Listen to Mums:

Ending the Postcode Lottery on Perinatal Care

A report by The All-Party Parliamentary Group on Birth Trauma

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About

About the Birth Trauma Inquiry

On 9 January 2024, the All-Party Parliamentary Group (APPG) on Birth Trauma established the first national inquiry in the UK Parliament to investigate the reasons for birth trauma and to develop policy recommendations to reduce the rate of birth trauma. Seven oral evidence sessions took place on consecutive Mondays between 5 February and 18 March 2024 in the House of Commons.

The Inquiry was also informed by written submissions which were received following a public call-for-evidence.

About the Author

The report was written by Dr Kim Thomas, Secretariat of the APPG on Birth Trauma and CEO of the Birth Trauma Association. She has also published two books about birth trauma: “Birth Trauma: A Guide for You, Your Friends and Family to Coping with Post-Traumatic Stress Disorder Following Birth”, and “Postnatal PTSD: a Guide for Health Professionals”.

Acknowledgements

The APPG on Birth Trauma would like to thank the following individuals without whom this Inquiry would not be possible:

Birth Trauma Inquiry Special Advisory Group: Gill Castle, Rhiannon Evans, Chloe Oliver, Laura Seebohm, Kim Thomas and Nikki Wilson.

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About the All-Party Parliamentary Group for Birth Trauma

Theo Clarke MP – Chair
Theo was elected as the MP for Stafford in 2019 and set up the APPG for Birth Trauma following the difficult birth of her daughter. She led the first debate on birth trauma in the House of Commons. The public response to her speech led her to launch this inquiry. Theo was previously a member of the Women and Equalities Select Committee in Parliament. She serves as one of the Prime Minister's Trade Envoys and as Parliamentary Private Secretary to the Department of Education. Theo chairs the sub-committee of the International Development Select Committee on the work of the Independent Commission for Aid Impact.

Rosie Duffield MP – co-Chair
Rosie was first elected as MP for Canterbury in 2017. She has served on the Environment, Food and Rural Affairs select committee since 2020 and was previously chair of the Women's Parliamentary Labour Party and a member of the Work and Pensions select committee. Rosie is a vocal advocate for women's rights, having spoken in the House of Commons about her own experience of domestic abuse, and representing her constituents affected by the deaths of mothers and babies at the East Kent University Hospitals NHS Trust.

Cherilyn Mackrory MP – Vice-Chair
Cherilyn has represented Truro & Falmouth since 2019. Before her election She was a Cornwall Councillor. Before moving to Cornwall, Cherilyn worked as an IT project manager.
Cherilyn is Co-Chair of the APPG on Baby Loss where she fights for better and safer maternity services and aims to develop policies that support families dealing with the grief and loss of a baby. She is Co-Chair of the Women's Health APPG**,** aiming to ensure women are listened to and make informed choices. She is married to Nick, and they have a young daughter.

Bell Ribieiro-Addy MP – Vice-Chair
Bell has represented her home constituency of Streatham in South London as a Labour MP since the 2019 General Election. Bell is a dedicated feminist, anti-racist and trade unionist, who has campaigned extensively on the issue of Black maternal health currently sits on the Women & Equalities Committee and Joint Human Rights Committees in Parliament. She also chairs the All Party-Parliamentary Groups for Black Maternal Health, Afrikan Reparations, and Endometriosis.

Mark Pawsey MP
Mark has represented Rugby since 2010. Before entering politics, Mark obtained a degree in Estate Management from the University of Reading, before moving into business and becoming a local Councillor.
Mark has been a member of Select Committees and acted as a Parliamentary Private Secretary to the Departments of Defence, BEIS, and Work and Pensions. He chairs the All-Party Groups for Packaging and Manufacturing. Mark is married to Tracy, and they live in the village of Grandborough, close to Rugby.

Darren Henry MP
Darren has represented Broxtowe since 2019. Before entering politics Darren spent 26 years in the Royal Air Force. Darren has been Trade Envoy to the Caribbean, as well as an Assistant Government Whip. He began campaigning to ensure that parents who lose their partner in childbirth have an automatic right to leave in 2022 following a surgery with a constituent who found himself unable to do so. Following his work, this Bill is now set to become law this year. Darren is a father to twins, who themselves had difficult births so is passionate in helping others through this report.

Helen Morgan MP
Helen has represented North Shropshire for over two years during which she has campaigned continuously for improved maternity services. Unfortunately, in Shropshire, preventing avoidable baby loss is an extremely poignant cause for many people so shortly after being elected, Helen became a Co-Chair of the APPG for Baby Loss. By holding debates and events, Helen has worked to be a voice for bereaved parents and urge the Government to act on staffing issues in UK maternity services.

Sally-Ann Hart MP
Sally-Ann has represented Hastings and Rye since 2019. Before entering Parliament, she went to university in London and qualified as a lawyer specialising in corporate finance law with a City of London law firm. After taking a career break to bring up her children, Sally-Ann later became a local Magistrate in Hastings and a District Councillor at Rother. Sally-Ann has a drive to support rough sleepers and the homeless, as well as vulnerable children, young adults and families.

FOREWORD

For any parent, having a child will be one of the most momentous and memorable occasions of their life. When something unexpected happens during a pregnancy or birth it can lead to lifelong physical and psychological consequences that often remain unknown and unspoken about.

This Birth Trauma Inquiry is, in its simplest form, an attempt to break this taboo and share the stories and experiences of mothers and fathers publicly and start a public discussion on the realities of giving birth and how we can practically improve maternity services.

Our key conclusion has been on the need to introduce a base standard in maternity services across the United Kingdom. **Currently there are several strategy documents relating to maternity but no single overarching document. We believe that maternity strategy should be brought into a single, living document, hosted on the UK government website and continuously brought up-to-date.**

To this end, the All-Party Parliamentary Group on Birth Trauma calls on the UK Government to publish a National Maternity Improvement Strategy, led by a new Maternity Commissioner who will report to the Prime Minister, which will outline ways to:

1. Recruit, train and retain more midwives, obstetricians and anaesthetists to ensure safe levels of staffing in maternity services and provide mandatory training on trauma-informed care.
2. Provide universal access to specialist maternal mental health services across the UK to end the postcode lottery.
3. Offer a separate 6-week check post-delivery with a GP for all mothers which includes separate questions for the mother’s physical and mental health to the baby.
4. Roll out and implement, underpinned by sufficient training, the OASI (obstetric and anal sphincter injury) care bundle to all hospital trusts to reduce risk of injuries in childbirth.
5. Oversee the national rollout of standardised post birth services, such as Birth Reflections, to give all mothers a safe space to speak about their experiences in childbirth.
6. Ensure better education for women on birth choices. All NHS Trusts should offer antenatal classes. Risks should be discussed during both antenatal classes and at the 34-week antenatal check with a midwife to ensure informed consent.
7. Respect mothers' choices about giving birth and access to pain relief and keep mothers together with their baby as much as possible.

8. Provide support for fathers and ensure nominated birth partner is continuously informed and updated during labour and post-delivery.
9. Provide better continuity of care and digitise mother's health records to improve communication between primary and secondary health care pathways. This should include the integration of different IT systems to ensure notes are always shared.
10. Extend the time limit for medical negligence litigation relating to childbirth from three years to five years.
11. Commit to tackling inequalities in maternity care among ethnic minorities, particularly Black and Asian women. To address this NHS England should provide funding to each NHS Trust to maintain a pool of appropriately trained interpreters with expertise in maternity and to train NHS staff to work with interpreters.
12. NIHR to commission research on the economic impact of birth trauma and injuries, including factors such as women delaying returning to work.

Over the past three months, we have been privileged to hear from parents from across the United Kingdom. They have trusted us with some of their most personal reflections and thoughts, often relating to deeply troubling memories and experiences. This, the first Parliamentary Inquiry into Birth Trauma, is as much their report as it is ours.

Our special thanks also go to all those who have supported the Inquiry and most especially to Kim Thomas who has authored this report. The issues and stories contained in the following pages may be difficult to read but underline that this issue transcends party lines and it will be up to whoever forms successive Governments to listen and act.

Theo Clarke MP
Chair
APPG on Birth Trauma

Rosie Duffield MP
Co-Chair
APPG on Birth Trauma

EXECUTIVE SUMMARY

The inquiry received more than 1,300 submissions from people who had experienced traumatic birth, as well as nearly 100 submissions from maternity professionals. It also held seven evidence sessions, in which it heard testimony from both parents and experts, including maternity professionals and academics.

The stories told by parents were harrowing. They included accounts of stillbirth, premature birth, babies born with cerebral palsy caused by oxygen deprivation, and life-changing injuries to women as the result of severe tearing. In many of these cases, the trauma was caused by mistakes and failures made before and during labour. Frequently, these errors were covered up by hospitals who frustrated parents' efforts to find answers.

There were also many stories of care that lacked compassion, including women not being listened to when they felt something was wrong, being mocked or shouted at and being denied basic needs such as pain relief. Women frequently felt they were subjected to interventions they had not consented to, and many felt they had not been given enough information to make decisions during birth. The poor quality of postnatal care was an almost-universal theme. Women shared stories of being left in blood-stained sheets, or of ringing the bell for help but no one coming.

The inquiry also heard, both from the submissions and the evidence sessions, accounts of the short-term and long-term impact of birth trauma. This included difficulties in bonding with the baby, stress on the relationship with their partner and wider family and, often, an inability to return to work.

Some of the most devastating accounts came from women who had experienced birth injuries, causing a lifetime of pain and bowel incontinence. Many of these women said they could no longer work, and described their injuries as having destroyed their sense of self-worth. Other women wrote movingly of having to provide round-the-clock care for children left severely disabled as a result of birth injuries.

Women from marginalised groups, particularly those from minoritised ethnic groups, appeared to experience particularly poor care, with some reporting direct and indirect racism.

The inquiry also heard from partners who had been psychologically distressed after witnessing traumatic birth, but whose emotional needs were disregarded, both during the birth and postnatally.

Many women wrote of their difficulty in accessing maternal health services, either facing long waiting lists or being told they didn't meet the criteria for help. There were, however, some positive stories from women who had successfully accessed therapy and been helped to recover.

We also heard from maternity professionals who reported a maternity system in which overwork and understaffing was endemic. Some referred to a culture of bullying.

The picture to emerge was of a maternity system where poor care is all-too-frequently tolerated as normal, and women are treated as an inconvenience. We have made a set of recommendations that aim to address these problems and work towards a maternity system that is woman-centred and where poor care is the exception rather than the rule.

Introduction

Why an inquiry into birth trauma?

While many women in the UK have a positive experience of birth, resulting in a healthy baby, this is not always the case, and this inquiry has focused on the times when birth has been traumatic, leading to poor outcomes for the mother or baby. In the past 10 years, there have been three major investigations into failings in maternity care at specific NHS trusts: Morecambe Bay[1], Shrewsbury and Telford[2], and East Kent[3]. A fourth is underway at Nottingham University Hospitals. These reports all led to recommendations to improve maternity care, but a current programme of inspections by the Care Quality Commission (CQC) has resulted in nearly half of maternity units in England being rated as either "inadequate" or "requires improvement".[4] Current policy on improving maternity care is fragmented. Although there are several national policy documents that address the need to improve maternity care, the inquiry heard that there is no single overarching strategy document.

Donna Ockenden, who is chairing the inquiry into maternity care failings in Nottingham, told the inquiry: "Leaders across maternity services report continuous requests for information from multiple bodies responsible for 'oversight' of maternity care in the UK. Frequently the requests are duplicated or only very slightly different showing that there is ineffective coordination between these multiple bodies. This is not efficient and wastes time. The system of maternity service oversight must be streamlined & this made more effective."

Research evidence shows that 4-5% of women develop post-traumatic stress disorder (PTSD) every year after giving birth[5], amounting to approximately 30,000 women in the UK, while about a third of women experience birth as traumatic.[6]

It is clear that this could have significant social and economic consequences, including: the cost to the NHS of treating PTSD and birth injuries; the cost to the NHS of litigation; of the effect on women's relationship with their baby and partner; and the effect on women's ability to return to the workplace. Yet the data on the impact of birth trauma is sparse. We welcome the UK government's decision to include birth trauma in the Women's Health Strategy, an important step in recognising the importance of birth trauma and making it possible to take steps to address it.[7]

Inspired in part by a parliamentary inquiry into birth trauma in New South Wales, Australia, launched in 2023, the aim of this inquiry was to look at the reasons why women experience birth trauma, how the condition affects them, the wider social impact and the steps we can take to prevent birth trauma.

The inquiry was guided by a Special Advisory Group (SAG) consisting of representatives from five organisations that campaign on issues relating to maternity (the Birth Trauma Association, MASIC, Make Birth Better, the Maternal Mental Health Alliance and Mumsnet), as well as birth campaigner Gill Castle.

How we gathered and analysed evidence

Our inquiry invited written submissions both from parents about their experience of traumatic birth and from maternity professionals. The call for evidence was published on Theo Clarke MP's website and advertised widely through social media. Witnesses were asked to provide their evidence as free-text submissions, up to 1,500 words in length.

The window for submissions ran from 9 January to 20 February 2024. We received 1,311 personal submissions from parents, and 92 from professional bodies, charities, campaign organisations and individuals working in maternity, such as midwives and obstetricians.

The inquiry also carried out seven oral evidence sessions, each with a different theme, which ran on consecutive Mondays from 5 February to 18 March. The inquiry heard from many NHS professionals as well as parents.

Apart from the second session, which heard from international experts and was held online, all the sessions were held in parliament in front of members of the all-party parliamentary group (APPG) of MPs, and were open to the public. The parliamentary sessions consisted of two 45-minute panels, with one panel consisting of expert witnesses, and the other of parents with lived experience of birth trauma. The final question for each panel was about the policy steps they'd like to see the UK government take to improve maternity care in the area discussed in the session. Their answers helped us shape our final recommendations.

Finally, Chair Theo Clarke MP held a separate online meeting with parents affected by failings in care at Nottingham. A short report on this meeting is included in Chapter 1.

Both the professional and personal written submissions were read by a team of volunteers linked to the organisations represented on the SAG.

The team reading the submissions kept a record on a spreadsheet of each account, including quotes and key details of the birth (such as the year it took place, whether it was a caesarean section, whether the baby was induced, whether the woman experienced tearing and so on).

We also used an open-source statistical package using R software to help us identify some of the word clusters and hence, key themes, to be found in the submissions. For example, the words "pain", "agony" "screaming" and "paracetamol", "epidural" and "finally" were often clustered together, leading us to stories where women were offered paracetamol for serious pain. Similarly, "husband," "Covid", "hospital" and "home" often appeared together, pointing to stories where partners were sent home from hospital during the pandemic. The words "forceps," "bladder", "stitches," "incontinence" and "surgery" also appeared together, telling their own story.

The oral evidence sessions were all transcribed, and, along with the written submissions, informed the findings of this report.

The structure of this report

We begin with a section on the key themes to emerge from the written submissions from parents. The following seven chapters map on to the themes of the seven inquiry sessions:

1. Birth trauma: an overview
2. What we can learn from other countries
3. Birth injuries
4. Birth trauma and mental health services
5. The wider impact of birth trauma
6. Partners' perspectives
7. Marginalised groups

Each chapter draws on research evidence, as well as evidence from the personal written submissions, the professional written submissions and the oral evidence. We conclude the main body of the report with a Vision chapter, which describes what we think a good maternity care system would look like. Appendix 1 lists recommendations for improvement in maternity care. These were drawn up by SAG members and are largely based on the recommendations made by witnesses in the oral sessions in answer to the question about policy changes.

Note on quotations

Unless otherwise stated, the quotations in this report come from the written evidence, and, except for one standalone case study in Chapter 5, who gave permission to be named, they have been kept anonymous. Names are used for quotations from the oral evidence sessions.

Thanks

We are immensely grateful to everyone who wrote in, particularly those who shared personal stories, many of which shared intensely distressing experiences. Every single story was read, and, although we were unable to acknowledge each one individually, they all provided valuable insights that have gone to inform the findings in this report.

KEY THEMES

Although the majority of personal submissions related to medical emergencies, the emergency itself typically only formed part of the trauma. Many spoke of feeling fearful that they or their baby would die: the word "terrified" appears in 266 submissions. Words like "shame," "humiliation" and "embarrassment" also come up repeatedly, while the word "broken" appears in 328 submissions. The overwhelming narrative was one of distress at being neglected, ignored or belittled at a time when women were at their most vulnerable.

Below are some of the most common themes to emerge.

Failure to listen

A failure to listen to women when they said that something was wrong was a feature of many, if not most, of the written submissions. Often, they were told they were being over-anxious. One woman who was in extreme pain for the last few weeks of her pregnancy, had "anxious mother" recorded on her notes. In fact, she was bleeding internally as the result of spontaneous hemoperitoneum, a rare and often fatal complication of pregnancy whereby tissue had torn behind her uterus.

Another woman wrote of how she kept calling the hospital for a scan:

"My bump height had dropped 8 days before and my midwife had sent for a growth scan, but nobody contacted me to tell me the scan had been refused. I called up chasing it 44 times on one day, but was just told there was a note saying 'scan refused, bring induction forwards', which nobody did. My midwife kept reassuring me it was her head in my pelvis, so I didn't know whether to be worried or not so I pushed for the scan to see if there was something wrong."

Had she been given a scan, as recommended in National Institute for Health and Care Excellence (NICE) guidelines, it would have identified that her baby was experiencing growth restriction and appropriate action taken. Her baby died during labour.

This failure to listen continued postnatally. One woman who experienced "horrendous urinary and faecal incontinence" was told by a consultant that there was nothing physically wrong with her, and that the symptoms were a result of her poor mental health. Another described reporting her concerns about her baby:

"I was concerned that my baby was looking 'yellow' and asked the midwife. She told me I was being overly anxious and he was fine. She wrote in my notes that I was an overly anxious mother and my baby was NOT jaundiced. My husband intervened and a doctor confirmed my baby was jaundiced and he was treated. The next day the page written by the midwife had been torn out."

One woman described how her severe physical symptoms, including fatigue and tremors, were wrongly diagnosed as psychological in origin, leading her to receive eight sessions of electroconvulsive therapy. After several years, she was diagnosed as having a rare thyroid condition.

Lack of informed consent

The problems with consent start antenatally. Although the case of Montgomery v Lanarkshire[8] established that patients should be informed about risks, this is often not happening in practice.

Many women told us that they were not informed that they had raised risks of particular complications, such as tearing, which would have enabled them to make more appropriate decisions. One woman was told she had a bicornuate uterus, but was not told that this put her at risk of premature birth. She went into labour at 28 weeks, and her baby died shortly after birth. Another wrote:

"Nobody informed me of the tear or in fact any risks associated with episiotomies and forceps deliveries, and when it became clear to me, due to daily incontinence, that extended well beyond 6 weeks postpartum that I had suffered some major injuries, it took constant emails to the midwives and my GP before anyone would refer me to gynaecology where they eventually, after months and months on a waiting list, diagnosed the tear, multiple organ prolapse, cysts caused by infected stitches, and nerve damage."

During labour itself, numerous women told us that they had procedures such as vaginal examinations or cervical sweeps performed without consent. This caused a lot of understandable distress. One wrote:

"Whilst contracting and alone a doctor came to examine me. She did a vaginal examination and without consent broke the rest of my waters."

There was also a clear problem with consent when interventions such as forceps or caesarean sections were being carried out. Many women said that, at the point when they were required to sign a consent form, they were in no position to give informed consent, either because of the urgency of the situation, or because they were too ill:

"Feeling slightly delirious and with tears streaming down my face I kept asking [my partner] where the doctor was. I became more hysterical by the minute and felt nauseous and disoriented from all the gas and air. Finally the doctor arrived to tell me that a theatre was being prepared and to talk me through the consent form. I had absolutely no interest in going through anything, and I could barely talk properly anyway. I took the gas and air attachment out of my mouth, nodded my consent then scribbled my signature on the form and stuck the mouthpiece straight back in again. I closed my swollen, tear-stained eyes and just wished for the whole experience to be over."

A number of women also reported having their request for caesarean section denied, either before labour or during labour. One wrote:

"I had stated I felt my little boy was stuck and that I was not going to be able to get him out myself. I was only getting pain on my right side which was so intense. I had to wait for what felt like forever for an epidural and begged them for a c-section as I just knew something wasn't right. She laughed at me and told me it doesn't work like that."

Poor communication

Many women described not being told what was happening during labour, with some only finding out that they had a particular condition when they read their medical notes or had a birth debrief months later.

In other cases, there were unfortunate communication mix-ups. Heather Simmons, giving oral evidence in session 5, told the inquiry that, after an intensely traumatic birth, in which her baby was taken to the neonatal intensive care unit (NICU) and she herself was barely able to walk, she was told by the midwife that her blood results showed she had been taking drink and drugs in her pregnancy. As a result, her daughter was given an HIV test, without Heather's consent. In fact, the midwife had been reading from someone else's notes.

One woman described in a written submission how her daughter was born poorly. Although she was well cared for, the neonatal team did not give clear information about her prognosis:

“They were saying her condition could cause anything from mild dyslexia to severe cerebral palsy, and in the same conversation they were talking about end-of-life care. How is a discussion about mild dyslexia compatible with deciding on end-of-life care?”

Her daughter was transferred to a specialist unit at a different hospital, where she received good care until she died when she was five days old. The first hospital, however, had informed the health visitor team of the birth, but not the circumstances, so the day before she died, the mother received a call: “Congratulations on your baby! When can I come and see you?”

At her daughter’s inquest, the hospital repeatedly called their daughter by the wrong name.

Lack of pain relief

A high proportion of the submissions referred to a lack of pain relief, with women left to labour in agony. In many cases, women in acute pain were offered paracetamol. One woman who turned down paracetamol because she thought it was insufficient says the midwife responded by throwing the paracetamol in the sink:

“I was literally left lying on the ground in pain wanting to die as the pain was so intense and unbearable. Although I was not dilated enough to push, I was having intense contractions every 2 minutes and the pain was excruciating and exhausting. My partner kept asking for help but was dismissed.”

During her 36-hour labour, she was also denied an epidural because her platelets were too low. She remembers being violently sick, and jolting from the pain of having her waters broken. She sustained a third-degree tear:

“Without an epidural the pain was intense, but the midwife nonetheless chastised me for flinching in pain when he had a go at stitching me up when in fact surgery was necessary.”

Lack of kindness

The overwhelming majority of written submissions referred to a lack of kindness or compassion on the part of the health professionals looking after them:

“My husband was sent home. It was after visiting hours. I was moved to the ward. I could not stand or walk. I had a catheter. I was covered in blood and my own faeces but there was no one to help me wash. A plastic sheet was put on the bed and I lay on it in my filth. Around midnight I was woken up by a woman (I don't know who she was? A nurse? A midwife?) who reprimanded me for not feeding my baby. He was asleep. I didn't know what to do and I couldn't pick him up. I tried to get out of the bed but when she saw I was covered in blood and shit and hooked up to a catheter, she told me to get back in and said she'd hand him to me. I didn't know how to breastfeed. She told me if I didn't get it, she would take my son and give him a bottle. I felt like I was failing at mothering and I'd only been a mother for a few hours."

This lack of kindness was apparent even in cases where the baby died. Giving oral evidence in session 4, Emily Barley told the inquiry that staff ignored red flags during her labour, including meconium-stained waters. After her baby was found to have died, Emily pleaded for a caesarean, but the consultant obstetrician refused, and then walked out, without explanation, followed by all the other midwives and obstetricians who had been in the room:

"I was around eight centimetres dilated. The baby was imminent. But I was left without care for over half an hour. Just my mum. I remember asking 'Where has everyone gone? Where are they?'"

A few written submissions mentioned how much women valued kindness from health professionals when it was displayed, with one writing: "The kindness of midwives/nurses where it exists stands out for its rarity – and there were, both times for me, some truly wonderful staff."

Breastfeeding problems

A large number of women referred to problems with breastfeeding as major contributory factors in their trauma. There were stories about being forced to attempt breastfeeding when it was impossible (for example because they had a severe postpartum haemorrhage), or being made to feel like a failure for not being able to breastfeed.

Frequently, women were pressured to breastfeed, but not given help to do so:

"As my baby lay crying, waiting for a feed that I had no idea how to give, covered in my own blood, without even a glass of water by the bed, I have never felt so alone. I had no idea how to breastfeed – ringing the bell brought no one during the night, and attempts to ask midwives during the day were brushed off."

“When the midwife returned I said I wanted to breastfeed my baby, she just lifted my top and flipped my breast up and said ‘You’ve got no milk in there’. I was completely blindsided and humiliated, I couldn’t process what was happening to me.”

Postnatal care

Poor postnatal care was mentioned in nearly all the personal submissions. On the postnatal ward, women described being left alone, often unable to move after an emergency caesarean or difficult forceps birth, but with no one to help them go to the toilet or lift their baby. Many wrote of ringing the bell to call for help and having no one come:

“About 6 hours after [my son] was born, I experienced a heavy bleed. I could see my white hospital bedsheets going red and I thought I was haemorrhaging again. I pressed my bell, nobody came. I pressed it again harder and nobody came. Another mum opposite me saw the sheets going red and my distress and went to get somebody. In that moment, I believed I was dying and my baby was going to be there in the hospital alone, with his mother dying next to him and nobody there who loved him or even knew his name. I was terrified.”

Several had stories of being left to lie in their own blood, urine or excrement, or even berated by midwives for having soiled themselves. One woman said that after an emergency caesarean she developed sepsis and was put on an antibiotic drip, restricting her mobility. Her husband was sent home. Her baby, having been taken away and given antibiotics for suspected meningitis, was brought back:

“I was not only expected to try and calm her but also change her as she had been sick and was soiled on arrival. Staff pushed her in to the end of the bed, told me to clean the baby up because she’d been sick and was soiled and walked off. I could hear the staff all outside the bay sat at the nurses’ station laughing and planning on ordering a Chinese takeaway before they closed.”

The poor care typically continued once women had gone home. In some cases, women reported having birth injuries that went undiagnosed. Mental health symptoms as the result of a traumatic birth were ignored or treated dismissively. The six-to-eight week GP check, if it happened at all, was often cursory, and frequently focused on the baby rather than on the physical or mental health of the mother.

Giving evidence to the enquiry, Professor Angie Doshani, a consultant gynaecologist and obstetrician, quoted an American obstetrician, Alison Stuebe on the lack of postnatal care: "The baby is the candy, the mum is the wrapper, and once the baby is out of the wrapper, we cast it aside." This felt particularly pertinent in the stories we read.

The impact of Covid

Surveys of women in England after they had given birth showed a sharp increase in the proportion experiencing postnatal post-traumatic stress (PTS) in 2020.[9] The most plausible explanation is that restrictions during pregnancy and birth (for example, partners not being allowed to attend throughout the labour or remain on the postnatal ward, and the absence of mental health support or networks postnatally) raised the likelihood of women becoming traumatised by birth.

We had numerous submissions from women who gave birth in 2020 and 2021. They typically spoke of feelings of isolation and fear when their partners were not allowed to be with them during the early stages of labour, or sent away after the birth. One woman experienced a postpartum haemorrhage on the postnatal ward after her husband had been sent home, and was given a manual clot removal. "It was the scariest and most painful experience of my life," she wrote. "My daughter lay nearby, but I couldn't reach her. I felt like a failure... My husband was contacted, and he came back, but I'd already experienced my trauma alone."

Another woman who gave birth during lockdown, found herself left alone after a traumatic birth:

"I cried. I cried and cried. I couldn't walk, I had no strength to hold my baby, I had no breast milk yet, I had no help, no aid, no support. This was the most vulnerable state I'd ever been in. The magic and joy of having your first child, experiencing the hardship yet pride of childbirth had been brutally removed."

The midwife told her to "stop being a baby" and that it was "time to grow up."

She added: "I felt bullied, humiliated and dirty. As I was wheeled away, covered in dried blood stains, oily hair, dirty skin, smelly sweaty clothes, pants still covered in my birth water. I felt disgusted and embarrassed."

For some, the pandemic reawakened memories of earlier trauma. A woman whose traumatic birth happened in 1990 has been left with long-term anxiety, flashbacks and intense needle phobia. She wrote that the pandemic "was unbearable, it was like living in my own hellish mind. Who would have thought that the whole world would become reliant on the NHS, and a needle delivering a vaccine? The continuous news stories, images, publicity campaigns and conversations tormented me to the point of a breakdown. I had multiple triggers every single day. I had to have 6 months off work." She now despairs of ever overcoming her trauma:

"My life is like a never-ending horror show, with triggers every day. It is often unbearable. I took an overdose in December 2023 out of pure desperation, and I was disappointed that I survived it."

Complaints and medical negligence

Many written submissions described how the experience of birth trauma was made worse by a failure of hospitals to deal sensitively with complaints about poor care. A common theme was that complaints were often treated dismissively, with failings in care unacknowledged. Birth notes were often falsified or lost.

One woman gave birth to a stillborn baby. At 36 weeks she reported that her baby's movements had slowed, and she says she was told that this was "normal for this stage in pregnancy". Her notes incorrectly stated that she had said the baby's movements were normal. In labour, she was denied a caesarean section and administered a morphine injection that she did not consent to. Later she agreed to a post-mortem for her daughter "with the expectation and assurance that my placenta would also be analysed." The placenta, however, was "lost due to midwife admin errors resulting in no details as to why my daughter died."

Some women struggled to take legal action because, by the time they felt well enough to go to law, they had passed the three-year time limit. In other cases, hospitals challenged the woman's version of events. One husband wrote:

"The hospital basically discounted her account, and seemingly tried to find flaws, even saying that someone suffering with PTSD could not have mentally written the complaint. The eventual outcome was the hospital admitted failures and settled out of court, after stringing her along for over a year, I believe in the hope she would give up."

It is clear that the statutory duty of candour, introduced in the wake of the Francis report, is not being applied effectively. The government's decision, announced in December 2023, to review the statutory duty of candour may help to change this.

Chapter 1: Birth trauma: an overview

Drawing on research evidence, testimony from the first oral evidence session and written testimony from parents and maternity professionals, this chapter offers an overview of the causes and effects of birth trauma, and highlights the key themes to emerge from the inquiry. It also has a section looking specifically at stillbirth and neonatal death, because these were a feature of many of the personal submissions. It concludes with an account of concerns reported by parents affected by poor maternity care in Nottingham in a meeting with Theo Clarke MP. Later chapters will explore in more detail the wider consequences of birth trauma for the NHS and for the economy.

What is birth trauma?

Birth trauma can be defined as "a woman's experience of interactions and/or events directly related to childbirth that caused overwhelming distressing emotions and reactions, leading to short- and/or long-term negative impacts on a woman's health and well-being."[10] Some people also use the term to describe injuries the mother may have sustained during birth, such as third- or fourth-degree tears. Traumatic birth experiences are subjective – it is the woman's perceptions of threat that are most important. About 4-5% of women develop post-traumatic stress disorder (PTSD) every year after giving birth, equivalent to approximately 30,000 women in the UK.[11]

Women with postnatal PTSD are also at greater risk of developing depression.

Symptoms and diagnosis

Birth trauma presents on a scale. At the most severe end, women may meet the clinical diagnosis of PTSD, a severe and debilitating mental illness. Even those who would not meet the diagnostic criteria, however, can struggle intensely with their symptoms.

To be diagnosed with PTSD, someone has to have been exposed to actual or threatened death, serious injury or sexual violence. Women who develop postnatal PTSD have almost all had an experience of childbirth where they believed that they or their baby were going to die. There are four symptom categories: intrusions; avoidance; changes in cognition and mood; and arousal and reactivity (such as becoming hypervigilant). A diagnosis of PTSD requires someone to experience all four symptoms for at least one month. [12]

Intrusion symptoms typically encompass flashbacks and nightmares, while arousal symptoms take the form of a feeling of intense anxiety or being on high alert. Avoidance means that an individual avoids any reminder of the trauma, such as television programmes about birth or appointments with health professionals. Characteristic changes in cognition are feelings of guilt or low mood.

Causes of birth trauma

Research has identified particular risk factors for developing PTSD. Women who have preterm births, stillbirths, or severe complications are more likely to develop PTSD (16%-19%).[13] Other risk factors include a negative subjective birth experience, an assisted vaginal birth (forceps or Ventouse) or caesarean, and psychological dissociation. Support during birth is a protective factor.[14]

Certain factors not related to the birth also increase the likelihood of a woman developing PTSD. These include depression in pregnancy, fear of childbirth, poor health or complications in pregnancy, previous trauma (such as sexual assault), or previous therapy for pregnancy or birth-related problems.[15] Survivors of sexual abuse, for example, are 12 times more likely to experience birth as a traumatic event.[16]

People are twice as likely to develop PTSD after a traumatic event caused by another person (such as rape) than after an impersonal trauma such as a natural disaster.[17] Research into postnatal PTSD suggests that for most women, it is not simply the birth complications, but the combination of complications with poor care from health professionals, that leads to psychological distress.[18]
This was supported by the first-hand personal accounts we received in written submissions, as well as the evidence we heard in the oral inquiry sessions from both experts and women.

Am analysis of the personal submissions highlighted some of the most common features of women's birth experiences:

- 694 gave birth by caesarean section (in almost all cases, this was an emergency rather than planned)
- 378 women gave birth by forceps
- 247 had a baby who spent time in intensive care or special care
- 106 experienced a third-degree tear
- 41 experienced a fourth-degree tear

In most cases, then, there was an objectively traumatic element – a baby who was born poorly, for example, an emergency resulting in caesarean or forceps, or a physical injury. On their own, however, these don't necessarily mean that a woman will develop postnatal PTSD. In practice, the vast majority of evidence, both in the written submissions and in the oral testimony, spoke of poor and sometimes negligent care as major contributory factors to the trauma, as we already saw in the Key Themes section.

In session 1, Rachael McGrath gave oral evidence about her twin pregnancy, which ended with her being rushed to hospital with an abrupted placenta, and believing that she was bleeding to death. Her babies were born by caesarean section under general anaesthetic and then taken to special care. Rachael went into renal failure and on day five postpartum experienced a complete dehiscence (disintegration) of her C- section scar. "Nobody treated the fact that my insides were now on the outside," she said. "They stuck a sanitary towel over my abdomen and left me there for 10 days until eventually…I became gravely ill again."

Rachael described being treated as "a birthing vessel" and "a slab of meat." She added: "It was so impersonal…I would have somebody holding a blood pressure cuff taking my blood pressure and on their phone giggling and texting with the other hand. I was in for such a long time and some of the staff would come and get in my room and talk about other patients unkindly and talk about other staff members unkindly."

Many of the personal submissions talked about feeling unprepared for childbirth, with many women unaware of the possible adverse outcomes, such as third- or fourth-degree tearing. Dr Ranee Thakar, president of the Royal College of Obstetricians and Gynaecologists, told session 1 of the inquiry that women commonly asked her why they hadn't been told that perineal tearing was a possibility: "We often don't talk to them because we think that women will be frightened and they will want to have a caesarean section if we tell them about birth trauma, but research that we have done has actually shown us that women want to know, they want to know the details and they will be the people who will make the decisions."

How birth trauma and PTSD affect women

At a time when a woman is already dealing with the difficulties and stress of looking after a newborn, PTSD is debilitating. Women may avoid mother-and-baby groups because they fear being triggered and experiencing flashbacks. They may be so fearful of the baby coming to harm that they refuse to leave the house or let anyone else hold the baby. Rachael told the inquiry how postnatal PTSD made her terrified her babies were going to die: "If I don't check that the babies are still breathing, they will stop. If I go and get a shower, the babies will be dead by the time I get out. If I go downstairs the dog is downstairs, the dog is dirty, the babies will catch a bug." Her marriage nearly broke up, and because she couldn't go back to work, for a while faced financial ruin. Eleven years on, she still experiences the mental and physical health consequences of what happened to her.

While the majority of the submissions we received described births that happened in the past 5-10 years, a minority of submissions came from women still affected by a traumatic birth that happened decades ago. These were profoundly moving. Women in their 60s and 70s wrote about how the memory of the birth was still vivid, and how the experience of writing it down had affected them emotionally. Some of these stories were heartbreaking accounts of baby loss, often compounded by a lack of care and compassion. One woman who gave birth in 1973, for example, wasn't allowed to see her stillborn baby, or told whether it was a boy or a girl. In other cases, it was the trauma of the birth itself that continued to affect them.

There were other women who had given birth in the past 10-25 years who were deeply affected, physically and psychologically, by their traumatic birth. In many cases, they continued to suffer depression or PTSD. Often their marriages had broken up, or they had chosen to have no more children, supporting the findings of a joint survey carried out by the APPG on birth trauma and Mumsnet in 2023. This survey, which received 1,042 responses, found that more than half of the mothers who replied said they were less likely to have more children because of their experience.[19]

Some women had had to give up work. Many spoke of having their self-confidence, and their sense of worth, destroyed. Others wrote of living with constant physical pain or incontinence as a result of damage sustained during the birth. One woman provided a list of injuries she had sustained as a result of birth, and which continued to affect her many years afterwards. These included a broken hip, broken pelvis, multiple internal injuries and infections, a twisted bowel, damage to the base of her spine and damage to her glutes. She can no longer carry out simple tasks such as standing to wash dishes.

Kate Lough, a pelvic health specialist physiotherapist, told the inquiry that she sees women in their 60s and 70s who have developed prolapse many years after their birth, but are able to vividly describe the events of their birth decades earlier: "They can still tell you exactly what went on, how they felt, the language that was used."

Some women described how the memory of the birth continued to affect them. One wrote:

"I've tried, but at times I'm transported back to that darkened room where I'm held down as someone cuts me open without my consent and then belittles me for daring to show that I was in excruciating pain. Fifteen, nearly sixteen years down the line, and that feeling of being dehumanised is still as fresh in my mind as the day it happened. Mothers are frequently described as heroes, but how much of our heroics are only necessary because our pain is dismissed?"

Stillbirth and neonatal death

Some of the most concerning stories in written submissions came in those (a sizeable minority) that recounted stories of babies who were stillborn or died shortly after birth. These stories were almost all characterised by two things: mistakes made during labour and a lack of compassion towards the mother. One wrote:

"The scenes in theatre can only be described as chaotic and these along with subsequent events have left me traumatised and suffering with PTSD. During the operation I could hear phrases such as 'where the bloody hell is the consultant', as well as other panicked comments."

There were several stories from women who experienced signs of labour in the second trimester but were told that they were mistaken. One woman carrying twins, who went into premature labour at 19 weeks, was initially disbelieved. After she lost the first baby, she wrote:

"I was told by one of the consultants to stop my crying, calm down and try to save the other baby. His words were: 'This baby was dead a long time anyway so you should stop stressing over it and let's try to save the other one.'"

The other baby also died, however, and 17 years later she is still "traumatised by this whole experience that has left me suicidal. I am unable to move on with a normal life, while still struggling with my mental health…I don't know if I will ever be myself again. Animals are treated better than the way we were treated in hospital."

In another case a woman who had a high-risk pregnancy started having period-type pains at 23 weeks. Initially the hospital told her they were "growing pains" and gave her paracetamol. A few days later, a midwife told her the pains were caused by thrush. Shortly afterwards, it became clear that she was in labour. She gave birth to a little boy who died 11 days later.

Other women mentioned being put on a ward with other women who were labouring. One woman, who gave birth three years ago, was advised to terminate her pregnancy because her baby had an abnormality that meant she would likely die before birth. She describes having an injection to stop the baby's heart and then being admitted to the labour ward for an induction:

"I was ultimately there for 11 days trying to deliver my dead baby, listening to other women's labouring noises and baby's cries. They had a 'bereavement suite' which we were able to move into partway through but it was still on labour ward."

In some cases, the neglect continued after the birth. One woman, who gave birth to a stillborn baby at 23 weeks in 2023, described being told by her GP that she wasn't entitled to a six-week check because she didn't have a living baby.

Almost all the women who had lost a baby, whether recently or decades ago, said that it had permanently affected them psychologically, with many reporting feeling suicidal.

What does good care look like?

It is clear that some problems in maternity arise from under-staffing, resulting in overworked staff experiencing burnout. As Gill Walton, president of the Royal College of Midwives, told session 1 of the inquiry, having a "fully-staffed and highly-trained workforce that have time to work with women antenatally to provide the right care during labour and birth" is a prerequisite to preventing birth trauma.

Donna Ockenden, chair of the Independent Review of Maternity Services at Nottingham, told session 4 of the inquiry that there was a particular problem with retention, which was not easily solved by recruiting junior midwives: "If we are losing midwives with 20, 30, 35 years' experience, if they are leaving the NHS in their fifties, early sixties because they can't cope with the physicality of the role, and if they are then being replaced by a more junior workforce who are not being supported in those early days of their career…two going out doesn't equal two coming in."

Without addressing the issue of retention and recruitment, improving care will be challenging. Some women who wrote to the inquiry were able to provide examples of good care, however, despite the birth itself being traumatic. One contrasted the care she received at her local hospital with the care she later received at a tertiary care hospital. Initially, she was told by a consultant that one of her twin babies would likely die, thereby causing the death of the other. He recommended "selective feticide". She decided to keep the babies, and from that point had shared care between her local hospital and the tertiary hospital 160 miles away.

The care at her local hospital was poor (for example, she was kept waiting up to 12 hours for regular blood tests), but her babies were delivered "safely and calmly" at the tertiary hospital, at 27 weeks, 5 days of pregnancy. While the birth was traumatic, there was "a strong sense of solace and comfort that here…they clearly had done this many times before and they knew what to do. I felt as a patient, actively heard and firmly and safely 'caught.' The delivering consultant proudly telling me hours before the birth, 'This is the safest place in the world for your girls to be born today.' And I believed and trusted her. I remember her."

This sense of being heard, and being cared for, seems to be the key to good care, and the element that is missing from so many of the other stories we received. Having a premature baby is a traumatic and anxious experience, and she describes her twins' 150 days in NICU as "filled with major surgeries, ventilation and many blood transfusions." Two years on, she reflects that she is "one of the lucky ones", because her babies came home, but her maternity journey was a bumpy one, and she has not found an NHS service to provide her with the emotional support she needs. She adds: "We have to provide safety netting universally throughout the whole passage."

Nottingham families

After the formal inquiry sessions were over, Theo Clarke MP met with seven families affected by failings in maternity care at Nottingham University Hospitals Trust. Currently nearly 1,900 cases are being investigated by Donna Ockenden as part of her review into maternity services at the trust.

All the families shared stories in which medical neglect led to the deaths or injuries to their babies, or in one case, injury to the mother. The neglect was compounded by a cover-up on the part of the trust, who failed to acknowledge mistakes, falsified notes and lied to families about what had happened.

The stories were uniformly horrifying. Jack and Sarah Hawkins spoke of how Sarah had experienced contractions for six days but was refused admission to the maternity unit. Their baby Harriet was stillborn, because of staff's failure to perform basic checks. The hospital then falsely told the parents that Harriet had died from an infection. Because Harriet was stillborn, there was no inquest. "The reason she was a stillbirth was because I had such negligent care that she couldn't take a breath," Sarah said.

In another case, Natalie Needham's son Kouper died of respiratory problems one day after being born. Natalie told the meeting that a midwife had wrongly stated on Kouper's discharge papers that she'd seen him have a four ounce bottle and that she was "happy and content that he was established feeding." Natalie and her husband were initially arrested on suspicion of murder, and not told for six months that they were in the clear. She was also mistakenly sent pictures of Kouper's postmortem in the post.

During an emergency caesarean, Felicity Benyon had her healthy bladder removed, and was wrongly told that the placenta percreta had enveloped the bladder, and that she would have lost it anyway. It was a urologist who blew the whistle and told her that the mistake had been covered up.

Sarah Sissons's son Ryan suffered brain damage at birth. Again, the hospital tried to avoid taking responsibility for his injuries, and at one point Sarah was accused of having Munchausen's by Proxy – in other words, of inventing his injuries.

Kimberley Errington's son Teddy died after the hospital failed to carry out monitoring for post-natal hypoglycaemia. Carly Wesson and Carl Evlington had a test that indicated their baby had a condition that meant she wouldn't survive much beyond birth and were advised to terminate the pregnancy. After they made a complaint about aspects of their treatment, the hospital carried out a further investigation and told them that tests showed there had been nothing wrong with their daughter. No one has been held accountable for the errors.

Sarah Andrews's daughter Wynter died after numerous mistakes were made during labour, including a failure to monitor the baby's heart rate.

The parents felt it was important that hospitals should be subject to greater accountability than they are at present. Jack Hawkins said: "Not a single person has been held to account in any way whatsoever by the regulatory bodies…All of these are manslaughter, failure of duty of care, failure of duty of candour. "

Chapter 2: What we can learn from other countries

Introduction

In session 2 of the inquiry, we heard evidence on birth trauma from experts based in Australia, Switzerland and the Netherlands.

Access to, and provision of, maternity care varies widely across the globe. Women in low and middle-income countries (LMICs) generally have poorer access to maternity care and higher levels of socio-economic disadvantage, leading to worse maternal and infant outcomes.[20] Information gathered during the UK-led INTERSECT study (www.intersectstudy.org), which publishes its first results later this year, is expected to highlight vast differences in access and type of maternity care across countries.

Most research on traumatic births and postnatal post-traumatic stress disorder (PTSD) has been conducted in high-income countries, such as the UK, Australia, USA and some European countries. Research on postnatal PTSD in LMICs is sparse but largely suggests a higher rate than that in developed countries (29% in Iran, for example[21]), though a study from Sri Lanka reported a rate of 3.6%.[22]

In Europe, collaborative work has resulted in a set of recommendations for reducing traumatic birth, including respecting women's rights before, during, and after childbirth; preventing maltreatment and obstetric violence; and integrating principles of trauma-informed care across maternity settings.[23]

Initial work on prevention by Professor Antje Horsch at the University of Lausanne found that, by engaging women who'd experienced a potentially traumatic birth in a visuo-spatial game, Tetris, it was possible to interrupt the laying down of traumatic memories and stop the development of PTSD.[24] This proof-of-principle study is now being followed by a double randomised controlled trial with 100 women, in which women are asked to come back to the hospital where they had a traumatic birth, having avoided it for up to several years afterwards. "If they play Tetris for 20 minutes as part of a procedure that we carry out with them, we are actually able to reduce the already established post-traumatic stress and symptoms," Professor Horsch told the inquiry in the oral evidence session.

Support for women with birth trauma is limited, however. A 2021 mapping exercise of 18 European countries, which looked at policies on prevention and support for traumatic birth, found that only one, the Netherlands, had a national policy relating to screening, treatment and prevention of a traumatic birth. The exercise "highlighted a lack of national policy guidance on the prevention, care, and treatment of a traumatic birth experience."[25] In a small number of countries, the gap is filled by charities, notably the UK's Birth Trauma Association, founded in 2004, the Australasian Birth Trauma Association (ABTA) and New Zealand's Birth Trauma Aotearoa.

Australia

Australia's Birth Experience Study (BESt), a national survey of more than 8,500 women who had given birth in the previous five years, found that 11% responded "yes" or "maybe" to a question asking whether they had experienced obstetric violence, which refers to abusive behaviour or forced intervention on the part of a maternity professional. Many of these reported feeling violated, dehumanised or powerless.[26] Complaints from dozens of women about traumatic births experienced as a result of poor care at Wagga Wagga Base Hospital led to a decision by the New South Wales parliament to hold an inquiry into birth trauma. The inquiry, whose results have not yet been published, received more than 4,000 submissions and heard oral testimony from many deeply traumatised women.[27]

ABTA's submission to the New South Wales inquiry, based partly on its own survey of women with birth injuries, included stories in which physical injuries combined with poor care to cause psychological trauma. Women in severe pain as a result of injuries found it difficult to access medical treatment, with one saying: "I also presented to an emergency department on multiple occasions in extreme pain, being barely able to walk. The medical staff laughed at my extreme reaction of pain to a physical examination and dismissed me as a stupid woman who should see her GP."[28]

Amy Dawes, CEO of ABTA, told the UK inquiry that the Australian maternity care and training system are largely modelled on the UK and therefore have similar outcomes. One of the themes to come out of the New South Wales inquiry was a lack of informed consent. Ms Dawes said that women were not informed antenatally about the risks of instrumental birth. This includes obstetric tearing and ani levator avulsion, when the ani levator muscle separates from the pubic bone, creating a risk of urinary and bowel incontinence and pelvic organ prolapse. She said it was impossible to "provide informed consent if the first time you're hearing about an induction is in that moment, and you're not being given the facts and the risks and the potential outcomes of a cascade of intervention."

Ms Dawes said that birth injuries could have a major impact on women's ability to lead a normal life. They may be unable to engage in physical activity, for example, return to work, or enjoy a sexual relationship. Often women's self-esteem suffers, and women with these injuries have higher rates of suicidal ideation, Ms Dawes added. She highlighted her concerns about the normal birth policy, "which is really adopting that one size fits all approach to birth and not looking at individualized care and bringing it down to an individual's unique set of wants and needs."

ABTA, Ms Dawes told the inquiry, recommended a model of care "where we have midwives and doctors and pelvic health, physios and mental health clinicians working collaboratively to provide information that's relevant to their expertise so that women can be empowered with information and make the choices that best suit their individual wants and needs."

Emma Hurst, an MP in the New South Wales Parliament, who chairs the Australian inquiry into birth trauma, said that she had also heard stories from sexual assault survivors who had been given physical examinations during birth without consent being sought, retraumatising them: "It's made them feel as though they were sexually assaulted again, so we need to make sure that trauma-informed care goes across the entire healthcare system."

Some women who had experienced stillbirth gave accounts of being left in a birthing suite where they could hear other mothers giving birth. Others reported being denied pain relief, or of being subjected to inappropriate comments, such as being mocked for not knowing how to breastfeed their babies. Many said that they felt they were not listened to.

Like the UK, Australia has a high proportion of women giving birth whose first language isn't English, with 30-40% of birthing women having immigrated from another country. Ms Hurst said that while there were interpreters available, they weren't always expert in health care: "This adds more stress on the marginalised women that are entering hospitals to give birth as well."

Dr Hazel Keedle, senior lecturer and director of academic programmes for midwifery at the School of Nursing and Midwifery, Western Sydney University, added that the BESt study had found that First Nations communities had a birth trauma rate of 37%, higher than non-Indigenous women, whose rate was about 28%.[29] Among Indigenous groups, one in six said they had experienced obstetric violence, compared to one in 10 of non-indigenous women.

Dr Keedle said she would like to see the implementation of a continuity of care model, in which a woman is supported during birth by a midwife who knows her personal history and what her expectations are for the birth. Women would also be better able to provide informed consent, because they would have had conversations with their midwife during pregnancy.

Europe

Across Europe, there is variation in the incidence of birth injury, particularly obstetric anal sphincter injury (OASI), also known as a third- or fourth-degree tear. The association between OASI and postnatal PTSD is well-established,[30] so efforts to reduce OASI rates could also reduce the incidence of PTSD.

OASI is much more common with forceps births and, to a lesser extent, Ventouse (also known as vacuum) births. In England, approximately 7.5% of all births are by forceps, while 5.1% are by Ventouse.[31] Forceps can result in damage to a woman's pelvic floor, anus and perineum leading to urinary and bowel incontinence and pelvic organ prolapse, in which the uterus, for example, bulges out of the vagina.[32] In some cases, the prolapse occurs many years after the birth.[33]

In certain European countries, such as Sweden and Austria[34], the incidence of forceps use is much lower, and some countries have abandoned its use altogether.[35] These countries use Ventouse as the main instrument of delivery, leading to much lower rates of OASI. One plausible explanation for the differential use of forceps is that in the UK, the failure rate with Ventouse is high – about 25%, compared to a 2% failure rate for forceps.[36] If a Ventouse delivery fails, then the obstetrician is likely to move either to forceps or to a more risky emergency caesarean section (compared to one planned or performed earlier in labour). For this reason, anecdotally, many obstetricians prefer to avoid Ventouse in favour of forceps.

In contrast, the Netherlands has a 3% failure rate for Ventouse.[37] If we could identify why some countries have a lower failure rate for Ventouse, that could help improve Ventouse success rates in the UK, and reduce the use of forceps, thus lowering the number of women experiencing birth injuries and developing PTSD or birth trauma. Jan Willem de Leeuw, a Dutch obstetrician, told our inquiry that in the Netherlands, only 7% of births used instruments, and in the vast majority of cases, this was Ventouse rather than forceps. At the same time, caesarean rates are much lower than the UK – about 18% to the UK's 28%. Leeuw attributed the difference in rates of forceps use between the Netherlands and the UK to "tradition", adding: "I had discussions with colleagues from the UK who denied my thesis that it is possible to perform modern obstetrics almost entirely without the use of forceps."

One woman's written submission to this inquiry contrasted her experience of giving birth in the UK with that of giving birth in Switzerland. After her baby was born she developed a prolapse, but the physiotherapist she sought help from did nothing other than to perform a "very rough" internal examination, announce she was "fine" and advise her to do some Kegel exercises. She noted that she had not been informed of the possibility of prolapse antenatally. In Switzerland, however, she was given help from a psychiatrist to help her process her first birth and a consultation with an anaesthetist to discuss pain relief options. In the waiting rooms there were leaflets about common postnatal difficulties such as prolapse, and after birth women are offered sessions to rehabilitate their pelvic floor. The new Perinatal Pelvic Health Initiative (PPH) is now making this available in England.

Chapter 3: Birth injuries

This chapter addresses the topic of perineal tearing, drawn on personal testimony from women in written submissions, and oral testimony from both experts and women with lived experience given in session 3. It goes on to look at work in Norway that shows how we could reduce the rates of birth injury.

During vaginal birth, many women experience perineal tearing. In most cases, these tears are minor and heal quickly. Some women, however, experience third- or fourth-degree tears, also known as obstetric anal sphincter injuries (OASI). These can cause lasting problems, including urinary and bowel incontinence, chronic pain and pelvic organ prolapse, when an organ such as the uterus or bladder descends into the vagina. Professor Mike Keighley, a colorectal surgeon, told the inquiry that he and his colleagues saw a high referral rate in women aged 50-60, "in whom incontinence or prolapse had either emerged for the first time or has become worse, all due to an injury during childbirth that becomes unmanageable in later life."

Financial cost of OASI to the NHS

There has been little research on the financial cost to the NHS of anal sphincter injuries sustained during childbirth, though it can be partly measured through litigation costs. NHS figures show:

- The highest rate of litigation in clinical practice is for childbirth injuries.
- The value of maternity claims doubled between 2016/17 and 2022/23.[38] In 2022/2023 the total cost of maternity payouts was £1.1bn.[39]

The value of the average damages awarded for these claims has increased significantly. In 2006/2007 the average maternal injury claim was worth approximately £82,011 and in 2022/2023 it averages at £301,492.

Other costs to the NHS (GP appointments, repeated surgeries, physiotherapy and counselling) have not been measured – though Professor Keighley told the inquiry that he estimated the cost to the NHS of one woman's repeated procedures over 20 years to be approximately £80k. His "guesstimate" of the overall cost to society was £100-400m a year.

Incidence of OASI

There is a shortage of good quality data about OASI incidence, but the most recent available figures suggest that 3.1% of all vaginal births result in OASI – roughly 14,000 a year in the UK.[40] This is likely to be an underestimate, however, because so many tears are missed, with one study estimating the incidence as about 10% of all women who give birth vaginally.[41] This is important, because if an OASI is diagnosed and repaired shortly after birth, it is possible for women to make a full recovery. In the past 12 years, Professor Keighley told the inquiry, he had seen more than 200 women with third- or fourth-degree tears, and in 60% of cases, the tear had been missed when the baby was born.

Risk factors for OASI

The two biggest risk factors for OASI are first vaginal birth and instrumental (assisted) birth. Amongst first-time mothers giving birth instrumentally, 7.5% experience a severe tear, compared with 1.6% of those who have a spontaneous, non-instrumental vaginal birth, and have given birth before.[42] The risk of OASI is nearly six times higher with forceps, and three times higher with Ventouse, than with spontaneous vaginal delivery.[43]

Canadian research found that more than a quarter of successful forceps births involved maternal trauma. In nearly nine out of 10 of those cases, the injury was an OASI, but other injuries included cervical tears, vaginal lacerations and damage to the urethra or bladder.[44] Forceps birth is also associated with a greater risk of pelvic organ prolapse.[45]

As we saw in Chapter 2, one likely reason for the UK's high incidence of OASI is the preference amongst obstetricians for forceps: 7.5% of all births in England are by forceps, compared with 0.5% in Sweden and Austria.[46,47]

Currently a collaborative group led by the two main obstetric societies and including representatives of the royal colleges, is producing a consensus statement on assisted vaginal birth, which aims to ensure the safety of mother and baby. The statement may help obstetricians to make decisions about when forceps or Ventouse may be more appropriate.

While first-time vaginal birth and forceps use are the two principal risk factors for OASI, others include[48]:

- Prolonged second stage of labour
- Persistent occipito-posterior position (baby is "back-to-back")
- Baby's birthweight is greater than 4kg
- Older maternal age
- South Asian ethnicity
- Baby is born quickly (precipitate labour)
- Shoulder dystocia (the baby's shoulder gets stuck behind the pubic bone)
- Short maternal stature

OASI risks and informed consent

There are good arguments for making women aware of their individual risk profile during pregnancy, taking into account factors such as age and ethnicity. One study has found, for example, that Asian women have an OASI risk nine times higher than that for Caucasian women.[49]

The 2015 Supreme Court Montgomery ruling states that clinicians should disclose risks of childbirth with patients.[50] Yet many women told us that their care providers did not discuss the risks of OASI with them before giving birth. Geeta Nayar, a South Asian woman who gave oral evidence to the inquiry, said that she had not been informed antenatally of her higher risk.

We saw many other examples where informed consent was not sought. In a written submission, one woman described telling a community midwife that, as a sexual assault survivor, her biggest fear was a forceps birth, and that in the case of an emergency, she would prefer a caesarean. The midwife told her a caesarean would be dangerous, without further explanation. In the event, she experienced a frightening forceps birth that led to a complex third-degree tear and two organ prolapses leaving her in constant pain. She feels that if she had been informed of the comparative risks, she would have requested caesarean. She describes feeling "broken" and "permanently damaged," adding: "I used to think I was a resilient and strong woman. Birth showed me I am not."

Diagnosing and treating OASI

If OASI is diagnosed shortly after birth, and treated appropriately through a repair of the tear followed by a course of physiotherapy with a specialist, then women can make a full recovery. We received dozens of submissions, however, from women who wrote of their distress at their tear either going undiagnosed or being misdiagnosed (for example, as a second-degree tear), leading to significant long-term problems. They then found it difficult to access support, as Sarah Embleton told session 3 of the inquiry:

“GPs are the gatekeepers to any referrals. So, first of all you have got to have a GP that understands there is something wrong and acknowledges it and understands it and can send you somewhere else. Then there is: where do you go? Do you go to the gynaecologist? Do you go to a colorectal surgeon? Do you go to physio? You know you probably need a multidisciplinary team, but I couldn’t get referred. I couldn’t get anyone to understand there was something wrong with me.”

One woman described in a written submission how her fourth-degree tear was misdiagnosed by a midwife as a second-degree tear and repaired accordingly. Her later bowel incontinence was then wrongly diagnosed as irritable bowel syndrome, while a consultant at the hospital where she gave birth told her simply that her symptoms were the result of being “psychologically traumatised”. Over the course of 21 years she had 18 surgical procedures, the last being a colostomy in 2019.

In a number of cases, health professionals seemed ill-equipped to give even basic guidance about managing a tear. One was given a booklet that said she should not wash her wounds, until a gynaecologist told her otherwise. She wrote:

“For three months, with urinary and faecal incontinence as well as post-partum bleeding, I hadn’t been washing properly. Sometimes I think I can still smell myself, on days where my mental health is really low.”

This theme was echoed in many of the submissions. Twenty-two women experienced rectovaginal fistula (a hole between the rectum and vagina), yet some reported being disbelieved by health professionals. One wrote:

“In the months that followed I suspected I wasn’t healing well. I had many trips back and forth to the GP practice and to the local hospital, nobody seemed to appreciate my concern that stool was leaking from my vagina. My GP questioned the direction I was wiping, which felt really condescending. I was told by one gynaecologist that what I was describing was ‘extremely rare and normally only seen in third world countries.’ I felt dismissed and unheard again.”

Much of the problem stems from a lack of understanding on the part of many health professionals, including midwives and GPs, of the causes and impact of OASI – a midwife who assisted at a birth is unlikely to see a woman again and therefore may not be aware of the long-term impact. Midwife Posy Bidwell told the inquiry that midwives currently receive little undergraduate training in pelvic health anatomy and the impact of tearing on a woman's pelvic health. She recommended that there should be an annual "mandatory perineal health update day for every midwife on the shop floor."

The planned introduction of pelvic health clinics, as part of NHS England's new perinatal pelvic health initiative (PPHI), which offer a one-stop shop for women with problems such as incontinence and prolapse, aim to address the difficulty women have in accessing expert help. There is also a case, argued Professor Pauline Slade, for linking the pelvic health clinics with maternal mental health services so that women can receive integrated care.

Impact of OASI

In both the written submissions and oral evidence, women spoke movingly about the lasting impact of OASI on their lives. This included:

- Ongoing physical pain
- Bladder and bowel incontinence
- Sexual dysfunction and difficulties in their relationship with their partner
- Effect on body image
- Difficulties in bonding and developing a relationship with their child
- An inability to return to work, because of incontinence and the need for multiple surgeries over the course of many years
- Financial problems, resulting from the inability to work and the cost of treating the injury
- Psychological distress, including depression and suicidal feelings, as well as a loss of confidence
- An inability to carry out normal everyday activities such as going shopping, taking exercise or socialising with friends

In written evidence, one specialist pelvic health physiotherapist described the emotional impact of OASI as "isolation, loneliness, shame, disgust, depression and anxiety." This was confirmed by women who highlighted the profound psychological impact OASI had on their self-confidence. Geeta, a high-flying lawyer at the time her daughter was born, described how, as a result of her birth injury, she "went from being a resilient, independent young woman to needing significant help, not able to leave the house, enduring multiple repair procedures."

A number of women found that an OASI affected their ability to work. Jenny Tighe told session 3 of the inquiry: "I was having daily episodes of bladder incontinence, bowel incontinence. My job initially was quite supportive, but I got demoted and that just destroyed my self- esteem and confidence, so in the end I just resigned and then I didn't work properly for several years."

Many women described in written evidence how her fourth-degree tear affected their ability to lead a normal life. The following experience described in a written submission is typical:

“I still had accidents. I had to take spare clothes with me at all times. I had to strip off in disabled toilets with my children watching as I cleaned the faeces off me. I was scared to be intimate with my husband, as the risk of soiling myself was so high. I would never have another child. I was ‘tutted’ at for using the disabled toilets by strangers and acquaintances. I eventually had to leave a job that I loved. I was teaching children with complex needs, but I couldn’t control my bowels during a lesson and would have to take the children back to their classes so I could get changed. I could only wear black jeans, otherwise the staff would know I had soiled myself again.

"The pain was chronic and still is after 10 years. Being in constant pain and soiling myself had a huge effect on my mental health. I was diagnosed with severe depression and anxiety, was given more medication. I didn’t want to leave the house. I didn’t want to socialise, I was constantly thinking about where the closest toilets are and I still am. My pain was stopping me being able to do basic functions in the house, like cooking for the family, walking the dogs or sorting out the laundry. The pressure on my husband and our relationship took its toll and there were times we were close to divorce.

“I had to reduce my hours at work and we decided that we would make adaptations to the house so I could have more independence. We had to re-mortgage our house to do so. Financially we were close to bankruptcy, so I applied for PIP. I had to go to tribunal, where the doctor on the panel said to me ‘why don’t I just a stick an anal plug in and get on with my day,’ one of the many comments from healthcare professionals that don’t understand the complexities of a birth injury. In 2023 alone, I have had three gynaecologist appointments, two pessary fittings for my prolapse, three pelvic floor physio sessions, two colorectal appointments and surgery planned again for a few months’ time.”

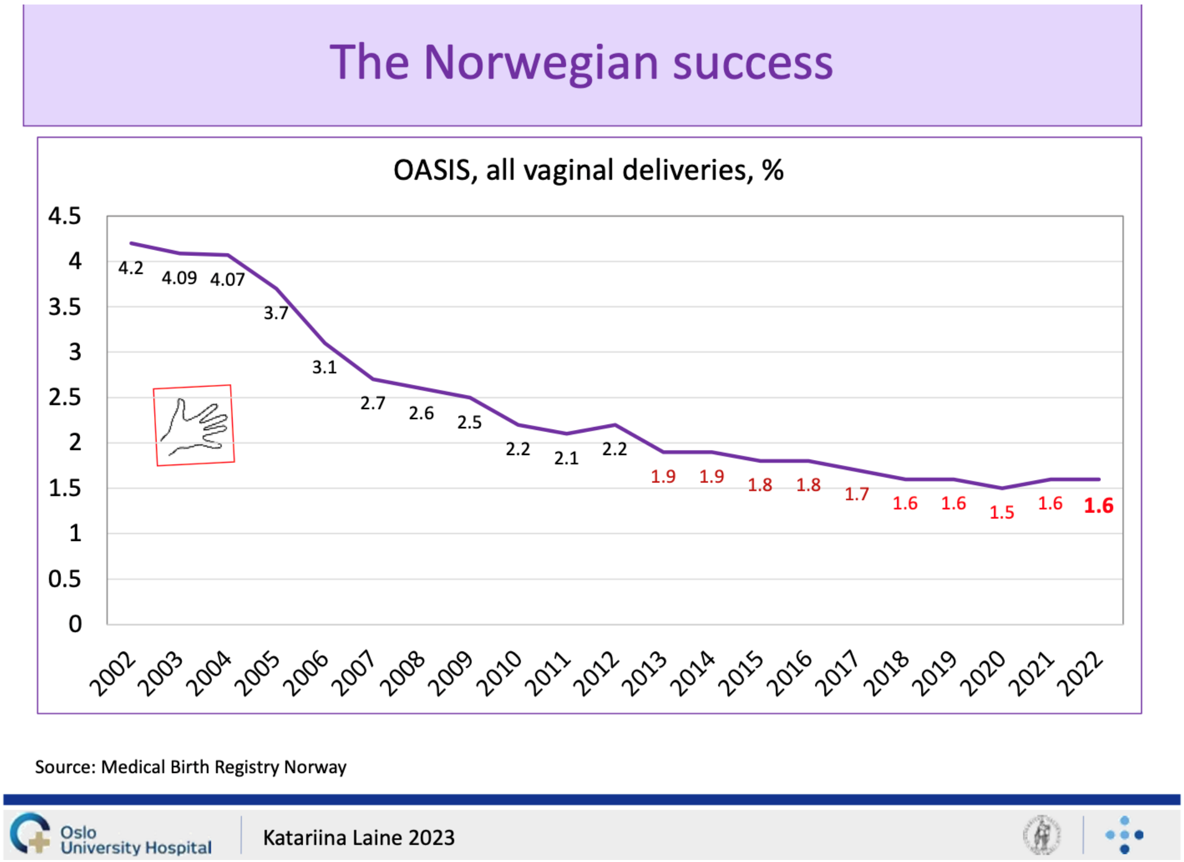
Addressing OASI

OASI can best be tackled through prevention, as well as better diagnosis and treatment. One method is to adopt a risk assessment tool such as UR-CHOICE, which can calculate a woman’s risk of developing symptoms in the long-term after pelvic floor injury and enable women to make decisions based on that information.[51] Risk calculators are routinely used to assess risk in other areas of health care, such as prostate and breast cancer and heart disease.

Several Scandinavian studies have shown it is possible to cut OASI rates by manually supporting the perineum during the pushing stage. In Norway, this change in practice has cut rates of OASI by 50%.[52] In the UK, an OASI care bundle developed jointly by RCOG and RCM incorporates:

- Antenatal education that informs women about OASI and how to reduce the risk of it occurring
- Manual perineal protection during birth
- Episiotomy when indicated
- A rectal examination after birth, provided the woman consents

It has been piloted in 16 maternity units, which saw OASI rates fall in over 50,000 women by 20%.[53] In Norway, the two pilot hospitals showed a rapid reduction of 50%. When rolled out more widely, however, the reduction was more gradual, and it took a number of years before a national reduction of 50% was achieved (see graph). In total, however, the policy has led to approximately 16,000 women avoiding OASI between 2005 and 2022.


The Norwegian success

Source: Medical Birth Registry Norway

Oslo University Hospital | Katariina Laine 2023

Despite the successful pilot, the OASI care bundle has not been implemented in all maternity units, partly because it has not been recommended by the National Institute of Health and Care Excellence (NICE).

Chapter 4: Birth trauma and mental health services

Introduction

This chapter looks at the mental health support available for parents with birth trauma. It includes evidence from experts and people with lived experience of birth trauma from session 4 of the oral evidence session, as well as testimony provided in written evidence from women and mental health organisations.

After birth, about one in 10 women develop postnatal depression, while one in 25 develop post-traumatic stress disorder (PTSD).[54] A larger number develop symptoms of psychological distress such as intense anxiety as the result of traumatic birth. While not meeting the full criteria for a PTSD diagnosis, these women may still be in need of mental health support.

Postnatal PTSD is more common in women who have had previous trauma or pre-existing health challenges.[55] About half of women who develop postnatal PTSD also develop postnatal depression.[56] About one or two in 1,000 women develop postpartum psychosis, the most severe form of postnatal mental illness. It is characterised by symptoms such as mania, delusions and low mood, and is considered a psychiatric emergency.[57]

Mental health problems after birth can be debilitating and need to be taken seriously. Suicide is the leading cause of maternal death six weeks to a year after birth.[58] Left untreated, PTSD symptoms can continue to affect women for many years: the inquiry heard from women in their 60s, 70s and even 80s, who still felt traumatised by their experience of giving birth decades earlier. One mother wrote in to describe, tragically, how her daughter had taken her own life, having been profoundly affected by a traumatic twin birth nine years previously. Many others wrote that they had attempted suicide or were plagued by suicidal feelings.

Postnatal PTSD and other symptoms of trauma can, in the majority of cases, be treated effectively by two therapies, both recommended by NICE: trauma-focused cognitive behavioural therapy (CBT) and eye movement desensitisation and reprocessing (EMDR). In people with PTSD, the experience of the trauma feels ever-present: they continually relive the traumatic event. Both trauma-focused CBT and EMDR are intensive therapies that involve going over and over the trauma until it is stored in long-term memory, the same as any other memory. Typically, these therapies require eight to 12 sessions with a specially-trained therapist. Other treatments are available, but lack the strong evidence base of trauma-focused CBT and EMDR.

Peer support has also been shown to be effective in helping people experiencing trauma symptoms after a traumatic birth.[59]

Mental health services in the UK: current provision

Specialist perinatal mental health community services support women and their families experiencing the most severe mental health problems, during pregnancy and for the first year after birth.

Money for these services is now administered at the local level, as part of the general allocation to integrated care systems, but 73% of teams in England reported a shortfall in funding for 2022/23.[60] Workforce-related issues were the most frequently cited reason for underspending against budgets.

Between 2019 and 2024, NHS England set up regional Maternal Mental Health Services (MMHS) that provide treatment for serious mental health problems arising as a result of a woman's maternity experience, including stillbirth, postnatal PTSD, tokophobia (fear of childbirth), neonatal death, pregnancy termination and loss of custody. These offer support up to two years after birth. Susan Ayers, professor of maternal and child health at City University, London, told session 1 of the inquiry that in providing these services, England was "ahead of the rest of the world".

The services face challenges, however. There is significant variation in size and therefore the support they are able to provide.[61] Some have not secured ongoing funding. An NHS workforce census in 2023 concluded that the rapid set-up and expansion of these services mean there are workforce challenges that are likely to remain for some time.[62] Similarly, a report by the Maternal Mental Health Alliance in May 2023 found that many women still face long waiting lists for therapy, through a combination of high demand and under-staffing.[63]

A joint submission to the inquiry from Oxford Specialist Perinatal Mental Health Services (OSPMH) and Oxfordshire Maternal Mental Health Service (MMHS) spoke of a lack of funding to recruit permanent staff, resulting in staff burnout. Women were having to wait six months for a psychologist appointment, and nine months for a debrief. The submission also reported challenges in integrating with maternity wards that do not see mental health as a primary concern.

Another challenge mentioned in submissions from MMHS organisations was of communication being fragmented across services, because of the use of different electronic record systems. A submission from the Perinatal Parent Infant Mental Health Service) and TULIP/Maternal Mental Health Service in North East Foundation Trust mentioned problems caused by the 28-day window midwives have for making a referral, which meant that some women were being referred too soon after birth, when often their symptoms resolve on their own without the need for specialist input.

Women who want to access a mental health service can ask for a referral from their community midwife, health visitor or GP. In practice, while new guidelines[64] state that GPs should ask women about birth trauma at the six-to-eight week postnatal check, some women report that GPs ask little, if anything, about mental health.[65]

Other specialist services

In England, women experiencing mental health problems postnatally can also self-refer to NHS Talking Therapies (formerly IAPT). The therapies offered vary locally and not all have specialists in perinatal mental health. Waiting lists are often long. There are also specialist perinatal mental health midwives and consultants who work within maternity teams or the local perinatal mental health team to make sure that there are clear integrated pathways of care for women with perinatal mental illness.

Many maternity units run birth debriefing services, which offer women the opportunity to review their maternity notes with a clinician (usually a midwife) to better understand their birth experience. Research shows a wide variation in how the services are run, however, and there is currently no published standard for how a debriefing service should be carried out.[66] One specialist debriefing midwife said in written evidence that women were often referred inappropriately to the debriefing service when they should have been referred to the complaints service, with the debriefing experience then leaving them frustrated and angry.

A number of voluntary organisations also offer peer support services, including SANDS, the Birth Trauma Association and MASIC. In their written submissions, some women reported being supported by these charities when they could not access help elsewhere.

Devolved nations

Scotland, Wales and Northern Ireland all offer community-based perinatal mental health services. There are examples of good practice, such as Scotland's introduction of a participation officer role, working with health boards and the Scottish government to gather feedback from women and family members to improve the service. Nonetheless, provision is patchy in each of the devolved nations, and all face workforce challenges.[67]

Accessing mental health services: barriers to care

The inquiry heard evidence that mental health provision is very much a postcode lottery.

We received many submissions from women who had been unsuccessful in accessing appropriate mental health help. Reasons included a failure on the part of GPs or other health professionals to recognise PTSD symptoms, long waiting lists, or a refusal by services to accept women because they were not ill enough or, in some cases, too ill, or because they were past the cut-off point of one year after birth. One woman whose baby was stillborn wrote that in the area in which she lives, there was no specialist maternity loss and trauma service:

"The final kick in the teeth after she died and I was feeling intensely suicidal was that the perinatal mental health team wouldn't take me on because I had no living baby."

Dr Rebecca Moore, a consultant perinatal psychiatrist, told the inquiry of her concern that some services were "tailored to diagnoses, so to fit this service you have to have PTSD, whereas in reality you can have seven of the 11 symptoms of PTSD and be significantly affected and traumatised day-to-day, and that might persist for years and flare up in the next pregnancy."

In oral evidence, Natalie Tasker told the inquiry that when she described her obsessive anxiety about the baby to her GP, the GP responded with: "I just don't...sorry, what's the actual issue here, because you've had this beautiful baby. Are you depressed? Are you upset? I don't really get what you're saying is wrong." Even though Natalie's husband explained that she wasn't depressed, but was experiencing intrusive thoughts, the GP wrote a prescription for anti-depressants.

Emily Barley, whose daughter was stillborn after failings of care during labour, was told by the perinatal mental health team that they were unable to help her. However, her GP was able to refer her to the local mental health trust's specialist suicide prevention team. She had her first session within two days of referral, and in all had nine weeks of treatment. Giving oral evidence, Emily said: "They did save my life. They were amazing." The service was a pilot project, however, available in only a few areas of the country.

One written submission describes a woman's difficulty accessing support after a traumatic birth, which had left her psychologically distraught:

"I was crying uncontrollably daily; suffering flashbacks multiple times a day; nightmares; screaming in my sleep; unable to leave my son and hypervigilance; lost contact with friends; no socialisation with other parents; unable to go to or past the hospital; panic attacks when seeing ambulances; unable to travel down certain roads".

When she eventually decided to seek professional help, she was given a diagnosis of severe complex PTSD with severe anxiety and moderate depression, but because her son was more than 12 months old, she was not eligible to be fast-tracked. After spending time on a waiting list, she was assigned a trainee counsellor, and, later, a trauma-focused CBT counsellor who had no experience of birth, which meant she had to explain to him some of the practical elements of childbirth. This was so distressing that her trauma scores increased. She decided to seek EMDR, which involved being discharged, completing a second self-referral and starting the whole assessment process from the beginning: "By the time I received EMDR it was approximately 18 months after my first self-referral. I had no support at all whilst on the waiting lists. At no point did I receive therapy from any one with experience of birth trauma."

Other women told us they had no option but to turn to private therapy. Neera Ridler-Mayor, who experienced nightmares and intense anxiety after she lost seven litres of blood in a postpartum haemorrhage, told session 4 of the inquiry that she had spent over £6,000 for more than 50 hours of mental health support after she was unable to access NHS therapy.

Barriers to access for marginalised groups

Giving oral evidence, Honey Attridge said that she had been frightened that if she admitted to mental illness, her baby would be taken away from her. Since becoming a peer support worker for an NHS perinatal mental health team, she had found that many other women have a similar fear. These fears may be particularly prevalent among ethnic minority women, younger women and women from disadvantaged communities, who are (often with reason) distrustful of people in positions of authority. Some women may feel that seeking specialist help is a sign they have failed as a mother. Dr Moore told the inquiry that peer support could play an important part in bridging the gap for women who felt reluctant to access professional help.

Dr Moore also noted that, among the women who have died by suicide, very many are young women with multiple disadvantages, who have been let down by fragmented services: "Often when you look at the women that have died, they have been involved with numerous services, none of whom have been communicating with each other and they have often had lots of different support, but nobody has really looked at it as a whole. Then when you see the story afterwards, you see that everybody held a vital piece of information but no one shared it together."

Good practice

We saw examples of good practice in some of the written submissions. Several women said they received excellent support from their perinatal mental health team and were helped to recover by referral to appropriate therapy. One woman said that the care she received from the perinatal mental health team had been "second to none" and that "I truly believed they saved my life."

For women who have had a traumatic birth, a subsequent pregnancy can be a very fearful time, and it is important that they are supported through the pregnancy and birth. One woman described in a written submission how she had developed PTSD after experiencing poor care during a long, painful labour, followed by a retained placenta and postpartum haemorrhage. In her second pregnancy, however, she was well looked after:

"As a result of my prior experiences, I was placed under the case of the perinatal health team during my pregnancy, and I was allowed to carefully plan my delivery and chat through my concerns in advance with a specialist midwife and anaesthetist. The team looking after me during and before my son's birth spoke to me with kindness and compassion, always explaining their actions and seeking consent. I can say that my son's birth was the happiest day of my life."

Chapter 5: The wider impact of birth trauma

This chapter looks at the impact of birth trauma, not just on the individual who experiences it but on those around them. It includes evidence heard in session 5 from experts and people with lived experience of birth trauma, as well as testimony provided in written evidence from women and health professionals.

Birth trauma can have a profound psychological impact, with flashbacks, nightmares and feelings of intense anxiety. This means that birth trauma can affect every aspect of a woman's life, including her bond with her baby, her relationship with her partner, her older children and her friends and family. It can also affect her ability to work. All of this ripples out into wider society, with the cost felt in NHS treatment, family breakup and the removal of women from the workplace.

Relationship with the baby

Research suggests that birth trauma makes it harder for some women to bond with their babies, while others become excessively protective, sometimes to the extent of refusing to leave the house with their baby.[68,69] Traumatic birth is also associated with low birth weight and lower rates of breastfeeding,[70] and there are suggestions that postnatal PTSD "may be associated with an increased number of problems in mother-infant attachment and child behaviour."[71]

The inquiry received submissions from a number of women who found their relationship with their child had suffered as a result of traumatic birth, though some also wrote that it had improved with time. Feelings of guilt are common. One woman wrote: "I struggled with sleep deprivation and I started to become really tearful and have negative thoughts about putting my baby up for adoption as I felt that I couldn't do it. I couldn't be a mum."

Four years on, she has "the most special bond" with her child, but is still "haunted" by the birth trauma, which included losing four litres of blood: "I continue to struggle with anxiety and depression and feel that I will never be the person I was prior to this experience. I am now trying to navigate life as a mum with a mental illness and I am at last hoping to start some trauma-based therapy in the near future."

Physical injuries can also affect the mother-child bond. A survey of 325 women by the charity MASIC, which supports women with third- and fourth-degree tears, found that 85% believed their injury had affected their relationship with their child, with 14% saying the damage to the relationship was irrevocable.[72] In a written submission, one woman said that her third-degree tear had affected her ability to mother effectively: "I am now just over a year postpartum and still unable to actively play with my children. I can't lift or chase my eldest child, the tear has completely limited the mother I want to be for my children."

Relationship with partner and family

A mother's relationship with her partner may be affected in several ways after a traumatic birth.[73] Some report that, because their partner did not advocate for them effectively during birth, they no longer trust them.[74] Others find that their partner discourages them from talking about the birth, telling them to "move on" or "focus on the baby", making the woman feel isolated. Postnatal PTSD can make people feel irritable or lead to outbursts of anger, further damaging the relationship. Many women avoid sexual intimacy, in some cases because a birth injury has made it too painful, or because sex triggers flashbacks to the birth, or because they fear becoming pregnant again.[75] One woman wrote: "Even though I'm on birth control I am so scared it won't work and I will end up pregnant I won't go anywhere near my husband which is starting to put a strain on our marriage."

A number of women said in written submissions that their birth experience affected relationships with friends and wider family as well as with their partner. This was particularly the case for those whose babies were born with brain injuries caused by being deprived of oxygen at birth (see box-out).

In cases where a child has a severe disability, siblings live with the knowledge that when their parents die, they may be expected to take over the care of the child, Suzanne White, head of clinical negligence for law firm Leigh Day, told the inquiry: "That's a huge responsibility that they live with all their life."

Economic cost

There is currently no research on the economic cost of birth trauma. Professor Susan Ayers of City University, London has suggested that NHS Resolution data on litigation claims could be used as a proxy measure, and that there is a lack of current funding to analyse the data.

A government cost-benefit analysis of the women's health hubs notes that the average cost of a maternity claim is about £293,000, and that if the harm leads to brain injury at birth the average cost of a claim is about £9.4 million. This economic impact applies only to cases where there has been a physical injury leading to litigation, however. We know that the majority of women psychologically affected by traumatic birth will not make a negligence claim.[76]

It is clear, however, from the numerous submissions we received from women either unable to go back to work, or delaying going back to work, as a result of PTSD triggers, that there must be a wider economic cost.

In other cases, women felt that financially they had no choice but to return, even if they were too ill to do so. Heather Simmons, giving oral evidence to session 5 of the inquiry, described how her traumatic birth had led to her child having a hypoxic brain injury. Before the birth she'd worked in a hospital as an ophthalmic technician. She described how her "place of safety," where she'd always felt comfortable, became her "place of trauma". When her daughter was six months old, Heather was in the middle of a "full breakdown," but returned to work for financial reasons. It was, she said, a "horrific" experience: "I had panic. I couldn't concentrate. I couldn't bear to be away from her."

Heather left the NHS and took a private job working nights so she could be with her daughter during the day. Ultimately, however, the culture of workplace bullying was too traumatising and she left, later becoming a full-time carer for her husband when he fell ill.

Women with birth injuries may also find their physical ill-health prevents them from returning to the workplace, with one survey finding that one in five women with birth injuries said it had affected their ability to work.[77] Even those who do go back to work say that their trauma has had an impact on their working life. The woman with a third-degree tear, quoted earlier, wrote in her submission that she "spent thousands of pounds on private appointments, gynaecology, and pelvic floor physiotherapy".

Ms White noted that, even if a woman returns to work after a birth injury, the effect of the injury can re-emerge at menopause. One professionally successful client was "likely to be incontinent after menopause because the perineum deteriorates at that stage, and that is something that she is dreading throughout her whole life."

Case Study: Helen

Helen's son Julian was born with a hypoxic brain injury as a result of proven medical negligence during his birth, which the hospital tried to cover up. (Helen won substantial damages against the hospital to pay for the care of her child.)

Her son's injury has affected every aspect of Helen's life.

"My marriage broke down as he [her husband] could not handle a disabled child. He more or less had a breakdown and ran away to start a new life," she says. He has not seen his child for nine years.

Her own life has been turned upside down: "I am now a single mother, doing this alone. Julian will always be dependent on me. I had my elder children young and always thought that I would be able to live life when they were older, but now I have Julian as a forever dependant."

Her other children have been affected too: "They are all fantastic with their little brother but ongoing sleep and behavioural issues have caused disruption with exams and schooling through lack of sleep for instance."

Helen still suffers mental and physical pain, and has never been able to heal. Having to explain what happened to her over and over again during a six-year litigation was particularly mentally draining. She adds: "My life will never be as it should be. I never returned to work, I live a very secluded life, as friends and family shun you when you have a disabled child that they might not understand or are scared of."

Maternity staff

Evidence suggests that midwives in particular experience high levels of stress and burnout, with data showing that they have the highest rate of absences for mental health reasons of any group in the NHS.[78] One large-scale survey of midwives found significant levels of emotional distress, with two-thirds saying they had considered leaving the profession.[79]

Several studies have looked at the incidence of PTSD in maternity professionals. A review of research that looked at studies of midwives, nurses and obstetricians found that the proportion of participants meeting the diagnostic criteria for PTSD ranged from 3.1%-46%.[80] Authors of a scoping review of research found that "witnessing abusive care was associated with more severe post-traumatic stress than other types of trauma events" and concluded that "adverse events during childbirth have a serious impact on care providers."[81] An Australian study found that staff of black or minority ethnicity were at increased risk.[82]

Amongst the submissions we received from midwives, common themes included under-staffing, a poor physical environment and a harmful working culture. Some found it difficult to see how women were treated in the system: one midwife wrote that she and her colleagues "are witness daily to the devastating impact of poor staffing, poor provision of resources, poor care and poor communication, which result in people lacking confidence in the service and the standard of care they will receive."

Another former midwife described how she'd left the NHS in 2022 after 15 years as a result of "accumulated vicarious trauma and moral injury". She described working in a particularly hierarchical maternity unit where one consultant obstetrician behaved aggressively towards staff and treated the women in his care inappropriately. In one instance, during repair of a second-degree perineal tear, the woman "was leaping up the bed and groaning in agony due to his stitching. I asked him to stop and provide more pain relief; he shouted at me in front of the woman and told me that 'women do not have nerves in their vagina'." She also described an extraordinary incident when the same doctor "dragged another outspoken midwife by her hair along an antenatal clinic corridor."

In her final NHS shift, she described caring for a mother whose baby was stillborn before being called to an emergency forceps birth in which "the woman was screaming with fear and panic in her eyes, the obstetrician was useless in her communication and didn't gain consent for the episiotomy or the forceps." The result was "another unnecessarily traumatised mother and father starting parenthood."

Chapter 6: Partners' perspectives

This chapter looks at the impact of traumatic birth on partners, using evidence from written submissions and oral testimony to session 6 of the inquiry.

Partners can be affected in two main ways by a traumatic birth:

- They may develop psychological symptoms of trauma, as a result of experiencing the terror of believing that they are going to lose both mother and baby. A review of research has found that 1.2% of fathers develop PTSD after witnessing their partner give birth – approximately 7,000 people every year in the UK.[83] It is likely that many more develop some trauma symptoms.
- They may be required to support – practically, emotionally and financially – a woman who is experiencing the physical and psychological consequences of traumatic birth.

Yet there is very little help available for partners. After birth, the focus is on the mother, and her partner will not normally be asked by health professionals whether he (or she) is coping psychologically. Many partners feel that, because they did not go through the traumatic birth themselves, they are not entitled to ask for help. They may also feel that they have a responsibility to be strong and hold the family together.

The impact of traumatic birth on partners

The small amount of research on the impact of witnessing traumatic birth on partners has identified recurring themes, such as feelings of helplessness as the trauma unfolds, a fear that the mother or baby are going to die, a sense of abandonment if the mother and baby are taken to a different room and a lack of communication from staff.[84]

Dr Andrew Mayers, an academic psychologist at Bournemouth University, told the inquiry that his research had found that "fathers who are in that birthing room when it all starts going so dramatically wrong feel utterly helpless." He added: "They are witnessing potentially the loss of their partner, wife and/or baby and yet what we were finding consistently was that they were not being informed." Conversely, his study found, when health professionals communicated effectively, this acted as a protective factor against the father developing postnatal mental health problems.[85]

Dr Mayers's findings were echoed in the submissions the inquiry received from fathers. One man wrote that his wife experienced an obstetric emergency that resulted in the death of their baby daughter. Describing the "chaos" in the operating theatre, he wrote:

“As a father I was sat at the head end of the table with my partner and had no explanation as to what was happening or going on. When my partner started feeling sick and shaking I was literally presented with an anaesthetist sat to my left on her mobile phone and handed a sick bowl and told she will be all right in a minute…Prior to that any other requests for information were ignored, all I knew was that alarms were going off and people were running into theatre. No support was offered to myself or my partner. This experience has left me with regular flashbacks, mental health issues and a diagnosis of PTSD.”

Scott Mair, whose son was taken to intensive care after the birth, had to visit him alone while his wife lay ill in bed. That was traumatic enough, he told session 6 of the inquiry, adding: “My biggest trauma came from the fact that I was then told to go upstairs and break that news to my wife that our baby might not make it. There is no support, there was nobody to come with you to have that conversation.”

One man told us in a written submission that after he had witnessed his wife receiving abusive treatment during birth, he found himself reliving the birth in the form of flashbacks and nightmares. He added:

“I developed avoidance behaviours in the form of avoiding any conversation about birth or hospitals, avoiding friends, family and isolating myself from the outside world. During conversations I would completely tune myself out to the point I could not hear or take in what was being said. Having another baby felt like an impossibility.”

He also experienced “heightened feelings of a sense of threat in the form of over sensitivity to sounds, feeling jumpy, extremely irritable, worried about losing my wife or daughter.”

In some cases, both partners are affected. Mark Williams and his wife both developed mental health problems after her traumatic birth experience 20 years ago in which he feared that she and their baby would die. The effect has been long-lasting: Mark told the inquiry that even recently he had woken up in “in sweats, thinking my wife and baby died.”

The impact of traumatic birth on the couple relationship and family life

We saw in Chapter 5 the impact a traumatic birth could have on the partner relationship, often creating tension and anxiety, with women sometimes blaming their partner for not advocating effectively for them during labour. [86]

Physical injuries such as OASI can, as we have seen, have a devastating impact. One man said that his wife’s birth injury, sustained before they met, had affected every aspect of their lives: “where we can go, our careers, the additional financial outgoings associated with treatments, our sex life, not being able to have further children, our health and wellbeing." Before each of his wife's surgeries, he had had to prepare himself for the possibility that she might die on the operating table, adding: "I'm just grateful that she has shown the resilience and courage to keep going."

There may often be a financial impact. Paternity leave is only two weeks, but if a mother is too ill to look after herself and the baby, the partner may have to take unpaid leave to take care of her or sometimes drop out of employment altogether. Lucy Allen-Goss, whose partner was unwell after a traumatic birth, told the inquiry she was unable to return to her academic post, leaving a year-long gap on her CV that she couldn't easily explain – which led, ultimately, to a change of career.

Same-sex partners

There is a dearth of research on the impact of traumatic birth on same-sex partners. Laura-Rose Thorogood of LGBT+ Mummies told the inquiry that there was an assumption in the NHS that same-sex partners were less important, even though in some case, the partner may be genetically related to the child through egg donation. There was, similarly, a lack of awareness amongst health professionals that some same-sex couples will have a history of trauma in overcoming barriers to conception, such as repeated attempts at IVF.

Lucy told the inquiry of witnessing her female partner have a traumatic emergency c-section, after which both mother and baby developed sepsis: "One of the things that went wrong was that people didn't know who I was. So I kept getting shut out of the room she was in and they tended to think I was another nurse or another midwife."

This happened both during the birth and postnatally. While she was in the postnatal ward with her partner Emma, staff assumed that she was a health professional taking care of her: "My partner was catheterised, she was bleeding very heavily, she was very high on morphine, she didn't know where she was. And she was being expected to change and also to tube feed this very fragile newborn we'd got, and a lot of the time I couldn't get to her. We realised quite a bit later that we nearly killed our daughter because they had expected both of us to tube feed this baby without actually having told us how to do it."

When they returned home, Lucy found that the midwives and health visitor who attended Emma seemed to resent her presence: "I remember at one point the health visitor saying, 'You know you can tell her to go away' to my partner about me, and my partner said, 'I don't want her to go away.'"

Laura-Rose and her wife have both given birth twice, and their experiences echoed Lucy's, with the non-birthing mother being asked to leave the room and make tea while the health professional was talking to the birthing mother.

Mental health support for partners

The lack of support for partners continues postnatally. Scott shared with the inquiry his experience of leaving his sick wife and baby in the hospital: "The worst thing is after all of that you get in the car and you go home. Nobody helps with that transition out to the car park, nobody sits you down and says 'Is everything okay? That was rough'. You don't get any sort of debrief."

Currently, neither mothers nor fathers are screened postnatally for PTSD, though the means to do so is available – researchers at City, University of London have devised separate scales to measure postnatal PTSD in mothers and partners.[87] Whereas mothers are routinely screened for postnatal depression, and have opportunities to mention mental health difficulties to health professionals, fathers and non-birthing mothers are not offered mental health screening after the birth. The NICE guideline on antenatal and postnatal mental health does not mention fathers at all.[88]

The only time partners have the opportunity to share their mental health difficulties with a health professional is if they choose to accompany the mother to a birth debrief. Otherwise, a father who wants mental health support must actively seek it. In England, this will typically be by self-referring to the local NHS Talking Therapies service. In the other UK countries, it will entail asking for a GP referral. Kieran Anders, operations manager for Dad Matters, told the inquiry that, while new mothers with psychosis are treated as a blue-light emergency with direct treatment, a father with psychosis may have a three month wait for treatment, even though the risk to the child is the same.

Research suggests that fathers would welcome the opportunity to share their experience of the birth. In one study, fathers expressed the view that healthcare professionals were unconcerned about fathers' mental health, and that support is only offered once "you try to harm yourself or you have a breakdown."[89] Fathers, another study found, "specifically wanted healthcare professionals to sign-post them to someone they can talk to for emotional support, and to be taught coping strategies which would help them to support both their partner and baby."[90]

Since 2018, NHS England has been gradually expanding its perinatal mental health services to include partners, so that if a woman has a perinatal mental health problem, her partner is also offered a mental health check and signposted to professional support if necessary. The limitation of this, as Dr Mayers pointed out, is that it does not identify those fathers who have developed mental health problems, but whose partners are not in contact with perinatal mental health services.

There is a postcode lottery to the support available. Dr Mayers noted that, when he helped develop local mental health services for fathers, in Hampshire and Dorset these were provided through the local mental health trust, but in London, they were provided through the charity Mind.

There are areas of good practice, however. Leeds Perinatal Mental Health Service, for example, has set up a Partners Peer Support Service to support new fathers. These include face-to-face sessions, dads and kids pram walks, baby sensory sessions and Zoom games nights to help new fathers gain confidence as parents and talk about their mental health.[91] In Greater Manchester, the NHS funds Dad Matters as part of their peer support offer alongside Home Start and other charities. Dad Matters takes referrals from professionals who see fathers, and offers attachment and bonding support, as well as signposting fathers to Talking Therapies if necessary.

Financial and economic costs

A 2014 report calculated that perinatal health problems in women cost the country £8.1bn a year, and that an investment of £280m annually could offset much of that cost.[92] Similar figures are not available for partners, but Dr Mayers told the inquiry that he believed that investment in caring for partners, coupled with extended paternity leave and greater support in the workplace, could reduce the likelihood of PTSD and subsequent problems for the child.

Chapter 7: Marginalised groups

This chapter looks at the experience of birth trauma on marginalised groups, using evidence drawn from written submissions and oral evidence given by experts and parents in oral sessions, particularly session 7, of the inquiry.

There are approximately 700,000 births a year in the UK.[93] Regular reports from the MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) programme, however, show that maternal outcomes vary widely according to demographic factors such as age, ethnicity and deprivation. These outcomes include maternal deaths during pregnancy, childbirth and the postnatal period, as well as stillbirths and neonatal deaths.

Evidence suggests that marginalised groups also have a poorer experience of maternity care. As well as ethnicity, deprivation and age, other factors that may affect an individual experience of maternity care can include neurodiversity, sexuality and gender identity. Some factors may, of course, interact.

Maternal outcomes

The most significant variations in maternal outcomes relate to ethnicity and deprivation.

In 2021, 28% of babies in England were born to mothers of non-white ethnic minority origin.[94] MBRRACE's most recent report, which analysed data from 2020-22, showed that Black women were almost four times as likely as white women to die during pregnancy, childbirth or the postnatal period, while Asian women were twice as likely to die as white women. Similarly, the maternal mortality rate for women living in the most deprived areas of the UK was more than twice as high as that of women living in the least deprived areas. [95]

Ethnic disparities can also be seen in stillbirth rates, which are significantly higher for babies of Black ethnicity (7.52 per 1,000 total births) and babies of Asian ethnicity (5.15 per 1,000 total births) than for babies of white ethnicity (3.30 per 1,000 total births). Again, there are striking disparities relating to socioeconomic status, with rates of 2.37 stillbirths per 1,000 total births in the least deprived quintile compared with 4.69 in the most deprived quintile.[96]

Although Black and Asian mothers are more likely to live in deprived areas, and are therefore particularly affected by the socioeconomic disparity, MBRRACE found that stillbirth rates for babies of Black and Asian ethnicity are higher than for babies of white ethnicity in all five socioeconomic categories.

Black women are also one-and-a-half times more likely to develop pre-eclampsia than white women, and six times more likely to develop pre-eclampsia superimposed on chronic hypertension.[97]

Gypsy, Roma and Traveller women are not included in the MBRRACE statistics, but a review of research suggests they have worse maternal outcomes than other groups.[98]

Certain other marginalised groups experience strikingly poor outcomes. Women in prison are five times more likely to have a stillbirth,[99] while young women who have been through the care system are far more likely to die by suicide in the perinatal period.[100] Women aged 19 and under are more likely to have premature babies and extremely low birthweight babies than women aged 20-35.[101]

Disparities in experience of maternity care

The reasons for the disparities in maternal outcomes are not clear – apart from suicide, the causes of maternal deaths are not broken down by ethnicity or socioeconomic status. Research provides some clues, however. Studies show that risk factors vary between ethnic groups. For example, Black women are more likely to have a history of cardiovascular disease than white women,[102] while South Asian women have higher rates of gestational diabetes than white women,[103] and six-to-nine times the risk of anal sphincter injury.[104] Yet, as Professor Angie Doshani, a consultant obstetrician gynaecologist, told the inquiry, women are not routinely informed antenatally of their greater risk.

Similarly, Black and South Asian women are at greater risk of Vitamin D deficiency, which leads to a greater risk of diabetes, miscarriage, pre-term birth, high blood pressure and pre-eclampsia. This could be addressed by a simple campaign to take Vitamin D in pregnancy, Carol King-Stephens, the equality, diversity and inclusion lead midwife at Walsall Healthcare NHS Trust, told the inquiry.

A 2022 report by campaign group Five X More, based on a survey of 1,320 Black or mixed heritage women, found three areas where maternal health care fell short: attitudes, knowledge and assumptions. These included, for example, using racially discriminatory language, poor awareness of Black women's physiology (one woman was told that "black people are more stretchy") and an assumption that Black women were being over-dramatic. Some reported that health professionals did not understand how particular conditions such as jaundice might appear differently on black skin.[105]

One South Asian woman, Neera Ridler-Mayor, told session 4 of the inquiry that the reason her major obstetric haemorrhage was initially missed was because of her skin colour: "A Caucasian lady who has a postpartum haemorrhage would go pale. I don't go pale. I will go grey and ashy." It was Neera's mother who spotted that her skin colour had changed, but her medical notes had been amended to state, incorrectly, that the midwife had noticed she had a haemorrhage because she had gone pale.

A survey on the experiences of Muslim women in maternity found many reported being patronised and having decisions made without their consent.[106] Describing a focus group of Somali women, some of whom had previously given birth in European countries, the report says that in the UK maternity system they were "subjected to racist attitudes" whereas in countries such as Norway and the Netherlands they were treated "with more kindness, consideration and compassion."

Mothers from ethnic minority backgrounds may be more likely to suffer from mental health problems, with one study finding that Indian and Pakistani women were at greatest risk.[107]. A study of Black Caribbean women found, however, that their interactions with professionals in the perinatal period were "protocol driven and formulaic, affording little scope to discuss psychological distress, identify morbidity, or deliver interventions that might restore or maintain maternal mental health."[108]

Language is also an important factor in the experiences of minority ethnic women in maternity care. In 2022, 30.3% of all live births in England and Wales were to women born outside the UK, the majority of whom were non-EU nationals. The most common country of birth for non-UK mothers was India, followed by Pakistan, Romania and Poland respectively.[109]

Many of those women will not have English as a first language, meaning that interpreters are essential. Yet an investigation by the BBC found that a lack of interpreters in the NHS is leading to adverse outcomes in maternity. Interpreting issues, it found, "were a contributing factor in at least 80 babies dying or suffering serious brain injuries in England between 2018 and 2022." Some staff are using online translation tools to deliver serious news to non-English speaking patients.[110]

Giving oral evidence to the inquiry, Professor Doshani said that for some women, the use of interpreters from their own community could be problematic because of the lack of confidentiality. She also noted that some women from ethnic minority communities can't read, even in their mother tongue. The app she has developed, JanamApp, includes animated videos to reach those women. Speaking to service users, she also found that if they didn't understand a question they were asked by a health professional, they would often say “yes”, creating the impression that they were giving consent when they weren’t.

Ms King-Stephens told the inquiry that many women from marginalised groups simply cannot afford to travel to the hospital or their GP practice, and therefore miss important antenatal appointments. In Walsall, the council and the local bus company have now provided free day savers so mothers can attend the appointments. Sometimes the NHS is not mindful of cultural practices, she added – offering appointments to Muslim women on a Friday, for example, when they might be at mosque. Similarly, Clotilde Abe, co-founder of Five X More, giving evidence in session 1, suggested that it was possible to reach some minority women through offering sessions after church services.

A number of submissions, including some from professionals, mentioned more explicit racism, with one Asian woman, for example, saying that she was treated with greater respect when her white husband was present. Another, who was very seriously ill after a complicated birth (and suffered permanent injuries) wrote of the on-call consultant:

“She came the next morning and spent the whole time talking to my sister (who is also brown skinned) who was sat on the chair next to me. She said I looked much better and didn’t even realise that wasn't me.”

In a written submission, Dr Aditi Sharma, who conducted research with South Asian women on birth trauma, said that many feel coerced and dehumanised in childbirth, with one saying that two white women giving birth at the same time “had a lot more support and staff were being very responsive to them.” Similarly, some organisations representing Black mothers said that many were treated automatically as being of higher risk than white women, and therefore put on a more medicalised pathway.

There were examples too of medical professionals making inappropriate comments. One woman wrote: “I tore, and as I was being stitched up, the doctor said, ‘I’ll stitch you up so you’ll never do this again.’” I thought the doctor told me this because I was young and my baby was of mixed heritage. I thought I probably deserved it.”

Other marginalised groups

We have less information about the outcomes and experiences of women from other marginalised groups, such as lesbian women or women with neurodivergent conditions, though a large-scale Californian study found that same-sex couples had significantly higher risk of adverse outcomes such as postpartum haemorrhage.[111]

There is some research evidence that marginalised groups may experience poorer maternity care, supported by testimony heard by the inquiry. Same-sex couples, for example, can face prejudice from health professionals, including the assumption that a birthing mother must be heterosexual. They therefore find themselves having to "come out" repeatedly to health professionals throughout the pregnancy, birth and postnatal period.[112] One qualitative Swedish study found that LBTQ parents experienced "disrespectful treatment from healthcare professionals that violated their bodily integrity."[113]

Laura-Rose Thorogood, a woman in a same-sex relationship, told session 6 of the inquiry that when she introduced her wife to the consultant, the consultant's attitude "just switched", and from that point on the care was "unprofessional". This included "shouting at the midwife in front of a whole room of us because she couldn't work out where baby was facing, to giving me an internal and crudely yanking a massive clot out of me, without an apology or explanation." When the baby was born by forceps, the doctor "pulled the baby out and she was 'flung' on top of my lower stomach and landed like a sack of potatoes. My wife gagged, because as she did, blood flew up everywhere and went all up me and over my face."

Qualitative research on how autistic women experience pregnancy has found they have more physical difficulties, such as nausea and pain, during pregnancy than non-autistic participants. Maternity professionals did not have a good understanding of autism and the women did not always feel comfortable telling professionals about their autism diagnosis. They also needed professionals to communicate with them clearly and to make changes during appointments such as dimming lights to reduce sensory overload.[114] Because autistic women may appear calm even when in severe distress, caregivers do not always trust women's reports of being in pain.[115] As one woman quoted in a submission from the National Autistic Society said: "It can be difficult when people expect you to be performing your pain in a way they recognise at a time when you have nothing spare to spend on doing the right facial expressions!"

Some submissions from young mothers suggested that they were treated less sympathetically because of their age. Jayde Edwards, who became pregnant when she was 15, told session 7 of the inquiry that the first question her GP asked her was whether she had considered having an abortion: "When I said to her, 'No I'm keeping the baby', she made a referral to social services and didn't tell me why…if she had explained, 'Maybe you need a bit more support,' I would've said I have family around, I was attending a church at the time and I have a really strong support network."

Jayde drew the inquiry's attention to the fact that many people may be marginalised in more than one way, and that certain types of marginalisation go together: young mothers, for example, are 22% more likely to be living in poverty by the age of 30[116], while those who have been through the care system are three times more likely to become mothers by the age of 18.[117]

Exceptionally vulnerable women

There are some women who are so vulnerable their voices are rarely heard: women in prison, for example, refugees, women who have been through the care system, or women whose babies are taken into care. One woman described in her submission feeling that she was "tortured" by midwives withholding essential care from her while she was in labour, which she believes is because she had been a heroin addict, though clean by the time of giving birth. She was given opiates for pain relief, and the fact that her urine test then showed traces of opiate was used against her in court when a decision was made to take her baby away from her. She wrote of the aftermath of her traumatic birth: "I have urine infections constantly and need to always be near a toilet as I have to urinate frequently, but the mental scars are far worse. I was treated like an animal, a second-class citizen that didn't deserve to be treated with any form of care."

Naomi Delap, a director of the charity Birth Companions, which supports marginalised women in childbirth, told the inquiry that many women have overlapping vulnerabilities: they may be victims of domestic abuse, of child sexual abuse, of trafficking; these women are likely to be single mothers, and they may be in prison, or have had a baby taken into care. Birth Companions is able to advocate for these women, who often may not feel listened to, or and who often feel pressured into particular choices during labour. Women who have had previous trauma, she pointed out, are three times as likely to develop postnatal PTSD as other women. Survivors of sexual abuse, for example, may find vaginal examinations – a common way of establishing progress during labour – intensely traumatic. "If maternity staff are aware of this aspect of woman's history this is something that can be planned for," she said.

Improving care

The evidence presented to the inquiry demonstrated the variety of ways in which it is possible to feel marginalised during labour and childbirth. Every individual who gives birth has their own unique history and needs. It might be that their ethnicity puts them at greater risk of tearing, or that their trauma history makes them terrified of internal examinations, or that their autism makes them particularly sensitive to sensory input. As Jacob Stokoe, a trans man giving oral evidence in session 7, said: "It's about seeing the person in front of you and responding to them as they need."

Ms Delap emphasised the importance of continuity of care – which, she pointed out, "doesn't necessarily reside in continuity of carer." Instead, it could be that "everybody has an understanding of trauma, that everybody is compassionate and kind, that there is continuity of information-sharing so that people don't have to keep on reiterating their trauma, telling their stories over and over again to different people." It should, she added, "also include individualised approach, individualised care plans, meaningful consent."

If we are to offer good quality maternity care to everyone, then this focus on individuality, on care and on consent is essential.

Vision: what does ‘good’ look like in maternity?

Our inquiry has uncovered a pattern of poor maternity care across the country, resulting in many women being deeply traumatised. In many cases, the effects extend beyond the individual woman to her partner, her children, wider family and friends. Many women spoke of being unable to return to work and of having to spend years undergoing NHS treatment for both psychological and physical injuries. In some cases, the impact of traumatic birth was still felt decades later.

We believe that it doesn’t have to be like that. Sometimes unavoidable emergencies happen during birth, and sometimes, unfortunately, mothers or babies are harmed. It is not always possible to prevent stillbirth, for example, and sometimes a woman will experience a severe obstetric tear as the baby is born.

But it is possible both to reduce the incidence of harm and to make sure that women and their partners are better supported when harm occurs.

The common theme running through the personal submissions was of women not being listened to when they thought that something was wrong, or when they asked for help. Red flags that indicated a difficulty in pregnancy or labour were often ignored. Women told us that they felt belittled or dismissed when they raised concerns. After birth, women wrote of being unable to access basic help on the postnatal ward, even if they were too ill or weak to lift their baby. Partners, too, wrote of being ignored by staff and left unaware of what was happening. Attempts by parents to gain answers after a difficult birth in which mistakes were made often result in efforts to cover up or minimise the harm caused.

We suggest that a good maternity service would include the following elements:

Antenatal education

All pregnant women should have the opportunity to access good quality antenatal education that explains, clearly and straightforwardly, what giving birth involves, what the risks are and the kinds of choices they might have to make during labour so that they can think them through beforehand. Women should also have access to a risk calculator that helps them understand their own individual risk profile and to make choices about their birth accordingly.

Listening to women

Too many of the stories we heard involved women not being listened to. If a woman is concerned about bleeding in pregnancy, or reduced fetal movements, or that her bump has stopped growing, for example, then these concerns should be taken seriously and investigated. If she asks for pain relief, then she should be offered it. There should not be a default assumption that women are being over-anxious or over-dramatic when they express concerns.

Sharing good practice and using evidence-based care

Women should be able to feel reassured that the care they receive is based on agreed standards and guidelines. Where a maternity unit has been successful in, for example, reducing stillbirth rates, staff in other maternity units should have the opportunity to learn from that. Training in known problem areas (for example, correctly reading a CTG trace) should be given regularly, so that staff skills are up-to-date.

Consent

Except in an emergency, no procedure should be carried out on a woman without her consent.

Safe working environment for staff

All maternity units should be fully staffed. Staff should not be subjected to bullying from other staff members. It should be taken as a given that obstetricians and midwives work as a team, with the same goals in mind. Instances of bullying or bad behaviour should be dealt with robustly.

Postnatal care

All women should receive good quality postnatal care. This means that, on the postnatal ward, they are given appropriate help to go to the toilet, if necessary, or to pick up their baby. Women who want to breastfeed should receive help from staff trained in breastfeeding support. No woman should be made to feel inadequate or a failure for not being able to breastfeed. Staff should be trained to identify signs of illness postpartum, such as sepsis or haemorrhage.

Transparency and accountability

If mistakes happen during a woman's care, then hospitals must be open and honest with her about the mistake, in line with the duty of candour requirement. Mistakes should be treated as an opportunity to learn and improve future practice.

Partners

If a woman chooses to have her partner with her during birth, then a staff member should be assigned to keep the partner informed about what is happening if a problem arises.

Racism

No woman or staff member should be subjected to racist attitudes or assumptions. Women whose first language is not English should be offered a good-quality interpreting service. Cultural differences should be understood and respected.

Trauma-informed care

Women who disclose that they have had a previous traumatic experience (including traumatic birth) should be offered trauma-informed care, including the opportunity to receive mental health support from a professional and the opportunity to discuss potential triggers, and how they can be avoided, with the obstetric team.

Mental health support

Women and partners should be offered routine screening to see if they display trauma symptoms after birth, and offered appropriate mental health help if necessary.

Conclusion

Some of the findings in this inquiry – in particular the scale of birth trauma and the devastating impact it has on women and their families – will be new to a lot of people. Yet there is much still to be explored, and we hope this inquiry will begin a national conversation on birth trauma. Despite being a relatively common experience, the very first time birth trauma was discussed in parliament was in October 2023. Now that the taboo has been broken, we hope there will be many more such debates and that birth trauma will be taken seriously. We call on the prime minister and the UK government to implement our recommendations in full.

APPENDIX 1

Birth Trauma Inquiry Witnesses

Evidence session 1: 5th February 2024

Ranee Thakar, President, Royal College of Obstetricians and Gynaecologists

Gill Walton, Chief Executive, Royal College of Midwives

Professor Susan Ayers, Professor of Maternal and Child Health, City University London

Maureen Treadwell, Co-founder, Birth Trauma Association

Rachael McGrath, Chair, Birth Trauma Association

Clotilde Abe, Co-Founder, Five X More

Evidence session 2: 12th February 2024

Emma Hurst MLC, Member of the Legislative Council of New South Wales

Dr Hazel Keedle, Researcher, BESt Study and New South Wales Birth Trauma Inquiry

Amy Dawes, CEO Australasian Birth Trauma Association

Professor Antje Horsch, University of Lausanne

Jan Willem De Leeuw, Consultant Obstetrician and Gynaecologist

Evidence session 3: 19th February 2024

Dr Nitish Raut, Gynaecologist, Stoke-on-Trent Hospital

Dr Posy Bidwell, Chair of the MASIC Foundation, Deputy Head of Midwifery, South Warwickshire Foundation Trust

Professor Michael Keighley, Founder, MASIC Foundation

Geeta Nayar, mother with lived experience

Jenny Tighe, mother with lived experience

Sarah Embleton, mother with lived experience

Evidence session 4: 26th February 2024

Dr (h.c.) Donna Ockenden, Chair, Independent Review into Maternity Services

Dr Rebecca Moore, Perinatal Psychiatrist

Honey Attridge, Peer Supporter for the CNWL Maternity Trauma and Loss Care Service

Neera Ridler-Mayor, mother with lived experience

Emily Barley, mother with lived experience

Natalie Tasker, mother with lived experience

Evidence session 5: 4th March 2024

Professor Pauline Slade, Professor in Clinical Psychology, University of Liverpool

Kate Lough, Chair, Pelvic Obstetric and Gynaecological Physiotherapy Group (POGP)

Suzanne White, Head of Medical Negligence, Leigh Day

Professor Robert Freeman, Consultant Gynaecologist, University of Plymouth

Heather Simmons, mother with lived experience

Neya Joshi, mother with lived experience

Evidence session 6: 11th March 2024

Dr Andrew Mayers, Psychologist, University of Bournemouth

Mark Williams, Founder, Fathers Reaching Out

Kieran Anders, Operations Manager, Dad Matters

Scott Mair, Director, Fatherhood Solutions

Lucy Allen-Goss, Academic and Writer

Laura-Rose Thorogood, Founder, LGBT+ Mummies

Evidence session 7: 18th March 2024

Professor Angie Doshani, Consultant Obstetrician and Gynaecologist

Illyin Morrison, Midwife and Birth Trauma Specialist

Carol King-Stephens, Midwife and Lead on Inequality for the West Midlands

Jayde Edwards, Project Manager at Mental Health Foundation for Young Mums Connect

Naomi Delap, Director, Birth Companions

Jacob Stokoe, Founder, Transparent Change

APPENDIX II

Summary of Recommendations

Chapter One:

1. Recruit, train and retain more midwives, obstetricians and anaesthetists to ensure safe levels of staffing in maternity services and provide mandatory training on trauma-informed care.
2. Make sure all NHS trusts offer antenatal classes to inform parents of what to expect from birth and to outline their options.
3. Make an awareness of the causes and impact of birth trauma a mandatory part of both midwifery and obstetrics training.

Chapter Two:

1. Make training in trauma-informed care a mandatory part of midwifery and obstetric education.
2. At the 34-week appointment, discuss with women their options during birth, including the risk factors relating to instrumental and caesarean birth.
3. Offer regular CPD training to maternity professionals on communicating risk.

Chapter Three:

1. Roll out and implement, underpinned by sufficient training, the OASI (obstetric and anal sphincter injury) care bundle to all hospital trusts to reduce risk of injuries in childbirth.
2. Introduce mandatory data gathering, so we know exactly how many women experience OASI.
3. Maternity units to adopt the recommendations of the consensus statement on instrumental birth, to be published this year.
4. Government to provide funding to validate the UR-CHOICE pelvic floor risk disorders calculator so it can be used in clinical practice.
5. Maternity units to implement NHS England's Perinatal Pelvic Health service specification, which includes providing information for women in antenatal period, such as the importance of pelvic floor exercises; increased education for health professionals including GPs; and early access to care for symptoms of incontinence. Women with perineal injuries to be seen by specialists in pelvic health clinics.[118]

Chapter Four:

1. Provide universal access to specialist maternal mental health services across the UK to end the postcode lottery.
2. Make a more focused effort to train and recruit perinatal mental health staff.
3. Introduce specialist training in birth trauma for CBT and EMDR therapists.
4. Introduce national oversight of maternal mental health services, with resources developed nationally instead of each service having to create their own.
5. NHS to commission research on birth debriefs, with the aim of creating a standard, evidence-based model that works and can be applied throughout the country.
6. NHS to commission an academic researcher to develop two standard screening questions about birth trauma that can be asked by the GP at the six-to-eight week postnatal check.

Chapter Five:

1. Government to commission research on the economic impact of birth trauma, including factors such as women delaying returning to work, the break-up of relationships and the costs of raising a disabled child.
2. Government to commission research on the costs to the NHS and social care of birth trauma, including the long-term cost of repairing birth injuries, providing mental health support and providing care for disabled children.
3. NHS to offer better support for maternity professionals, including opportunities to debrief and receive counselling after witnessing trauma.
4. Government to introduce more robust procedures for investigating bullying behaviour in NHS maternity care.

Chapter Six:

1. Offer mental health screening to partners after birth. This could be in the form of one or two questions from a health professional.
2. NHS England to develop guidance for keeping partners informed about an obstetric emergency (for example, assigning a health professional to update the partner on what is happening during and after the emergency).
3. Government and employers to consider offering extended parental leave in cases where a father or non-birthing mother has to support a new mother who is physically or mentally unwell.

Chapter Seven:

1. Commit to tackling inequalities in maternity care among ethnic minorities, particularly Black and Asian women. To address this NHS England should provide funding to each NHS Trust to maintain a pool of appropriately trained interpreters with expertise in maternity and to train NHS staff to work with interpreters.
2. Launch a national NHS-wide campaign to publicise the importance for Black and Asian women of taking Vitamin D during pregnancy.
3. Introduce specialist midwives for young parents who understand the intersection with other vulnerabilities, such as deprivation or care experience.
4. Provide training for maternity staff in trauma-informed care.

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