AIMS For a better birth...

Colchester General Hospital

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Lana Bartholomew shares her experience of labour, birth and a complete lack of support

When I gave birth to my daughter in 2010, it should have been the happiest day of my life. However, it turned out to be a day filled with fear, panic and drugs and it led to a series of events which changed my life and outlook for ever.

Unfortunately, I went into premature labour at 37 weeks. I was very scared by the pain. My family and I explained the situation to the midwife who saw me upon admission. She was very kind and understanding and gave me entonox to alleviate pain. A couple of hours later, another midwife, aided by a student, took over my 'care'. I asked to be given pethidine as I had heard that it was the usual drug offered and she obliged. The pain became unbearable despite the pethidine.

Statistically, pethidine adversely affects one in three women who take it and I was one of them. I felt dizzy and disorientated but I could still feel the pain and it was getting worse. I was very frightened and sought an epidural. I asked the midwife about this but she ignored my concerns. As an experienced midwife, she should have realised how advanced my labour was and asked to examine me. Aside from occasionally appearing to inform me of yet another 'emergency' which prevented an epidural, she was always busy.

The pain became worse and I begged for an epidural and reassurance about my baby. The medical notes suggest that my baby was monitored and doing well until the last half an hour, but I was not informed of this. I felt alone, despite the fact that my family was present in the room. I knew that these midwives were in control, not me. When I felt as though I needed to go to the toilet, and my mother informed midwives of this, they realised what was happening. The senior midwife flew into the room in a panic.

In desperation, I asked my grandmother for a knife so that I could cut my throat and end the pain. A few minutes later I remember saying that my baby could be cut out of me. I repeatedly stated that they needed to hurry because of the safety of my baby. I remember the senior midwife's response was to tell me how 'concerned' she was that I had threatened to self-harm. There was no attempt to reassure me and say: 'Your baby is fine and you're going to be fine.' My daughter was born in the evening and by the time I was cleaned up it made sense to stay overnight. The midwife arranged for me to see a nurse counsellor the next day. I believed that it was because of the negative birth experience. She gave her apologies for the lack of effective pain relief and I was perfectly pleasant, delighted at the prospect of never seeing her again.

I was anxious about the fact that my daughter did not seem to be taking her milk during the night. I felt as though midwives thought it was because I wasn't doing it properly as an inexperienced mother. However, when they had no success either, they began to realise that something was wrong. Her blood glucose level was monitored and as it dropped, my daughter was admitted to SCBU. I don't think I managed to get any sleep that night.

The next morning, a midwife came and told me that there were 'concerns' about the comments that I had made during labour. When the nurse counsellor came to see me, I was non-committal and stated that I was tired, in pain and didn't feel like talking. I didn't want to say anything that could be written in my notes and used against me.

In the afternoon a young midwife told me that, because of the concerns, a Social Services referral might be made. I almost broke down. The young midwife seemed distressed and reassured me that it was for 'support', not to take my baby away from me. After looking at my medical notes it seems as though she argued my case and said that my behaviour was normal. Apparently, there were also concerns because during a painful monthly period I've been known to say 'I want to die.' The safeguarding nurses took this to mean that I had suicidal tendencies! Every day, I had one midwife in particular outlining 'concerns' about me and about the possibility of Social Services involvement in my life. Another midwife repeatedly stated that I was a high risk for postnatal depression.

I was in the hospital for five days, initially because of my daughter's hypoglycaemia and then due to my urinary retention problems. Once my daughter was well, I went to SCBU and spoke to a doctor and nurse who said that she was well. I was asked about Vitamin K which I had initially refused, because as I was not breastfeeding, she would be receiving Vitamin K from formula milk. I accepted it, knowing that the atmosphere was such that I would not be able to take my daughter from the hospital if I refused. However, once I consented, the patronising doctor told me that I might be able to take her home in a few days or so once 'support' was put in place for me. I walked off, angered, distressed and attached to a cathete,r saying that I would contact my family. This incident was used as further evidence of my mental instability!

Afterwards, a midwife spoke to Social Services on the telephone and explained what I had said during

labour. She explained that I have no history of mental illness, that I had behaved appropriately since the birth and that 10 days of visits from midwives upon discharge would suffice. The social worker she spoke to conferred with her own manager and agreed. No further action was to be taken. My daughter and I were to be discharged the following day. I was happy. I was even happier that my daughter was discharged from SCBU and lay in an incubator by my side.

The next day I had my catheter removed and was still unable to urinate. I asked the midwives for a catheter but they told me to keep drinking and to try to pass water. It was suggested that I listen to running water, run a bath, and such, so as to trick my bladder back into action. It didn't work. After spending the whole day without a catheter, drinking water, I was in agony. I begged the midwives for a catheter. My grandmother kept going to the reception desk and stating that I needed help. Other patients on the ward were disgusted by the midwives.

The ward consultant came to see me and suggested that I be shown how to use 'in-out' catheters and would be discharged the following day. She stated that one of the midwives would assist me. The midwife in question told me that she needed to discharge six patients before she could spend two minutes to relieve my pain. I broke down. Just as had been the case in labour, I was being left to suffer. It was only due to my grandmother's persistence that a catheter was finally supplied.

At 8am the next day, a midwife told me that a pre- discharge meeting would be taking place at 11am with the safeguarding nurse, Social Services and other parties present. My understanding had been that the pre- discharge meeting was cancelled and that Social Services were not involved. I had no family present at the hospital and three hours to organise myself to face a situation I had thought was resolved. I complained at the lack of notice and she claimed that the meeting had been arranged late the previous night and that it had not been possible to inform me earlier. My medical notes reveal that this was a lie and that the meeting had actually been arranged the previous afternoon.

The meeting was attended by the safeguarding nurse and a few midwives. There was no social worker present. The midwives themselves were in control of the hospital child protection process. This was confirmed when I was later in possession of my medical records, which showed that a second Social Services referral had been made that morning which they had politely declined to investigate.

During the meeting I was subjected to embarrassing questions. I answered them as honestly as I could, knowing that if I refused to answer I wouldn't be going home with my daughter. Once the midwives were satisfied that I had 'support' in place, we were discharged. At home, I was subjected to daily visits from midwives. The visits were impromptu and sometimes late in the day. Finally, one of the midwives who had provided the care during my pregnancy could see that the visits were needless and discharged me earlier than planned. I was relieved to be free but I could not seem to bond with my daughter. I got in touch with AIMS and Beverley Beech was wonderful. Her support and advice, as well as that of my family, helped me get through the aftermath and the complaint process, which is still ongoing one year later.

First, I wrote a letter requesting to see my medical records. I agreed to pay a fee and sent my birth

certificate as proof of identity, as the hospital requested. The hospital claimed not to have received it and I had to send additional proof of identity. The hospital waived the fee for the photocopies of my notes. I then received a letter stating that the notes were enclosed but they were not so I had to get in touch again. It took months to obtain the notes.

Upon examination of them, I was certain that pages were missing, so I wrote back and the hospital sent pages of blank notes. I insisted that there was more and was sent a photocopy of an entry in a ward diary. I wrote a letter of complaint which took several months to process. The hospital admitted that its own psychiatric nurse had not felt that there were concerns to proceed against me but that the matron had sanctioned a second Social Services referral anyway.

I found no evidence in my notes of any consultation with a psychiatric nurse, so I queried this. The hospital admitted that there were notes which it had withheld from me because they would 'distress' me. I could view them at a meeting. I wrote back stating that I wanted to see the notes in the privacy of my own home before I would attend a resolution meeting.

The hospital agreed and the notes raised more issues. Several pages of the notes had been falsified by the midwives in the delivery suite. The midwives claimed that I had repeatedly threatened to kill myself several hours before the birth of my daughter. This did not happen.

One of the midwives also claimed that my grandmother had been 'aggressive' and 'confrontational' towards her. Considering that my grandmother is in her seventies, with several health problems and is reliant on a walking stick, the claim sounds ludicrous. However, the timings in the original notes make it clear that the midwife was not even in the room at the time the events took place! I believe that those notes were written retrospectively as protection in the event of a complaint being made. My grandmother and I attended a resolution meeting.

We were led into a meeting room upstairs by a gentleman from PALS [Patient Advice and Liaison Services]. There was a woman in her thirties already in the room who was introduced as the Information Officer. Two other ladies, one of whom was the matron, entered the room shortly afterwards. The other lady left it to me to discuss my concerns. I stated my first concern and wished that it be discussed but she stated that I should outline all of them. I briefly stated my main concerns and returned to the first concern to discuss it in depth. I was very conscious of the fact that although they were trying to make it seem as though they were letting me take charge of the meeting, they wanted to show me who was really in charge. These meetings take place because a woman has not felt empowered in the childbirth process and, again, members of staff attempted to make me feel powerless.

The Information Officer agreed to add amendments to my notes and supplied some information on relevant statutes and government guidance. She was sympathetic and understood that the negative comments might affect my treatment in the future and wanted to allay my concerns. I also discovered that a clinician responsible for my treatment would have decided to withhold some of the notes. She promised that she would find out who it was and add amendments. However, she refused to delete notes

that I could prove were factually inaccurate. A number of issues were discussed including the administration of pethidine two hours before the birth of my daughter, without a prior vaginal examination. The matron asked the time it had been administered and looked in the notes only to be dismayed to discover that I was correct. She admitted that normal procedure had not been followed and did not deny that the pethidine had caused my daughter to suffer from infant hypoglycaemia. I managed to demonstrate that the notes were untrue because of the inconsistencies and witness statements to the contrary. Despite this, the ladies maintained that the notes were accurate. As for the midwife's comments about my grandmother, despite the fact that the midwife's own notes show she was not in the room, the matron maintained that the student midwife was stating what she felt at the time! In terms of the child protection measures taken against me, Baby P was quoted at me as justification for damaging the chances of bonding with my daughter. I had 'won' because I was allowed to take my baby home without Social Services involvement. The hospital had a duty of care towards my daughter, which it had fulfilled. I pointed out that it had a duty of care towards both of us which it had not fulfilled because of the difficulties in bonding.

They would not accept that it was ludicrous to act as they did based on a single comment made during labour. Although the hospital was sorry that I had not been happy with my treatment, the staff will not be giving personal apologies as it is 'not the usual practice' of the hospital, and the staff will not be disciplined as, looking at their conduct as a whole, they are perceived to be good midwives. However, there have been some positive outcomes. The doctor who made me feel as though I had to consent to Vitamin K is no longer on the GMC Register. One of the midwives wrote me a personal apology. The Information Officer has composed a letter to put at the front of my medical record to say that the midwives' comments are inaccurate and must be disregarded. At the moment, the Health Ombudsman and Information Commissioner are investigating the way I was treated and the manner in which my medical notes were compiled and subsequently withheld from me.

Despite this, my negative birth experience has left me reluctant to have children in the future. If members of staff make mistakes, unless it results in the death of mother or child it seems as though they are not made to account for their actions, and I don't suppose Colchester is unusual in this respect.