

**Submission
No 223**

**THE SAFETY AND QUALITY OF HEALTH SERVICES PROVIDED BY NORTHERN
BEACHES HOSPITAL**

Name: Mrs Helen Broadley

Date Received: 20 May 2025

Partially
Confidential

A traumatic birth - losing baby Finn.

We wanted to include a warning for people reading our submission that we've written about the loss of a baby and provided some detailed descriptions which we know people might find upsetting.

Dear Committee,

Thank you for providing the opportunity to read the submissions and concerns of the Northern Beaches community and their experiences in receiving substandard care at Northern Beaches Hospital (NBH, the hospital).

It's taken my husband and I a long time to agree that by publicly sharing our story, we could contribute to positive change in the care our community receives. It's the courage shown by other families in communicating the systemic failings that resulted in the loss of their loved ones, that's convinced us to share ours. While there's ongoing discussion as to the future of the hospital and its ownership and we feel for the Drs, Nurses and workers that do their best every day, it doesn't take away from the traumatic experience we had, with a tragic outcome.

My family and I were failed by Northern Beaches Hospital when we put our trust in them to care for us through a complex pregnancy for monochorionic diamniotic (MCDA) twins in 2019. Our twin boys were born prematurely on Monday 25 November via a crash c-section at 30 weeks and 4 days gestation. Both twins were born not breathing, Finn devastatingly could not be resuscitated, and Asher was nearly lost, but after 10 minutes of resuscitation survived, yet required significant intervention and stabilisation before he was transferred to North Royal Shore Hospital (RNS) for ongoing care, where he remained for nearly 7 weeks. During this time, we were told by the neonatology team that his prognosis was unclear and it would be a waiting game to see if he had lasting brain damage that could result in cerebral palsy.

A root cause analysis (now called a SAERs report) was conducted by the NBH, which determined there was no one root cause for the resulting loss of Finn and impact to Asher and his chance of survival, however key findings were delivered and recommendations were made of how care could have been improved.

Following the release of the Report, we engaged the Local Health District partnerships team to request further information and questioned the validity of some of the findings. This included our experience of receiving the SAERS findings, which we didn't deem satisfactory and the incorrect recording of information by midwives during our care the night prior to the twins being delivered - specifically in reference to a medical note 'mother reports babies moving well' which was not the case.

We also followed up on multiple occasions to find out if the recommended actions had in fact been implemented, with the most recent request for information in February 2025, following media reports of families losing their children while seeking care at the hospital. My heart broke

when I read the Massa story and the tragic loss of Joe in what felt like continued systemic issues that had not improved over the years', however, it was reading the tragic loss of baby Harper, that for us affirmed the same errors continue to be made.

When I met with the clinical team at Northern Beaches Hospital back in 2020 five months after losing my son, they outlined how they thought their care had been satisfactory and when asked at the end of the meeting if I had anything else I'd like to ask, the only question I could them was 'Would you have been happy if this was the care your child had received?' The obstetrics and paediatric team didn't respond, but a member of their clinical team said 'no, of course not'.

Five years on, we live with the loss of Finn every day and the lasting trauma of how he and Asher entered this world. We will never be able to accept his loss and the circumstances of how it occurred. His twin brother Asher started kindergarten earlier this year, and as we took photos of him standing proudly at the front door in his uniform, it was a stark reminder of the many milestones he will go through life without his identical twin brother.

We have reached a stage where we feel sharing our experience within a public forum such as this Parliamentary Inquiry and proceeding with a complaint via the HCCC are our only remaining avenues. However, our key request is for an independent review of our case, without the involvement of Healthscope, but rather a fresh set of eyes to assess the evidence with our input this time, to determine whether substandard care was in fact delivered.

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[REDACTED]

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We'd previously been told by Drs that a size discordance of more than 12% between the twins, indicates a potential issue and given the size between the twins had never been more than 8-10%, a sudden jump could mean there was an issue. Twin B had a two velamentous cord insertions which wasn't central to the placenta, which meant he could be at risk of not getting enough nutrients and Twin to Twin Transfusion Syndrome. We had friends who'd tragically lost one of their twins to the condition and were aware of how serious this could be. I immediately called the birthing suite and spoke to the Manager where I explained the problem. Initially she thought I was making a complaint about my care and then commented on how anxious I sounded. She said she'd see if an Obstetrician could call me back. Later in the day, an obstetrician called, who I'd not met, and he explained, my report would have likely been reviewed by the specialist and I could discuss my concerns at my next antenatal appointment with an obstetrician at the clinic. With ongoing concern, I decided to seek another opinion. At this point, we saw a different Obstetrician of varying seniority at every appointment with no key contact. I found the details of the specialist obstetrician hired to assess high risk pregnancies and called her private rooms for an appointment. After explaining she was really the only consistent point of care we had, her team booked me in for a scan that week, where I received an OB specific sonogram which confirmed, there was in fact, no significant size discordance, and it was likely an error in the hospital's scan measurements.



At 30 weeks, I attended my standard fortnightly antenatal appointment, where I met the 12th obstetrician I'd seen at the hospital. She saw the size discordance and voiced her concern - at which point, I informed her I'd received limited support from the hospital and had sought a private scan which confirmed the size discordance was an error. After leaving the room to find a senior obstetrician, I met my 13th obstetrician, who came into the room to explain she didn't want me to worry, as they were closely monitoring my pregnancy to make sure everything was ok. Following this, the junior obstetrician attempted to use the doppler to check the babies' heart rate - she couldn't detect twin B's heart rate and did an fundal measurement of my bump - both felt redundant having just completed a scan two days previously and at this point I felt strangely calm and almost resolute that this was the situation. At this point, I was completely physically and mentally exhausted.

Two days later we attended our first antenatal class - we walked into a room and sat down where the midwife explained the agenda for the day including what we could expect as a private patient. After realising we'd gone into the wrong class, we were directed out the door, into the immediate next room to a much larger group of expectant parents, giving birth at the hospital as public patients. As the only twin pregnancy, we were quite the novelty, and as we spent the next 4 hours talking through birth, I started to notice how active the twins were- to the point it was highly distracting- there were limbs protruding and pushing and I assumed it was probably due to the hard seats. At one point the midwife explained she was planning to show a natural birth, but as we were the only planned c-section and she made the comment 'you never know when

twins might arrive' she'd show us the c-section delivery, followed by a demonstration of what to expect when receiving a spinal anaesthetic.

That night I spent most of the night awake, experiencing some pain, which felt like it might be ligament pain, but I'd also noticed what felt like a sudden reduction in movement of the twins. I put it down to their exertion during the day and assumed they were both asleep, but the patterns were different and I knew from leaflets I'd received, this was not a normal part of pregnancy.

The next morning on Sunday 24 November, we met friends for coffee, ran errands and during this time I noticed further reduced movement and felt increasingly concerned. I completed the usual checks of cold drinks, kick counts before I called the birthing suite to say I was incredibly concerned and needed monitoring - I was asked to visit the birthing suite.

Arriving at the Northern Beaches Birthing Suite on Sunday evening, we found a chaotic department, with stressed midwives and a registrar who while caring for us, was repeatedly talking about how busy it was and how annoyed she felt. Multiple midwives came in to palpate my bump, saying 'I can feel the babies moving' and I started by replying 'I can't feel them moving like they usually do though'. As time went on, and we were left for long periods of time, I started to doubt my gut instinct and almost felt embarrassed for going to the unit - I kept apologising to the staff and when the registrar suggested sending me to maternity, I didn't question it and felt relieved that at midnight, everyone could get some rest. I was told there were no concerns, and a scan would be repeated.

I spent the night awake, incredibly uncomfortable, trying to sleep on my side with a couple of welfare checks from nurses - in my medical notes, it's reported 'mother feels babies moving well' which I would not have said, as this wasn't the case. In the morning, I ate breakfast, called my husband to say I'd been told they were planning on a reassurance scan, but then I'd likely head to work and he should too.

Two midwives arrived chatting about their plans for the day as they attached the fetal heart monitors. Looking back on the day, I'm still shocked by how relaxed and slow everything felt. Aside from the fact we'd presented to the birthing suite at 7.30pm on Sunday night and I was left unmonitored from later that evening until the following morning, the timeframe from when the midwives arrived on the Monday morning at around 8.30pm resulted in another 2 hours before any action was taken. I berate myself for not being more vocal, but at this point had almost convinced myself I must have been over-reacting and the symptoms I was experiencing were 'normal'. Hindsight can be incredibly cruel and for me personally, it will remain one of my greatest challenges to come to terms with what happened and not putting all the blame on myself - yet as a mother, you do feel completely responsible - I was mine, Asher and Finn's advocate and I thought I'd sought the right help and support.

One of the midwives commented 'one of these boys is being a bit naughty', I'm just going to call the OB team to come and have a look. The next stages are quite blurred, until the point the OB, another person I'd never met, turned to me and said bluntly 'this is a life and death situation, and we don't deliver babies this early here'

She pressed the button on the back of the wall and it felt as if half of the hospital's staff arrived - my clothes were removed, I had injections of steroids in my legs, a canula put in my arm and whilst this happened, I kept asking to call Dan to update him, as I'd just spoken to him to say everything was fine and to go into work.

As the nurses and Drs ran down the hallway pushing my bed, I remember thinking, was it a life and death situation for me as well as the babies - if so, I hadn't even told Dan how much I loved him. I knew I had no control over what was happening and the only thing I could really do was to remain as calm as possible to get the babies delivered as quickly as possible. At that moment, I had a flashback to the demonstration of the midwife two days before at the antenatal class administering an example spinal to one of the dads, shirt lifted, laughing, and I couldn't comprehend, how less than 48 hours later, I was in a theatre, delivering my babies under these circumstances.

The delivery itself was chaotic, and I remember looking at Asher in the NICU the following day, and he had cuts and scrapes to his heels and knees, and I had the same on my elbows and hands, and I still don't know why. I was lying flat on my back with a nurse standing above me, while people leant over to give me updates. When I turned my head to my left and looked past the delivery team, I could see two big groups of people gathered around tables, the pediatric team who were working on each of the twins. There was a lot of shouting and panic, with the anesthetist who'd come to my room prior to delivery, shouting to the different teams to try to coordinate the chaos. People were shouting to administer adrenaline and CPR over and over and over, there were monitors beeping but there was no sound of crying and at that point, I saw the nurse over me with tears in her eyes and I thought 'I've lost them both'.



Personal Statement – Daniel Broadley, Finn and Asher's Dad

On Sunday 24 November 2019, Helen and I became increasingly concerned. She was 30 weeks pregnant with our identical twin boys and throughout the day their movements had noticeably reduced. We tried everything we were told might help—cold drinks, lying on her side, even a swim in the ocean—but there was still limited movement and we were getting increasingly anxious.

At 6:30pm we called the hospital's birthing suite and they advised us to come in for precautionary checks. We arrived around 7:30pm and they told us they were having a busy night with multiple births underway. The midwives attempted to find a trace on both babies but struggled. On more than one occasion, we were asked to hold the CTG monitors in place ourselves while staff attended to other patients. They tested for a urine infection, had two failed attempts at drawing blood and did a physical assessment of Helen based on the reduced

movement she felt and pain in her pelvis. It felt like we weren't a priority, despite being 30 weeks into a high-risk twin pregnancy with very concerning symptoms.

I remember feeling confused and increasingly frustrated—Helen and I were left to try and adjust the monitors ourselves, unsure what we were doing, watching the trace drop in and out as we tried to find the heartbeats. It was bewildering. Eventually, two hours after the first attempt, the Registrar sat on the bed next to Helen, holding a trace. She frequently shared her frustrations at how busy the unit was and that we just needed to get a 15 minute consistent trace. She reassured us that everything looked fine, but said they would perform an ultrasound in the morning and it was best that Helen stayed overnight in the maternity unit.

The next morning, I called Helen early. She told me she hadn't really slept as the babies weren't moving and she had some pain which she thought might be ligament, muscle pain, and although her vitals were checked, no one had reviewed the babies. Still, we were both under the impression that everything was on track. She was even planning to go into work later that morning—it was her final week before maternity leave. And I went to work too.

At around 9:30 am, I received a call from Helen and I could immediately tell she was trying to stay calm, but her voice was wobbling as she said "You need to come back to the hospital... they're going to deliver." That was all she managed before her phone was taken by a nurse and the call ended.

I arrived at the hospital within 20 minutes, where I was asked to put on scrubs and was taken to a small room where doctors explained Helen had undergone an emergency caesarean. Both of our boys had been delivered, but neither had been breathing at birth. Helen was in a stable condition, but the twins were in critical condition. I felt myself go into shock and disbelief, that I'd spoken to Helen earlier that morning and everything had seemed fine, yet between leaving work and getting to the office, the babies had been delivered. When I saw Helen wheeled out from the theatre, her face was one of shock, devastation and trauma.

The recovery area was noisy and chaotic and in the neighbouring bed, a man cried out in pain for his mum. The paediatric team came behind the curtains to our bedside, with little privacy. They told us that both boys had required significant resuscitation, and at this point Helen asked if both twins had died. The Drs confirmed Finn had not survived but Asher had been resuscitated for nearly 10 minutes, and he was alive but in a critical condition.

We spent a short period of time together holding and cuddling Finn, unable to understand what had happened - he looked perfect as if he was a newborn sleeping.

The doctors told us Asher was stable enough for me to see him while Helen was moved to the birthing suite with Finn. I'll never forget seeing Asher for the first time - he was impossibly small,

fragile, with tubes and wires everywhere. I was told to place my hand on his chest and spoke to him and said how much we loved him and sorry I was.

There was talk of a helicopter transfer to Westmead hospital, but Asher surprised everyone with his resilience and he and I were transferred by the specialist NETS team to Royal North Shore Hospital while Helen stayed behind with Finn, and we were reunited nearly 10 hours later, when Helen was transferred, leaving Finn behind, arriving at midnight, where she saw Asher properly for the first time.

Asher spent nearly seven weeks in the NICU at RNS, during which every day felt traumatic. The day after we arrived, the neonatology team told us Asher may have suffered lasting damage due to the circumstances of his birth, including a prolonged resuscitation and oxygen deprivation and that time would indicate his prognosis, along with an MRI when he reached 36 weeks. At the same time, the pediatric team from Northern Beaches visited, advising us to consider an autopsy for Finn to understand what had happened and potentially provide insights that might help Asher. The idea of Finn being alone and not with us, is something that continues to affect us today. The autopsy results were presented to us by an obstetrician at RNS and showed no specific events that led to the traumatic, early delivery, and that Finn had been perfect. There were queries as to whether a bacteria could have entered the placenta, but in the chaos of the delivery room, a swab wasn't taken before the placenta was stored in forma, removing evidence, so we'll never reach a final conclusion.



It was during these first two weeks post delivery in the NICU with Asher that we were also trying to organise Finn's funeral. The paperwork from NBH was delayed, which required repeated follow-up and a return to the hospital to collect it and during Helen's transfer from NBH to RNS, we discovered the medical notes were in fact a front page of Helen's note attached to another women's medical notes who'd also been transferred, resulting in a serious breach of privacy.

We had also been very clear that we didn't feel able to return to NBH yet received multiple calls, emails and texts from the NBH team asking us to return to the hospital when Asher was strong enough to receive ongoing care in the special care unit - we ended up asking RNS's NICU manager to intervene and she confirmed Asher could receive all care at the hospital - we've never returned to NBH.

It was also during the first week in the hospital that we repeatedly followed up on the completion of Finn's autopsy. We'd been separated as a family for over a week and were desperate to be together - our friends who'd lost one of their twins contacted us to say they lived with the regret of not having them all together and getting at least one photo. With no specialist social worker, we had no-one guiding us on this journey and instead with no immediate family in Australia, we leaned heavily on our friends for support. Finn was brought to us in the NICU and Asher was

able to be removed from his heated incubator, for less than 5 minutes for us to hold them together for the first and only time and we treasure these photos.

The NICU environment was overwhelming—we were given a huge volume of printed information from charities, but very little of it helped us process our grief or find support and after a few weeks while in the NICU we asked if we could access grief support and counselling services, only to be told there was no availability in the public system. It was through one of Helen's work contacts who'd previously worked in the private hospital sector, that connected us to a specialist social worker in the private hospital sector, supporting bereaved parents who took our hand and guided us to get the right help - we had our first appointment on Christmas Eve and have continued to see this counsellor for the past five years to help navigate our grief and access post traumatic stress. That connection was a turning point for us, but it should not have been so hard to find support during such a profoundly vulnerable time. The specialist social worker is truly a guardian angel, committed to supporting families at their most vulnerable time, but we know it's not a service every grieving parent can access, especially if they're in the public system.

