Submission No 234

INQUIRY INTO BIRTH TRAUMA

Organisation: Australian Lawyers Alliance

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Lawyers for the People

AUSTRALIAN LAWYERS ALLIANCE

Birth trauma

Submission to the Select Committee on Birth Trauma, Legislative Council, Parliament of NSW

10 August 2023

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Protecting and promoting justice, freedom and the rights of the individual.

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Who we are

The Australian Lawyers Alliance (ALA) is a national association of lawyers, academics and other professionals dedicated to protecting and promoting justice, freedom and the rights of the individual.

We estimate that our 1,500 members represent up to 200,000 people each year in Australia. We promote access to justice and equality before the law for all individuals regardless of their wealth, position, gender, age, race or religious belief.

The ALA is represented in every state and territory in Australia. More information about us is available on our website.[1]

The ALA office is located on the land of the Gadigal people of the Eora Nation.

[1] www.lawyersalliance.com.au.

Introduction

1. The ALA welcomes the opportunity to have input into the Select Committee on Birth Trauma's inquiry on birth trauma.

2. Studies suggest that birth trauma, defined as "a woman's experience of interactions and/or events related to childbirth that cause overwhelming distressing emotions and reactions, leading to short and/or long-term negative impacts on a woman's health and wellbeing",[2] is experienced by up to fifty per cent of women who give birth.[3]

3. Birth trauma is often associated with obstetric violence, which has been "recognised by the United Nations as a form of gendered violence".[4]

4. ALA members report being approached by and representing clients experiencing the effects of birth trauma – including across New South Wales – throughout the year, every year, in increasing numbers.

5. In the following submission, the ALA will address:

    a. the prevalence of birth trauma and its impacts, including nine de-identified case studies of clients represented by ALA members in New South Wales;

    b. the underlying causes and factors contributing to birth trauma; and

    c. the ALA's recommendations for reform to ensure that trauma-informed and culturally-appropriate care is provided for women giving birth and for their support networks across New South Wales.

[2] Julia Leinweber PhD, RM, Yvonne Fontein-Kuipers PhD, RM, Gill Thomson PhD, Sigfridur Inga Karlsdottir PhD, RM, RN, Christina Nilsson PhD, RM, RN, Anette Ekström-Bergström PhD, RN, RM, Ibone Olza PhD, MD, Eleni Hadjigeorgiou PhD, Claire Stramrood PhD, MD, 'Developing a woman-centered, inclusive definition of traumatic childbirth experiences: A discussion paper' (2022) 49 *Birth* 687, 687 <https://onlinelibrary.wiley.com/doi/full/10.1111/birt.12634>.

[3] Ibid 688.

[4] Wendy Tuohy, 'Dehumanised and violated: Women tell of 'obstetric violence' during childbirth', *The Sydney Morning Herald* (online, 6 December 2022) <https://www.smh.com.au/national/dehumanised-and-violated-women-tell-of-obstetric-violence-during-childbirth-20221202-p5c37o.html>.

The prevalence of birth trauma and its impacts

6. The ALA submits that, since women can feel so vulnerable when giving birth, they need to be able to have trust in medical providers and rely on those professionals to inform and advise them in the lead up to and while giving birth.

7. However, the clients of ALA members have found that medical providers in New South Wales have ignored them and/or actively dismissed their concerns or requests. When that trust between a woman in labour and her medical providers is broken, and when women giving birth are left feeling powerless and without agency, there can be – and there are – truly devastating consequences.

8. Breaches of the duty of care in birth cases can result in significant injury to women giving birth: physical trauma, psychological trauma, or (in many cases) a combination of both. The Australasian Birth Trauma Association provides the following examples of those physical and psychological injuries:[5]

> Physical trauma can present as:
>
> - Perineal tears
> - Bladder damage
> - Pelvic floor muscle damage
> - Pelvic organ prolapse (POP)
> - Infected stitches
> - Incontinence/leaking of wee or poo
> - Pelvic fractures (public bone, coccyx, sacrum)
> - Caesarean wounds
> - Pudendal neuralgia (nerve pain/damage)
> - Wound dehiscence (wound breakdown/separation)
> - Hysterectomy (removal of womb/uterus)
> - Postpartum haemorrhage (PPH/secondary PPH)
> - Other injuries that may not have been categorised here
>
> Psychological trauma may present as:
>
> - Postpartum post-traumatic stress disorder (PTSD)
> - Postnatal depression and/or anxiety (PNDA)
> - Obsessive Compulsive Disorder (OCD) (For example, obsessive thoughts that can affect our behaviour, such as checking on baby constantly or recurring thoughts that impact your enjoyment of daily life).

[5] Australasian Birth Trauma Association, *What is birth trauma?* (Web Page, 2022) <https://birthtrauma.org.au/what-is-birth-trauma>.

9. The ALA refers the Select Committee on Birth Trauma to the Centre for Epidemiology and Evidence's report from June 2023,[6] which details the prevalence of and statistics for many of the above physical injuries.

10. ALA members also seek to emphasise that physical trauma is usually the result of an instrumental birth, which can lead to lifelong, embarrassing and restrictive outcomes for women, such as incontinence. This is addressed further in the next section of this submission.

11. The ALA notes that trauma related to the birthing process can also be experienced by partners, family members and friends of women in labour. Further, babies can die during traumatic births or can experience injuries as a result of a traumatic birth, including but not limited to:

    a. Physical injuries (broken limbs and fractures);

    b. Hypoxic brain injuries resulting in Cerebral Palsy and/or intellectual impairment;

    c. Brachial Plexus injuries;

    d. Subdural and cerebral haemorrhage;

    e. Facial and peripheral nerve injuries; and

    f. Spinal cord injuries.

12. Finally, the ALA also notes the economic impacts of birth trauma on women and their families. ALA members report that women injured while giving birth have great difficulty in returning to work and/or education, yet incur increased expenses related to those injuries – including medication and ongoing treatments. Partners, family members and friends also need to forgo work and education to provide much-needed care for women injured while giving birth, as well as their babies (who may also be injured and require additional care). There are broader economic impacts on government systems and services, including Medicare, Centrelink and the National Disability Insurance Scheme.

[6] See: Centre for Epidemiology and Evidence, NSW Ministry of Health, *NSW Mothers and Babies 2021* (Report, June 2023) <https://www.health.nsw.gov.au/hsnsw/Pages/mothers-and-babies-reports.aspx>.

Case studies

13. The ALA notes countless cases of birth trauma covered in the media and detailed during inquests.[7]

14. The following de-identified case studies have been provided by ALA members, with permission from their clients, for the purposes of consideration by the Select Committee on Birth Trauma.

15. The first case study was written by a client experiencing the effects of birth trauma, long after giving birth. The other case studies are summaries developed by ALA members based on their clients' experiences of birth trauma. Any names used are not the clients' real names, and other identifying features have been excluded where necessary.

Case study A

Joanne's Account

My antenatal care lacked continuity and I saw a series of different midwives. The information given to me was quite general and I was not told about what to expect while I was in labour. I didn't know what questions to ask as it was my first baby. On one occasion the midwife told me to go into a bathroom to give urine sample. In the process, the midwife picked up a container of urine from a previous patient and spilt the other person's urine on me.

I now know that I should have had a birth plan. There was no plan before I went into labour. As a result, my delivery was chaotic and I was left unsupported and I and my baby were put at risk.

[7] See, egs, Olivia Willis and Kathleen Calderwood, 'Birth trauma's debilitating impacts on physical and mental health revealed in Australian survey', *ABC News* (online, 22 July 2022) <https://www.abc.net.au/news/health/2022-07-22/birth-trauma-survey-major-impacts-women-mothers-health/101252586>; Sally Sara, 'Pregnant mothers in rural Australian town fear giving birth roadside due to midwife shortages', *ABC News* (online, 11 July 2022) <https://www.abc.net.au/news/2022-07-11/deniliquin-midwife-shortage/101226542>; Deputy State Coroner HCB Dillon, State Coroner's Court of New South Wales, *Inquest into the death of Elsie Coghill* (Findings, 11 March 2016); Magistrate Harriet Grahame, Deputy State Coroner, State Coroner's Court of New South Wales, *Inquest into the death of Michaela Perrin* (Findings ,27 February 2018); Magistrate Derek Lee, Deputy State Coroner, State Coroner's Court of New South Wales, *Inquest into the death of Jaxon McGrorey-Smith* (Findings, 14 November 2018); Gemma Sapwell, Bruce MacKenzie and Miranda Saunders, 'Michaela Perrin: Coroner finds mother received 'grossly inadequate care'', *ABC News* (online, 27 February 2018) <https://www.abc.net.au/news/2018-02-27/michaela-perrin-coroner-findings-say-inadequate-care-given/9489790>.

5 January

At around 9pm my husband Andrew came with me when I presented for a check-up at the hospital with the midwives. They confirmed I had commenced the labour process and gave me a sleeping tablet and pain medication. I was advised to go home and get some rest and to proceed to the hospital when the contractions got closer. Midwifes at hospital rang hospital and I was advised of this by the midwife at .

My contractions started approximately between 11.30- 12 midnight, and were around 30 minutes apart. They gradually became 20 minutes, then 15, then 10, and then 5. By 5am they were only a few minutes apart.

6 January

At around 5am my contractions were only a few minutes apart. We rang the maternity ward to let them know when my contractions started, and how far apart they were and that we were heading to as instructed. phoned ahead to alert so say that we were on our way and would be there in 20-30 minutes.

We presented at hospital at approximately 5.30am and found the maternity ward. We waited to speak to someone, however we could only find the cleaner who advised us there were chairs in the maternity waiting room we could sit on. She said that she would notify someone to let them know that we were there.

We waited unattended in the waiting room for over an hour, then we found an empty room to utilise with a bathroom and bed, as the waiting room was not comfortable, nor private, as there were other people waiting in there.

After several hours of waiting, and numerous attempts by Andrew to search for someone, a nurse/midwife came to see us and advised that both birthing suites were in use and that she would let us know when one was available.

The midwife returned to check how dilated I was and advised I could use the shower if needed. We were left unattended once more. No one checked the baby's position, and no one put a cardiotocograph (electronic fetal monitor) around my belly to monitor the baby's

heart rate and my contractions.

We were told we were able to move into the birthing suite at approximately 10.30am (about five hours after we arrived). By this stage my contractions were becoming very strong, and I had been in the shower for about one hour to get the warm water on my back to alleviate pain. We moved to the birthing suite and I was offered to go into the bath or shower once more. I tried the bath but I felt too hot and I was in too much pain to sit in the bath. I felt so hot and the outside temperature was around 47 degrees and I couldn't cool down.

After around 12.00 to 1pm we were left unattended again; I was so thirsty to the point that I had to send Andrew out to find someone to get me a bottle of water.

I was offered lunch, which I could not eat as I was in too much pain. Over the next several hours, I struggled through the contractions and the pain, not knowing what to do, without appropriate advice or guidance. I was given gas to assist with the pain and breathing, however this did not provide any pain relief and my back pain was becoming increasingly unbearable.

I had to ask for further pain relief and the midwife went to get clearance to see if I could have morphine. I was given a morphine injection, which reduced the pain slightly for approximately 15-20 minutes.

When the midwife gave me the morphine I was on my hands and knees and I had such serious pain that it could not tolerate being on my back. I later found out that the baby was in the OP position (occipito-posterior) and that I had an obstructed labour. Further intervention and assessment were needed.
I sent Andrew out again to find the midwife to ask for further pain relief, which she denied saying that the morphine should have lasted several hours. By this stage I was in excruciating pain and distress. I had been in labour now for approximately 12 hours and was not coping.

The midwife attempted to show Andrew how massage my lower back, however it was too late for that as it was already too painful and unbearable for the midwife to touch (I can't

remember if this was pre or post morphine). The midwife may have been able to advise a different technique, or position to help ease the pain, if she had correctly assessed the situation/the baby's positioning. The midwife left me and I was feeling increasingly afraid so I asked Andrew to find the midwife as the morphine had given me little relief and the gas was not helping either.

Neither I or my baby were being monitored during this time.

At approximately 2pm, after not being able to have any further pain relief, the midwife performed another dilation check, which she thought to be approximately 8cm (I believe I had not progressed). I was in an extreme amount of back pain and I was in a state where I could hardly move or speak due to the pain. The midwife finally sent for the obstetrician who came in to review me.

When the obstetrician arrived, he flew in action, asking why I didn't already have monitors on the baby or me and insisted that they be put on right away, stating he needed to see what was happening with the baby. He performed an internal examination, and discovered that the baby was posterior, with head twisted and stuck in my cervix, which had swollen as a result and was preventing me from dilating any further. My labour could not have progressed any further without intervention. He was also extremely concerned, as my labour had been ongoing for so long since my waters had broken, and that I hadn't been started on antibiotics (risk of infection?). They hooked all of the equipment up to me/the baby, and started antibiotics through a drip. He proceeded to try and manually rotate the baby and manually dilate my cervix, which were both unsuccessful. He then called for an emergency caesarean, and attempted to phone the anaesthetist to attend as he could not proceed without him.

The attempt at manual rotation took me to a new level of excruciating pain and is the worse pain I have ever experienced. I felt like I was losing consciousness as the pain was so dreadful. I was put on my back when the rotation was being attempted and the pain went across my back and radiating down my legs. It felt like my pelvis was going to split open. I felt like I was ready to give up.

The staff could not contact the anaesthetist over the phone and after several attempts, apparently, they sent the police to his house in an effort to locate him. I could hear someone talking on the phone to other people at hospital asking to try to send their anaesthetist to by helicopter. I overheard the obstetrician say that I was too unstable to be sent to . I could hear all the staff talking in the room and I was extremely anxious as I heard them discussing and panicking over the fact that they couldn't get on to the anaesthetist. I felt extremely helpless and feared for my baby's life and mine.

During this time, I was left lying supine on the bed (worst position for a posterior baby in regards to back pain). I was in so much pain and distress that I began to feel like I was going in and out of consciousness. I heard the beeping of the machines and I thought I was dying. When I later became conscious again, I told Andrew I had believed that I had died. I was terribly scared for my baby's life and mine.

I was told I needed an emergency Caesarean section.

I was prepped and ready for an emergency Caesarean. I was left waiting in the hallway outside the doors of theatre for some time, while staff were still trying to locate an anaesthetist. I remember laying there in the fetal position, still without pain relief, in a state of survival mode.

At approximately 4pm I was taken into the surgical room, and I was seated on the side of the bed while the anaesthetist (who had finally arrived), administered an epidural into my spine. While sitting there, I reported that I felt like I was sitting on the baby's head.

I was laid back down where the obstetrician did another examination to see whether I could in fact have the baby vaginally. He attempted once more to manually rotate and move the baby and manually dilate me which was excruciating. He asked if I would like to try and proceed with a vaginal birth, which I consented to in a stressed state. The obstetrician noted that without the epidural, my body would not physically be able withstand the birthing process as I was already in so much pain and fatigued.

The epidural only gave pain relief to the right side of my body. I told the anesthetist who said there was no time to correct this. I was laid down and put in stirrups. Andrew was told

to hold my left leg in the stirrups. Without Andrew visible at my side, I felt alone and afraid. I didn't know when to push or what to do.

Andrew had been holding my hand and providing me with support (the only support I was getting), but when he had to hold my foot in the stirrup I was left feeling completely alone, un-supported and not knowing what to do. The epidural had also not worked properly the left side of my body was still in excruciating pain. The obstetrician said there was no time to readminister the epidural, and that it may provide just enough relief for my body to go through the birthing process.

I heard the obstetrician saying my baby's heart rate was dropping and there was an emergency.

During the course of my labour, I was not given any directions or help as to how or when to push until the obstetrician told me that the baby's heart rate was dropping and not coming back up and that I had to push as hard as possible as the baby's life depended on getting her out right away. I frantically looked around, to find the midwife on the right-hand side of me. I looked at her to provide me with some guidance. She then (and only then) came to hold my hand and told me when to push. With every part of my being, and the help of an episiotomy and the ventouse, the baby was pulled out and taken straight over to the baby crib for checking- I was not told what was happening or if she was even alive.

The euphoria of giving birth and seeing our baby for the first time was stripped from me, and I was left feeling physically and psychologically drained and emotionless.

On 7 January 2018, in the morning, the obstetrician returned to check on the baby and me. He apologised and said that yesterday's incidents were a disgrace, and that he can generally handle any situation, however he cannot do anything without an anaesthetist present, which he admitted had him extremely concerned.

I was transferred to Hospital and Andrew drove me and our baby, Charlotte, to , where we stayed for a couple of days before going home.

Problems since delivery

At the time of delivery, I was given an episiotomy. It was done in a rush. At about two weeks after the delivery, I still felt pain and a gaping hole somewhere between my vagina and anus and could feel a stitch coming out. I saw my GP, who said that over time it would heal up.

I went back to see my GP at around six-seven weeks after the delivery and he told me the hole would not heal over and that if could actually rip open if I had sexual intercourse. He said I needed surgery to fix the problem. At the time I was still having pain with bowel movements and was using Movicol to avoid any straining when I had a bowel movement. I was having intermittent bleeding from my anus. I was very worried about possibly tearing myself.

The hospital experience has left me with PTSD. I did not previously have these feelings and responses.

I don't trust people with baby Charlotte and repetitively check things such as her sleep monitor. I get anxious feelings as though my chest closes up and I can't breathe properly. I feel stressed if we travel past hospital.

I used to be a really good multi-tasker, now if I'm actively doing something or thinking about something and get asked a question, I can't find the words e.g. I will answer with "the thing in the thingy". This is stressful, and I become very overwhelmed if there are several things happening at once.

Sometimes I build up with so much tension in my neck and shoulders that I can't relax in bed, I feel like my shoulders and head can't rest into the pillow.

I can't handle noisy environments anymore, I want to run and just want to get out, especially if I'm trying to concentrate e.g., trying to listen to conversation if someone speaks with the TV loudly in the background.

I am extremely sensitive to people's tone of voice or body language; I am very jumpy and scare very easily. I overanalyse what people say/how they say it, and often stress and worry

about it.

I still get very overwhelmed in crowds or with a lot of noise and sometimes I get anxiety symptoms like cold extremities, goosebumps and shaking or diarrhea before I realise that I'm really anxious about something. I am still very tense in my neck and shoulders and get tension headaches.

From July

My GP referred me to an obstetrician/gynaecologist (O&G), who I saw on 13 July 2018. I told her that I was still having pain at the episiotomy scar, that this was slowly improving but that I was worried about tearing if I had intercourse. My O&G told me that I had also had a second or third-degree perineal tear. I have a button hole defect in my perineum below my vagina and that it should be repaired at the time of a future delivery.

I have discussed with my O&G about future pregnancies. After my traumatic experience I am very worried about a pregnancy. It is possible that I will need to have a Caesarean section. Andrew and I would like the chance to have two more babies when I feel able to.

My O&G referred me to a psychiatrist and psychologist. The psychiatrist has prescribed me fluoxetine and quetiapine which has helped steady my PTSD. The dose of the medications was increased in the latter part of 2021, which has helped me.

We tried for a pregnancy in early 2021, but at the point of me stopping contraception and trying, I became very distressed and anxious. My PTSD became much worse and could not go ahead with trying to fall pregnant.

I have had intermittent bleeding from my anus. Occasionally I see bright red blood in the toilet. I have been told following a colonoscopy that since the delivery that I have developed haemorrhoids and have a skin tag left over from being poorly sutured, which is prone to occasional bleeding.

I still have problems with bowel movements which are painful. This can cause bleeding. The bleeding can sometime happen when I'm passing urine.

I can still feel the location of the scar and the hole. It is not as painful as it used to be, but I can still feel it.

I experience pain in my groin area which causes me sharp pain if I cough or sneeze. My O&G and my physiotherapist said this was due to ligaments being stretched at the time of my labour. The pain gets worse when I am pre-menstrual. I have been advised to do pelvic floor exercise to help this.

In 2022 friends' lost their baby due to still birth. This brought back very distressing memories where I thought I and my baby nearly died. It brought back a surge of nightmares and flashbacks of my time in hospital.

Case study B

A 24-year-old woman from regional NSW sustained severe physical and psychological injuries during the traumatic birth of her second child. Our client's injuries were so severe that the case had to be heard in the Supreme Court.

Our client was admitted to a regional hospital at 39 weeks gestation in active labour. The doctor who assessed her on admission formed the view the baby was in the cephalic position. The doctor ruptured our client's membranes and prescribed a Syntocinon infusion to augment labour.

Our client was not reviewed for 4 hours. A vaginal examination after 4 hours revealed our client to be 9 centimetres dilated and the baby to be in the breech position.

A Resident Medical Officer was notified, and a decision was made to perform an emergency caesarean section. However, upon re-examination our client was found to be fully dilated and it was too late to perform a caesarean section – our client was not informed of this.

She was rushed to theatre and assisted into the extended lithotomy position which caused immediate and substantial pain and discomfort the patient's right hip and leg. An episiotomy was performed. The episiotomy caused horrific pain. The attending doctor yelled several times at our client to 'shut up and stop screaming.' Notwithstanding the

episiotomy, our client suffered multiple and significant perineal tears requiring repair of the birth injuries she sustained.

Our client was diagnosed with PTSD caused by the traumatic birthing experience, and later found to have suffered major injuries to her right hip including a labral tear and trochanteric bursitis.

Case study C

A 34-year-old woman suffered significant birth trauma injuries during the delivery of her second baby. Our client had had a very difficult delivery with her first pregnancy and had been advised that any future babies should be delivered by caesarean section.

During the antenatal period in our client's second pregnancy, a c-section was scheduled. However, our client went into early labour and presented to her nearest hospital. She informed the treating obstetrician and midwives there that an elective c-section had been planned. The obstetric staff noted this arrangement however, our client was in active labour for six hours before being taken to theatre and the baby was delivered by forceps. The case was complicated because a junior obstetric registrar with minimal instrumental experience delivered the baby using forceps. Part of the evidence in this case was that junior obstetric registrar needed to be guided through the procedure.

In addition to the lack of experience of the junior obstetric registrar, there were several issues that were central to the case in negligence which were argued to have led to our client's birth injuries:

- the c-section had not been performed in a reasonable time and had a c-section been affected in a timely way, the injuries our client suffered would not have occurred;
- consent had not been obtained to perform a forceps delivery – it wasn't discussed with our client, nor were the potential risks involved and she was not given the option to consent or not to the procedure; and
- the forceps delivery was performed in a technically incompetent manner and there was inadequate supervision of the junior obstetric registrar.

Our client suffered extensive injuries during the birth which included a vaginal tear, perineal tear, lateral vaginal tear, labial tear, sphincter tear, levator ani muscle avulsion.

Case study D

Following the rapid delivery of her baby, a young, healthy, Aboriginal woman was diagnosed by a midwife with a second-degree tear. Several hours later, an obstetrics and gynaecology registrar diagnosed a fourth-degree tear. As our client had eaten, the tear was not repaired under general anaesthetic but in the birthing suite under local anaesthetic.

Our client was discharged from the hospital and not had a bowel movement and was not given a starter pack of antibiotics. The hospital expected that the service would follow up with our client but did not notify of our client's tear. During the second visit by our client revealed she had experienced a fourth-degree tear. Accordingly, she was started on antibiotics but unfortunately one week later than she should have started taking them.

The original repair of the tear was found to be deficient, and the surgical wound broke down. Our client developed a rectovaginal fistula and underwent a further four procedures to repair the tear, including two by a colorectal surgeon. Our client had a colostomy created which was later reversed.

We argued that the hospital failed in its duty of care in several ways:

1. That if the repair had been done with the proper technique by an experienced surgeon in an operating theatre – and if our client had been properly treated with antibiotics and constipation medication – the rectovaginal fistula would probably have been avoided.

2. With respect to the colostomy, our expert said that without it our client's injuries (in particular the fistula) would be an ongoing problem.

Our client has ongoing chronic and at times debilitating pain which affects her energy levels and motivation. She was reluctant to take pain relief medication for fear of becoming constipated, which was a trigger and reminder of the original trauma. She was unable to be intimate with her partner for two years.

Case study E

We acted for a client who was aware of pain during her third c- section despite the administration of a spinal anaesthetic.

The anaesthetist administered spinal anaesthetic and then tested its efficacy using pinpricks and ice. When asked, our client informed the anaesthetist that she still had sensation from her navel upwards. The anaesthetist told our client that he would allow "a little more time" for the anaesthetic to work.

After about three to five minutes, the anaesthetist advised the obstetrician that it was safe to proceed with the delivery. He had not first retested our client again to ensure that the anaesthesia had taken effect.

Whilst not feeling the initial incision, our client felt everything that was subsequently done. Our client described being able to feel the obstetrician's hands inside her uterus, she experienced excruciating pain.

The c-section lasted 46 minutes.

Our client developed post-traumatic stress disorder and a major depressive disorder as a result of her experience.

Case study F

Rachel developed gestational diabetes in her pregnancy with her first child. Her antenatal care was at a public hospital. Gestational diabetes can cause the fetus to become larger and as a result more difficult to birth. Rachel was not informed about her increased risks of shoulder dystocia which could result in a stuck baby and mean that forceps would be required. She was not warned about the injuries associated with forceps. She enquired about an elective caesarean, but she was reassured by the midwives that she was capable of giving birth vaginally.

The fetus did become stuck as a result of the shoulder dystocia. Forceps were required to get him out. Rachel suffered a 4th degree tear. This meant that her anal sphincter muscle was damaged. She required surgery and a stoma. She also developed psychiatric sequelae. She suffers from ongoing pain, faecal incontinence and psychiatric sequelae.

These problems could have been avoided had an elective caesarean been offered to her.

Case study G

Claire was a fit young woman who was pregnant with her first child. Her labour commenced at home and accelerated very quickly. She attended her public hospital's maternity ward as she had planned.

Not long after her arrival Claire started to feel the urge to push. A CTG demonstrated some decelerations of the fetal heartbeat. These were normal decelerations associated with pushing and the later stages of labour. Claire was told she needed forceps. She did not consent. She understood that she needed them due to the fetal heart beat decelerations, so she agreed.

Claire found the forceps to be horrifically painful and she was traumatised by the birth. She has suffered nerve damage and psychiatric sequelae. We understand that she did not need the forceps as the baby was coming regardless and could easily have been pushed out without the need for instruments.

Case study H

Dani was aged 37 at the time her antenatal care and labour were managed at a Hospital in . During her antenatal care, Dani was diagnosed with gestational diabetes, and her baby was very large with estimated foetal weight in the 97th percentile. In the weeks leading up to the baby's due date, Dani indicated to those managing her antenatal that she was worried about the size of the baby and shoulder dystocia. Multiple times, Dani requested a caesarean section to deliver her baby. Dani's request was refused.

Having had her requests for caesarean section denied, Dani was induced to undergo a vaginal delivery at 39+2 weeks gestation, given the size of her baby. She was examined multiple times during her labour by the Hospital's Obstetrician and Gynaecologist medical officer. Dani had been in active second stage of labour for almost an hour and the baby's head was not yet in view. CTG monitoring showed there were foetal heart decelerations with each contraction that were becoming slower to recover and the medical officer discussed the need to assist the delivery.

The medical officer discussed an instrumental delivery with Dani, who firmly indicated she did not want an instrumental because she was aware of the risks of pelvic floor damage and damage to the baby. She requested a caesarean section. Dani's request was again refused.

The medical officer told Dani:

(a) normal vaginal delivery was the most desirable option;
(b) vacuum delivery was not advisable due to the foetus's high presenting part;
(c) vacuum delivery could increase the risk of subgaleal haemorrhage;
(d) forceps delivery was the most appropriate option;
(e) lower segment caesarean section had a much higher risk of foetal skull injury; and
(f) lower segment caesarean section had an increased risk of postpartum haemorrhage due to her prolonged labour.

Dani again requested a caesarean section which the medical officer strongly advised against, and that medical officer strongly urged Dani to undergo an instrumental delivery. Dani was reassessed every 30 minutes and continued to have her request for caesarean section refused and Dani felt pressured to consent to forceps. She eventually felt compelled to consent to forceps delivery after being told that other birthing options, including ventouse and caesarean section, carried high risks for her baby.

Dani's baby was delivered by Neville Barnes forceps. No episiotomy was performed before or during this procedure, and Dani suffered a perineal tear as a result of the forceps delivery. The perineal tear was classified as a second-degree tear with the skin torn to the anal verge version. The tear was repaired. Dani's baby was born "floppy" and was admitted to special care nursery. He was later transferred to .

Dani experienced a painful lump in the perineum, constipation, rectal bleeding, haemorrhoids, urinary incontinence, painful sexual intercourse following her birth trauma. She suffered psychological trauma because of her birth experience particularised above.

Dani's medical records clearly show her repeated requests for a caesarean section, but her requests were ignored and/or refused. It appears there was a clear intention from the

Hospital's medical staff to dissuade Dani from a caesarean section in favour of instrumental delivery.

The evidence obtained in Dani's case against the Hospital, from expert Obstetricians, revealed that Dani was provided with misinformation and incorrect advice as to the risks to her and her unborn child with caesarean section and/or vacuum extraction delivery options.

The expert opined that Dani's autonomy in deciding what was in her and her unborn child's best interests was discarded and her requests for caesarean section were not only ignored but she was given misinformation about the risks of methods of delivery, designed to essentially force Dani into consenting to forceps delivery.

The expert opined that Dani ought to have been advised of the significant risk of anal sphincter and levator ani muscle tears, and postpartum haemorrhage with forceps delivery. The expert opined the maternal complications of forceps delivery have been known for decades.

The expert stated:

"There is a risk of extension of the episiotomy and additional vaginal lacerations occurring during application of the blades and during traction, particularly if forceps of unsuitable design are used. Any additional trauma can make suturing more difficult and increased the risk of painful scars and dyspareunia. The cervix is particularly susceptible to damage during rotational deliveries, either during the application of the blades or during the rotation. Lateral lacerations may extend upwards into the lower uterine segment, with rupture of the uterine artery or main branches. Damage anteriorly can involve the bladder, with production of a vesicocervical or vesicovaginal fistula. Associated traumatic haemorrhage may be severe… Retention of urine and urinary tract infections are known complications of forceps delivery… It is well known that even after normal vaginal deliveries obstetric sphincter damage is in excess of 10 percent may reach 40 to 60 percent after forceps delivery. It is certainly well understood that forceps deliveries is the highest risk factor for obstetric anal sphincter injury. The risk of third or fourth degree anal sphincter tear is between 20 and 60 percent…"

The expert evidence further revealed:

(a) Dani was not provided with appropriate advice during antenatal and postpartum care;
(b) Dani was denied the option of an elective caesarean section in circumstances where the likelihood of Dani having a normal vaginal birth without major permanent trauma was well below 30 per cent, due to her age, gestational diabetes and large baby;
(c) In Dani's circumstances, her request for a caesarean section was entirely rational and ought to have been granted;
(d) To deny Dani a caesarean section was irrational and immoral, and a breach of professional standards;
(e) Dani was misinformed about the relative risks of all modes of delivery; and
(f) Dani was incorrectly advised that a caesarean section at full dilatation carries a greater risk for mother or baby than forceps delivery – the expert said this is a gross misrepresentation, and to advise Dani in this way, is a breach of professional standards.

Two experts retained in the Dani's case said there was no conceivable reason why Dani's reasonable request for a caesarean section were not pursued. They opined that had Dani's request been granted and she had undergone a caesarean section, Dani would have avoided her perineal tear and obstetric anal sphincter injury.

Addressing the issue of informed consent, the expert stated: "*It is plain to me that [Dani] was treated as a competent adult. She was not involved in intrapartum decision making in any meaningful sense.*"

The expert noted the requirements of informed consent as contained in the NSW Department of Health's *Consent to Medical and Healthcare Treatment Manual 2020* were comprehensively disregarded in Dani's case.

It was further revealed that Dani's actually had an unrecognised 3a obstetric anal sphincter injury (OASI) that was not diagnosed after her delivery, nor was it repaired. That untreated 3a OASI is the cause of Dani's ongoing anal incontinence.

Case study I

Narelle suffered an undiagnosed sultan 3c obstetric anal sphincter injury caused by instrumental delivery at a Hospital. She continues to suffer uncontrollable faecal and urinary incontinence, psychological injuries. Narelle's partnership broke down and she was unable to return to her work in commercial kitchens as a chef.

Throughout her antenatal care, Narelle was not provided with any information about birth options or potential complications and/or intervention that may be required prior and/or during birth.

After a delay in second stage labour, a medical officer at the hospital told Narelle she needed instrumental delivery. No risk warnings were given and no consent was obtained.

The medical officer first used a cup vacuum extractor – it was applied, dislodged and reapplied six times (which is well above acceptable standards). After vacuum extraction the medical officer then applied forceps (again without obtaining informed consent). The forceps blades did not meet properly and the forceps were removed and reapplied and one pull on the baby's head was performed. A mediolateral episiotomy was performed after the first unsuccessful pull and blood loss was considerable. Narelle's very large baby was delivered on the second pull with forceps. Her episiotomy had extended to a tear, which was diagnosed as a second degree tear (i.e.. that is not involving the anal sphincter) and repaired.

Narelle was discharged and suffered urinary incontinence, urinary leakage and faecal urgency and incontinence. During her second pregnancy, Narelle underwent an endo-anal ultrasound that revealed external and internal anal sphincter tear and a fistula. It was recognised that she had an undiagnosed 3c anal sphincter tear during the first pregnancy.

The expert evidence in Narelle's cases identified multiple breaches of duty of care on the part of the hospital during the first delivery, including:

(a) a failure to advise and warn of the potential risks of vacuum and forceps delivery, including the increased risk of obstetric anal sphincter injury (OASI);
(b) failure to abandon the ventouse extraction after three failed attempts;

(c) failure to convert to caesarean section after the failed ventouse attempts;

(d) performing a forceps delivery when it was unsafe to do so – that is, the foetal head was not 2cm below the ischial spines; and

(e) failure to properly examine and repair the OASI.

The expert engaged by the Hospital asserted that the 2010 NSW Health Policy *Towards Normal Birth in NSW* mandated that caesarean sections, within public maternity units, should be avoided. The expert acknowledged that instrumental delivery significantly increases the risk of maternal trauma however he asserted that the hospital was duty bound to take steps to reduce the caesarean section rate in their institution as mandated by that NSW Health policy document.

It is disturbing that the expert engaged by the defendant hospital asserted that the NSW Health Policy supplants the right of self-determination and autonomy and/or curtails obstetrician intervention to perform caesarean sections, by promoting vaginal deliveries regardless of the risk to material welfare.

The underlying causes and factors contributing to birth trauma

16. This section of the ALA's submission will address the underlying causes and factors contributing to the prevalence of birth trauma in New South Wales, including exacerbating factors.

17. The ALA contends that these causes and factors reflect serious systemic issues, which the ALA submits must be urgently addressed. The ALA will present our recommendations for reform in the final section of this submission.

18. The ALA acknowledges that understaffing and scarce resourcing across New South Wales' health system, including maternity care, greatly underwrites decisions and actions which ultimately lead to birth trauma and the associated injuries. **The ALA urges the Select Committee to recommend the NSW Government addresses these staffing and resourcing shortcomings as a matter of priority in the interests of public safety.**

Lack of communication, informed discussions and education compromising informed consent

19. The ALA submits that a lack of communication between medical professionals and women (during pregnancy, when in labour and after delivery) – and by extension her support networks – is a feature in many birth trauma cases.

20. There appears to even be a reluctance generally to discussing birthing options and the likely risks and complications associated with giving birth, including in relation to the use of instruments or undertaking a caesarean section. This is putting women and their babies at increased risk before, during and after delivery, as well as robbing women of the opportunity to provide proper informed consent.

21. Since *Rogers v Whitaker*,[8] the law in Australia has recognised and protected the individual's autonomy to make informed decisions about what happens to them and their body. The ALA submits that this is particularly important in pregnancy since the baby is being born via a mode or modes of delivery – staying in is not an option. Therefore, proper and informed consent should include a discussion of all reasonable alternative modes of delivery, and the risks and benefits (to the woman giving birth and the baby) associated with each. It is only when presented with the full suite of such options can the woman giving birth's right to make an informed choice be truly respected.

22. The ALA further submits that informed consent must not be considered as a 'one-time event' during labour and, moreover, it is not limited to signing a consent form that is often thrust upon women in a rushed and emergency situation. Pregnant women need to receive adequate information throughout their pregnancies and be involved in decision-making at all stages. That is true and informed consent.

23. As detailed in our recommendations for reform in the next section of this submission, the ALA contends that this process should commence in the antenatal period and continue through the labour and into the post-partum period.

24. Further, good documentation of care and the development of a birth plan are very important, especially when there are breaks in continuity of care (as discussed below).

[8] [1992] HCA 58; (1992) 175 CLR 479.

25. NSW Health has published *Consent to Medical and Healthcare Treatment Manual* ('the Code'),[9] which explains the requirements for obtaining and documenting consent. This codification reiterates and reaffirms widely accepted principles of patient autonomy being the right to decide what happens to their own bodies with respect to consenting, refusing and/or withdrawing consent to medical procedures.

26. Too often ALA members hear from clients that the so-called consent process is performed in an emergency and rushed setting, where the woman is in pain and unable to properly comprehend the options and associated risks being put to her. Women are often guilted to consent to a particular birthing option in order to avoid a caesarean section. The Code mentioned above is often not adhered to.

No continuity of care

27. The ALA contends that there is currently a lack of continuity of care for pregnant women and women giving birth, especially in the public healthcare system in New South Wales.

28. Care is fragmented and women are often seen by different medical professionals at antenatal appointments, even in the immediate leadup to giving birth. Those women are often then assisted by medical professionals they have never met during the birth.

29. There can often be minimal, inconsistent or rushed communication between the various medical professionals caring for pregnant women and women giving birth. This places those women at greater risk of having a traumatic birth. A lack of continuity of care is particularly risky for first-time mothers, who do not have prior experience giving birth.

The use of instruments during delivery

30. In the experience of ALA members' clients, the use of instruments during vaginal deliveries greatly increases the chance of the woman giving birth (and others involved) experiencing

[9] See: NSW Health, NSW Government, *Consent to Medical and Healthcare Treatment Manual* (26 March 2020).

birth trauma. In 2021, 22.9 per cent of women surveyed had an instrument-assisted delivery in New South Wales.[10]

31. Forceps and vacuum extractors during vaginal deliveries are routinely used throughout New South Wales, notwithstanding the risk of injuries. Those injuries include urinary and faecal incontinence, as well as nerve injury that can occur during instrumental delivery.

32. The Australian Institute of Health and Welfare has noted the following about instrumental delivery:[11]

> Both vacuum and forceps assisted delivery are associated with an increased risk of injury to the tissues of the vagina, perineum and anus. This may lead to long-term perineal pain and sexual difficulties; additionally, a very small number may have urinary or faecal incontinence.

33. The literature reports that forceps deliveries are a major cause of levator avulsion injuries leading to a significant risk of symptomatic pelvic organ prolapse and incontinence – specifically, a 40 to 60 per cent increased risk of obstetric anal sphincter injuries (OASIs) and other maternal pelvic floor injuries with forceps delivery.[12]

34. While NSW Health has produced guidelines on achieving "a successful assisted vaginal birth with a single instrument and minimal/no maternal or fetal trauma",[13] the ALA submits that the rate of birth trauma cases arising from the use of instruments speaks to the increased risk of birth trauma posed by the use of these instruments.

[10] Australian Institute of Health and Welfare, *National Core Maternity Indicators* (Web report, 13 July 2023) <https://www.aihw.gov.au/reports/mothers-babies/ncmi-data-visualisations/contents/labour-and-birth-indicators/instrumental-vaginal-birth>.

[11] Ibid.

[12] See, egs, Talia Friedman, *Instrumental Delivery and OASI* (IUGA annual meeting, August 2016); Hans Peter Dietz, Peter D Wilson and Ian Milsom, 'Maternal birth trauma; why should it matter to Urogynaecologist?' (2016) 28(5) *Current Opinion in Obstetrics and Gynecology* 441; Hans Peter Dietz, 'Pelvic floor trauma in childbirth' (2013) 53(3) *Australian and New Zealand Journal of Obstetrics and Gynaecology* 217.

[13] South Eastern Sydney Local Health District, NSW Health, *Assisted Vaginal Birth* (Guidelines, February 2022) 3.

Exacerbating factors and experiences

Regional, rural and remote New South Wales

35. ALA members report that there are increasing numbers of women presenting for legal assistance after experiencing significant problems giving birth in regional, rural and remote areas. Many medical negligence claims arising as a result of maternal birth trauma are against regional and remote Local Health Districts in New South Wales.

36. The issue centres on the care women feel able to access from early in their pregnancy. The Australian Institute of Health and Welfare reports that women living in remote and very remote areas (including in New South Wales) are less likely to have an antenatal visit in their first trimester, not receiving that care until their second or even third trimester.[14]

37. The ALA thus submits that being located in a regional, rural or remote area is currently a barrier to receiving trauma-informed care in New South Wales.

38. This is directly connected to staffing levels, poor staff training and limited resourcing (including available technology and medical equipment), as well as the distance regional, rural and remote residents must travel to receive medical care or specialised medical services.

Aboriginal and Torres Strait Islander peoples

39. The ALA notes that, in general and across Australia, the gap in health status between Aboriginal and Torres Strait Islander peoples and non-indigenous Australians has always been unacceptably wide.

40. Studies and reviews have demonstrated that the needs of Aboriginal and Torres Strait Islander women (including but not limited to those living in regional, rural, and rural areas) during their pregnancies and while giving birth are not being met physically and holistically.[15]

[14] Australian Institute of Health and Welfare, *Australia's mothers and babies* (Web report, 29 June 2023) <https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/antenatal-period/antenatal-care>.

[15] NSW Health, NSW Government, *Continuity of Care Models: A Midwifery Toolkit* (June 2023) 7 <https://www.health.nsw.gov.au/nursing/practice/Publications/midwifery-cont-carer-tk.pdf>.

41. The ALA submits that this is particularly concerning given the pre-existing conditions experienced by Aboriginal and Torres Strait Islander peoples at higher rates than non-Indigenous members of the public means that many Aboriginal and Torres Strait Islander women will have high-risk pregnancies. Examples of those conditions are diabetes, cardiovascular disease, hypertension, and respiratory illnesses.

42. The experience of Aboriginal and Torres Strait Islander clients of ALA members reveals that the system is currently failing Aboriginal and Torres Strait Islander women before, during and after they give birth in New South Wales.

43. The following factors are currently compromising the experience of Aboriginal and Torres Strait Islander peoples in receiving proper and culturally safe care during their pregnancies and while giving birth, which exposes them to birth trauma as a result:

    a. A lack of culturally-appropriate and accessible information about pregnancy, labour and post-partum recovery for Aboriginal and Torres Strait Islander peoples;

    b. Antenatal care for Aboriginal and Torres Strait Islander women "occurs later and less frequently than for non-Indigenous women",[16] which increases the likelihood of those women having pre-term or low birthweight babies;[17]

    c. Unconscious bias and/or complacency with respect to Aboriginal and Torres Strait Islander health outcomes by some medical professionals – for example, Aboriginal and Torres Strait Islander clients report sentiments (either implicit or explicit) from medical professionals that poor health for Aboriginal and Torres Strait Islander peoples is either their own fault or inevitable;

    d. Relatedly, there is a lack of cultural competency among medical professionals – for example, a lack of protocols around 'women's business' and 'men's business', and the need to ensure the appropriate people are assessing, examining or questioning an Aboriginal and Torres Strait Islander patient to ensure that patient feels safe;

[16] Australian Health Ministers' Advisory Council, *Aboriginal and Torres Strait Islander Health Performance Framework* (Report, 2017) 7 <https://www.niaa.gov.au/sites/default/files/publications/2017-health-performance-framework-report_1.pdf>.

[17] Ibid 8.

e. An inherent distrust in government and government services (extending to hospital settings) felt by many Aboriginal and Torres Strait Islander peoples – especially those who have experienced racism directly in healthcare settings;[18] and

f. A lack of Aboriginal and Torres Strait Islander healthcare workers available to better communicate with and support Aboriginal and Torres Strait Islander patients, which is a symptom itself of the high rates of bullying, harassment and discrimination in healthcare settings.[19]

<u>People from culturally and linguistically diverse (CALD) backgrounds</u>

44. ALA members' clients who are from CALD backgrounds report a number of factors which led to their experiences of birth trauma in New South Wales, including:

    a. Language barriers and a lack of available interpreters (if one is even offered at any appointments or during/after labour) with adequate training in medical terminology;

    b. A lack of understanding among many medical professionals of patients' religious and cultural practices – for example, male medical professionals can be sent to undertake a physical, internal examination of a female patient from a CALD background, who would rather only be seen by female medical professionals; and

    c. Unconscious bias and/or complacency with people from CALD backgrounds by some medical professionals.

<u>Young parents</u>

45. While the average age of women giving birth for the first time has been increasing over time, there are still many becoming parents at a young age. In New South Wales, 1,357 of women who gave birth in 2021 were under the age of 20 years.

[18] The National Justice Project provides many examples of this through their profiles and case updates on Aboriginal Health Justice: National Justice Project, *Aboriginal Health Justice* (Web Page. 2023) <https://justice.org.au/category/aboriginal-health-justice>.

[19] Housnia Shams, 'Indigenous doctors call for cultural reform in health sector to address workplace discrimination', *ABC News* <https://www.abc.net.au/news/2022-05-02/indigenous-doctors-workplace-bullying-discrimination-reform/101027964>.

46. The ALA contends that it is imperative that young parents receive respectful, safe and comprehensive care before, during and after labour, since women who are under the age of 20 years and who are giving birth "have an increased risk of complications and adverse pregnancy outcomes".[20]

47. Young parents report that their concerns and wishes are often dismissed by medical professionals due to perceptions and their age and inexperience. This is putting young parents at greater risk of experiencing birth trauma, especially if they are not listened to in the birthing process and/or are not afforded the opportunity to provide informed consent.

Recommendations for reform

48. In addition to our recommendation above regarding rectifying staffing and resourcing issues within New South Wales' health system, the ALA submits the following recommendations for reform for the Select Committee's consideration.

49. We contend the following should be implemented in order to avoid or reduce instances of birth trauma in New South Wales moving forward.

Clear, respectful communication and trauma-informed, culturally-appropriate care

50. The ALA contends that clear, respectful communication along with the provision of trauma-informed, culturally-appropriate care will improve outcomes for women giving birth and their support networks in New South Wales. It will empower women to make informed choices and provide consent based on being informed – not based on being afraid, intimidated or guilt-tripped.

[20] Australian Institute of Health and Welfare, *Australia's mothers and babies* (Web report, 29 June 2023) <https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/demographics-of-mothers-and-babies/maternal-age>; Patricia A. Cavazos-Rehg, Ph.D., Melissa J. Krauss, M.P.H., Edward L. Spitznagel, Ph.D., Kerry Bommarito, M.P.H., Tessa Madden, M.D., Margaret A. Olsen, Ph.D., M.P.H., Harini Subramaniam, M.S., Jeffrey F. Peipert, M.D., Ph.D., and Laura Jean Bierut, M.D., 'Maternal age and risk of labor and delivery complications' (2015) 19(6) *Maternal and Child Health Journal* 1202.

51. Understanding the birthing process from antenatal care to the birthing suite, as well as from labour care and delivery to post-natal care, empowers women and their support networks to make decisions about their birthing experience. This has been found to reduce adverse outcomes like birth trauma.

52. While many women giving birth may not be medically-trained themselves, they certainly know how they are feeling throughout their pregnancy, during labour and in the post-partum period. Those women should be listened to, given time to advocate for themselves, and immediate action taken to address their concerns.

53. **In order to generally improve the safety and cultural safety of pregnant women and women giving birth in New South Wales, the ALA recommends that comprehensive training is provided to medical professionals about birth trauma and about how to engage with a diverse range of patients**.

    a. That includes the provision of training in cultural safety and accessibility, such as in relation to the provision of healthcare to Aboriginal and Torres Strait Islander peoples and any related policies/protocols – which are now compulsory for professional medical bodies to produce for medical professionals across New South Wales under the amended *Health Practitioner Regulation National Law* (NSW).[21]

54. **The ALA recommends that during a woman's pregnancy, the following processes and services should be standard across New South Wales as part of providing trauma-informed care which prioritises informed choice and consent**:

    a. Discussions must be initiated by medical professionals early in the pregnancy about birthing options and any risk factors and possible complications associated with natural, caesarean section and instrumental deliveries, so that women and their support networks can be prepared to make informed decisions if/when complications arise;

    b. Written material – in accessible and culturally-appropriate forms – must also be provided after those verbal discussions, so that women and their support networks can consider such material in between antenatal appointments; and

[21] National Justice Project, *Health practitioners must now deliver culturally safe care* (Web Page, 18 January 2023) <https://justice.org.au/health-practitioners-must-now-deliver-culturally-safe-care>.

c. Ultimately, birth plans should be developed in advance of labour (with the assistance of interpreters and/or Aboriginal and Torres Strait Islander healthcare support services), as birth plans have been found to empower women during their birthing experience.

    i. Birth plans should include a woman's preferences regarding pain relief, instrumental/surgical interventions, and by which medical professionals she is (or is not) comfortable being examined or treated.

55. **The ALA recommends that the following processes and services should be standard for women while giving birth and when post-partum across New South Wales, as well as for their immediate support network, as part of providing trauma-informed care**:

    a. Appropriate debriefing after the birth (including apologies, if relevant);

    b. Regular conversations and check-ins, especially with the woman who has given birth;

    c. Accessible counselling being offered; and

    d. The provision of any physical treatments needed (such as pelvic floor physiotherapy and general physiotherapy).

56. **The ALA contends that the above recommendations will only have impact if they are implemented alongside processes which facilitate continuity of care for women and their support networks before, during and after those women give birth in New South Wales**.

Developing a regional, rural and remote strategy

57. The ALA notes that the NSW Ministry of Health produced a "Blueprint for Action" in relation to maternity care earlier this year, which described a vision that:[22]

> All women in NSW receive respectful, evidence-based and equitable maternity care that improves experiences and health and wellbeing outcomes.

[22] NSW Ministry of Health, NSW Government, *Connecting, listening and responding: A Blueprint for Action – Maternity Care in NSW* (Publication, March 2023) 7.

58. While this blueprint acknowledged that women want improved access to maternity care in areas beyond urban centres,[23] there was no specific plan for how to improve outcomes for women, their babies and their families in regional, rural and remote parts of New South Wales.

59. **The ALA recommends that a clear and detailed strategy must be developed by the NSW Ministry of Health or another government agency/department to improve outcomes specifically for those giving birth in regional, rural and remote areas of New South Wales.**

Adherence to existing and new legislation, regulations and policy guidelines

60. The ALA submits that comprehensive regulations and policy guidelines, some referenced earlier in this submission,[24] have been released to educate and inform medical professionals – and by extension the women and support people under their care.

61. **The ALA recommends that NSW Health provides comprehensive training on regulations and policy guidelines to all medical professionals in New South Wales who interact with women and their support networks at any stage of a woman's pregnancy or delivery**.

62. This would encourage adherence by those medical professionals to those regulations and policy guidelines for safe and trauma-informed deliveries. In turn, those medical professionals would also be better placed to communicate effectively with patients and educate them about risks and potential injuries before, during and after birth.

63. **The ALA also supports exploring ways birth trauma could be directly enshrined in legislation in New South Wales**. An example can be found in New Zealand, where the Royal Australian and New Zealand College of Obstetricians and Gynaecologists supported amendments to New Zealand's Accident Compensation legislation "to enable more women to access the care that they need after experiencing birth injuries".[25]

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[23] Ibid 28.

[24] A further example can be found here: NSW Health, NSW Government*, Continuity of Care Models: A Midwifery Toolkit* (June 2023) 7 <https://www.health.nsw.gov.au/nursing/practice/Publications/midwifery-cont-carer-tk.pdf>.

[25] The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *RANZCOG supports amendments to Accident Compensation in Aotearoa New Zealand* (News, 15 June 2022) <https://ranzcog.edu.au/news/maternal-birth-injury>.

64. **Finally, the ALA also recommends that the following be considered by the Select Committee**:

    a. Ensuring that whistleblower protections and mechanisms are available to medical professionals across New South Wales, so that concerned medical professionals can anonymously report incidents and systemic issues without fear of repercussions; and

    b. Where processes fail and women (or their support networks) experience birth trauma, there must be adequate, independent and responsive complaints processes in place.

Conclusion

65. The Australian Lawyers Alliance (ALA) welcomes the opportunity to have input into this inquiry on birth trauma.

66. The ALA is available to provide further assistance to the Select Committee on Birth Trauma on the issues raised in this submission.

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