Kirsten Chilcott

[redacted]

Emailed to: rmphs@parliament.tas.gov.au

To The Secretary, House of Assembly Select Committee on reproductive, maternal and paediatric health services in Tasmania.

I would like to put forward a submission relating to the adequacy, accessibility and safety of the maternal health services, specifically in the North West region of Tasmania. My submission is twofold;

1. My current experience with my second pregnancy, due to be delivered via planned caesarean section on [redacted].
2. The pregnancy, birth and paediatric care of my first son in [redacted], which is relevant as it explains the birth trauma I have faced in the past and the reasons for my concerns relating to the standard of care I am currently being provided.

I believe my submission will be of use to you due to having experienced maternal services both before and after the recent changes from private to public at the North West Regional Hospital (NWRH).

1. My current experience with my second pregnancy, due to be delivered via planned caesarean section on Friday [redacted].

To preface this submission, I would like to make it known and clear that I have had a complaint in progress since Wednesday 5th June 2024. I have attached a copy of my complaint email as **Appendix 1** to this submission.

At my 20 week scan, I was told that there seemed to be abnormalities that couldn't be identified correctly and that I would urgently need to go to Hobart for further testing. All of the details are provided in my complaint in the **Appendix 1**, so I will not repeat this as it contains a lot of information, however to summarise, there was actually nothing wrong with our child at all and we were put through weeks of mental trauma, severe stress, and unnecessary travel all because the sonographer was unable to conduct the scans properly. Since submitting my complaint, I have spoken with different obstetricians as the NWRH all of whom have commented on the amount of errors that occur from imed radiology. One went so far as to assume that the scan had simply been read backwards, due to them saying that the main arteries were entering the wrong side of the heart.

I am yet to receive any formal response to my complaint, in which I specifically advised that I did not want to deliver in the North West Regional Hospital. I provided ample time for an investigation to be completed and a response to be provided to me regarding the location of my care. It has, at the time of writing, now been fourteen weeks since I submit my complaint, and I am a mere two weeks away from my planned caesarean section which I have had to book in at the North West Regional Hospital due to having my complaint completely ignored.

The timeline of my complaint in progress is as follows:

- *Wednesday 6th June 2024*: emailed complaint to northwest.feedback@ths.tas.gov.au
- *Thursday 6th June 2024*: I received the generic acknowledgement of complaint, requesting the consent to share personal information forms be completed.

- *Thursday 6th June 2024*: I responded with the requested documents.
- *Friday 14th 2024*: I emailed to follow up as I had not yet received any response.
- *Monday 17th June 2024*: I received a response advising that the concerns were with the senior management team, who would provide a formal response.
- *Tuesday 23rd July 2024*: I emailed to follow up again, as it had been 7 weeks without receiving any formal update or outcome.
- *Wednesday 24th July 2024*: I received an email from a team member [redacted] recognising that my social worker [redacted] had been in contact with the feedback department, and that they had been working with other areas to find ways to ensure I felt more supported.
- *Wednesday 21st August 2024*: I emailed my social worker [redacted] to see if she'd heard anything. [redacted] called me the following day and advised she had not received any further contact, despite trying to contact [redacted] numerous times herself. [redacted] provided me the details of [redacted], the Executive Director of Quality and Safety, and recommended that I escalate my complaint to her directly due to the significant delay and not having received any response at all. I emailed [redacted] at 11:05 that day, advising that I was extremely disappointed that there has been such a delay, and expressing serious concerns. I have attached a copy of this email as **Appendix 2** below.
- *Thursday 22nd August 2024*: miraculously, after I escalated my complaint to [redacted] I was contacted less than four hours later by the patient safety team. However, their response was the same as I received back on 24th of July, but I was also told to direct enquiries only to the generic email address. I immediately replied to this email, expressing my frustration that no update was being provided, and that I was essentially being told not to escalate my request. This email was again unanswered.
- *Wednesday 11th September 2024*: my assigned social worker [redacted] emailed me to follow up on whether I had heard anything, as she had received an email on Thursday 29th August 2024 advising that a final written response was with the Senior Management team for clearance and approval. I have not received any such response.
- *Thursday 12th September 2024*: I finally received a response from the Patient Safety Team which completely dismissed my actual concerns. The response did not acknowledge that the poor processes were the cause of my distress and experience. The only thing the response contained was confirmation that the processes were followed correctly, and did not offer any apology regarding the seriously unprofessional 14 week delay, nor did it in any way address my initial request which was to not give birth at NWRH. It contained incorrect information, stating I was booked in for my caesarean in October, when I'm booked in September, and even said it was noted I was happy with the decision which I am absolutely not. I have attached a copy of the response I received for full transparency also.

Throughout this above timeline, my assigned Social Worker, [redacted], had also made multiple follow up attempts as well. Through this incredibly tedious process, I've only received two actual emails, neither of which provided any form of apology nor support.

In light of all of the above issues, I'd like to ensure I make a point of recognising the hard work and dedication of my social worker [redacted] Her support has been the only part of my experience with the North West Regional Hospital that has made me feel heard, and cared for.

2. The pregnancy, birth and paediatric care of my first son in [redacted]:

My pregnancy in [redacted] resulted in an emergency C-section due to severe, undiagnosed pre-eclampsia. From very early in my pregnancy I experienced severe swelling and my skin would stay indented when poked. The swelling was so bad by 28 weeks that I could not wear shoes, and had to buy a larger pair of slip-ons. At the time, I went into the antenatal clinic for monitoring as I knew something wasn't right. They allocated me a student midwife, who hooked me up to the monitor, but I was told swelling during pregnancy was normal and then sent home. When I attended my next appointment 2 weeks later with the OB, I was immediately admitted for further testing and monitoring due to an extremely high blood pressure and protein count in my urine. As soon as I walked in the door of her office she could tell something was not right. She asked how long the swelling had been like that, and I explained it had been weeks and that I did come in concerned but was sent home.

Just hours after being admitted, I was advised that I would be sent to Launceston for delivery the following day due to me being less than 34 weeks gestation. The care I received there was exceptional. I require testing multiple times a day, and daily ultrasounds, before being told I needed to deliver via an emergency caesarean section on [redacted]. My son was in their NICU, and the staff there were highly trained and competent, and took the time to explain everything to us as well as teach us how to care for our son using the feeding tube and how to fix the monitors etc.

We were transferred back to Burnie after the first week, which we were so excited about as it meant we were closer to home. However we quickly realised that the level of training and care provided by the nursery staff were nothing less than appalling. I met multiple staff who openly admitted that they had not worked in the nursery before and were just covering shifts due to staffing issues, or that they had not worked there for a long time. I had one nurse admit she didn't have experience with NGTs but told me she would "*have a go*" replacing my son's, to which I refused and requested a trained staff member change my son's tube. On multiple occasions the staff were so busy that they held the feeding tube too high, so they could be done faster, causing my poor premature baby to continuously vomit back up his feeds, which caused concerns with the paediatricians who just saw the notes of constant vomiting. I eventually took over as many feeds as I could to ensure the tube was held at an appropriate height which improved things significantly.

We met new paediatricians every day, and every day things seemed to change in terms of what their advice was. The lack of consistent advice or one consistent approach to care was confusing, at an already stressful time. Each paediatrician had their own opinion, often re-calculating the amount of formula required. When we were finally allowed to go home, the inconsistency continued as we were required to attend regular paediatric outpatient appointment, where we always saw a different doctor, having to re-explain our story every time. I raised concerns multiple times at these appointments that my son was having feeding issues, projectile vomiting after every feed. I was told it's normal, babies vomit, but was not listened to when I explained it was projectile and certainly not normal. I was made to feel that I was being paranoid as a first time mother. I eventually resorted to taking a bottle to one of our paediatric appointments, and feeding him in front of the doctor. He of course projectile vomited across the room, and the doctor said no that's not normal. Despite having witnesses this, they didn't want to prescribe any medication or formula to help, wanting to "*see how it improves*" by the next appointment. It was at this point I refused to leave without having something we could try to improve the situation, as it had been weeks of this going unheard. I was distraught that my poor, premature, baby was being subjected to an issue that could potentially be easily fixed. He was always upset and in visible pain. We were given a trial prescription for Esomeprazole, and Aptamil Pepti Junior formula. A matter of days after making these changes, we had a completely

different baby. He was no longer screaming after his feeds, and would only do minimal vomits sometimes rather than the projectile vomiting at every feed.

I did not make a complaint at the time, and it is one of my biggest regrets. I did however submit my story as part of the inquiry into the private maternity ward and poor level of care that has historically been provided to mothers, which led to the ward being taken back over by the public system.

There is far more I could add to both of these stories, minor bits along the way such as being given someone else's medical records, having appointments booked incorrectly and having to experience significant delays waiting for appointment, however I only became aware of the submission deadline quite late notice. I hope, for once, my story can be heard and that maybe it helps to improve things for future mothers,

Appendix 1: Copy of Complaint Email – Wednesday 5th June 2024.

To whom it may concern,

My name is Kirsten Chilcott, I am currently pregnant with an expected due date of [redacted], and I would like to formally lodge a complaint regarding the care and lack of information that I received regarding to my condition as a patient of the North-West Antenatal Services.

The details are as below:

- My 20 week anatomy scan was booked for 17th May at 8:00 am
- This appointment was cancelled at 5pm on the 16th May, due to the sonographer calling in sick. I understand these issues are unforeseeable and cannot be helped.
- On 17th May I received confirmation my appointment could be re-booked for 20th May at 8:45 am and was reassured that the report would be sent to the antenatal clinic in time for my appointment which was on the 21st May at 3:45 pm
- I attended the scan on the 20th May, where it took almost two hours and required me to go for multiple walks due to the position of the baby. I again understand this cannot be helped and is not part of my complaint.
- I attended my appointment on the 21st May, which went through the routine information for 20 weeks, and also the midwife asked to listen to the baby's heart beat which was completed.
- The midwife then attempted to view the report on the computer, however advised that it had not yet been signed off for a doctor so we needed to go to the labour ward to speak with a doctor, and then escorted me down.
- Once we arrived at the labour ward, I met with a female doctor whose name I do not recall. We were moved into the assessment room for a conversation. This doctor advised that there were abnormalities in the scan and that I urgently needed to be seen by the Maternal Fetal Medicine specialists in Hobart. She reiterated the urgency and then advised that I should be prepared to go that same week.
- The doctor was unable to provide any information at all around what the issue was or why I needed to go, and advised that she could see there were some issues with our baby's heart but she was a general doctor and did not feel comfortable interpreting the scans and explaining it to me. I requested more information but was not provided it. She said I could call the specialist clinic the following day to get the information I needed. By the time I left the hospital (Burnie) it was after 5pm.
- I called the specialist clinic the following morning (22nd May), as I was understandably very nervous and wanted to confirm that the referral had been received. When I requested confirmation I was told that it had come through overnight, and that I needed to wait. When I explained I was told I'd need to go that same week and it was already Wednesday, and I needed to make arrangements for my other child, I was told "yes we see lots of people from the coast these things take a few days, you have to wait". I understand the reasoning behind this and if I had of had any information I may have felt comfortable waiting, but after being told nothing but my baby has an issue with her heart I was very upset.
- I attempted to call the midwife team at Burnie and was unable to speak with anyone at the time.
- Later that morning a senior midwife returned my call and explained that they really couldn't see what the abnormality was and that the reason we needed to go to Hobart was that they have more advanced machines to conduct the ultrasounds, that would give us further clarity. She also advised that they may request we wait until 22 weeks due to the size and growth of

the baby. This was the most information anyone was willing to share with us but again nothing had been confirmed.

- Later that day I called again and spoke with another receptionist, with a plea for information as I was still yet to have any explanation as to why we needed to go in the first place. I was again told I needed to wait, and may not hear back that week. When I questioned what the cause of delay was, and again explained we were told it was urgent, I was advised the specialists triage them and we must not be that urgent. Again with no further explanation.
- On the morning of the 23rd I received a call from the specialist clinic to confirm my appointment would be on the 13th of June. I asked for more information, explaining yet again that we had been told nothing, and she apologised and advised she is only responsible for booking the appointment. I requested to speak with someone who could tell me anything, and was told the referring hospital needed to provide the details.
- I again called the antenatal clinic at Burnie and explained what the receptionist at the specialist clinic told me. I spoke with the same senior midwife who told me she couldn't offer any more information but would try to have one of the doctors call me that day.
- One of the doctors from Burnie called me later in the afternoon of the 23rd, again whose name I do not recall. This doctor said that although she was not trained in the correct area, she could see that the superior vena cava was going into the wrong chamber of the heart and that the aorta looked abnormal. She was able to mention a variety of names of conditions etc that it may be, including transposition of the great arteries and tetralogy of fallot, however could not confirm. She then said "the specialist team will confirm if these conditions are compatible with life or if a medical termination will be required." She confirmed that the best case would likely be surgery on the baby. At the time, I was grateful for any information and trusted the doctor knew what she was saying enough to feel confident in relaying the information to me. This information of course though sent me into a state of significant distress, I was in tears for days and even needed time away from work to process what may be coming. Looking back, I do not feel as though this doctor should ever have provided that information when she did not have the confirmation required, and despite my desperate pleas for information, it would have been far more appropriate to approach the situation in a way which explained I just needed to be sent to a hospital where they had better imaging. This would have been far less traumatic, given the significant wait that I still had until the appointment.
- With the information that was received, I was under the impression the specialist clinic was making me wait THIRTEEN days, to find out if my baby would live or not. In any situation, and no matter the outcome, this is not acceptable. If the specialist clinic did not think it was urgent enough to warrant an immediate appointment, some sort of information and reassurance should have been provided as to why to calm our nerves.
- After waiting the thirteen days between my antenatal appointment on the 21st where I received the advice I needed to go to Hobart that week, and the 3rd of June, I endured constant sleepless nights, unnecessary stress to myself and my unborn baby, and a complete lack of adequate communication.
- Attending the appointment on the 3rd of June, we were told immediately that the doctor we needed to see had called in sick. Again, unpreventable but worth mentioning in this incredibly unfortunate chain of events.
- We underwent the ultrasound for just over 1.5 hours, and the two technicians/medical professionals there were wonderful at keeping us calm and being very friendly. They explained that because we had travelled so far, they'd arranged for a specialist who was on shift at the

Royal to review the scans and another senior staff member was going to take over our appointment.

- After the scan, we had another short wait before being called in for results.
- We were told, that our baby is perfectly healthy. There are no signs of any issues at all, and they were not sure what had happened or how it had been so wrong in the first place. The doctor did mention that often some sonographers are not adequately trained in pregnancy scans. The doctor was very sympathetic, and said that because we've had two such conflicting sets of advice, they would like us to come back in 4 weeks to do a final reassurance scan.

While we are absolutely ecstatic that our baby has no issues and is perfectly fine, I am deeply traumatised and extremely angry at the entire experience. Along with my formal complaint, I would like to request investigation into how our scan could possibly have been reported so wildly inaccurately. I would understand if they had of just said it was unclear, but to provide the specific information that was provided to me someone must have done something extremely wrong. Considering they thought the superior vena cava was in the left side, but it is in fact in the correct place on the right side, did this person somehow look at the baby upside down? And if so, how is this even possible for a trained sonographer to do? I am now afraid to have another scan at imed Burnie, for fear of what may happen. If there are not the staff qualified and trained to do these scans, do not book them to be completed.

Additionally, we did not receive information regarding travel/accommodation bookings in a timely manner, so we booked our own for fear of incurring a last minute price hike. It was only during late morning on the 30th of May that we received the forms and information for travel. We were then unable to claim back the cost of that accommodation, and were also out of pocket for meals etc for an unnecessary trip. We again have to go to another early morning appointment in 4 weeks and will have to incur the same costs. I spoke with a social worker [redacted] who requested I call her on 4th of June to debrief from my appointment however have not been able to get hold of her.

Furthermore, I believe that it is worth mentioning that I had a very traumatic experience with my first pregnancy, which I believe was made worse by the care I received from antenatal at the time in [redacted] I had severe pre-eclampsia which was not diagnosed despite me advising on multiple occasions I felt unwell, and even presenting for monitoring due to increased swelling and decreased movement. I was monitored for a short time but then sent home, and when I attended my next appointment 2 weeks later with the OB, I was immediately admitted for further testing and monitoring due to an extremely high blood pressure and protein count in my urine. Just hours after being admitted, I was advised that I would be sent to Launceston for delivery the following day. The care I received there was exceptional. My son was in their NICU and the staff there were highly trained and competent. We were transferred back to Burnie after the first week, where the level of training and care provided by the nursery staff were nothing less than appalling. I met multiple staff who openly admitted that they had not worked in the nursery, or had not worked there for a long time. I had one nurse admit she didn't have experience with NGTs but would "have a go" to which I refused and requested a trained staff member change my son's tube. On multiple occasions the staff were so busy that they held the feeding tube too high causing my poor premature baby to vomit back up his feeds, which caused concerns with the paediatricians who just say the notes of constant vomiting. I eventually took over as many feeds as I could to ensure the tube was held at an appropriate height which improved things significantly. We met new paediatricians every day, and every day things seemed to change in terms of what their advice was. I did not make a complaint at the time, and it is one of my biggest regrets. I submit my story as part of the inquiry into the private maternity ward and poor level of care that has historically been provided to mothers.

I'd like to know, do I have any options at all as a public patient to refuse care from the North West regional hospital, and deliver in Launceston? I have gone through significant trauma as a direct result of this hospital and their staff and the anxiety induced by the thought of having to have my baby there this time is causing a lot of stress on myself and my unborn baby.

Kind regards,

Kirsten Chilcott.

Appendix 2: Copy of Email Escalation to [redacted] - Executive Director of Quality and Safety

Hi [redacted]

I attempted to call through to you this morning but the switchboard were unable to locate a number for you. I wanted to reach out regarding my below complaint, that has now been in progress for in excess of 11 weeks. I have not yet even once received any real update. I am extremely disappointed that the people who are supposed to support the complaints process have been unable to do so in a timely manner, despite multiple follow ups from both myself and [redacted] It is seriously concerning that there must be so many complaints going unheard, if I have had to follow up this many times.

This process has left me with even more concerns regarding what is going to happen with the pending birth of my second child, and very little confidence that the North West Regional Hospital care at all about the concerns of patients. I do not believe my complaint is insignificant. Not only did my experience have a severe impact on my mental health, it also impacted my work requiring unnecessary time off. The constant stress of having to follow this up, just so I know I've been heard, leaves little for me to cling to in the hopes that my birthing experience is going to be a good one.

Since submitting this initial complaint, I've had an appointment booked for the wrong time, causing issues with my work schedule, and I was also incorrectly given another patient's medical history and scan referrals rather than my own. I've heard multiple stories of how people have been put through similar situations, one of the OBs I saw for an appointment at Burnie mentioned that imed frequently get reports wrong, and the medical professionals at Hobart even admitted themselves they've seen an increased number of patients from the North West Hospital for referrals that have turned out to have been nothing.

I will continue to follow this up and take it further, even if I give birth before I hear back. Not just for me, but for the mothers who may not have the confidence to do so themselves and who will go unheard if this process doesn't improve.

I really hope you can assist with this matter.

Thank you.

Kirsten Chilcott

Department of Health

GPO Box 125, HOBART TAS 7001 Australia
Web: www.health.tas.gov.au

Tasmanian Government

Contact: Quality and Patient Safety Service
Phone: 1800 062 322
E-mail: northwest.feedback@ths.tas.gov.au
File: [redacted]

Kirsten Chilcott
[redacted]

Dear Kirsten

Thank you for your contact with our Quality and Patient Safety Service (QPSS) about your experience with the health service about your screening morphology scan and subsequent appointment for further screening.

We have received feedback from I-MED Radiology Network who did your screening morphology scan. The I-MED Head Sonographer spoke with the sonographer who performed your scan, reviewed the images that were made from your scan appointment, and report from the Royal Hobart Hospital (RHH) Fetal Echocardiogram. Your screening morphology scan was performed by an experienced qualified sonographer. The images obtained at the morphology scan do suggest the presence of a persistent left superior vena cava (LSVC) and it was for this reason that it was suggested that you have further imaging, which was appropriate. Tertiary scans involve an Obstetric Specialist Sonologist and sonographer and provide a more in-depth view to further assess the pregnancy. The Head Sonographer is pleased that the tertiary scan had a great outcome.

We have also received feedback from the RHH Maternal Fetal Monitoring (MFM) Midwife Unit Manager about your experience with booking your appointment for the further scanning. On review, it was identified that the RHH staff followed the appropriate process and actions in triaging, actioning, and completing this referral to the MFM clinic. They have advised that your referral was triaged on the day that your referral was received, and it was returned to clinical staff to book your appointment. The MUM has advised:

> *When you rang and then were rang back the next day, each of your interactions would have been with a member of our clerical team, whilst I appreciate your frustration at receiving no further details during these interactions, our clerical staff have no clinical knowledge and are therefore unable to discuss anything clinical with consumers. As stated above the wait for your MFM appointment (14 days from your morphology ultrasound) was to ensure your baby was between 22- and 24-weeks' gestation to allow for an accurate tertiary ultrasound. Again, I apologise that this was not communicated with you and left you feeling that your situation was not important or a priority to our team.*

You were offered a follow up ultrasound for reassurance given your understandable anxiety.

Your complaint has also been reviewed by our Clinical and Nursing Directors of Women's and Children's Service. I am sorry to hear that you were distressed during this screening and further assessment process and that you were upset with the information provided to you by a North West doctor when you requested more information about your screening scan results. I am pleased to hear that you recognised the attempt for the doctor to assist you while you were waiting for your further scanning with the MFM. Our Clinical Director is sorry that you have had a stressful time during your pregnancy. She has advised that the service will try to work on ways of better communicating with women about the importance of referral for detailed assessment of possible abnormalities, so that they feel supported during this process.

I recognise that there was a delay with the results from your screening morphology scan reaching your health record, which has been escalated to our senior staff for review to ensure that this process is timelier.

I understand that you are booked for an elective Lower Section Caesarean Section in early October, which our records indicate you are happy with. If you continue to have concerns, I encourage you to raise these with the midwives or doctors when you attend for your antenatal appointments.

I am pleased to hear that you are well connected with our Maternity social worker, and I wish you a positive birthing and post-partum experience.

Yours sincerely

[redacted]

[redacted]

12 September 2024

Enc: N/A

Copy to: Consumer Liaison Service – Royal Hobart Hospital
I-Med