Submission No 1035

INQUIRY INTO BIRTH TRAUMA

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In October of 2019 I was due to have my first baby. Although having tertiary qualifications in medical science, nursing and dietetics I considered myself a novice in birthing and all related matters. I diligently completed the hospital-run antenatal course and did as much prior reading as I could to prepare myself. I was planning to give birth at Hospital in Sydney Local Health District and was under the care of the Midwifery Group Practice (MGP) program.

I attended all appointments via the MGP program and was considered to be a low-risk pregnancy. During these appointments, I spoke very clearly about wanting a natural birth, preferably drug-free. I wanted to be active during birth, moving and laboring freely. I also wished to have a water birth. At 40 weeks pregnant I was informed by my midwife that at 41 weeks pregnant I would likely be induced for going 'post dates' ie. beyond my due date. I was quite despondent at this stage as I had significant reflux throughout my pregnancy. However, I trusted the advice provided by my caregiver. At 41 weeks pregnant I received a stretch and sweep as this was 'routine practice'. Again, not knowing any better (ie. that this could be refused with no harm to myself or baby) I agreed. at 41 +3 I lost my mucous plug. However, this was also the day I was to be induced. At 8:30am I walked into the birth suites at Campbelltown Hospital for my induction. I agreed to have this done because I thought at the time, there was no other way. I was led to believe that if my baby was allowed to come in their own time there would be significant risk to its health. My induction was commenced at 9am on the 23rd of October 2019. I was induced using syntocinon. I experienced significant pain with labour contractions using this method. My primary midwife who had been my MGP midwife did all she could at the time to assist including offering pain medication or suggesting changes to positions. At around midday, I was moved from my birth suite to another birth suite for no particular reason. I was in so much pain and barely able to move with contractions that they transported me via wheelchair to the next room. This room was significantly smaller, with a tiny bathtub. This is of importance as I wanted to have a water birth and therefore needed a birthing pool. I was assisted into a small domestic size tub to which I could barely move to find a comfortable position. The morphine which was given for pain relief was making me vomit. I continued to vomit for hours and was becoming quite dehydrated.
At around 6pm on the 23rd of October I requested for an epidural. I was hoping that the epidural would allow me to have some rest, which would allow me to dilate so I could push when ready to bring my baby to me. The anesthetists arrived to perform the epidural shortly after. During the procedure, they informed me that after the needle has punctured my skin I should not feel the needle. After the needle was inserted, I felt the needle puncture a space. Turns out the needle was inserted too far and had punctured my dural space. The needle was retracted, and the epidural was administered to poor effect. I continued to experience significant pain radiating through my left hip. After buzzing for my midwife and complaining multiple times that I could not manage the pain the anesthetists returned. They informed that the epidural had been administered away from the midline of my spine and hence why I was only having pain relief on one half of my body. They tried to reposition however I continued to experience pain. For a third time the anesthetics team returned to administer bolus pain relief. During this time the bolus doses started causing my baby to have heart decelerations. My usual midwife had clocked off for the day and I had a new midwife who I had never met before. She repositioned me and attended to the monitor until baby settled. During this time I continued to have regular vaginal examinations to check my dilation. At

12am on the 24th of October 2019 I was around 7cm dilated. By now I was starting to feel extremely tired. I had not slept well the previous night and had now been in labour since 9am that morning. I spoke to the midwife and asked how am I going to see this through as I am so tired already, to which she replied, its your body do what you see fit. The thing Is I didn't know I was in transition at this point. This state of fight or flight or feeling like you can't go on, is well documented as a classic response to being in transition. None of which this midwife picked up on. At the time, all I was looking for was some reassurance. at around 2am the obstetrics team came to visit and check my dilation. They advised I was at 7cm still and labor was stalling. I was told this was because I had requested an epidural and was resting. In other words my labor wasn't progressing because I had chosen to rest and have pain relief. At this time I asked the medical team is everything ok, why has the labor stalled and where do we see it going. I told them I was tired. I really needed someone to give me some hope that this was normal and I could see it through. they advised that everything was fine and to carry on. all the while my epidural still was not working properly and I was still in significant pain. Half an hour after this, the same doctor comes in and advises that she has shown her consultant the progress of my labor and they have determined that I have 'failed to progress' and therefore they recommend an emergency c-section. I was completely heartbroken by this. She returned with the paperwork and informed me of all the risks. I cried while I signed the consent form. I did not know how this had all gone so wrong or how I had ended up here. I didn't know why my midwife seemingly didn't care or why she hadn't come to advocate for the birth I wanted although they knew.

I gave birth to my son via a cat 3 emergency c-section at 5:30am on the 24th of Oct 2019. To my knowledge, the c-section was called due to a 'failure to progress' labor although there were no signs of maternal or fetal distress. At the time of the surgery I was noted to be 9cm dilated.

Once my son was born he was shown to me over the drapes and then taken to be cleaned. He was bought back wrapped in a blanklet, placed on me for approx. 3 minutes and then my son and my husband were asked to leave the theatre and head to the ward. I was alone while I was stitched up and taken to recovery. In recovery I asked for my son so I could breastfeed him. The nurse told me 'don't worry, you better soak in this time, it will be the last moment you will have to yourself.' I didn't care about this. I just wanted my baby. Two hours later (~7am) I was returned to the maternity ward to find my son and my husband. Our care was handed over to a student midwife. I tried to breastfeed my son for the first time as the lactation consultant came to visit. She saw my son latch for the first time, commented that I 'had great equipment' (referring to my breasts and nipples) and then left. I didn't know if I was feeding my son correctly or not. I didn't even know how or when to feed. We continued to be under the care of the student midwife which I don't really remember as I was very drowsy for the rest of that day. I barely fed my son because he continued to sleep and I didn't know that I should be waking him and encouraging him to feed in order to bring in my supply. At around 2pm I was introduced to the enrolled nurse who would be taking over my care. She advised that at 5pm she would return to get me out of bed (12 hours post surgery), remove my catheter and send me for a shower. I advised her at this time I have an irrational fear of catheter removals. She acknowledged this. At 5pm when she returned I mentioned I was fine to try getting out of bed. She attempted to remove my catheter. As I laid back for her to remove the catheter my legs were shaking. She mentioned that she thought this was strange behaviour from me. I reiterated that I was anxious regarding the removal and that I had been shaking since they sent me back from

theatres. I ambulated to the shower and back however as I was only 12 hours post-surgery I was in a lot of pain and was not able to move well. I asked if my husband could stay to help me out overnight. the Nurse unit manager denied this request and assured me that the nursing staff would be there to assist me. My husband went home. My son had a very unsettled first night. In extreme pain I got out of bed multiple times to take him out of his bassinet and change his nappy and attempt to feed him. I had a lot of difficulty doing this and also could barely see as I could not locate my glasses in the night (I am legally blind). I eventually found the light switch and my glasses. I buzzed the nurses for assistance as my son was very unsettled. They said they would take him to the nurses station to settle him. 15 minutes later he was hurriedly returned to my room as they had a raft of new admissions coming in. I spent the entire first night awake with him. Over the course of this night, he struggled to latch and feed adequately. Likely as a result of. exhaustion from both of us, we slept through most of the second day. The EN that had been on the previous afternoon returned for the night shift on the 25th of October. I struggled to get her attention to assist me with my son who again, had become very unsettled over the evening. We were not being regularly monitored and had seen no one for hours. No matter how many times I buzzed I could never get anyone's attention. Approaching 9pm in the night my son was screaming and could not be settled. One nurse managed to answer my buzzer. In an attempt to get some attention so someone could look at my son I requested for immediate breastfeeding education. I needed someone to see that my son was so agitated that he wouldn't even latch. The EN arrived to provide some education. She tried to settle him with no avail. It was during this settling that she realized he was having a fever. She advised that we needed a paediatrician review. She also witnessed that he was so unsettled that he wasn't able to latch. During the paediatrician review ~2am on the 26th of Oct, the paediatrician mentioned that my son was exhibiting signs of 'withdrawal' and asked if I had taken any substances during my pregnancy. At this comment I was extremely taken aback. I was a current employee of as a dietitian. I was very proud of my profession and professionalism. I replied that I had done no such thing and would never had done that. I informed the doctor that I was a practicing dietitian and had done my best to provide the perfect intrauterine environment for him. At this point the EN interjected to inform the doctor that she thought my behaviour was odd because I was shaking yesterday post surgery and had continued to have the shakes throughout the day. Once the meeting with the paediatrician was finished the EN followed me to my room and asked me again if I had taken any substances during my pregnancy. I replied no again. She then advised that she was going to take my son to continue observing him at the nurses station and I should go to sleep. I didn't know what else to do so I returned to my room. For an hour I sat and pondered what. had just happened in disbelief. I could hear my son crying at the nurses station but I didn't know what to do. After an hour I approached the nurses station and asked if I could have my son back. when I got there I was he was dressed with a singlet hat on his head and the nurses were playing with him. I was told to go back to my room and my son was to stay with the nurses. During this time I didn't get to attempt to breastfeed him. I text my husband at ~4am to let him know what was happening. I was so upset that they weren't giving my son back to me. Between 3am to 6am I continued at various stages to hear my son cry with the nurses but they never returned him. At 6am the EN gave me my son and informed she had given him a 'breastmilk substitute' ie. formula. I had not given consent for this to happen. Upon seeing my husband she asked him if he had seen me taking any substances during my pregnancy to which he also replied no. She then informed me that the morning staff were

going to take over my care and that I really needed to have some lessons in ‘mother crafting’ as I had no idea how to settle my baby. After this whole set of interactions, I felt completely incompetent and incapable of caring for my child. It was the first time I thought, my child is better with another mother and not me.
Fortunately, the nurse that took over my care on the 26th of October happened to be a previous nursing colleague of mine. She advocated for my character and trusted that I would have never intentionally harmed my baby. She spoke to the medical teams and suggested that my son might be having another issue. The head consultant checked him over and concluded that he was severely dehydrated. We were then transferred to the special care nursery where my son had bloods taken, had a tube placed and I had to pump breastmilk for his tube feeding. The nursing care I received in the special care nursery was amazing. They taught me how to breast feed for the first time in my whole care journey. On the 27th of October 2019 we were discharged home.

The poor care received over the course of my admission, especially the treatment, accusation and lack of education on the post natal ward left me having PTSD of the events. I could not get this entire birthing journey out of my head and relived it constantly. I started to know there was something wrong when I would get extremely anxious to leave my son or have other family members hold him. I was petrified he would not be returned to me. I cried all the time for everything. I felt completely incompetent and second-guessed everything I did. I continued to believe I was a horrible and incapable mother. I felt my body at failed me and was incapable of birthing. I started to think and believe my son's life would be better without me in it. At 10 months postpartum I realized this was not normal. I informed my GP who referred me to a psychologist. I was diagnosed with postnatal depression and anxiety as a result of birth trauma due to the grossly inadequate care I received. After many counselling sessions I finally came to believe that none of what happened was my fault however, this situation still affects me today. I can’t retell my story without crying. I still feel guilt even though I was the person who was wronged. We need an inquiry to ensure other mothers don’t have their children taken from them, to ensure that birthing partners and husbands are allowed to stay to provide additional care and support.
I have since gone on to have two more children including a drug free VBAC.