LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH, AGEING AND COMMUNITY SERVICES
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Submission Cover Sheet

Inquiry into Maternity Services in the ACT

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Submission to the Standing Committee on Health, Ageing and Community Services inquiry into Maternity Services in the ACT

We are writing to make a submission in relation to the delivery of maternity services in Canberra Hospital. Thank you for agreeing to extend the timeframe for us to draft this submission. We are willing to appear in person or to provide any further information necessary to support this submission.

We received services from Canberra hospital earlier this year related and ancillary to the delivery of our baby twins on 29 March 2019. The concerns in relation to the maternity services we received began prior to admission on the 29th of March 2019, when we were patients of the clinic and continued until discharge for the hospital in early April 2019.

By way of background, is a recent migrant to Australia (arrived 2015) and although she speaks English well, it is her third language. We live in and delivered our first child at Calvary Hospital in 2016.

When we were told we were expecting twins we considered whether should go back to for the delivery where she would have more family support and understand the language better. After discussing this we were reassured the standard of care in Australia is good and that we would receive excellent services and support. Unfortunately there were many aspects of care that were unsatisfactory as detailed below.

Failure to administer pre caesarean steroids we attended the consultant appointments and were advised that it was medically recommended to have a caesarean as both babies were in the 'breach' position, it was also medically recommended to have a pre caesarean steroid to help the babies 'transition' and breathe on delivery. We advised the consultant that we lived in she advised us that it should be available at Hospital and she will provide a letter, but that if it is not it can be administered at the hospital between 24 and 3 hours before the caesarean and she will make notes in the system to this effect. attended hospital on 27 March 2019 and was advised that they should have this steroid but do not have it.

then called the natal clinic and was told to come to the Maternity Assessment unit at 0930 on the morning of the caesarean as it could be administered on the morning of the caesarean. At 0900 on the 29th March we attended the clinic, reporting to the reception and telling them we were reporting to have a steroid injection and were told to wait. We waited some time and then enquired about what is happening as this is urgent and we need to go for day surgery at 1200, the male receptionist was quite curt and told us to wait. After about 45 minutes went back to the reception again and told them we need to report for surgery and this is urgent. The receptionist went away and told us to go to pathology as there was a pre-surgery blood test pending too. We went to pathology and then returned to the clinic.

We waited a further period then a doctor came at around 1130 and told us it is too late to administer the steroids and we should report to the day surgery unit. We protested saying we were there in time - the doctor then told us that there are some studies showing some negative impacts on the child at the age of seven with the drug (steroid) so don't worry about it. We were very upset about this, we had decided the take the steroid and followed all of the advice of the doctors. This approach by the doctor was disingenuous and self-serving, it was clear to us that the notes left by the consultant had not been read. was becoming quite panicked at this point as we had been told this drug was medically recommended to assist with breathing. We attended the day surgery

suite and in conversation mentioned about twins – the nurse advised this was not noted anywhere on the file where it should be and called for a second resuscitation unit etc. to be ready, by this point we were extremely underwhelmed with the whole hospital system.

We were taken to have the caesarean and when our son, , was born, he was having trouble breathing. Rather than having skin to skin as the hospital promotes as essential he was taken, with me, to NICU. In NICU the nurses made at least seven attempts to cathetise him without success and gave him a feeding tube and CPAP – this was highly traumatic for and for myself and . He was in NICU for about 8 hours before being returned to our room. was not given updates on what was happening and was under the impression he was seriously ill. The eventual diagnosis was transient tachypnea of the newborn. During the next days the surgeon visited us as advised he had only been told about the non-administering of the steroids fifteen minutes before the surgery and had to decide whether to go ahead or wait till the next 'twins day' the week after. To his credit he owned the decision but advised he was not happy about the short notice.

The original consultant later came by to visit and indicated she had put notes in the system about the steroid which had clearly not been read and apologised. The consultant was also extremely professional in her approach.

The doctor who had failed to administer the drug came to our room about two days later, without saying anything she said 'I need to let you know I am not here about babies so I can't talk about babies I am only here about the mother'. We asked if she could remember us and the penny dropped. She didn't say anything further.

continues to be affected by this issue, specifically we are both concerned that such failures could lead to the death of babies. continues to breathe roughly and have trouble settling. has been seeing a psychologist and was traumatised by being alone with in NICU and that this was all unnecessary.

In this instance there was;

- A systemic failure of communication between the doctors in the different areas of the hospital and between the doctors within areas of the hospital and;
- A lack of knowledge on the part of at least one doctor and;
- No communication between the Canberra Hospital and Hospital and;
- The wrong information provided by the desk staff in the pre-natal clinic.

Treatment of placentas – we advised prior to the birth, on several occasions, that we wanted to keep the placentas as we have a family tradition of tree planting. When we tried to obtain the placenta we found that it had been cut into pieces and treated with formalin, without our consent. This caused great upset to our older son who we had been preparing to plant companion trees with his birth tree as part of his meeting and getting to know his new siblings. Placentas are not the hospital's property so the hospital should get informed consent before they are sliced up and put in toxic chemicals. It was even more traumatic to have to sign a waiver when getting the contaminated placenta back which basically implies they are (now) toxic. In many cultures the treatment of the placenta has a religious and culture significant – the treatment of a placenta in this way despite express requests not to do so is inappropriate. When our first son was born at Calvary they happily complied and allowed us to take the placenta home.

Handling of sensitive medical information was given her discharge book (including confidential medical information) by the midwife on 6 May 2019. When we arrived home we

identified that the midwife had given us another patient's medical information on discharge. We still have this booklet with us and the hospital has asked us to post this back, which we are willing to do.

Administration of anaesthetics during C-section surgery without proper **supervision** – while a senior anaesthetics expert was present during the surgery, she was busy with doing paper work. The junior staff member seemed to be a trainee was administering the anaesthetics. Upon administering a local anaesthetic the said staff did not wait before proceeding with administering a spinal injection. This caused a great amount of pain and additional stress in an already stressful situation of which the team present during surgery was aware. As a result, the spot where spinal anaesthetics was administered was bruised and even months later my wife complains she occasionally feels the spot and worries it has caused some damages which will create health issues in future. It was clear that the senior an anaesthetist was overwhelmed with paperwork and not really present for the procedure.

There were also more minor issues that showed a general 'cookie cutter' approach after all of the above issues we had two people contact us about contraception advice, despite the medical information available to them about the age of the mother and the circumstances of the conception.

also asked for a medical certificate for six weeks after the birth and the doctor refused to provide this, saying even though this is necessary we need to go to a GP, which with three kids under three is very difficult.

What needs to be fixed?

- **Fixing of procedures –** it is apparent that in running this huge organisation there are communication gaps between the natal assessment unit, day surgery and surgeons. The fact that we were given the wrong medical information and that the record was not checked shows lack of care and inexperience amongst doctors, obversely it was clear that the anaesthetist had insufficient time to do her role due to paperwork.

- **Disciplinary action and retraining of the reception staff and the doctor in the maternal health unit –** the reception staff were not listening to what we were saying, we were very calm but clear with what we were saying – I understand they deal with stressed people all day but they need to be able to deal with exceptions effectively. The doctor who we saw in the morning who did not read the notes should be formally counselled and provided training from the senior doctors on the appropriate administration of steroids – we have been advised that this may have occurred (see below).

We have complained about these matters to Canberra Hospital and received a verbal response and apology on some counts and have bene advised they will schedule an appointment to review but we believe these are systemic failures that will not be able to be solved without someone outside the system looking at the issues wholistically.

Thank you for your consideration