Submission No 677

INQUIRY INTO BIRTH TRAUMA

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I gave birth in 2021 during the Covid-19 pandemic after my waters broke before labour at 36 weeks. I was told to present to hospital and was unable to bring a support person aside from my husband due to hospital covid policies at the time.

After presenting to hospital I was told I had to stay and was not allowed to go home and that they would not induce me until I was 37 weeks, so if labour did not begin, I had to remain at hospital and wait. However, they also did not allow labour to begin as whenever I began having contractions, they would insist on my taking endone in order to disrupt the labour and keep it from establishing. I was also prohibited from using a breast pump and birthing ball to aid to the progression of labour, which was my preference that I expressed on multiple occasions.

After nearly two days in hospital, I stopped communicating with nursing and midwife staff about my contractions in order to allow labour to establish without interruption. Once it did, I was unable to be moved to birth unit for several hours because of a lack of available beds and therefore also did not have access to birthing aids or low-risk pain relief such as gas and air, or further pain relief should I have wanted it. I was just continually offered endone, which at this stage I declined.

Once I was finally moved to birth unit, things did improve. I was under the care of a Caseload midwife, but she was unfortunately away on holidays over this period, so I was instead supported by her back up who I had met a few times before. She had come up to see me in the antenatal unit earlier to advise she was unable to give me a timeframe as to when I'd be able to make it to birth unit, but prior to getting there, I was otherwise under the care of ward staff only despite having a Caseload midwife. Due to the fact that I was not yet 37 weeks and therefore considered in premature labour, I was required to have continuous fetal monitoring, which was initially in the form of CTG monitor, but once I received an epidural, I was told I had to have the fetal scalp electrode placed on my baby's head.

A little while later, after a short nap, I woke up and told my midwife I had a lot of pressure and a need to push. She gave me a vaginal examination and said I was about 9cm dilated and she wanted to get the opinion of the doctor before we moved forward. When the doctor arrived, they performed another exam and told me they could maybe just stretch me to 8cm and told me I was not allowed to push.

My midwife encouraged me to do what felt natural so I began pushing with the urge. After a while, there was a full room of people working with me coaching me to push my baby out and then it was identified that she was no longer descending with pushes and the doctor mentioned that we may need to do a ventouse or forceps delivery. I told the doctor that I did not want a forceps delivery and would prefer a caesarean if it came to needing that. She brushed me off and said "we'll see how we go". The team leader midwife who was with me in the room by this stage pointedly asked me "did you say you do not consent to a forceps delivery?" and I nodded and repeated her language to be clear that I was not consenting to

forceps. They placed the ventouse and I overheard the doctors say I heard the doctors discussing that they would only do five pushes with the ventouse and so I felt panicked knowing I only had limited opportunity to get my baby out. After a couple of pushes, they recommended an episiotomy because they had discovered a nuchal hand and want to provide her with more space and limit the risk of tearing. She was born in the next push and she was placed straight to my chest, and rubbed down. My partner was asked if he wanted to cut the cord and was assisted to do so - I don't remember being asked if I was ready for the cord to be cut, despite having expressed a desire for optimal cord clamping in pregnancy. They were concerned about 'foggy head' (apparently a side effect of ventouse delivery) and was taken to the heater for more assessment.

Either the obstetrician or a paediatrician said that she would have to go to NICU. While she was being assessed, I was being stitched up and then my partner was asked to help dress baby. The doctor that had mentioned NICU left the room and my midwife assessed my baby and did not believe that she had foggy head and called up for a NICU opinion. That doctor confirmed she did not have foggy head or need NICU attention.

She was brought back over to me and latched straight away and had a great breastfeed. She was then placed back in the bassinet and was sleeping up until we were moved to the postnatal ward. It was then they asked how many times she'd been fed. I said she'd been sleeping and hadn't since her first feed and the midwives were concerned that she hadn't eaten in six hours. They took her sugar levels, which were low, and given glucogel. I was shown vaguely how to express colostrum, and then kept encouraging me to put her to the breast to feed but were not available to assist with learning that skill. The next morning they sent for a lactation consultant who was quite aggressive with handling my breasts to 'show' me how to feed. I was also told she had an upper lip tie and this was why she was not latching. Prior to this lactation consultant visit, I had felt confident that because my baby had latched so well immediately after birth, that we could make breastfeeding work well, but following this visit, I lost all of this confidence and decided to pump. However, within a couple of days it was clear how unsustainable this was and my milk had not yet matured and I decided to formula feed from there on in.

After we got home from hospital, the day after she was born, the maternal community health nurse rang and did a phone consult with us. They booked in another phone consultation in place of an in-person visit because we were still in covid lockdown and they were reducing in person visits as much as possible. Within a week, I had another phone call from them asking how everything was going and I reported that we were fine, didn't feel like I could go into much over the phone, and then they informed me that given we were well, I'd be taken off the books due to staff being redeployed to covid vaccination hubs. Thankfully, because I was under Caseload, I was also receiving home visits from my Caseload midwife (we had four of these visits across the first two weeks).

After our second night at home, I'd had a midwife visit where she had mentioned slight jaundice that we would keep an eye on. By the third day at home she was beginning to look

very yellow. The next morning, I had called the midwife and asked her to check her because of her colouring. They came and took heel pricks to check her levels and I was encouraged to give her exposure to sunlight while we awaited the results of the tests. Her first test came back high, but not enough to warrant transferring into hospital (although it was borderline). The next test came back borderline as well. By fifth day home, the morning test came back much lower. Throughout this process, we were in constant contact with our caseload midwife about the situation which helped enormously to put my mind at ease, as well as being able to avoid going into hospital to have the testing done.

Throughout all of this early postnatal period, I was struggling with my mental wellbeing, but because of both covid restrictions on having MCHN visits, and that my baby had needed a lot of the attention on her health, I feel that I fell through the cracks and unfortunately went most of my baby's first year of life before I was officially diagnosed with postnatal depression. Looking back, I believe that this was probably already affecting me within a month of her birth. I believe without so many Covid restrictions in place, I would have been diagnosed much earlier.

In summary, I would like the committee to recognise the important role that continuity of midwifery care had in my birth and postnatal experience, while still understanding that even within that model of care, there were multiple areas where I believe I was essentially abandoned.

The worst part of my entire experience was not having the support, both in early labour, but especially in that postnatal stage, that could have helped me feel more confident, in control, and heard. I've also since discovered that my hospital notes have conflicting information about what I did and didn't consent to (for example, the obstetricians notes state that I had consented to a forceps delivery if required which is resolutely untrue).

I don't believe that there is enough protection for women from birth trauma, because we are repeatedly told in pregnancy, labour, and postpartum that we doctors know what is best for us and are rarely giving informed consent for anything.

I believe there needs to be access to mental health supports after birth. Women should not have to pay or sit on a waiting list to access psychology or counselling after birth.

Thank you for your time in reading this submission.