Submission No 882

INQUIRY INTO BIRTH TRAUMA

Name: Mrs Naomi Bowden

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Partially Confidential

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Hi, my name is Naomi Bowden, and I am 41 years old. I am writing to the birth trauma enquiry because wanted to share my story of my birth trauma when I had my late daughter Bella Grace Bowden. I felt that there was insufficient duty of care for myself and my daughter.

On the 4th of November 2009 I gave birth to my beautiful daughter at Public Hospital. It was meant to be a happy and amazing event meeting our first baby, things did not go to plan and in result Bella was stillborn. I received massive ongoing birth trauma, not only from the hospital, but from individual staff members too. It was disrespectful, it impacted on my mental health which to this day has affected me not only emotionally but psychologically, physically and impacted my personal finances.

In the lead up in my pregnancy I started heightened anxiety which led me to start experiencing mild perinatal depression. From 18th September 2009 onwards I was being classed as a high-risk patient and was having weekly checkups due to high risk of postpartum depression. This was flagged in the hospital, and I was placed in the high-risk category and was offered extra weekly appointments, yet when I had these appointments, I constantly had to explain and go through all the details with each different person I saw. It was stated that the baby would be the NUIC unit for the first 24 hours due to withdrawals of the medication I was taking. This was not only confronting but making my anxiety and mild depression so much worse. I was seeing a psychologist and seeing a psychiatrist, who was in contact with the hospital, however I was the proactive one and sought after these professional myself and had regular appointments. This was all communicated to the doctors and staff at Public Hospital, yet they kept flagging me as high risk but the care and follow through was not there. My last appointment at the clinic on the 30th of October 2009 at Hospital I was told I had a textbook pregnancy and that the head was engaged.

On 4th November 2009 I had started having contractions at approx. 9:30am. I had been in contact with the birthing unit a couple of times with questions about my contractions, then at approx. 10.20am they advised me to come into the hospital. I arrived at the hospital around 11:20am in my first stage of labour with Bella, I was calm and relaxed. I provided an additional copy of my birth plan (which had been discussed during my appointment with the head midwifery consultant on which I outlined suggestions for my birth. On admission to the hospital, I was assessed monitor regularly over the next few hours until the labour progressed.

At 16.35 I was 9cm dilated. At approx. 17.45 I was assisted into the bath and was assessed to be fully dilated at 17.55. I was in the bath and assessed several times which showed no decelerations of FHR. Contrary to the clinical notes, while in the bath I was pushing and bearing down during contractions. As mentioned in the notes and my birth plan I was using the Calm Birth Technique which focused on breathing and calmness, therefore my pushing was not expressed vocally as seen during most births. I felt that my birth plan was discarded and place out of the way. We played the calm music, and I was allowed to take a bath which

was short lived as my blood pressure elevated and FHR suddenly dropped then began to rise again. The decision was made to get out of bath and return to the birthing room where CTG monitoring could be applied. CTG was applied at 18.57 then removed a few minutes later. The main midwife would pop in and keep checking in and seeing how I was progressing. I felt pressured to make loud pushing noises in my birth and they kept saying push. They were concerned about my heighted blood pressure and kept checking it, asked lots of questions on how I was feeling but not once explain the why. That wanted to make sure that my vision wasn't going blurry as I was having a hard time. I was placed on the bed and had a CTG machine place around my belly to check the baby. I was reassured everything was fine.

Next minute I knew the registrar had come into the room to investigate further. He told me that he needed to check the baby and wanted to perform an ROT. Not once did anyone explain what exactly this was, I gave my consent, and he inserted his arm and turned my daughter who was stuck and her hand slightly on her head. This was one of the most painful experiences I had ever gone through. I wanted to get up and move around, which I did but then they removed the CTG and used a doppler to try and get the baby's heartbeat. As they felt I was not progressing in their time frame, the registrar returned to the birthing room and instructed I needed to hop back in the bed and needed some assistance. They place the CTG back around my stomach and they said that they were going to get the vacuum or forceps because I could not push this baby out and felt like I was sucking her back up after my contractions. I felt like I had to beg for no intervention as I was scared and didn't know any better. Nothing was being explained to me in detail, and as far as I was aware, the baby's heartbeat was fine.

Bella was born at 20.45 then staff assisted my husband in cutting the cord. Clint noticed when cutting the umbilical cord that it was not coil and looked quite flat, like it had been squashed. Could the rotation of Bella have compressed her cord? These are answers that we never got. She was then placed upon me where she seemed white, floppy, not crying, moving and unresponsive to which I was alarmed. Suddenly they took her off me and were working on her. I was unaware of the severity of the situation and kept asking what was happening. They were trying to resuss her next to me. She was raced out of the room with doctors flying by her side and I was left to birth the afterbirth. The nurse told me to jump in the shower because more than likely I would be either going to the NICU unit or potentially being flown to Sydney. As I was high on adrenaline and in shock, I just had a quick shower and heard the room door open, and I raced out. The look on the hospital teams faces I just knew she didn't make it. I fell to the floor broken, my husband dropped to the floor and sobbed. What just happened? How did this happen? All I wanted was to see her and hold her, I was escorted to the NICU unit, where on arriving the nurse was so rude and unpleasant and I was not treated with any sensitivity, nor did anyone seem to have any knowledge of why I was being taken there. APPALING! I finally got to see and hold my baby. She had all her tubes in her mouth, and it was horrific. Family members had to go up to the same nurse and ask permission could we take Bella back to my room. She was loud, disrespectful and abrupt. I was a mess, shaking and in shock. Not once was I escorted with a nurse or provided comfort. I took Bella back to my room and for there, it felt like things just kept worst. I now know that 6 babies every day are stillborn and that this hospital lacked the compassionate and understanding that I needed and deserved.

One of the worst moments of my life was knowing I wasn't bringing home a baby. What I experienced over the follow years left me with birth trauma.

1. The communicated between the staff members at   Hospital was appalling. The treating paed would not sign the death certificate and did not consult or follow protocol with the registrar that night and called the coroner and said that we had an unexplained death. We were told that the police were coming to take Bella's body away to the coroner's office in Sydney for an autopsy and we basically didn't have a say. This could have been avoided and handled differently. We had to call family members quickly in the middle of the night and some members had to come straight away. It was distressing having your baby taken off you by police officers and placed into an ice box. We had to identify our babies body that I just birthed to the police! I felt confused, unsure and the information about this was confusing. No one was there to help us understand at all.

2. Once everyone left, they left me in the birthing suite overnight for observation with my husband, where they tried to medicate me to have some sleep, but I didn't sleep a wink. All I could hear was other woman having babies and hearing the babies being born crying, repeatedly. This was so distressing. In the morning, the head midwifery consultant came in and took bloods. I straight out asked her why did she kept me in overnight, why couldn't I go home? She bluntly told me that due to my history they didn't want to send me home because they were afraid, I would commit suicide. I just cried why would I do that; I just lost my baby!

3. The next week was a total blur. My family called the mental health hotline when I was discharged from hospital, as they were concerned about my welfare and the perinatal depression. The hospital supplied a social worker the next morning, however she was unhelpful and basically gave me an envelope to take home and read. There was no appointments booked or made and I just felt alone. They booked a nurse through the hospital to check on myself through the week, which I had met through the birthing classes. I ended up retaining placenta and had to revisit the birthing centre for follow up tests etc. I found this quiet distressing and confronting.

4. At my six-week post birth hospital checkup, I was made to wait in the same waiting room as everyone else. When I presented for my appointment, the hospital team asked where my baby was. I broke down hysterically and said she died! They didn't even read my notes and I was told by the head midwifery consultant that if I was to present for any appointments I would be treated with care and compassion. They called her immediately into the check-up to de-escalate the situation and she walked out with me. I booked a follow up appointment with her. She was my main point of contact as she looked after the department.

5. Before the meeting we received PDF files, I was really confused as I wasn't sure why they were being sent and with the wording; FYI, I have not read these yet so cannot give you feedback. At the meeting the midwifery consultant talked about these documents to my husband and I, and they basically stated that the antidepressant medication I had been taking in my pregnancy caused lack of oxygen to infants. She was implying that's what happened to Bella and that's why she died. We walked out of the that meeting not being able to function, yet along the words she just said to me. That due to my mental health and the medication that I need I compromised the health and wellbeing of my baby! I was the one who always picked up the phone and read the labels and this is exactly what I did before taking the medication with   . As I was highly distressed, I contacted both my psychologist, psychiatrist and   .

6. I met with one of the head geneticists at   Clinic in Sydney, provided all the information on what happened and the documentation on what was provided to me. She was

absolutely appalled not only at the treatment, but someone presenting such files to me and having these conversations without any consultation with relevant parties. She called the Head OBGYN at hospital and had a frank and direct conversation with him whilst I was there and how this suggestion and treatment was appalling and not called for.

7. We then had a follow meeting with the Head OBGYN to talk through everything that happened. I felt he was unhelpful and as I obtained my records from Bella's birth I asked basic questions about her heart rate dropping and that my concerns were not being heard or acknowledged. With my questions I felt he couldn't give me the answers. I was heartbroken and destressed, especially as my pregnancy has been flagged as high risk, yet where was the care, the extra follow through. He apologises for falling through the cracks and that my notes were not read and that it created more trauma for me yet didn't say he would follow up or recommend a solution so this didn't happen to other people in my situation. He just told me it was all black and white and we will have to wait for the autopsy results to come back.

Just before Bella's second anniversary late October 2011, I finally received the autopsy and cause of death. Prolonged 2nd staged labour resulting in neo natal asphyxiation. My gut feeling was right, she suffocated. A HCCC representative contacted myself to organise a meeting with the hospital for resolution. I was in shock. I prepared myself with all my documents and arrived for the meeting. In the meeting I felt I wasn't being heard, belittled and at one stage was told that I made things up, although the person who was speaking at the time wasn't even present. My sister was shocked and said to me I can't believe you took that. I was so broken, broken at a system that flags you at high risk, but then doesn't follow suit.

The changes or solutions that I would like to see this type of birth trauma:

Why there was difference of opinions between the LHD and Coroner regarding "prolonged 2 nd staged labour" This by far caused the most heart ache and disbelief, being told two different things.

Hospital Protocols:

Baby monitoring: eg CTG Readings, dopplers. I had unclear tracings of the doppler being used and because I was upright the CTG kept falling. Not one person, including my midwife suggested a foetal scalpel monitor. I asked this in the HCCC meeting and received we don't know. What is protocol? And with the CTG you could see the decline in the heart rate. This needs to be constantly checked and monitored, especially with signs of high blood pressure with the birthing mother.

Address questions and concerns: Could the manual rotation of Bella caused her distress in anyway? Was Bella's heartbeat monitored closely enough at this time? I presented this question to the midwifery consultant and to this day I did not get an answer. Bella was not monitored after the manual rotation was performed. Although I did have the CTG attached to me the read was very sketchy. The registrar confessed to me after Bella was born that he never checked her heartbeat. Everyone was focused on me pushing, but no one checked the CTG machine to see Bella's heart reading was constant. I brought this up constantly and the staff constantly dismissed it.

Oxytocin: At what time should the Oxytocin be administered when in final birthing stages? I had birthed the baby's head and hooked up to the drip. Why wasn't this administered sooner? Or even after ROT?

Information and procedure: The baby was turned manually (I had been informed that there is no policy), however I had been advised that procedure was followed. With consent the OBGYN inserted his arm in and turned the baby. Could this make the baby go into distress? Can there be detrimental effects after rotation? There were no clear answers once again.

Medication Advice: This has a huge impact on mothers asking for help. Throughout the pregnancy I was aware of my dosage of Cipramil and advice from my Psychiatrist, and . Documents provided to me after the birth were inappropriate, caused emotional damage and distress. There should be a strict protocol releasing such files at a vulnerable time of loss.

Safe Spaces: Every hospital should have a soundproof room or a safe space to be offered. Being kept in the maternity ward environment overnight caused a lot of trauma and unnecessary grief for me and my husband.

Assign Loss/Grief Nurse: After our loss, we experienced very unpleasant behaviour and not treated with any sensitivity, nor did anyone seem to have any prior knowledge to appointments etc.

Staff Members: Two main staff members, the midwifery consultant and the midwife that was present throughout my care, delivery and aftercare never were not present in my final dealing/meeting with the hospital and HCCC. A lot of questions went unanswered because these staff members couldn't answer on behalf on them. This made me infuriated, frustrated and most of all how can one begin to heal or have closure with such a traumatic event. I felt that the midwife that was assisting in my delivery kept being interrupted by staff members about her husband who was on the phone and was flying out somewhere. Did she want to talk to him? She also seemed flustered to me. I felt that her mind on the job at hand was not 100%. I raised questions with or answer for the midwife and that my birth plan confused her? As for the midwifery consultant, nothing. No apology and never heard from again. I was broken. This impacted my life in so many ways. Not only the emotionally damage which I still deal with to this day, the hospital trauma is uncontrollable. I recently took my eldest into hospital for an emergency and I dropped to the ground. I still experience anxiety, how bouts of depression and my future pregnancies suffered significantly, with my last pregnancy I was admitted to in Sydney in my final trimester as I worked through the nightmares, trauma and grief all over again of losing my baby.

We need to be better. We need to love and support the Mum's in one of the most empowering times of our lives. I would like to be called as a witness to the inquiry as our voices need to be heard.

Regards,

Naomi Bowden