Submission
No 1001

INQUIRY INTO BIRTH TRAUMA

Name: Name suppressed

Date Received: 11 August 2023

Partially
Confidential

On Tuesday June 13th, I attended my scheduled midwife and Dr appointment at . I had been monitored throughout my pregnancy for preeclampsia due to persistent, mild hypertension and a family history of the same. In the week leading up to this appointment I had increasingly high readings on my home monitor. On consultation with the Dr, it was decided that I should attend Maternity to discuss induction as I was 40+4.

That evening I had a stretch-and-sweep, and the plan from that point was to contact maternity on Thursday at 10am to book a time for Foley catheter placement that afternoon, and likely return Friday morning to commence Syntocinon.

On Wednesday June 14th at 10pm, I began contractions. From around midnight they were regularly spaced and very strong, and from 3am they were less than 5 minutes apart and last at least 1 minute. I contacted maternity at 4am, but was advised to wait until my contractions were closer together, I lost my mucous plug, or my waters broke, and that in the meantime I should walk around and have hot showers. I followed this advice.

The contractions continued throughout the morning but did not become closer together, so I contacted the hospital again at 10am as planned. The midwife I spoke to was unsure whether I should come in, so (who I believe was the NUM) called back soon after. He advised that as my contractions weren't any closer together, I should wait until 2pm as planned to come in for the Foley catheter.

At 2pm we arrived at maternity. My contractions had slowed down significantly on the drive in and were much weaker while we were in the waiting room. After some time I was taken into the delivery suite and placed on the CTG. I was advised that the baby was tachycardic and they were unable to place the catheter until his heart rate settled.

At approximately 3:30pm I had a very strong contraction while returning from the bathroom. At this point the midwife decided to do a vaginal exam and found me to be 7cm dilated with bulging membranes. Although I was excited at this stage, I was also frustrated as I felt that I had not been believed about my labour until this point.

My birth plan was to have an epidural, and while waiting for the anesthetist to arrive I utilised hot showers and gas with good effect. There was some difficulty placing a cannula. The epidural was placed on the second attempt and I was pain free soon after.

Later in the evening, I believe around 7pm, Dr performed a vaginal exam. While I didn't have discomfort during the VE, it was noticeably rougher than previous exams as she pushed me up the bed during it. She then stated that the initial VE was misleading and that she did not believe I had been 7cm. She artificially broke my waters with my consent. They also commenced Syntocinon, although I don;t recall if this was before or after the waters being broken.

Not long after this, Dr   performed another exam and made a statement to the effect of "We're heading towards a c-section" before leaving the room. No further explanation was given.

We had been having difficulty keeping the CTG in the correct position, so a scalp clip was placed by Dr   . The midwife informed me that the baby was slightly transverse and "trying to come out ear first". We began trying to find a position to assist the baby to move positions, however whenever I was placed on my right side, the baby became distressed. There was no further mention of a cesarean section, however the midwives stated that Dr.   was giving us time limits i.e. have the baby in the correct position by 11pm.

During another VE, the scalp clip was dislodged. Dr   placed a second clip.

At around 2.30am the midwives advised me it was time to start pushing. The advised me to bear down when they instructed me to for as long as possible, as I was unable to feel contractions at that stage. After approximately 15 minutes I was able to feel the tightening of the contractions, so I stopped using the epidural and continued to push with them.

I recall the midwives telling me that we weren't progressing, and that we were attempting different positions. This increased my pain, so I was again utilising the epidural. After a while I realised that my pain was only increasing despite my increased usage. We stopped pushing to reassess, and my pain became suddenly, dramatically worse. I felt as if the baby was pressing against my perineum, and I felt unable to speak or think clearly. I was screaming in pain.

It was around this time that Dr   returned to the room and stated that they had called in Dr   and that we needed to go the theatre for intervention. My husband,   , asked why we were going to theatre, and she stated that I was likely to need a c-section. He asked why we needed to do that, and she only stated that it was "medically necessary". This made me extremely anxious and I was not able to calm myself at all. My husband was also distressed as he felt he was not able to speak up for me.

No further pain relief was offered at this time, despite my ongoing distress. Dr   returned to the room and stated that even if I did not need a c-section, I was going to have to have an episiotomy. No explanation was given at this time, and I felt my anxiety worsen. I felt completely out of control and unable to verbalise this. I did not understand why no one was explaining the situation to me or my husband.

My husband was given scrubs while we were in delivery suite. I recall a man I believe was the anesthetist asking me questions about my pain level and the sensation in my lower body. He expressed doubt over my statement that the epidural wasn't working, and when he placed ice on my left leg I was able to feel it clearly. My right side was still very numb. He repeatedly placed the ice on my legs and torso, despite my repeated statements that I could feel it very easily.

I was given a consent form to sign. I presume it was for the possible c-section, but it was not clearly explained. I clearly did not have capacity to sign this form, but when I told them to give it

to my husband they said I had to sign, so I did my best to do so. Later, in theatre, I was asked to confirm that it was my signature on the form.

When they were ready for us to move to theatre, a wardsperson arrived. She immediately stated that she was unable to move the bed in its current position (head elevated) and lowered the head down to flat without asking or warning. This caused a dramatic increase in my pain level. Enroute to theatre, the changes in speed caused further pressure in my perineum. My husband was by my side on the walk.

Before I knew it we were in the pre-op area, and my husband was gone. Without warning they had removed him, and left him alone in the hallway outside theatre with no instructions, advice, or access to me. He was able to hear my screaming in pain.

While in this area, the anaesthetist did further assessments on my pain level. I believe that they had some success at this point with the epidural, as what was previously one continuous contraction seemed to have short breaks in it at this point. The anaesthetist advised that he was unable to get my pain under control without a spinal block, which required me to sit on the edge of the bed, curled up, for at least 15 minutes. I said I was unable to do that, and he said if that was the case then a caesarian section would mean I needed to go under general anaesthetic.

I was continually asking for my husband, asking “Where’s   ?”. I was told by multiple nurses and midwives that he was close by and that I didn't have to do anything until he was back by my side.

They moved me into the operating theatre, and the obstetrician, Dr   , introduced herself and told me that she intended to perform an episiotomy and a vacuum. I was still asking for my husband. My legs were elevated, and Dr   was asking me to start pushing. I refused, as   still was not there. I believe that they forgot to bring him in.

When   was with me, they administered the local anaesthetic.   had not been informed of the plan and did not know what procedure they were performing until he asked. After the local,I felt the insertion of the suction cup, and the sensation of the episiotomy. They provided different instructions on how to push than I had been given earlier, and I believe this method was the more effective one.

I believe it took 7 pulls to deliver my baby.   recalls them saying that were were not progressing after 6 pulls, and that they needed to prepare for the caesarian section.   said I then pushed hard once more, and with assistance from the vacuum, we delivered at 04:31, 16/6/2023. I have no memory of this.

I recall the baby being placed on my chest. I know I cut the cord, but I don’t remember it.

went with the baby to be assessed while Dr stitched my episiotomy. She was telling me, which stitching, that she didn't want this experience to "put me off" having other children, and that every pregnancy and birth is different.

At this stage a midwife asked if I wanted to see the placenta, which I confirmed, but that never happened.

In recovery, my observations were normal. They advised me to "put him on the boob". I didn't know hot to breastfeed, but I placed his mouth near my nipple and he suckled. The midwife said "well done: so I presumed that was the correct technique.

We were moved to the maternity unit soon after. I was told to wait until I had full sensation back in my legs before trying to get out of bed and to rest. stayed with us for a couple of hours then went home for some sleep. I was unable to relax. I was upset after he left and crying.

I had a lot of trouble getting (my baby) out of the bassinet. The bed I was in was an older style, and the bassinet was a newer style. This meant that the highest setting on my bed was still much lower than the bassinet. I was unable to sit up straight due to pain, and lifting him made me feel like my stitches were pulling. He continued to suckle when I held him.

After a few hours of being unable to rest, I decided I would go to the bathroom to clean my face and try to feel a bit better. I couldn't call the nurse as the call button had been left on the wall. With difficulty, I moved to the edge of the bed and stood up. I didn't realise that I had a sanitary pad between my legs rather than a brief pad, and it fell as I stood up, followed by the blood that had been pooling while I was laying down. There was a large amount of blood splashed onto my legs, feet and the floor, and the bed was covered in fresh and dried blood.

I made my way slowly to the call button on the other side of the bed. I tried to sit on the chair but was unable to due to the pain. The nurse came in after approximately 5 minutes, and immediately left to get the cleaner, leaving me standing and unsure what to do. When the cleaner arrived she found me trying to get the blood off my feet with a baby wipe as I didn't want to walk more blood around. She was lovely, and said she would watch the baby for a moment while I went into the bathroom.

I asked the cleaner to ask the nurse to change the sheets on the bed as they were covered in blood, and she did. I washed my feet in the shower then returned to the room to find that the nurse had brought fresh sheets but had left them folded on the chair rather than change the bed. I decided I might as well have a shower while I was up and waiting for her to clean the bed.

I only showered quickly as I felt lightheaded and tired. When I returned to the bed it was still dirty, but I couldn't sit due to the pain. I pressed the call button again but no one came for 5 minutes, so I had no choice but to go back to bed in the soiled sheets.

The nurse did not return to change the bed until after lunch.

Mid-afternoon, my husband changed nappy on the bed and he got urine on the sheets. When we asked for another sheet we were reprimanded for not changing him in the bassinet, despite not having received any advice until that point.

and myself continued to have our temperatures checked as I had declined the GBS swab, however that was the only observation that was completed in my 2 night stay in maternity. No one checked my blood pressure.

I did not receive any advice on how to care for my episiotomy. I was taking endone and paracetamol regularly to manage the pain, but no one checked my wound until we were discharged and I asked about it. I did not see a Dr (aside from Dr returning to do the baby wellness check).

I repeatedly told nurses that I was unable to sleep. When I tried to sleep I had vivid flashbacks, I felt like the bed was moving and that I was returning to theatre, and I felt myself being tugged down the bed as if I was delivering again. They all offered compassion but all said the same thing “relax and have some rest”.

My nipples were becoming increasingly painful, but was told by multiple nurses that I could expect pain in the first weeks of breastfeeding and that I appeared to be doing it correctly. No breastfeeding consultant was offered. After discharge I had an urgent appointment with the community nurse who found that I was “nipple-feeding” and had trauma to the nipples.

On our discharge day, I was asked if I felt that I needed further pain relief at home. I asked for a short script of endone as that is what I had been using and I still had significant pain. As we were leaving the hospital, the midwife handed me a script for panadeine forte. She said Dr was “uncomfortable” discharging me with endone. Dr was unavailable to speak to us at that time, but I would have advised her that previously panadeine forte had caused me gastric upset. I elected to go home without waiting to see her.

I was advised by 2 separate midwives that they had referred my case to the Perinatal Emotional Health Program (PEHP) and had requested a debrief for me. I did not hear from PEHP until 6 weeks after birth, when my community nurse made another referral.

1 week after discharge I received a call from , a midwife. She asked if I was free for a debrief with her over the phone on 26/6/2023, which I confirmed. When she rang on the 26th, she said she would call me back in the afternoon when she had a break. She did not call until 19:30, and the phone only rang once. She did not leave a message.

After being contacted by PEHP 6 weeks after birth, they asked if I still wanted a debrief. I confirmed that I did. We finally had a face-to-face debrief with , the Midwife Unit Manager, on 3/8/2023.

In the months after ’s birth, I experienced physical pain from my episiotomy every day. I had difficulty bonding with my son, and I had a delay in my milk coming in due to the poor breastfeeding assistance that I received at the hospital.

I still have extreme difficulty in sleeping due to vivid nightmares and flashbacks. I am unable to look at the photos from the birth as I am scared that they will cause me distress. I find myself crying frequently. I have a short temper.

My discharge notes were inaccurate, with incorrect recordings of times and no notes regarding my pain or anxiety.

As someone who works in health as a paramedic, I found my lack of care extremely confronting. I understand that much of the issues I experienced in labour may have been unavoidable, but with more communication and after care these would have been manageable. Instead I felt ignored, disregarded and dismissed. The difficulty I had in receiving contact from the management team or PEHP only exacerbated these feelings.

Thank you for reading my submission. I understand that my hospital is in Victoria, however as a NSW resident I believe my experience should be counted in the inquiry. I also believe that this is a nationwide issue.

I am happy to provide further statements or evidence by writing, phone or in person.