The midwives were not busy at this point and I am confused as to why this standard procedure was not followed. I finally received contact from from Midcall at 1126 on 07/09/12 who stated that "she had just found my notes and that when she asked, no one knew who I was and she wanted to know if I was ok and if she could see me". I am concerned that my notes did not come to someone's attention before now especially as I was advised that I would be contacted the following day.

Upon obtaining the medical certificate of cause of perinatal death I have since discovered that although this is supposed to be a legal document there are several errors in it which could have been avoided upon consultation with my husband or myself. I find this to be both upsetting and disrespectful.

According to your website:-

"Birthing Suite offers a safe, private, comfortable environment where an experienced midwife will remain with you during your labour and birth." This did not occur.

"All members of the Health Care Team have a commitment to provide you with the best care possible and will actively seek your opinion in relation to the care you receive." This did not occur.

Upon Discharge "A summary of your pregnancy, birth and postnatal care will be given to you and also sent, with your consent, to your GP and the Maternal and Child Health Nurse, so they can continue your care." This did not occur

I am sending you this letter in hope that these shortfalls can be addressed in the future. An apology and acknowledgment of our experience would be greatly appreciated to help our family recover from an extremely traumatic experience and I hope that no other family has go through what we have experienced.

Should you require any clarification of this matter please feel to contact me on the details provided below.