Submission No 1153

INQUIRY INTO BIRTH TRAUMA

Name: Mrs Caitlin Out

Date Received: 10 August 2023

To whom this may concern,

The following submission outlines my pregnancy care / birth & aftercare experiences in 2018-2019 as part of the MGP at Hospital, Sydney NSW.

I had what I was led to believe was a perfect, healthy pregnancy. Due to my BMI, (starting pregnancy weight was 89kgs) I was required to complete two gestational diabetes tests (both of which came back as negative) & had additional growth ultrasounds. During these scans, it was mentioned that my baby was measuring on the smaller side. When I followed this up with my midwife; she expressed that baby is happy & moving around so there's no concern.

I didn't put on any weight during my pregnancy. I brought this up at every appointment but was told because of my BMI it was fine as they didn't want me to put on too much weight.

At 40 weeks pregnant (31/01/2019), I attended Hospital for my check-up. This was a regular appointment and a stretch & sweep was conducted.

At 41 weeks pregnant (06/02/2019), I again attended Hospital for my "post-date" check up & was placed on CTG (foetal monitoring) for 1 hour to monitor baby's heartrates & movements. Throughout this hour, the midwifes were having issues establishing what the baby's base line heart rate was and fobbed it off as her "just being sleepy". A quick bedside ultrasound was conducted to check if there was still enough fluid & we were sent on our way. I asked the OB conducting the ultrasound if he could quickly check her size to see if she had grown since our last growth scan at 34 weeks pregnant, and he advised me that he was only checking for fluid & that she was fine.

The next morning (07/02/2019), I woke up to my waters breaking spontaneously at 7.30am. I again presented to Hospital to be monitored. The midwife had difficulty establishing bubs baseline similarly to the day prior, yet still encouraged us to return home to see if labour progressed. Contractions began to pickup throughout the day and into the night & by early hours the next morning I rang my midwife to let her know we would be coming into hospital.

We arrived at Hospital Birthing Unit in the early hours of 8th February 2019. As it was approaching 24 hours since my waters broke, the midwife advised that if she were to check me, I would need to be administered antibiotics through an IV. I agreed & a canula was eventually administered into my hand after numerous failed attempts. I was checked & was only 1-2cm dilated. To help speed things up, they began a drip of Pitocin at 4am. I was again placed on A CTG (foetal monitors) and again, there were issues picking up bubs heartrate. Because of this, they discussed placing the monitor internally direct into the baby's scalp to help get an accurate reading. My midwife attempted this, however the 1st placement was tangled in the babies hair, and therefore she needed to remove it & was able to successfully place it a second time. Throughout the morning, my contractions increased & I was offered an injection of morphine at around 10.30am (4cm dilated). I accepted and continued to labour in the bed with the added use of gas to manage the pain. Over the course of a couple of hours, there were murmurs that they were STILL not satisfied with the heartrate of my unborn baby. This continued until the first shot of morphine wore off & I began to be in extreme pain. I was checked again & this time I was 6cm dilated, but "could be stretched to an 8". I recall this check being extremely painful & pleading for my midwife to stop. She did and expressed that as I was only 6cm she could administer another morphine injection. I accepted. This would have been around 2.00pm – 2.20pm. Keep in mind – Morphine should not be administered if the birth of

the baby is impending as it does transfer to the baby. Not long after the second morphine shot, one of the doctors came and expressed that they were concerned with the sporadic nature of my baby's heartrate and that they wished to do a foetal stress test to check the lactate levels in her blood – this is done by extracting a small amount of blood from the baby's scalp. She advised that the level must be under a certain number (I think 4), and if it was anything over that they we would need to discuss the need for an emergency caesarean. I remember this being extremely painful and the doctor telling me to keep sucking on the gas, as the morphine hadn't hit my system yet. The test came back at level 8. A code blue emergency caesarean was called and within seconds my birthing room was filled with nurses & doctors rushing around to get me to theatre. I recall one nurse in particular scolding me because I was in so much pain from the lactate stress procedure happening. She said something along the lines of "Caitlin, I don't think you understand the severity of this issue, you need to calm down". I politely told her to F off as I did understand the severity of the situation, however I was in extreme pain & fear. I was quickly rushed out of the room toward theatre where I was made to sign a piece of paper & was handed a small medicinal drink. I wasn't informed what the drink was, or what I was signing. My fiancé at the time (now husband) was taken into a small room and was provided with medical gear to change into. He was only given pants – no shirt. When he came out of the room half dressed, he was then informed that; no, he wouldn't be allowed in the operating room as I was put under general anaesthesia. This caused him extreme stress as he was then ushered back to a waiting room to meet with my mother and wasn't given an opportunity to say goodbye to me. Given the severity of the medical procedure – and the fact that both mine & the baby's life was at risk at that moment, he should have been able to give me a kiss goodbye. I was quickly put to sleep & my beautiful daughter was born at 2.49pm on the 8th of February 2019 – 31 and a half hours after my waters broke at 41.2weeks.

My daughter was born with an APGAR score of 1. She weighed 2.58kgs (<3 percentile). She was born floppy with a heartrate of <60/min and needed intubation for 13 minutes. Chest compressions were conducted for 30 seconds. At the time of her birth, her lactate had risen to 12. Once stable, she was immediately admitted to the Special Care Nursery at Hospital where she remained until we were discharged on 13/02/2019.

Whilst I was in recovery and coming out of the general anaesthesia, a nurse had asked for me to provide them with my fiancé's phone number – even though they had it on file & listed on my yellow antenatal card. I incoherently tried to relay his number to them but must have provided an incorrect phone number as they then asked me for my mother's phone number. I was then taken directly up to the maternity ward where I was placed in a room of 5 beds. One of the beds had at least 10 guests at the bedside who were loud & disruptive. I had just come out of MAJOR surgery & was chucked into what I call a party room! I remember over the course of that afternoon/night asking the nurses if I could please go and meet my baby. I was refused. My fiancé had been with her and was able to show me pictures and videos of her. This is how I met my daughter for the first time. It wasn't until about 12am (09/02/2019) that I pleaded with a nurse to please let me go down to see my baby & she assisted my fiancé to put me in a wheelchair. When I got up off the bed, it was at that stage that we realised that they placed me directly onto a bed following the surgery, without putting down any incompetence pads for blood. I was basically laying on a sheet covered in my own blood. My fiancé tried his best to wipe away as much blood from my legs as he could. He pushed me downstairs & I met my daughter for the first time.

At this point, we still didn't know the severity of her condition, or what happened during her birth / moments preceding her birth as stated above. I asked one of the nurses who was caring for my daughter what happened, and she bluntly stated that my daughter wasn't breathing at birth, and she

was resuscitated but she's fine. After a couple of hours cuddling, I went back up to my room to discover that my blood-soaked sheets were still on my bed and the floor was still covered in blood. My fiancé had to change my sheets & clean up the blood from the floor. He then slept in a plastic chair next to my bed for the rest of our duration at the hospital.

My fiancé was my nurse. He changed me, showered me, pushed me in the wheelchair, went to retrieve the breast pump, chased down the nurses to provide me with required medication & helped to get me in & out of bed. Rarely did the nurses on the ward offer assistance – if at all! On one occasion, my fiancé had gone home for a well needed shower & rest. My Parents were at the hospital and were about to take me down to special care nursery. I had asked a nurse to come in to empty my urine from the catheter bag. She requested that I walked with her to the toilet so she could empty it directly into the toilet. When I advised her that I couldn't walk, she huffed and walked out of the room. When she returned 20 minutes later, I asked her again if she could please empty my urine bag. She did, but I could sense that I was being a hassle to her.

During our admission following the birth of my daughter, my fiancé and I were never fully explained to what happened during the birth and what that meant moving forward. It wasn't until I was able to read the discharge paperwork – weeks later, that I realised exactly what had happened. I wasn't told that my placenta and cord had been sent off for testing until I asked what happened to it. I had to ask my GP what the results were – I was never contacted about it. I was still never given a clear outline of what the results meant for me and subsequent pregnancies until I researched what "high grade chronic villitis" meant. As a precaution, I had to be on Clexane (injectible blood thinners) for the duration of my 2nd pregnancy "just in case". The opportunity to have a natural birth for subsequent pregnancies was stolen from me because I'm terrified of the same situation happening again, and the fact that we might not be so lucky in subsequent births. Our 1st daughter almost died in childbirth. We were so close to coming home without a baby.

This event significantly affected my ability to connect with my precious little girl, who needed her mum so much following such a traumatic birth. Whilst I have never been diagnosed, I know that I suffered with postpartum depression for about 2 years following my daughter's birth. It wasn't until I found out I was pregnant with my second daughter in 2021 that I realised that I also suffer from PTSD. I had to retell my daughter's birth story to my GP and plead with her to please refer me to Hospital for my 2nd birth as the thought of birthing at Hospital made me physically sick - given the circumstances of our trauma and also the fact that reports came out about other babies who were stillborn at Hospital due to missed signs of distress in the months following my daughters birth. I opted for a planned c-section with my 2nd child as I couldn't put myself or my now husband through such a traumatic event again. It was after her birth and my recovery with her that I realised I suffered from PPD in my 1st pregnancy as I didn't feel the same way the 2nd time around as I did the 1st. The impact of almost losing my daughter had a significant affect on me & my husband. As new parents, we struggled with mundane tasks like all new parents do, but we had the added guilt of almost losing our child – so we weren't allowed to struggle – because we were so lucky that we got to bring our girl home. This mentality was so damaging, especially for me.

In hospital, following the birth of our 1st daughter, the doctors & nurses seem so hard pressed on ensuring I spoke with my GP about birth control to ensure I didn't fall pregnant in the 18 months following my c-section – but they should have been pushing; or referring me to someone who could help me navigate my emotions post traumatic birth. Rather than pushing me out the door in my blood-filled pad with sex being the last thing on my mind hounding me to make an appointment with my GP to not get pregnant again, I would have benefitted so much for an organisation to turn to. I didn't know if they existed, what they were called, or where I would even begin to look to find them.

Because all the healthcare professionals were so nonchalant about the circumstances surrounding my daughter's birth, I thought that all the emotions I was feeling was normal, when, in reality, I was severely struggling to cope.

To conclude, my wish is that no other woman, 1st time mother or 10th time mother ever experiences the lack of care of which I did. If I had been listened to about my concerns of not putting on weight, my daughters' ultrasounds showing she was small, the concerns of not being able to establish her baseline heart rate at 3 appointments – would our experience have been different? Would I have been able to connect with my daughter on the same level as I have been able to with my 2nd daughter? Would I have felt the guilt of struggling when I had no right to struggle because I was so lucky to bring my daughter home alive? To those nurses and doctors, I am just another number – another patient with another baby who they don't think about again, but to me; those people ruined me. I, daily, am reminded of the poor duty of care that was provided to me and my baby. I live with the trauma every day. I don't wish this feeling upon anyone. More care needs to go into mothers – especially post birth; regardless of if the nurses/doctors believe the birth to be traumatic or not. Mothers need to be listened to – we can't be fobbed off as a first-time mum who doesn't know any better – because I did. I knew that the lead up to my daughter's birth wasn't normal, but I believed the professionals when they said everything was fine.

I wish I pushed back harder.