Submission No 716

INQUIRY INTO BIRTH TRAUMA

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Date Received: 14 August 2023

The future is bright.

Our baby boy was born on a Monday, 21st November 2021 at 11.26am in Hospital, after 41 weeks and 3 days gestation via an emergency caesarean. He let out the biggest scream when lifted out by the surgeon, it was heavenly to hear. He was the picture of good health with an APGAR score of 9 (albeit smaller than his predicted weight, weighing in at 3.6kg). Sadly, his journey into the world was far from acceptable and my birth experience at Hospital left me in pieces.

People would constantly say to me after the birth "all that matters is that you have a healthy baby" and I would want to scream. Rather than just sitting in the mud with me, they would instantly diminish my traumatic experience. I have heard so many times from various people including those medical professionals who contributed to the experience "we are sorry that you felt that way" or "it's bad, but it's not that bad".

My experience at Hospital left me with severe PTSD symptoms (flashbacks, panic attacks, night terrors, insomnia, severe anxiety, and mistrust). I was left to cope with minimal support, completely traumatised. While I have been fortunate enough never to have experienced mental health challenges in the past, this experience triggered post-natal depression almost instantly and left me extremely sad, detached, anxious, lonely, and completely unable to be present with my family.

Prior to this experience, I was naturally optimistic, outgoing, trusting, confident, an advocate for the NSW public health system and creating positive, empowered birth experiences. Having had such a positive experience at Public Hospital 2 years prior for the birth of my daughter, I had no reason to doubt that another public hospital wouldn't provide the same excellent level of care.

All my trust in the healthcare system and medical professionals has been completely eroded. If a nurse or doctor walks past me on the street I instantly feel fear and anxiety. Myself and my husband have been left petrified about having a third baby. I find some comfort in the fact that this trauma happened to me with the birth of my second child, as I cannot imagine the grief I would have had to face if this had happened to us with my first birth and ultimately been too fearful to face giving birth again.

The focus for me has always been to get better for my babies. I am fortunate to have the support to do this. I have been seeing a specialist post-natal phycologist twice a month over the past year and a trauma therapist (EMDR) every week. Without phycological support I would not be coping or strong enough to even share my story. There is still a long road and a lot of work to do. This has all come at a personal and financial cost, one that I have had no option but to pay as I simply will not let this trauma impact me long term. But what about those who simply cannot pay that price? What support is in place for them?

From my experience at Hospital, it was glaringly obvious that the maternity ward is not functioning properly, they are not communicating effectively with each other or their patients. They are understaffed, under resourced and lack consideration for the mental health impacts their actions on patients. The lack of consideration and empathy from Hospital maternity and ICU staff for to the psychological wellbeing of mothers is so damaging and dangerous. The women and families they are caring for are in extremely vulnerable and they must understand that their actions have major effects long term.

Throughout my experience at Hospital there were breakdowns in communication between ourselves and the staff, the staff themselves, their differing opinions and open disagreements that ultimately resulted in trauma for my family and what's worse a risk to myself and my child's life. There was a several risks to myself and my child's life.

Summary of my experience:

1. Lack of Respect for my birth plan:

With the birth of my daughter in Public Hospital in 2019, I went into labour naturally at 41 weeks + 6 days gestation and birthed naturally with my wishes fully respected and no complications. The midwives and doctors at Public Hospital had been extremely supportive of my wishes and monitored the health of the baby extremely closely in those last few days to make sure she was safe. The midwives who helped in her delivery listened and respected our wishes from start to finish and even encouraged me to consider a home birth for future babies. I know what a good birth experience looks like.

As soon as I fell pregnant with my second child, I called Hospital to enrol for the MGP and unfortunately, they had no space for me. This meant that each appointment would be with a different midwife. No continuity of care. At each appointment, I would repeat my birth wishes, my background of my first birth and the consideration that I would likely be overdue with my second child.

I was told numerous times by the midwives that Hospitals policy was "not to allow mothers to go overdue by more than ten days" and if I reached that point, I would have to "negotiate with the doctor on call". This news filled me with fear and dread particularly given that my daughter had been 13 days overdue.

Separately, when I raised a query about homebirth with a doctor at one of my antenatal appointments, it was met with utter shock, dismay and I was swiftly told that Hospital do not provide this service, that they believe birth is a medical procedure that should be conducted in a hospital environment and that it would be far too risky to birth at home. This sharp response filled me with enough fear to put an end to any further research on the topic.

2. Pressurized into Induction:

When I was a week overdue the midwife on call was pressuring me to go for an induction and ignoring what I was saying when I would explain my first birth experience. She kept reiterating that there is only “skeleton maternity staffing at weekends” and it wouldn’t be good to go into labour at that time. This understandably left me feeling very anxious, confused, and fearful. She sent me to get an ultrasound at a private clinic to check the health of the baby. It seemed that the hospital was making decisions based on the resources of the hospital rather than the needs of a birthing mother.

3. Baby put at risk:

The sonographer from the private ultrasound and the doctor on call at
Hospital who reviewed the scan recommended that my “baby is born within the next 24hours” due to low amniotic fluid levels. My baby wasn’t born for another 68 hours. Happy to provide more details on this however in summary due to no continuity of care, the differing views and decisions of the various medical team, communication issues and resource constraints meant that my baby was put at risk.

4. Induction despite being in labour:

The hospital booked me in for an induction after reviewing the ultrasound which indicated that he had low amniotic fluid levels. While awaiting my induction slot, my contractions started naturally at home. They felt strong and showed all the familiar signs of early labour. Upon calling the hospital, they didn’t seem at all excited by this news and advised to continue as planned for induction. We arrived at the hospital and told another new midwife our story. She didn’t seem interested and advised that she will be continuing with the induction process despite labour starting naturally and my contractions now 4-5min apart. This was not the right decision, and I should have been reviewed fully with my background and the full picture taken into consideration.

5. Traumatic epidural:

A doctor entered the room after almost 10 hours in labour to advise she could “hear my screams from the nurse’s station” and that we needed to check my progress. The pain of being in labour with my second child was so much more extreme that my first. Now approx. 6 cm dilated, and the baby still wasn’t engaged. She reviewed my file and flagged that the ultrasound predicted him to be approx. 4kg (a larger size baby) and this could result in shoulder dystocia. This was the first time that this risk had been mentioned. She recommended an epidural as I was clearly in a great deal of pain and this labour wasn’t moving as it should be.

I was completely overwhelmed with all this new information. I was supportive of the recommendation to get an epidural as I was unable to keep going at this level of pain. The doctor advised that it could take an hour for the anaesthetist to arrive as it is the middle of the night, and she would be coming from home. I couldn’t quite believe that it would take that long but had no options. As soon as the anaesthetist arrived, she explained that I would need to sit still on the side of the bed for her to execute the epidural successfully.

To keep me still on the side of the bed, the midwife and my husband had to hold me very tightly to stop my body from moving during the procedure. My contractions were now every 2 minutes. Sweat was rolling down my forehead and my body kept convulsing. The anaesthetist struggled to put the needle and had to stop frequently to allow me to take a contraction. It took 3 attempts and approx. 45 minutes. This experience has left me with trauma, flashbacks, and fear.

6. Lack of consent:

After the epidural was administered, the baby wasn't progressing any further and not responding well to all the medication. His heart rate was spiking during contractions. She also reiterated that the ultrasound report he is likely to be a "big baby" and spoke to the high risks associated with shoulder dystocia. At this stage there was no options but to move forward with an emergency caesarean.

The doctor casually breezed through a short spiel about getting a caesareans.

1. Classified as a major surgery however its very frequently carried out and that people elect every day.

2. I would be awake however unable to feel anything from the neck down.

3. That there would be moving me around on the table a bit and baby would be out within 30 minutes and then it would take about 15/20 minutes to close.

4. She even advised that seeing as he is still quite high up, he would be likely to be easier to get out.

5. She mentioned that the risks include bleeding, blood clots, unable to drive for 6 weeks.

I now know that the above wasn't providing me with all the information to make an informed decision. My consent for a caesarean wasn't informed, I did not receive accurate, relevant information, any understanding of the true risks associated with the procedure and there were no alternative options provided to us that wouldn't risk our baby's health. We only learned about the true risks of my caesarean through a very traumatic experience and in the discussion with the Obstetrics and Gynaecology Consultant four days post op. The doctors and midwives need to be providing patients and their families a true picture and open, honest information about the risks associated with their case. We cannot use the same general speil for each patient. Each patient is different.

Had my consent to caesarean been informed and all the true risks been presented, I am confident I still would have proceeded with the decision to have a caesarean however I firmly believe that it wouldn't have been as traumatic and unexpected for me when something did go wrong, and I find myself separated from my baby in ICU.

7. Emergency Caesarean Experience:

During the emergency caesarean, my healthy baby boy was delivered however a laceration occurred to the uterine artery. Myself and my husband were not informed of this at the time. There was a sense of panic in the room. We could hear an increase in panicked chatter from over the curtain. The anaesthetist stepped away and I overheard him say "you need to come now". In my mind, he must be calling him for someone else. I couldn't fathom that he was talking about me. I overheard the nurse ordering blood to be brought to the surgery immediately.

I could see my husband's face go very pale and frozen when he looked up and took in what was going on. This was when it clicked for me that something was wrong. The room was a hive of activity, it felt frantic. Still, no one was communicating with us or telling us what was happening, it was as if I was asleep but I was there, awake.

The midwife advised that they wanted to take out of the room. I felt a deep sense of panic. I longed to be leaving the room with him. I felt completely helpless. I was fearful that I might not see him again. The mood in the room was giving me no reassurance and no one was telling us anything.

A second Obstetrics and Gynaecology Consultant entered the room. The room went quite silent, and I remember the sound of his rushed footsteps approaching the table. He instantly said very loudly "Why did you do it like that!!"to the surgeons frantically working on the patient. His tone was angry and shocked. Those are words that have rung in my head for over 18 months.

The senior anesthetist arrived and put a line in my hand. My mind was racing, confused, helpless about what was going on. I felt cold and my body was being moved around quite forcefully. Warren was working hard to distract me with chatter, but I was getting sleepy. It seemed important for me to stay awake by everyone's demeanour and they kept calling to me "Meabh stay awake". Warren started to tell me how much he loved me. This further made me feel panicked as I knew why he was saying this, he was afraid I was going to die. I had no idea if I was going to die, I just felt cold and very sleepy.

I cannot quite remember the end of the surgery. I was only mildly conscious at this time. My husband remembers what he refers to as the "milestone moment" and the doctors saying among themselves "we got it! we got it!". Up until this point he was completely in the dark about what was happening. The anaesthetist told him that there seemed to be a bleed however they have it under control and they are now putting back in her uterus and bladder. Warren was shocked to learn that my uterus and bladder were outside of my body however grateful for the update.

I was kept conscious throughout the caesarean section (over 2 hours). The doctors and nurses in the room behaved like I was asleep. My phycological wellbeing wasn't considered during the caesarean section. There was a complete breakdown in communication. Looking back on this caesarean trauma, I wonder why no one considered putting me under general anaesthetic or a sedative so that I wouldn't hear or witness what was going on in the room. The phycological damage that was being caused at that time should have been taken into consideration. This experience has been a large source of trauma and PTSD.

I have subsequently met with the member of senior hospital staff at Hospital, to discuss my experience. I questioned whose responsibility it is to ensure the mental wellbeing of the patient and communicating effectively to keep them informed in a caesarean section. They advised that the anaesthetist is considered the person responsible for communicating with the patient in the surgery. This is not what I experienced and, in my view, doesn't make any sense. My understanding of the role of an anaesthetist is purely relief from pain. I have never seen a job

description for an anaesthetist that states this would be part of their remit. When I probed this point and queried if anaesthetists are training in this area with the Hospital senior staff, they acknowledged that this is a gap that needs addressed and waivered on their original response about it being the anaesthetist's responsibility. We must fix this.

There needs to be someone in the room responsible for the physiological wellbeing of the patient. t needs to be a consideration in the escalation process when something goes wrong, the staff inside an operating theatre need to behave appropriately when a patient is awake.

8. Lack of consent:

While recovering in Intensive Care I overheard some medical staff chatting in the hallway outside my door that I was being administered antibiotics because a second Obstetrics and Gynaecology Consultant had to be called into my surgery to assist in the caesarean and he was transferring from a highly infectious disease ward. I didn't know this and hasn't provided any consent. Particularly concerning seeing as I was breastfeeding a newborn.

9. Intensive Care Experience:

Following my unplanned caesarean section and uterine artery laceration, I was separated from newborn baby boy and transferred to the ICU. I was handed over to the ICU team in a very cold and curt manner. It was very evident that the ICU ward team had no training on the additional requirements of a post-natal female who required acute care. I proceeded to have a panic attack when the staff left the room after hand over, most likely triggered by the lack of information, this cold stark environment, the stress of the surgery and being completely separation from my newborn without any idea where he was now.

I was unable to reach for the red buzzer despite my best efforts as my body was so weak so started shouting for help. I kept shouting for help for several minutes before a nurse finally passed my door. She was bewildered and confused but very quickly realised by my tone that I was in a state of panic, and she alerted the doctor on call. I pushed for them to tell me what had happened? Where was my baby? I was a completely in the dark. This experience has been a large source of trauma and PTSD symptoms.

10. Medically cleared for transfer back to Maternity Ward:

Despite my large blood loss of 2L, 5 hours after being in ICU, I was medically cleared by the ICU team for transfer to the Maternity ward. Despite being the quote "sickest patient on the maternity ward" the midwife assigned to me then proceeded to miss two blood pressure checks due to, in her words, "workload on the ward". When the midwife is finally able to check my vitals, she finds that I have deteriorated, and despite her best attempts she is unable to get my blood pressure up. My blood pressure levels drop to 72/42 and the midwife initiates a Rapid Response for severe hypotension. Both ICU and maternity team doctors attend the rapid response. Medical teams discussed concerns of internal bleeding. I was awake and witnessed all of this, the tension, open disagreements and conflicting views between the ICU team and maternity team during the above incident. Furthermore, as the midwife had not checked me regularly my catheter bag had now overflowed onto the floor in this room.

The decision was made to transfer me back to the ICU and conduct a CT scan to rule out internal bleeding. No evidence of active bleeding was detected however this experience was extremely traumatizing and played a large role in my lack of trust for medical professionals moving forward.

Once back in ICU, the team there had a complete lack of resource and training to care appropriately for me as post-natal women. They couldn't understand my need for simple items like a breast pump, a nappy for the baby, why I would ask to remove some wires from my chest while I attempted to breastfeed my baby. The worst and most damaging part of my experience in ICU, was being separated from my newborn baby boy. I was advised that he was not allowed into the ICU with me and had to stay in the maternity ward. The midwives did their best to take him over and back however it was extremely sporadic and was always rushed as they would need to escort him back again. We remained mostly separated during the coming days. If a hospital is unable to Keep mothers and babies together. If a mother needs acute care, move them together to a hospital that can accommodate them together. Find a way to keep baby and mother together.

11. Lack of Post Birth Support:

While I was recovering, I had daily visits from different social workers. All of them extremely empathetic. However, they were clearly so limited in their ability to provide us with the support we needed. Better mental health support for mothers and their partners post birth if required.

In conclusion:

I cannot stop thinking about the other mothers, families and babies who are being mistreated in public maternity wards daily and potentially going through similar experiences to mine at this hospital. Having a baby is such a vulnerable time, it should be met with kindness by those who are treating the patient and her support. Having read my medical records and seeing everything in black and white, I can see that it's not fair on the medical personnel working in these wards, who are clearly crying out for help and acknowledged several times in my records that they need more support to do their jobs effectively.

I am so inspired and impressed to see all the other courageous women who have come forward with their stories. From reading through the submissions to date it's clear that there are very clear themes in the shortcomings of the birthing system in NSW. That issues extend much further than just Hospital; this is a widespread issue.

It's so sad that these experiences have happened to all these women. By speaking up together we can hopefully drive change for our daughters, friends and females coming behind us.

I am willing to give evidence at the hearing if required.