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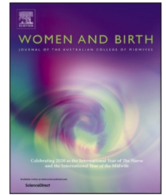

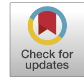

“We shouldn't have to beg to be heard” – A qualitative framework analysis of the public submissions to the NSW Birth Trauma Inquiry

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ABSTRACT

Objective: To explore the experiences of the individuals (women and non-birthing people) who made a submission to the NSW Legislative Council Select Committee on Birth Trauma (2023).
Design & setting: A qualitative theory-driven deductive framework analysis of the 1213 uploaded submissions available on the Select Committee on Birth Trauma website.
Participants: The qualitative analysis explores the 1127 individual and 16 non-birthing person submissions and the 70 clinicians who also gave individual personal birth accounts in their submissions. This resulted in a total of 1213 submissions included in the qualitative analysis.
Results: There were five categories in the framework. The category with the highest number of inclusions from submissions was obstetric violence, followed by lack of care and support, physical trauma, loss of control, and fear for own or baby’s life.
Conclusion: Analysis of 1213 submissions to the NSW Birth Trauma Inquiry revealed recurring themes of obstetric violence, lack of care and support, physical trauma, loss of control, and fear for maternal or neonatal life. Obstetric violence emerged as the most frequently mentioned experience, yet this critical issue was absent from the inquiry’s final report and government response.

Problem or Issue	The NSW Legislative Council Select Committee on Birth Trauma resulted in a large number of submissions from individuals, clinicians and organisations however there has been no research based analysis of these submissions.
What is Already Known	Birth trauma is multifaceted and can result in poorer postnatal outcomes for women such as increased postnatal mental health issues and issues with maternal-infant bonding.
What this Paper Adds	Submissions to the inquiry demonstrated a variety of traumatic birth experiences such as obstetric violence, lack of care and support, physical trauma, loss of control and fear for maternal or neonatal life. The category with the highest amount of mentions in submissions was obstetric violence

Introduction

Around one third of women experience birth trauma [1], with rates varying across different models of care, modes of birth [2] and characteristics, such as being a First Nations woman, a young person or from a culturally and linguistically diverse background [3]. Following a concept analysis involving women and maternity care professionals traumatic birth has been 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 wellbeing*” [4].

Some women experiencing birth trauma report this as obstetric violence due to experiencing disrespect or abuse from health care providers which results in them feeling dehumanised, powerless and/or violated [5]. Obstetric violence has been recognised by a United Nations

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Special Rapporteur report on mistreatment and violence against women in reproductive services as a form of gendered violence that includes "*any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life*" [6,7]. A legal definition of obstetric violence from Venezuela includes experiences that were dehumanizing, physically and/or mentally abusive and intrusive [8].

Birth trauma can have a significant impact on outcomes for women, babies and families. Women who experience birth trauma can develop postnatal mental health issues including post-traumatic stress disorder (PTSD), depression and anxiety [9]. These can lead to decreased breastfeeding rates, bonding issues with their baby, negative impacts on interpersonal relationships, as well as impacting women's subsequent reproductive decisions [10–13].

Government inquiries play a critical role in addressing matters of public concern by establishing facts, analysing evidence, and producing recommendations that can inform policy [14]. These inquiries often invite submissions from community members, stakeholders, and experts, providing an opportunity for voices to be heard and for accountability to be pursued [15]. For many, inquiries represent a pathway to change, with the hope that their findings will lead to meaningful improvements in policy and practice [14].

In Australia, inquiries occur at both federal and state levels, reflecting the country's governance structure of six states and two territories. Since the opening of the 47th federal Parliament in July 2022, sixteen inquiry reports have been tabled on diverse issues, alongside numerous state-based inquiries [16]. Maternity care has been the subject of repeated scrutiny over several decades, beginning with state inquiries in the late 1980s and 1990s and culminating in a national senate inquiry in 1999 [17]. While these earlier reports recommended reforms such as increasing access to birth centres and reducing caesarean rates, they largely overlooked the issue of birth trauma.

More recent inquiries have begun to acknowledge trauma, including reports from Queensland (2019) [18] and the ACT (2020) [19], which addressed postnatal post-traumatic stress and traumatic birth experiences. A national inquiry in 2023 highlighted the need for trauma-informed care for marginalised groups, though it did not specifically examine birth trauma [20]. Current inquiries underway in South Australia and Tasmania signal a growing recognition of this issue, with the Tasmanian inquiry explicitly including birth trauma in its terms of reference.

In New South Wales a parliamentary Select Committee was established in on June 21st, 2023 to examine birth trauma in that State, following consumer advocacy and research identifying more than 1 in 10 women experienced obstetric violence in Australia [5,21]. The inquiry received over 4000 submissions from individuals, clinicians and organisations and six hearings were held across NSW, with the report published in 2024 [22]. The NSW birth trauma inquiry (NSWBTI) gained international attention and contributed to an All Party Group on Birth Trauma national inquiry in the UK Parliament in 2024 [23] and another inquiry in Tasmania in 2024/25.

The aim of this analysis is to examine the submissions to the NSW Legislative Council Select Committee on Birth Trauma to explore the experiences of the individuals (women and non-birthing people) who made a submission. This work was undertaken to identify recurring patterns of harmful practices, communication failure or systemic issues that underpin parents' experiences of birth trauma. It also aimed to understand the emotional, psychological, behavioural and relational impacts of birth trauma, to inform future policy, practice and research.

Participants, ethics and methods

Qualitative framework content analysis

A qualitative theory-driven deductive framework analysis was used for this methodology. Deductive coding involves creating predetermined codes prior to data analysis [24]. Five deductively derived categories from previously published studies on birth trauma and obstetric violence and underpinned by Leinweber et al. (2020) [4] definition of traumatic childbirth [5,25–28] were developed. The five categories were loss of control, fear for own (woman's) or baby's life, physical trauma, lack of care and support and obstetric violence. While there are multiple definitions of birth trauma in the literature, the interdisciplinary professional and consumer co-design process undertaken by Leinweber et al. (2020) ensured that their definition reflected clinical, research, and consumer perspectives and remained grounded in women's lived experiences. The obstetric violence category was informed by an Australian study of 626 comments, from which the subcategories of feeling dehumanised, powerless, or violated were derived and applied in our deductive coding [5].

The categories included a variety of women's experiences and interactions with clinicians. Only submissions that were from an individual who experienced maternity care services as a birthing or non-birthing person, were included in the qualitative framework analysis. If a submission from a clinician included their personal experience of birth trauma, their personal experience was analysed. Submissions written by organisations or clinicians (except for their personal experience of birth trauma) were excluded from the framework analysis.

As framework analysis can be used for large datasets [29,30], it was determined as a suitable methodology for this analysis due to the large number of submissions and the variety of formats submitted. A five phase qualitative analysis process was undertaken as detailed in Table 1 below [24,30].

Comparative analysis of manual and AI coding

To assess the reliability and consistency of thematic coding across the submissions, a comparative analysis was conducted between manual coding performed by a research assistant and an AI-generated algorithm.

The manual coding dataset consisted of binary indicators (1 = category present, 0 = category absent) for each category across all submissions. The AI-generated thematic coding was conducted using Google's Gemini 2.5 model [31], a large language model applied to a random 10% sample of submissions to identify the five pre-defined categories. The model's utility in qualitative inquiry is supported by its proven application in research contexts for structured document analysis, summarisation, and pattern recognition [31,32].

To compare the two methods, submissions were matched by their unique identifiers (submission number/inquiry number) using Microsoft Copilot [33]. For each category, binary vectors were extracted from both datasets and aligned for direct comparison. The evaluation employed standard classification metrics: precision (the proportion of correctly identified category instances out of all flagged instances), recall (the proportion of actual category instances that were correctly identified),

Table 1
Deductive qualitative analysis phases.

Phase	Description
Phase 1: Organising of the Data	Research team decided on deductive theory-driven coding framework Create matrix in Excel Spreadsheet using coding framework
Phase 2: Sorting and Familiarisation of the Data	Each submission downloaded and numbered in matrix and folder. Read through each submission and complete the matrix using binary indicators.
Phase 3: Understanding and Coding the Data	Identify exemplar quotes for each category.
Phase 4: Interpreting the Data	Identify and write up the findings and create data visualisation tools
Phase 5: Explaining the Data	Identify and write up the discussion in alignment with existing research and literature

and F1 score, which combines precision and recall into a single measure by calculating their harmonic mean, providing a balanced metric that accounts for both false positives and false negatives. Additionally, depth of analysis was calculated as the proportion of submissions in which a category was identified, indicating the breadth of thematic coverage.

These metrics were computed using Python and the scikit-learn library, a widely accepted tool for statistical and machine learning analysis. Scikit-learn provides efficient tools for classification, regression, clustering, and dimensionality reduction, and is commonly used in AI workflows due to its integration with the Python data science ecosystem and robust performance across supervised and unsupervised learning tasks [34]. This approach ensured transparency and reproducibility in evaluating both manual and AI coding methods [35].

The submissions to the inquiry

The publicly available submissions were downloaded from the NSWBTI website and read in full by WK. Information including regional or metro location / State or Territory / length of submission (pages) / source of submission (individual / clinician / organisation) was recorded in a matrix within an Excel spreadsheet. The framework analysis consisted of reading each submission in full and recording the presence of data reporting on any of the five categories, including exemplar quotations. Each submission could contain multiple categories.

Reflexivity

The initial analysis was undertaken by WK, an experienced qualitative research assistant. Due to the traumatic content of the submissions the analysis process was limited to three hours per session to prevent researcher vicarious trauma. Regular debriefing sessions were conducted with HK and HD, experienced midwifery researchers, to discuss the content of the submissions and the analysis process. HK and HD read several of the submissions to ensure the relevance of the coding framework. HK undertook the Comparative Analysis of Manual and AI Coding. GT provided content expertise as an experienced researcher in birth trauma and psychology.

Ethical approval

This analysis sourced submissions to the NSW Birth Trauma Inquiry that were published by the NSW Parliament as publicly accessible documents. Under the Government Information (Public Access) Act 2009 (GIPA Act) [36], NSW government agencies are required to proactively release information to the public unless there is an overriding public interest against disclosure. Section 18 of the GIPA Act specifically defines categories of open access information that must be made publicly available, including documents tabled in Parliament, which encompasses Inquiry submissions published on the NSW Parliament website. These Inquiry submissions were therefore made publicly available as open access information for community use.

As the submissions were publicly available, there was no requirement to seek ethical approval from a human ethics committee. In line with the Privacy and Personal Information Protection Act 1998 [37], we avoided re-identification of individuals and excluded any data that could reveal sensitive personal details.

Findings

From the over 4000 submissions to the inquiry there were 1445 uploaded and available on the inquiry website [22]. The Chair of the Select Committee confirmed that all submissions were given to the select committee however due to volume and nature of the submissions there was a priority to upload submissions from NSW to the inquiry website. Each submission that was submitted to the inquiry was read in detail by allocated staff at the NSW legislative council to identify adverse events and at times to remove identifying information. This included contacting individuals who shared their story in a submission to ensure they were aware of the public access to the website. To ensure the inquiry timeline was not extended, the number of submissions that underwent this process and were uploaded was limited to 1445.

From the 1445 uploaded submissions, there were 62 confidential submissions that were listed on the website that could not be accessed. The submissions that were multiple (eg 5a, 5b, 5c) were counted as one submission. The multiple submissions were primarily organisations that collated submissions provided by their community. Duplicates of submissions were also removed. This resulted in 1383 available submissions that were downloaded for analysis.

Most submissions were from individuals describing their experiences of birth trauma (n = 1127). There were also submissions from non-birthing people (e.g. partners or family members), organisations, clinicians and clinicians who also shared their individual experiences. There were 43 submissions from organisations, 127 from clinicians, 1127 from individuals, 16 from non-birthing people and 70 from clinicians who also shared their personal birth stories.

From this dataset, there were 29% of submissions clearly identified as coming from NSW and some from other identified states included Queensland (0.22%) and Victoria (0.36%). There were 68% of submissions that had an undisclosed location. There were a variety of models of care identified in the submissions and as well as experiences coming from women who had different modes of birth. See Table 2 for an overview of submissions.

Where dates were given for the birth experience, the earliest account of birth trauma was from 1957 through to births in 2023. The length of submissions varied from 1 page to 20 pages (average 3 pages).

The qualitative analysis in this paper explores the 1127 individual and 16 non- birthing people submissions and the 70 clinicians who also gave personal birth accounts in their submissions. This resulted in a total of 1213 submissions included in the qualitative analysis.

Evaluation of thematic coding accuracy

The results of the comparison between manual and AI coding demonstrated that the manual coding had high recall across all categories, indicating that the research assistant consistently identified relevant submissions. This suggests strong sensitivity and reliability in capturing nuanced experiences. While precision was lower (ranging from 0.284 to 0.727), this reflects the research assistant's tendency to include borderline or contextually relevant cases that may not be flagged by AI as the research assistant identified more instances of each category than the Gemini AI model. This suggests that manual coding may be more sensitive to nuanced expressions of trauma, especially in complex or emotionally layered narratives. For example, categories such as *Fear for Own or Baby's Life* and *Loss of Control* may be embedded in subtle language or context that AI models might miss without explicit cues.

The AI analysis showed perfect precision (1.000) across all categories, meaning every category it identified was accurate. Recall was also high (ranging from 0.913 to 1.000), indicating strong alignment with manual coding. The AI's depth of analysis was comparable to manual coding, suggesting it can reliably identify key categories with minimal false positives.

These findings support the value of human-led qualitative analysis in capturing the full emotional and experiential depth of submissions. While AI offers scalability and precision, manual coding provides richer thematic coverage, which is particularly important in qualitative research. To summarise, the comparative analysis validated the integrity of the coding framework analysis undertaken by the research team.

Thematic analysis

There were five categories in the framework. The category with the highest amount of mentions in submissions was obstetric violence,

Table 2
Overview of submissions.

Type (n = 1383)	Organisation	Individual	Clinician	Clinician & Individual	Non-birthing person		
	43 (3.11%)	1127 (81.49%)	127 (9.18%)	70 (5.06%)	16 (1.16%)		
Location (n = 1383)	**NSW**	**QLD**	**VIC**	**SA**	**National**	**ACT**	**Undisclosed**
	404 (29.21%)	3 (0.22%)	5 (0.36%)	1 (0.07%)	30 (2.17%)	1 (0.07%)	939 (67.90%)
Region (n = 1383)	**Metro**	**Regional**	**National**				**Undisclosed**
	106 (7.66%)	183 (13.23%)	8 (0.58%)				1086 (78.52%)
Care Provider (n = 1383)	**Standard care (fragmented care)**	**Continuity of care with public midwife (MGP)***	**Continuity of care with doctor (private ob)**	**GP shared care**	**Private midwife (privately practising midwife)**	**No health care**	**Undisclosed**
	159 (11.50%)	168 (12.15%)	101 (7.30%)	52 (3.76%)	58 (4.19%)	1 (0.07%)	844 (61.03%)
Mode of Birth (n = 1383)	**Vaginal birth**	**Caesarean during labour**	**Assisted Vaginal birth**	**Caesarean before labour**	**Vaginal breech**		**Undisclosed**
	293 (21.93%)	324 (23.43%)	281 (20.32%)	45 (3.25%)	5 (0.36%)		435 (31.45%)

followed by lack of care and support, physical trauma, loss of control and fear for own or baby's life, see Table 3. There was a strong sense of altruism amongst the submissions, with women wanting their story to make a difference and contribute to better maternal care for other women, although for some there was sense of resignation that there may be limited impact (Table 4).

> *"I left feeling like I had just been assaulted in a room full of people. I'm writing this through tears and have questioned if I should even bother writing this, what difference will it actually make?" (ID216)*

Obstetric violence

The largest category with 75.6% of instances, was obstetric violence. This category included examples of dehumanisation where women were left feeling like they were a number in the system.

> *"To those nurses and doctors, I am just another number – another patient with another baby who they don't think about again, but to me; those people ruined me. I, daily, am reminded of the poor duty of care that was provided to me and my baby. I live with the trauma every day" (INQ 1153)*

Women felt dismissed which resulted in feelings of neglect and disrespect.

> *"I simply needed to feel safe, respected, reassured, and supported. This was completely lacking in the birth of my first child; instead, I felt unsafe, unseen, unsupported, neglected, dismissed, disrespected, mocked, coerced, and controlled" (INQ 1122)*

Similarly, the following quote from a non-birthing person submission highlighted an experience of disrespect and obstetric racism.

> *"The doctor said to Jane "You're an Asian woman – why aren't you more submissive?" in reference to her declining medical procedures" (INQ 1169)*

Women described experiences of being undermined, patronised and infantilised by clinicians, which undermined their hopes and wishes for childbirth.

Table 4
Category breakdown.

Category Breakdown	Count	% of total mentions (n = 1213)
Category: Obstetric violence	917	75.6%
Category: Lack of care and support	708	58.4%
Category: Physical trauma	496	40.9%
Category: Loss of control	373	30.8%
Category: Fear for own or babies' life	233	19.2%
Total (Multiple possible)	2727	

> *"When denying certain interventions, the head doctor at hospital told me I was risking the life of my son. He would roll his eyes at me and mutter things like 'typical' or 'you're one of those' and 'oh and who's the doctor here?' under his breath. It was like I was a child being punished by the school principal for speaking out of line" (INQ 86)*

On other occasions, women experienced, coercion through clinicians using fear mongering tactics, such as threat of their baby dying, to influence them to change their decision or plans for birth.

> *"He immediately shut this idea down and said point blank "after 41 weeks, your baby will die." It was said so callously and he meant to fear monger and shame me into submitting to his will" (INQ 1423).*

The experiences escalated from verbal threats to women feeling that interventions were forced upon them, to instances of physical assault.

> *"They did not ask me or tell me what they were doing but cut me, cut open my vagina and anus to a point that I could hear my daughter crying inside me" (INQ 806)*

Lack of care and support

Over half of the submissions (58.4%) mentioned instances where there was a lack of support. This ranged from a lack of support to a lack of services in hospitals. Some women who wrote a submission experienced birth during Coronavirus Disease (COVID) restrictions which impacted them negatively.

> *"As this was during COVID with the restrictions in place, I was forced to be alone while losing another baby and experiencing something very*

Table 3
Comparison of manual versus AI analysis across key categories.

Category	Manual Precision	Manual Recall	Manual F1 Score	Manual Depth	AI Precision	AI Recall	AI F1 Score	AI Depth
Obstetric Violence (OV)	0.727	0.976	0.833	0.917	1.000	0.976	0.988	0.976
Lack of Support (LS)	0.514	0.966	0.671	0.908	1.000	0.966	0.982	0.966
Physical Trauma (PT)	0.398	0.975	0.565	0.817	1.000	0.975	0.987	0.975
Loss of Control (LC)	0.303	1.000	0.465	0.908	1.000	1.000	1.000	1.000
Fear for Own or Baby's Life (FOB)	0.284	0.913	0.433	0.617	1.000	0.913	0.955	0.913

scary. My partner was left at home and simply told he wasn't allowed to come" (INQ 1264)

Outside of COVID times, other women received a lack of support due to restrictive hospital policies regarding visitation.

"I really needed my wife and support person there that night. But she wasn't allowed to stay. Instead I was "cared" for by busy, understaffed, jaded, unfriendly and uncaring midwives" (INQ 406)

Submissions highlighted that a lack of care resulted in feelings of abandonment and trauma.

"It's hard to describe, but the absence of care was my trauma" (INQ 43)

"I felt neglected and uncared for and as though no one could see or hear me" (INQ 1212)

"The lack of care and postnatal depletion from my adverse birth experience was a huge contributing factor to the postnatal depression and anxiety" (INQ 464)

The post birth period in hospital was identified by women as a time they experienced less care.

"I was so unwell after the birth. I had lost blood, was freezing, alone and completely depleted. I had this beautiful baby boy to care for but no one to care for me" (INQ 921)

For some women, a lack of access to services resulted in feeling unsupported. One woman highlighted how she was unnecessarily restricted from receiving limited culturally sensitive support.

"Being an indigenous Australian I said in my birth plan that if possible I'd like an indigenous midwife, they used this against me and only allowed me access to one if I did what they wanted" (INQ 275)

Physical trauma

The category 'physical trauma' mainly included descriptions of perineal and caesarean wounds. In one submission, a woman from a culturally and linguistically diverse background described being sutured without local anaesthesia.

"The worst thing about my birth experience was when I was being stitched up … When he started stitching, I was in so much pain that I moaned and cried out. I told him it was too painful and that I could feel everything. He said multiple times "I think you are being dramatic", I think you're exaggerating" … I could feel every single stitch. I told him "I am traumatised". He ignored me. He did not offer to numb the area after I asked so many times. I was screaming in pain." (INQ 269)

Another woman highlighted the impact of an infected caesarean wound on her post birth experience.

"My post-partum experience involved no visit on (home visit) after being discharged from the Hospital. This resulted in an infected c -sec on scar and meant I was admitted in and out of hospital during the first 5 weeks with my newborn son" (INQ 1159)

Other submissions described experiences of pelvic floor trauma such as severe tears and resulting prolapses.

"I feel I was discharged following both my births with significant pelvic floor damage and emotional pain that was dismissed and ignored by the hospital system" (INQ 426)

"I suffered a 3 C year to my anal sphincter and subsequent 3 compartment prolapse to my bowel, bladder and uterus. The treating doctors did not gain my consent to use forceps and made errors that made me feel that the best day of my life would also be my last" (INQ 1226)

Some women identified the ongoing effects of physical trauma from childbirth, such as mental trauma, and the implications for future conceptions.

"Whilst I have accepted what has happened and worked through the mental trauma, my physical birth trauma will stay with me for life" (INQ 305)

"I have been left with so many scars, physically and emotionally, that I will never ever risk having another child again in fear of not being able to have my autonomy taken seriously and dying because of mistreatment" (INQ 680)

Loss of Control

Overall, 30.8% of submissions included descriptions of woman or her non-birthing support person feeling that they had lost control or were out of control during childbirth.

"We felt we had no control over anything and that we had failed our child already" (INQ 1054 Partner)

Some women identified that these feelings resulted from having limited choice regarding the interventions they received or due to women feeling 'done to' rather than actively involved in the decision-making.

"During the birth of my son I did not feel like I had a choice about the interventions, they were not communicated as an option but I was told what was happening next. They were done to me. This includes the episiotomy, vacuum, forceps and c-section. I was not made aware of the risks and benefits or the alternative options I could consider. The decision making felt out of my control" (INQ 1027)

"My births were a cascade of intervention, something that just "happened to me", and it completely stripped away my self-confidence, my belief in my body and mind, and my ability to bond with my children in the early postpartum period. I was broken. Physically and mentally. My trauma enthralled me for years, requiring counselling, and will never leave me" (INQ1166)

For some women, feeling out of control was linked to feeling unsafe, especially for women with a history of trauma.

"As a victim of trauma this immediately sent me into panic as I suddenly realised I was not in control of the situation and the people who were supposed to support me were not going to" (INQ 1013)

"I did not feel safe during birth and felt like everything was out of my control" (INQ 323)

Fear for own or baby's life

The final category, present in 19.2% of the submissions, was where women identified feeling fear for their own or their baby's life.

"My first birth was very traumatic, and I thought both my baby and I were going to die. It's been nearly 10 yrs and I still cannot talk about it without crying or getting upset. I have since been diagnosed with PTSD." (INQ 1379)

Some women described their fear when they experienced complications during birth, which included being transferred to intensive care units (ICU).

"I was transferred to ICU… and losing over 2.5 L of blood. It was rough and terrifying… he was left alone and thought I was going to die." (INQ 787)

Women also identified being fearful for their baby's life, which often included separation due to their baby being transferred to a special care nursery (SCN) or a neonatal intensive care unit (NICU).

"Once bub was born no one said anything. My partner had to move around the midwife to check the sex of bub. During this they then told my partner to cut the cord and had to suction him. I asked "is he okay" no one said a word." (INQ 6)

"When my youngest was born she was in the NICU for an extended period. She stopped breathing after birth and was put onto a CPAP machine. I wasn't told until 2.30 am the night she was born! She was born earlier around 3.30 pm that afternoon." (INQ 16)

This category also included a few submissions where women had experienced a perinatal loss, either during pregnancy or labour, or shortly after labour and birth. These submissions highlighted sadness and grief, along with the impact of interactions with health care providers.

"An Obstetrician… finally looked at us and said 'I'm so sorry, there's no heartbeat.' Those words will haunt us for the rest of our lives." (INQ 620)

Discussion

Overall, the submissions to the NSWBTI demonstrate a diverse range of categories including obstetric violence, a lack of care and support, physical trauma, a loss of control and the fear of losing their own or their baby's life. These findings mirror those within the wider literature regarding how negative interactions and a lack of and inconsistent support from healthcare providers play a key role in how women interpret and experience birth trauma [5,38]. A recent study drew on postnatal women's experiences of a negative birth from a range of international settings to focus on the 'social space' of childbirth [39]. This study, like ours, demonstrated how relational (e.g., quality of the relationships between parents and healthcare providers) and institutional (e.g., rules, policies, staffing ratios) factors interact to influence women's 'personal' responses (e.g., disconnection, horror) to birth trauma.

Within the submissions there was clear evidence of overt racism and cultural insensitivity, associated with sweeping generalisations and women being denied care. This finding aligns with a recent scoping review of 57 studies to explore discrimination amongst migrant women in maternity care [40]. This study found that ethnically minoritised women experience differential treatment in a multitude of ways including access difficulties, lack of interpreters, delays in care, and disrespectful and judgemental care.

While details on the type of birth were missing from a sizeable number of submissions, available data indicates that less than half related to a vaginal birth. Over recent years a 'normal birth at any cost' rhetoric has been levied against maternity care professionals, linked to claims of increased morbidity and mortality [41]. However, the submissions indicate the relationship that medical interventions have on experiencing birth trauma, for example in the 'loss of control' category. While there is limited research focusing on the impact of medical interventions on experiencing birth trauma, an integrative review identified multiple interventions during labour/birth as a risk factor for developing postnatal PTSD [42]. A European study of moments of extreme stress, described as 'hot spots' during labour/birth also found that receiving medical interventions was the most frequently reported worst hotspot [43]. Studies have identified that midwifery continuity of care models can result in lower rates of medical intervention. A recent Australian study found that midwifery continuity of care models had lower rates of induction and augmentation, lower rates of both elective and emergency caesareans and lower rates of perceived birth trauma [44].

A noteworthy issue relates to the prevalence of obstetric violence across the submissions, with most women feeling mistreated, dehumanised, powerless and/or coerced. The term 'obstetric violence' is controversial for ethical, professional, legal and political reasons including its implications for deliberate harm, clinical defensiveness, and the lack of consensus regarding its definition [45,46]. The term is also contested by some professional bodies based on a narrow definition of obstetric violence only including 'intentional harm'. There are challenges to both narrow and broad definitions of obstetric violence, with a narrow definition potentially limiting the breadth of women's experiences and not addressing the wider systemic issues that contribute to obstetric violence [5,47]. However, broad definitions of obstetric violence can hinder lawmakers' ability to delineate what legally constitutes obstetric violence [47]. It is perhaps these controversial reasons that led to members of the NSWBTI select committee voting to remove the term obstetric violence from the final NSWBTI report [22]. This action was noted by the Chair of the NSWBTI select committee in an accompanying dissenting statement stating that she had wanted recommendations that specified obstetric violence to be included [22]. Ultimately, the removal of obstetric violence from the final NSWBTI report resulted in obstetric violence not being included or addressed in the NSW Government Response to the inquiry report [48]. Nonetheless, it can equally be argued that the concept of OV captures the severity of the abuse women describe, and that avoiding the term risks overlooking the harm evident in their accounts, representing yet another failure of the system to acknowledge women's experiences. Importantly, a key finding from our analysis, and other research [5,49], is that birth trauma is not solely about clinical events, but rather socially produced from environmental and relational issues, and is thus largely preventable [50].

In response to these submissions the NSWBTI final report called for a maternity system that is safe, respectful, culturally responsive, woman-centred, and accountable, with better support before, during, and after birth [22]. Its 43 recommendations span five key areas to 'improve quality and safety of maternity care', address 'cultural safety and equity', provide 'support after birth trauma', offer 'better information, education and antenatal preparation', and 'system accountability and complaints handling'. The NSW Government have formally responded to the Select Committee [48]. Overall, the government support 42 of the 43 recommendations in full or in principle and have committed over $83 million to improve maternity care including continuity of midwifery care [51] which is a known intervention to improve clinical and psychosocial-based outcomes for parents and infants [52]. Following the budget announcement, there have been further developments based on the NSWBTI recommendations with the appointment of a Chief Midwife in NSW, 10 new and expanded midwifery group practices and increased staffing ratios in 7 postnatal wards [53].

The 2024 Birth Trauma Inquiry in the UK produced similar findings and outcomes to the NSWBTI. However, one year on, and despite initial governmental backing and support, only partial progress has been made: the maternity service budget has also been cut from £ 95 million in 2024–25 to just £ 2 million in 2025–26 [54]. This outcome echoes the apprehensions of some women in NSW who provided submissions, while questioning whether their stories would make a difference. Ultimately, while government inquiries can raise concerns, prompt statutory accountability, and stimulate financial investment, their impact depends on whether and how their recommendations are enacted in practice.

Other concerns relate to some of the NSWBTI recommendations is lacking a suitable evidence base. For example, while a recommendation of the NSWBTI focuses on comprehensive antenatal education, currently there is insufficient evidence about what or how this information should be provided [55]. The same applies to the suggestion for debriefing/postnatal listening services for women following birth trauma, with a lack of robust information to inform what works [56,57]. Therefore, even while government support for all recommendations may be lacking, they offer an important call to action for the research community to address these gaps, and to produce high quality evidence to inform future policies, guidelines and practice.

Strengths and limitations

A key strength of this work is that it represents the largest corpus of birth trauma accounts to be analysed to date. Using a deductive framework supported conceptual coherence with broader theoretical accounts and strengthened through the identification of key mechanisms underlying experiences of birth trauma. The use of AI to check the accuracy of the coding ensured transparency and reproducibility, while offering a novel approach for others to adopt. A key limitation is that only ~1.3 K submissions were publicly accessible, raising concerns about the criteria for their availability, and what may have been missed by not being able to analyse the remaining submissions. Using a deductive framework may have meant that more contextual nuances were not identified and reported. This analysis is also limited by its reliance on the definition of birth trauma developed by Leinweber et al. (2020); while this co-designed definition reflects clinical, research, and consumer perspectives, alternative definitions in the literature may frame the construct differently. Moreover, as the data was pseudonymised this prevented sociodemographic analysis, limiting insights into whether different groups of women were disproportionately more likely to experience birth trauma.

Conclusion

The qualitative framework analysis of the 1127 individual submissions to the NSW Legislative Council Select Committee on Birth Trauma included a variety of traumatic birth experiences that were categorised into obstetric violence, lack of care and support, physical trauma, loss of control and fear for own or baby's life. The category present in the most submissions was obstetric violence, reported in over three quarters of submissions; however, this significant aspect of traumatic birth was not addressed in the final report or government response, except for a dissenting report by the Chair. While the exclusion of obstetric violence is deeply concerning given its prevalence across submissions, the NSW government's substantial commitments to maternity reform demonstrate a degree of system responsiveness. However, this omission raises critical questions about the effectiveness of recurrent public inquiries themselves, signalling a need for research that examines why systemic harms persist despite repeated consultation and reform processes.

Authorship contributions

HK: Conceptualisation, data curation, formal analysis, supervision, writing-original draft, writing-review & editing. WK: Formal analysis, writing-original draft, writing-review & editing. GT: Writing-original draft, writing-review & editing. HD: Conceptualisation, funding acquisition, supervision, writing-review & editing

Ethical approval

As the submissions were publicly available, there was no requirement to seek ethical approval from a human ethics committee.

Declaration of Generative AI and AI-assisted technologies in the writing process

During the preparation of this work the authors used Google Gemini 2.5 model and Microsoft Copilot in order to perform a comparative analysis assess to assess the reliability and consistency of thematic coding across the submissions. After using this tool/service, the authors reviewed and edited the content as needed and take full responsibility for the content of the published article.

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Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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