Submission
No 243

INQUIRY INTO BIRTH TRAUMA

Organisation: Early Pregnancy Loss Coalition

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NSW Parliamentary Select Committee Inquiry into Birth Trauma

Submission by the Early Pregnancy Loss Coalition
August 2023

Chair
The Hon Emma Hurst MLC
NSW Legislative Council
Select Committee on Birth Trauma
Via online submission

Dear Chair,

Submission – Select Committee on Birth Trauma

Please find attached the Early Pregnancy Loss Coalition (EPLC) submission to the Select Committee on Birth Trauma.

The EPLC endorses publication of this submission by the Select Committee.

Members of the EPLC Management Committee would be pleased to give evidence at a hearing should it assist the members of the Select Committee.

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Australian College of Midwives

Australasian Society for Ultrasound in Medicine

Bears of Hope

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Doctors the Environment

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EARLY PREGNANCY LOSS COALITION

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EARLY PREGNANCY LOSS
COALITION

Glossary of Terms

- **Abortion** Also known as termination, this is the intentional ending of a pregnancy using surgical or medical intervention.

- **D&C (dilation and curettage)** A procedure to remove pregnancy tissue or uterine lining. This procedure is commonly used for pregnancies under 14 weeks gestation.

- **D&E (dilation and evacuation)** Similar to a D&C, but the tissue is removed using a suction device, as well as other instruments such forceps. This procedure is generally used at gestations over 14 weeks.

- **Early pregnancy assessment service or centre (EPAS/EPAC)** Outpatient clinics in hospitals designed to support patients who have bleeding or other issues during the first 12 to 15 weeks of pregnancy.

- **Expectant management** This is the 'wait and see' strategy of miscarriage care, where you wait to see if the body will miscarry naturally.

- **LGBTIQA+** An acronym standing for lesbian, gay, bisexual, trans and gender diverse, intersex, Queer, asexual and aromantic, and a range of other identities and experiences. Some communities also see the + as representing people who are HIV+.

- **Miscarriage** is the loss of a pregnancy before reaching 20 weeks gestation, including but not limited to the experiences of:

    - **Blighted ovum** An out-dated term that is still commonly used, this is the name of a pregnancy that has a gestational sac but no fetus. It can also be called an 'anembryonic pregnancy' because there's no embryo.

- **Chemical pregnancy** A pregnancy that ends before reaching five weeks of gestation.
- **Complete miscarriage** This means the entire pregnancy has left your body. An incomplete miscarriage means that there may be some tissue left in the uterus.
- **Idiopathic miscarriage** This is early pregnancy loss in which no cause has been identified.
- **Missed or delayed miscarriage** This is when a pregnancy has stopped growing or an embryo has failed to develop and your body hasn't realised yet. That means that the body doesn't trigger the process of ending the pregnancy.
- **Molar pregnancy (hydatidiform mole)** A non-viable pregnancy that results in a placenta developing in an irregular way, with little sacs of fluid, a bit like a bunch of grapes. Molar pregnancies are surgically removed. In some cases the placenta can become malignant and develop into a rare form of cancer called choriocarcinoma.
- **Recurrent miscarriage** Either two or three consecutive miscarriages. The Royal Women's Hospital in Melbourne defines it as three losses, but the Australian Journal of General Practice defines it as two.
- **Termination for medical reasons (TFMR)** An abortion due to a fetal abnormality or because a pregnancy threatens the life of the birth parent.
- **Threatened miscarriage** A threatened miscarriage usually occurs in the context of vaginal bleeding in an ongoing pregnancy before 20 weeks gestation, where the cervix is closed.

- **Medical management** The strategy of treating miscarriage where either misoprostol or a combination of misoprostol and mifepristone are given trigger to the miscarriage process and pass the pregnancy tissue.

- **Mifepristone** A drug used in abortion and D&Cs, which blocks the production of progesterone and causes uterine contractions.

- **Misoprostol** A drug also used in abortion and D&Cs, misoprostol causes the cervix to dilate.

- **Non-binary** People who identify as living outside the prescribed gender binaries of male and female.

- **Pregnancy tissue** Tissue that develops as part of pregnancy, including but not limited to fetal tissue and the placenta.

- **Products of conception** The 'formal' medical terminology for pregnancy tissue. "Pregnancy tissue" is now becoming more widely used as a more compassionate and delicate alternative.

- **Spontaneous abortion** The formal medical terminology for a miscarriage or early pregnancy loss. Its usage was formally abandoned in the UK, but it is still used in the Australian context.

- **Stillbirth** The death of a baby after 20 weeks of gestation either before or during labour.

- **Surgical management** One of the three options for miscarriage management, surgical management of a miscarriage is a procedure to end the pregnancy, usually a D&C or a D&E (see above).

EARLY PREGNANCY LOSS COALITION

Who is the EPLC?

The Early Pregnancy Loss Coalition was founded in 2023 by author and journalist Isabelle Oderberg (Hard to Bear), Miscarriage Australia co-founder Dr Jade Bilardi (Monash University) and Associate Professor Dr Melanie Keep (University of Sydney). Our Mission is to advocate for improved care and support for people affected by early pregnancy loss (miscarriage) and their families.

The Coalition is structured to ensure representation across all sectors and organisations with an interest in miscarriage care including pregnancy loss support organisations, medical professionals, researchers and academics, allied health professionals, mental health workers, economists, health policy experts and those with lived experience.

The Coalition has a four tier membership structure:

1) Management Committee who are responsible for the administration of the EPLC
2) Organisational Members from organisations across all sectors with an interest in miscarriage[1] care
3) Expert Policy Advisory Group who give advice and inform the EPLC's policies and platforms[2]
4) Public Membership.

The four key goals of the Coalition are to improve:

★ care
★ communication
★ data
★ research

The EPLC provides a collective voice to the government and advocates for critical changes needed to address the current gaps in patient care, support and funding in Australia.

The EPLC applauds the NSW Legislative Council for holding this Inquiry. The mere fact of this Inquiry will assist to remove some of the societal stigma and taboo regarding birth trauma, including early pregnancy loss. The EPLC anticipates significant positive change will also emerge from the Select Committee's findings and recommendations.

[1] Our use of the term "miscarriage" includes all forms of early pregnancy loss (under 20 weeks gestation), including termination for medical reasons.

[2] EPLC.au

EARLY PREGNANCY LOSS COALITION

Terms of Reference

This submission addresses Terms of Reference 1(a), 1(b)(i), 1(b)(iii), 1(c), 1(d), 1(e), 1(g), 1(h) and 1(i).

In referencing "birth trauma" in the context of this Inquiry, we note that this is additional to the significant trauma experienced by the majority of birthing persons and bereaved families impacted by miscarriage.

We also note that some birthing people do not experience pregnancy loss as trauma; it is therefore important for all care in the pregnancy loss space to be birthing person-led and individualised to that person's experience and needs.

This submission refers to "baby", but the use of language by medical caregivers should always be led by the birthing person, reflecting each individual's personal terminology.

1(a) The experience and prevalence of birth trauma in the context of early pregnancy loss

Miscarriage or early pregnancy loss is sadly common in Australia, estimated to occur in anywhere from one in three to one in four known pregnancies, or anywhere from over 100,000 to 150,000 miscarriages per year. In Australia, a family experiences a miscarriage every five minutes(31).

Clinical levels of anxiety, depression and post-traumatic stress disorder following miscarriage are common(3-5).

Gestational age and other obstetric factors have little association with the level of psychological distress(6-9), with up to 40 per cent of women experiencing grief of a similar intensity and duration to other major losses(10), including late or perinatal death(11).

Future pregnancies are also often adversely affected due to heightened grief, fear, and anxiety during the pregnancy(12, 13).

These psycho-social effects are significantly compounded by a lack of support and acknowledgement of this "unseen" loss in both healthcare(14-20) and social settings(6, 18, 21-23), leaving people alone and isolated in their grief.

Lack of support is highly concerning, as it is one of the major predisposing risk factors to psychological morbidity(4, 24).

Evidence consistently shows positive support experiences can buffer the loss and lead to better psychosocial outcomes(11, 20).

However, research, including our own, has consistently shown high levels of dissatisfaction among women with healthcare professionals' emotional support care in general.

Issues commonly cited include:

- Focus on physical but not emotional needs
- A lack of sensitivity, empathy, and acknowledgement of the loss
- Use of medicalised terminology; lack of follow-up care, including referral to support services
- Lack of information provision around causes, physical symptoms, recovery, and subsequent pregnancy prospects
- An expectation that recovery from grief should occur quickly(14, 16).

In a 2020 survey we conducted, nearly two-thirds of female participants reported they were not offered any information about miscarriage or pregnancy loss support organisations or referral/access to counselling services at the time of miscarriage, despite almost all reporting they would have liked further support(25).

Through our research we also know consumers and clinicians are often not even aware of the miscarriage support services available in Australia(26). Research shows clinicians often do not consider themselves responsible for patients' emotional care following miscarriage, citing time, resources, desensitisation to women's losses, and a need for self-protection as restricting their ability to provide this (26, 27).

Indeed many of our members provide these services, including Red Nose Australia, Pink Elephants Support Network, Miscarriage Information Support Service, Bears of Hope, Perinatal Anxiety and Depression Australia and Mums Matter Psychology.

Birth trauma can be generated through the use of terminology that is deemed to be medically correct, but is often deeply offensive and upsetting to the birthing person and bereaved family. This includes terminology such as "spontaneous abortion", "products of conception", "incompetent cervix" and "failed pregnancy".

This birth trauma continues to be caused in NSW despite the *NSW Government Policy Directive* on *Maternity – Management of Early Pregnancy Complications* (Policy Directive) containing a table of appropriate terminology recommended for use by healthcare professionals, at Appendix C.

The Policy Directive relates to Early Pregnancy Assessment Services or Centres (EPAS) and also to Emergency Departments (EDs) regarding suitable treatment for ambulatory management of early pregnancy complications and loss. The Policy Directive has been in place since 2012, and was scheduled for review from 30 June 2023. Recommendations from the Select Committee should form part of that review process, to ensure further birth trauma is not caused to people experiencing pregnancy loss.

Birthing people and their families also report significant levels of birth trauma due to the location of their care during pregnancy loss. This is particularly so for people cared for in hospital EDs, EPAS and maternity units.

Birthing people cared for in EDs are typically treated as non-urgent cases because the majority of birthing people are clinically stable during miscarriage. This is despite the birthing person usually experiencing significant grief, emotional distress and anxiety. While the non-urgent status is understandable in the context of critical emergencies EDs must provide care for, it causes birth trauma for the birthing person and bereaved family through delay in care and care that is often very clinical rather than empathetic. There are also instances of birthing people miscarrying in ED waiting room toilets and then needing to decide whether to flush or retrieve their baby, causing additional birth trauma.

Pregnant people who are treated in EPAS units for pregnancy loss report birth trauma from sitting in waiting areas alongside pregnant people who are not experiencing complications or loss. This birth trauma continues despite the Policy Directive stating that an effective EPAS requires "a discrete waiting area and appropriate consultation room"(28).

This birth trauma is compounded when medical caregivers are unaware the pregnant person is miscarrying, due to issues such as medical files not being updated appropriately, the pregnancy loss not being prominently identified in the file, or caregivers not having time to read the file. When caregivers then engage with the pregnant person presuming their baby is still alive or healthy, this causes further trauma and distress.

The EPLC was pleased to note the creation and deployment of guidelines for parent-centred communication in obstetric ultrasound by its Organisational Member, the Australasian Society for Ultrasound in Medicine(29).

The EPLC advocates for similar guidelines to be created across all areas of care, including in EDs, with guidelines for specific minority groups, such as parents who are Aboriginal or Torres Strait Islander, LGBTIQA+, disabled, Culturally or Linguistically Diverse (CALD) or any combination of these demographics or others.

Birthing people who have been admitted to maternity units during pregnancy loss express distress at the birth trauma caused when they are inadvertently exposed to the sights and sounds of living babies, such as cardiotocography (CTG) monitors, babies crying and family celebrations.

For birthing people who choose or are medically required to have surgical management, surgical delays cause birth trauma. Pregnant people have been required to continue carrying their deceased child for days and weeks beyond the diagnosis of their miscarriage.

Further birth trauma can be caused to a birthing person when plans are not put into place for follow-up and their primary health care professionals are not informed of their pregnancy loss. Birthing people have been contacted weeks later by the same hospital where they miscarried, with an appointment reminder for a twenty-week scan that is no longer required. This is again despite the Policy Directive requiring plans for follow-up to be clearly recorded, and a system to be in place to ensure primary health care professionals are advised of the pregnancy loss.

The EPLC also notes that while early pregnancy loss is thought to affect between 100,000 to 150,000 Australian families per year(31), Australia does not collect miscarriage statistics. The EPLC moves that all state governments – including NSW – immediately move to collect/collate this data as a matter of urgency.

1(b)(i) Causes and factors contributing to birth trauma – current practices in obstetric care

Fourteen years ago, had a horrifying miscarriage in the emergency department toilets at Sydney's hospital. Despite an inquiry and promises that miscarriage care would change, there are still far too many documented cases of these instances and many others in the media.(30)

EPAS were rolled out at all public, tertiary hospitals. But media reports indicate that some of these services operate in name only. When asked how many EPAS clinics are running in the state, how many patients they see and who has oversight, NSW Health couldn't offer an answer. (30)

Both current literature and research shows women commonly experience poor healthcare support experiences at the time of miscarriage, only serving to exacerbate the trauma associated with it. Issues in care consistently reported include:

- Focus on physical but not emotional needs
- A lack of sensitivity, empathy, and acknowledgement of the loss

- Use of medicalised terminology; lack of follow-up care, including referral to support services
- Lack of information provision around causes, physical symptoms, recovery, and subsequent pregnancy prospects
- An expectation that recovery from grief should occur quickly(14, 16).

This needs to change.

1(b)(ii) Causes and factors contributing to birth trauma – the availability of, and systemic barriers to, trauma-informed care being provided during pregnancy, during birth and following birth

The challenge facing birthing parents whose pregnancies end in miscarriage or termination for medical reasons is an endemic, national issue. NSW is not immune from these challenges, though despite the uproar over loss 14 years ago and a Parliamentary Inquiry that led to significant intended change, cases of sub-standard care or practices are not difficult to find.(30)

In 2021 Hannah (name changed) attended a hospital emergency department in Sydney after repeatedly calling the hospital's EPAS with no response.(30)

"So we went to the emergency department, they gave me the painkillers and said call the clinic again [because] 'they're the ones that know what they're doing'," she says. Finally, after again calling repeatedly, Hannah got a call back from the clinic.

"[The nurse from the EPAS] was like, 'What's going on?' And I said, 'I'm having all of this pain.' Basically, what I wanted to ask her was, if my husband leaves the house, is he going to come home and find me dead in the bathroom? That was where my brain was at because I'd never experienced anything like that … And she said to me, 'Darling, it's just a miscarriage.'"

Another patient, Rose (name changed), experienced a miscarriage earlier this year. After her GP in coastal NSW confirmed the loss via an ultrasound, he referred her to the local EPAS, which took three days to get back to her.(30)

"When I went into the EPAS, I was in the waiting room and I was seeing pregnant women everywhere, which was kind of shit," she says.

Once Rose got into the clinic she says she "broke down", but the service was good.

"The nurse was fantastic and so was the obstetrician," she explains.

Rose opted for a surgical procedure to end the pregnancy. Usually she would have to wait up to two weeks, but by luck they were able to fit her in two days later. This still meant a total 10-day wait from the first confirmation of the miscarriage to bringing the pregnancy to a close. Rose appeared grateful her case was treated in two days whereas most would be required to wait up to 14 days for their preferred method of management, which is in itself unacceptable.

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

The Policy Directive states that "[a]ll health professionals must be aware of the psychological sequelae associated with pregnancy loss and must provide support, follow-up and access to formal counselling when necessary", yet this is not consistently happening throughout NSW.

In a study conducted in 2020 with nearly 400 women, many from NSW, exploring women's access to healthcare services and support at the time of miscarriage, more than half of women were not offered any information from healthcare providers about miscarriage or pregnancy loss support organisations or referral/access to counselling services at the time of miscarriage, despite almost all reporting they would have liked various forms of support.

Less than a quarter of women received information about miscarriage or pregnancy loss support organisations and far fewer received referral or access to counselling services (private counselling, social worker or pastoral care).

When asked about a list of potential support items, nearly all women reported they would have liked to be asked how they were coping emotionally, to receive referral for counselling and to receive leaflets for support organisations either at the time of miscarriage or in a follow up appointment.

As stated previously in this submission, clinical levels of anxiety, depression and post-traumatic stress disorder following miscarriage are common(3-5). Gestational age and other obstetric factors have little association with the level of psychological distress(6-9), with up to 40 per cent of women experiencing grief of a similar intensity and duration to other major losses(10), including late or perinatal death(11).

Male partners and LGBTIQA+ people in particular often feel their role and loss is devalued and their grief is unacknowledged in the same way, if at all, as women(32-34).

1(d) exacerbating factors in delivering and accessing maternity care that impact on birth trauma generally, but also in particular: (i) people in regional, rural and remote NSW; (ii) First Nations people; (iii) people from CALD backgrounds; (iv) LGBTQIA+ people; and (v) young parents

We note that the Policy Directive does not use inclusive language or acknowledge:

- Aboriginal and Torres Strait Islander people
- LGBTQIA+ people
- The importance of respecting and incorporating different cultural and religious beliefs into management of miscarriage

While best practice care includes the ability of the patient to select their method of miscarriage management (surgical, expectant or medical) this choice is rarely extended to rural and regional services due to high stress on medical professionals and services, or indeed, a lack of those services at all.

1(e) the role and importance of "informed choice" in maternity care and 1(g) the information available to patients regarding maternity care options prior to and during their care

The Policy Directive states:

- "apart from certain specific clinical circumstances, women should be able to choose their preferred method of management";
- "[t]o the fullest extent possible, a woman should be given the choice of treatment option"; and
- "…women with miscarriage who chose their own treatment had the best health-related quality-of-life (HRQL) assessments compared with women who were randomised to one or other treatment modality…This confirms the importance of allowing and encouraging patient choice in the management of early miscarriage".

However, birthing persons experiencing pregnancy loss in NSW are not consistently provided with the full range of options for miscarriage management (expectant, medical and surgical), which causes birth trauma when (for example) they choose surgical management without being aware they had an option to labour and give birth.

The Policy Directive states that "the full range of therapeutic options (expectant and surgical) must be available to women who miscarry whenever possible", and therefore does not specifically include the category of medical management as an option. It is noted that the detail of the Policy Directive does contain details about medical management, but this needs to be included as a specific category so that this language is reflected during consultations and birthing people are fully informed of their options.

Bereaved families have also not been provided with complete information (and sometimes are not provided with any information) about their options regarding memory-making and/or funeral arrangements, which also contributes to birth trauma and prevents families from fully experiencing memory-making, bonding with and paying tribute to their baby.

In some instances, the lack of options regarding funeral arrangements has prevented families from following their religious faith or culture, layering further birth trauma.

Any care that does not provide birthing persons with their full options cannot possibly comply with the legal, ethical and professional requirements for health care providers to ensure that an informed choice has been made and that therefore "informed consent" has been given.

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

The continuation of birth trauma for birthing people and bereaved families in NSW despite the existence of the Policy Directive indicates that the Policy Directive is not being appropriately implemented, adhered to and/or enforced in NSW hospitals. In addition to the scheduled review of the Policy Directive, a review should also be undertaken to identify which NSW hospitals have an appropriate written local protocol in place and being actively implemented, as required by the Policy Directive.

Similarly, there are already legal and regulatory frameworks in place in NSW regarding the need for "informed choice" and therefore "informed consent".

However, the instances of a lack of informed consent in the context of pregnancy loss indicate that these frameworks are not being sufficiently upheld or enforced to protect birthing people from experiencing birth trauma during pregnancy loss.

1(i) any legislative, policy or other reforms likely to prevent birth trauma

NSW legislation should be amended to require research to be undertaken and programs to be established or expanded in support of pregnancy loss and infant death, consistent with legislation introduced in Ontario, Canada in 2015. The *Pregnancy and Infant Loss Awareness, Research and Care Act 2015* amended the *Ministry of Health and Long-Term Care Act 1990* to include the following as a function and duty of the Ontario Minister for Health: to undertake research and analysis on pregnancy loss and infant death that assists those, including [parents] and families, who experience such loss and that informs the establishment or expansion of programs related to such loss".

The societal impacts and costs of early pregnancy loss are enormous; the costs and numbers of NSW citizens impacted every year by miscarriage and related birth trauma are too significant to ignore. Legislative change such as this would enable NSW to lead the way in Australia by preventing birth trauma associated with miscarriage through the funding of research and analysis, and the provision of appropriate support for bereaved families.

Recommendations

The experience of birth trauma associated with miscarriage can be significantly reduced, and ultimately eliminated in the following ways:

Care

Birthing persons experiencing pregnancy complications or pregnancy loss should be cared for in dedicated pregnancy complication/pregnancy loss units. The EPLC notes the opening of the ACT's recent dedicated unit[3] and calls on the Select Committee to recommend the inclusion of such a unit in each NSW public hospital offering maternity services whenever any construction, renovation or relocation of public maternity service facilities occurs throughout NSW.

At a minimum, EPAS clinics must be located away from maternity services, and discrete waiting areas must be offered to pregnant people experiencing complications or loss, so they are not accommodated with pregnant people who are not experiencing complications or loss.

Medical caregivers must inform pregnant people of the three methods of management for miscarriage and pregnant people must have the ability (subject to the pregnant person's individual situation, preference and medical advice) to select any of those options.

Once the pregnant person chooses an option for management of their miscarriage, this must be undertaken within a reasonable timeframe, avoiding situations where a patient is for instance:

- Required to deliver a deceased or dying baby outside a clinical setting (for instance in an ED waiting area or toilets)
- Required to return numerous times to hospital for treatment
- Subjected to long waiting periods before surgical resolution of a miscarriage

[3] https://www.cmtedd.act.gov.au/open_government/inform/act_government_media_releases/rachel-stephen-smith-mla-media-releases/2023/new-dedicated-unit-for-early-pregnancy-service

Additional education and training specific to pregnancy loss and bereavement care must be provided to all NSW healthcare professionals who provide obstetric and related services, to ensure appropriate behaviour and birthing person-led language is used at all times. This includes both medical and ancillary health care providers, such as sonographers and social workers.

Communication

The Policy Directive and Appendix C regarding appropriate terminology have been in place for a significant period of time, but there continues to be use of inappropriate terminology by NSW healthcare providers that causes birth trauma during pregnancy loss. NSW healthcare providers must be directed to immediately cease the use of offensive and upsetting terms, including but not limited to "spontaneous abortion", "products of conception", "incompetent cervix" and "failed pregnancy".

The language used by NSW healthcare providers in the context of pregnancy loss must be birthing person-led language, and healthcare providers must also be directed to use alternative phrasing for any terms or language the birthing person and bereaved family find to be offensive, inappropriate or traumatic.

Where pregnant or birthing people cannot be medically treated within a reasonable period of time, printed resources and information must be provided that includes appropriate support service information, with additional information specifically tailored to marginalised groups including but not limited to:

- Aboriginal and Torres Strait Islander people;
- People with disability
- LGBTQIA+ and gender diverse people
- People whose first language is not English
- Those from diverse cultural groups

The Policy Directive should also be amended to specifically acknowledge and highlight care for these marginalised groups during miscarriage.

There should not be undue reliance on online resources and information to support people experiencing pregnancy loss, as people in regional, rural and remote NSW do not always have reliable connection to online resources. Telephone and printed support, resources and information should always be available in a variety of languages appropriate to the diverse cultures living in NSW.

In addition, the review of the Policy Directive should ensure that the listed 'Support Group Websites' are reviewed and updated to ensure current and relevant Australian websites are included. There has been considerable expansion of services available for Australians regarding early pregnancy loss since 2012.

Data

NSW has the opportunity with this Inquiry to play a significant and groundbreaking role in instigating a national effort to collect and collate miscarriage data. This would help identify whether rates are increasing, whether there are key demographics or geographic areas in which miscarriage is more common and identify where emergency care measures must be taken.

In addition, the EPLC would like see NSW Health:

- Establish how many EPAS clinics are running in NSW (and compare this number to other states)
- Establish their locations
- Establish their funding
- Establish the model of care for each clinic
- Quantify how many patients they are seeing annually
- Conduct qualitative research on the services provided and whether they are fit for purpose
- Provide audit records for miscarriage numbers/management?

Research

The EPLC is currently raising funds to commission Health Economists at the University of Melbourne to undertake a study into the economic cost of miscarriage, using the framework of the same research done by a cross-institutional range of medical researchers based in the United Kingdom.

Select Committee hearing

Members of the EPLC Management Committee would be pleased to give evidence at a hearing should it assist the members of the Select Committee. The Management Committee can extend invitations to its members, but the decision of whether or not to attend would be made by each organisation alone.

EARLY PREGNANCY LOSS COALITION

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