Submission No 993

INQUIRY INTO BIRTH TRAUMA

Name: Name suppressed

Date Received: 15 August 2023

I, , am writing to detail the issues my wife and I experienced in the hours before the birth of our daughter on the 7/6/22.

was born at 36 weeks gestation after a delivery complicated by a placental abruption. She needed resuscitation at birth and CPAP respiratory support for 24 hours. She had evidence of acidosis and neurological depression at birth and developed moderate hypoxic-Ischaemic encephalopathy.

Our recent one year follow up assessment at hospital has revealed that has evolving Cerebral Palsy.

We believe that a more thorough assessment by the doctor at hospital in the hours leading up to birth may have prevented significant injury to our daughter. It also took approximately 40 minutes to get in contact with the hospital on call midwife who did not answer her phone.

Addressing terms of Reference

1a, 1b(i), c, d(i), i

Day of Birth 7/6/22

woke around 6.30 am with an abdominal cramping pain. We travelled to from our farm between and (1.5 hrs. travel) for an antenatal 36-week appointment with a doctor at hospital at 10.30 am. The Pain continued.

We asked the doctor at the appointment about the cramping pain and it was immediately dismissed as Ligament pain. The doctor made no further enquiries or investigation. As had Gestational Diabetes, she was considered a high risk pregnancy. Our daughter's condition was not checked on a CTG which records the fetal heart rate. The doctor could have seen a high heart rate or decelerations in heart rate as well as uterine irritability with this check which would have only taken a few minutes, or this could have been referred to a Midwife to do.

This check could have saved our daughter from permanent brain injury.

The doctor also had not reviewed blood results from a specially requested test recently completed (We asked about this as we were being shown out the door). Due diligence was not being done.

We left the hospital somewhat reassured that the cramping was normal.

After making the trip home, 's cramping continued and getting increasingly concerned she decided to call the on-call Midwife at Hospital at 6.32pm. She did not answer and left a message detailing her concerns. called again at 6.39pm and at 6.44pm.

After also calling the hospital front desk to ascertain the midwifes whereabouts and calling the hospital again at 7.07pm we were transferred through to the on-call Midwife at approximately 7.11pm. politely detailed her symptoms and requested for a checkup at the hospital, where we had almost arrived.

was then taken aback by the on call midwifes response of '' I have other things to do you know''. She was hostile and reluctantly agreed to come in to the hospital to meet us where we waited for her to arrive at approximately 730pm. As a result, we lost around 40 minutes, trying to get

in contact with the midwife to meet us at the hospital. We were not greeted with a hello at all, despite being completely polite at all times. The Midwife made feel silly for calling.

Shortly after commencing a CTG test on , an ambulance was called and was rushed to hospital for an emergency Caesarean.

was born at 11pm after a delivery complicated by a placental abruption. Our beautiful daughter was essentially starved of oxygen and vital nutrients throughout that day.

She was transferred to hospital the next morning

spent 11 days in NICU at , fighting for her life, it was a very difficult time for us all.

The Impairment to 's mental health following our life altering chain of events has been significant and the effect has impacted and 's bond. did not have the emotional capacity to write this submission, she is drained and has lost part of herself that was present with our first child.

While we felt well cared for in and NICU, and are forever grateful, the ache of our experience and the fear of the unknown with 's future continues to weigh heavily on us as a family.

In summary

Our previous antenatal care and birth at hospital was thorough. CTG'S were done multiple times leading up to the delivery. We felt well informed about appointments and what to expect from them. During those appointments, time was given, our questions were answered fully and we felt heard when we voiced concern. In contrast, our experience at hospital was very underwhelming. We felt under informed and rushed over and over, particularly so during our final appointment when a little bit of curiosity about our situation could have ended with a life changing outcome.

Our main recommendation is that CTG's should be mandatory at checkups for all high risk pregnancies such as ours in the later stages of pregnancy. Or mandatory for all pregnancies.

We would be willing to give evidence at a hearing. We would prefer our names to be kept confidential.