Submission No 1041

INQUIRY INTO BIRTH TRAUMA

Name: Name suppressed

Date Received: 15 August 2023

Birth Trauma Senate Inquiry Submission

14/8/2023

My name is . I am 36 yrs old and live on the of NSW.
I live with my husband (35) and my daughter (7).
I am writing to submit my story to support the Select Committee Inquiry into Birth Trauma.
I am grateful for this inquiry and the opportunity to submit my experience.
I am prepared to share my experience in great detail. I have erred on the side of a lengthy submission in order to describe the impact of microaggressions in perinatal and medical abuse. This large document aims to communicate the impact and accumulation of seemingly small negligent moments.
I will address the following topics in order. All parts have trauma woven into the fabric of their memory or future.

1. Birth Trauma Inquiry Submission Process
2. Long Term Impact
3. Ante-Natal Clinic + Outpatient Care
4. Birthing Unit
5. Operating Theatre
6. Recovery
7. Maternity Unit
8. Recommendations
9. Reflection

Submission Process:

I'd like to note that many more women would make submissions but the current process is prohibitive and inaccessible to diverse or vulnerable people who have experienced PTSD. I am a white, middle class, tertiary educated, disabled woman with an immense amount of privilege and I found the process of writing a submission has caused a significant deterioration of my mental health. I have spent many days in dread and tears. I can only imagine the difficulty for someone who has experienced this trauma more recently or who is a person with less privilege than I have.
This Inquiry has received the number of submissions it has in spite of the process which indicates the gravity and scale of Birth Trauma in NSW.

I'd suggest this Select Committee expands the format and care in the submission process to be more accessible and less disabling. Survivors of obstetric/medical violence often live with distrust and fear of institutions. Requiring us to relive our trauma, by only being able to submit a written submission, requires under-resourced and volunteer based advocacy groups to do the heavy lifting in providing outreach and mental health support.
It is particularly difficult for survivors to build the courage to submit our experiences (again, in some cases) to the public institution that ultimately is responsible for our trauma and abuse. We have often attempted this previously and been dismissed. There are many ways the Select Committee could provide ethical and effective submission options:

- 'In person' consultation events in partnership with support organisations such as Better Births Illawarra, Australiasian Birth Trauma Association, CACD or Disability organisations.
- Funded community organisations to run consultation processes.
- Virtual workshops guided by clinical psychologists to provide safety.
- Hotline with a qualified counsellor.

The current arrangement requires traumatised, vulnerable people to make submissions alone. It also will mean that thousands of women who could make submissions will not do so for fear of being triggered. The Inquiry could be more effective and accessible if it engaged in outreach rather than required women to do the work themselves.

Long Term Impact:

It has been over 7 years since my traumatic birth experience and I am haunted by it daily. I continue to feel deeply unsafe and desperately sad. I live with hollowed grief, rage and paralysis.
Its impact has dramatically altered the course of my life.

- I continue to receive regular counselling sessions from a clinical psychologist for my PTSD recovery. This is an emotional and financial burden that would not have existed. The financial burden over 7 years is approx $30,000 and I expect this to continue.
- My husband and I originally desired a large family with 4 children. I will never have another child. I am physically capable but the obstetric abuse and emotional trauma is too great to surmount. My husband had a vasectomy at 32 in order to eliminate the fear that I could get pregnant again. If I could obtain permanent sterilisation without interacting with the medical system, I would without hesitation.
- I experience flashbacks and feel extremely unsafe in any medical environment. Dentist, GP, Pharmacies, Emergency Department visits, Physiotherapists, Neurologists. My heart races, my hands shake and I can barely speak. My nervous system is in a fear response.
- Additionally, I feel unsafe in any institutional organisation or environment. Any company that could have power over me. I can have flashbacks or find my nervous system goes into a fear/panic response if I am required to speak to an employee in a shopping centre, local school, bank or library.
- I require a support person (usually my husband) to attend appointments in any context.
- My husband works in a hospital and I cannot enter to visit him or see his place of work. In 7 years, I have never entered a hospital unless an extreme situation has required care for another person.
- I have delayed my personal medical care and treatment in order to prevent exposure to these unsafe environments. As a disabled woman, this has come at great cost and the rapid deterioration of my health and wellbeing.
- I'll feel a deep concern that the hospital will come and take my child away from me without my consent. I live with a deep (some might say unfounded but I believe otherwise) fear that authorities will deem me an unfit mother and remove my child from me.
- I do not feel I can use the word ‘birth’ in my experience. I feel I have not earnt this word.
- I continue to feel that I am ‘less of a woman’ because my body failed to do what I was confident it could. I know cognitively that this feeling is a toxic gift given to me by the callous medicalised language and treatment of midwives and medical staff. Nonetheless, it is an embodied emotion I work diligently to dismiss.
- While most strongly experienced during the first 2 years of becoming a mother, I am and can never be fully confident that my daughter is the baby I gave birth to. I love her with a desperate longing and more than my own life and wellbeing. I have laid down my life and body for her. And yet, I was robbed of the evidence our bodies required to attach and rest in the knowledge that she is the body I carried in my body.
- The first 18 months of my daughter’s life, I was barely alive. I participated in the actions of a loving mother. I changed nappies. I breastfed. I rocked her to sleep. And I was a dead inside. A robot. I experienced preventable PTSD, anxiety and post-natal depression. I disassociated and did not attach to my daughter. I felt no connection. I acted in love while also growing my love for her. I had to start from scratch. All this, while being emotionally dysregulated and cognitively catatonic. In an attempt to find hope, I returned to work at 11 weeks postpartum without yet having recovered from my physical wounds.

AnteNatal Care:

In mid 2015, when I first discovered I was pregnant, I was shocked by the lack of communication and guidance provided by NSW Health or the health sector in general. I received no handbook or guidance on what to expect. It was a 'fend for yourself' situation. There was no information session or even a pamphlet to describe the timeline, responsibilities or different options available. There wasn't even any information available regarding changes to expect in my body. Medical staff often mock it but thank goodness for Google DR.

I had heard through a friend that I should try to get into the Midwifery Group Practice program if I wanted to do a homebirth. My friend advised that I really needed to have booked a place before I was pregnant. My GP, local medical centre, Hospital main reception and the AnteNatal Clinic could not provide a phone number. There was no phone number or website online. I eventually received a personal mobile number of a MGP midwife through a friend.

After securing contact, a MGP midwife took my details and allocated me a spot based on my potential 'due date'. She advised she would be in touch later. I received no contact until my 12 week ultrasound (something my GP told me to do after I initiated a GP appointment to seek answers) when I called the MGP to check in. I was advised that because my ultrasound had 'guessed' a different due date, making me due in the last week of March rather than first week of April; I was being kicked out of the program. They stated they had limited capacity and could no longer fit me in. This meant that I could not have a home birth nor continuity of care. I was not advised what my alternate options were.

I initiated another appointment with my GP who told me to choose the 'shared care' option (GP/Hospital).. I was never presented the options and able to make an informed choice, I had no idea which option included 'what' at any point. It was vaguely defined and I never knew details like 'where to go to seek care, what appointments were with who, whether costs were involved, who had what responsibility or authority'. Every time I asked these questions of any medical employee, it appeared they did not know themselves and I was told it would 'sort itself out'.

I discovered 'shared care' meant that I had to attend obstetrician appointments at the antenatal clinic at Hospital. This experience involved arriving and standing in line at the reception desk, while staff ignored you for 15 minutes; then waiting up to 2 hrs in the waiting room. We were never told why we were there, what they were looking for or what the next steps were. We eventually were approached by 'presumably' a midwife who never introduced themselves or their role. Each visit would require the pregnant women to be weighed and measured publically in the waiting room, in front of everyone. Our results were displayed and discussed for everyone to see.

I received 5 minutes with an obstetrician who didn't look at me once except when touching my pregnant belly without first asking for consent. I was told that I was high risk because I was flagged for gestational diabetes (something that defied any evidence and was later proved inaccurate) and despite my questions about high risk for 'what' and any mitigating steps I could take, I was dismissed, ignored and given no answers. It was not that the answers were unsatisfactory. It was a complete lack of reply or attempt to answer. This theme continued through the entire perinatal experience.

Thankfully we were randomly approached by a student midwife who was required to follow 10 pregnancies through the journey. This student midwife became our saving grace in what was an extremely difficult journey. She was able to ask questions of clinicians that they ignored when we had asked. She was able to explain entry level knowledge on process and relationship between wards, clinical practices and procedures. She didn't have all the answers but she filled many gaps. I cannot imagine what it would have been like without her presence. She had no authority, power or experience but she was able to keep a semblance of continuity of care. Because we were partnered with the student midwife, most medical staff left us alone with her and we never saw supervision provided. We were not informed nor consented to being in the sole care of an unqualified clinician.

In my ante-natal appointments, I have various experiences that I believe significantly contributed to poor care and medical negligence:

1. I routinely asked midwives and obstetricians for information and details on birthing experience and pregnancy information. I was told 'not to worry' and laughed at for asking questions. I was regularly told to 'not think' about the process of birth or how it works until a later date.
2. On our first visit to Hospital, we were informed we were required to attend antenatal classes which involved a tour of the hospital. 10 minutes later, we attempted to sign up at the front desk. We were then informed that we were unable to because these classes were fully booked until June 2016; months after our baby would have already been born. We searched for alternative classes, even considered driving 2 hours away to

attend them in another health district. These were also booked out. Eventually, we had to organise and pay for expensive private midwife classes.

3. The GP (while well intended) and no experience in perinatal healthcare. Nonetheless, I was pressured and then scolded for refusing the CVS test. I was pressured to attend specific Imaging centres for ultrasounds. I was not provided information on my rights or responsibilities. I was given no information at all regarding my labour, birth or postpartum.
4. Fortunately, our student midwife arranged a tour of the birthing unit (no workshops or sessions) for us. When we took the tour, a number of midwives were standing around the nurses station. We were introduced and I asked about how sound proof the rooms were in order to play music or not disturb others with my vocal sounds of labour pain. I was laughed at by the midwives and explicitly told that 'women don't need to scream and they should just keep their mouths shut'.
5. In the same conversation, I mentioned that we'd been developing a birth plan. Our understanding was that a birth plan was not a linear plan for our birth to follow. We weren't naive. But a birth plan was rather a statement of priorities and values. A way to communicate to staff our needs, values and ideal hopes for the journey. A midwife responded to my reference of my birth plan by laughing and stating 'oh we just rip them up and put them in the bin' while the rest of her colleagues laughed. This was a common response through the entire antenatal journey. Any mention of a birth plan resulted in verbal dismissal and mockery.
6. At every point, in any scenario, medical staff would never introduce themselves or welcome you into the space. They never sought consent before touching you. They never knocked on the door and waited for an answer. I would be in any position, any state of undress or conversation and staff would enter and leave rooms without any explanation or apology. It was a consistent and flippant attitude towards exposure and consent. I felt like a piece of meat or a number being processed through the system.

Birthing Unit:

I will now share details about my birth experience. My daughter was delivered in Public Hospital on the 30th of March 2016. I went into labour on March 27th and finally finished labouring in an emerging c-section at approx 5pm on Wednesday 30th. I was in active labour for over 60+ hours. My contractions were less than 2-3 minutes apart and lasting under 1 minute from Monday morning. Many of the Birthing and Maternity Unit staff mocked and rejected my knowledge of my own body. Despite uncommon, I was in fact in active labour for this time.

I had a difficult physical delivery experience but I am confident it would not have been traumatic if I had received empowering, empathetic and consent seeking care. I did not expect a perfect birth. I knew it would be difficult and painful. I felt strong and brave beforehand. I felt confident and knew that 'I had what it takes' to go through pain and agony for a beautiful child to be birthed. Little did I know that these feelings of bravery and determination would be stripped away from me for many years to come. I have only recently been able to feel more than a hollow shell of the person I was.

As previously mentioned I laboured for a long time. I laboured at home until I could bear it no longer. After labouring through the night and day, we contacted the birthing unit at 10pm when I was experiencing contractions that were lasting 1 minute and less than 3-4 minutes apart. Hospital Birthing Unit staff informed us that we should come into the hospital. We arrived in the evening and were directed to a consultation room. We brought all our equipment with us as Hospital did not provide any resources or equipment for labouring. This included gym ball, music, food, clothes, nappies, soap, yoga mat and more. .

We provided our printed birth plan to staff where it was swiftly removed from the room. Our plan requested consent to be sought prior to physical engagement, the staff did not follow this. They also performed a 'stretch and sweep' on me without seeking even consultation. Staff entered the room without knocking (despite our request) while I was exposed, undressed and a staff member had her fingers in my vagina. Staff never introduced themselves, their intentions nor their clinical position.

I was advised that despite my contractions, I was not progressing and not dilated 'as much as they would like' at 5cm. I was informed I should return home and have some panadol. They stated I was clearly not in enough pain to be in 'actual labour' as I could talk through my pain. I explained that I am a disabled woman with severe and fluctuating pain so talking/breathing through pain was well within my capacity but this was very much labour and not Braxton Hicks

contractions. My husband and I stated that paracetamol as a pain relief strategy did not work for my body due to my disability. I was patronised, ignored and the staff left the room. We were left to pack up and return home.

After an additional 24 hours of labouring at home, my contractions continuously arrived hard and fast, lasting less than a minute and under 1-2 minutes apart since returning from the hospital. I had not slept, eaten and was extremely fatigued. I was in excruciating pain. We called a midwife who we had privately paid for education workshops.. She shared that she thought we should go to the hospital because we were experiencing active labour, with clear signs of contractions in active labour and over 5cm dilated. She was concerned about how long I had been active labouring and felt I needed support.
At this stage I had laboured with continual contractions for 48+ hours without reprieve or sustenance.

We called the Hospital Birthing Unit that evening and they agreed that we could return to the hospital. We were told that they were busy and didn't have much support for us. When we arrived the exact same situation occurred as the evening before. I received a 'stretch and sweep' without consent being sought nor check in about preference. We provided a printed birth plan which disappeared instantly. I was exhausted and devastated when the staff informed me my dilation was 'not good enough' at 6 and ½ cm.
I was in agony and they informed me that I 'could not possibly be' if I was able to breathe, speak or check my phone. They refused to listen when we attempted to explain my chronic pain management strategies and my disabilities.

The midwives or nurses instructed me to return home again with panadol. This time, my husband and I expressed our distress as we would be labouring with no break from contractions for over 48 hours. Up until this point no one believed our description, or knowledge of my body. We understood that these clinicians had more experience than we did but didn't understand why we were treated as idiots. Their tone, attitude and actions communicated to us that we were foolish, ignorant and an inconvenience. They openly sighed in intolerance in our faces and rolled their eyes at my questions.

After my husband pushed the point about my state of exhaustion and pain, we were informed that they were very busy and had no rooms currently available. We were left alone without instruction. We felt uncertain, abandoned and confused.

After 20 minutes, a new midwife arrived. She was one glimmer of hope for us during the process… until the end of her shift. She stated that she had read our birth plan, she understood what we wanted, she acknowledged that I was fatigued and was worried for my well being. She felt confident we should stay in the hospital and she would help us have our baby by the morning. It was approx. midnight Tuesday 29th.

We felt we had been listened to and it was a moment of hope for us. We were so thankful to be taken seriously that we didn't realise we received no information on what would be involved in this next stage. I was directed to a room in the Birthing Unit. There was paint peeling off the walls. It was an empty blue room with a clock in front of the bed. We closed the door and I laboured at the same rate for the next 6 hours using the shower and no pain medication. I barely saw any staff for this period of time, except when they entered unannounced to get something they wanted from the room.

After 6 hours, the 'one midwife who listened' returned and told us that she was concerned about the length of time that I was 'failing to progress', that she was worried the baby would be exhausted and unable to birth successfully. Additionally, as she would be finishing her shift soon, if we wanted to continue with her present I needed to have an induction.
I reflect now that I would have not agreed to this if I had been listened to in the first 24hrs of labouring. But we were told that our baby's wellbeing was at risk if we waited any longer than this midwife's shift lasted.
It was, in hindsight, a coercion for the sake of convenience.

While I provided verbal agreement in a haze of exhaustion and anxiety, I did not provide informed consent to all procedures performed on me from this point onwards. The medical staff induced labour by artificially breaking my waters. I was provided no information on what was involved in this procedure, nor the consequences or cascade of interventions that would follow.
Multiple people entered my room without introduction and stared openly into my vagina while this procedure was being performed. This occurred at every stage, whenever I was receiving treatment.

I was informed by hearing a midwife's exasperated sigh, 'Oh. That's a shame', that my waters were meconium stained. I was given no information about what that meant except I was told that because my waters were stained with poo ('was it mine?') I lost all access to the birth I wanted and instead my baby was in danger. I now know this is not evidence based.

We were reminded that the clock was ticking and pressured into receiving a further induction of oxytocin before the impending shift change. I was provided oxytocin with no information about long term impact or further cascade of interventions. I received no support or guidance on how it functioned in my body. Nor the impact on the baby except that from now on I was required to stay laid down on the bed. We asked if there were any alternatives to the oxytocin and were led to believe that any alternative choices would lead to the baby's death.
Oxytocin escalates the pain, frequency and severity of contractions so I was told I had to have an epidural with it. I waited over an hour for the anaesthetist to arrive and deliver the epidural. My birth plan stated that I wanted to choose alternatives to any form of induction or epidural but with every choice we were gaslighted into thinking that it was a certainty that we would cause the death of our baby if we chose otherwise. Every time we asked questions such as 'What happens if we don't? How long could we continue without it? Is there another way?' the medical staff and midwives would openly show their irritation and disdain for risking our babies life or wasting their time.

Early Wednesday 30th March, I laboured with oxytocin but the epidural never worked. Throughout this period I felt my body's urge to push but whenever expressed to staff, I was dismissed and told that I was wrong. In my fatigued state, I was in greater pain than imaginable but I was also paralysed and unable to escape. I cried and pleaded with staff that I could feel the contractions throughout my body despite not being able to move it. I was again ignored and this issue was not addressed for hours. Eventually after my husband intervened, the anaesthetist returned and performed another epidural as we discovered I had in fact been experiencing the full effects of labour on oxytocin I required 3 rounds of epidurals and was never informed of the long term impact on my spine nor the risks involved. I still feel the epidural site and experience burning pain.
I had no idea that administering oxytocin in the active stage of labour significantly increased the risk of fetal distress and neonatal morbidity. I had no idea I was on the track to receive an emergency c-section. Despite this, I was attached to an ECG to monitor my baby's heartbeat.

Simultaneously, between approximately 5am - 2pm Wed 30th, medical staff would enter the room every 30 minutes and check the ECG. Each alternating time for 9 hours, an unknown staff member would read the ECG results and share 'Oh no. Your baby is not okay. They are very distressed'. They'd run to find another staff member and whisper over results just out of hearing distance, shaking their heads with extremely worried expressions. They would disappear and I never received an update. 30 minutes later, another midwife would arrive to look at the ECG results. We would ask anxiously for an update and the staff member would respond exasperated and annoyed, 'Nothing is wrong. Your baby is absolutely healthy. Stop worrying'. This repeated ongoing and alternating over 18 times. I cannot describe the emotional rollercoaster and traumatising consequence of this thoughtlessly executed experience. It was literal torture.

During this time, we were constantly told there was a 'consulting obstetrician' who knew about us and was making decisions about what happened to us next. We never met this person, knew their name and had no idea what their authority was. They were apparently sought for approval in every decision regarding my body.

After labouring like this for an indeterminate number of hours, a midwife entered with a new staff member to perform an internal examination on me. I had to verbally call out to stop them while this unknown staff member reached for my paralysed legs. After asking them to introduce themselves, we discovered they were an obstetrician. They insisted on an internal examination and determined I was 9 and ½ cm dilated. The obstetrician said I was able to start 'pushing' if I wanted to. She left me for 40 minutes to confirm this with the unknown 'consulting obstetrician' who apparently gave my body permission to do this thing I had felt I could do hours earlier and was ignored.

I pushed for 2 hours with staff coming in and out of the room and an obstetrician with their fingers inside me to try and adjust the angle and lip of my baby. I was yelled at and scorned for the way I breathed and used my voice to vocalise. I was told to stop doing these things and the staff rolled their eyes and wouldn't let me breathe the way I wanted to. I am a trained Opera Singer and am confident in my breathing skills. But rather than encouraged in a strengths based approach, I was humiliated and patronised in my most intimate vulnerable moment.

Suddenly, the room was full of medical staff rushing in. The staff started to move me out of the room and set things in motion for an emergency c-section without first informing us. We had to yell to get the attention of the midwives, wardspeople nurses and obstetrician. We asked for someone to explain to us what was happening. The obstetrician told us that our baby was distressed and could die if we didn't get an emergency c-section. They started to pressure into signing consent forms which were being shoved in my face.
We asked if it was an immediate danger and were informed that we had a couple of moments. We miraculously had the courage to tell everyone to get out of the room and give us 1 minute to make an 'informed choice'. The looks of frustration, disapproval and annoyance were palpable.
My husband and I wept together for a minute. I was overcome with grief that I was not a capable woman. I had failed my baby and myself. We committed to asking more questions.
Before the minute was finished, the obstetrician entered the room and told us that we had to go to the operating theatre now. We attempted to ask follow up questions but were told that we would cause the death of our child if we chose any alternative. We were never given information on what was actually wrong with our baby. We were never told 'why' it was dangerous. What was her condition? How much time did we have? What were the long term consequences of emergency c-sections?
We shared our birth plan values and what would be important to us in regards to delayed cord cutting, skin to skin contact and ensuring connection. These were ALL ignored in the operating theatre.

I was then handed the consent form. I have never seen these forms since I signed them. I have no memory of what I signed after labouring for over 60 hours without food or sleep.

Operating Theatre:

I was whisked away. I had no information on where my husband was or where I was going. I was out of my mind with fear. I was devastated at my failure and petrified for my daughter's life.
The anaesthetist attempted 3 times to secure my cannula and then when I was in the operating theatre, staff were laughing and joking while I received another epidural, half naked and exposed on a table. I was shaking with fear so much that the anaesthetist had to force my body in half, squashing my baby in my belly, to administer the epidural.

The only assurance I received by the surgical staff was that my surgeon was the 'best in minimising the look of my scar because other surgeons just butcher them'.
The surgery was already under way when my husband appeared. He sat close to me while I shook with fear and nausea.
My body was pulled in all directions and I heard staff remark that the surgeon has her leg up on the operating table leveraging her weight to pull my baby out of me.
I hear the surgeon cry out ' Omg. What a very big baby.' and then the sound of my baby screaming.
My daughter is held up over the blue sheet for less than 1 second. It's barely a glimpse. Her umbilical cord has already been cut. And then she is taken away from us. She is somewhere in the room but I have no access or sight.
Eventually she is apparently handed to my husband as he is being escorted out of the room. But my body is in shock and my sight is blurry. I'm shaking so much and I can only see medical staff walking around me talking carelessly about their weekends. No one addresses me. No one tells me I'm okay and my body is okay.
At this point I still have no idea if my baby is okay or even alive. I am completely ignored now that I am empty of the baby I grew.

Recovery:

I was rolled to Recovery without an update. I was left in recovery for over 2 hours. Most of my body is paralysed and was desperately hungry and thirsty as I've not been allowed to eat for 3 days.
I remember listening to staff mock a distressed patient in a bed across the room from me. I remember a nurse in scrubs holding a Subway footlong, flinging it around and yelling across the ward at his colleague. I tried desperately to get his attention. I tried for over 90 minutes to get the attention of the staff.
I had no idea if my baby was dead or alive. I desperately feared for them. I had no idea where she was, how she was or even if she was a girl or boy. I imagined her dead and lived with that grief for the full 90 minutes.
I also was given no knowledge of my own body, how the surgery went and if I had suffered any damage. No one approached me.
When I finally managed to secure the attention of a nurse and asked my questions. The answer was 'I'm not sure.' Then they left and never returned. After 2 hours, I was approached by a ward person who started rolling my bed out of the room. I had no idea where we were going.

My experience of the Birthing Unit, Operating Theatre and Recovery was incredibly traumatic. At no point was I ever made aware of my rights, my responsibilities or the authority and role of any staff member. At no point did anyone seek follow up support for me. No one ever introduced themselves or their role to me and I only discovered who people were because I asked them to please identify themselves. It was never clear if I was speaking to a nurse, student, wards-person or a midwife.

Maternity Unit:

I have provided my Maternity Unit experience in dot points as this mistreatment occurred repeatedly throughout my stay and did not occur in a linear timeline.

- When I arrived in the maternity ward it was 7:30pm. I had not been informed or told where my husband was or if my baby was alive or dead. I was not taken to see my baby or given access, except that when I was rolled into the hospital room where I would be staying, my husband decided to take my daughter himself and bring her to me. No midwife or nurse met me. No one welcomed me or explained any information about the surgery or my daughter. No one shared or showed me how to breastfeed. No one gave me any information on how long I was expected to stay, what happened in maternity, who worked there etc.

- 30 min after my arrival in the Maternity Unit, my husband was told he had to leave the hospital as visiting hours were over. I was left alone,unable to move from my waist down and over 2 metres from my daughter. I couldn't reach her, couldn't pick her up. I was in excruciating pain and incredibly scared. My daughter was screaming with hunger. I used the buzzer to signal to the staff to get support. Over 90 minutes later, a woman arrived in my room. Her first words and actions to me were to aggressively draw back my curtain while yelling 'Geez. What do you want?'. I had pressed the buzzer once.
  I explained that I could not reach my baby and she was evidently screaming. I explained I had never breastfed before and I was wondering if someone could help me.
  She openly sighed in frustration. Picked up my baby and dropped her in my lap. She ripped down my hospital gown, grabbed one of my breasts, squeezed it hard and then started shoving my baby's head onto it. She told me it was not hard and then left the room. I did not see her again until later in the early hours of the morning when she yelled at me for falling asleep while my baby was in my arms. I had been awake for over 3 days at this point and it was 3am in the morning. My daughter screamed in hunger throughout the night. In the morning, I was told that this one midwife was the only staff member on the ward for 30 women and 30 babies.
- This night midwife was on various night shifts. She would bully and yell at me. She would ignore me or swear at me when she entered my room. Her colleagues during the day acknowledged that they knew she was awful and problematic but she was never held accountable. I was petrified every time my husband was forced to leave at 8pm.

- The maternity ward provided no resources. We had to bring from home the following: Wound care/First Aid for my surgical wound and my vaginal recovery. Soap. Nappies and everything that a baby needs. Every single thing. We received no booklets, information, resources, nappy rash cream, swaddles. Nothing.

- We were not allowed to take babies out of the room unless they were in a trolley. We were restricted in access. It was essentially a locked ward for us. At one stage, a 'roommate' had her partner + children arrive with fresh clothes, undies and hygiene products. They were yet to meet their new sibling. They arrived at 7:50pm and had driven over 90 minutes to arrive. They were completely denied access, unable to meet their daughter/sibling and they were unable to deliver the supplies until the next day because of the arbitrary 'visiting hours'. I was informed I could not leave the ward without my daughter even if she was in the care staff or family. This was also the case for using the bathroom. I had to wait until my husband arrived to help me to the bathroom and watch our daughter. I was denied access to fresh air, hospital garden, cafe, chapel, outside balconies or other facilities often provided to hospital patients.

- I never saw any surgeon or medical staff about my ongoing wound from the c-section. I was provided no instructions or referrals. No one would answer my questions about how my surgery had gone or what was actually involved in the surgery. Not one medical staff reviewed my body for surgery follow up.

- I was mocked and ridiculed by a midwife/nurse when I mentioned I was nervous about seeing/feeling the new c-section scar. She told me 'not to be stupid'. She was watching me undress at the time.

- 'Handovers' were done either outside my door in whispers creating an awful unequal power dynamic or at the bottom of my bed in front of me. I was never given eye contact, referred or deferred to in handovers. I was never asked about my experience. Language used would be 'she is failing to breastfeed', 'she had an unsuccessful birth', 'she isn't coping'. To which I once responded in tears 'Yes. I am not coping. I need support. I need help. Please.' The older midwife sighed 'You'll be fine.' in response and left the room. The younger midwife returned minutes later, sobbing and apologising. She stated that she was a new graduate, she was doing her best but she knew that it was awful. She apologised on behalf of her colleague and reflected on her experience of moral injury in working there. She offered me no new resources but she was very upset and apologetic. She stated that she didn't think she would remain working there for long.

- On my second night, my baby screamed and screamed all night. I had managed 2 or 3 hours of sleep throughout the day while my husband was present. I had yet to have a shower or get clean since the surgery. I wept and wept all night while not one staff member came to support or help me. My daughter cried, screamed and did not sleep the entire night. She was in visible distress, as was I. This was obvious to staff through sounds and sight. I was never once offered support or checked on.
- On the third night, a new midwife came on shift. I had learnt that no one answered the buzzer and had stopped pushing it. She entered my room around midnight and heard my baby crying. She offered to take my baby to the nurses station for a couple of hours while she slept and return her when she awoke to attempt a breastfeed. She stated this was standard procedure and as I'd had a c-section, I should have had this offered. At this stage on the third night, in a 120 hour period, I had 2-3 hours maximum of sleep. This was the only night I received this support.

- Any member of the public was let into my shared room. Including multiple unrequested visits from local religious organisations.

- I shared a room during my stay with 2 women (because my room changed) who required my attention and emotional support. Both women were in the process of receiving child protection service interventions. They received no support themselves, no privacy nor discretion. I became their emotional counsellor during this time despite barely surviving myself. These provided me with more information and clarity than every single hospital employee combined.

- I once left the room to look for some information on breastfeeding. I thought surely there was a brochure or information booklet that could assist me in getting better as I was failing so far. I left my baby with my husband in

the room. I could not find any resources anywhere. Nothing on the noticeboards. I returned less than 5 minutes later to the room where a midwife (maybe?) was waiting for me. She yelled, reprimanded and patronised me, telling me off for leaving my baby.

- I had been told I was failing at breastfeeding, that my daughter was at risk of dying if I couldn't and then directed to attempt to breastfeed my baby constantly. It took me 90 minutes to produce 1 mil of colostrum for my daughter. I was continuously attached to breast pumping equipment or syringes when I wasn't attempting to teach my daughter how to latch and breastfeed. When I wasn't attached, I had to attempt to feed my daughter the 1 mil of colostrum. This was a continuous cycle without relief. I was essentially a dairy cow. One morning, I was, as always, in this cycle and my breakfast was delivered at 7am. I was unable to reach it due to my caesarean wound. I was unable to use my hands to eat because I was unable to stop pumping. I missed breakfast.
  The wards-person removed my uneaten breakfast. And later at approx. 11:30am, they returned with lunch. I was still within this cycle and unable to move, drink or eat. The meal was poached chicken with veggies and a cream sauce. My husband arrived later. He was able to hold my daughter and attempt to put her to sleep. Before he did this, he moved the now cold and hours-old plate of chicken closer to me. I raised one bite to my mouth, when a midwife walked into the room. She saw me eating and my baby crying while my husband rocked her to sleep. She turned to me, walked closer to my face, pointed her finger at me and said 'what are you doing?'. I responded by saying 'I haven't eaten. I need food.' Her response was to poke her finger at me and yell 'No. Baby. Comes. First.'
  At this point, I had been bullied, ridiculed, mocked, ignored and abandoned for almost a week. I had no fight left in me except to put down the fork, lie back on the bed, while the midwife presented the baby to me to return to my breastfeeding attempts. I wept openly. This was the moment I retreated into my internal world; lost any remaining attachment to my baby; and disassociated from my life. This was the moment I returned to in every counselling session and every flashback.

- We knew that evidence and research pointed to 'breastmilk coming in' or flowing successfully, predicated on the mother feeling she was in a safe and home environment. We asked midwives and medical staff if we could leave the hospital and head home with support. We were admonished and criticised. We were told we would be leaving without their approval. We were told it would mean we were 'discharging against medical advice' and there would be repercussions and consequences although these were never outlined in detail. We were warned that she might die or something go wrong and if we left the hospital we would be held accountable for this.
  At this point, I became convinced that the world outside the hospital no longer existed.

- The only reason why we eventually were able to leave was because my mum physically arrived and pushed her way into the maternity ward. She took my baby in her arms and she instructed my husband and I to leave and go for a walk outside. When we had shared with medical staff earlier that morning that we needed fresh air because my mental health was deteriorating, we were advised that it was a bad idea and that our baby would be hungry and we'd be abandoning her. We had only suggested a 15 min outdoor walk around the block. I had not been out of the maternity ward in 5 days. My mother knew this and said she would deal with the consequences of the medical staff if they found out. I was scared for my life and petrified that my daughter would be removed from our care. But my mother insisted and we chose to trust her. My husband and I sat on a bench for 15 minutes outside the hospital and watched the everyday people live their lives in traffic whizzing by. I felt dead inside but my husband had a renewed purpose to 'escape'. We committed to discovering 'who, how and what approvals could be given' to release us. We committed to 'playing the game' and realised the only way to get home was to charm our way and slowly convince them that our baby would be okay in our care. My husband and I said to ourselves 'We need to convince them to answer the question - *What are the steps required to allow us to go home?*'

  We left 24hrs later after discovering we needed 3 approvals from 3 different doctors and also a midwife was required to sign an authorisation that they felt our daughter would be safe. After all those were secured, we had to wait an additional 6 hours before a midwife would approve our 'bathing' technique for In this time, my physical or mental well-being was not considered.

- We were provided no referrals, no follow up appointments and no information on how to take care of a baby on going. We did not have any knowledge or access to a community maternity nurse or midwife until receiving an unexpected call weeks later. I was never referred to a lactation consultant or Tresillian. I even visited my multiple

times and identified that I wasn't coping and our daughter just screamed through the night. No one referral to a sleep specialist or lactation consultant. I was told that 'everyone experiences this' and given only a mental health plan (which I had initiated and fought to be approved).

- I was sent home with 1 single day worth of Endone medication, no refills from the GP or hospital and told I could use paracetamol when this ran out despite having major complex surgery 5 days earlier. I received nothing of the following: physical rehabilitation, pain management or medication, resources for my physical recovery, follow up appointments or check in of any kind. I live with chronic pain and am a disabled woman. Pain medication works differently on me and this was never discussed or addressed. In the 7 years since March 2016, I have never once been offered any follow up or medical support regarding my major surgery recovery. My father recently had a knee operation. He received ongoing opioid medication for 2 months post surgery, 2 weeks in-patient rehabilitation and months of physio outpatient case management.

- My 'milk came in' within minutes of me walking through my own front door.

Recommendations:

I agree with all the evidence based recommendations that are currently being distributed including:

- Increase in continuity of care measures including a mechanism to keep track of staff and patient interactions.
- Increase in funding and target of at least 80% of all birthing parents to be enrolled by 2028 in the Midwifery Group Practice program for All-Risk birthing parents. As the program is a risk mitigation factor itself.
- Increase in policy and resource support for birthing parents choosing home birth options. Review potential for an improved proactive integration of the relationship between staff and procedures for home births and medical hospital risk interventions.
- Mandatory training for medical, allied health and admin staff specifically addressing Obstetric Violence and Consent in HealthCare.
- Mandatory training on issues such as systemic prejudice, sexism and institutional racism and the impact on confirmation bias for medical staff.
- Internal debriefing and external counselling offered to hospital staff after traumatic births including implementation of 'reflective practice' and peer supervision.
- Patient entitlement to debriefing during and after every birth regardless of perceived trauma. This should be made standard and readily available.
- Individual and Private rooms in all contexts to ensure capability for support person/partner to stay or discretion for birthing parents especially for women recovering from surgery.
- Unprecedented increase in funding for maternal and women's health across the state in ante-natal, inpatient and postnatal stages.
- Signatures for Consent Forms and intervention options education takes place prior to a 12 week appointment with follow up appointments.
- Increase in funding for maternal out-patient and accommodation services for parents with a child in NICU or requiring additional medical support.
- Increase in funding for mental health support including a specialised trauma-informed Mental Health Care Plan package of 24 sessions in the first 12 months for a parent screened for perinatal PTSD.
- An 'Introduction to Parenthood Services' package mandatorily provided to all birthing parents at initial GP appointment.
- Implementation and review of all medical and cultural language used when referring to patients. Change of language from deficit based to strengths based language. Removal of term 'failure' in any maternal context.
- Investigation into impact and best practice of 'Handovers' and patient experience of the access and transfer of medical information.
- Increase in financial resources and partnerships with community advocacy organisations prioritising CALD, low socio-economic, disability and First Nations communities.

- Mandatory annual retraining and professional supervision in Trauma Informed Care, Empathy, Non-Violent Communication, Strengths Based Approach, Disability, Pain Management and Consent for all staff working in Maternity and Women's Health Departments.
- Annual training in the Australian Charter of HealthCare Rights for medical staff. Distribution of the Charter and hospital policies to all patients prior to intake.
- Minimum Standard list and allocated budget for patient resources including birthing equipment, baby nappies and hygiene/wound care for birthing parents in the Birthing Units and Maternity Units across NSW Health.
- Mandatory standard of midwife/patient ratios across NSW Health. Drastic urgent increase in current ratios.
- Financial investment in best practice education, training and increased recruitment of student midwives.
- State-Wide consistent NSW Health Policy that birthing parents have the right to the presence of a partner/support person at all times in all units/contexts. Including access to external doulas and midwives within the hospital setting at all stages including operating theatres.
- Audit and implementation of recommendations of the referral screening checklist and processes between perinatal hospital staff and allied health staff. Screening criteria to meaningfully include Birth Trauma as a risk factor and referral reason. Birth Trauma to include anything the patient identifies and not staff opinion.
- Recognised definition of Birth Trauma within NSW Health - determined by birthing parents and patients.
- Strategic and proactive termination of NSW Health employees with consistent complaint records. Review and increase visibility of a mechanism to report abusive behaviour to an external body rather than the direct supervisor of staff members.
- The requirement for hospitals to report on and be held accountable (with significant consequences) for high rates of interventions. Statewide standards and targets for reducing and maintaining low rates of interventions.
- Public/patient access and distribution of all public and private hospitals' perinatal intervention statistics, complaints and conflict of interests. Additionally, accessible statistics and complaints for individual senior medical staff.
- A review and overhaul of ante-natal clinics to consider models similar to ServiceNSW.
- Increase in community based Birthing Centres outside of the medical model and hospital setting.
- Implementation of Australian based research into Birthing Unit Architecture and design best practice in all future renovations and capital works.
- An investigation of conflict of interest protocols for commercial/private interests from monopolised public referrals to private commercial services providers such as Imaging, pathology,diabetes and medical equipment companies. These unnecessary referrals lead to 'high risk' labels on birthing parents and lead to unnecessary medical interventions
- Increase and communication of support offered to birthing parents after c-sections and surgeries including access to allied health, physio, support person accommodations and reprieve from supervising baby in order to sleep.
- A mandatory patient advisory group with allocated budget for each local hospital group to advise changes and patient experience.
- Post surgical Recovery rooms specifically within all NSW Health Maternity Units to ensure birthing parents have access to babies for urgent immediate skin to skin contact, breastfeeding. These Maternity Unit Recovery Rooms would be not only for post surgery recovery but also for the emotional recovery from long and/or complicated labour, interventions and traumatic birth experience.
- Standard meeting of every birthing parent when arriving in the Maternity Units with a lactation and breastfeeding clinician. Especially for new parents to learn how to breastfeed.
- Requirement for all patients notes to be detailed with inclusion of all interventions, interactions, timelines and casenotes.

Reflection:

I firmly believe that while the physical challenge of my labour was awful and difficult, I would not have Post Traumatic Stress Disorder if I was encouraged, listened to or at a minimum - not verbally abused.
People can do anything when others have their back. Going through the physical experience of labour and birth is as close as we come to life and death combined. We are incredible. Why isn't every new parent handed a damn trophy when they enter the Maternity Unit?
Instead we are stripped, exposed and abused.

Some time after my Birth Trauma, I reached out to Hospital to submit my complaint. I asked for my patient notes and was heartbroken when they returned with inaccuracies and mostly empty blank spaces. The word 'failure' was used and I felt my story was invisible.
I requested a meeting off site in an administration building as writing down my story was too triggering and difficult.
My husband and I met the new Director of the and an admin officer.
They wept while I shared my story. They apologised, thanked me and acknowledged they knew this was an ongoing issue.
I left vulnerable, hollow but slightly hopeful.
6 months later we were told that the new Department Director had quit. A month later I received a letter from the Hospital management acknowledging that I had submitted a complaint but that they took no responsibility and wished me luck in the future.