Submission No 226

INQUIRY INTO BIRTH TRAUMA

Name: Name suppressed

Date Received: 4 August 2023

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Committee Secretariat
Select Committee on Birth Trauma
NSW Parliament
Macquarie Street
Sydney NSW 2000

birthtrauma@parliament.nsw.gov.au

Re: Inquiry on Birth Trauma

Dear Chair,

I am a NSW resident and birthing parent and I would like to make a submission to your inquiry on birth trauma.

Addressing the Terms of Reference

Terms of Reference	My Response
1(a) the **experience and prevalence of birth trauma** (including, but not limited to, as a result of inappropriate, disrespectful or abusive treatment before, during and after birth, also referred to as "obstetric violence")	I opted for a private obstetrician. The level of education I received in the lead-up to the birth was minimal, and the risks of birth were not discussed with me. At 35 weeks gestation, a dating scan showed the baby was 'full term', and my obstetrician advised an induction at 38 weeks. I declined and wanted to explore other options. All discussion was stopped, and no further dating scans took place. No discussion of the risks of delivering a large child took place. No education or discussion for decisions or the plan for birth took place. At 6 week check-up when asked why what happened took place, the response was 'Well, you had a big baby.'
1(b) **causes and factors contributing to birth trauma** including: (i) evaluation of current practices in obstetric care, (ii) use of instruments and devices for assisted birth, for example, forceps and ventouse, (iii) the availability of, and systemic barriers to, trauma-informed care being provided	Use of forceps without proper consent, and without understanding risks and benefits. Left with a failed epidural for 3 hours before the second epidural was attempted. Care providers ill equip to treat physical injuries as well as psychological injuries concurrently, resulting in the common triggering of one or the other.

during pregnancy, during birth and following birth	
1(c) the **physical, emotional, psychological, and economic impacts of birth trauma**, including both short and long term impacts on patients and their families and health workers	Massive PPH of 3.3 litres, ICU for 2 nights, 3c tear, likely alleviator avulsion on the right side of my pelvic, partial on left. Lifelong injury has resulted in cystocele prolapse and partial uterus. Conservative management is ongoing. PTSD, PND and PNA are ongoing. To date, more than $15,000 minimum of expenses for physical, emotional and psychological treatment postpartum (14 months). Ongoing. Fathers and non-birthing parents play a vital role in the lives of women affected by psychological and/or physical trauma and they themselves may experience trauma related to a traumatic birth. It is estimated that 1 in 10 fathers experience postnatal depression. (1) Traumatic or negative birth experiences, such as haemorrhages, concerns about the baby's or mother's survival, physical damage, and unexpected emergency surgical interventions, cause fathers distress and may increase their risk of depression. The impact on family relationships and sexual intimacy should also be noted, with around two thirds of mothers who experience a traumatic birth reporting that it impacted their partner relationship. (2) We ask that the impact of traumatic birth on fathers and non-birthing parents is not overlooked in any reforms resulting from this inquiry. This view is shared by members of the Plus Paternal Network: a national network of organisations committed to the goals of the Plus Paternal Case for Change of which <your organisation> is a member. One of Plus Paternal Network's shared goals is that *Parents who experience loss, distress or are struggling with parenthood receive the care they need.* Within the Case for Change we collectively argue that the emotional wellbeing of all parents should be routinely monitored by health professionals if they have a traumatic birth-related experience.

	Refs: (1) Paulson, J. F. & Bazemore, S. D. (2010). Prenatal and postpartum depression in fathers and its association with maternal depression: A meta-analysis. JAMA, 303(19), 1961-1969.(doi:10.1001/jama.2010.605). (2) Dawes, A. Beard, C. Pistone, C. Callaghan, S. Thomas, K. Wilson, N. Docherty, N. (2022) Birth Injuries: The Hidden Epidemic. Australasian Birth Trauma Association (ABTA), Birth Trauma Association (BTA) and Make Birth Better (MBB)
1(d) **exacerbating factors in delivering and accessing maternity care that impact on birth trauma** generally, but also in particular: (i) people in regional, rural and remote New South Wales, (ii) First Nations people, (iii) people from culturally and linguistically diverse (CALD) backgrounds, (iv) LGBTQIA+ people, (v) young parents	History of sexual trauma resulted in an inability to mitigate a 'flight or fight' response throughout labour and examinations.
1(e) the **role and importance of "informed choice" in maternity care**	Extremely important. I believe if I was informed of the risks associated with all the various options of birth, even if I still choice to give birth vaginally and the same things occurred, I would be far more mentally resilient as I chose the risk willingly.
1(f) **barriers** to the provision of **"continuity of care" in maternity care**	Care providers do not talk to each other. The obstetrician, midwives, women's physiotherapists, and psychologists, all seem to be offering conflicting advice. Or, in some instances, tell you they knew of risks but did not inform you as it's not 'their job'. Once the baby is out, care for the woman is passed onto the physiotherapists and psychologists to maintain and repair. However, obstetricians or midwives don't seem to consider the long-term consequences. I am very thankful I had personal savings available to me for my postpartum care, as the expenditure is extraordinary, even with government mental health care plans (used maximum amount and also the COVID care

	plans when they were available). I have private health care, but the gap cover is so minor it doesn't have much of an impact in the long term.
1(g) the **information available to patients** regarding **maternity care options** prior to and during their care	Most information I found was resources and purchased on my own. There was no 'standard' monitoring of the material being produced, and many midwives or other providers make their 'birth plans' based on their own experiences. The ones that I purchased and researched only focused on two methods: vaginal and emergency caesarean. None of them focused on what could go wrong during a vaginal birth, or what could go wrong during an emergency caesarean. During my care, I found that a lot of information was withheld from me. I found out the meaning of the extent of my injuries through YouTube. This was extremely difficult to process on my own without a support person.
1(h) whether **current legal and regulatory settings** are **sufficient to protect** women from experiencing birth trauma	Fathers of non-birthing parents experience birth trauma. My husband watched with our newborn in his arms as I was moved to resuscitation. He had to sign safety wavers so I could receive blood transfusions whilst I bled to death. He has to navigate looking after a newborn on his own for the first 2 nights, in shock at what our future will look like. He had to become my full-time carer for the first 4-6 weeks until he was required to return to work when I couldn't even walk. The trauma, fear and guilt he experienced is ongoing today.
1(i) any **legislative, policy or other reforms** likely to prevent birth trauma	Education. A 'health care advocate' to advocates for your personal health. That speaks and brings together all health care providers to ensure everyone is aware of the past, present and future circumstances and is managed on a personal level.
1(j) any other related matter.	

Thank you for holding this inquiry. I look forward to seeing the outcome and hopefully a substantial improvement in reducing birth trauma in NSW and beyond.

Sincerely,