Submission No 1187

INQUIRY INTO BIRTH TRAUMA

Name: Name suppressed

Date Received: 15 August 2023

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15 August 2023

Committee Secretary
Select Committee on Birth Trauma

Dear Committee Secretary,

NSW Parliamentary Inquiry into Birth Trauma

This submission focuses on the episodes that occurred prior, during and following the birth of my first and only child at the Hospital in April 2021.

Included terms of reference:

1(a) the experience and prevalence of birth trauma (including, but not limited to, as a result of inappropriate, disrespectful or abusive treatment before, during and after birth, also referred to as "obstetric violence")

(b) causes and factors contributing to birth trauma including:

(i) evaluation of current practices in obstetric care

(ii) use of instruments and devices for assisted birth e.g., forceps and ventouse

(iii) the availability of, and systemic barriers to, trauma-informed care being provided during pregnancy, during birth and following birth

(c) the physical, emotional, psychological, and economic impacts of birth trauma, including both short and long term impacts on patients and their families and health workers

(d) exacerbating factors in delivering and accessing maternity care that impact on birth trauma generally, but also in particular:

(i) people in regional, rural and remote New South Wales

(e) the role and importance of "informed choice" in maternity care

(f) barriers to the provision of "continuity of care" in maternity care

(g) the information available to patients regarding maternity care options prior to and during their care (

(h) whether current legal and regulatory settings are sufficient to protect women from experiencing birth trauma

(j) any other related matter.

The following incidents and events address the above terms of reference:

Leading up to labour my baby was positioned correctly and no issues had been identified. I was arrived at the hospital at approximately 10:30pm on the 19th April 2021. I was admitted as a public patient though I should have been admitted as a private patient, which did not occur until the day after I had given birth.

At this time a midwife performed a vaginal examination on me with a doctor present. She advised after this examination I was 3cm dilated and my membranes had not completely broken. She asked if I wish for her to complete this. I agreed and the procedure was performed by the midwife. The doctor watched. Following this the midwife advised that I had an anterior lip on my cervix, and this would be an issue as I hadn't had children before. No further explanation was provided about the anterior lip nor was this confirmed with a vaginal examination by the doctor.

My labour was progressing normally throughout the early hours of the morning and no concerns were raised with me. After spending a significant time in the bath I was advised to get out in the early hours of the morning. I asked the midwife on duty at the time how I was progressing and was not given a clear indication of how far dilated I was at this point. I started to feel shut out of my own labour. I wanted to know how I was progressing and wasn't being told.

By approximately 7am that morning my contractions were very close apart (less than a minute) my body was pushing beyond my control, change of shift came into effect at this time and another midwife was now present. She was advising me to stop pushing, in which I expressed my inability to control this response. During this period, I was advised I should have epidural due to the anterior lip on my cervix.

I had not planned to have an epidural and wasn't happy about feeling forced into this decision. I had not planned to have an epidural prior to or at any stage of the labour so far.

An epidural was administered and the midwife on duty proceeded to tell me that I did not have an anterior lip on my cervix and the prior midwife on duty had failed to rupture my membranes correctly. This concerned me as I had been advised to have an epidural based on being told I had an anterior lip. I became confused and unsure about the level of care I was receiving.

Following this I was asked what I wanted to do with my placenta, I said I would like to keep it.

Following the epidural my contractions moved very far apart, between 5-10 minutes apart. A registrar doctor was present and began to complete an ultrasound, she seemed confused at where to place the transducer and placed it higher on my abdomen rather than lower in the pelvic region. A monitoring device was placed transvaginal to reach my baby to monitor her vital signs as there was concern about the stress she was under following the epidural.

I was being guided to push as contractions would occur by the registrar doctor and midwifes. This went on for 1.5-2 hours.

During this time there were a number of people coming and going from my birthing suite. It almost felt as if I was on show, I felt there was no respect for me or my privacy.

An obstetrician had come in at one point to see how things were progressing and perform an examination. He showed concern about the lack of fetal movement and advised the baby had bradycardia and was not breathing.

Another obstetrician was brought in with an additional medical team and respirator as the obstetrician began to attempt to deliver my baby. He proceeded to use the vacuum suction to deliver my baby which was unsuccessful. Forceps were then used to deliver the baby.

Whilst the obstetrician who had delivered the baby was dealing with my unresponsive baby the registrar doctor stepped in and pulled on the umbilical cord. She did not ask for my consent prior to pulling on the cord. The cord broke, the registrar doctor immediately went pale and began to panic. The obstetrician realised what had happened and pushed her out of the way, he inserted his arm up to his elbow inside me to attempt to remove the placenta. The registrar doctor was taken out of the room by a midwife as she said she felt she was going to pass out.

The emergency alarm sounded and within minutes there were several medical staff in the room. The doctor explained that I would require emergency surgery to save my life. My husband began to panic as blood was gushing out of me. I remember telling my husband I would be ok, but so scared that I would not be. At first my husband was advised he could come to surgery with me and then was told he was not allowed. I remember shivering as I lay in surgery in shock, freezing cold. As I had been given an epidural in labour, I was awake for the whole surgical procedure, I tried to stop myself from passing out. I was told I had lost nearly 3 litres of blood.

Following the surgery, I was placed in recovery for over 1.5-2 hours. I remember asking a nurse if my baby was ok. I had no idea where she was or what was happening. The registrar doctor came to see me in recovery, she seemed extremely worried and concerned. She advised that we needed to have a debrief following the incident. I was worried about my baby. I had no idea how she was.

I was returned to a room outside of the maternity ward to my husband who had been left alone with our baby trying to suckle him for over 3 hours. During this time a midwife came to check on him once. By the time I returned to the room my baby was desperate to latch onto me.

The presenting midwife on my return advised she was so “traumatised by the birth and what had happened that she was going to go home and cry”.

In the debrief given to me the following day, I was told my cord was tissue thin and this is why the “cord snapped”. He advised that it would be possible I would have a retained placenta again for my next birth. He advised that I did not have an anterior lip on my cervix and the unbroken membranes wouldn’t have stopped my baby from being delivered. I was so confused about why I was advised to have an epidural. I never wanted one. I felt the doctor was trying to cover up things and he advised me to have another debrief when I felt ready in a month or so. I asked where my placenta was and was told it was gone.

I had a urinary catheter with a urine collection bag attached for 3 days due to the swelling, I had several stiches and am still unsure to the extent of the damage of the forceps and during the attempt to remove the placenta or what repair was required internally following the emergency surgery.

I was not given a blood transfusion for 3.5 days following the birth/haemorrhage. I had lost ¾ of my blood supply during the haemorrhage and felt I needed to fight to have a transfusion. The hospitals

reason for not providing this directly following the event was due to my hemoglobin level reading not being as low as expected, which was advised a day following the birth this was expected due to an iron infusion I had received 3 weeks prior to my baby being born. The doctor stated they needed to have a reasonable case for requesting blood.

I was kept in hospital for 4 days following the birth.

My regular obstetrician raised the issue following my birth that my placenta should have been sent away to be assessed by a histopathologist. She was furious this had not been done and rang the hospital to see if any tests had been performed that had not been reported to her. She requested a debrief twice on separate occasions following the birth. She requested via email and phone call. I was not contacted following both requests. On the third request the obstetrician asked why I had not been contacted, the response I received was "she wasn't on our list". I was advised on 3 occasions within 24 hours following my labor that debriefs were required given the level of the incident that had occurred.

Prior to going into labour I was not concerned or worried about having my baby. I was looking forward to starting a family. Following my experience, I dread the thought of having another child and am left deeply traumatized. I have been diagnosed with post-natal depression and the experience has had a negative effect on the relationship I have with my daughter, my husband and other people in my life.

I once stated to my regular obstetrician that I feel if I had stayed home for my birth I would have been safer and I still feel this way. I hope this inquiry will assist and prevent other women experiencing what I did and will assist me in moving forward from the trauma I suffer daily due to my experience at the hospital.