Submission No 445

INQUIRY INTO BIRTH TRAUMA

Name: Name suppressed

Date Received: 11 August 2023

Late August 2020, my husband and I found out that we were expecting our first child, due in late April of 2021.

Weighing 120 kilograms at my initial confirmation GP appointment, I was immediately categorised as a 'high risk pregnancy' and was told that I would not be able to birth at my local hospital in [redacted] NSW, [redacted] Between 10 and 15 weeks pregnant, I was contacted back by the [redacted] Birthing Options Team and advised that because I then resided in [redacted] mere minutes from the [redacted] border, that I was ineligible to access the Continuity of Care program offered within the [redacted] Healthcare system. My preference for continued and personal health care and emotional support was denied because of my residential address, all while the option of a continuity program and birthing at my local hospital, was not an option.

I soon contacted the then [redacted] Minister for Health, disputing this decision and discussing the irony that although labelled as a 'high risk pregnancy', that having an ongoing team of the same midwives and medical professionals was not available to my family and I.

I received a reply, stating that due to my circumstances (and my strongly worded email), that I would have access to an ongoing midwife throughout my antenatal period. My antenatal appointments continued with the incredibly professional, supportive, and knowledgeable midwife, [redacted] I was appreciative of having access to the same medical team throughout my antenatal period, however, not having access to this team during labour and birth and then in the postnatal period, was very upsetting and disappointing, and I strongly feel was a disservice medically and emotionally to my pregnancy and birth experience.

My pregnancy was progressing 'normally' and my growing baby and I were happy and healthy. At 35+ weeks, I attended my routine midwife appointment with [redacted] to receive the concerning news that I was showing signs of preeclampsia and would need to be assessed at the Maternity Assessment Unit at the [redacted] Hospital.

Later that night, after approximately 10 hours of waiting for confirmation and testing, it was confirmed that I had preeclampsia and that ongoing monitoring and blood pressure reducing medication was necessary for the remainder of my pregnancy. From this point I didn't see [redacted] again and the cycle of differing medical professionals began. I was attending the [redacted] Hospital on average twice, weekly, for monitoring, scans, and appointments. I vividly remember calling my husband at 36 weeks pregnant after my routine appointment, sobbing, shaking and trying to catch my breath in disappointment and fear, after having just seen a different doctor/registrar, having to re-explain my medical and pregnancy history, justify my pregnancy and birthing wishes, insist on them checking my blood work results following their assumption that as an overweight pregnant woman, that I MUST have gestational diabetes (I did not have gestational diabetes), and process their medical review on the health of me and my unborn baby. From that appointment, I didn't ever attend another appointment alone.

At 38 weeks pregnant, we attended our routine appointment to be seen by again a different doctor/registrar. She explained that due to my response to the blood pressure reducing medication and the results of my scans and monitoring, that it would be safe for both my baby and I, to continue our pregnancy and that an induction was not necessary at that point. I was so hugely relieved as an induced labour and birth was not something I wanted. I remember saying 'thank you' to that doctor/registrar. She soon left the room to what I assume was confirm her medical decision, and minutes later returned, to say that no, it was absolutely necessary for me to be induced and that my induction would take place the day after next. This left both my husband and I grappling for answers and justification and greatly concerned for the health of our baby.

I was told I would need to be assessed at the Maternity Assessment Unit the following day to ensure the health of my baby and I. This assessment proved 'normal' and no significant concerns were brought to my attention. I was told that the following morning I would receive a phone call to tell me what time to be at the hospital to prepare for my induction. The following morning, I received a phone call with a midwife stating that they did not have enough staff to cater to my induction and that I would need to wait for a phone call on the following day, however that I should again be seen at the Maternity Assessment Unit. This was an extremely distressing time for my husband and I. We had only hours earlier been told that the health of our baby was relying on an induced labour and birth and to prepare for the arrival of our baby the following day, to then be told that I wasn't able to be tended to and that I would need to simply wait. I attended the Maternity Assessment Unit to be seen by the same midwife as the day previous.

She was outraged that I had not been admitted to hospital and that my induction had not begun. Given that she was the midwife monitoring the health of my baby and I, this caused greater concern and angst for my husband and I. She insisted that she would be calling the maternity and birthing ward, and that I WOULD be admitted and induced later that day (Wednesday). I was told to go home, collect my belongings, and return to the hospital for admission at 4:00pm the same afternoon. We followed this guidance to then wait in the waiting area for more than six hours, be admitted after 10:00pm. At admission I was told due to the time that my induction would not take place that night and instead it would begin after 'handover' the following morning. Approximately an hour later, a midwife arrived and told me that we would begin the Foley Balloon, catheter like induction process. Upon insertion I quizzed her on how the balloon should feel and where in my pelvis and vagina I should be feeling pressure. She assured me that there was 'no way it could be inserted incorrectly' and that she was sure it would be working to open my cervix, preparing me for labour. I trusted her medical experience and judgment and my husband, and I settled in for the night. The following day, around midday I used the bathroom and the balloon fell out.

I buzzed for a midwife, and she arrived. She suggested a cervical examination to see the progress of my cervix following the balloon. During the examination, she proceeded to tell me that she was extremely sorry but that the balloon had not been inserted properly and was not sitting high enough to be having effect on my cervix and that the last 12 hours were wasted. It was here I began to feel that I was losing emotional strength and became greatly

concerned for the welfare of my baby. Hours later a midwife arrived to insert the Cervedil tape to continue to ripen my cervix. I was told this would need to be in for 12 hours and then it would be removed. After the 12 hours when I asked when it would be removed and when Syntocinon Infusion would begin, I was again told that there were not enough staff to be allocated to my induction and that we would need to wait. 24 hours later (Friday) the tape was removed. At this point I was told again that the Syntocinon Infusion induction method could not begin because there were no staff available to support my labour and birth. At this point, I had reached a point of exhaustion, relentless fear, and extreme frustration.

Against my birthing wishes, I was told an almost immediate induction was necessary for the health and welfare of my baby and I, by this stage we were more than 48 hours post the recommended induction time and no one was able to tell me when I would definitely be induced. I remember curb walking, nipple stimulation, raspberry leaf tea and bouncing on the birth ball, doing all I could to bring labour on without needing to wait for someone to be available. Unfortunately, nothing was working. I remember sitting in our allocated room, room 19, directly opposite the midwife station and main desk, crying almost at a point of hyperventilating. I felt failed, ignored, lost and emotionally depleted. These emotions would be the emotions that saw me into my first labour and birth experience, these emotions were the emotions that saw me meet my first born baby. Later that night, at around 9:00pm a new midwife, [redacted] introduced herself as the midwife that would be beginning my induction. My induction began and 12 hours later (Saturday), my beautiful baby girl was born.

Although I hold no trauma in the birth of my daughter, the service and support received in the months, days and hours before her arrival caused emotional turmoil and feelings of isolation and distress for my husband and I. As I was moved from the birthing ward and to the maternity ward, a leading midwife, [redacted] sincerely apologised for the lack of medically and emotionally sound care and support we received and for the inadequate time frame that saw our daughter welcomed into the world. In this conversation she handed us an experience review form and strongly encouraged us complete it and forward it to the [redacted] Department of Health.

Again, reflecting on our experience, highlights the unsatisfactory service we were provided and unearths the emotional distress from this time. In the most vulnerable time of my life, I deserved better.