

Submission
No 608

INQUIRY INTO BIRTH TRAUMA

Name: Name suppressed

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Partially
Confidential

My name is _____, I live in _____ NSW and I'm a midwife, nurse and mother to a beautiful 16mth old boy. As a midwife mum-to-be I had hopes for how my birth would unfold, this was made impossible when I experienced an unprovoked placental abruption at 38 weeks resulting in my son being born by caesarean under a general anaesthetic one hour later. I was in an MGP model of care but my midwife was out of hours due to short staffing, preventing continuity of care at birth. Another MGP midwife stepped in for my birth but due to short staffing was only able to attend my birth and then handover to other staff. I was put to sleep in theatre afraid my baby would die, and awoke in recovery with strangers. Uniquely, as a midwife-mum I knew what the emergency was and the significance of the events as they unfolded. The recovery staff I did not know could not tell me if my baby was okay, where he was or what had happened. They told me they had to sort me out before I could go upstairs to the unit for more information. There was no midwife with me due to staffing, neither was my baby or my partner.

Once allowed to return to maternity about an hour later a midwife stopped the bed in motion in the hallway to put a baby on my chest. I had to ask, "is this my baby?". Though a small thing, it hurts me deeply to have had to ask if my baby was mine because of the circumstances of this meeting and that I had been sedated for his birth. He was mine, my partner wasn't present as someone had sent him home to get colostrum. I never got to see the moment my partner became a father, nor he when I became a mother. The moment I met my son was in the middle of a corridor surrounded by staff that were my colleagues. I burst into tears.

I was wheeled down to the maternity ward and left alone in the room with my baby while I desperately tried to achieve skin to skin and breastfeed amidst all the cords, nobody had accompanied me. What had I missed? How long had he been alive for? Was he hungry? Was he okay? Where was my partner? What has happened?

After some time a new staff member (a nurse because there were no midwives available) entered the room to take my observations. She saw me struggling to breastfeed, "I could try to give you some advice but you probably know more than I do. Would you like me to get you a nipple shield?" She said. I continued to have breastfeeding pain and difficulty for four months, the lactation consultant wasn't on this day or over the weekend as we're not funded for that, I saw her privately as an outpatient plus an additional lactation consultant I found privately in the community, as well as a chiropractor. They couldn't find an anatomical reason for the issues so the advice was keep trying. My son now has dental issues from a thick anterior frenum and speech delays. We still don't have a diagnosis.

When my partner arrived in maternity I learned all baby checks had been completed without me present, they had also given vaccines without my consent (my birth preferences outlined this was not our wish, this document had been discussed and signed antenatally with my midwife and a doctor, a copy was in the front of my medical record).

In the days that followed kitchen and cleaning staff did not enter my room because I had contact precautions in place for an MRSA infection (diagnosed in the pregnancy). My food was left on the floor outside, nobody knocked to let me know it had arrived.

On the way to theatre I asked them to please make sure to use MRSA-sensitive antibiotics in the operation due to my MRSA positive status. On the ward postnatally I asked several staff members to please check if this had happened but they didn't get back to me. I developed a wound dehiscence and infection on about day 7 postnatally for MRSA infection because the wrong antibiotics had been given in theatre. This required an additional course of antibiotics to treat, affecting my gut micro biome and that of my newborn for a second time, my baby developed loose stools from the antibiotics going through my milk and then nappy rash.

Though our emergency birth was scary, and a caesarean was not what I had hoped for, my trauma does not stem from this. I know this was a life saving procedure and we are both lucky to have survived. Once the emergency had passed, when my baby and I were both safe, there was no thought given to the fact that I was a woman who just became a mother, who had hopes and dreams of this moment as a midwife who had helped so many women meet their babies. I missed the first hours of my sons life. My partner was left in a waiting room outside theatre alone, waiting to hear if either of us had survived. My preferences were not considered or upheld where possible to do so. I was not included in the care of my baby, my consent was not given. As a woman who had gone to sleep thinking her baby would die there was no consideration or plan for my emotional safety upon waking in recovery. I did not receive a debrief from the midwife who attended the birth. I developed postnatal depression. I put in a complaint which was made uniquely challenging as I was complaining about my colleagues and my workplace, to my boss.

I felt angry that this had happened to me, as a staff member, I worried about the care that other women were receiving, I wanted change for others in the same position. I didn't know how I could return to work in the same place where all this sadness had happened to me. I took a long time to bond with my baby. The response to my complaint was a meeting with my manager and a doctor who was not briefed prior. 30 minutes had been allocated. My manager gave reasons for the care provision, she attributed short staffing to many of the issues. I did not receive an apology. I was told at the end of the meeting which was cut off due to timing, "I think you're still emotional about this, let's try again in a few weeks." In the context of postpartum depression, trying to heal and learning to be a mum, I felt defeated and not motivated enough to fight this further. I did not go back for a second debrief. I returned to work ten months later. For a long time I would have flashbacks of the day every time I walked into the hospital. The MGP program was shut down due to inadequate staffing while I was on leave. Our unit is currently 20 full time staff members in deficit.