Submission No 1092

INQUIRY INTO BIRTH TRAUMA

Name: Name suppressed

Date Received: 10 August 2023

I'd like to share my experience with both Hospital and Hospital during my pregnancy and birth of my first child in 2022, which has caused significant and ongoing trauma to myself and my partner. To maintain confidentiality, I will refer to myself as Mother and my partner as Father.

We have sought advice from psychologists, social workers, psychiatrists, birth trauma counsellors and solicitors, all of whom support our claims. We've been told that we have a case of medical negligence, however legal fees will outweigh any compensation, so no lawyer is willing to help. The HCCC has dismissed the matter and refused to comment on specific breaches of law and professional standards of practice. We'd like the opportunity to provide evidence at a hearing, but would also like to remain anonymous.

We feel utterly voiceless and powerless. Our rights have been violated and we were not afforded our right to self-determination. It's not easy to summarise our experience, as every piece of information feels as important as the next. Please continue reading to hear our story and why the healthcare system is completely broken.

Hospital

During visits to Hospital for my antenatal appointments, my partner and I always left feeling anxious and unheard or cared for. We both have special health care needs that were not accommodated for. I have epilepsy which is triggered by sleep deprivation, and Father has medical trauma in relation to the near death of a child in his family due to medical negligence at Hospital, in addition to two family friends who lost their children under care of the same doctor. Father also has difficulty managing stress due to a psychosocial illness. These factors made us quite anxious about birthing at Hospital so we chose to birth at Hospital (the next closest that would be equipped to handle any emergency that may arise due to my epilepsy or other factors).

On several occasions we tried contacting Hospital to discuss our background and concerns, but the staff were completely unhelpful and their actions showed incompetence. They failed to pass on our messages or return our calls and emails. The staff inaccurately documented our encounters with them; e.g. stating they returned our calls yet we had no voicemails or missed calls; they documented that someone spoke to me over the phone about being iron deficient, but that conversation never happened so I was unaware and going without treatment. They claimed they would return our calls but never did, and every time we reached out to them, we were always told to contact someone else. We eventually left a message for the NUM to call us, but she didn't.

Eventually, one of the midwives told us that as a solution to minimise my risk of an epileptic seizure due to sleep deprivation, they would remove our baby from our room and keep him in the nurse's station. We expressed how uncomfortable we were with that. About 8 weeks after the fact, Father called the hospital frustrated and asked the NUM to return our calls or we will attend in person and pursue complaints. Father called the NUM the next day, she was very unpleasant and said they won't extend visiting hours for Father and that I will likely have to share a room with another mother and their baby who is likely to wake me anyway. The NUM also provided information conflicting with that from the midwife, in that under no circumstances would our baby be removed from our room.

We began losing trust in the nurses. I felt like just another number to them, not a real person. We submitted a written complaint which outlined several healthcare standards that they breached. A complaints officer contacted Father and organised for him to meet with executive staff. Initially pleasant, they offered to meet in person. Father felt this was unnecessary as he believed in good faith that they could address the issue over the phone, and he

wished to avoid a two hour journey. They said they'd investigate the option of transferring me to post-birth where I'd be more likely to have a private room. Executive staff returned Father's call and confirmed that if a doctor would accept us, she'd make the transfer happen, but Father would not be allowed to provide care for me and our child, and that visiting hours would not be extended.

Father told executive staff that he didn't believe this met the healthcare standards, and he asked her to justify this. She refused, and also refused to have the hospital legal team to confirm such. Executive staff then accused Father of not caring about the matter, as he didn't want to meet in person. Father reiterated his reasoning for not meeting in person, but later offered to meet her, to which she declined and instead told him she'd call back to organise a meeting. In the interim, we contacted Hospital and were told that nobody had contacted them to discuss the matter, and under no circumstances would they accept a transfer from unless for medical reasons, which was better equipped to handle, so this would never occur anyway.

Father explained during a joint meeting with the executive staff and complaints officer, that Hospital confirmed they wouldn't accept a transfer, and he queried why the executive staff offered this. The executive staff confirmed they hadn't contacted , that they only assumed the transfer would be okay, and stated that the hospital doesn't have to comply with the healthcare standards. Father said he still wanted an in-person meeting as they made him feel bad for not meeting earlier, but she declined again. They told Father that he had to speak to someone higher up.

Senior staff had been emailing us without addressing our concerns regarding the hospital failing to meet the standards, and they wouldn't comment as to whether the executive staff's comment about the hospital not needing to meet the standards was true or not. This was an ongoing saga where the hospital refused to acknowledge our concerns or address them directly, and instead only provided generic responses.

We no longer trusted the healthcare workers at , and felt we would be better to transfer care to Hospital (which we were trying to avoid due to family history and near-death of a child).

Senior staff sent us a final email advising us that the hospital could arrange for me to be transferred to Hospital post-birth, but as outlined above, we have already confirmed with Hospital that this would not be allowed. Neither executive staff or senior staff thought to confirm if the transfer was possible, and were clearly not communicating between themselves, and ultimately weren't taking our concerns seriously. Father responded by asking them to address our concerns directly, and expressed that we felt we had been treated with little dignity and that we intended to follow the complaint through beyond the birth.

Staff at Hospital submitted a report to DCJ accusing us of being a risk to our child's safety. The lack of communication, misrepresentation of events, disregard for our unique healthcare needs, lies told by the hospital staff (e.g. offering solutions they knew weren't available), inconsistent information from staff, and the simple fact that we weren't worth the time of returning a call, deeply offended us and caused us to have great distrust of them, and eroded our patience over roughly three months. In good faith, Father disclosed his medical trauma and mental illness from our first interaction with the hospital, so that this could be factored into our care during the birthing experience. He found the staff's actions to be very triggering, and he maintained his resolve for three months before writing an unpleasant email that preceded the DCJ report. The staff were relentless in ignoring and lying to us, and we feel that this referral was unfair and inappropriate. Senior staff continued to ignore our email, and still haven't addressed our concerns. We feel that we are now socially disadvantaged because of this report, and it has deeply impacted our self-esteem and mental health. Father is now afraid to disclose his mental illness to healthcare staff in the future.

We confirmed transfer of our care to Hospital and were no longer involved with Hospital. Roughly 2 weeks prior to the birth, and after several weeks of zero contact with , the police turned up at our house. They were instructed by Hospital to advise us that Father was not to attempt to stay overnight at the hospital. I had been discharged from their care at this point, which we confirmed with the NUM at Hospital, as she had completed all documentation and advised of the transfer. The staff at again failed to communicate between themselves and were unaware that we had been discharged.

Hospital

I was booked to give birth at Hospital. As we had a very difficult time with Hospital, we organised to meet with the NUM to establish what happened with them, that there was an outstanding DCJ report, to discuss my health needs, and to explain Father's mental health history and the medical trauma that he has associated with Hospital. The NUM was very understanding and compassionate and agreed to organise a private room for our stay following the birth. Due to the outstanding DCJ report, I organised an appointment with a hospital social worker to establish that I wanted Father to advocate for me during the birth. We also established a birth plan and provided this to staff.

On the day of the birth, things were going well and I progressed into established labour. My waters broke at 7am the previous morning and I only had two hours sleep by 9am the following day, so the nurses suggested an epidural to mediate the risk of a seizure following sleep deprivation. Father and I discussed this, and I accepted the procedure. Two anaesthetists attended; one was receiving basic verbal instructions from the other on how to perform the procedure, including how to identify basic anatomical landmarks to inject the epidural. It was clear that the anaesthetist was inexperienced which made Father very anxious, but he refrained from saying anything as he didn't want to make me nervous. The inexperienced anaesthetist then announced that he "hit the bone".

As Father was aware the procedure can result in paralysis, hearing this from the inexperienced anaesthetist caused great concern and made Father very anxious. He told the anaesthetist that we don't want him performing the procedure, and that we're like the experienced anaesthetist to do it. They ignored Father and they continued; the inexperienced anaesthetist still requiring ongoing verbal instruction on how to correct his mistake. Father told them to stop, but they said they'll continue. Father explained that my birth plan specified I didn't want students, to which they replied he is a qualified doctor; though clearly inexperienced in performing this procedure and needing constant guidance.

Father explained that I had spoken with a social worker and that it's documented that he can advocate for me. He asked them to stop and for the experienced anaesthetist to take over; they refused. Father reminded them of my wishes in the birth plan that specified 'no students'. The anaesthetist told us that "this is a teaching hospital so you don't have a choice". Father reiterated again that my birth plan didn't permit students, to which the anaesthetist replied "we don't read birth plans". They continued to perform the procedure despite being asked to stop, thus without informed consent. While I initially consented to the procedure, I was sleep deprived, in severe pain and afraid of having a seizure. I don't recall the staff discussing the risks, and I wasn't aware of the risk of paralysis (which I told the NUM the day following the birth, and to the DCJ caseworker).

Father asked the midwife to intervene, but she refused. He asked again and reminded her of my birth plan and that he is documented as an advocate for me, but again, she refused to intervene. Father asked the midwife if she read our notes and was familiar with our social circumstances. She acknowledged that she had, and was aware of our circumstances. Father asked why she thought what had occurred was appropriate, and asked her to intervene,

but again she refused. The midwife simply repeated “it’s fine”. Father calmly asked the midwife three times to remove the inexperienced anaesthetist from the room, before swearing at the staff telling them to stop. Father asked for a social worker to be present which the nurse refused to organise. The staff continued the procedure.

Due to the outstanding DCJ report, Father had a panic attack and asked three staff members to organise a social worker; two refused and one told him he wouldn’t be able to see one because it’s a long weekend. He then asked to speak to the NUM which was also refused. He was terrified of DCJ being called so he continued asking for a social worker. I was awake in bed at this point and we discussed the situation in front of the nurses; both agreeing that the situation shouldn’t have unfolded and we should have been allowed time to discuss the matter as there was no medical emergency to administer the epidural. The nurse then loudly spoke from across the room “some things are out of my control”. Father told her that she knew our circumstances so she should have intervened. She told us that she wasn’t able to intervene because he was a doctor and she was a nurse. Father continued to panic about DCJ being involved, so he removed himself from the room but continued to ask for a social worker.

The nurse continuously offered Father tea as a solution, but refused to organise a social worker. Father told the nurse that managing this situation is part of managing my care and that we needed to speak to a social worker. Because of our experiences with Hospital misrepresenting events, Father was afraid this would happen again so he emailed the hospital between the event and the birth of our child. Eventually, senior staff attended a separate room after several repeated requests for a social worker, where Father explained the situation, and the nurse acknowledged that this shouldn’t have happened and also apologised. I was then ready to give birth and their conversation ended.

The day after the birth the NUM asked us how the birth went. We acknowledged what had happened, Father apologised for his panic attack but we expressed that we shouldn’t have been put in that situation given our social history and the fact that the nurses knew our circumstances. I told the NUM that I didn’t remember being told the risks of the epidural and that I think we should have been allowed time to discuss the procedure further.

The following Monday the DCJ caseworker turned up at our house and told us there was a new report and that we were now considered a high risk of danger to our child. We were made to undergo extensive psychological testing, had our medical records subpoenaed and people in our social circles interviewed to defend our character. The experience has been so traumatic. Four months after DCJ’s initial contact, the file was closed as their investigation found nothing to uphold. We now have a record with DCJ, which we are forced to carry with us everywhere we go, all because medical staff failed to listen to our concerns and refused to follow our birth plan.

We are now moving to another region because we’re too afraid to access health care if we need to. Every time the doorbell rings we fear that someone is coming to take our child. Father has trouble sleeping and difficulties at work. We are both so embarrassed and ashamed. This has significantly affected our first year as parents, spoilt the memory of pregnancy and birth, and placed a huge strain on our relationship. We feel completely voiceless and powerless. This has affected our lives so badly that Father contemplated suicide out of guilt and shame.

I am saddened and fearful of having another traumatic birthing experience. The events that unfolded throughout my pregnancy and during the birth, and the following DCJ reports haunt me and my family, every single day. I always wanted to have two or three children, but I feel like this is no longer a choice, as I will be forced to relive this trauma. I shouldn’t have been made to feel like this, and I shouldn’t have to live in fear for me and my family.

Professional standards of practice, codes of conduct and laws broken by the hospital staff:

Grievances (Nursing Staff):

The nurse failed to meet the following Midwife Standards of Practice:

3.5 Engages in timely consultation, referral and documentation – The nurse failed to consult with us regarding our wishes for the administration of the epidural, failed to communicate our social circumstances to the anaesthetist, and failed to refer us to a social worker, and Father for mental health support.

2.1 Supports the choices of the woman, with respect for families and communities in relation to maternity care - the nurse failed to abide by Mother's wishes to refuse treatment from students (the inexperienced anaesthetist who required verbal instruction on how to perform the procedure and correct his mistake), she ignored that Mother had established with a social worker that she wanted Father to advocate for her if needed, she failed to acknowledge or respect Father's concerns as her family member, and as her advocate.

3.6 Uses relevant processes to identify, document and manage complexity and risk – The nurse was acutely aware of our complex social circumstances, she acknowledged this to Father as the situation was unfolding. We went to great efforts to make these circumstances known to the hospital; these were established with the NUM, who passed this information onto the nursing staff.

5.2 Collaboratively develops plans until options, priorities, goals, actions, anticipated outcomes and timeframes are agreed with the woman, and or relevant others – the nurse failed to advocate for Mother and her birth plan; she ignored that Mother had established that she wanted Father to advocate for her; and the nurse went against our wishes when she refused to intervene in this situation. We weren't allowed time to discuss the procedure or our options, or be involved in the planning of the procedure. There was no medical emergency; and there was no time given for this to be discussed.

5.4 Documents, evaluates and modifies plans to facilitate the anticipated outcomes – the nurse was aware of our social history and Father's mental illness; she was able to see his anxiety levels increasing and allowed the situation to unfold. The anticipated outcome was clear, and she did not intervene.

6.2 Practices to achieve the agreed goals and anticipated outcomes that meet the needs of the woman - Mother had established her birth plan, and the fact that she wanted Father to advocate for her; the nurse was aware of these factors and failed to intervene which led to a foreseeably negative outcome for Mother and our family. There was no medical emergency, and we weren't given time to discuss the circumstances to agree on a new plan.

6.4 Provides and accepts effective and timely direction, allocation, delegation, teaching and supervision – the nurse failed to direct the anaesthetist to cease the procedure and respect our wishes; the nurse refused to refer us to a social worker and refused to refer Father to a doctor for mental health treatment.

Grievances (Anaesthetist Staff)

The anaesthetist has breached the following standards of ethical and professional conduct expected of doctors under the AHPRA Code of Conduct (Good Medical Practice; A Code of Conduct for Doctors in Australia):

3.1.1 Assessing the patient, taking into account the history, the patient's views, and an appropriate physical examination. The history includes relevant psychological, social and cultural aspects – by failing to take into account our social history and the specific medical needs (including psychological) of our family unit as a whole, and how the anaesthetist's clinical decisions would have caused negative social and emotional outcomes for us.

3.1.5 Recognising and respecting patients' rights to make their own decisions – by refusing to acknowledge and follow Mother's advanced care directive to allow Father to advocate for her during the birthing process; and by refusing to acknowledge her request for the absence of students (including doctors taking part in teaching experiences).

3.2.4 Considering the balance of benefit and harm in all clinical-management decisions – by failing to consider the negative consequences of refusing to acknowledge and accept Mother's advanced care directives; and by failing to recognise the escalation of anxiety caused by the anaesthetist's actions. Also failing to consider how this would interact with our social history, and the foreseeable outcome (especially given that the request made for a different staff member to perform the procedure was simple and reasonable, and a qualified staff member was immediately available in the room).

3.2.5 Communicating effectively with patients (see section 4.3) – by continuing the procedure when asked to cease, without allowing opportunity to discuss our options or explaining the risk levels of what had occurred; and by refusing to read Mother's advanced care directives or acknowledging our concerns.

3.2.9 Taking steps to alleviate patient symptoms and distress, whether or not a cure is possible – by failing to acknowledge the escalating situation and not allowing time for discussion and counselling to us in response to the error that occurred, especially since there was no medical urgency to continue the procedure.

3.2.10 Supporting the patient's right to seek a second opinion – by not allowing any time for discussion amongst ourselves or any other medical staff by continuing the procedure without ceasing when asked to do so, especially since there was no medical urgency to continue the procedure.

3.2.11 Consulting and taking advice from colleagues, when appropriate – by failing to liaise with nursing staff regarding our social history and Mother's advanced health directives when asked to do so.

3.2.13 Encouraging patients to take interest in, and responsibility for, the management of their health and supporting them in this – by refusing to read or acknowledge Mother's wishes as outlined in her advanced care directives.

3.2.14 Ensuring your personal views do not adversely affect the care of your patient or the referrals you make – by conducting themselves under the view that we do not have any rights to self-determination in our health care in terms of advanced care directives (requesting no students – including teaching experiences for doctors – or the right to choose our care staff).

3.3 Making decisions about healthcare is the shared responsibility of the doctor and the patient. Patients may wish to involve their family, carer or others. See section 1.4 on substitute decision-makers – by refusing to allow Father to advocate for Mother as outlined in her advanced care directive.

4.2.4 Encouraging and supporting patients and, when relevant, their carer or family, to care for themselves and manage their health – by denying us the right to advocate for each other and make our own decisions as outlined in Mother's advanced care directives.

4.2.5 Encouraging and supporting patients to be well informed about their health and to use this information wisely when they are making decisions – by not acknowledging that Mother was sleep deprived, in an extreme state of pain, fearful of having a seizure, desperate for pain relief and unable to comprehend medical risks and

benefits associated with the procedure; by not pausing the procedure to allow for further information exchange; and by not allowing Father to advocate for her based on his understanding of the situation.

4.2.6 Recognising that there is a power imbalance in the doctor–patient relationship, and not exploiting patients in any way, including physically, emotionally, sexually or financially – by not recognising that the anaesthetist's position of power denied us our right to self-determination and placed us in an unsafe situation given our medical and social history.

4.3.3 Informing patients of the nature of, and need for, all aspects of their clinical management, including examination and investigations, and giving them adequate opportunity to question or refuse intervention and treatment – by continuing the procedure when asked to cease, not allowing time to discuss and review our choices, and denying us the right to refuse the treatment.

4.3.5 Endeavouring to confirm that your patient understands what you have said – by not considering or understanding that Mother was sleep deprived, in an extreme state of pain, fearful of having a seizure, desperate for pain relief and unable to comprehend medical risks and benefits associated with the procedure. Then by not allowing Father to advocate for Mother (given her mental and physical state, as per her advanced care directives), based on his understanding of the situation; and by failing to cease the procedure when asked to do so, to allow time to discuss risks and benefits of continuing the procedure.

4.5.2 Obtaining informed consent from the patient or where the patient does not have the capacity, from their substitute decision-maker and taking into account any advance care directive (or similar) before you undertake any examination, investigation or provide treatment (except in an emergency), or before involving patients in teaching or research - by not acknowledging that Mother was sleep deprived, in an extreme state of pain, fearful of having a seizure, desperate for pain relief and unable to comprehend medical risks and benefits associated with the procedure; by failing to acknowledge and allow her advanced care directive for Father to advocate for her; by failing to acknowledge Mother's advanced care directive to prevent students participating in the birth including teaching experiences for doctors; and by failing to cease the procedure when asked to do so to allow time to discuss risks and benefits of continuing the procedure.

4.9.1 Ensuring that you reassess a patient's decision-making capacity when indicated – by failing to acknowledge that Mother's decision making capacity was impaired by her medical state and that she was unable to comprehend or consider medical information in her current condition at the time of the birth.

4.9.5 Recognising that there may be a range of people involved in a patient's care, such as carers, family members, a guardian or other substitute decision-maker, and involving them when appropriate or required by law, being mindful of privacy considerations – by refusing to acknowledge Father's role in the birth, and that Mother's advanced care directive specifically advised that Father was to advocate for her if he felt necessary during the birth.

4.10.1 Being considerate to relatives, carers, partners and others close to the patient, and respectful of their role in the care of the patient – by speaking to Father in a condescending manner, and exerting a power imbalance over him in a state of panic while he experienced re-lived medical trauma as outlined in our admission notes; by denying him his role in the birth and denying him his right to advocate for Mother as outlined in her advanced care directives.

4.10.2 With appropriate consent or where otherwise permitted, being responsive in providing information – by being completely unresponsive when asked to review our medical and social history including advanced care

directives; and by refusing to cease treatment when asked to allow time for discussion (despite Mother having provided consent in her advanced care directive for Father to have this right).

4.11.1 Recognising what has happened (adverse events) – by failing to acknowledge the escalating situation and aggravating it by arrogantly refusing to follow Mother's advanced care directives.

4.11.2 Acting immediately to rectify the problem if possible, including seeking any necessary help and advice – by failing to attempt to rectify the problem and instead aggravating the issue and increasing distress levels which led to permanent social disadvantage.

4.11.3 Explaining to the patient as promptly and fully as possible in accordance with open disclosure policies, what has happened and the anticipated short-term and long-term consequences – by failing to cease treatment when requested, and by failing to explain to Mother and Father the event of the inexperienced anaesthetist "hitting the bone", and what the implications of this were; and by failing to allow time for discussion.

4.11.8 Ensuring patients have access to information about the processes for making a complaint (for example, through the relevant healthcare complaints commission or the Medical Board) – by failing to acknowledge the written complaint that was made to the hospital on the day of the birth, nor providing any written or verbal response of any kind.

4.12.1 Acknowledging the patient's right to complain – by failing to acknowledge the written complaint that was made to the hospital on the day of the birth.

4.12.2 Providing information about the complaints system – by failing to provide information to Mother or Father at the time of the event and by failing to acknowledge the written complaint that was made to the hospital on the day of the birth.

4.12.3 Working with the patient to resolve the issue, locally where possible - by failing to acknowledge the written complaint that was made to the hospital on the day of the birth.

4.12.4 Providing a prompt, open and constructive response, including an explanation and, if appropriate, an apology - by failing to acknowledge the written complaint that was made to the hospital on the day of the birth; by acting condescending and arrogant at the time of the event; and by failing to provide any suitable explanation or apology.

4.12.5 Ensuring the complaint does not adversely affect the patient's care. In some cases, it may be advisable to refer the patient to another doctor – by ignoring the request/complaint of Mother's appointed advocate (Father) at the time of the event, and allowing the situation to escalate to a point that caused psychological distress, affected the positive experience of the birth, and resulted in permanent social disadvantage.

The anaesthetist breached the following professional guidelines of the Australian and New Zealand College of Anaesthetists:

PG07(A) Guideline on pre-anaesthesia consultation and patient preparation 2017

3.3 Allowing discussion with the patient and/or guardian – by failing to cease treatment when requested, to allow time for discussion; and by refusing to engage in discussion with Father as her appointed advocate.

3.4 Obtaining informed consent for the anaesthesia and related procedures – by not acknowledging that Mother was sleep deprived, in an extreme state of pain, fearful of having a seizure, desperate for pain relief and unable to comprehend medical risks and benefits associated with the procedure; by not pausing the procedure to allow for further information exchange; and by not allowing Father to advocate for her based on his understanding of the situation.

4.6 In some circumstances, early consultation will not be possible (e.g. emergency surgery, labour ward, and in emergency and critical care departments) but the consultation should not be omitted except when the overall welfare of the patient is at risk – by failing to provide full consultation given that this situation was not an immediate emergency.

5.5 Consultation with professional colleagues if required – by failing to liaise with nursing staff to discuss medical and social history when requested by Father, to help inform risk versus benefit of refusing to acknowledge Mother's advanced care directives.

5.7 Provision to the patient (and/or guardian) in a timely manner, of information of significance to the patient including details regarding the conduct of the anaesthesia/sedation, pain management (see PS45(G) Position statement on patients' rights to pain management and associated responsibilities) and relevant potential complications and risks. This material may be in the form of verbal discussion, written pamphlets, electronic information or internet links, which can only be effective should be if given to the patient ahead of the proposed procedure to allow time for consideration. In addition, the patient should be provided with an opportunity for questions on, and discussions about, issues of concern to them. An interpreter should be provided if necessary – by failing to cease treatment when requested to allow time for discussion; and by refusing to allow Father as her advocate to question the safety of the procedure and inexperience of the staff member performing the procedure; and by failing to discuss the risks associated with the complication of "hitting the bone" and carrying on with the procedure.

5.8 Obtaining informed consent for anaesthesia/sedation and related procedures. This should include consent regarding the type of anaesthesia, invasive procedures, blood and product transfusion if appropriate, procedures and plans for pain management, and where, pertinent, informed financial consent (see PS26(A) Position statement on informed consent for anaesthesia or sedation). Where consent has been obtained in a pre-anaesthesia assessment clinic the procedural anaesthetist should still discuss the proposed treatment with the patient to ensure that all required preparation and explanation has occurred. Provision of additional information to patients intending to breastfeed should be guided by Appendix 2 below. – no information was ever discussed or provided regarding the risks associated with breastfeeding; this was only made aware to us through our independent research for the purposes of writing this complaint.

5.13 The pre-anaesthesia consultation should identify and take note of any advanced care directives. In their absence the consultation may represent an appropriate opportunity to recommend consideration of such directives, where relevant – by failing to recognise, acknowledge or follow Mother's advanced care directives in a non-emergency situation.

Appendix 2 – Effect of anaesthesia on breastfeeding – July 2022 – Recommendations: (v). Patients should be advised that most medication used in anaesthesia and analgesia will pass in small amounts to the breast milk but are not likely to cause adverse effects on the infant – this information was never provided to us and it is only through our own independent research for the purposes of writing this complaint that we have become aware of these risks.

4. It is a legal requirement in both Australia and New Zealand to obtain consent for all medical treatment. It is a basic tenet of our society that everyone has a right to determine what is done to their own body and is entitled to know the implications of any treatment before it is administered, and seek clarification of any issues that may be of concern. The standard for consent in Australia is established by the common law. In New Zealand doctors are referred to the Code of Health and Disability Services Consumers' Rights (the Code). Although legal processes that test the validity of consent differ, both Australian and New Zealand law state that the provision of information is an integral part of obtaining consent for a medical procedure. This document should be read in conjunction with the relevant standard for the country in which one is practising. In particular, New Zealand doctors are bound by "the Code". A statement as to the necessity for anaesthesia, which may form part of the consent for an operative procedure, does not constitute informed consent for anaesthesia. The process of consent for medical treatment is one of shared decision making and agreement to treatment that involves discussion in which both the patient and the anaesthetist/sedationist participate actively and openly. The process should be open, honest, and effective from both the anaesthetist/sedationist and patient's perspective – by failing to cease treatment when requested to allow time for discussion; and by refusing to allow Father as her advocate to question the safety of the procedure and inexperience of the staff member performing the procedure; and by failing to discuss the risks associated with the complication of "hitting the bone" and carrying on with the procedure.

5.1 Consent must be given voluntarily without coercion. The environment, timing of the consent process, and presence of support people are important considerations. Where urgency permits there needs to be sufficient time to consider, review, and seek advice relating to matters discussed. The time pressure associated with high turnover day stay procedures resulting in abbreviated consultations is acknowledged, however, the essential process of consent nonetheless still applies – by failing to acknowledge Mother's appointed support person and advocate's role in the consent making process and by failing to allow time to review the situation once consent was withdrawn.

5.2.1 All persons are presumed to be competent to give consent, unless there are reasonable grounds for believing otherwise. A judgement that the patient is incapable of giving consent must be supported by evidence, such as a known diagnosis of dementia or certification of incapacity with an appointed person having medical power of attorney. Where patients are of very young age, have diminished mental capacity, are unconscious or under the influence of sedative medication, they may not be capable of providing informed consent – by not acknowledging or understanding that Mother was sleep deprived, in an extreme state of pain, fearful of having a seizure, desperate for pain relief and unable to comprehend medical risks and benefits associated with the procedure; by not pausing the procedure to allow for further information exchange; and by not allowing Father to advocate for her based on his understanding of the situation.

5.2.2 The age at which a young person is able to consent independently to medical treatment depends on the nature of the proposed treatment and local legislative requirements. To be able to give consent, the young person must be able to understand the nature, purpose and possible consequences of the treatment, as well as the consequences of nontreatment. If in any doubt, consult relevant management representatives or legal advisers – by not acknowledging that Mother was sleep deprived, in an extreme state of pain, fearful of having a seizure, desperate for pain relief and unable to comprehend medical risks and benefits associated with the procedure; by not pausing the procedure to allow for further information exchange; and by not allowing Father to advocate for her based on his understanding of the situation.

5.2.3 In the absence of capacity to give consent, another person can give consent on behalf of the patient in circumstances that are legally defined, such as the parent or legal guardian of a child or designated legal

authority for an adult. In such circumstances, the person giving consent has a legal duty to always act in the best interests of the person for whom consent is being given – by failing to acknowledge Mother's advanced care directive that Father was to advocate for her on the day of the birth; and by denying him this role in the birthing process and carrying out treatment without consent.

5.2.4 For patients treated in Australia, if no person is able to give consent, then treatment can proceed only if all of the following are satisfied:

5.2.4.1 It is in the patient's best interests – the actions of the anaesthetist resulted in psychological distress, negative birthing experience and emotional damage, and permanent social disadvantage. A reasonable request was made for a more experienced staff member to perform the procedure, who was present in the room at the time of the event, but this was refused.

5.2.4.2 Reasonable steps have been taken to ascertain the views of the patient – Mother's advanced care directives were not acknowledged or respected, and were openly rejected by the anaesthetist.

5.2.4.3 The doctor believes that it would have been the patient's choice had they been competent to do so – Mother's birth plan did not include an epidural, this decision was made at the discretion of Mother and Father in prior discussions; Father was aware of Mother's values and wishes and provided this information to the anaesthetist which was rejected.

5.2.4.4 The doctor takes into account the views of other persons with a genuine interest in the welfare of the patient – the anaesthetist openly rejected Father's requests and advice, and refused to acknowledge Mother's advanced care directives.

5.2.4.5 Any delay is likely to be detrimental to the patient – there was no immediate threat to Mother, following the epidural she was provided breakfast before resting; while this procedure was to address sleep deprivation the risk was not immediate. A reasonable request was made and a solution available which aligned with Mother's values and advanced care directives, but this was rejected.

5.2.7 It must be recognised that any patient can change their mind, and withdrawal of consent at any time must be respected (e.g. during multiple attempts at regional blockade) – it was requested that the procedure cease, and consent was withdrawn from the inexperienced anaesthetist performing the procedure; however, they continued.

5.3.1 It is a legal requirement that patients are provided with the information that a reasonable person in the position of that patient might wish to know, and to which they might attach significance. It is necessary to provide information about all material risks inherent in any proposed treatment. This should include advice regarding any interactions between medications being taken by patients and those administered as part of anaesthesia management (refer accompanying background paper) – Mother was not informed of any potential transmission of the epidural medication to our child through breast milk; which is of significance to her values.

5.3.2 Basic information about the proposed treatment should be provided, even if the patient requests no information - Mother was not informed of any potential transmission of the epidural medication to our child through breast milk; which is of significance to her values.

5.3.3 The discussion of risks and benefits should include those associated with the proposed treatment, alternative treatments, or no treatment at all – the benefits of the other anaesthetist performing the procedure as requested were not discussed; the implications of the inexperienced anaesthetist "hitting the bone" were not discussed; we were not given the opportunity to discuss our concerns or wishes.

5.3.5.2 Whether the particular patient would be likely to attach significance to that risk. In other words, is it possible that the patient, if informed of that risk, would change their mind about having the procedure? In considering risks to be discussed with patients – we were not provided the opportunity to discuss these risks and our choices once the event occurred; this was denied to us. In particular, if we were aware that the anaesthetist may hit the bone, that the epidural medication may be transmitted to our child, or that the inexperienced anaesthetist's actions could increase the risk of paralysis, Mother would not have continued with the epidural; Mother was not advised that this was a teaching experience for this doctor, which she directly instructed against in her advanced care directive, and was requested to cease by her appointed advocate Father which was refused.

5.3.6.2 Known risks should be explained when an adverse outcome is rare but the detriment severe, and an adverse outcome common but the detriment slight – Mother was not informed of any potential transmission of the epidural medication to our child through breast milk; which is of significance to her values. The benefits of the other anaesthetist performing the procedure as requested were not discussed; the implications of the inexperienced anaesthetist "hitting the bone" were not discussed; we were not given the opportunity to discuss our concerns or wishes.

5.3.6.6 It is important that patients be given the opportunity to discuss the nature and risks of the treatment, and the alternative treatment(s), and to have questions answered honestly and accurately – Following the event it was requested that treatment cease which was refused, we were not allowed the opportunity to discuss any risks, and any requests or questions made to the anaesthetist were rejected.

5.4 Advanced Care Directives (ACD)/Advanced Directives and End-of-Life Directives. Since the last review in 2005, the community has been encouraged to prepare Advanced Care Directives, the uptake of which has been increasing. These are essential documents of legal standing, containing information that must be considered when deciding on treatment and when discussing risks with patients. The existence of ACDs should be confirmed preoperatively so that they can be consulted and incorporated into the consent process – Mother's advanced care directives were rejected by the anaesthetist who refused to read them; quoting "we don't read birth plans".

7. The use of standard "consent forms" and information sheets will not necessarily be sufficient to satisfy "informed consent" in specific circumstances. Standard information forms are useful but no substitute for the provision of information to individual patients. Under the requirements of "informed consent", the information to be given to patients should be specific to the particular patient. It should take into account the particular circumstances, and requirements, of the patient. Similarly, a simple form signed by a patient is not conclusive proof that valid consent has been obtained. The process of valid informed consent revolves around the discussions between the doctor and patient, rather than the presence of a signature – Mother does not recall signing a consent form because of her condition at the time of the event; however, it is known to us that she did as Father was present. In the event of the hospital's response quoting the existence of this form, we would like section 7 of "PS26(A) Position statement on informed consent for anaesthesia or sedation 2021" noted; and like it noted that Mother can't recall having signed this document.

Appendix 1 - Examples of risk which might be discussed with the person giving consent include: c) Rare adverse effects which are unpredictable, such as anaphylaxis, awareness, neurological damage or death in healthy people – Mother was not aware of any of these risks, and can't recall them being discussed because of her condition at the time of the event.

PS45(G) Position statement on patients' rights to pain management and associated responsibilities 2010

2.2 To be cared for in a timely manner by health professionals who have training and experience in assessment and management of pain, and who maintain such competencies through professional development consistent with their discipline. Where such competencies are unavailable, patients should have access to appropriate referral – Mother's advanced care directive indicated that she did not want students involved in her care, this was communicated through her birth plan and verbally by Father at the time of the event – with teaching experiences for doctors being deemed as students by us at the time of the event. It was requested that the inexperienced anaesthetist cease the procedure and care be handed over to the experienced anaesthetist, but this was refused.

2.3 To participate actively, or have their families, carers or guardians participate, in education regarding pain and in the development of realistic goals for their pain management plan – Father was denied from advocating for Mother as outlined in her advanced care directive.

3. Responsibilities in addition, ANZCA recognises that patients or their carers and families have responsibilities that include:

3.1 To engage openly with their health care providers – Father's requests and direction to Mother's advanced care directives were openly rejected.

3.5 To advocate for better pain management – Father's requests and direction to Mother's advanced care directives were openly rejected; and he was denied the right to advocate for her as appointed in Mother's advanced care directive.

PG58(A) Guideline on quality assurance and quality improvement in anaesthesia

3.4 Achieving the Triple Aim depends on high quality care, which implies: Doing the right things (which means providing care that is evidence based and meets patients' individual needs and wishes); doing things right the first time – the inexperienced anaesthetist failed to perform the procedure correctly in the first instance; and the care provided didn't meet Mother's individual care needs and wishes, as they didn't take into account her social situation and her advanced care directives.

The anaesthetist breached the following ethical and professional standards outlined by the Australian Medical Association:

2.1.1 Consider first the well-being of the patient – the anaesthetist allowed his implicit bias and personal views to interfere with Mother's care. He valued the learning experience of the inexperienced anaesthetist over Mother's wishes outlined in her advanced care directives, and as advised by her appointed advocate; and didn't consider how our social history would complicate the outcomes caused by his actions.

2.1.2 Treat the patient as an individual, with respect, dignity and compassion in a culturally and linguistically appropriate (acknowledge advanced health directive) – he openly refused to acknowledge Mother's advanced care directives.

2.1.3 Respect the patient's right to choose their doctor freely – when consent was withdrawn for the procedure and it was requested that the more experienced anaesthetist take over, this was rejected, and we were told that "this is a teaching hospital so we don't have a choice".

2.1.4 Communicate effectively with the patient and obtain their consent before undertaking any tests, treatments or procedures (there may be an exception in emergency circumstances) or involving them in research, teaching or disclosing their personal information to others – informed consent was not obtained as Mother's ability to comprehend medical advice was impaired, as she was sleep deprived, in an extreme state of pain, desperate for pain relief and fearful of having a seizure; Mother requested that no students be allowed,

including teaching experiences for doctors; consent was not given for an inexperienced anaesthetist to perform any procedures.

2.1.5 Respect the patient's right to make their own health care decisions. This includes the right to accept, or reject, advice regarding treatments and procedures including life-sustaining treatments – Mother's advanced care directives and birth plan were openly rejected, quoting that the anaesthetists "don't read birth plans".

2.1.6 Respect the patient's right to refuse consent or to withdraw their consent – consent was withdrawn yet the anaesthetist continued the procedure.

2.1.8 Respect the patient's request for a support person – Father was not allowed to advocate for Mother as outlined in her advanced care directive.

2.1.18 Recognise the patient's right to make a complaint in relation to their health care. Ensure they are provided with information on the complaints process and do not let a complaint adversely affect the patient's care – the written complaint made on the day of the birth was not acknowledged or handled, and the event resulted in a referral to DCJ which has permanently socially disadvantaged us.

2.3.2 Recognise that some patients may have limited, impaired or fluctuating decision-making capacity. As such, any assessment of capacity for health care decision-making is relevant to a specific decision at a specific point in time – informed consent was not obtained as Mother's ability to comprehend medical advice was impaired, as she was sleep deprived, in an extreme state of pain, desperate for pain relief and fearful of having a seizure.

2.3.4 Recognise that some patients will have capacity to make a supported decision while others will require a substitute decision-maker – Mother had appointed Father as her advocate as outlined in her advanced care directive and this was not respected.

2.4.1 Treat the patient's family members, carers and significant others with respect – Father was denied from his role as Mother's advocate in the birthing experience; and was spoken to condescendingly; and his requests and wishes openly rejected.

2.4.2 Recognise that the patient's family members and carers may also need support, particularly where the patient's condition is serious or life-limiting. Provide them with information regarding respite care, bereavement care, carer's support and other relevant services, where appropriate – Our social history was well documented, both from previous notes and from a face to face meeting with the NUM outlining Father's mental health and medical trauma. It was obvious that the situation was escalating Father's anxiety and the anaesthetist's actions were provocative and detrimental to Father's condition and Mother's care; and subsequently resulted in permanent social disadvantage.

2.6.2. Before conducting clinical teaching involving patients, ensure that the patient is fully informed and has consented to participate – consent was not obtained for an inexperienced staff member to practice on Mother, and went against Mother's advanced care directive and against her appointed advocate's wishes, quoting that "the anaesthetists don't read birth plans".

2.6.3 Respect the patient's right to refuse or withdraw from participating in clinical teaching at any time without compromising the doctor-patient relationship or appropriate treatment and care – consent to participate in a teaching experience was refused, and that refusal was reiterated when the event occurred, and the procedure continued.

2.6.4 Avoid compromising patient care in any teaching exercise. Ensure that the patient is managed according to the best-proven diagnostic and therapeutic methods and that the patient's comfort and dignity are maintained at all times – Our dignity was not maintained, and our wishes and requests not honoured; the actions of the anaesthetist compromised Mother's care and her birthing experience.

3.3.1 Recognise your professional limitations and be prepared to refer as appropriate – when requested, the inexperienced anaesthetist refused to hand over care to the experienced anaesthetist.

3.3.2 Obtain the opinion of an appropriate colleague acceptable to the patient if diagnosis or treatment is difficult or in response to a reasonable request by the patient - it was requested that the anaesthetist liaise with nursing staff regarding our social and medical history which was refused; it was also requested that they review Mother's birthing plan and advanced care directives which was refused. It was also reasonably requested that the experienced anaesthetist take over the procedure which was refused.

3.4.3 Work collaboratively with other members of the patient's health care team – it was requested that the anaesthetist liaise with nursing staff regarding our social and medical history which was refused; it was also requested that they review Mother's birthing plan and advanced care directives which was refused.

3.4.4 Adhere to your responsibility in delegation and handover of care of the patient – when requested, the inexperienced anaesthetist refused to hand over care to the experienced anaesthetist.

3.5.1 Ensure your financial or other interests are secondary to your primary duty to serve patients' interests. Financial and other interests should not compromise, or be perceived to compromise, your professional judgement, capacity to serve patients' interests or the community's trust in the integrity of the medical profession – The training experience for the inexperienced anaesthetist was given priority over Mother's care and the wishes outlined in her advanced care directives.

Grievances Hospital):

- **Midwife standards as outlined above in hospital grievances**

Australian Health Care Standards:

- Action 2.11 - by failing to recognise the diversity of our family unit and our unique health care needs.
- Action 2.05 - by failing to plan for the post-partum care of our child by liaising with us as the substitute decision makers, as they couldn't yet make their own decisions.
- Action 2.06 - by failing to communicate with us to plan, set goals and make decisions about our current and future care needs, and preventing us from being involved in our own care and case management.
- Breach of confidentiality by disseminating our private information to external parties (the police) whilst we were not under their care. Which is a violation of Section2.2.2 of the AHPRA Code of Conduct (Good Medical Practice; A Code of Conduct for Doctors in Australia):

NSW Health Child Wellbeing and Child Protection Policy and Procedure

Section 7.3.8 of the NSW Health Child Wellbeing and Child Protection Policy and Procedure Section states that Healthcare workers must inform the "non-offending'' caregiver of the impending report prior to submission which did not occur. There was no attempt to contact Mother in the first instance, and the only reason we were made aware of the second report is because Father asked the NUM directly; with her answer being "we have to let them know baby has been born because there is an outstanding report, and that is all it will say"; there was no further discussions with Mother despite Father being absent from the hospital on several occasions. It should also be noted that in the second instance Father was allowed to stay at Hospital in the maternity ward unsupervised the night of the incident resulting in the referral, and a subsequent night thereafter despite staff 'considering him a risk' to Mother and Baby's safety. The policy reads: "The non offending caregiver should be

informed of a report and the reasons why a report has been or will be made where they have provided the information and the Health worker assesses it to be safe and appropriate".

Crimes Act 1900

Section 61 of the Crimes Act 1900 outlines that the actions of the anesthetist amounts to assault in that: the act was intentional and reckless, and caused Mother to apprehend immediate and unlawful violence; the act occurred without informed consent; the act was intentional or reckless in the sense that the accused realised that the complainant might fear that the perpetrator would then and there be subject to immediate and unlawful violence and none the less went on and took that risk; the act was without lawful excuse as there was no medical emergency, it was against advanced health directives and there was not informed consent. And as such a referral for a response to this behaviour is unfounded. Furthermore, this act meets the definition of negligence under Civil Liability Act (Part 3, Mental Harm), meaning that any reasonable actions (telling him to stop and requesting a social worker) amounts to self-defence in the interest of another (Part 7 Self Defence and Recovery by Criminals of the Civil Liability Act 2000), meaning that a child protection report in response to these actions is unfounded.

Health Practitioner National Law

Part 7 Directing or inciting unprofessional conduct or professional misconduct

A person must not direct or incite a registered health practitioner to do anything, in the course of the practitioner's practice of the health profession, that amounts to unprofessional conduct or professional misconduct - Where the anesthetist directed the student doctor to continue despite consent being withdrawn and not allowing time for discussion, and going against advanced health directives.

Part 8 Health, Performance and Conduct (d): placing the public at risk of harm by practising the profession in a way that constitutes a significant departure from accepted professional standards - as demonstrated several standards of professional practice were breached by midwives and anaesthetists.

Part 8 Health, Performance and Conduct (1) Subsection (2) Mandatory notifications by treating practitioners of substantial risk of harm to public: applies to a registered health practitioner (the *treating practitioner*) who, in the course of providing a health service to another registered health practitioner (the *second health practitioner*), forms a reasonable belief that the second health practitioner is placing the public at substantial risk of harm by practising the profession - Midwife aware of and acknowledged our social circumstances and Mother's advanced care directives and allowed the inexperienced anaesthetist to continue, later citing that she couldn't comment because she is a midwife and he is a doctor.

Part 8 Health, Performance and Conduct (2) The treating practitioner must, as soon as practicable after forming the reasonable belief, notify the National Agency of the second health practitioner's conduct that forms the basis of the reasonable belief - Midwife took no action, we informed the hospital of these actions by email and our complaint was not responded to or followed up.

Part 8 Health, Performance and Conduct; 142 Mandatory notifications by employers - (1) If an employer of a registered health practitioner reasonably believes the health practitioner has behaved in a way that constitutes

notifiable conduct, the employer must notify the National Agency of the notifiable conduct - Hospital ignored our complaint.

Part 8 Health, Performance and Conduct; Subdivision 2 How complaints are to be dealt with [NSW]: 145 Complaints to be dealt with expeditiously [NSW]. All complaints are to be dealt with expeditiously - the hospital did not acknowledge our complaint.

Civil Liability Act 2000

Part 1A Division 2 Duty of care: (1) A person is not negligent in failing to take precautions against a risk of harm unless: the risk was foreseeable (that is, it is a risk of which the person knew or ought to have known), and the risk was not insignificant, and in the circumstances, a reasonable person in the person's position would have taken those precautions. - professional standards outline what a reasonable course of action would have been in this instance, which was not taken; there was a foreseeable risk of injury as outlined by previous documentation, communications, meetings, disclosures and reports; the risk was supposedly significant enough to warrant a child protection referral.

(Part 1A) Division 8 Contributory negligence: 5R Standard of contributory negligence:(1) The principles that are applicable in determining whether a person has been negligent also apply in determining whether the person who suffered harm has been contributorily negligent in failing to take precautions against the risk of that harm - we had several instances of direct communication with several staff members at different levels of management informing them of a social and health circumstances. This is well documented and we took all steps that we possibly could have to avoid this outcome, the onus falls with NSW Health staff.

Part 3 Mental harm - Definition; Negligence: failure to exercise reasonable care and skill

30 Limitation on recovery for pure mental harm arising from shock

(1) This section applies to the liability of a person (*the defendant*) for pure mental harm to a person (*the plaintiff*) arising wholly or partly from mental or nervous shock in connection with another person (*the victim*) being killed, injured or put in peril by the act or omission of the defendant; (2) The plaintiff is not entitled to recover damages for pure mental harm unless— (a) the plaintiff witnessed, at the scene, the victim being killed, injured or put in peril, or (b) the plaintiff is a close member of the family of the victim - Father witnessed close family members put in peril because of actions that constitute negligence as per above definition; meaning a reasonable response to these actions does not warrant a child protection report.

Part 7 Self-defence and recovery by criminals - 52 No civil liability for acts in self-defence: (1) A person does not incur a liability to which this Part applies arising from any conduct of the person carried out in self-defence, but only if the conduct to which the person was responding — (a) was unlawful, or (b) would have been unlawful if the other person carrying out the conduct to which the person responds had not had a mental health impairment or a cognitive impairment at the time of the conduct. (2) A person carries out conduct in self-defence if and only if the person believes the conduct is necessary— (a) to defend himself or herself or another person, or (b) to prevent or terminate the unlawful deprivation of his or her liberty or the liberty of another person, - Father's actions were in response to a perceived threat to his partner and child; the staff member's actions were unlawful and breached professional standards of practice and deprived Mother of her liberty by violating her advanced care directives. Father's actions by legal definition were in 'self-defence' and did not warrant a child protection report.