Letter to Government of Jersey Scrutiny Panel in relation to the current Maternity services

Date of letter: 14 February 2021

Further to the publication on 8 February 2021, where an in-depth review of the Island's maternity services has been launched by the Health and Social Security Scrutiny Panel, I am writing to you to share my (varying) experiences and suggestions/considerations.

I realise that this is a lengthy letter and so understand if you scroll to the end of the letter to see suggestions/considerations for improvements.

1st Child – born May 2013

From my recollection, the antenatal care for our son was excellent – regular scans, regular midwife appointments, sessions at the hospital with other to be first-time mum's. Our son was a week overdue and so I was induced twice, which the second induction worked, and my waters broke soon after. I arrived at the hospital and, although I was not fully dilated, I insisted that I would not be sent home due to knowing a friend who was sent home after their water broke and unfortunately lost their baby due to an infection. Thankfully, the midwives/doctor agreed that I stay in hospital and I was in a delivery room for most of the day. Labour lasted 12 hours and I had to have stitches following the birth (our son was 9 and half pounds).

After the birth of our son, I was transferred to the maternity ward with other mums and our son was by my bedside. I felt like I could not leave my son for a second so I could not go to the toilet or have a shower. When my husband visited me that is when I took the opportunity to try and have a shower, however, I could not get the shower to work probably and so had to wipe myself using toilet paper and wipes I had brought for the baby. I was in the ward for three days and felt so dirty for the duration, which just made me want to go home. The midwives came to show me the basics, including assistance with breast-feeding. I cannot remember to midwife's name; however, she forced my baby onto my breast, and I had trouble getting my son to latch onto my breast, but the midwife kept forcing. Since that first feed whenever I tried to breast-feed our son I was in agony. I asked the midwife if I could try using formula in a bottle for the baby and she glared at me and said I should keep trying to breast feed. I said that I was in pain every time I would breast feed and she said I had to keep going. I felt like a terrible mum for not being able to breast feed properly and even worse for suggesting using formula. After three agonising days I was discharged and, as soon as I got home, I asked my husband to get baby formula and a breast pump (as I still wanted my child to have breast milk). The community midwife who visited after birth was more understanding and helped me on the best way to use a breast pump and how to store the milk. I felt a bit better that I could still give my son breast milk even though it was through a bottle and not my breast – I had developed mastitis and cracked nipples.

I went to social gatherings with other mums at the community centres and remember other mums and even the social workers/midwives staring at me with judgement because I was using a bottle for my baby. I became self-conscious and kept thinking I was a bad mum, so I generally stayed at home for months. The community midwives had stopped seeing me after a few weeks and I had healed, so no further assistance from the hospital/community midwives. I went to see my GP who diagnosed me with post-natal depression, which I got some medication. When my son was a year old, I still had post-natal depression and had to see a counsellor for a year (through my GP 's surgery). When my son was a toddler, I finally felt

better as a mum but still struggled with my thoughts that I had been a terrible mum from the start. My son is now 7 years old and healthy. I now have a new perspective on breast-feeding versus formula and it should be whatever the mother feels comfortable with doing and that there should be no judgement. I hope that this view has gotten better over the years.

2nd Child – stillborn June 2020

I write this difficulty as the devastation and pain of losing a baby never goes away.

The antenatal experience was slightly different this time due to COVID-19 in that I was having scans by myself (as partners were not allowed to attend). I had been having regular scans and more scans than usual due to having surgery a few months earlier (I had a twisted right ovary and had to remove it while I was pregnant – luckily, surgery went well, and baby was fine). In my third trimester I had been having scans every 3 weeks and had my last scan on 27 April 2020. As my due date was 24 May, I had no further scans and was going to the community midwives at the Bridge. I was a week overdue and was still only going to the bridge, no further scan even though it had been over a month since the last scan. I received a medical sweep from one of the midwives at the Bridge on 1 June 2020 and they tried again on 3 June 2020, both times they checked the heartbeat, and all was fine. They then scheduled an induction at the hospital on 5 June 2020 (12 days after my due date). I entered the hospital early morning on 5 June 2020 and the midwives got me settled in the room, did a COVID swap test and went to get equipment. The midwife was searching for a heartbeat and was very discreet when she said that the machine might not be working so will get another one. They brought in a scanner to see the baby and a doctor with 5 other people entered the room (including the two midwives already in the room). I started to feel unsettled and concerned. That is when the doctor said there is no heartbeat, and the baby had gone. I was in absolute shock considering that two days before there was a heartbeat and all was fine. The doctor then said these words that will forever stick with me forever and I think of those words everyday – "Did you not feel any movement?". When he said that I broke-down, I said there was movement the day before and during the night and the midwife heard the heartbeat two days ago. The two midwives comforted me while the doctor and the 5 other people left the room. The mid-wife, called [member of staff], called my husband to come into the hospital and she comforted me until he got there.

Myself and my husband were then moved to the 'family room', which is used in such instances happening. All I could do was cry on the bed in the room. [member of staff] came into the room and explained what would happen next – I would still have to deliver the baby as usual. I do not know why I thought I would not have to still go through labour. I was induced later that same day and went into labour. All I can remember is trying to get through it while crying the whole time. I lost track of time; I did not know how long I was in labour although our daughter was born that evening. Another doctor, called [member of staff], helped with the delivery of our daughter, and was very understanding. I cannot thank [member of staff] enough; she tied my hair up during labour and talked to me throughout. [member of staff] even stayed on after her shift had ended. When my daughter was born, the umbilical cord was wrapped round her and so believe this is the reason she had passed. Although, my husband recalls the midwives saying that the growth prediction was wrong as the weight of the baby did not correspond.

The next day, we were in the family room and a midwife called [member of staff] came in to see how we were and if we would like to see our daughter (she was in a cold cot in another

room). I just could not bring myself to see her yet, I needed a bit more time. I asked my husband to go home to remove the baby items we had set-up in preparation for her arrival, as I could not bear seeing this when I got home. After my husband left, [member of staff] came in and put several leaflets n the bed and then left. I read the titles of each of the leaflets – 'How to cope after having a still born', 'How to talk to your employer after a stillborn', 'What you should expect form your employer after a still born' and 'How to plan a funeral for a stillborn'. After I read the title of that leaflet it dawned on me that we would need to arrange a funeral – that thought had not occurred to me yet. I was crying in that room on my own as my husband had gone home to move the baby items. A doctor, called [member of staff] (not sure of spelling), came in to talk about a post-mortem on our daughter. I asked that we wait for my husband to return, which she did. Once my husband returned, [member of staff] entered the room again asking about a post-mortem and saying we needed to complete a form. We had decided that we did not want a post-mortem as we know what happened to our daughter (the umbilical cord was wrapped round her) and so did not feel the need to go further and the thought of our daughter going through that was too much to bear. [member of staff] said that we still needed to fill in the form so that they could take a tissue sample. We were confused about the form, which mentioned Southampton, and were not sure what we were agreeing to. We went through the form and ticked 'No' for the majority. We did tick 'Yes' that they could have a tissue sample as it was only a small amount of skin to be removed. [member of staff] came back into our room and took the form. [member of staff] then came back again, and we were advised that the form had not been filled in properly (although were not really told why it was not). [member of staff] provided us with a new form to fill in. We said to [member of staff] that we did not want the post-mortem and so none of the other parts of the form applied. The only thing we would agree to was the tissue sample. [member of staff] said we still had to fill in the form. We filled in the form and annotated comments to some of the questions to make clear what we did and what we did not want to happen. [member of staff] had entered the room several times and it felt like she was trying to sway us to have more done on our baby (such as for research/training purposes). Usually, I would want development of research and training, however, this was our daughter and I just did not want her being violated in such a way – we made this clear to [member of staff]. I had managed to some up courage to see our daughter before we left the hospital – something I will never forget. The charity, Philip's Footprints, created a memory box for us containing items that would remind us of our daughter – such a good charity.

The next day I was called back to the hospital for an anti-D injection and asked that a bring a copy of the form I had filled in the day before. When I got into the room (which was opposite from the family room and was the room I was told our baby had no heartbeat – which was a struggle to even be in that room), the doctor I saw was [member of staff] who was at the birth of my daughter. [member of staff] explained that, as we did not want a post-mortem, we did not need to complete that form at all – that form is only to be completed if going ahead with the post-mortem. [member of staff] advised that [member of staff] had already taken the tissue sample and apologised that this had happened along with the confusion with the form. [member of staff] said that she would talk to [member of staff] about this. I said to [member of staff] that it was a devastating time and amplified by [member of staff] coming into the room several times to talk about the form, which now was not needed at all. [member of staff] said that she would discuss with [member of staff]. Before I left the hospital, I asked for all the forms to be passed to me so that I could destroy them to ensure that the post-mortem (and other details) could not happen, and [member of staff] agreed.

Over the next few weeks at home, I had multiple visits from the community midwife who was understanding and seemed genuinely concerned for me, her name was [member of staff]. About 3 weeks after the birth, [member of staff] was checking me, and I felt abdominal pain/tenderness and I also had high blood pressure. [member of staff] arranged for me to go to the hospital for further checks. I went to the hospital expecting to have a scan, however, no scan on my abdomen area was done. A few days later, I told [member of staff] and she was surprised that the hospital did not scan me while I was there. I asked about when my 6-week check-up appointment would be, and [member of staff] said she would check. I received notice of when my 6-week check-up appointment would be and went to the outpatient's area in the hospital. I saw the consultant, [member of staff], and the midwife from my GP surgery was there. There were only discussions about the birth and what might have happened and that we might never know what happened. I had to mention about inaccuracies of the growth chart. [member of staff] reviewed the chart and had noted that the weight of our daughter when she was born was the same weight as my scan on 27th April, however, that could not be correct as the baby must have been still growing as was over a month until birth. It was also noted that my file showed that our daughter was in the 9th or 10th percentile but was in the 7th percentile. I tried to get further information about it, and they acknowledged that there were inconsistencies on the growth chart but was not pursued further. They then asked about my well-being; however, I did not feel comfortable talking with them about my real feelings as they seemed dismissive and I also did not have a scan (again) even though I still had abdominal pain. [member of staff] did check my tummy and agreed that there was tenderness, and I was in pain and so she did finally schedule a scan.

I had my scan a couple of weeks later, which was daunting as I had to enter the hospital again seeing new mum's pass by in the corridor with new-borns (I know that cannot be helped though). In Radiology they started the internal scan and I just cried. The scanner and the assistant said that it may hurt and that is why they thought I was crying and asked if it was OK for them to keep going. I had to explain to them the reason I was crying and that it was not due to the scan – they were not aware that I had a stillborn less than two months ago. When the scan finished, I was told that I would receive the results in a couple of weeks.

It had been two weeks since the scan and I still had abdominal pain and was getting worried, as I had not received the results from the scan yet. I telephoned Radiology who had to transfer my call to the Consultant's secretary (as the consultant needed to review before releasing). The secretary advised that my results had not been looked at yet. I then made an appointment with my GP.

A week later I saw my GP and mentioned what had been happening. My GP tried to contact the consultant, however, the consultant's secretary said that she could not discuss anything with her (even though she is my GP).

Weeks went by and I had heard no further about the scan. Finally, over a month later I received a letter via post (note that the letter was dated 17 August but was received at my house on 27 August). Thankfully, the results only showed a small cyst, and they would do another scan in a few weeks' time.

Suggestions/considerations for improvements

1. Pre-natal – possible review of scans and how they are conducted to show growth/predicted growth of babies due to the inaccuracies I had during my second pregnancy.
2. After labour/post-natal in the maternity ward – working and improved shower facilities.
3. After labour/post-natal in the maternity ward – training for midwives on breast-feeding and it should be a mother's choice to use formula (not to force breast feeding).
4. Post-natal at home – better help for new mum's, especially those feeling excluded due to them being perceived as doing something wrong as a mother (such as, choosing to use formula instead of breast-feeding).
5. Stillbirths – better training for both doctors and midwives and how to talk and support those going through this. I have researched stillbirths and note that the UK have specially trained bereavement midwives for miscarriages, stillbirths, and other traumatic experiences someone may have in pregnancy. I know that Jersey may not have the same number of stillbirths as the UK, however, providing periodic training sessions to midwives and doctors in relation to this would be beneficial. This should include better training for doctors on what the forms are that they are communicating to persons and consider timing of providing information/leaflets to those dealing with loss.
6. Post-natal – follow-up appointments – there should be better communication following a birth regarding any check-ups or results after having a scan.
7. Radiology/scans – hospital staff review a patients file and note details that may be useful to know (such as knowing why they are doing the scan – for me it was after having a stillborn, which they were not aware of). I also had another scan in October and the scanner said he was having trouble finding my right ovary, which I responded saying that he would not find it since it was removed a year ago (this would have saved time and confusion for the scanner).
8. Radiology/scans – better communication when patients enquire about their results of scans and better turnaround for the results to be provided to patients (especially as a letter dated over a week before it was received at my house).

Special mentions

I would like to give a special mention to [member of staff] (midwife at the time of labour for 2nd child), [member of staff] (doctor at the time of labour for 2nd child) and [member of staff] (community midwife who I saw after 2nd child). Without these persons, I am not sure how I would have coped, and their support helped during an exceedingly difficult time.

Possible complaint

Please note that I was going to write a formal complaint about the experience of my stillbirth just before the announcement of the scrutiny panel reviewing maternity services. I have, therefore, used this platform instead to voice my concerns, however, I may still make a formal complaint.

I hope that this letter is of benefit to the panel and thank you for launching a review into the maternity services.

Yours sincerely,

[redacted]