Submission
No 1127

INQUIRY INTO BIRTH TRAUMA

Name: Name suppressed

Date Received: 14 August 2023

Partially
Confidential

NSW Parliamentary Committee on Birth Trauma submission

I had a baby in late 2021. I didn't die. My son didn't die.

I am addressing many of the terms of reference and would be OK with giving evidence at a hearing.

Summary

After a good pregnancy I was looking forward to meeting our bub. However, through the birth of our boy, a *series* of failings, misgivings, coercion, inattention or sheer inhumanity, I left Hospital after almost a week, broken. A shell of my pre-pregnancy sporty self, but my son and I were alive, right? That survival mindset was very much present when the hospital social worker ticked the boxes for my discharge. I got quickly on-board and started doing what a new parent does, survive, in any way they can.

I feel grief over a birth and early parenthood experience that didn't happen. I feel robbed of the joys of motherhood and was unable to bond with my baby due to living with undiagnosed PTSD. I was in survival mode unable to relax, sleep or feel joy until well into my baby's second year. The feelings of failing myself and my family were overwhelming.

I lost trust in medical processes so far that **I do not trust that I can safely have another child**. I want another child, but putting my life in someone else's hands is a no-go for me.

A formal PTSD diagnosis was made, at 15 months post-partum. That is a long time to jump when someone approaches, break down when you see a blood bank, have no sex drive and feel utterly ashamed that you can't get be present for your child.

Childbirth is *the* most vulnerable time for a woman. I relive the surgery daily. I live on constant alert.

I think of my birth trauma as a consequence of systemic failure whereby multiple care opportunities failed. I don't feel like I birthed my son, but rather he was delivered to me. That key difference and basic safety expectations not being met created trauma for me. Promises of being 'held' through the delivery, cared for, and that it would be OK were in reality a series of turned backs, invisibility, haemorrhage and maladministration.

1. Pregnancy

I was a first-time mum-to-be, between 30-35, had low thyroid for pregnancy but this was detected early by GP and well managed, no gestational diabetes, existing antianxiety medication which was considered easier to leave me on it than remove through pregnancy, and in otherwise the <u>best</u> health for years; competing in adventure races and mountain biking a lot. I was looking forward to recovering and being able to take our baby on our adventures. I wanted a natural birth and not a caesarean which I was clear about throughout pregnancy, to allow best chance of recovery and subsequent pregnancies.

It was an uncomplicated pregnancy. However, there was a lot of conflicting communication between hospital staff on the same case. At midwife checks and tests all was mostly normal until week 35 when I was referred for a scan due to a large bump.

2. Arrogance and inhumanity

Midwives discussed induction might happen during my 37-week appointment, to induce around 38 weeks as baby was measured as big, 4.6kg, on the 36-week scan. Some staff said no early induction, favouring 'watchful waiting'. Notably Dr dismissed the 36-week scan at my 37-week appointment, saying baby could be smaller, or bigger(!) and minimised me and my fears for tears, prolapse or complications, and stated "*the only way to know how big the baby is, is when they are out*", looked me up and down, said "*and you are quite small*". He then asserted that he wouldn't make any decisions until at least 39 weeks and that had been at Hospital for years, and the 'action' would be watchful waiting. He egotistically followed up with "*and what I write in this today <indicates medical file> will be picked up by attending staff and carried out*". My choices, my options, my body were seemingly his to command and abuse. I pressed him about an action plan to get baby out safely, for both of us now and for recovery and he dismissed induction or anything but 'wait and see' without explanation.

In the same appointment Dr made me hang up on my husband who was only allowed to dial in and not attend in person due to Covid restrictions. The hospital policy was to allow a support person to be on the phone. The irony was that there was also a trainee in the examination room, but I wasn't allowed a support person. I was shocked and he called me over for examination. Like a rabbit in headlights, I got on to the table. I felt like a piece of meat, prodded, peered at, referred to as if not there, and that I had no say in what was being done, or to be done to me. He had the audacity to shoot, mid discussion with his junior, "*why are you anxious*". I wonder – 37 weeks pregnant with an estimated 4.6kg baby, apparently too small and no plan. He caused unnecessary fear and I had a panic attack when I got in the car. My husband called and reported it to the hospital who allowed me another appointment for a second opinion.

3. No room at the inn

Then at 38 weeks, I saw a consultant with a much more humane bedside manner. We discussed that baby was not engaged yet, I had no gestational diabetes or factors for an induction before 40 weeks, and theatres were full for planned caesarean-sections in my 39th week, the ideal time, so we would have to 'watchfully wait' (do nothing). I didn't really consider there would be facility availability issues, in Sydney, and as we were near the large public hospital, however transferring care to another public hospital was not discussed.

39 weeks comes and goes. I had growing anxiety around a large baby and 'waiting and seeing'. At our 40-week appointment, I was told after examination "*this baby isn't coming*". Baby still wasn't engaged, and I was reluctantly booked for a planned caesarean in another week, i.e. at 41 weeks, as

there was *still* no space in theatre. I signed the c-section consent as I'd been informed that there would be risks to baby if they were in there too long, that if *induced* labour happened with a big baby, then they could get stuck half way or have complications and require an emergency caesarean anyway. Avoiding any harm to my baby, I reluctantly signed the consent, for the health of baby, hoping they would come on their own, naturally.

Three hours later I went into spontaneous labour. I wanted a natural birth and not a caesarean which I was clear about throughout pregnancy, and when I arrived at hospital midwives encouraged me to state that I wanted a natural birth and not a caesarean even though there was paperwork consenting a caesarean.

4. Mis-informed consent

Arriving at hospital around 2am, I reiterated that I wanted a natural birth. The midwives were onboard. Time passed, contractions intensified, the obstetric registrar examined me and checked my file after her second surgery of the night.

Shortly after, the registrar came back recommending a caesarean as baby was not engaged. She painted a picture of urgency and that if I continued with natural labour (I was only in the very early stages) that the baby might get stuck, have shoulder dystocia and require a collar bone to be broken to deliver vaginally, or worse, that baby would get stuck half way and have to be pulled back up through the vagina and delivered via caesarean, causing both vaginal- and Caesar- related damage. I hope you can empathise with the choice my husband and I were **coerced** into, to go to surgery, based on the gory picture and threat of something being likely to impact your baby. She was persistent with the fear that something terrible may occur and I felt pressured and scared in to consenting to a caesarean for the health of our baby. I usually can advocate for myself and so can my husband, but when the fear of harming your unborn baby is at stake, you'll agree to almost anything. I feel **conned** into the surgery and consider that it was more in the surgeon's interest than mine, that my reasons for wanting a vaginal birth were **ignored**. The consent was not informed but was out of fear. It was **coerced consent**.

I communicated that if I had to go, I wanted; 1, my husband to be with me throughout, 2, to have skin-to-skin as quickly as possible, 3, to have delayed cord clamping and to 4, be suitably sewn up to allow a VBAC (vaginal birth in the future). The surgeon agreed too all.

5. Surgery

Promises that was made through my care were broken, communication was inconsistent and basic observations were not made or acted on.

I was having contractions while the anaesthesiologist was inserting the spinal needle and had to ask a theatre person passing by to hold their hand. There were people, but no faces. I was invisible. No one saw or acknowledged that I was a birthing woman, at a vulnerable time, without a support

person and in a lot of pain. I was breathing through intensifying contractions alone, trying to remain still while someone put a needle in my spine.

My husband was kept outside to 45 minutes before he could come in to the theatre. I kept asking where he was, but no one would answer. I felt invisible and powerless. This was not the procedure they explained, and I was starting to think something was going wrong. Eventually when my husband was allowed in, the theatre nurse said it was because partners are only allowed once the prep is done and 'we're ready to go'. I don't see that that would have been hard to tell me in the countless times I asked where my husband was in the past 45 minutes.

I was laid on my back and anaesthesia tested as working. The process started and there was a burning smell and a lot of tugging feelings. What felt like a long time passed and then our son was raised above the blue screen. A *wonderful* moment, which quickly turned to a very busy operating room. I had meconium in my uterus and my son had to be aspirated by a paediatrician. They took him off to the side in a tiny table but didn't tell me what was going on. I was scared for him. They separated my baby from me and while they may have had an emergency or work to do to clean my insides, I was just there like meat on the table, invisible that I was a person and new mum, that this was happening to! No one told me what was happening, and my husband was caught between needing to be with me or our baby. I instructed him to be with our baby. Moving between our baby and me, he saw my uterus open. The theatre nurse who said she'd be there, wasn't. My husband later told me that they were one more try away from having to take baby to the NICU and a bigger hospital.

While my son was being helped and my husband with my son, I started *vomiting* on my back, paralysed and scared. My surgery nurse had vanished after promising that she would be at my head the whole procedure, and I could only see the back of the anaesthetists gown out the corner of my eye, who had also promised he would be watching the whole time. I called the anaesthetist's name. He turned my head and I continued to vomit. I now recognise this to be a significant loss of blood pressure (intraoperative hypotension) or haemorrhagic shock, which occurs after losing about 20%, or more, of your blood (Healthline, 2023). He stayed with me after that and provided clear fluids.

The surgeon took over 45 minutes to clean my uterus of meconium and stitch the wound. I was taken to recovery, still not having seen my baby properly. My son was placed on me in the recovery ward, a long time after delivery. I had observations taken and was moved to a maternity ward.

Tan and Habib (2020) write "Preventing nausea and emesis is a top priority for women undergoing cesarean delivery and is included in the quality of recovery measures and enhanced recovery after cesarean delivery protocols. The majority of known perioperative emetic triggers *can be avoided or mitigated* by optimizing anesthetic and surgical management." Lonjaret et. al. (2014) state that Intraoperative hypotension must be treated according to its cause…such as: effect of anesthetic agents, hypovolemia, position or surgical technique…Moreover, the severity of hypotension, associated signs, and the effect of initial therapy can be used to guide the treatment.... During surgery, hypotension may be linked to hypovolemia, high doses of anesthetics, and heart failure." In my case, a significant blood loss was not noticed and incorrectly documented. The vomiting was likely induced by hypovolemia (from blood loss), leading to hypovolemic shock. If the anaesthetist attributed vomiting to anaesthetic agents, they missed the *actual* cause.

6. Post-surgery

I remained catheterised and was confined to my bed. I informed the post-operative nurses that I was cold and exhausted, but these signs were missed or ignored.

The consultant obstetrician who signed my surgery notes, was never present. He operates from the nearby private hospital as well as . I was familiar with his name, and face, as I'd looked in to switching to private when a caesarean looked probable, but I did not see him *at all* during my care. I had trust that the public system would be sufficient to keep baby and I safe. Registrars seem to be given free reign and in the case of underreporting incidents on their watch, how can they be accountable if their managers simply sign off incorrect notes?

I was not allowed up for a few days, but when I did stand up with help from a midwife, I developed a labial edema. This was horrifying. The extra fluid in me from surgical blood pressure fluids, flowed south. Not only was I very lightheaded, but looking at the Frankenstein wound from hip to hip was confounded by what I can only explain as the appearance of having testicles where my vagina was. My labia had swollen and partially blackened. I just cried. I couldn't believe just how horrific I felt and looked. The nurse took me back to bed. The next nurse/midwife comes by, checks down there and offers ice. A short while later, a midwife(or nurse) asked if another staff member could have a look. I thought they meant so they could medically help me. I later found out they were a trainee! I was a side show, not a sore new mum. *"No"* I was screaming inside, but couldn't form words. When said staff member came in and I was sat on a chair, they asked if I could move forward. My labia were now hanging over the edge of the chair like testicles, I couldn't believe the inhumanity of it. Yes, you may want to gawk, but I am a person here! I would soon figure why I was unable to verbalise what I wanted to say. I had acute anaemia.

My surgery hand over notes had written that I had lost 700ml of blood, but blood levels checked 2 ½ days post-surgery indicate much higher blood loss (category 3 haemorrhage). 2+ days after delivery, weak and pale, my 38-week consultant, came in to check me as he saw my file. He took one look at me and said "*has anyone checked her bloods? She's as white as the wall!*". I was. (Photographic evidence available on request).

Blood tests were taken, and I had a **haemoglobin level of 5.1g/dl**, 2 ½ days after surgery, cold and exhausted. For reference, normal haemoglobin levels should be between 12.0-15.5 g/dl.

I received 2 blood units/transfusions immediately then received a further transfusion as my haemoglobin levels had not improved far enough. When the 38-week consultant shared my blood results and back calculation of blood loss with me, he said "*it's more like 1.7 litres, not [0].7 litres*". That blood loss difference is significant and had consequences for how I could interact with my baby in the first important hours and days. I could barely keep my head from nodding.

The surgeon registrar came by later to check up. She ran through the surgery, which I couldn't fully comprehend, and she considered it went well. Baby was wrapped in his cord and it took a while to clear out the meconium from my uterus, but I was assured that she herself that stitched suitable for VBAC (not the trainee surgeon quivering in a yellow gown when I entered surgery).

My wound looked like a mess to me, wonky and over 20cm. She then took a look down there and said "*hmm, it looks like you've had a forceps delivery but you haven't*". I wanted the ground to swallow me up. *The very person* who had coerced me in to theatre for *threat* of having excess damage was now telling me my vagina looked like it had been invaded too? I felt so ashamed for agreeing to the caesarean and conned. By this point, I really didn't think I could pile on any more shame and horror, but there it was. No woman wants to hear their vagina looks bad, in any circumstance.

I cannot trust the integrity the surgeon's comments on stitching given the other failures.

I then had to have a scan for potential haematoma in my labia, which required a whole new set of staff looking at my parts, checking they read the form right and looking back at me inquisitively. Just delightful.

There were a cascade of failures. I had little functional blood left, **because someone wrote down the wrong number**, one side of the operating screen didn't seem to interact with the other, staff appeared tired with red eyes, the post-surgery team missed me looking white as a ghost and didn't act on symptoms I voiced, and staff were not sensitive to having a vulnerable new mum in their care. These are **avoidable mistakes across multiple areas**, which have made me lose trust in medical processes.

Haematocrit is the percentage of red blood cells in a person's blood. A typical haematocrit range in adult women is 37–47% (Cohen at. al., 2017). Mine was around **15%**, for 2 ½ days. I don't know if I sustained organ damage or brain function loss due to limited oxygen delivery for days, and the impacts from maladministration could have been **fatal**. I don't know if a near-miss report was filed. I still have significant difficulty in verbal communication struggling to find the right words, brain fog and memory recall issues, but I don't know if this is due to the blood loss, or PTSD.

Either way, I left Hospital with birth trauma that was recognised and acknowledged by the hospital staff *including hospital social worker* who the hospital ensured I saw before I left and who asked peripheral questions. I was passed on to my GP for follow up; 'hands dusted off, job done' from .

I do not know if there was a near-miss or follow up with the surgery staff on the blood loss reporting error, but transparent incident reporting, or proper cross checking of surgery notes before signing off, might help avoid this.

The physical symptoms during surgery (vomiting) didn't trigger any blood count follow up, and the volume of fluid (not blood product) I was pumped with to retain blood pressure didn't trigger any follow up. The surgical team, or someone writing the notes, estimated or **documented the loss incorrectly**. Blood transfusion is typically indicated at haemoglobin level at or below 8g/dl (Carson et. al., 2012), which I was well below and telling the staff symptoms of acute anaemia. My symptoms were ignored or did not trigger investigation by countless staff I saw for observations and checks. Medical documenting errors/ 'typos' cause me great concern in trusting medical processes again. What else was not documented or not properly written up? What is missing that the staff can't see someone looks decidedly pasty and tells you they feel off? I have not reached out to the hospital for a debrief, as I simply do not believe the records will be accurate.

The staff appeared tired, were on their 3rd caesarean of the night and working against the clock to hand the surgery back for day-procedures by 7am.

Assuming the staff had best intentions and that errors were solely due to staff fatigue, cries that all of this was avoidable. The alternative thought, that the staff were not competent or were negligent, is distressing.

The medical staff were so focussed on ticking the boxes of their distinct roles, and failing even then, they lost sight of the expectant or new mum **in their care** (and at their mercy).

Ultimately, I do not feel safe to have another child even though we want to grow our family.

Finally, nothing in my hospital discharge summary to my GP mentions blood loss, nor the 3 blood transfusions I required a 2 ½ and 3 *days* post-surgery having been left with a critical or life-threatening blood count and level. This is not acceptable, and **hospital did not give my GP sufficient information to actually follow issues up.**

7. Ongoing health and financial impacts

Impacts from the event permeate though all elements of life since delivery, including:

- difficulties bonding with my baby,
- fear to even consider having another child,
- loss of self-confidence; I regret not advocating harder for a natural birth and being coerced into a caesarean.
- loss of sex drive,
- inability to focus on work and associated career stagnation,
- living in hypervigilance, with general feelings of being unsafe,
- burnout,
- relationship difficulties,
- inability to bond with other mums, leading to isolation,
- loss of trust in the medical profession overall
- a deep-seated fear that promises made cannot or will not be fulfilled, reinforcing feelings of not being safe.

A note, the financial costs of mental health impacts and burden are mostly worn by our family. I have been through counselling immediately after returning home, ongoing and now or more intrusive PTSD treatment. It is costly in time, emotional commitment and money.

I did not ask for birth trauma. I expected a reasonable level of care, but find myself and my future family decisions made for me by the actions and inactions of care.

8. General observations, notes or points from an affected person

Duty of care

A reminder that patients are *in the care of* professionals and that dynamic demands clear communication to the patient. Society's structures whereby you trust doctors, you trust the hospital, you trust the medical communication, means patients may minimise their own instincts and feel complete injustice if that trust broken by trauma or abuse through birth/delivery.

Pragmatic, achievable discharge care

A new mum, especially after caesarean, has limited mobility and time, energy or resource to seek additional help for themselves. It is an unrealistic expectation that a new mum will be able to access rehabilitation or mental health support. You cannot drive after a caesarean so there are physical and energy barriers to receiving physical rehabilitation. Simply discharging a new mum to their GP is not sufficient and if the responsibility to close-out issues remained with the hospital there may be more accountability, continuity of care and outcomes. Double-handing of issues could be reduced thereby reducing costs to the system for existing issues.

Seeking care post birth trauma

It took me a long time to seek help for my mental health, having had my confidence in the health profession completely destroyed during the birth and post-partum. I was referred for support through community midwives at an appointment for my son. As a consequence of the delivery and hospital 'care', I have had to increase antianxiety medication to get through day to day, to function.

Loss of faith in medical profession was reinforced when I did seek GP help at a year post birth, seeking am updated mental health care plan. I was dismissed by a male doctor, Dr. , who said about my abdominal separation and back pain "*it's OK, women's bodies change through pregnancy and many women have it. We can't do anything anyway*", without actually checking the 4cm gap between my core muscles. I left with even more self-doubt. He was factually incorrect, and I felt shamed for having bought up the issue. I felt so small, dismissed. It spoke to a wider issue of post-partum care and respect. Three months later after seeing a private women's health physio, I got the courage to see a different GP, who assessed and validated my core muscle issues, and subsequently diagnosed my PTSD from the delivery and post-natal period.

Trigger appreciation, family impacts and submission rates

I'd like to flag that this is a triggering topic, and the submissions the committee receive are likely a fraction of the lived impacts. A systematic investigation into rates of birth trauma through post-natal impacts could be achieved without triggering traumatised persons, by using available anonymised data from PANDA, community midwives or GPs as they may be the groups most likely to pick up or hear from affected families. I'll reiterate that, *families*. Birth Trauma, while impacting the birthing mother, also has *profound* impacts on fathers and families, directly (living the trauma themselves) and indirectly by associated mental health impacts including household work burden, lack of bonding, burnout and relationship breakdowns.

There was a cascade of failures. Every promise that was made through my care was broken, but we are alive, right? **That should not be the only metric**.

I hope that sharing my experience will destigmatise discussing Birth Trauma and improve perinatal health.

Avoidance of Birth Trauma

I believe that the impasse between expectations and reality are or can be the cause of feelings of injustice, and cause or exacerbate birth trauma. Where an expectation is reasonable, but the reality doesn't meet the expectation, change needs to happen. Below in **Table 1**, I summarise the experience and *select* stop-points in my care that I see as areas for improvement:

Table 1: Hindsight patient feedback

Expectation	**In-line with societal norms:** Yes/No/Maybe	**Reality**	**Recommendations**
Staff will be ready to fulfill their duties	Yes	Staff were tired after being called to the 3rd operation of a night that their eyes were blood shot and mistake were made, likely due to staff tiredness	• Have processes which support staff to not be in a compromised position which could affect patients. • Provide safe ways for staff to raise concerns, and a policy to address those concerns.
I will be listened to through my care	Yes	Inconsistent advice and a lack of active listening from some staff. Patient fears are real, and communicating accurately didn't happen before procedures.	• Communicate consistently. • Communicate the process of a caesarean or procedure before you abuse someone's body. • Listen to a patient's history to manage concerns appropriately.
My partner will be present for my caesarean	Yes, if wanted	My partner was only allowed in once the spinal anaesthesia was in place and the room made sterile, however this was not communicated in the pre-operation meeting. I asked that he would be there the whole time in theatre, but he was kept outside, and I was without a support person, in a lot of pain.	Have a dedicated patient nurse.
One can connect with their baby	Yes	Constant fatigue from 'fake-it-till-you-make-it' belief that I would at some point connect with my child.	• Manage-out birth trauma. • Consider women and family health holistically rather than discharging to disconnected or inconsistent community services.

Closing statement

I hope that sharing my experience will in some way normalise talking about Birth Trauma. It is a deeply personal issue and a societal taboo to talk openly of. I beg that the Committee recognises that many families are suffering in isolation and may not have felt safe, ready or able to make a submission. Birth Trauma needs to be better managed in my view, but doing it though a parliamentary process must bring real change, or there's a real Social Impact of engagement fatigue if people have to re-live these events without seeing **meaningful** improvements.

People making submissions would be doing so to ensure that no one else has to endure avoidable physical and mental health impacts. I hope collectively our submissions can help improve perinatal and family health.

9. Recommendations:

- Targeted support for fathers, other parent or support people for new mums. The dads/partners are often the first and only support a new mum has.
- Post operative blood tests to check iron and blood levels. There are pre- but not post- tests.
- More staff to cope with the maternal health workload.
- Transparent and accountable error reporting from hospitals or staff to aid better outcomes.
- Provide in-home post-natal physiotherapy for better recovery.
- Assess or quantify abdominal separation as part of discharge commentary.
- A multi-level state-wide study into the occurrence and rates of birth trauma (note, some women can only access PANDA or call lines in rural areas and may not have an opportunity to speak with a health worker face to face, which may be where trauma is identified)
- Thorough and equally provided antenatal classes, including clear risks, intervention options and impact likelihood.
- Publication as standard of obstetric performance by health district and by hospital, to flag issues early and highlight where training may be needed.
- If a hospital social worker needs to tick off on someone's discharge, there should be a follow up from the hospital, rather than simply referring to GP. Stating you've had a traumatic birth and will likely need counselling around the birth is not enough.
- Include a target blood pressure and protocol for managing hypotension intra- and post-surgery
- Use the NICE Guidance, or adopted Australian equivalent, NICE Guidance [NG192], for caesarean birth
- Use the NICE Quality Standard, or adopted Australian equivalent, Quality standard [QS32], for caesarean birth
- Closer attention by consultants to registrars and cases.

10. Bibliography

Balki M, Carvalho JC. (2005) *Intraoperative nausea and vomiting during cesarean section under regional anesthesia*. International Journal of Obstetric Anaesthesia. 2005 Jul;14(3):230-41. doi: 10.1016/j.ijoa.2004.12.004. PMID: 15935649. Accessed online 14/08/2023: https://pubmed.ncbi.nlm.nih.gov/15935649/

Carson JL, Grossman BJ, Kleinman S, Tinmouth AT, Marques MB, Fung MK, et al.(2012) *Red blood cell transfusion: A clinical practice guideline from the AABB*. Annals of Internal Medicine. 2012;157:49–58.

Cohen, Eytan MD; Kramer, Michal MD; Shochat, Tzippy MS; Goldberg, Elad MD; Krause, Ilan MD. (2017) *Relationship between hematocrit levels and intraocular pressure in men and women: A population-based cross-sectional study*. Medicine 96(41):p e8290, October 2017. | DOI: 10.1097/MD.0000000000008290 Accessed online 14/08/2023: https://journals.lww.com/md-journal/fulltext/2017/10130/relationship_between_hematocrit_levels_and.29.aspx

Heathline.com (2022) *How Much Blood Can You Lose Without Severe Side Effects?* Accessed Online 09/08/2023: https://www.healthline.com/health/how-much-blood-can-you-lose

Jarvis, M.S. et al. (2023) *A survey in the West Midlands of the United Kingdom of current practice in managing hypotension in lower segment caesarean section under spinal anaesthesia*. International Journal of Obstetric Anaesthesia. 2023 May. Volume 55. DOI: https://doi.org/10.1016/j.ijoa.2023.103899|Accessed online: https://www.obstetanesthesia.com/article/S0959-289X(23)00253-4/fulltext

Johnson and Burns (2023) *US National Library of Medicine: Hemorrhage.* Accessed online 12/08/2023: https://www.ncbi.nlm.nih.gov/books/NBK542273/

Healthline, 2023. *How Much Blood Can You Lose Without Severe Side Effects?* Accessed online 12/08/2023: https://www.healthline.com/health/how-much-blood-can-you-lose#fainting

Lonjaret L, Lairez O, Minville V, Geeraerts T. (2014) *Optimal perioperative management of arterial blood pressure*. Integrated blood pressure control. 2014 Sep 12;7:49-59. doi: 10.2147/IBPC.S45292. PMID: 25278775; PMCID: PMC4178624. Accessed online 14/08/2023: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4178624/

National Institute for Health and Clinical Excellence (2021a) *NICE Guidance [NG192] Caesarean birth*. Accessed online 13/08/2023: https://www.nice.org.uk/guidance/ng192

National Institute for Health and Clinical Excellence (2021b) *NICE Guidance – Quality Standard [QS32] Caesarean birth*. Accessed online 13/08/2023: https://www.nice.org.uk/guidance/qs32

National Institute for Health and Clinical Excellence (2015) *NICE Guidance [NG4] Safe midwifery staffing for maternity settings*. Accessed online 13/08/2023: https://www.nice.org.uk/guidance/ng4

PANDA – Perinatal Anxiety & Depression Australia (2023) *Factsheet resources and downloads.* Accessed online 09/08/2023: https://panda.org.au/learn/resources-for-download

Tan HS, Habib AS. 2020. *The optimum management of nausea and vomiting during and after cesarean delivery*. Best practice & research. Clinical anaesthesiology. 2020 Dec;34(4):735-747. doi: 10.1016/j.bpa.2020.04.012. Epub 2020 Apr 23. PMID: 33288123. Accessed online 14/08/2023: https://pubmed.ncbi.nlm.nih.gov/33288123/