I sat beside the baby, waiting for her mother to arrive for our appointment. Mother and baby were in a study in which we helped mothers understand premature baby body language and how changing their ways of handling the babies helped infant development (see page 6). The nursery was unusually busy and noisy. It was nurse-shift change-over time. There also seemed to be lots of visitors that afternoon. The noise and the heat in the room was getting to me and I could feel a headache was coming on. I looked down at the baby beside me and she had, in those last few minutes, vomited everywhere.

The NICU environment in normal times involves sensory overload and a mismatch between the needs of a baby’s developing nervous system (quiet, benign) and the actual environment (on that afternoon, noisy and hot). Babies can’t tell us when they feel a bit fragile, or if they have a headache. We can read some of their body language, but for the most part, we need to assume they will not want a lot of noise, or bright lights in their face, ever.

The NICU provides the medical management that ensures premature babies will survive. However there is often a mismatch between what the baby needs medically, and what they can cope with developmentally at this very early stage of development. Premature babies should be in their mother’s body, protected from external stimuli. Light, sound and caregiving interventions are the most common things that will overload a NICU baby. In recent times, following the principles of Developmental Care, lights are dimmed, incubators are covered, noise is kept at a minimum and caregiving interventions are clustered so that infant sleep is protected. Yet sometimes, sensory inputs are still frequent, long, or complex. Babies will respond to sensory overload with a range of behavioural, autonomic and state changes that tell us whether they are coping. Their favourite default environment is consistency which allows the baby to maintain stable body systems, an ideal way to develop in a benign environment. Changes, especially sudden changes, cause a disruption that upsets the calm surroundings and will cause dysregulation in the baby.

One study examined how increases in sound, light and nursing interventions affected babies’ equilibrium. It found that these environmental stressors resulted in increased heart and breathing rates, facial grimaces, hands brought to mouth, hands holding on to something, fingers splayed, yawning and hands and legs stuck up in the air - all signs of a baby struggling to “hold on”.

The responsibility for keeping NICU babies’ environments benign belongs to all of us. Hospital nurseries have protocols (or rules) in place to keep noise levels down. Yet almost all studies of decibel levels in nurseries find that the optimal (low) level is often exceeded. Home environments of full-term babies are sometimes very quiet (usually a first baby) and often very noisy (usually a home with older brothers and sisters). Healthy, robust full-term babies are more likely able to adjust to various home noise levels. Yet if someone is sick and in bed, we tend to creep around and have a quiet house so that they can sleep and get better. Even some full-term babies are noise sensitive and are easily aroused by the smallest noises.

Talking quietly, closing incubator doors gently, not using the top as a shelf and watching out for other kinds of possibly intrusive noise is one important way parents can protect their premie.

Carol Newnham PhD
Albert Einstein, the Nobel prize Winner of 1921, is famous for his enormous contributions to maths and science. He had language delay and lack of verbal fluency until age 9 years.

Charles Darwin who convinced the scientific community about evolution

Mark Twain the famous American writer

Napoleon Bonaparte who achieved great military successes and was regarded as a genius leader by many.

Stevie Wonder became blind because of retinopathy of prematurity. His dark sunglasses became part of his professional signature as a musician.

Sir Winston Churchill the prime Minister of England during the second World War was born 2 months early.

Victor Hugo, the famous French novelist who wrote Les Miserables and the Hunchback of NotreDame was born prematurely in 1802. His mother described him as “no longer than a knife” and he could still not hold his head up at 15 months of age.

Sidney Poitier, the actor and film director, was the first black actor to nominated for and to win Academy Award

Charles Wesley who started the Methodist church and wrote many popular hymns was born 2 months early.

Anna Pavlova, the famous Russian ballerina

Sir Isaac newton, mathematician, astronomer and physicist, a scientific genius

Other famous premies include Voltaire, Renoir, Goethe, and Michael J. Fox.
There is normally an air of quiet and calm in a Neonatal Intensive Care Unit (NICU). Nurses, doctors and others attend to the endless details and checks that keep premature babies alive. Parents sit quietly by their tiny newborns, often in some level of shock, in reaction to such an unexpected start to their life as parents. The rhythm of the day and life unfolds for them, as they learn to put one foot in front of the other for the sake of their tiny, but very fragile newborn baby.

Despite the air of calm, there are at least two “elephants in the room”. The first and most extreme elephant is that their baby might not make it. This hangs in the very air, yet is rarely expressed (and is less of a concern for some babies). Details of the baby’s ups and downs, the rollercoaster that every parent of a premmie learns, are fed to them by kind doctors and nurses. Shock can be so great that parents do not, cannot and are afraid to absorb the details of their baby’s hour-by-hour, day-by-day, medical condition.

Once the baby achieves a consistent level of medical stability (the rollercoaster flattens out and weight gains become fairly consistent), a second elephant may slowly emerge for the parents. What will be our future with this precious child? Will they have problems that will mean changing some of our hopes for the future during this pregnancy and even beforehand? The reality is that only a small proportion of very preterm babies (who were born at less than 28 weeks of gestation) will have severe sensory, physical or cognitive difficulties. About half will develop less serious issues that still affect their lives in some way. Whilst very preterm children are at the greatest risk, there is a sliding scale, whereby even late preterm children (who were born at 35-36 weeks of gestation) have an increased incidence of mostly less severe issues than full-term children.

When these developmental problems become evident (often many years later), it is usually assumed that they were caused by a medical condition that happened back in the perinatal period, when the baby was still in hospital. In the third trimester, when premies are often on life-support in a NICU, the brain is extremely vulnerable to the effects of the environment. Yet studies show that the relationship between perinatal medical conditions (such as birth weight, how early the baby was born and medical complications) and the child’s subsequent level of development, is quite low (about 30% explained). This is good news since as much as 70% of the factors that impact on the

Parents are encouraged to remember that the early years are times of optimal brain plasticity, and that following a premature birth there is a lot to offer - gentle, sensitive interactions between parent and baby will all help.
Evidence is mounting that two other environmental factors may have an effect on the long and short-term development of premature babies. First, the difficult start to life for babies and their parents may, for some, change their ability to adjust to each other. The babies are sometimes overwhelmed by human contact. Parents, who have been separated from their baby, may sometimes inadvertently overwhelm them when they are finally able to cuddle, care and feed. Secondly, stress is harmful to the human brain at any age, and it is even more so at this early stage of development. Yet necessary life-saving procedures in the NICU can cause stress. This may to some extent be balanced by the babies ideally learning that handling from their parent is predictable and gentle: that is, not overwhelming and not associated with sudden movements or unpleasant sensations.

At the Parent-Infant Research Institute (PIRI) we first replicated, and then extended an earlier program that is delivered to mothers while their premmies are still in hospital. We called this program “Premiestart.” Mothers are taught how to recognise very subtle changes in their baby’s body and behavioural reactions that signal “not coping”. They learn how to pace handling of the baby to keep them within a coping range. The message at this early stage is – less is more. When a baby is overwhelmed, less stimulation (touch, rubbing, rocking, wiping, noise) for a short time helps the baby get back into a state of equilibrium. Having mastered the “less is more” message, mothers are then encouraged to identify the times when “more is more”. If the baby is in a relaxed state, they are more able to handle extra stimulation such as voices, kisses and touch.

We met with mothers of babies who had been born at less than 30 weeks of gestation for 10 one-hour sessions. At 40 weeks (term equivalent) the babies’ brains were scanned. After just 10 weeks there were positive changes in the myelinated (cabling) parts of the brain of premmies whose mothers received the intervention. The wonderful “plastic” brains of these very tiny babies could be helped by helping their mother tune in to typical premmie behaviour and to change their handling accordingly. The earlier study that we had originally modelled found that the children of intervention mothers had improved cognitive abilities to nine years of age.

So why should a very short early intervention with the mothers of premmies have the potential to change growing brains and long-term outcomes? There may be two important aspects to the program. First, by helping mothers tailor their handling of the baby to their ability to cope, the baby’s stress is reduced. Second, the baby learns to discriminate their mother from others, that she is often there to help them to remain in a less stressed state (less is more) and that she is the person who provides pleasant and interesting experiences (more is more). And there may be many more advantages – skin-to-skin contact, bonding and supporting parents through their difficult experience. This then creates the foundation for the all-important attachment system that underpins a child’s long-term security and learning.

Jennifer has such an intimate knowledge of Amy that she can see when she is overwhelmed and can intervene before it all gets too much for her. Jennifer very kindly described how helpful the Premiestart program was, as it helped her understand when Amy, the premature baby still in an isolate, was not coping. Her skin might go mottley or her breathing become faster. She might yawn, sneeze or get the hiccups. Jennifer said that for a mother who felt completely useless and powerless beside her baby, this knowledge gave her some agency and a feeling of usefulness. Those signs in Amy have changed as she grew, but the principles are still the same. Watch how she is coping and adjust the environment so she can stay in a coping range that is acceptable to Amy. Over time, Amy learned to cope with more, she learned to do things for herself and she has learned that her mother will help her in times of distress. Jennifer also described how being confident in “reading” Amy, she is now able to avoid overprotecting, overcompensating and wrapping her in cotton wool. “Amy gets that she is smaller, weaker etc than other kids. She doesn’t need me hovering over her and smothering her and picking up constantly as well. I am a proactive mother in so many ways, but on the other hand I can be purposefully very slow to react. Often, if you stand back a second and stop your natural instinct to interfere, she shows natural capabilities. I give Amy the benefit of the doubt she will do the right thing and nine times out of ten it is justified.”

Parents are encouraged to remember that the early years are times of optimal brain plasticity, and that following a premature birth there is a lot to offer - gentle, sensitive interactions between parent and baby will all help.

We are extremely grateful to all the families who participated in Premiestart studies (previously called Beautiful Beginnings) at the Mercy Hospital for Women and The Womens in Melbourne. You have contributed to our understanding of how to help future parents and their premature babies.

Dr Carol Newnham developed and implemented the Premiestart intervention program. It was trialled in three randomised controlled studies with approximately 200 mothers and their premature babies.

Parent-Infant Research Institute
Austin Health
Dummies (pacifiers or soothers) calm babies down. This is helpful when mothers have tried everything else and cannot find the magic button to stop their baby crying. Dummies are used in Neonatal Intensive Care Units because it is important to help premmies remain calm in all kinds of circumstances. Another huge benefit of dummies is also emerging – they appear to protect babies against Sudden Infant Death, particularly when used at bedtime. However some people worry that dummies might interfere with breastfeeding in some way.

The latest evidence about the use of dummies in full-term babies indicates that they do not interfere with breastfeeding. The benefits of breastfeeding to both mothers and babies are well known, and if dummies interfered with the baby’s developing suck, swallow, breathe skills, their benefits may have to be weighed up against a possible big disadvantage. Two recent reports, one a review of 4 and another of 2 very large randomized controlled studies conclude that “pacifier use in healthy term breastfeeding infants started from birth or after lactation is established, did not significantly affect the prevalence or duration of exclusive and partial breastfeeding up to 4 months of age.” (when the study period ended). There have not been similar high quality studies with premmies. However dummy use in the hospitals seems to be widespread because the effect of stress on premmies is to be avoided.

Gastro-oesophageal reflux (GOR) is when gastric (stomach) contents flow up into the oesophagus (the tube that carries food to the stomach) but without the baby actually vomiting. It is a normal process and occurs daily in healthy babies, children and adults after eating. There is a similar incidence of GOR in breast- and formula-fed babies, although it may last for a shorter time in breast-fed babies.

Regurgitation, the positing or spitting-up of milk happens in about 50% of babies less than 3 months old and mostly resolves by 12-14 months.

Gastro-oesophageal reflux disease (GORD) involves gastric or acid reflux that causes pain, trouble swallowing, heart-burn, repeated vomiting, food refusal and inconsolable crying. It can result in faltering growth, apnoea, irritability, feeding difficulties, iron deficiency anaemia and inflammation of the oesophagus. Premature babies and babies with chronic lung disease are at increased risk of GOR and GORD.

First line of management
• Note the volumes of milk taken by your baby (for breast-fed babies you many need to weigh before and after feeds and note the time taken for the consumption of specific volumes). Reduce the volume of each feed slightly (feed time) to ensure that babies stomachs are not over-full and feed the baby more often. If formula is being used, divide the total daily volume into more frequent, smaller feeds.
• Posture - keep baby upright after feeds
• Feed the baby lying on their left-hand side (the stomach is positioned to the right and therefore it will not be cramped in this position)
• Avoid tight clothing
• Avoid exposure to tobacco smoke
• Use frequent winding/burping before, during and after feeds

Dietary management
• Feed thickeners, which are based on maize starch or carob bean, and pre-thickened, anti-regurgitation feeds, can reduce vomiting but not the excessive acid levels that seem to give so much discomfort to babies with GORD. The use of thickeners based on maize starch is not recommended for children under 3 years of age, and then only when there is growth faltering and not for healthy, thriving children with GOR.

Feeding problems are common when babies have had unpleasant feeding experiences (including oro-gastric tubes, being encouraged to drink more milk than feels comfortable, and having GOR or GORD). Weight and weight gain are already anxiety-provoking for parents of premature babies and if an aversion to eating develops, their anxiety can escalate. Feeding problems can include an aversion to any food texture and food refusal. If this occurs, parents need professional help, preferably with a multidisciplinary team at a feeding clinic (speech therapist, psychologist, dietitian, paediatrician and gastroenterologist).

Guidelines for parents for children with feeding problems
• Limit mealtimes to 20-30 minutes
• Give only praise and do not react to negative behaviour
• Provide regular mealtimes (3) and snack times (2-3)
• Avoid force-feeding
• Manage your own anxiety and distress to give confidence to your child
• Consider the texture of the diet and appropriate finger foods (e.g. bite and dissolve foods)
• Eat as a family as often as possible (this normalises eating as a social and family activity)
• Avoid distractions during meals (TV, toys)
• Encourage self-feeding
• Do not offer alternate food if the meal is not eaten
• Get professional and peer support

I spoke with one young mother in the nursery – about her baby, about her feelings and ways of coping. Then I asked about her partner – how was he going, how did he cope with the birth and the day-to-day needs of working and visiting the hospital every night? She looked at me in horror, realizing in that moment, that she had been so full of anxiety and worry about the baby and full of keeping herself on an even keel, that she hadn’t even asked him. In fact, she hadn’t even thought about asking him. He had been her strength, her rock and support person throughout. She thought he was fine, as always. That night she asked the questions and told me later about the conversation. On the night their baby was born, he thought they were both going to die. As he spoke, he cried. He had been so full of terror that he hadn’t been able to speak to anyone about it. It was the first time anyone had thought to ask him about that time. It was the first time he had allowed himself to face his own trauma, and to cease being the strong one, just for a moment. He had been stoic for his wife and baby, had been the conduit for information flowing between them and their social world, but had not allowed his own trauma to surface.

With the best of intention, good relationships can go off the rails during difficult times. Relationships are like a piece of fabric, with many strands running in parallel or crossing over each other, some strong, thick and brightly coloured, and others less obvious, thinner, beneath the surface, and less visible. We are different people, who in normal times meet each other and fill each others’ needs in known and comfortable ways. When one is feeling strong they can make up for the other feeling vulnerable, when you are both happy and confident, you join each other in fun and conversation. Unless you have had previous experience of trauma, you may not yet know how to meet and help each other during such times.

Here are a few obvious suggestions that may remind you of how to meet each other in this difficult time.

- Ask each other the questions as often as they are needed and welcome – how are you today, what was your high, what was your low, what are you worrying about?
- Practise random acts of kindness – favourite food, holding hands, flowers, help with tasks
- Accept that one of you might need to talk and the other might need to withdraw.
- Understand that you may have different coping strategies. Women often need to talk and get things out (without being given directions or solutions), while men may be action and solution-focussed.
- Accept that you may have different worries, different levels of worry and different ways of coping. For example sometimes men seem to be less caring about what is happening than their partner and this can upset the mother and cause unspoken (or spoken) misunderstandings
- Stay in touch – phone each other during the day to update about arrangements, hospital/baby news
- If you can, have “non-baby” conversations – about friends, family, work news
- Go out for a meal together

I was once caught up in an evacuation of a NICU, because there was someone acting inappropriately and dangerously in the adjacent hospital. As we all walked out, a young mother beside me was crying. I assumed that she was upset because she had to leave her baby behind and I moved to reassure her of the arrangements that had been made to keep the babies safe. No, that was not her problem – her fear and anxiety was that the dangerous person might be her partner who was depressed and was upset and concerned about his premature baby. The person was not her partner. However this anecdote tells us that the stress of a premature birth hits parents at their level of vulnerability and it behoves us all to look after each other.
How ex-premie adults perceive their well-being

20-year-old ex-very low birthweight premies, born between 1977 and 1979 (when the science of neonatology was still relatively new) completed questionnaires asking how they perceived aspects of their well-being. Their answers were compared with a group who had been born full-term. They were asked about:

- Satisfaction (self-worth and overall satisfaction with own health)
- Comfort (physical and emotional sensations and feeling, limitations on activity due to illness)
- Resilience (psychosocial adaptation to stressors, including social problem solving, physical activity, home safety, family support and time spent with family)
- Achievement (academic performance at school, work performance – attendance, being on time, getting work done)
- Risk Avoidance (individual risks, negative behaviours that disrupt social development and health, being influenced by peers in risky behaviour)
- Disorders (ill health, injuries and impairments)

The ex-premies reported satisfaction with themselves and their health (physically and emotionally) and quality of life and comfort in similar fashion to the ex-full-term 20-years olds. The ex-premies were less likely to be risk-taking and to have lower resilience (although there may be an influence of the families themselves in not having family systems set up to help the children learn these skills). The ex-premies had better achievement scores, especially in work performance and more long-term medical, surgical and psychosocial problems, although overall health itself was perceived to be similar to the full-term group.

This study of adult ex-very premature babies shows that there are few differences between them and other adults who were born without medical complications, long-term hospitalisation and early family distress. There were more physical health problems in the same ex-premies when they were assessed as children and yet they seem to have overcome them in terms of their adjustment to being satisfied and happy within themselves.

The study of premature babies – how to manage their health problems and how they subsequently develop – has traditionally focussed on smaller and even younger-born babies. These babies, on average, have the most severe medical complications and the most severe developmental problems. “Late” preterm births (between 34 and 37 weeks of gestation) have had less interest. Yet even though these late-born premiers tend to have fewer and less serious problems, they do have more problems than full-term babies. And because they are a much larger group (more than 75% of all premiers), there is still a large burden from these babies on hospitals, parents and the community. The number of late-born premiers is increasing more than any other premie group (because of women having babies at older ages, the use of assisted reproduction, and more multiple gestation babies).

Infant death in late-born premiers is 3 times higher than in full-term babies. They have more short-term medical problems such as hypoglycaemia, jaundice, apnoea, respiratory distress, temperature instability, feeding difficulties longer hospital stays and higher health care costs. The chance of needing delivery room resuscitation is twice as high in late-born premie and more babies with low pgar scores. Late preterm babies are more likely than full-term babies to be readmitted to hospital.

**Gastrointestinal (gut) maturation and feeding**

There is tremendous growth in the gut in the last trimester with a doubling of its length. There is also a huge increase in the surface area of the tract (where digested food is absorbed into the blood stream) because of the enormous growth of villi during this time. The ability to absorb food is not usually a big problem in late-born premiers, yet there can still be some feeding problems in this group – suck-swallow coordination, motility (the ability to move food down the tract) and emptying can be delayed. Some late-born premiers need a longer time to achieve normal feeding and therefore longer hospital stays. The advantages of breastfeeding seems to be even higher in premiers than in term babies, although getting it established can be that much harder. Premiers are often more sleepy, have less stamina, and more difficulty latching on to the breast.

**Cold stress**

Late preterm babies are particularly vulnerable to cold stress partly due to their immature epidermal layer. These babies need to have their skin and scalp dried quickly after birth, skin-to-skin contact with their mother and swaddling with warm blankets.

It is sometimes assumed that later preterm babies are like term babies in terms of their medical risks. Despite being nearly fully “cooked” they require additional surveillance because of increased susceptibilities to a variety of conditions they could prove to be serious if not picked up quickly.

**Reference**

DISCHARGE DAY — FOR THE PREMmie BABY
Medical discharge for the baby, from hospital to home, means treatment success, a time for celebration. The long journey from birth to discharge home can have many layers of meaning and conflicting emotions. Your baby is finally coming to live in his real home, in his own bed, in privacy and intimacy with his parents. You can stay in bed all day or cuddle together in your pyjamas every morning. You can choose when to pick your baby up, when to feed, when to bath. No-one will be able to notice what you are or are not doing. You are no longer in public. This is a new chapter in your family life.

The flip side of this finally-achieved parent-empowerment is that for months you have had the security of having others to rely on, to refer to, to give expert advice and to take over for much of every day.

Both emotional extremes, the celebration and the nervousness should be acknowledged and where possible, given voice.

Prepare for your baby's homecoming day. Here are some suggestions:

- If you have not yet announced your baby's birth in the paper or elsewhere, announce his homecoming day
- Buy some new clothes for your baby to come home in (make sure that they will be easy to remove, just like the hospital clothes as too much handling can still unsettle some babies)
- Dress up yourself, put on makeup carefully and arrange your hair carefully
- Think about how you want to say goodbye to staff at the nursery and other parents that have become part of your lives. Small gifts, cards, photos and other mementos will be valued as keepsakes.
- Think about how being at home, and not visiting the nursery every day, might leave a gap in your life and what steps you might take to ease yourself into this new, perhaps solitary, phase of life and parenting (e.g. hooking up with others via internet, phone or playgroups)
- Put signs on your baby’s cot before discharge (“I’m going home this week” “I’m a NICU graduate”) to alert others about the imminent discharge, so that they can say their goodbyes as well. Some nurses and parents may not be there on the day you’re discharged.
- Take photos on discharge/homecoming day – at both ends of the trip
- Take some time for yourself, to revel in this day and to reflect on your own journey through the nursery, beside your baby and in parallel with them
- Prepare for the anxiety that might come when you’re home and in total charge of your baby. Try to understand how you react to anxiety, what you can do to control it, what you might look out for that tells you whether your anxiety is valid (e.g. the baby is ill) or is just your own anxious over-reaction.
- Have important phone numbers handy (e.g. the nursery that your baby has been discharged from, the local Maternal and Child Health Nurse, your local general practitioner, the nurse on call, ambulance, mental health call-in services).
- Be prepared and organised at home – have the washing up-to-date, the house clean, cooked meals in the freezer.
- Be prepared to be quietly at home for some time. Babies who have had breathing problems should not be exposed to infections and therefore you may need to be home-bound and strict about visitors for a while.
- Have the important papers and documents for your baby safely in one place- discharge notes, CPR information, doctors’ notes, medical equipment information, specialists’ appointments and names, follow-up clinic times and places, early intervention organisations and contact details.
- Make a log chart for the first few days or weeks to keep track of feeds, dirty nappies, sleep times, bath times, play times etc. If your baby has settling problems you will be able to track changes over the first week or so and be able to assess when it gets better or worse.
- Write everything down. The chances are that with all the excitement and fuss, you will forget some details and it is better for you to be calm and feeling in control.
- Make the homecoming day low-key for your baby. Even though there may be excitement in you and others, your baby will be experiencing major changes (his first fresh air, first wind on his face, first time in a pram and a car, first time in the very different ambiance of your home, different smells, sights and sounds, first time experiencing silence) and your calm attentive presence and responding to his signs of anxiety are important.
- Do not have lots of people around, do not have lots of noise and fuss, do not hand your baby around like pass-the-parcel to other people.
- Sit in the back seat of the car with your baby so he can see and be comforted by your face.
Linda and her husband Paul donated all their beautiful NICU photos to PP after baby Justin was born prematurely. They have appeared in many editions, plus in many of the presentations I have given at conferences here and internationally. It is with great sadness we heard from Paul that Linda died suddenly. Here are Paul’s words that we print as a tribute to a wonderful mother, wife and friend to PP. Carol Newnham.

Linda was born 15/10/1981 third child to Michael and Anna sibling to Susanna and Dominic. She had always wanted to get married and have 14 children...... She loved word finds and Tetris but most of all she loved her children.

I first met Linda at Telstra Dome approx 2001 (now Edihad Stadium) down in level two of the basement in the off duty area for St John Ambulance (volunteer services). She was in Brimbank and I Altona Division. After making her two coffees with six sugars in each she was bouncing up and down, how could she not catch my eye. I went to almost every event there that year just to see if she was there. Our first date was Carols by Candlelight in Caroline springs after a moto X Duty at Mt Cottrell.

I proposed to Linda on 03/05/2005 after hiding the ring in a gold pan near Beachworth. Prior to this event I had asked her father Michael for his blessing to marry his youngest daughter (what are you waiting for was the reply). A secret he did not even tell his wife until we had left to go gold panning. On the way up to Eldorado, I had dropped the comment that I don’t have enough money for a ring, where we are going there is gold and diamonds we might find enough to make one. (The ring was in the spare wheel arch, after a prior episode of a friendship ring in my jacket pocket being found...) I had seen the ring in the pan well before she saw it, when she did, She said “Look honey I found a ring, it fits” My reply was “It should it’s size K” and she asked “Well are you going to ask?” This event nearly didn’t occur due to members pulling out of duties.

on the 18th of august 2008. We were married At her ladies church in Maid stone. Not easily done, her father took a 7 meter swan dive through a roof at work. He broke his arm several times clean and spiral fractures and several ribs, the skull and his nose. He was discharged a week before the wedding but readmitted the day prior to the wedding with pneumonia.

On the day the Priest had to stop the service due to myself having a severe chest infection.

Justin William was born on the 4th of august 2008 at 28.1 weeks 805 grams. I always knew becoming a parent wasn’t meant to be easy but we didn’t expect it to be this hard.The second ultra sound showed iugr and an enlarged lateral ventricle in the brain and we were handballed out of there to the Mercy hospital, almost weekly ultra sounds until he was born as an emergency cesarean (classical) there goes the 14 children. 137 days later with us both not missing a day or night, phone calls all hours of the day or night. How often did we hear we don’t think he will make it.

Robert Anthony was born 03/03/2011. Linda didn’t tell me at the time that he had stopped growing. He was born at term cesarean 2090 grams. A large baby for us a quick visit to special care due to his sugars. (I think the midwives did not like his size) the Paeds on L2 said he is fine and the parents know what to do with a small baby. Time went by the boys are developing with help.

On the first of December the boys and myself had a new challenge.

My wife was due to go to the Wiggles concert with St John. I woke to her alarm. My worst nightmare, one I could not imagine had begun, she had passed away from a heart attack age 31. The boys lives changed forever, never the same. and its up to me how they remember this time.

April 2013

VALE LINDA, MOTHER OF JUSTIN AND HUSBAND OF PAUL, FRIEND OF PREMIEPRESS
Tiny D’s Photography is exclusive to premature and sick babies who have had a rough start to life.

Celebrate your little one’s strength and courage with a beautiful collection of photographs to treasure forever. Contact Katia to arrange photography of your little one in the hospital, at home or at Tiny D’s Photography. With each package you are presented with discount vouchers for photography of baby’s milestones (due date or first birthday) and you also have the option of having a personalized collage designed of baby’s time in the hospital.

Being the mum of a miracle baby herself, there is no better person to trust with your little one at such a pivotal time in their life.

Visit our site or find us on Facebook to see the inspiring stories of the tiny miracle bubs we meet, and their families.

Tiny D’s Photography
Ph: 0402 300 401
E: katia@bareimage.com.au
W: www.tinyd.com.au
Facebook: www.facebook.com/TinyDsPhotography
ANNUAL SUBSCRIPTION AND ENQUIRIES

MISS/MS/MRS/MR/DR  FAMILY NAME

GIVEN NAME

ADDRESS

INSTITUTION

ADDRESS

POSTCODE

PHONE (b)  (h)

FACSIMILE

EMAIL

Premiepress is delivered electronically to your email address.

(NB: To receive Premiepress electronically you must have an email address and be able to open a pdf file. Adobe Acrobat Reader is the software to do this and is obtainable free from the Adobe website-http://www.adobe.com/products/acrobat/readstep2.html

Australia $50  2yrs $90  3yrs $120  (These prices now include GST)

NUMBER OF COPIES  TOTAL COST

I would like this subscription to start with the

April  September  edition

PAYMENT INSTRUCTIONS

I enclose my cheque made payable to AHMRF - or please debit my credit card as follows. (note: Diners and Amex cards not accepted)

Please charge my (tick one)

☐ Visa  ☐ MasterCard  ☐ BankCard

ACCOUNT NUMBER

EXPIRY DATE

PLEASE DEBIT MY CARD ACCOUNT WITH THE AMOUNT OF

CARDHOLDER'S NAME (AS SHOWN ON CARD)

ADDRESS

TELEPHONE

CARDHOLDER'S SIGNATURE

DATE

We thank the William Angliss (Victoria) Charitable Fund for their invaluable financial support.

Thank you to Meridian and Earlybirds. Thank you to all parents and babies who allowed their photos to be printed. We wish to thank the WCF Thomas Charitable Trust and the William Angliss (Victoria) Charitable Fund for their support of Premiepress. Thanks to Entertainment Books. Special thanks to Toni Prime Design for wonderful design work.

DISCLAIMER. The information in Premie Press is of a general nature and does not relate to individual babies, children or parents. It is for your general knowledge only and is not intended to replace the advice or care of your doctors, nurses or other specialists. If you or your family member require advice regarding individual needs or concerns, seek out your local health care provider. Always ask the advice of your baby’s neonatal nurse or doctor before implementing interventions (such as massage) that are reported in Premie Press. Similarly, please consult your doctor if you have any questions regarding products advertised in Premie Press. We accept advertisements in good faith, but cannot accept responsibility for individual decisions regarding the appropriateness of every product for every baby.

ACKNOWLEDGMENTS. Thank you to Meridian and Earlybirds. Thank you to all parents and babies who allowed their photos to be printed. We wish to thank the WCF Thomas Charitable Trust and the William Angliss (Victoria) Charitable Fund for their support of Premiepress. Thanks to Entertainment Books. Special thanks to Toni Prime Design for wonderful design work.

NEXT EDITION

• Strengthening your baby’s mental and emotional muscles.
Beautifully crafted clothing for premature babies

Freecall 1800 666 550
www.earlybirds.com.au
Earlybirds proudly supports Austprem

Austprem offers knowledge, information and support in all aspects of prematurity & most other prenums

Was your child born early?
Austprem
Premature birth, babies and beyond

website: www.austprem.org.au
email: austprem@austprem.org.au

© 2008 Austprem Inc. ABN 67 731 996 376

Specialising in trauma, loss, grief, stress, anxiety and depression

Melanie Birch
psychologist & trauma therapist

Working in a gentle way to relieve distress and help get life back on track

Meridian Counselling & Psychotherapy
49 Frank St Eltham
phone 9439 8208

Elkanah Counselling
1 Whitehorse Rd Balwyn
phone 9817 5654

APS Psychologist

Elkanah Counselling
The featherweight club
Special care for families with special babies

Premie Playgroup @ Banyule
1st Wednesday each month
10 am - 12 noon
Maternal & Child Health Centre, Bellfield

Premie Playgroup @ Borondara
2nd Tuesday each month
10 am - 12 noon
Craig Family Centre, Ashburton

Telephone: (03) 9005-8325
Email: playgroup@featherweightclub.com.au
www.featherweightclub.com.au

© copyright 2005. All rights reserved