From:	Chelsea Wingrove
To:	Reproductive, Maternal and Paediatric
Subject:	Submission into the Select Committee on Maternal Health Services in Tasmania
Date:	Monday, 9 September 2024 11:48:07 AM
Attachments:	Complaint.pdf

Good morning,

I'd like to share my recent experience of birth trauma at the LGH.

I gave birth as a surrogate to twins on [redacted]. The first twin was born vaginally with no issues, the second twin was in the wrong position (with her arm up) at which point I was advised to move up to theatre for another internal exam with the intention to continue natural delivery. Upon reaching the theatre, there was a miscommunication and an anaesthetic nurse put me under general anaesthetic (while I screamed no, stop).

I woke up to the doctor saying she was devastated that this had happened and that the second twin was in a position that she could have been delivered fine. She had been doing the internal exam as the mask was put on me and had screamed at the nurse "wtf are you doing?" There has since been a safety investigation into the breach of consent and unnecessary surgery.

From a personal perspective, I had wanted to be a surrogate not only so that I could help create a family for my friends, but so that I could experience the birth process again (I have a 7 year old daughter and no intention for more). During labour and the first twin's birth, this experience was everything I had hoped for; great teamwork, the support from the doctors and midwives was wonderful and it was a really empowering experience. Then all of that was just completely taken away from me. I was left in so much pain and the recovery from the c-section was really difficult. It affected my life as I couldn't look after my own daughter (I'm a single parent), due to not being able to drive.

Luckily I had great family support around me at this time, but the feeling that it all could have been avoided and the baby was put at risk still plays on my mind daily. I have never felt so vulnerable and disappointed that this mistake was made. Nothing can make up for this, except the hope that it never happens again.

I have attached full details of the birth from the account of Tristan, one of the fathers of the twins. Tristan is a Nursing Unit Manager at the Royal Hobart, but even with his experience was completely traumatised by how this all happened. I can only imagine how much it affects fathers who have no support to work through birth trauma their partners have endured.

Either of us are happy to be contacted to provide further details if needed.

Many thanks

Chelsea Wingrove
[redacted]

Dear [redacted]

I am writing to provide feedback in relation to the admission of Chelsea [redacted] Wingrove to the Launceston General Hospital Maternity Unit. Chelsea's admission commenced on the [redacted] and Chelsea was discharged on the [redacted].

This feedback is being provided by myself, Tristan Streefland, who was Chelsea's support person during her admission. Further information will be provided below as to our relationship and why I am providing this feedback.

This feedback is divided into two sections: complaint about a significant breach of consent for Chelsea, and compliments.

Background:

Chelsea was admitted for an induction of MCDA twin girls. Chelsea had incredibly chosen to be the surrogate for myself and my partner, Corbin Halliday. Through an embryo transfer in October 2023, we were successful in becoming pregnant with MCDA twins.

Throughout this process, we were patients of the LGH High Risk Pregnancy Clinic. As outlined by our treating team – which included [redacted] (Consultant Obstetrician), [redacted] (Complex Care Clinical Midwife), Chelsea and our twin girls would aim to progress as far as 36 - 37 weeks gestation, whereby if Chelsea has not gone into spontaneous labour, she would be induced. Our plan as a team was vaginal delivery for both twins – this was supported by the treating team as long as the positions for both twins was favourable.

Chelsea reached 37 weeks on [redacted], and was electively admitted on Monday the [redacted] for an assessment and potential preparations required to begin induction on Tuesday the [redacted]. Chelsea was assessed, and on the [redacted] a cervical balloon was placed to assist with dilatation. Both twins at this stage were head down.

On the morning of the [redacted], at approximately 0700, Chelsea had an amniotomy to begin her augmented induction of labour. With contractions not commencing, Chelsea was commenced on Syntocin at approximately 1000.

Throughout the day, Chelsea and the twins were closely monitored with Twin A ([redacted] via a scalp clip, and Twin B ([redacted] the CTG.

As was discussed in previous with the treating team, there was a high chance that Chelsea may require internal or external manoeuvres to assist with the repositioning of [redacted] post the vaginal birth of [redacted] to allow for the vaginal birth of [redacted]

During the evening, Chelsea, in consultation with the midwives and obstetrics team, opted for an epidural, in order to ensure that she had adequate analgesia in the scenario where manoeuvres were required, due to the high levels of pain this might cause.

This was attempted 3 times by the evening Anasthetic Registrar, however there was not successful placement of the epidural catheter due to extensive back pain from Chelsea. The Anasthetic Consultant was called, along with the night anasthetics registrar who despite inserting the epidural catheter twice, did not create an effective block. The anaesthetic consultant, in consultation with the obstetric registrar and Chelsea, prescribed a Fentanyl PCA to assist in managing Chelsea's pain. This was determined to be best alternative to be able to manage Chelsea's pain during labour and if there was a requirement to perform any manoeuvres on [redacted]

That the time of the final attempt of the epidural, the obstetrics registrar performed a bedside ultrasound to determine the position of each twin, and found that [redacted] (Twin 1) was still head down, however [redacted] (Twin 2) was now breach. Understandably, Chelsea was upset, however the Obstetrics Registrar explained that it is not unusual that the second twin could be delivered breech and that she would still attempt the manoeuvres to turn [redacted]

Around approximately 0130, Chelsea commenced the second stage of labour, and at approximately 0200, the obstetrics registrar and the obstetrics consultant on call (a locum) arrived. At 0207 [redacted] was delivered with no complications, and immediately post delivery, the obstetrics registrar performed an external manoeuvre, successfully resulting in [redacted] turning head down. The obstetrics consultant performed an internal assessment with Chelsea's consent. This assessment however determined that [redacted] feet were above her head, and therefore complicated delivery. The consultant discussed with Chelsea that he could attempt to deliver breech, however would with the timeframe of needing to get [redacted] out within 30 minutes of [redacted] delivery, that a decision would need to be made quickly.

At this point, to the best of my recollection, the obstetrics consultant and registrar made the decision to alert the operating theatres that there was a potential patient requiring a caesarean section.

In this time, another assessment was made by the obstetrics consultant (with Chelsea's consent), whereby [redacted] feet were no longer in the way, however her arm was above her head.

The obstetrics consultant outlined that there was no way that vaginal delivery could occur in this manner, and that [redacted] would need to be delivered via C-section. Chelsea was understandably upset, and asked whether we could wait longer for [redacted] to move her hand, however, the obstetrics consultant again reiterated due to the timeframe of 30 minutes, we could not wait. He however, along with the obstetrics registrar, discussed with Chelsea and myself that we could go to the operating theatre, perform another internal assessment prior to having the general anaesthetic and C-section, in final attempt for vaginal delivery.

At this point the obstetrics registrar consented Chelsea for an assessment, general anaesthetic, C-section and blood products, and explained the risks and complications of the afore mentioned.

From here, Chelsea was moved onto a ward bed, and I asked to go with Chelsea to theatre, knowing that once she was under a general anaesthetic, I would no longer be allowed to remain. I asked to go along to support Chelsea, as this was a highly stressful situation for Chelsea and myself.

I was allowed to put on scrubs and went with Chelsea to the anaesthetic assessment room.

Chelsea and myself were transferred to the anaesthetic assessment room outside theatre around 0245.

Breach of consent:

On arrival to the anaesthetic assessment room, slightly after Chelsea due to having to put on scrubs, I could see that Chelsea was commencing to have contractions again, and was visibly upset. The anaesthetic consultant introduced themselves, and said that they would be performing the general anaesthetic today. At this point, both Chelsea and myself reinterated that there was to be an internal assessment first, prior to the general anaesthetic and c section, as there was still a chance [redacted] would have moved her arm in the travel time to theatre, and therefore vaginal delivery could occur.

The anaesthetic consultant said to Chelsea words to the effect of 'I'm going to give you something to calm down, here is 3ml of Propofol'. At this time the midwife and obstetrics registrar were attempting to find a CTG trace for [redacted] – once found, [redacted] heart rate was ranging from 120 – 150. A bedside ultrasound machine was brought into the assessment room, and the obstetrics registrar undertook an ultrasound, which showed that [redacted] was still head down, however could not determine if her arm was still above her head.

Chelsea was moved into the operating room, and moved across to the OT table. The anaesthetic consultant allowed me to enter the OT, and I was placed behind Chelsea next to what I recall was the ventilator.

I recall the obstetrics registrar was off to the left preparing to perform the internal assessment, and the obstetrics consultant was to the right against a bench looking down writing some notes. I recall looking to my left, where I saw the anaesthetic registrar, who I remember from earlier in the evening, was also to my left preparing IV lines and what I assumed were intubation medications. She then moved towards the OT table where Chelsea was, which drew my attention to Chelsea.

What I recall seeing next, was Chelsea repeatedly saying 'No, no, no' and looking back at me with what can only be described as terror, which I would assume was due to the fact that mask with gas was being placed over her face and she was aware that she was now going to be anaesthetised. The obstetrics registrar was down at the end of the bed performing what looked like the internal assessment. To my recollection, the obstetrics registrar looked up, saw that they were commencing the anaesthetic, and called out word to the effect of 'what

have you done, that wasn't the plan' whilst I also called out to the room word to the effect of 'this is not what was supposed to happen'. I do not remember much post that, apart from the midwife who was in the labour room assisting me out of the theatre.

After breaking down crying in the corridor of the Level 4, I returned to the birth suite, to my partner Corbin and my new daughter [redacted] distressed, upset and traumatised by what I had just witnessed.

Within an hour, the anaesthetic consultant came to the birthing suite where we were, and outlined that the procedure went well, that Chelsea was okay, had lost some blood, and that [redacted] was doing well. She also discussed that the right decision had been made to perform the C-section, as [redacted] APGAR was low when she was out. She showed us photos of [redacted] and then left us.

[redacted] was transferred to us in the birth suite by the midwife, where we could commence skin to skin.

These are the following concerns that I would like to raise:

- What I witnessed was a breach of consent
- The reduced APGAR score for [redacted] was due to the anaesthetic administered, not due to foetal distress – the CTG on [redacted] in the assessment room showed a good trace of a HR 130 – 150, which was consistent with majority of the reading that were taken throughout the duration of the labour
- Chelsea was not draped or prepped prior to the anaesthetic commencing, therefore increasing the amount of anaesthetic agent that [redacted] was exposed to – from my understanding, normal process is to prep and drape prior to anesthetising
- There was no timeout that occurred prior to the anaesthetic being administered

The rationale behind making this complaint, is to ensure that no one will ever have a similar thing occur to them again. This has been a deeply traumatic event for Chelsea and also myself who witnessed this.

Post the incident, the response from the THS-N has been one of action, which I can commend.

Chelsea and myself have received support and debriefing from the Obstetrics team, including the registrar, locum consultant, Clincal Midwife and Head of Department. We have also had discussions with the HoD for Anasthetics, and the Deputy Head of Department.

I am also aware that a safety event has been submitted, which will result in an investigation. I would appreciate being made aware of any recommendations as a result of the investigations, as well as any actions required, and the subsequent completion of those actions.

I am happy to be contacted via email or via mobile on [redacted]