

TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Melbourne — 4 September 2017

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Witness

Ms Kate Ravenscroft.

The CHAIR — I welcome to these public hearings Ms Kate Ravenscroft and her friend Ruby. Thank you for attending here today. All evidence at this hearing taken by the committee is protected by parliamentary privilege as provided by the Constitution Act 1975 and is subject to the provisions of the Parliamentary Committees Act 2003 and other relevant legislation. Any comments you make outside this hearing will not be afforded such privilege. It is a contempt of Parliament to provide false evidence. These proceedings will be recorded, and a proof copy of the transcript will be sent to you. Welcome.

Ms RAVENSCROFT — Thank you.

The CHAIR — Now we have got that out of the way, perhaps we can start. Can you just give us a brief summary of maybe your presentation and what you think this inquiry should be looking at?

Ms RAVENSCROFT — Sure. I want to start by thanking you for inviting me today. I think it is really important that the inquiry hears not only from medical professionals and organisations supporting women and infants but from Victorian women, so I am really delighted to have the opportunity to come and share my experience today.

As I discussed in my submission to the inquiry, I have had some good experiences but also some very poor experiences of perinatal care. Thinking about today and preparing to come along today, there were three moments in my perinatal care experience that I thought were relevant to the terms of reference that the inquiry is looking at and that I wanted to speak about. It was my birth experience and then the postpartum haemorrhage that I experienced two weeks after the birth. Then I thought there were a few moments in that fourth trimester period — so being back in the community and accessing care through the maternal and child health nurses and a few experiences that I had there — that I wanted to speak about.

So I guess I, in preparing today, thought about my experience and what I wanted to share from my experience, particularly where the experience was a poor experience and where it resulted in poor outcomes for myself or for my daughter. Then I guess I was thinking about how I thought that experience could have been better and what would have made a difference to result in better outcomes for me and my daughter. Can I continue?

The CHAIR — Absolutely, please do.

Ms RAVENSCROFT — Just over 19 months ago I gave birth to a little girl as a public patient at the Mercy Hospital for Women in Heidelberg. After 11 hours of labour she came into the world and changed everything. Although I did not realise it at the time, I would say now that my birth experience was traumatic, and there are several reasons that I would say that.

The midwife came and went from the room where I was labouring about once per hour. The rest of the time there was no-one there but my mum and my husband. I often felt desperate for a medical professional to be there with me — it was my first birth, so just somebody who could provide me with information, with guidance, with encouragement, with just a sense of what was happening and whether I was progressing well and things were going as expected. When the midwife was present she seemed really preoccupied and rushed and focused on checking my blood pressure and things like that rather than focusing on talking to me and kind of hearing me and giving me that guidance and information.

I had not met the midwife prior to arriving at the hospital mid-labour. Despite having been in a team of midwives where it had been explained to me that I would meet all the midwives in the team and one of those midwives would be present at birth, that was not what happened. So it was a completely new person who I did not know and who did not know me.

Nobody told me that my daughter was posterior. At a point during the birth the midwife had called in the doctor and they were trying to turn the baby. I kind of realised that I had read about posterior labour and that must have been what was happening, but nobody explained that to me or what that meant and what was happening. I was given an episiotomy. Again nobody told me about this before it was done. I found out after it had been done that that is what had been done, so my consent was not sought for that procedure. I was not informed, consulted, given any choices; it was just done and then I was informed afterwards, as I was being stitched up, that that is why I was being stitched up.

The doctor who was present for hours during the labour tried to turn the baby, delivered the baby, delivered the placenta and stitched me up afterwards. He never spoke to me directly. He did not call me by my name or anything like that. He spoke to the midwife, and then the midwife spoke to me and relayed information to me. So it was a really dehumanising experience to be there and to be quite disoriented with that lack of communication and being sort of treated like I was invisible or somehow irrelevant to the process.

Once my baby was born she had a poor Apgar score, so she was whisked away. A code blue was called. Doctors filled the room. Again there was very limited explanation to me about what was happening or what that meant. My husband and mum ended up leaving the room with my baby when she was taken from the room, and I was just kind of left there, being stitched up, not really knowing what was happening or whether my baby was okay. It was just a really distressing and disorienting experience.

Thinking about that, thinking about my birth experience, it really seems to me that what would have made a difference, what would have prevented a difficult but ultimately deeply rewarding process from becoming a traumatic process, was really simple: if I had just had medical professionals who spent more time talking to me, keeping me informed, consulting me throughout the process; if I had had a midwife at the labour who had known me during the pregnancy and I had known them, so just some familiarity, some continuity of care; if there had just been time and opportunity within that experience of labouring for me to ask questions, to be informed, to be given choices and to be consulted and involved in the decision-making process; if the doctor had introduced himself, had addressed me directly, had treated me as somebody who was relevant and important and a participant in the process rather than, I guess, somebody who was just there and acted upon; if the consent had been sought for the episiotomy and if it had been explained to me why it needed to be done and I had just been consulted and involved in that process; and similarly with the posterior labour, if I had been informed and involved, if I had been able to be more active and in control and I guess respected ultimately by the people that were providing me with care.

It also would have made a huge difference if I had seen a doctor after the birth and I had had an opportunity to have the birth discussed with me and been debriefed and informed about what had happened during the process and what that meant for me in terms of my postnatal care; if I had been informed that I had retained placenta and what that meant; and if I had been given information about the risks of postpartum haemorrhage and when I might need to seek medical care — what is normal and what is a sign that maybe you need to get some further medical care. As I mentioned in my submission, I was discharged from hospital without seeing a doctor and without any information about the fact that I had retained placenta, what I needed to watch out for and how I needed to care for myself. Ultimately it was a very poor experience, I think, but interestingly my experience as a patient of the Mercy was very different from the experience that I had as a parent of a newborn in the neonatal intensive care unit.

My daughter was in the neonatal intensive care unit for three days, and each day our daughter's doctor met with me and my husband and explained to us what was happening for our daughter, how her health was, what care they were providing, what that meant and what they expected in terms of how long she would be in hospital. They just really took that time to keep us involved and informed. We felt really respected and supported by the entire team in the neonatal intensive care unit. The nurses were available; they were really responsive. We could ask any questions at any time. We could get support if we were concerned about anything or did not understand anything. One of the nurses arranged for the lactation consultant in the hospital to visit me by our daughter's bedside in the neonatal intensive care unit to support the establishment of breastfeeding, because we did not have an ordinary start to breastfeeding with her being in NICU. The nurses taught us how to take her temperature and involved us as much as possible in her care so we really felt part of things. At every moment it really felt like all of the medical professionals involved in her care were deeply invested in us and in ensuring the best possible outcomes for us as a family.

The discrepancy between these two experiences in the one hospital, I think, is really important. Perhaps the differences are small, but the effect is really profound. Just taking that time to communicate well, to keep people informed and to respect your patients as participants in the process results in a completely different care experience. I believe that if the quality of care that had been provided in the neonatal intensive care unit had been replicated on the ward for me, then perhaps the next experience I want to speak about — the postpartum haemorrhage — would not have happened at all.

For two weeks after the birth I bled heavily. I passed tissue, and I was often losing blood so heavily that I was faint and had to lie down. Being a first birth, I did not have any way to judge whether that was normal or not, but it continued for two weeks with no sign of improvement and I reached a point where I thought it just cannot be right. It cannot be right that I feel this way, and it is clearly not sustainable for me to continue like this. So with my husband and my daughter we went to emergency at the Mercy hospital. I was seen by a doctor who initially dismissed me and was preparing to send me home when I began to haemorrhage heavily and I ultimately lost 1.5 litres of blood. I was very fortunate that I was there in emergency at that time when the heavy haemorrhaging started. I was rushed into emergency surgery to stop the bleeding, and as a result of that prompt care I did not require a blood transfusion. However, I have been told by people, including medical professionals afterwards, that if I had not had the good fortune to be in an emergency unit at that time, the outcome may have been very different for me and perhaps even resulted in death. Just thinking about that today scares me. At the time, as I lay there in that hospital bed haemorrhaging, with my daughter and my husband next to me, it was just deeply distressing and just a terrifying experience, which really set back my recovery from birth and jeopardised my capacity to care for my daughter and to breastfeed her, having been through that medical, physical shock.

Ultimately I think it just was an experience that could have been avoided if I had received a better quality of postpartum care; if I had been seen by a doctor after the birth; and if I had been given information about retained placenta, information about postpartum haemorrhage and what risks and what care I needed to provide for myself and when I might need to get extra care from a medical professional. Perhaps I could have even received some preventative health care in hospital had I seen a doctor. Perhaps they could have done an ultrasound or something like that to identify the risks and prevent a postpartum haemorrhage. It just seems to me that it is unacceptable to be discharged from a hospital after giving birth without seeing a doctor and without receiving any medical advice.

I guess for me, as I stated in my submission, I have serious doubts about the commitment to maternal health care in the perinatal period. In my experience both in the hospital and in the community I felt very un-cared for. That discrepancy between the attention to my daughter's health and wellbeing and the attention to my health and wellbeing as a mother was stark, and ultimately that was not good for me or my daughter. It jeopardised the health and wellbeing of both of us.

I thought that I would speak maybe just a little bit more about my experience in the community during the fourth trimester. When my daughter was 10 weeks old, her most defining characteristic was perhaps her complete and utter refusal to be put down. She wanted to be close. She wanted to be held all of the time. She did not want to be put down to sleep. She did not want to be apart from her parents at any time ever — or at least that was how it felt.

One afternoon alone and home, my daughter in a sling on my chest as I paced around the house to keep her from crying, my utter exhaustion reached a peak, and I called the Maternal and Child Health Line in a desperate fog, wanting the answer to the only question that circled my fatigued brain: why won't my child let me put her down to sleep? I was emotional. I was deeply tired. I was alone. What I needed to hear when I called that line was that this is really normal — a baby who does not want to be put down at 10 weeks old is really normal and the way I was feeling was completely normal. Instead I got a nurse who, on the basis of a few minutes conversation, suggested that I had postnatal depression and a child with sleep problems and put through a referral to my local maternal and child health centre. So the next day I found myself on the receiving end of depression questionnaires, referrals to sleep school and well-meaning but ultimately unhelpful and unnecessary suggestions of what I needed to do.

I think, for me, that is fairly exemplary of the kind of care provided through maternal and child health centres. There is a focus on judging, labelling, referring, handouts and clinical information, where really that was just not what I needed. What I needed was a relationship with a trusted practitioner — someone who knew me, knew my baby, knew my family and knew my situation and who could reassure me that I was not at fault, that I was not doing anything wrong and that there was not anything wrong with my baby. I needed somebody to listen to me, to offer me encouragement and to build my confidence as a new mother — somebody to reassure me that this too will pass, my daughter will not need to be held for the rest of her life and there will come a point where sleep will get better and where my own sleep will get better. Perhaps I needed somebody who could have asked me whether there was somebody in my life who could come and offer me some support or come and hold the baby for a little bit so I could have a lie down or a bath or something like that.

I just really needed simple things and that relationship of trust and someone with the time to listen. I think ultimately this is what maternal and child health centres get so wrong and what in my experience the Australian Breastfeeding Association helpline does so much better. After that experience I did not call the Maternal and Child Health Line again, but I did continue to call the Australian Breastfeeding Association helpline when I just needed someone to talk to or someone to ask questions about mothering, about breastfeeding and about my infant where I needed that combination of support and reassurance but also access to information and where maybe if there was a problem I could get that information and supportive care.

That is ultimately why I think maternal and child health centres need to be different if they are truly to meet the needs of parents and infants in the perinatal period. I believe there needs to be a focus on personalised care that includes the whole family and that really prioritises listening to the patient and getting to know them and their unique circumstances. There needs to be continuity so that a trusted relationship can be established between nurse and patient. I see a different nurse at each visit to the maternal and child health centre. I also saw a different midwife all the time in hospital, so there was no continuity of care. They did not know me, I did not know them, and I really think that undermines the quality of care that can be provided.

I feel in my experience that too much perinatal care is generic. 'One size fits all' just ends up fitting nobody. A lot of my visits to the hospital during pregnancy, along with visits to the maternal and child health centre, were focused, I felt, on what the practitioner needed to record in their system — lots of focus on measurements, lots and lots of measuring you as a pregnant woman, measuring your baby, weighing your baby and putting numbers down, but ultimately there was not that time to talk, to ask questions and for them to get to know you and offer you relevant information.

Connected to that is the need for more time in perinatal visits. My overall experience, both prenatal and postnatal, both in hospital and in the community, was that perinatal appointments were rushed. There was always just stuff that needed to be done, and there was not enough time to actually just ask questions to be heard, which just does not create the conditions for the provision of quality care. As a patient it leaves you feeling ignored, unable to ask questions and ultimately not cared for. I can think of examples both in hospital and through maternal and child health care where that rushed nature of the appointment prevented me from being able to ask the questions that I had come wanting to ask, and it ultimately resulted, I think, in poor outcomes for myself and my daughter.

Ultimately I would love to see Victorians having access to multidisciplinary perinatal centres where there are medical professionals who truly understand the unique challenges of this period — the steep learning curve, the social pressures, the intense physical and emotional demands — and have the training and skills to provide knowledgeable, informed, effective, non-judgemental care to mothers, infants and Victorian families. These multidisciplinary centres would truly take seriously maternal and infant health care and would provide Victorian families with access to a range of healthcare professionals — doctors who understand the healthcare needs of pregnant and postpartum women, doctors who specialise in newborn health, mental health professionals who can support families through the immense transition of the perinatal period, lactation consultants, physiotherapists who can help women with separated stomach muscles and pelvic floor health and social workers who could link families into relevant community supports and establish effective parenting groups.

These centres would not just measure babies and lecture mothers but would truly get to know the families they worked with and care for them, providing for them the right care at the right time. They would deliver information accessibly and non-judgementally and would involve partners and extended family, where relevant, in ensuring that mothers and infants are happy, healthy and well throughout the perinatal period.

Thank you very much for allowing me to speak.

The CHAIR — Thanks for your contribution, Kate. Can I start, I am sure on behalf of the committee, by thanking you for coming and sharing your very personal story. We appreciate how brave you are in coming out and telling us today because it is these kinds of stories we need to hear as well if we are to improve our system. We realise that experience was quite traumatic, and it probably should not happen that way, obviously. Do you mind if we ask you some questions?

Ms RAVENSCROFT — Yes, sure.

The CHAIR — I am just wondering, and you briefly touched on it: what was your experience of antenatal classes and antenatal education?

Ms RAVENSCROFT — We went to some classes through the hospital. We could not book into a number of them because they were full. They were in very high demand. I think for a lot of services through the Mercy you almost had to have booked in before you even knew you were pregnant because they were so in demand. We did go along to I think it was two sessions of an antenatal class where they did speak about birth and just different sort of pain options and ran through a whole range of things. It was, again, I just feel, a bit ‘one size fits all’, throwing a whole lot of information at you. I think each session was 4 hours, which is a long time, and when it is all kind of abstract — when you have not given birth before and you have not been through any of it — it is quite hard to make that a really useful experience, I think. So again, as I said, when I realised that my baby must be posterior and that was what was happening and why the doctor was doing these things, I could go back to having received that information at different points.

The CHAIR — Do you think there is an assumption by GPs — and this would not cover the fact that they were not actually explaining what they were doing — that ‘these people have learned this information at class so they should be prepared for it’?

Ms RAVENSCROFT — Yes, I think so. Maybe it just felt like I did not need to know as well, like I just needed to go along with whatever they believed needed to be done. It almost felt like there was an attitude that slowing down or stopping to keep me informed was just a hassle or an unnecessary kind of obstacle to then getting the job done. My experience in the hospital was that there were all these people with these jobs to do and they had their lists of things to tick off and somehow I just did not quite fit in anywhere. There was no time to slow down and say, ‘How are you going?’ and ‘What’s happening for you right now? Do you have any questions or things that are bothering you?’ or —

The CHAIR — So are you saying it is more baby-centric then? Baby and mother?

Ms RAVENSCROFT — Yes, it felt like that. It felt very process oriented and that there were always so many things that the practitioner needed to do that came first and that ultimately just left you feeling like you had been shown out the door before you had had a chance to say, ‘Hang on. I’d really like to talk about this’ or ‘I’d really like to know more about that’.

Ms BRITNELL — First of all, I would like to thank you very much for the presentation. You have articulated an amazing experience. As a nurse of 30 years I am really disappointed to hear that story. You have made me feel like, wow, that is the ultimate bad experience that no nurse would ever, I hope, leave their patient feeling like. Back in the day when we called people ‘patients’ instead of ‘clients’ you did not get that sort of outcome. That was probably unnecessary for me to say. But it is a really unfortunate experience, and I am sure there are a lot of mothers at this inquiry here today who have not experienced that. I hope that just because you have experienced that once, the next time, if there is going to be one, you will have a much better and different experience.

You have highlighted some really interesting things for me — to look at the supply and demand for antenatal classes, which you just brought up, but also to recognise some of the advantages we do have in the country, where I am from, which is out west. We have a maternal child health nurse and you often see the same one each time. You often see the same doctor. So we have some advantages. I recognise that that change in the last 30 years has contributed to a lack of continuity of care, which is an old term, which is very important for good client care. I just want to say thank you for the opportunity to hear your story, and I am sure we will take it on board and have a good discussion around that.

Ms COUZENS — Thank you for coming in today and sharing your experience. For the committee to hear that is really important. I can attest to Roma’s shock because she was sitting there next to me, going, ‘Oh!’, so thank you for sharing that with us. You talked about maternal and child health nurses. What do you think they need to do differently to improve things for new mums?

Ms RAVENSCROFT — I think the number one thing is people skills. Again, it is that idea that they have all these things to do and they have all this knowledge and it feels like a one-way street. It does not feel like a partnership or a collaboration. I know my experience is not the only one. I have a lot of friends who describe similar things. I have a friend, for example, who will not go to the maternal child health nurse on her own

because it has been such a traumatic experience. It is very rigid and it often feels very judgemental. It is very much focused on, 'We know and we're telling you what you need to do and what you need to know', as opposed to taking the time to build a relationship to find out what the priorities and values of that family are, what is happening for them, what is important to them and what they might be struggling with versus what they might feel confident with and really just that relationship and an investment in that relationship.

It is not just the continuity of care but having the mental health skills, especially for that fourth trimester with a first child. It is such a rollercoaster. You have hormones going crazy and you are absolutely exhausted in a way that you never even thought it was possible to be, so little comments can really knock you where at another time in your life you might be able to just take them on the chin and move on. The way you provide information is just so important at that time — providing it in a way that, first of all, is accessible so it can get through all the fog and the fatigue and you can process the information and make it useful but also that you feel that that person has your back, if you like, that they believe in you as a parent and that you are doing a good job and doing the best for your kid. They are building up your confidence and your capacity to take in all that new information and be the best parent you can. You often feel judged and undermined by the maternal child health nurse rather than supported and built up, so that instead of leaving the appointment feeling like 'I'm an okay parent. I've got this. I'm doing this. My kid's okay. We're all still here', you leave feeling like 'I'm doing everything wrong' and 'I should be doing this and I should be doing that'.

Ms COUZENS — I have heard that from lots of new mums — that they feel like they are being dictated to about what they should do, but in fairness there are lots of really good people out there who are providing a great service as well. Is there anything in particular that you think the committee should focus on in terms of changing things to improve that continuity of care?

Ms RAVENSCROFT — Not being across funding models and the complexity of how the system actually works, I think anything where there can be an investment in building a relationship with a family. I think it is also really important that we are actually thinking of families. My husband was just out there; he just seemed completely irrelevant to the process, so I think really including the whole family. If there was an opportunity to build a relationship with the whole family from the moment you found out you were pregnant through to postpartum and the fourth trimester and you were actually working with somebody who knew you and your family and knew what obstacles you faced and what your values and beliefs were and who kind of felt like a partner through the process with you.

Ultimately I found that in a GP. We found a really good local GP, so now I can go there. I know that whatever is happening for our family we can go there and talk. Even though GPs do not necessarily have any more time than any of these professionals, it is about the way you approach it. The moment we get there he just sits there and says, 'What's happening for you?' and talks to us and hears us before he rushes into, 'Here's the forms for the 18-month visit' and 'Here's our checklist of things that we need to do'. So I think ultimately it is about people having the time, the experience and the training to be able to focus on that relationship, because I think if you can get that relationship right, the other stuff will follow. Ultimately these people all do have lots of training and lots of great knowledge to offer, but if you cannot build that relationship in order to be able to offer it in a way that is accessible and useful to families, it just falls by the wayside and people do not feel supported.

Ms EDWARDS — Thank you so much, Kate. That was really brave of you, and I love that you are so articulate in expressing what you need to tell us. You came across as very passionate about being here, and that is what we want to hear. Maybe some time down the track we will hear from other mums too, but thank you so much for that.

While you were talking to us, and after having read your submission as well, there were two things that stood out for me. One was the medical intervention without consent, which raised some big red flags for me, particularly in relation to how hospitals have protocols around these matters, but more importantly the rights of women in labour. You are, as I said, a very articulate young white woman, and I can only imagine how difficult it must be for women from non-English-speaking backgrounds or even from low socio-economic backgrounds to be in a position where they have no power and no control and are completely treated as secondary to what is happening around them. I think for us as a committee we need to start thinking about how we are going to address the needs of women who are in labour and make sure that their rights are absolutely adhered to. It is unacceptable in 2017 that a woman would be treated like you were in a hospital situation.

I do not actually have any questions, but the other thing I did want to say was that in relation to your suggestion around multidisciplinary centres, I think the committee is already thinking along the lines of, particularly for our rural and regional communities, access to a multidisciplinary approach to families — as you said, the family nucleus — but also mother and baby sort of approaches. I thank you for articulating that, because I think it is something we will be thinking about along the way. So thank you again.

Ms RAVENSCROFT — On the consent issue, it is interesting to think that when I was haemorrhaging and they decided that I needed to be rushed into surgery, they still had time to get my consent for anaesthesia and to explain to me what was going on. I was literally just gushing blood, and yet they had time to stop and explain, ‘This is what’s happening to you. This is what needs to be done. Do we have your consent?’. So I do not see how in the birth process they could say that there was not an opportunity to say, ‘We need to do these procedures. Do we have your consent?’. Again, same hospital, different situations, but just completely different —

Ms EDWARDS — I am pretty sure most hospitals have protocols around these types of matters, so that is something we need to think about. Thank you very much, Kate.

Mr FINN — Thank you, Kate, for coming in and telling us of your experience. I have to say, I am with Roma on this. I am absolutely shocked that anybody would be treated in the way that you have been treated. I am just wondering if you raised your treatment with the Mercy hospital itself.

Ms RAVENSCROFT — I think I filled out a feedback form. After the birth I was focused on my child’s wellbeing and with her being in the neonatal intensive care unit. Straight after the birth I was wheeled up to there in a wheelchair. Really I guess most of the time that I was in hospital I was down in the neonatal intensive care unit, and I guess all of my energy was there. I think it really was not until afterwards, and even probably as a result of the postpartum haemorrhage and kind of going back to hospital and all of that, that I started to think, ‘Hang on, what did happen to me during the birth, and was that okay and was that right?’. I think at the time I did not really stop to think about that or to process that. I just kind of kept moving through that period. I think I did complete a feedback form at some point, but again that period of having a newborn is so demanding and so engrossing that I did not really stop to put a lot of thought into passing back my experience.

Mr FINN — Did you get any response from that form?

Ms RAVENSCROFT — No.

Mr FINN — That is a pity. I think any hospital that allows its patients to be treated in the way you were really needs to have a good look at itself. Thank you for coming in.

Committee adjourned.