REPORT ON PROCEEDINGS BEFORE

SELECT COMMITTEE ON BIRTH TRAUMA

INQUIRY INTO BIRTH TRAUMA

CORRECTED

At Sage Hotel, Wollongong on Thursday 7 September 2023

The Committee met at 10:30 am

PRESENT

The Hon. Emma Hurst (Chair)

The Hon. Mark Banasiak
The Hon. Susan Carter (Deputy Chair)
Dr Amanda Cohn
The Hon. Greg Donnelly
The Hon. Natasha Maclaren-Jones
The Hon. Sarah Mitchell
The Hon. Emily Suvaal

PRESENT VIA VIDEOCONFERENCE

The Hon. Mark Buttigieg

CORRECTED

The CHAIR: Welcome to the second hearing of the Select Committee on Birth Trauma. I acknowledge the traditional custodians of the Dharawal country, the lands on which we are meeting today. I pay my respects to Elders past and present, and celebrate the diversity of Aboriginal peoples and their ongoing cultures and connections to the lands and waters of New South Wales. I also acknowledge and pay my respects to any Aboriginal and Torres Strait Islander people joining us today. Thank you for attending today's hearing.

Owing to the nature of this inquiry, I would like to warn those in attendance and listening to this recording that evidence presented today may contain sensitive content or themes. If you feel distressed as a result of the inquiry's sensitive content and themes, please contact one of the resources available on the Committee's website. Today we'll be hearing from a number of stakeholders, including people with lived experience of birth trauma, advocacy and health organisations, health experts and local hospitals, and health districts from the Illawarra Shoalhaven region. I thank everyone for making the time to give evidence to this important inquiry.

Before we commence, I would like to make some brief comments about the procedures of today's hearing. While parliamentary privilege applies to witnesses giving evidence today, it does not apply to what witnesses say outside of their evidence at the hearing. I therefore urge witnesses to be careful about comments you may make to the media or others after you complete your evidence. Committee hearings are not intended to provide a forum for people to make adverse reflections about others under the protection of parliamentary privilege. In that regard, it is important that witnesses focus on the issues raised by the inquiry terms of reference and avoid naming individuals, hospitals, medical facilities or workplaces unnecessarily. All witnesses have a right to procedural fairness according to the procedural fairness resolution adopted by the House in 2018. Finally, I ask everyone to turn their mobile phones to silent for the duration of the hearing.

CORRECTED

JESSICA HOLLIDAY, Private Citizen, affirmed and examined

NAOMI BOWDEN, Private Citizen, affirmed and examined

AMANDA MACAULAY, Private Citizen, affirmed and examined

The CHAIR: I now welcome our first witnesses. Before we begin this session, I remind witnesses to avoid referring to specific names, hospitals or medical facilities in their evidence and to speak generally about the issues raised in the terms of reference. Do any of you have a short opening statement that you'd like to make?

AMANDA MACAULAY: Yes, thank you. I'm here today to share the story of my second pregnancy. My family and I have suffered immense trauma from what I believe was inappropriate treatment throughout my second pregnancy. On 13 April 2014 my son Connor was stillborn due to a uterine rupture. In the week leading up to this catastrophic event, I presented three times with increasing amounts of abdominal pain at Wollongong Hospital. On my third visit, I was reviewed by an on-duty obstetrician and given Endone. I was told to take the Endone for a few days and come back for my next appointment in five days' time and, even though I was experiencing a lot of pain, my baby was fine. Approximately 36 hours after this medical review and prescription of Endone, I was rushed via intensive care ambulance to Wollongong Hospital, where my son was stillborn. I nearly lost my own life and I required a hysterectomy.

I feel there were many issues with the care that I received. I presented multiple times to the hospital and there was no mention or consideration given to me about being admitted or further investigations as to the cause of the severe amount of pain that I was experiencing. I still wonder whether the prescription of Endone may have masked any further symptoms in the hours leading up to the loss of my son. I needed four months off work to recover. I felt broken, both physically and psychologically. A clinical incident review was conducted in July 2014 by staff at Illawarra Shoalhaven Local Health District, however my husband and I were not informed of this investigation or given any feedback from the process. It was only approximately 2½ years later that I found out that this review was conducted and, with my questioning, we were then offered a meeting with the head of obstetrics and a copy of the report. I feel that my concerns in the week leading up to this rupture were not listened to adequately. As a result, my family and I are continuing to live with the trauma associated with losing our son. Thank you.

The CHAIR: Ms Bowden?

NAOMI BOWDEN: Thank you for having me here today. Sorry, I probably should've went first.

The CHAIR: Take your time.

NAOMI BOWDEN: My name is Naomi Bowden, and my experience is just one of the many thousands submitted into the birth trauma inquiry. On 4 November 2009 I gave birth to my beautiful daughter Bella. It was meant to be one of the most amazing and happy days of my life, but things did not go to plan. Bella was stillborn and the time immediately after her birth holds vivid, painful memories, including seeing my baby for the first time after being rudely directed into a small room where she lay lifeless and intubated; having to call my family in the middle of the night to rush them to come and see her because we were told that the police were called; having to identify her body to the police and being forced to watch the police officer put her in a cold styrofoam box and transfer her to the Coroner; being kept in the maternity ward overnight, listening to the sounds of other mothers giving birth and then hearing their babies cry while I had just lost—and my baby had been so callously taken away; going to my six-week check-up appointment with hospital staff and being asked, "Where's your baby?", because staff had not informed them or even read my files before seeing me—I cried hysterically and I was told, "I'm sorry, you must have fallen through some cracks"; and the dismissive, cold way that was handled by the HCCC and the hospital.

The death of my baby was heartbreaking enough, but it was the disrespectful, inappropriate and appalling treating by numerous staff at this hospital, and the complete lack of care in the hours and weeks and months after losing my daughter Bella that exacerbated and compounded and left me profoundly traumatised. This has impacted my mental health and my overall health and life to this day. My story of Bella—my pregnancy, her birth and all that has come with it over the last 13 years is long. It contains so many experiences and so many mixed emotions, but mostly it's confronting and traumatic. To this day, I still hear stories. I meet women and families who have experienced similar things to what we experienced, and I know we can do better; we must do better.

My recommendations are training in communication, basic care and compassion in every hospital; policies and procedures to be created around miscarriage, around baby loss and all staff to be inducted in these areas; a social worker with grief and trauma-based training to be available at every hospital 24/7; continuity in support after leaving hospital—not being alone—and being linked with appropriate services, like PIMS teams, PANDA

and local, State, national support groups and emergency contacts, plus more public mother and baby units with perinatal and postnatal care. The manner and language in response letters to the family also needs to be reviewed. I understand from a legal perspective they have to be cautious around wording that they use, but they can still respond with compassion. Most importantly, please don't forget the dads. I am here today as my daughter gave me a voice. Thank you.

JESSICA HOLLIDAY: When I first found out I was pregnant, I remember my GP's enthusiasm as she shared in my joy. She was eager for me to embrace GP shared care, an option that she believed in. With her support, I ventured into the antenatal clinic at the hospital, hoping for a positive start. I was weighed and, due to my BMI, labelled as high risk. The option of shared care was off the table, and I found myself subjected to a revolving door of obstetricians. It felt like my worth was reduced to a number on a scale, and I was given no other option. Every appointment brought new frustrations. I had to provide a urine sample each time because of my BMI and my risk status. The scale became a source of humiliation as I was shamed for any weight gain, even though I was growing a baby.

Still, I clung to the belief that I was receiving the best care available, despite the confusion that clouded every appointment. At each visit I shared my story, my journey, only to receive contradictory medical advice. One moment I was told to take aspirin due to my high BMI and fearing blood clots; the next I was advised it was unnecessary. One day I was scolded not to gain any weight during pregnancy, and the next I was told that a mother's weight had no impact on pregnancy or birth. I was discouraged from seeking knowledge about childbirth on my own and repeatedly told to trust the hospital implicitly.

Despite testing negative for gestational diabetes three times in the first 20 weeks, I was encouraged to act as if I had it. I was warned of a big baby due to my size and advised early induction. The birthing pool was off limits because of my BMI as it was considered a workplace health and safety issue. Midway through my pregnancy, I saw a documentary was playing at the local cinema about childbirth, *Birth Time*. I got a ticket. I sat in the cinema with tears streaming down my face as I realised that other women were enduring similar treatment. I could not believe it.

Fortunately, I found a glimmer of hope through a local doula during a private birth class. She introduced me to the existence of private midwives in our area. Why had I not been informed of this earlier? I was fortunate to have some savings, allowing me to switch to a private midwife at 30 weeks. Kira, my amazing midwife, evaluated my health holistically and saw beyond my BMI, acknowledging my overall wellbeing. Though I still had some scans at the hospital and I did meet compassionate midwives towards the end of my pregnancy, it was heartbreaking that this was the first time I felt genuinely cared for during my journey—mainly because anything I was told at the hospital, I knew I could check in with Kira and she would give me research and help me make my own mind up about things happening to my body and my baby. I felt respected and I felt heard.

On one of my final hospital visits I was informed of low amniotic fluid and urged to consult an obstetrician. She warned me of the dangers of a home birth due to my weight, using comparisons that left me distraught. I felt coerced and trapped. I decided to trust my instincts, reaching out to my private midwife for reassurance. She reminded me that she would be monitoring the baby closely during the birth and assured me the obstetrician's claims were unfounded. I followed my gut, and one week later my 3.6 kilo baby was born at home, fulfilling my dreams of a home birth.

My journey was fraught with emotional turmoil, disappointment and frustration. It's essential that we address the systemic issues in our own healthcare system to ensure that no other expectant mothers experience the same distress I did. Thank you for the opportunity to share my story. If you want to know where to from here, we need to listen to birthing people. We need continuity of care. We need more accessible midwifery-based care. We need change. One woman, one midwife.

The CHAIR: Thank you all for your bravery in coming here today. The whole Committee really appreciates it. The way that this works now is that any one of the committee members may have a question for you. If you don't feel comfortable answering the question, feel free to tell us, or if you just need some time and space, let us know and we can come back to you.

I might start with my own question, and I want each of you to answer. I know some of you have actually covered this partly in your opening statement. The Committee will make a report with recommendations for changes that the Government needs to make in this space. I want to understand from you guys what you would like to see as some of those recommendations in that report. Your bravery in coming forward today will help us design those recommendations. I might start from my left and get any thoughts around recommendations and changes that are desperately needed.

AMANDA MACAULAY: It's a tricky one. I thought I was going through a best practice model of care. I was with a midwifery group practice. I had a midwife allocated to me. It was my second pregnancy. She knew me, she understood me. Yet I still, as you heard, presented three times in the lead-up to this catastrophic event and felt that I wasn't heard. It was put down as musculoskeletal pain.

The CHAIR: Was it more the follow-up, the investigation and information around the investigation afterwards that you were dropped out of that process?

AMANDA MACAULAY: Yes, I guess. That time is a bit of a blur to me. When I arrived at hospital I had a Glasgow Coma Scale of 3, which is the lowest anyone can have. I was intubated and in intensive care for a week. I don't even know what's the best—at that point I was just so overcome by grief—but more information following, and being informed that investigations are done and it's fed back to the family.

NAOMI BOWDEN: Sorry, can you repeat the question again?

The CHAIR: My question was that as a committee we will be putting together a report to the Government with a list of recommendations that we suggest that they make changes on. I wanted to ask what you wanted to see in those recommendations.

NAOMI BOWDEN: As per my opening statement, I have a list which I can send.

The CHAIR: Yes, please.

NAOMI BOWDEN: As I am 13 years into my grief, I have helped with numerous committees or organisations. I volunteer my time; I go to the baby and parent expos and hand out brochures on safe sleeping with Still Aware, so there is lots of information that I can definitely pass on.

The CHAIR: Great. Thank you so much.

JESSICA HOLLIDAY: I think, as well as the things that have already been mentioned, GPs need to be—there needs to be more of a policy around when a patient presents to you with a pregnancy or there is a positive, you need to give them all of the information. I actually went back to my GP and asked her, "Did you know private midwifery was a thing?" She was like, "We are recommended to encourage hospital." I just don't think—like, why? She is my GP; I guess that she works for the health district. But, yes, I think that is a really good place to start. Medicare has some subsidies for private midwifery care. If you can't get into a—I understand there is a midwifery shortage, so let's make it easier for people to access. I was lucky that I could afford it at the time, but there are lots of women who can't. It's one woman, one midwife. That's what we want. So if there is a shortage of midwives in hospital care, let's make it more accessible for women to approach private midwives.

And then obviously, of course, the other things I have said. Continuity of care is really important. If you have a high-risk birth, you are immediately not even able to apply for MGP. You see obstetricians, but you don't have the one obstetrician. When I was classed as high risk, I was actually like, "Great! Now I don't have to pay for an obstetrician; I just get one," obviously not realising that it meant whoever was on shift is who I would see for my antenatal care, and whoever was on shift is who I will see when I give birth. It's hard. I never, ever saw the same obstetrician—not once. Even when I asked, "Can I please be put—that person was great. They know my story now." "No, that's not the way it works." That just needs to be a change. If I am high risk, then why am I being given—there is so much evidence of continuity of care. Why am I being given almost, to my mind, the worst type of care—no continuity at all?

AMANDA MACAULAY: Just jumping back on—I guess, more follow-up afterwards, particularly with loss and trauma at the time. You don't know what you need. I remember being handed a manila envelope from a social worker who was young and appeared inexperienced. I understand people need to start their health career at some point, but when you get handed that to you when you are in the intensive care unit, it's not particularly meaningful. You don't know what you need at that point. I think, to follow up, it needs to be continued; it needs to happen afterwards. I stumbled on a baby loss support group through a random person in the community who told me, "Do you know this exists?" maybe 18 months after I'd lost my son. I was like, "No, I didn't know that existed. Nobody has ever told me that."

It's really hard to advocate for yourself in that point of trauma. My husband was amazing, but he was also going through an extreme amount of grief at that point. He's a shiftworker. He wasn't at home at the time where an ambulance was called to our house. My mother-in-law was there. He got called home from work to be directed straight to the hospital, where he arrived and was handed his stillborn son and told that my life was uncertain at that point in time. You don't know what you need. You need someone to advocate for you. You need support and, for me, that wasn't there.

NAOMI BOWDEN: And I just want to mention too that we do have a local support group in the Illawarra. We have packs ready to go into the hospital with information, with sensitive stuff, other services being referred, and I know, at one of our last meetings, we are still waiting to get in and have a meeting. It's like we are still not being heard.

The CHAIR: Can I ask, when you said "still waiting"—

NAOMI BOWDEN: For someone to reply to our email to make a time for us to come in.

The CHAIR: Yes, and so you're waiting for days, weeks, months?

NAOMI BOWDEN: Months.

The CHAIR: Months?

NAOMI BOWDEN: Yes.

Dr AMANDA COHN: You've already started answering my question, which was particularly to you, Amanda and Naomi, about that process of grief, particularly in those early days in the hospital. Both of your submissions were really heartbreaking and compelling in terms of your experiences of grief not being handled well at that time. On that note of recommendations, you've already talked about how in that postnatal period things could be better. But in terms of your time in the hospital, if you can imagine a really compassionate space in the future for a future parent who is going through grief, what might that look like? What could hospitals do differently in terms of physical design, in terms of rostering? How can we support people experiencing grief?

NAOMI BOWDEN: Better Births Illawarra, they actually helped the redesign of the new Wollongong Hospital ward and had input from our community, and I believe that there is—and I'd have to double-check this information—a room available for parents that were presented in, you know, to be moved to. But I would have to follow that up and give you that information. But I think every kind of hospital should, potentially, get a soundproofing room or a compassionate room. Because the next hospital that I went and birthed at, I had to have an overnight stay, and this was a regional, country hospital, and they had one.

AMANDA MACAULAY: Sorry, can you repeat it again for me?

Dr AMANDA COHN: That's all right. You already half answered my question. It's about that process of supporting people through grief. You already talked a little bit about how we can do better in those months postnatally, so, thank you, you don't need to repeat that. In that acute period when you were in hospital, what might it look like in a more compassionate hospital for a future patient?

AMANDA MACAULAY: I guess, longer term follow up. Grief definitely goes through phases and, like I mentioned, you don't know what you need and you don't know what exists out there. I remember being given a phone number for an organisation that could come in and take photos for us of my son, but I probably needed someone to actually make that phone call for me. I was not—my husband and I, we weren't capable of even picking up a phone and making the phone call for an organisation to come in and take photos for us, and so we didn't get them. But, I guess, people to be—I guess, just more awareness and checking in and being there, because no-one expects to have a stillborn child and nobody knows what to do when they have a stillborn child. People don't know what to say and you feel lost, you feel alone. You leave hospital and you still look pregnant. People ask when you're due. And it's heartbreaking.

The Hon. SARAH MITCHELL: I don't really have a question, but I just wanted to say thank you so much for coming and for being brave enough to tell your stories, particularly Amanda and Naomi, and talking about Connor and Bella. I'm sorry. I'm so sorry for your loss. I think it must just be something that no-one ever wants to go through. But, for what you've been able to do, to come here, to put these in the submissions and to represent many, many other women who've had birth trauma and pregnancy and infant loss, I think it's really important. I think it's something that, as a committee, to be honest, we probably haven't looked at those sort of recommendations in the first day of hearings. But I do think that's a really important part of the trauma story that we need to be telling. I just wanted to say thank you for that and for the recommendations that you do have around how we can improve the system. For what you've been through, to be strong enough to be able to be such advocates, I just think you're amazing, incredible women. I just wanted that on the record. Thank you.

NAOMI BOWDEN: Thank you.

AMANDA MACAULAY: Thank you. I haven't looked at statistics recently, but the last I heard was that six babies are stillborn per day across the country. This is not something that doesn't happen. It happens, and it's happening every day, and it's happening to families every day.

NAOMI BOWDEN: Then we're left to pick up the pieces and, in a way, do it the best way we can. But then there's those layers of trauma. We've just got to be looked at a bit more respectfully, with a little bit more compassion. Because I didn't know what to expect from grief and trauma, but I can tell you that it never leaves your body. My last son that I had, who is now six—my trauma is still quite there, alive in my body, that I ended up in a mother-and-baby unit in hospital, away from my family, in Sydney.

The Hon. SARAH MITCHELL: If you don't feel comfortable sharing, Naomi—but obviously having had another child after the experience that you had with Bella, that continuity-of-care piece, did you have to tell your story multiple times with subsequent pregnancies?

NAOMI BOWDEN: Yes.

The Hon. SARAH MITCHELL: How did that work? Could that be better for people who have been through loss?

NAOMI BOWDEN: I had three subsequent pregnancies after Bella. One of them was a quite difficult loss. I had a cornual ectopic pregnancy, which was very hard to go through. The care that I got in the two other hospitals that I birthed my other—I didn't really birth that one, but still had—the care was there. The care was amazing. I told my story. They went above and beyond to help, whatever I needed, even the second public hospital that I went to. It's like they were just listening—just basic listening, supportive and understanding.

The Hon. GREG DONNELLY: Can I sincerely thank you all for coming along today. It's very hard to do what you've done. This Committee is very grateful. You've been able to inform us with much that we need to take into account. Once again, thank you very much. My question is—perhaps if we provide each one with an opportunity to answer it, starting with Amanda. I presume, in the period since the loss of your babies, you've spoken to a number of women that have experienced something or similar to what you've had. Is that a fair statement, that you've become aware of others that have experienced it?

I'm wondering, in your discussions and talks with women who have had the experience of a loss of a child, is it a different experience for them when the loss is so close to what would have been the birth, in terms of that the child was well developed in its life, or is it different as you move backwards towards the child being younger? Or is the sense of grief and loss not so much determined by the age of the child but other reasons? In other words, is there a different sense of an early loss compared to a later loss? I am just wondering what women's experiences have been shared with you.

AMANDA MACAULAY: I'm not sure I can answer that. I might hand that to Naomi, if that's okay.

NAOMI BOWDEN: Sorry, can you just retouch on some points again so I understand it better?

The Hon. GREG DONNELLY: I'm just wondering, as women have shared with you their loss, have they expressed a different feeling of loss for a child or a baby who was about to be born and in a late stage of development compared to—

JESSICA HOLLIDAY: Sorry, are you comparing maybe a miscarriage to a stillbirth?

The Hon. GREG DONNELLY: I guess what I am saying is that it's a loss; one is a stillbirth and one is a miscarriage. I am just wondering from the experience of the woman if that loss is perceived and felt differently.

JESSICA HOLLIDAY: I guess that would be up for individual women to feel.

NAOMI BOWDEN: Just as Jess said, it's up to the individual to feel that.

JESSICA HOLLIDAY: A loss is still a loss; it's always going to be a loss. It's just up to how individual women—

The Hon. GREG DONNELLY: How they process it.

NAOMI BOWDEN: How they process it, yes. Any gestation, in my opinion, should be treated exactly the same.

The Hon. SARAH MITCHELL: I don't want to cut in, Greg, but I think for us as a committee—I think pregnancy loss is really hard, no matter what time you are.

NAOMI BOWDEN: Yes.

JESSICA HOLLIDAY: I think the statistics for miscarriage are one in three women. So there are multiple women in this room who have experienced that.

NAOMI BOWDEN: I've experienced that.

JESSICA HOLLIDAY: Multiple miscarriages is a huge topic. But I definitely think that a loss is a loss and it really is dependent on how individual women process that. I definitely think you still need a lot of support, no matter what gestation.

The Hon. GREG DONNELLY: I was only making the point because this inquiry is specifically looking at birth trauma towards the end of what is that period of gestation and birth. I am just wondering, beyond this inquiry, is there a bigger issue for women that really needs to be thought through?

NAOMI BOWDEN: I can give you just a quick example. When I presented to my GP with my cornual ectopic pregnancy, he informed me to call the local hospital in which I birthed my daughter at. Their response was "Well, what do you want me to do about it?" They said, "You're under this amount of weeks. You're just going to have to wait and see." And he gave me a direct care line at the time. I just said, "This is the phone number I was told to call. Thank you for wasting my time."

JESSICA HOLLIDAY: Also, can I just add in as well, when we are talking about birth trauma, it doesn't just mean the birth. I didn't have a traumatic birth, but my pregnancy was traumatic. That is still inclusive into what we are talking about here and to the inquiry. When we are talking about birth trauma, some women are traumatised from their pregnancy and for some it is the birth. It's definitely all meaningful to talk about today and talk about in the future, when we are looking at new policies and when we are talking about birth in general. It doesn't just mean the actual birth; it means the pregnancy leading up to the birth as well. I still think that miscarriages would be included.

The CHAIR: And I think it's in the terms of reference. It says before, during and after. It's that whole birthing experience.

The Hon. MARK BANASIAK: My question is to all of you, but particularly Amanda and Naomi. Naomi, you spoke about your HCCC experience being pretty abysmal. Amanda, you spoke about not finding out about a clinical review until two years later. Do you think being involved in that clinical review and a more compassionate HCCC process at the beginning would have lessened the trauma or made it less traumatic? It would obviously have been a difficult process, but the fact that you didn't find out until two years later that there was a review that you weren't involved in at the HCCC was appalling, let's say. If that was handled better, do you think that would be a good step forward in helping this issue?

AMANDA MACAULAY: Yes.

NAOMI BOWDEN: I think that in my meeting, all parties involved at the time of my birth and what happened needed to be present.

AMANDA MACAULAY: Yes, definitely. Being involved in that process and being able to debrief and ask questions—because, as I was saying, in those initial stages you don't know what questions to ask. You don't know what's going on. You're so consumed by the immediate grief and trauma. Then, as you start your healing process and grieving process, questions come up. To be given the opportunity to ask those questions, and potentially ask those questions of people who were there at the time—in 2½ years, staff changes. Staff that you're meeting with don't have any experience other than reading the report and giving it to you. Being able to be involved in a more timely manner and being able to ask those questions would definitely help in the process.

NAOMI BOWDEN: And answer a lot of unanswered questions and help with the healing.

AMANDA MACAULAY: If I hadn't had connections within the health service, I don't think I ever would've found out that a report was produced.

The Hon. SUSAN CARTER: Thank you to each and every one of you for being here today. I assure you that we are listening and you have been heard. Everybody who has made a submission, we are listening. Everyone is being heard in this process. I know we've covered a lot of ground, but I wondered if there was one thing, perhaps, that you thought would help your healing.

JESSICA HOLLIDAY: What would help my healing is knowing that it will not happen again—that women are going to be treated better, that we will be respected, that we will be heard, that we are given all of the options, that we are not coerced and that we are not threatened with our babies' lives or ignored. That's the way forward. Listen—and I appreciate this forum for that—but let's actually take steps. There are so many things that are already out there that show the research states this, but our policies are opposite. Going forward, listening and then actually doing—changing the policies and making those changes—is the most important thing. That's why we're all here.

NAOMI BOWDEN: Mine's more around if a stillbirth does occur, we need to do better supporting families. I put my submission in and I'm here today because I don't want anyone to feel that they're alone. For

example, if Amanda didn't find the group—I get referred to people all the time about, "I know this person who has had a stillbirth." I'm a person with a big heart that said, "Let them know I'm there to hold their hand." We need to do better about support leaving hospital. I saw the midwife who did my birth course. She was the only person who came out and saw me. And then I had to follow up, and I had to make the appointments. I got things sent to me that were inappropriate. I got handed an envelope. I got given a support worker who had no clue how to help me. That's a huge thing for me. You need that support. Because that really can stop ongoing trauma that impacts someone's life.

AMANDA MACAULAY: I think listening and learning—the idea of another family going through what my family has had to endure breaks my heart—and more conversations and more understanding of what could go wrong. People need to listen to—I felt like I was doing all the right things in my pregnancy. I had increasing amounts of pain and I continued to turn up to hospital and I continued to get sent away and told everything is okay without any further investigations as to what was causing my pain.

The CHAIR: Thank you all for coming here today. I know I speak for the entire Committee in saying we really appreciate you giving us your stories. This Committee has received over 4,000 submissions, the majority of which were individual submissions, which really goes to show the prevalence of birth trauma. The fact that you are willing to come forward today and advocate on behalf of all of those women really means a lot to every single one of us. Thank you.

Dr AMANDA COHN: I know it's not parliamentary process to clap, but could we?

Applause

The CHAIR: We may have some further questions for you. If we do, the secretariat will contact you with those questions, and you will have 21 days to answer them. The secretariat will be in contact if that's the case. Thank you all again.

(The witnesses withdrew.)

CARLY GRIFFIN, Private Citizen, affirmed and examined

OLIVIA PRAIN, Private Citizen, affirmed and examined

AIMEE KEATING, Private Citizen, affirmed and examined

The CHAIR: I now welcome our new witnesses. Do you each have short opening statements?

AIMEE KEATING: I am here today to talk about my experience of birthing in August of last year as part of the MGP program. I applied for the MGP program as soon as I found out I was pregnant. I was one of the lucky ones and was accepted onto the scheme. I had continuity of care with one known midwife and, later in my pregnancy, a student midwife joined my care team. Throughout my pregnancy my trust in my midwife grew and I was able to discuss all my wishes and worries without any fear of judgement or dismissal. She answered any questions I had with all of the information I needed to make sure I made an informed decision. These were the two midwives present during my labour and at the time of my daughter's birth. After a very fast and intense second stage of labour, my daughter was born unresponsive. She was resuscitated by a crash team of doctors at Wollongong Hospital. She was immediately taken from the room to NICU. My husband rushed out of the room to be with her, meaning I was left separated from my husband and newborn daughter within minutes of her arriving into this world.

They were the most distressing and difficult moments of my life. I knew that my daughter was alive, but I did not know how she was, where she was or what was happening to her. It was around four hours before I could see my daughter again. Those hours were incredibly difficult, but, throughout it all, I was supported and cared for by my two wonderful midwives. A familiar hand to hold and a familiar person explaining to me what was happening made all the difference to my mental state. My daughter was transported to Sydney and spent the next 72 hours in NICU there. Thankfully, she improved very quickly and we were able to take her home within five days. As a new mum, I was exhausted physically and emotionally. A midwife remained in contact with us throughout our stay, checking on the wellbeing of myself, my daughter and my husband and ensuring that we had all of the support in place that we needed. My family aren't here—they are overseas—and this helped me so much in a time that could have been so isolating. It was greatly appreciated to know that our support system was still there and would continue to be there when we came home.

As part of the MPG program you get two weeks of home visits from your known midwife. The day after we arrived home, we were visited by our midwife for our first home visit. This is an extremely emotional time for all involved. My husband and I were able to ask all the questions we had about our daughter's birth and debrief in detail what happened and why it happened with the people that were there on the day. I believe that this helped me greatly with processing the events of my daughter's birth. I'm so grateful that this is something I didn't have to wait for or ask for. I also believe that it helped our midwife. I know that she too was affected by our daughter's birth, and being able to see her discharged from hospital and thriving in her home environment was extremely beneficial to her after seeing our little family go through such a difficult experience.

It feels a little strange, sitting here today amongst these brave women, to talk about how I don't have birth trauma. Yes, I still struggle with the events of my daughter's birth and always will, but not because of the way I was treated. In fact, the way I was cared for and supported through my pregnancy, birth and early postpartum by a knowledgeable and incredible midwife saved me from further trauma and mental health decline and will be something I am always grateful for. I truly believe that this should be the standard of care every woman in Australia is entitled to.

OLIVIA PRAIN: I am here today to share my experiences of my two pregnancies and births. My first birth was through a private obstetrician in a private hospital. A slightly low platelet count in my third trimester resulted in an induction at 38 weeks. This led to a cascade of interventions, ultimately resulting in an emergency caesarean and a postpartum haemorrhage. Given that I had dreamt of a natural birth, I found myself disappointed and somewhat traumatised by this experience, and I felt that I wasn't adequately educated on the risks of induction. However, my baby was healthy and happy, so I told myself that that was all that mattered at the time.

Fast forward 18 months—I was then pregnant with my second baby. I found myself still desperately wanting to experience a natural birth. However, I knew this would actually be harder to achieve than it was the first time as I had now had a prior caesarean. Achieving a vaginal birth after caesarean in Australia is not an easy thing to do. So, for this birth, I really did my research on what would give me the best chance of a VBAC. What I found through researching and also through listening to other women's stories was that continuity of care is one of the most important factors.

So, at six weeks' pregnant, I applied for the Midwife Group Practice, or MGP, program and was fairly quickly told I had a spot, pending some medical checks. However, two months later, I was risked out of the

program due to my haemorrhage in the first birth. This was obviously distressing for me as I had felt really safe in the program. I was then faced with the option of seeing a different doctor or midwife for each appointment, where I felt issues could potentially slip through the cracks. Alternatively, I could pay a few thousand dollars to engage a private midwife to do all of my antenatal and postnatal care. I went with this option.

I felt so well cared for and truly held with my private midwife. She was so incredibly supportive and was available to answer my questions or provide advice at any time of the day or night. My appointments were in the comfort of my home and the focus was on both my physical and emotional wellbeing. I again had a slightly low platelet count; however, through doing my own research and getting great advice from my private midwife and from the OBs at the hospital this time I wasn't induced as a result of it. As the hospital doesn't allow private midwives to attend births in a midwife capacity, I also engaged the support of the doula so that I had someone in the room with me, apart from my husband, who knew my birth plan and would help me to achieve that.

With a private midwife, doula and public hospital model I was able to achieve an empowering, healing, intervention-free VBAC. I am privileged to have been able to afford the thousands of dollars for a private midwife and a doula, and as a family we made the decision to sacrifice other things so we could afford this nurturing care and hopefully avoid physical and emotional birth trauma and unnecessary interventions. However, there are many families that can't afford it and aren't in the approximately 7 per cent of women who successfully get a place in the MGP program. Or, like me, they get a place and are later kicked out. It really shouldn't be this hard to have continuity of care with a midwife when the evidence tells us just how successful this model is. I hope that from this inquiry we have more healthy women and babies and that women have supported pregnancies and empowering births where they have continuity of care, feel that they have been adequately educated, all options have been presented to them and, ultimately, their choices have been respected.

CARLY GRIFFIN: One in three women suffer from birth trauma. It could be your mum, your sister or your daughter who suffer at the hands of the New South Wales maternity system. Our maternity system is broken and unless we make improvements, the rate of birth trauma is never going to change. We need more compassionate, supportive and trauma-informed midwives. I want to make it clear that, although I mentioned poor treatment by midwives in my submission, I don't think midwives are inherently bad. I believe they are burnt out from unsafe staffing levels. They want to provide us the best care but they just can't. They don't have the staffing levels or the time to provide us with the care we need and the care we deserve.

We need bigger MGP programs. Midwifery-led care has been proven to be the gold standard throughout the world and a small step towards improving birth trauma is compassion and empathy from all birthing staff. The OBs I dealt with were cold and dismissive, and that treatment undoubtedly contributed to my trauma. Women feel better supported when there is continuity of care. It gives women the opportunity to form a relationship for nine months and build their trust with their midwife who will also be with them during labour, which leads to better birth outcomes. I was unable to participate in the MGP program as I was deemed high risk. There needs to be changes made with high-risk patients who don't qualify for the MGP program. High-risk patients should be seeing the same OB at all of our appointments instead of a different doctor every time we are at the clinic. It's hard to build trust when you get a different opinion at every appointment.

I was forced out of bed less than eight hours after an emergency C-section. I hadn't even held my own son yet but I was told that I needed to get up and get in the shower because if I didn't, in the words of my midwife, "I don't have time to take you to the special care nursery so get up or you won't be seeing him." Sobbing hysterically, with blood running down my legs, while my son's dad did the best he could to help me get cleaned up and help me get dressed, with no pain relief or assistance from the midwives, is a nightmare I'll never forget. I can only imagine the trauma he also suffered from watching the mother of his child suffer at the hands of the maternity system. I was called a junkie by an OB. I was told by midwives that I was showing drug-seeking behaviour. And I was denied pain relief on more than one occasion, as I was told, "You can't possibly be in that much pain." As you can imagine, these comments are not only hurtful but they are embarrassing, and I was left to suffer until I was discharged two days later while also trying to care for my son as a first-time mother.

Two years later I still suffer severe PTSD. Just walking through hospital doors causes me panic attacks and I break out in a stress rash. I also suffered from postnatal depression and spent the first six months of my son's life in a dark place mentally, not to mention the ongoing pain I still suffer today. We need to listen to women and believe them when they say something isn't right, not just dismiss them because they don't fit into the textbook narrative of what birth, labour and postpartum recovery should look like. We need to support women in their right to have a birth plan. We should be encouraging women to educate themselves on birth, empower women to know their options and their rights, and we need to do our best to facilitate those preferences.

Every woman that goes into labour with a birth plan understands that things change and that we have to adapt as our labour progresses. Our birth plan should be respected and we should not be told to lower our

expectations of labour and birth. Stop dismissing women and trying to shift the blame back on us—that our expectations were too high and that's why we have birth trauma. Especially at a time of vulnerability, we deserve respect, a basic human right that many of us were denied during our birthing experience. I went into labour with a plan. I was flexible in my wants and needs as my labour progressed. Yet I still suffered birth trauma.

Lastly, I'd like to thank the Committee for giving us victims a voice and an opportunity to speak and share our stories. I'd like to thank Better Births for not only their support during this inquiry but also the ongoing work that they do for the birthing community here in the Illawarra. And, finally and most importantly, I'd like to thank the 30 Wagga Wagga mothers whose complaints allowed for this inquiry to be held. Thank you for being brave and demanding better for the women of New South Wales. Without you ladies this inquiry never would have happened. Thank you.

The CHAIR: Thank you to all of you and thank you for your bravery in coming forward. As a committee, we really appreciate it and we appreciate your time as well. I'm going to start with the same question that I asked in the last session. This Committee will put together a report that will go to the Government and to the relevant health Minister with recommendations about what needs to change in the system. I know you've covered some of that in each of your opening statements. But could you let us know what you would really like to see in that list of recommendations that you think will either change an experience or, where you've had a positive experience, that needs to be available to every single woman? Did you want to start, Ms Griffin?

CARLY GRIFFIN: Yes. I believe that the MGP program is wonderful and it supports low-risk women, but what about the high-risk women? We are just as important. Why are we seeing a different doctor at every appointment? You get a different opinion: "Yes, we're going to induce you"; "No, we're not. We are giving you a C-section." There's a different opinion. We deserve the continuity of care that the MGP program provides. So we need to find some sort of option so that we have the same sort of services: We have one OB through our whole pregnancy, not a different OB at every appointment.

The CHAIR: I remember when I was reading your submission, it just seemed so strange that if somebody is identified as high risk—were you ever given any explanation as to why?

CARLY GRIFFIN: No. I think basically it's you get whoever is available on the day. But, from my experience, the high-risk clinic is run on the same days every week. Why can we not see the same OBs?

The CHAIR: Ms Prain?

OLIVIA PRAIN: I'd really echo that and what the previous group said of one woman, one midwife. We know, and the evidence shows, that that does result in the best outcomes for mum and baby. Also I had the same experience where they seem to go out of their way to give you a different OB each time with no apparent explanation. Even when I had asked to see the same OB, they sort of said, "Oh, we don't really do that. We like you to see a whole range of people"—and the same sort of experience of "Yes, you can have a waterbirth", "No, you can't have a waterbirth", "Oh, we don't have a policy on waterbirth." You're just getting inconsistent explanations every single time you go. If we don't have the midwives available at the hospital to support a one-woman one-midwife model, can we look at allowing more private midwives admitting rights into the hospital so that women, if they can't get it through the hospital, can at least pay to have their midwife there at the hospital for the birth? What other models are available to support that?

In terms of educating—and, again, this is nothing new on what the previous group said—we need to be educated on all our available options rather than just having a select few options presented to you. And then listen to the woman. Ultimately, you can explain the different risks, but allow them to make the choice on what risk level they are happy to accept. We need to be looking at holistic care. You go in for your appointment—I think one of my appointments was about three minutes long in total. So you're just quickly getting scanned and then you're moving on. It would be great if we could be looking more at the woman's emotional state as well. Then, in terms of postpartum, you've just birthed a baby, whether it be vaginally or via caesarean, and that's a really big deal. There's no physio access available that is publicly funded. I think I did ask in the hospital to see a physio. I was there at the hospital for three days. No physio came the entire time I was there. For women that can't afford to go out and pay for a physio, they really don't have access to one, and they may be left with lifelong issues as a result of not accessing a physio in those early days postpartum.

Also, on postpartum care for complications, once you leave the hospital after your birth, basically, if you need to go back to the hospital, if you experience any sort of issues, which I did, the official policy is that you go through emergency. This could be within a couple of days after giving birth. You're bleeding, you're engorged, you're leaking, you've got your newborn baby with you and you're expected to go back through the hospital because you might have left a couple of days ago. So you need to go straight back to emergency. I was fortunate that at the time that I went the birth suite wasn't full and so they did have capacity to see me, but if they were full

I would have been going and waiting in emergency for hours, which is obviously not ideal with a newborn baby. That also ties into the prenatal care. Up until 20 weeks, you're not really considered to be able to go into the birth suite if you have any issues and, again, you're going through emergency. It would really be great to establish clinics in the hospital that allow for women to go prior to that 20 weeks, or for postpartum, so they're not having to go back through emergency.

Again, the last group mentioned this—that the policy does reflect research. At the moment policies seem to be years behind what the current academic research is. Can we be looking at that and revising policies more often? Lastly, I had a wonderful experience with a doula, and that provided so much support for me. Is it possible to look at funding for doulas? I think some research that I have read is that that will potentially lower the cost of births because it might lower intervention rates, caesareans and that sort of thing. Can we look at that up-front now?

AIMEE KEATING: Olivia said so many amazing ideas and opinions there. I have a couple of ones even just surrounding postpartum care as well. While my daughter was in the NICU, I was allowed to stay in the hospital with her, and one thing that I think is huge is the ratios that midwives deal with on maternity wards. I remember pressing the buzzer—I had a very, very painful cannula in my arm that was causing me immense pain, and I couldn't get it out. Obviously, I couldn't take it out myself. I waited hours for the midwife. She came rushing in and said, "I'm so sorry. I have nine patients tonight. We're understaffed." And it wasn't until she walked out the door that my husband said, "She doesn't have nine; she has 18, because she also has a baby for every mum." You can't expect one woman to take care of 18 patients. It's insane. They are so understaffed and so overworked, and that's what is leaving women traumatised. They're not getting the care that they need.

Again, going back to postpartum services regarding physio, gynaecology and those kinds of things, I unfortunately had to get stitches after my birth and, as the OB was stitching me up, she was reeling off all these appointments that I would need—"You'd need this. You need this. You need this in so many weeks." I wasn't there in that room. My head was with my daughter, where of course it was. I left and that was that. I tried to call the hospital to make a gynaecology appointment. I was told I had to be seen at six weeks postpartum. I couldn't get an appointment with gynaecology until my daughter was 3½ months old. Again I was lucky that I was in a position to be able to pay for my own physiotherapy so that I didn't suffer the consequences and didn't suffer from prolapse and all those things that women do end up suffering from because they can't get that care.

This one does go back to the previous session and what the girls had to say regarding loss. I myself suffered a miscarriage before the birth of my daughter. I remember presenting to the early pregnancy unit. As soon as the lift opened in the hospital, there was a big sign in front of me that said "birthing suite". Why is the early pregnancy unit on the same floor as the birthing suite? Again, it goes back to why is there not safe space for women that have experienced loss? It doesn't make sense to me that I was going there, losing my baby at that moment in time, and that's the first thing that I saw. I think we definitely need to do more surrounding loss and have more support for women and a safe space for them in the hospital.

Again, I echo the continuity of care. It's huge. It made all the difference to me. I think, if anything, those postpartum visits were the main thing for me. My midwife knew me by then. I remember one day, postpartum—I think my daughter was maybe a week old—she called me to check that we'd got the right forms from the hospital, and she could just hear in my voice that I wasn't okay. She turned up at the door two hours later for a home visit to check in on me, and I needed that. Without that, like I said, my mental health would have greatly declined. But it was greatly appreciated to have that support from her.

Dr AMANDA COHN: I have two questions. My first question is for Carly. In your submission, you talked about being on the ward postoperatively and that your son was there with you but wasn't considered a patient, so the nurses weren't able to help care for him when you weren't able to care for him because you had had a complication from surgery. The reason I'm asking about this is that we've already heard from the NSW Nurses and Midwives' Association through this inquiry, and they've drawn a lot of attention to the issues with the staffing model. It's called Birthrate Plus and, as Aimee alluded to, it doesn't count babies as patients under the staffing model. They've been advocating for that to change. My question to you is what difference would it have made to your experience for that nurse to have been rostered in a way that allowed them to care for your son?

CARLY GRIFFIN: Well, all the difference. I didn't even see my son for 10 hours after he was born. I was able to touch him through an incubator; that was it. I was discharged from hospital two days later and then two days after that I was put back in the hospital due to a surgical complication. I had to leave my son at home. I spent a week in hospital by myself without my son. It was the middle of a COVID lockdown, so I also didn't want him to be brought up to the hospital for visits because I didn't want to risk his health. He was born at 36 weeks, so he was born a bit early. It would have made all the difference.

My milk didn't even come in because I didn't have enough contact with my own son. It would have made all the difference to have a staff member available to help with the care of my son. But even before that, when I was on the ward before I was discharged, I mentioned that my son was just brought to me from the special care nursery. He was left beside me and the nurse walked out. I could barely sit up in bed, let alone feed my child. I was offered no support for breastfeeding. I was given formula and told, "Here you go. Call us if you need us." What is that? It isn't all their fault, because they don't have the staff. We need more staff.

Dr AMANDA COHN: Both Olivia and Aimee talked about the value of having had some appointments at home. Olivia, you mentioned antenatal appointments at home, and Aimee, you mentioned postnatal appointments at home. That's obviously not something that's part of standard maternity care in New South Wales. I was hoping you could elaborate on what sort of difference that made or the specific experience of having had some of those appointments at home, rather than having to come into a hospital.

AIMEE KEATING: As I say, mine were postnatal appointments and it is part of the MGP program at our local hospital that you do get two weeks of home visits as part of that. It made all the difference. For my mental health it meant that the next day after we'd arrived home, like I said, I was able to instantly debrief and instantly talk and go through everything with my midwife that was there when my daughter was born. She knew exactly what we'd been through. I didn't have to repeat my story: She was there, she knew what we'd been through. I guess, yes, you're in a postpartum cloud. The thought of having to, you know, pack yourself and your baby up and go to the hospital for appointments or go to the GP for appointments, it's just not on your radar. You should be in your little love bubble, enjoying it, and the care should come to you.

Again, I truly believe and I do know that my midwife was also affected by my birth. It was, obviously, quite distressing for her too to go through that. She walked through the door on that first appointment and the first thing she did was put her arms out to hold my daughter, and held her so close and was just so grateful and thankful that she could do that. I think the fact that it came full circle for her helped her as well, to be able to see my daughter was well and she was thriving and she was okay. Because, at the end of the day, she'd been with me through my whole pregnancy too. That's how continuity of care works: You build a relationship with that person.

But, yes, I think it makes all the difference in those early days. And you're going through so much hormonal change too that—whoa! Everyone had told me about it, but you don't know it until you live it. Those first days of the hormones changing and everything that you're going through, I genuinely was very concerned for my mental health and so was my husband for a little while there. But to have that support and know that I could pick up the phone and call her and, like I say, she knew straightaway that something was wrong and turned up at the door to check in with me. The support was there when I needed it. So it made all the difference.

OLIVIA PRAIN: Yes, I found the at-home visits amazing. The care that I got through the private midwife in my second pregnancy versus my first with the obstetrician is really incomparable. I also have a two-year-old at home. I don't know if everyone's aware that the antenatal clinic at the hospital doesn't allow children to come and so you need to find someone to look after your child so that you can go to your doctors appointments. So having the appointments at home meant that I didn't need to worry about child care. Also, just from a personal perspective, it involved my son in the pregnancy too, which is really nice for transitioning to two kids. He still talks to me about hearing the baby's heartbeat and sweet things like that. It was amazing in the antenatal period. It was so nice. And then, as Aimee said, in the postnatal period it was so great to not have to leave your house. Having a private midwife, I had weekly appointments which, again, was a really big difference to my first pregnancy where you go in for a quick 15-minute check six weeks postpartum—is what I had with the OB initially. So, yes, I just think if we can do it, if there's any way we can do it, it really is the gold standard of care.

AIMEE KEATING: If I may just go back to the previous question about improving care as well, actually—Olivia just reminded me—the six-week GP check needs to be better.

OLIVIA PRAIN: Yes.

AIMEE KEATING: I remember walking in—after everything I'd been through, I walked in to my six-week GP check, they woke my daughter, they gave her injections. The GP came in and said, "How are you?" and I was like, "I think I'm okay." "What contraception do you want?" "Oh, I hadn't really thought about that." "Okay." End of conversation. That was my six-week appointment. That's not good enough. After I had a tear that hadn't healed, I had all of these things, I should have been provided with, "Here, this is how you access a physio," "Here, this is how you access the mental health support, if you need it," "Here's this blood test,"—anything to be done that's actually checking on your health instead of just a, "Tick the box, we're done."

CARLY GRIFFIN: Sorry, just to interrupt, I'd like to add to that. For me, for example, I had post-surgical complications. My son is two in two weeks and I've only just received an appointment with the gynaecology department at the hospital. I'm sorry, but why have I waited two years for them to see me? Women that give birth

via caesarean and have complications—we should be put higher on a waiting list. I shouldn't have had to wait two years just to get a single 20-minute appointment.

The Hon. SARAH MITCHELL: Thank you all for coming and for sharing, and also for coming with real, practical things that the Committee can look at as well. I think that's really important. For me, one of the consistencies that we are hearing from witnesses, but also from the submissions, is that continuity-of-care model. I guess, as women and mums, we all have our own experiences, but I think the thing that shines through is that if people have had that consistent care from someone who they trust, that's really important. I think we have really got to look at how we can make that more achievable for women everywhere. I mean, I live in a regional community, so it's a bit different for us, but I think that messaging is really important.

I wanted to talk a little bit about the information that you get, particularly before giving birth—it's something that the Committee has chatted about offline—and the need to have more informed decisions and a chance to really consider what might happen for your individual pregnancy. I think that's where that consistency of care is important. You have all talked about it in different ways in your submissions and in your evidence. One of the things that I am mulling over is if there is a way to have better one-on-one time—I know a lot of people do the antenatal classes, but to really have a longer appointment or something that is actually scheduled through Medicare so that you have time to sit down with someone, whether it's with your midwife or your GP or your obstetrician or whoever it is that you are seeing for your pregnancy, to really talk you through what may happen so that you are making informed decisions rather than being in the moment of what you're going through.

Do you have any thoughts about how we could do that side of things a bit better? As you said, some people get that. Some people get great relationships, but others—I think someone before mentioned a five-minute appointment where you come in and out, and that's not a quality time. Do you have any thoughts on how we could make recommendations around improving that process? I know it is a bit of a longwinded question, so I apologise.

AIMEE KEATING: I guess, for me, I feel like I kind of got that. Because I had the continuity of care with one midwife, it meant that she was obviously the midwife at all of my appointments. I remember, about halfway through my pregnancy, she did say to me, "Okay, it's time to start thinking about what you want—like, what your birth wishes are." She said, "We don't have a plan, because we always have birth wishes." And she gave me that space. She said, "I would like you to bring your husband to your next appointment if he is going to be your support person, and we're going to sit and we're going to discuss it, and we are going to talk about your wishes and your wants, and I'm going to do everything I can to make sure that you get those." I guess, for me, I did kind of get that. And maybe, with continuity of care—I'm sure you did with your private midwife too—you get that conversation.

OLIVIA PRAIN: Yes.

AIMEE KEATING: With continuity of care, that might just naturally happen. But, yes, I do think it needs to be a longer appointment than 20 minutes, which in my case I got. Yes, it's definitely something—yes. But the problem is, I suppose, that if there is not then that continuity of care and you do have that conversation with someone, is it just going to be put in your notes somewhere and completely forgotten about by the time you get to your birth, because it is not then being continued by the same person?

The Hon. SARAH MITCHELL: I mean, it does come back to that continuity of care, right?

AIMEE KEATING: Yes.

CARLY GRIFFIN: I think, even—because I obviously went through the high risk program. There's not enough midwives. They would love to sit down and chat with you; they don't have the time. I think staffing numbers, as we have all mentioned—if we can get more midwives and we can retain these midwives, they will have more time to provide that care. They just don't have it at the moment.

OLIVIA PRAIN: Yes, I was really fortunate in having the private midwife and a doula, where we went through in depth what my birth plan was. I guess the only thing that was up in the air was that it was kind of like, "Oh, it'll be a luck of the draw on who you have on the day and whether you can have a waterbirth or whether you can do that." Because policies aren't necessarily clear, and if you have some risk factors like mine, was the feedback—so there are certain risk factors. Some midwives and OBs will be comfortable with a certain level of risk and others will not. You kind of come up with "Oh, this is plan A and this is plan B. If I can use this, that would be great. If I get this room, that would be great." Because also not every room has a birth pool, so don't get your heart set on a waterbirth because you might get chucked in the other room. We do make the birth plans to be flexible, but at the same time there's not enough clarity on what's possible, what the policy is and it's done to different people's level of risk.

The Hon. SARAH MITCHELL: Olivia, to your point about being able to access postpartum care and not have to go through—like that is such a simple but effective solution that should be in place. Some personal experience made me go, "That would have been really handy."

OLIVIA PRAIN: Yes, it seems crazy to be like, "Sorry, I was here two days ago but now you want me to go through emergency with all of the people with different illness as well, and I'm bringing my newborn baby in there?" That makes me really anxious.

The Hon. SARAH MITCHELL: That's a really good recommendation, so thank you for that.

The Hon. SUSAN CARTER: I have one question directed primarily to Ms Prain, but I'm happy for anybody else to answer. Could you help us understand the different roles played by a doula and a midwife?

OLIVIA PRAIN: Yes. We see that a midwife is there for your clinical care, and they are a medical person. A doula is there really to support you and your partner, and support your birth plan—I don't know if anyone wants to chime in. I think a doula is there to support you in your birth wishes. They're not a medical person. They're not there to provide medical advice. They will help to advocate for you or, in moments when you're struggling, to remind you of what your birth wishes are, and help you to have the courage to advocate for yourself or to have your partner advocate for you. I think they're really there to support you and your whole family. My amazing doula would bring meals over postpartum or provide a massage or something like that, that's really looking after you as the whole person and more your emotional needs. Whereas a midwife will look after more of your medical requirements.

The Hon. SUSAN CARTER: So the doula can come into the birth room as a support person, as opposed to the private midwife, who is a medical person?

OLIVIA PRAIN: Correct. But I would also recommend that, in addition to allowing private midwives, more admitting access to birth spaces. Doulas at the moment—my understanding is—count as a support person when, really, they should be counted as a birth worker and not go towards the support people count. For example, I had my husband there and my doula—it would have been nice to have my sister there as well, but I already had my two support people.

The CHAIR: Ms Griffin, in your introductory statement you said that you had a birth plan and that you were flexible to that changing.

CARLY GRIFFIN: Yes.

The CHAIR: In your submission you said that you were told that you had to have an emergency C-section, but then everyone went to dinner and they said that they would come back to you.

CARLY GRIFFIN: Yes.

The CHAIR: I'm sorry if that sounds—

CARLY GRIFFIN: I shouldn't laugh. It's not funny at all.

The CHAIR: Yes, I think it's just shocking. We've done one session with a lot of advocacy groups, and we spoke to different people earlier this week. There was this real sort of grey space where it was unsure whether the C-section was a genuine emergency C-section or whether it was something else. Was it ever really explained to you it was an emergency or did you feel that—

CARLY GRIFFIN: No, there was no explanation to me or to my son's dad, who was at my birth. All I was told—I got to 10 centimetres and I was ready to push. I had a midwife come in and examine me and say, "Great. Okay, we're ready to go." And then the OB came in, did an examination and said, "No, we're going for a C-section. This is an emergency. Your baby is in distress. But I'm just going to go to dinner first before I take you up." My son was born with perfect Apgar scores. I don't believe he was in distress at all.

I don't want to assume, but I feel that they wanted my birthing room. I had been in there for so long, and there were so many women in labour, that they needed to get me out as fast as possible. That's what I believe. I wasn't shown the CTG tracing. I wasn't given any evidence. Further to that as well, I couldn't really give informed consent because I wasn't explained to how a C-section worked, what it involved, who will be in the room. All I did was sign a form to agree for blood product. That's it. They went for dinner; they came back. Next thing I know, we're in surgery. I don't believe that—I feel like maybe I wouldn't have as much trauma if I knew 100 per cent that that C-section saved my baby's life, and I don't think it had any effect on him at all, if that answers your question.

The Hon. SARAH MITCHELL: Sorry, I just wanted to check: You were induced?

CARLY GRIFFIN: Yes.

The Hon. SARAH MITCHELL: What time did that start and what time did you have your son? How quickly—

CARLY GRIFFIN: I was induced on the Tuesday afternoon; my son was born on Thursday morning.

The Hon. SARAH MITCHELL: Wow.

CARLY GRIFFIN: When the induction was started I was just put back on the maternity ward to hang out for a while. I was told I'd go to birthing at 6.00 a.m. I didn't go to birthing unit until 3.00 p.m. the next afternoon. From 3.00 p.m., my son was born at 2.00 a.m. the next morning.

The Hon. SARAH MITCHELL: Okay. But that was your second day in hospital?

CARLY GRIFFIN: Yes.

The Hon. SARAH MITCHELL: Sorry, I just wanted a time line.

The CHAIR: No, that's okay. Thank you all for attending today—

The Hon. GREG DONNELLY: I've got a question. Thank you all for coming along, and particularly delving into contributions about ideas that we can take away. I think there's a lot of rich information there that we'll deliberate over. My question goes to this matter of the emergency C-sections, the kind we've just been discussing. It's probably the case that there will be instances of an emergency caesarean section needed from time to time with respect to the birthing of a child. From the evidence that's been given—and I've heard this evidence before—there is a particular form of disappointment for the woman who was waiting to have a vaginal birth, particularly if they had a C-section in the first instance.

What do you think could be done better to deal with this resolution, after the birth in those circumstances, of that disappointment? In other words, there is the expectation—in fact, it might have been planned from the very start—but then there is this intervention, a radical intervention, to have the child born by C-section. How can that be managed better in terms of dealing with that disappointment, which can't be changed because the child was born that way, but to at least make some attempt to resolve the disappointment associated with it?

CARLY GRIFFIN: I think emergency C-sections should be exactly that: emergencies. They shouldn't be because you need the rooms or there's no-one available in the birthing unit or whatever it is. Emergency C-sections should be only emergencies. I think that would help. For me, I'm sitting here two years later still suffering from post-op problems, physical and mental, when we don't even know if I really needed that C-section. Maybe a good start is making sure that if it's an emergency C-section, it truly is an emergency.

The Hon. GREG DONNELLY: Well, that's a judgement that takes place inside hospitals all the time.

CARLY GRIFFIN: Yes.

The Hon. GREG DONNELLY: But my question is, in the circumstances where there is the emergency C-section and that is explained to the woman that that is the intervention—and she, like yourself, may have doubts and, certainly, great disappointments—if it has happened, can that period immediately after the birth be better managed in an explanation to try and provide some reconciliation that there's been this big disappointment?

OLIVIA PRAIN: I personally found comfort in my six-week check-up with my obstetrician after my first birth—

The Hon. GREG DONNELLY: Sorry, I couldn't hear that.

OLIVIA PRAIN: I personally found comfort in my six-week check-up with my private obstetrician after my first birth in her saying, "Your next birth, there's no reason why you can't have a vaginal birth"—I guess laying it out at the start that there wasn't anything fundamentally wrong there, that it was that my baby was in distress. I think, as a whole, Australia could go a lot further in being more VBAC friendly, so vaginal birth after caesarean. The stats in Australia—my understanding is that women who achieve a successful VBAC is about 12 per cent. This is in comparison to countries like Finland and the Netherlands that have stats of around 50 per cent. What are we doing differently here that is not supporting women to have vaginal births after a caesarean? What can we change? Because I think if you had that chat at six weeks after that initial caesarean and you said, "There is no reason why you can't; 50 per cent of women who try do," I think that's a lot more optimistic than 12 per cent.

CARLY GRIFFIN: I also think as well—sorry, further to your question—for me, I think maybe a psychologist should have come around to my room and just checked in and said, "Are you okay? Is there anything we can do for you?" A debriefing with a psychologist in the hospital should be available to women immediately

after things like emergency C-section, losses, as the women mentioned earlier. Psychologists should be offered in the first instance.

OLIVIA PRAIN: And then I'd just add to that, after my first birth I did have a psychologist come around, but you're still in shock and they're going, "Let's debrief about your birth," and you're like, "I'm just trying to feed my child."

The Hon. GREG DONNELLY: Was that very soon after the birth? Was that immediately after?

OLIVIA PRAIN: No, I think it was a day or two after, but I think you need—

CARLY GRIFFIN: Ongoing.

OLIVIA PRAIN: Yes, in addition to that, a few weeks, a few months, to really process that. It doesn't necessarily happen in those first few days in hospital when you're physically and emotionally still in shock.

CARLY GRIFFIN: Yes, agreed.

AIMEE KEATING: I think that's something: Just holding that space for a woman's feelings after her birth is huge. Just having that space available to her to be able to talk through it, let her cry it out or explain how she feels—all of those things. I haven't experienced an emergency C-section, so I can't talk on behalf of them, but I can say that just holding space for a woman's feelings after birth is huge and makes all the difference.

CARLY GRIFFIN: Yes, 100 per cent.

AIMEE KEATING: So having someone like a psychologist or social worker, someone that you can check in with, available to you 24/7, would make all the difference I think, and help women process and understand what happened a little bit more.

CARLY GRIFFIN: Agreed.

The Hon. GREG DONNELLY: Thanks. That's very helpful.

The CHAIR: Thank you all for attending and thank you for sharing your stories. They will go towards helping us to build some recommendations for this report. Thank you so much for your bravery in coming forward as well. Some of the committee members may have some follow-up questions. We've resolved that the secretariat will contact you. You will have 21 days to answer any of those questions. Thank you again. I think another round of applause is warranted.

Applause

(The witnesses withdrew.)

(Luncheon adjournment)

CORRECTED

Ms SHARON SETTECASSE, Vice-President, Better Births Illawarra, affirmed and examined

Ms ALYSSA BOOTH, Secretary, Better Births Illawarra, sworn and examined

The CHAIR: I now welcome our next witnesses. Thank you both for joining us. Before we begin this session, I remind witnesses to avoid referring to specific names, hospitals or medical facilities in their evidence and to speak generally about the issues raised in the terms of reference. Would either of you like to start by making a short opening statement of a few minutes?

SHARON SETTECASSE: Sure. Before I do that, I just want to really acknowledge and thank the women who bravely and generously shared this morning. I also want to thank the select committee for the space that's been provided. This is once in a lifetime for us. It's been a long time coming. So thank you for the opportunity. I thought I'd start with just my birth story very quickly. I am the mother of two. Both of my births were caesarean births. One was in the public system. I transferred from the Illawarra up to Sydney because of a breach presentation. My second birth was a planned homebirth. I also transferred to the local hospital and birthed by caesarean. They were both very powerful, very gentle experiences.

Alyssa's births—I have permission around this—two births, one in the hospital with an induction. Her second and third births were through a private midwife, homebirths. Our other two core executive members are public MGP for both births, the publicly funded homebirth. The fourth member had a very traumatic caesarean birth at the local hospital. Her second birth was an incredibly empowering vaginal birth after caesarean, otherwise known as a VBAC. The reason why I share this is just to be really transparent that we're not about which mode of birth is the most important. We have quite a diverse experience and spectrum. That's how we work.

In terms of our organisation, I'll keep this really brief so we can go straight to questions. We're a not-for-profit organisation. We're volunteer run. We always have been. We are embedded in the community. We live within the Illawarra, Dharawal country. I think it's important to note as well that we don't receive any funding. We've never received a grant. In all of the consultations and consumer engagement that we've done with the local health district, we've never been renumerated for the hundreds of hours that we've provided our service in terms of our community. Also the other thing that's really important is we started because our experiences really raised some flags with us around different models of care and how that manifests in how women birth and how they feel and the mental health and physical health of mother and baby.

The Hon. SARAH MITCHELL: Thank you, both of you, for coming today and for the work that you do. I think you've got quite a support crew here, which I think is testament to what you do in your community. I just wanted to say thank you for that. I wanted to ask you particularly about the part of your submission where you spoke about women who've been through caesarean not having their baby with them afterwards and talking about that separation. Obviously, there's a lot of things we're looking at as a committee, but I thought that particular part of your submission was really interesting in terms of women not being able to have that sort of skin-to-skin contact and the impact that it had on them and on their babies. I know that it's going to be very general, but could you elaborate on that a little bit more—what are some of the problems within the current system that make that not as available to women as it should be? Is it hospital policies and procedures? What could we be looking at recommending as a committee in terms of improving that particular part of postpartum care?

SHARON SETTECASSE: Thank you for that question. This is really important because of the alarmingly high rates of caesarean section, not just within our local health district but across New South Wales. We are well above the World Health Organization recommendations of 13 to 15 per cent; ours is closer to 40 per cent. So it's a really important question. I can give this research later through an email, but it's very well known that the golden hour or the first hour after birth is absolutely essential for a whole range of reasons. What we noticed was that that wasn't happening.

I think it's also important to say why. Why did we start looking at skin to skin when our primary goal is to expand the MGP based on what we were hearing? We started looking at this because community was coming to us and saying, "I've been separated from a baby. I was separated for six hours, and I have trauma as a result of that. I've been unable to breastfeed." What we did was we, almost reluctantly, were like, "Hold on a second. We are focusing on MGP." But that's what the community was asking us to look at. We put a survey out to our community via social media just to test the water and is this happening everywhere, is this a pattern and what's going on. Usually, we would get maybe 10 to 12 likes or something on our posts, but within 24 hours we received 100 responses. By the end of the week, there were 200 responses to that question. So we knew that it was an issue. Can you remind me of the question?

The Hon. SARAH MITCHELL: Obviously, many women have had that experience and felt that it was not ideal or what they would have liked. Where do you think some of the challenges are? Is it hospital policies and procedures or is it individual decisions that are made? Where are the gaps?

SHARON SETTECASSE: Sure. There is a skin-to-skin policy. I imagine that a lot of local health districts would have skin-to-skin policies because that's an evidence-based piece of work. The policy and the practice were disconnected. What we found out, and we have all of the stats in there from our—and we are not pretending that it's a research piece. This is just a question that was given to our community. We don't have the funding to explore that further.

Certainly, the disconnection between the policy and practice was very clear. What we were being told was that, while the mother was being stitched up from her caesarean section, rather than having the baby put straight on her, the baby was taken away, measured, wiped down and given to the birthing support person or a midwife while the woman went up to recovery. The reasons we were given was that there was no midwife up in recovery and there was just a general nurse, so there was too much of a risk to the baby just in case the mother may have been a bit out of it and rolled on the baby. These were some of the reasons that we were given. Rather than looking at it creatively and saying, "Why can't the dad go up with the mother", which is a pretty simple solution, it was, "Oh, no, he's not qualified to do that."

What the senior executives were not looking at was the incredible trauma that that was causing, separating a mother from her baby for no reason. The baby wasn't necessarily going to NICU. It was just a policy practice breakdown and not the right staff. This is a really interesting case study because we got some traction. What we did was we then held a community meeting and we invited the senior executives from the hospital. And the community was able to—like we saw this morning—talk directly, which is what we do. We facilitate these meetings. As a result of that, they funded a caesarean section midwife from, I think, 7.00 a.m. to 4.00 p.m. That was the solution. Now there is a midwife going up to the recovery with the baby and having that expertise.

We don't know if that's still happening. We're not sure. There was a blanket no, the father or birth partner would not be able to go up with the mother to recovery. All of these women are missing out, and birthing parents are missing out, on that vital skin to skin. There's a local psychologist, Alysha Fameli, who is currently looking at birth trauma and how that impacts mother-infant bonding. Just having a look here, some of the women—the parents were being separated. We heard this morning about separation for 12 hours, eight hours, with very little communication about "How is my baby?" That's really important for breastfeeding—those first few hours.

ALYSSA BOOTH: The only thing I would add to that is that one of the consistent feedback was, when we floated the idea that if we don't necessarily want baby on mum, maybe dad and baby can go up together, or birthing partner. But then they were told no. Then they would go to the maternity unit—the birthing partner and baby—and could not see a midwife for hours. So they were like, "How come in this unit I'm allowed to be in charge of my baby, but next to mum in the recovery unit I'm not qualified to look after my baby?" We had no answers for that, so that was one of the stories we passed on.

The Hon. SARAH MITCHELL: That's useful for us as a committee, particularly if you look at suggesting policy change for health districts. If a skin-to-skin policy exists but, in practice, that's not what families are experiencing, or if you've got differing rules in different parts of the hospital, that's something that we'll have to be conscious of. I also wanted to ask about one of your recommendations of having either a midwife, an enrolled nurse or a student midwife rostered on the recovery ward each day. I thought that was interesting because we've heard a lot about the workforce pressures, particularly for midwives, and we have to be realistic about the fact that that will take some time, presumably, to help build up a workforce. But the idea of having students or enrolled nurses in there and using that skill set, how did you come up with that as a recommendation? Is it better to have someone than no-one? Do you think that's something that we could be looking at recommending?

SHARON SETTECASSE: I think that we were so desperate to keep mothers and babies together that we needed to find a solution. This is the way we work. We wanted to provide some options out there. What we didn't want to see happen was mothers and babies being separated, so what are the other options? We're hearing all the time that there's a midwife shortage. A fully qualified midwife may not be available, so what else? We are not prepared to receive that as a response to this. It's a crisis, in a sense, because of the high caesarean rate. We would love to understand, across other local health districts, what are they doing that's working? Are they allowing birth support partners up in recovery with the birthing parent? What's going on? We don't have the resources to research that, but we'd love to know more around that.

The Hon. EMILY SUVAAL: Thanks so much, both of you, for coming to give evidence today and for all the work that you do in the community in your own time. It's a very important topic, and I'm so glad to hear you talking about skin to skin, which is something that we know now that there is an established evidence base for the reasons why that is so important. I wanted to quickly ask about the work that you've done and this

disconnect that you've found between the policy and the practice that has been occurring. How are you currently working with, if you are working with, the local health district about things like this? Do you foresee a role for you to work together more closely, whether it's now or into the future?

ALYSSA BOOTH: Do you want to take this one?

SHARON SETTECASSE: Yes, I'm going to take this one. We have been around for seven years. We formed in 2016, and we connected with the local health district very early on because what underpins our work is collaborative alliance and solution-focused solutions. Improving maternity care, everyone has to be responsible and involved with that. So we have been meeting with our local health district for seven years. We started pretty fresh. We made some mistakes; we did things like, "We're annoyed at this, let's go to the media"—not a good idea. We hadn't done this before, and it's not a lever we like to pull. So we learnt from our mistakes.

We got help from other people in our community who are really good at negotiating. We were skilling up ourselves around how to work with the local health district. We can track hundreds of hours of our engagement, and we can safely say that we've received pretty much the same response every time that we meet, so it feels like a bit of a groundhog day, if I'm completely honest and transparent. For example, with our core, primary goal of expanding the MGP, we've been trying to do that for seven years and nothing has changed at all. If anything, we have the belief that it has actually eroded since we began.

Just to go through, and I can give you the submission—in 2017 we had a 30 midwife shortage and the LHD was in crisis mode. It was made abundantly clear that expanding the MGP was just not going to happen. There just simply weren't enough midwives to fill the roles. Then we were told that there were no midwives who wanted to work in the model—midwives were parents themselves, and they don't want to be called out. What we did was, we were part of a committee called Project 2020, and we suggested, "When you're doing your advertising for midwives to come to the hospital, maybe you could do some targeted advertising for MGP midwives. Let's just see if that'll work." It did. It worked. There was great interest, so we were like, "Great! That works. Fantastic." And then Birthrate Plus happened. And when Birthrate Plus happened, the numbers hadn't been released, and that stalled things again. There was no budget for MGP midwives.

Then the next excuse was that the current MGP—so we're lucky, really, there's five LHDs that have publicly funded midwifery-led continuity of care, and we're one of them. We really acknowledge that. The next excuse was that the two existing teams were running in different ways, and in terms of client load management that wasn't a good thing. Again, we're trying really hard, going "What can we do?", so we connected the local health district with academics to see if we could commission a report to work out how do we solve this problem? How do we make the MGP a sustainable model, where midwives want to work there and where women, birthing parents and families get really good-quality care?

What came out of that were recommendations. We have eight recommendations, and not one of them has been implemented. That report was commissioned I think in 2018, so that's five years ago. I share that because that's an example of what it's like to engage, and the reminder that we're volunteers. We have other professional lives; we have families. We do this because we really care about birth and we can see the trauma in our communities. We hear the trauma that happens in our communities and we're not going to stand around and not do something about it. It's actually been quite exhausting. It's been extremely challenging working with the local health district and we're really committed to partnering in that way. Collaboration is the only way forward.

The Hon. EMILY SUVAAL: Further to that, you talked about the role of MGPs and some of the issues that were raised in terms of staffing. On Monday we heard evidence from NSW Health about this alternative MAPS model. Is that something you are aware of?

SHARON SETTECASSE: Very much so. We noted that on Monday—I think it was Deb Willcox, the deputy secretary. We don't concur with that. We are a group that follows the evidence. We listen to women and we only look at evidence-based care, and MAPS is not evidence-based care. I'm not sure if the committee members know what MAPS is. I don't remember what it's—maternity, antenatal, postnatal or something. This is a solution to try and address workforce. The way it works is a person comes in pregnant and they're allocated a midwife during pregnancy, and they see that same midwife. And you heard from our speakers this morning just how important that is. So they see the same midwife, and then it comes to labour and birth and that midwife is not there for her, but they see that same midwife postnatally.

We know the World Health Organization has a paper and—I can also send this through—that most birth trauma happens 15 minutes before the baby is born. So MAPS is great to plug some holes or to put a bandaid over this huge issue of birth trauma. How is it that we can have a midwife supporting a person in pregnancy and then postnatally, but isn't actually there for—dare I say it—the main event. It seems illogical. And the physiology of birth means that your hormones are different in that space. Women should not be advocating for themselves in

the birth room. They should just be focusing on having a baby. So if a midwife is not there with them, who knows them and trusts them, and that person is in the unit for 12, 18 or three hours and they have a midwife change—shift changes. There is simply no evidence. I know that there is some research happening at the moment that has been commissioned by the Ministry of Health on this, around looking at whether MAPS is a good model. From our experience, and what we hear from community, a lot of the trauma happens during labour. I hope that answered your question.

The Hon. EMILY SUVAAL: Following on from that again, in the hearing on Monday I think the main reasons NSW Health gave for moving to the MAPS model were around the difficulties with workforce, acknowledging that the midwifery workforce is predominantly women that have caring responsibilities, and the on-call requirements of the MGP are such that that is not always a conducive model and may be difficult to fill. Do you have any recommendations other than that in terms of the provision of maternity care, particularly to Illawarra Shoalhaven LHD?

ALYSSA BOOTH: I think it was highlighted on Monday—make it more accessible. Make it a job share or a part time rather than sticking specifically to a full-time case load. Make the teams work in a way where parents can say, "Hey, I'll do this shift", and make it more applicable to people who did have families. But we also need to make midwifery look more appealing. And there are only limited universities where you can study it, which makes it hard, particularly if you are in an area that doesn't have a university that can teach it. So it's not really something we focused on, because we are focused on consumers. But I think, from a consumer perspective, staffing comes up regularly, and so that would be something that the local health district and universities probably need to focus on.

SHARON SETTECASSE: We recently had a meeting with the local health district and we brought up this quite successful strategy of targeted advertising for MGP that proved in the past to have worked and gained interest from midwives. I think the question that we want to see answered is not just how to recruit midwives but how do we retain them. We're also seeing student midwives, through their midwifery degree—the attrition rate is pretty high. I'd be concerned if I was the head of midwifery studies in a university. Why are the midwives leaving? Well, they are leaving and this is what we're hearing. So as consumers, midwives are also accessing Better Births because they are consumers. They're getting pregnant and they're having babies.

We get messages all the time and we also have friends. That's the thing about being a grassroots, embedded-in-the-community consumer group: You go down the street for a coffee and you bump into one of the hospital midwives. So we want the focus on retention. We're hearing all the time, "There's a global crisis in midwifery shortage." We don't deny that and we don't disagree with it. We're not arguing that. But are we focusing on something when we could actually be retaining midwives? They're burnt out. I think Carly was saying there's not enough of them, that they're burnt out. If one in three women is experiencing birth trauma, and their workplace is full of trauma, why would you want to go back there? There's an expiry date on that.

I'm not a midwife but this is what we're hearing from our community. And that's not okay. We need to take care of midwives'—and doctors'—mental health. We need to be supporting them. We need to be focusing on trauma-informed care for women and trauma support for that vicarious trauma that happens when you're witnessing trauma. If we don't address that, they're going to keep leaving in droves and then in 10 years' time we're going to continue talking about midwifery shortage. I'm bored of that conversation. We need to be smart and we need to be intuitive. We need to be really innovative and just actually say, "Let's keep these student midwives going." They're learning one thing—about physiological birth—in their degree and then they're seeing huge rates of inductions and caesareans and lack of informed consent. We want that looked at. We don't want our midwives to leave; we adore them. They are amazing.

ALYSSA BOOTH: One of the other feedback comments that we get quite regularly from midwives who are using us once they become a consumer, or midwives who want to work with us, is that they don't actually get to operate in their full scope. The midwifery scope actually covers a lot. Once they work in that system, they're actually quite restricted on how much they can practise as a midwife. They might find that there is a disconnect between what they learnt in uni and what actually happens inside the system. It also becomes a challenge, then, to turn up and trust the skills that you have if someone is constantly telling you, "You can't do that," or "You're doing that wrong."

The Hon. MARK BANASIAK: Just picking up on some of the answers you've given to my colleague there. We're hearing a bit now about the people being risked out of MGP. In your opinion, what you're hearing, and also picking up on what you were just saying then about midwives not being able to practise their full scope, is this risk insurmountable in terms of some of these women that are being essentially kicked out of the program because of potential complications? Are they insurmountable or can we actually get creative, as you put it, to keep these women in MGP?

SHARON SETTECASSE: It needs to be redefined.

The Hon. MARK BANASIAK: In terms of the risk?

SHARON SETTECASSE: Well, what is high risk? So, for example, gestational diabetes is considered a high-risk presentation. It's not that more women have gestational diabetes; it's that the measure of it has changed over time. Because it's changed and it's gone up, more women are in that little pool of gestational diabetes and they're offered an induction. I think there has to be a redefinition of "high risk". Interestingly, I think it was earlier this year, or maybe even a couple of months ago—and I can send this through as well—in the UK they've gotten rid of the term "high risk". It doesn't exist in the lexicon. There were about eight terms that were removed from maternity and "high risk" was one of them. As you saw Jess here, she was told she was high risk because she had high BMI—"You can't get in the pool. You can't do this." She had a homebirth—an average-sized baby—with a private midwife.

I don't think it's insurmountable. I think it needs to be either completely removed, redefined—and trust the midwives that they know how to support these women and actually give them autonomy around that. But our health system doesn't support that because medical, so obstetric care—there's a hierarchy and the obstetricians have the last say. That's really quite unique to Australia. You've got obstetricians and then the midwifery care is underneath that, whereas everywhere else in the world they're in partnership and they're working together and there's no hierarchy. We're not trusting midwives enough that they can actually support all women to have physiological, positive births.

ALYSSA BOOTH: I think it's quite possible for midwives to look after high-risk women. They know their limits. They know when to refer to an obstetric team. So, if you have a midwife caring or a midwife as part of a high-risk team, they're going to consult with an obstetrician when they need to and you still get that continuity of care. If it comes down to it where she can't see a midwife, she could at least see the same obstetrician the entire way through. We know that that continuity of care improves outcomes and you are increasing the risk for these women by putting them in fragmented care.

The Hon. MARK BANASIAK: That's an excellent point in terms of the trust in midwives' expertise. I think we definitely need to do that.

Dr AMANDA COHN: I wanted to ask about something that my colleague Sarah Mitchell touched on this morning, which is about information provision during antenatal care and supporting people to make informed choice. We've heard lots of stories of emergency situations where people suddenly are recommended to have interventions during labour in a situation where it's impossible to explain all of the risks and benefits. People aren't really being given choice in those scenarios. It's obvious, I think, through the submissions that women want to have more information during their pregnancies about risks and benefits of various interventions. Having spoken to and supported so many people, when do you think is the most opportune moment to do that or in what setting or with who? How can we enable that risk discussion to happen?

ALYSSA BOOTH: Look, it probably comes down to staffing. We heard that one of the ladies had a three-minute appointment antenatal. What are you going to get across in that? You barely get basic observations done. You need to value antenatal care and there needs to be better protection around how many patients they're seeing in a day so that they can actually give adequate care. We often hear reports where people are sitting in an antenatal clinic for hours on end—now keeping in mind they can't take their kids to those, so they have a babysitter or someone looking after their kids if they have someone and then they wait. Having access to good quality education will make a difference. But who is it coming from and what angle? Quite often we hear that it's one sided and then they'll go and speak to a friend or a family member or they go into independent education and it's different. There is quite often a delay between research coming out and it actually filtering down into hospital policy, which means there's a difference between antenatal education and then what they're told at their appointments.

I think actually it can be done in the room. I've seen category 1 C-sections happen and that mum feel very supported and informed because the doctor sat next to her and said, "Hey, the team is going to do a lot of stuff, but I want to sit next to you and answer your questions." Because he at that moment trusted everybody else to do their job, and his job was to care for the mum. So that mum actually left feeling like she had it all, had the information, had the surgery and then he came around the next day and said, "Our midwives are going to give you pen and paper. Write down all your questions. I'll come and sit with you again tomorrow and answer your questions." So I don't think everything has to be given to women in the antenatal care, because there is such thing as information overload. But it can be done better in the room as well.

SHARON SETTECASSE: Just to add to that, I heard on Monday as well a lot of dialogue around the risks and benefits of things like instrumental deliveries—forceps, ventouse, vacuum—and also things like

induction, and that some birth trauma comes from not knowing that information about what that is, which I agree with. What I think is not happening in these antenatal conversations, and one of the things that we have to talk about, is the power in the room. Who has the power in the room? We are a society where, when we go to hospital, we really trust our doctors, and we listen. We believe what they say—of course we do. What we're here now doing is we're seeing a situation where women aren't trusted. It's very different going into a hospital pregnant. There's nothing wrong with you. It's not a pathology. It's not like you're going to ED or there's something wrong. That's a pathology, whereas when you're pregnant, you're just having a baby, but we're treating it like it's a pathology.

We need to do shared processing. The obstetrician has amazing expertise within their skill set. The midwife has a scope of practice, as Alyssa said, around what they can offer. And then the mother has her history and has created a birth plan, not because she wants to give birth in a yurt and howl at the moon but because she has been educated and she has the knowledge. That's what her birth plan is. She has gone away and taken responsibility for understanding what's going to happen and has put things down. That's what a birth plan is. Like some of the women said this morning, they had a birth plan but were really flexible within it.

What we are not hearing at these antenatal appointments is the discussion around induction. Great—what is it? What are the benefits? Are the risks explained that you could potentially have a postpartum haemorrhage? There's a lot of research. I don't want to get into dry academics, but is there a discussion around water immersion as one of the most effective pain relief factors or possibilities—you know what I mean—in labour. Is that being discussed? We have an amazing optimal birth environment in our local hospital, and we have all of these things in place that could shorten labour and make it a manageable pain for the woman, without the need for epidurals and without the need for inductions. We're not anti-interventions. I've had major abdominal surgery for my babies to be birthed. We're not anti-intervention, but we want people to have a spectrum of the information around interventions and waterbirths, props and active birth positions, because those things are proven to improve birth outcomes, shorten labours and that sort of thing.

ALYSSA BOOTH: There's also a disconnect. Particularly at our local hospitals, we hear from consumers that they did have a chance to sit and go through birth plans in the antenatal period but then, come time to labour or give birth, the birth unit staff said, "You can't do that. You're too high risk. You need constant monitoring. The monitor's not working, so you need to get out of the bath or the shower." So there's a real disconnect between what's being shared or spoken about in antenatal education or appointments and then what's actually happening inside the labour and birth units.

The Hon. SUSAN CARTER: My question follows on from that of my colleague. We've heard a lot about the issue of consent and informed consent and women having the right information at the right time. I'm interested in what you say about how there's antenatal education and there are birth plans, but then that's not consistent with the presentation of the individual woman when it comes time to give birth. Do you have a view as to whether there should be a curriculum that everybody should have to work through or whether the information should be tailored to the particular woman? If it is tailored, when is the best time for that information to be given, and who is the best person to be giving it? Then there's the other question, if you have a comment: There's a view that if you give women too much information about complications that may never occur, it may unduly worry them when it's not going to be their situation. How and when do we make sure that women have the right knowledge so that they can truly consent?

ALYSSA BOOTH: I teach antenatal education, so I don't know—do you want to answer this first?

SHARON SETTECASSE: No.

ALYSSA BOOTH: I just don't want to give any sort of bias. When you first go to your booking appointment at the hospital, which could be anywhere in your first or second trimester, depending how busy they are, you're given a stack of paperwork introducing your doc, the NSW Health booklet—there's so much. A large percentage of people I speak to never looked at it. They feel so unwell, they just had this massive appointment—it gets buried and they move on. I think giving women all that information at the beginning means it's probably not going to get looked at. They're not thinking that far in advance in their pregnancy. But it needs to be done throughout. You can't just do one appointment and then go, "Yep, ticked that box—done it all." It needs to be individualised care. You've got women's particular histories: They may have never given birth, they may have had loss, they may have cultural things that need to be taken into account.

I don't think you can create a curriculum that will do a well enough job. I think you need to have conversations with individual women about what they want and then how that looks for them. That is the responsibility of the healthcare provider, because they're the people that are having that care around them. We know that that looks different for—the examples of the women with private-practising midwives. That was ongoing as things evolved through pregnancy. It needs to be the same inside the system, where things will evolve,

pregnancy changes and you need to be able to have that conversation multiple times relevant to your particular case.

SHARON SETTECASSE: You touched on cultural concerns. Culturally and linguistically diverse communities need to be prioritised. Is the information in all the languages that is required? Are cultural concerns—and it's not just about language. We're talking about health literacy as well and also taking into account where people have come from and what the birth culture looks like there as well. For some people, they want a roomful. Having two support people just actually isn't culturally appropriate. They want their mother, their—

ALYSSA BOOTH: That's the current limit at our local hospital: two support people inside the birth room.

SHARON SETTECASSE: It's continued on from lockdown. We really want to see a concerted effort, not just within our local health district, but better literacy—it has to go back to basics—for culturally and linguistically diverse communities as well. I think the ISLHD would probably have a really good response to that as well.

The Hon. SUSAN CARTER: Would you perhaps recommend a model where there was a separate dedicated early appointment that actually addressed the individual needs of that woman—that wasn't wrapped up with observations but was sitting with her and talking with her in relation to the birth process and what she was likely to encounter?

ALYSSA BOOTH: That first appointment is pretty lengthy and they do do a lot of history and ask about family dynamics, mental health history and all of that. It is pretty detailed. I think they say to allow about an hour for that appointment. I think at that time it's probably not the right approach, particularly if you're one of those women who feel awful during pregnancy and you're just struggling to get through the hour. I think it would be better just to have it regularly throughout the entire pregnancy.

SHARON SETTECASSE: And, I think, respecting that women seek their own information as well. Not all birthing parents do that, but there are some excellent resources out there. There's a really simple one that shares birth stories. One of the things that we've lost in our society, because we don't see it, is, "How does birth happen? What does it look like?" This podcast is literally just birth stories, so that's a form of education. Again, it's going back to this idea of creativity. We can't patronise women and say, "You've done this birth plan because you were looking at social media or podcasts." These are created by midwives. There are midwives creating these podcasts. They are amazing resources. Storytelling, and just sharing your story about your feedback or sharing your story about your IVF journey or whatever it is—that's a form of education.

We can formalise it in the local health district, but I think it's really important to remember that communities are really stepping up to support women and birthing people, especially because of the state of affairs that we are in with birth trauma. Women and parents—dads—are going to resources like, "How do I avoid that? What can I do within my power to empower myself, to raise awareness within my own—I don't know anything." I didn't know anything about birth. As a first-time mum, I wasn't around friends who—I'd never seen a birth. I had to access resources that I was comfortable with. I think that's really important.

Better Births have different ways that we engage with our community and one of them is through an active birth skills workshop. We have people who are birthing in private with an obstetrician, at home—the whole range. They're so appreciative of just being in a day workshop, learning about birth positions, and we talk about inductions and all of that. That's a real collaborative way. The local health districts certainly do have to create accessible, consistent resources with different channels—videos, different languages. It has to be diverse so that if you're unwell but you can listen to something, that's more effective than having a stack of papers in a folder to read through.

The Hon. SUSAN CARTER: In terms of recommendations, can I summarise it in that the initial appointment is not the best time to be providing information women need to be able to consent. There should be a separate time after the first appointment, before birthing or any other procedures, where information can be checked, information can be delivered that's tailored to that woman?

ALYSSA BOOTH: Yes. I think I would also flip it back to clinicians because if women are going and seeking their own education often that education is coming out of research papers and studies that have just been released. If they then take that into the hospital and say, "I've just heard about this", the hospital says, "We don't know anything about it"—there's often a disconnect. So clinicians need to be held to some sort of standard to make sure they're actually reading the research as it comes out, and they're actually up to date with what the evidence is showing us.

The Hon. NATASHA MACLAREN-JONES: Thank you very much for coming today. I want to ask under the MGP model, where do midwives operate from? Are they attached to the hospital or are they working

from home? I suppose it comes from where you've said in your submission that to expand the model that's one of the things that has come back saying it's not possible because there's nowhere for them to operate from.

ALYSSA BOOTH: It's probably a question for the local health district.

SHARON SETTECASSE: We don't have that information. And it changes. We know some of the MGP midwives and then they're gone.

The Hon. NATASHA MACLAREN-JONES: That's fine. I can ask when they come next. In relation to your submission where you talk about a trial that was done—it was in relation to budget and costings—I was wondering if you had any more information? I'm happy for you to take it on notice. You were saying it was one of the barriers as to why they couldn't expand. I was wondering if you had that?

ALYSSA BOOTH: The M@NGO trial?

The Hon. NATASHA MACLAREN-JONES: Yes. I'm happy for you to take that on notice.

SHARON SETTECASSE: Thank you. Let's do that.

The CHAIR: Thank you both for coming. Going back to some of the conversations we've already been having around MGP—and I know that you've been advocating for the expansion of this since 2016. We've talked about funding and obviously midwife shortages, but I'm wondering what other factors are at play here that's potentially stopping that program from being expanded.

SHARON SETTECASSE: The will to do it, the culture. We're so frustrated by this. We're given different answers. Often the common thread is workforce shortage. In terms of the paper that we got commissioned for understanding how to create more sustainable models, one of the recommendations was, for example, to ensure that the leadership of or the management of MGP was by someone who was supportive of that model, because that certainly has not been happening currently in our region. Yes, certainly the will, the culture—and some of it is a mystery to us. We would really love to hear that expanded on this afternoon.

The CHAIR: You mentioned earlier that you've been meeting with the LHD for seven years with little or no change. What are your highest priorities? What would you have hoped to have seen them doing and what do you hope for with regards to action in the future? What are those top-line aspects that they should be actioning?

SHARON SETTECASSE: We've had some wins. It's like any partnership. We're under no illusion about how long it takes to create change. Even in our own work—we've worked in big bureaucracies—we understand that. We're not naive to all of the moving parts. We don't want to be called into any more steering committees to talk about the same thing. We've already laid our cards on the table. We've provided the evidence. We've really initiated those contacts with those academic researchers for the best evidence. I think that we've done a really good job in our role as consumer advocates, probably above and beyond.

We really want to see action on this. We want to see a replication of what has worked—the targeted advertising. We want to see the retention of midwives. We want to see some movement on the eight recommendations that came from that report in 2018. What a waste of resources and time for a report to be created that's based on evidence and the will of the community—the demand from the community—that they want this model.

There's so much trauma. We get so many messages from women when we simply upload a photo of a beautiful birth through the MGP. We don't have the admin to manage the messages that come through saying, "I applied as soon as I found out I was pregnant. I couldn't get on, and I know this is the best model of care" or "I applied"—like Olivia said before—"but I was risked out at 32 weeks and now I can't even access a private-practising midwife."

The demand is there from the community. The evidence is there. The partnership with the local health district is pretty rocky at the moment. Seven years is a long time for there to be no action. We want more action, we really do. If there is any other local health district where it is working, we want to know: How did they do that? I tell you, we've tried everything. We've thrown everything at this. It's disappointing.

ALYSSA BOOTH: It's also inconceivable to us that management didn't know that this much birth trauma was walking out of their hospital. How do you work there and not know that that's what people are saying about your birth unit? We don't understand. A big culture change—we need to see something significant, particularly in the local health district. Right across New South Wales, obviously, we know it's a big problem, but as a local, grassroots consumer advocacy group we want to see what we've been asking for for seven years: a culture shift and an acknowledgement that MGP works. It reduces the risk of trauma but it also saves NSW Health money. It's a cheaper way to run. Like Shaz said, we worked with academics. They wrote up reports acknowledging that those eight key points should be met.

The CHAIR: You mentioned the report and the eight recommendations. Is that the report that you mentioned in your submission that you couldn't get a copy of?

SHARON SETTECASSE: Yes.

ALYSSA BOOTH: Yes, that's the one.

The CHAIR: And have you got a copy of it yet?

ALYSSA BOOTH: No.

The CHAIR: Okay, so that is not a public document at all. And you were just given the summary?

SHARON SETTECASSE: The barriers and recommendations, yes. We can send that through.

The CHAIR: Thank you. You're saying that there's been no movement since those eight recommendations were made?

ALYSSA BOOTH: There are some that are partially complete.

SHARON SETTECASSE: There is one that has been partially completed.

ALYSSA BOOTH: "Increase women's access by advertising on the hospital's website and in the community" is partially complete.

The Hon. GREG DONNELLY: Through you, Chair, I just wonder whether the secretariat has a copy of the New South Wales Government report or submission? I've just got a copy of a report that I would like to take you to a part of for your comment. The document is titled *NSW Health submission: Inquiry into Birth Trauma*. Is that the document you've got?

SHARON SETTECASSE: Yes, that's the one.

The Hon. GREG DONNELLY: Could I please take you to page 11, and specifically the section headed "3.3 NSW Maternity Care Survey". Do you have it?

ALYSSA BOOTH: Yes.

The Hon. GREG DONNELLY: Could I invite you to share the reading of that? I'd just like you both to read that little section. I've got a couple of questions.

SHARON SETTECASSE: Sure.

ALYSSA BOOTH: Sure.

The Hon. GREG DONNELLY: This is a reference to a summary of a survey. This survey is conducted periodically by the Bureau of Health Information, which is not NSW Health; it stands as a body separate from it and it does independent research, so it's not beholden to NSW Health. You can see it periodically does these studies. The 2019 Maternity Care Survey summary is there. What I've been a little bit challenged with from the evidence thus far to the inquiry—and I will put this to you as a proposition to respond to—is that the headline figure there says—and this is from the report:

- 94% of women rated their care during labour and birth as 'very good' or 'good' …

You can read the other figures if you wish, but that's a very high percentage figure. What I am wrestling with is that, clearly, a number of women—not a few but a number of women—certainly in regard to that specific question, are very high rating with respect to their birthing experience. I am wondering, given that, if that is accepted as the figure—and you might say you don't like the survey methodology and that can't be right, or something different—how do we push it higher, taking into account the range of issues and proposals that have been put forward to address the concerns? Because if you look at all of the submissions and you look at all of the oral evidence—and now is the second full day of oral evidence—there is a multitude of proposals that have been put to us, very helpfully, about improving the situation. But the question is, if that figure is correct, do all of those things have to be done, or are there, within them, some that definitely need to be done to improve that figure?

SHARON SETTECASSE: We know that there is one thing that needs to be done: The most protective factor to reduce birth trauma is to fund midwifery-led continuity-of-care models. It is not the silver bullet. You heard from Amanda earlier this morning that she did not have a good experience in the MGP model. I didn't have a good experience in the MGP model; I chose a private midwife. So we're not saying that it is perfect, because there are human factors, but we know that the most protective factor to reduce birth trauma, or the protective solution, is that model of care. It has to be publicly funded because not everyone can afford thousands of dollars for private midwifery care. The Wollongong LGA is one of eight places in Australia that accepts humanitarian

refugees with the Women at Risk status. These are women who come here on their own from places where it's either war-torn or oppressive regimes. They come here and they're birthing in our hospitals. They're not going to be able to afford private midwifery care.

The Hon. GREG DONNELLY: Or doulas.

SHARON SETTECASSE: If you can think of the most vulnerable person in the room, if you're coming with lots of trauma, and I also want to respectfully include First Nations women of this country, if we include the most oppressed, vulnerable—strong but vulnerable—people, they need that care. So in response to this—and we do have questions about the methodologies. I won't—you asked me not to, you know—

The Hon. GREG DONNELLY: No, obviously, if you do have them and you'd like to comment, I'm not trying to close that discussion down.

SHARON SETTECASSE: Okay. I looked at that and I was like, "I'd love that." I hope that's really true.

The Hon. GREG DONNELLY: The link is there.

SHARON SETTECASSE: Sure.

ALYSSA BOOTH: We had a look at it.

SHARON SETTECASSE: Yes. So we were wondering how is the survey offered, who responds, what's the demographics, is it being offered to culturally and linguistically diverse women, for example?

ALYSSA BOOTH: The timing is odd, eight weeks postpartum.

SHARON SETTECASSE: Yes.

ALYSSA BOOTH: Most support people have gone back to work, you're at home with a newborn baby and at eight weeks there is a lot happening, so that's unique.

SHARON SETTECASSE: So it's like anything: When we look at research, methodology is absolutely key. When I read that, I'm in heaven if I see these 94 per cent of women, if they're happy with their care.

The Hon. GREG DONNELLY: That's what I'm trying to reconcile in my mind.

SHARON SETTECASSE: Sure. Yes.

The Hon. GREG DONNELLY: It may not be reconciled by the end of the inquiry. But putting that aside—I might just be slow on the uptake—the key is, it seems to me, that of all the things that are being proposed by the people on the ground, so to speak, like yourselves and others that are doing this work and are very alive to the matters—there have been so many—what is the distillation of those down to the most critical ones?

ALYSSA BOOTH: I think the consistent message through Monday and today has been continuity of care.

The Hon. GREG DONNELLY: Absolutely, yes.

ALYSSA BOOTH: It's not a hard reach; you just want to see the same face the whole time. I think whether you get that from a private practising midwife, a midwifery group practice, antenatal clinic, birth unit postpartum care or a private obstetrician, the positive stories are coming out of continuity of care. If you choose to see a private obstetrician and get your continuity that way, great—have a standard where they're going to be there the whole time. If you choose to go through your local hospital because you can't financially output thousands of dollars for a midwife and a doula, then you should be able to access the same face and not have to tell your story over and over, particularly if there is a history of trauma. You're retraumatising women by making them go over their notes because you didn't have five minutes to sit down and read it, and you don't know her. All the consistent messaging is continuity of care.

The Hon. GREG DONNELLY: Absolutely.

SHARON SETTECASSE: And the gold standard is midwifery-led continuity of care.

ALYSSA BOOTH: There is so much evidence to back that.

SHARON SETTECASSE: I prefer to flip it and say "midwifery-supported" because the person that needs to be leading this is the woman. So everybody should be taking her lead and bringing in your skill set—the midwife's skill set, obstetrician's skill set—when they're needed. I think we're wasting a lot of obstetricians' time. They've got a particular skill set and the scope of practice is really clear. If we want to ensure that women and babies come out of their birth healthy, well mentally and physically, then the gold standard is midwifery-led continuity of care. I like to do things in threes. So the second thing that I would offer to this is trauma-informed

training to all clinicians across the local health districts and that it be mandatory and that it be really well set up. Because if you've got a woman who's already birthed, she's had a caesarean, the most contributing factor to a C-section is having a previous C-section because there is a lot of trauma there—so, trauma-informed care.

And the third thing that I would say is, in the same way that Queensland has legislated informed consent, we need to do that in New South Wales because informed consent is not happening. No means no, and even if someone doesn't know all of the policies, if she says no or if they say no and you've got a different opinion because you're a clinician, it actually—they are a grown adult. They've just grown a baby. That's okay for them to say no. We all want a healthy baby when we come out. That is the baseline. That's the benchmark. It's actually a little bit insulting to say to a woman, "We just want you to have a healthy baby", because—guess what—she doesn't even think about that, because that's a given. She wants that, but she knows that what her baby needs is also an opportunity to have the best start in life. If they're starting with a mother who's traumatised, the research that I mentioned before, around infant mother bonding, that's going to get—we're going down a pretty—it's not a good road. So trauma-informed care, midwifery-led continuity of care and legislation for informed consent—I can give you a list of 10, and I will send that through to you in an email.

The CHAIR: Thank you. We have run out of time, but that was a really strong closer. Thank you for that. Thank you again for attending today and providing your evidence. The Committee may have additional questions for you after the hearing. We've resolved that the answers to these, along with any questions that were taken on notice, be returned within 21 days. The secretariat will contact you in regard to those questions. Thank you both again so much.

(The witnesses withdrew.)

Ms FIONA REID, Clinical Midwife Consultant, sworn and examined

The CHAIR: Thank you. I now welcome our next witness. Before I begin this session, I remind the witness to avoid referring to specific names, hospitals or medical facilities in their evidence and to speak generally about the issues raised in the terms of reference. Do you have a short opening statement you'd like to start with?

FIONA REID: I do, yes. I have been a clinical midwife for 36 years in every sphere of clinical practice, including Australian and international practice; rural, remote and urban settings; in midwifery models of care in public hospitals, birth centres, homebirth and MGP; and First Nations Birthing on Country. I have also taught midwifery in three major universities. In 2017 I established a formal birth debriefing clinic at Wollongong Hospital, where, as part of my role as a clinical midwife consultant, I provided formal birth debriefing for 563 women over a 4½-year period. This is what I've learnt, and I thank you for the opportunity to speak today.

This inquiry has been an important lifting of the veil that has been disguising birth trauma and obscuring it from view as a serious risk to mothers and babies in our maternity care system. We are now acknowledging that birth trauma is an experience of so many women, and that it is a foreseeable experience. We know that we have a responsibility to address the underlying risks and consequences of care management that are creating it. We know that the more interventions introduced antenatally and used at the time of labour and birth, the higher the risk of a traumatic birth experience. Trauma changes the mother's brain and interferes with her ability to recover both physically and psychologically from birth, often resulting in birth injury. It disturbs her ability to connect with her new baby.

We are now at a time in maternity care where more interventions are more frequently used than ever before. The hospital system has embedded medical management into every aspect of maternity care. Having a baby cannot easily be distinguished from having medical investigations in preparation for surgery. There is an historical and current investment in increasing medicalised maternity care which preferences high rates of antenatal and intrapartum interventions. Interventions directly correlate with birth trauma. Interventions have become standardised processes for the management of pregnancy, labour and birth, and are the opposite of individualised care. But medical and surgical management have a high tolerance for distress, and women having babies don't.

Our hospitals individuate birth trauma and identify the trauma as that woman's experience instead of taking a systems approach and reviewing and addressing the care and management that is contributing or causing trauma to many women. A failure to address escalating interventions without a proven benefit to maternal and infant outcomes and a failure to offer trauma-informed care debriefing to women in the postnatal period is a system that communicates that either her experience isn't important to the care providers or that the system doesn't care that having her baby has left her broken and has contributed to an experience of trauma, not joy, not happiness and not the satisfaction that she and her infant have survived, just a feeling that she or her infant or sometimes both of them nearly didn't.

It's an act of erasure to be told that the only important part of the birth experience is the end—the live baby and the live mother. I have a live baby, so I wasn't harmed. We know that this is an inadequate measure of outcome. A traumatic birth experience resulting in physical injury and/or psychological harm, prolonged physical pain and psychological suffering, an inability to care for and connect with her baby, and feelings of failure and isolation, guilt, shame, anger and neglect will mean that women begin to experience a disconnect from their lives and a descent into a darkness that doesn't lift. Women have been silently screaming for a decade, and now they can be heard.

The Murdoch institute, PANDA and James Cook University have recently released research into the causes of maternal suicide, the leading cause of maternal death in the perinatal period. They found that, after giving birth, women who had repeated suicidal thoughts had feelings of being violated and shamed by the birth. They experienced psychological isolation, resulting in disconnection from themselves, their experience and their baby. During the birth, they had received disrespectful care and care lacking in compassion, which created feelings of being defective and contributed to them feeling like defective mothers. Our system, the methods and communication at the time of birth and, yes, some of our clinicians are causing harm to mothers. To address this, Australian maternity care needs to be reviewed.

But birth trauma is not only affecting the women and babies in our care. It is affecting us, the clinicians. The clinicians are the second victims of birth trauma. The repeated exposure to trauma, the disempowerment of the midwife in the clinical environment that supports unequal power structures and medical dominance, the experience of being complicit in trauma-causing care and the inability to have validated professional autonomy when caring for women in the system is degrading the midwifery workforce. The effects of contributing to and witnessing repeated trauma affect our clinicians' brains, and the recurrent triggering of their own trauma experiences accumulated during their working life creates a compassion deficit associated with their need to

repeatedly survive shifts where the workload is too heavy and the staffing is too underskilled. The repeated stimulation of the sympathetic nervous system, and the requirement to comply with duties, procedures and policies protective of interventions that increase the likelihood of trauma or will result in injury reduces a clinician's ability to think, listen, ask questions, feel, express compassion, be authentic or advocate to be and remain woman-centred.

In the long term, a serious overhaul of the use of interventions at the time of birth and a major restructuring of maternity care that is less hierarchical and more inclusive is required. But it is my opinion that there are seven necessary improvements to maternity care that should be acted upon urgently in order to address the harm being done to mothers and their babies. First, research has shown that midwifery continuity of care improves maternal and infant outcomes and reduces all physical and psychological harm. MGP needs to be the dominant form of maternity care in all hospitals, and access to private midwifery care must be supported. Secondly, all women having their first baby must have one-to-one midwifery intrapartum care in hospital. Thirdly, all clinicians need to be trained in trauma-informed care, and all hospitals need an accreditation system imposed on them to ensure that a standard of trauma-informed care is met and not just talked about.

Fourthly, a validated screening tool to identify previous trauma needs to be introduced in the antenatal period to identify women who need support re-entering the system and who are at risk due to previous harm. Fifthly, women identified as "at risk" for birth trauma need to be offered antenatal care that is intelligent to their needs for planning, control and improved care that reduces all risks of repeated trauma. Sixthly, all maternity hospitals need to initiate formal debriefing clinics with appropriately trained trauma-informed care staff, and women must have access to self-referral for formal debriefing in an established birth debriefing clinic, which needs to be offered to women who meet a consumer-led criteria for birth trauma. Seventhly, and finally, all clinicians involved in clinical care that meets an established criterion for "traumatic" must be formally debriefed within 48 hours of the incident or birth. Appropriate clinical debriefing and regular clinical supervision has the capacity to reduce the effects of accumulative trauma, turn clinical desensitisation around and support clinicians to regain compassion and empathy in their work with women, with people in their care and also with each other.

The CHAIR: Thank you. The Committee resolved that we would do free-flow questions, so we will be calling out questions as we go through. But I'm going to start with the Deputy Chair, the Hon. Susan Carter.

The Hon. SUSAN CARTER: Thank you, Chair. Thank you, Ms Reid. I wonder if I could ask you some questions in relation to your experience running the debriefing clinic at Wollongong and your recommendations around that. I'm interested by your suggestion of the debrief within 48 hours, in light of evidence that we heard this morning that, perhaps, it's too soon or people haven't actually processed it enough. I wondered when, in the ordinary course of business, the debriefing happened in your debriefing clinic and, in the cases of known trauma, whether the one 48-hour touch base was enough or whether you would recommend further debriefs after that.

FIONA REID: Just to clarify, I was speaking about clinician debriefing in 48 hours.

The Hon. SUSAN CARTER: Sorry, in what way is the clinician debriefing different to what you're talking about in the debriefing?

FIONA REID: Debriefing for clients or women is—the research around debriefing generally internationally is very confusing. There is no gold standard because it is done so differently all over the world. But we do know from good neuroscience that the brain is too disrupted within the early days, hours, weeks—the frontal lobe is still recovering from an assault of adrenaline and cortisol. Immediate debriefing following a traumatic birth for a woman involved in the birth needs to be done once the brain has had a chance to calm down, resolve, and perhaps absorb a little more dopamine and some oxytocin. However, for clinicians—they are on shift. They are exposed to a very traumatic birth or a birth where they feel they have been complicit—

The Hon. SUSAN CARTER: Sorry, excuse me, so you're saying the clinician should debrief in 48 hours, not the woman?

FIONA REID: Yes. Sorry, that may not have been clear.

The Hon. SUSAN CARTER: And in the debriefing clinic that you were running—

FIONA REID: No, that was for clients, for women in the service.

The Hon. SUSAN CARTER: Yes, but at what time did that debrief occur?

FIONA REID: If a woman was referred to me—just to complete about clinician debriefing, because clinicians come back onto shift anywhere from eight, 12, 24 hours later if they're working regular shifts it's very important to debrief a birth before they are then put back into the clinical situation in a timely manner. So 48 hours allows for shift change or a day off to come back. For women accessing formal birth debriefing, as a result of my

studies, I resolved that it would be inappropriate to offer formal debriefing to women under 12 weeks postnatally. A lot of women I saw, I was seeing six months to two years after the birth of their baby.

The Hon. SUSAN CARTER: And was that the first time that they'd had an opportunity to debrief?

FIONA REID: Yes, it was.

The Hon. SUSAN CARTER: Is that perhaps too late, in your experience, because it gives them unsupported time where they haven't been able to work through issues with someone?

FIONA REID: It's a very good question, actually, because, as you can appreciate, women's drive to survive and to make their infants survive consumes their postnatal period. A lot of women whose brains and bodies are injured as a result of birth trauma will still enact the mothering role while they are internally completely disrupted. For some women, they will not only feed the baby, look after other children, engage back in their intimate relationships—relationships with friends, families—they will still do Christmas lunch, they'll still go out to functions, and they will return to work, but on the inside they are just barely coping, hence the high suicide rate.

The Hon. SUSAN CARTER: Which is, I suppose, why I'm asking what would be the optimal time when women were first provided with that opportunity to debrief.

FIONA REID: We do not know. What we do know is that it's very important that it's available for women to access when they feel ready, because of, as you can appreciate, the re-traumatising effect of telling a story and their experience. Delving back into the experience, the function of the brain is to trigger women to alert them to survive—again, the memory, the flashbacks, these sorts of things that are disrupting their daily life. Women have to feel ready to re-engage with the system. It's not ideal to hold a formal debriefing clinic within the hospital, because re-entering the hospital itself is a triggering event.

The Hon. SUSAN CARTER: Was your clinic self-referral rather than women being recommended at six, eight or 10 weeks?

FIONA REID: No. My clinic started with referral from the antenatal clinic, largely from midwives, then also from doctors, then from postnatal midwives, then from GPs, then psychologists, then child and family workers, then psychiatrists, then social workers, then physiotherapists and, finally, women started ringing the hospital and referring themselves.

The Hon. SUSAN CARTER: If we were looking to make recommendations, for example, that all women should have the opportunity to debrief every birth between six and 12 weeks or later as needed, would that be a reasonable recommendation?

FIONA REID: I don't think every woman needs to debrief a birth. I think there are women, as we know, leaving our system—approximately 30 per cent—who, in order to regain an ability to manage their life and engage with their baby, they need to understand what happened and why it happened and is she at risk of that ever happening again. For those women, a well-advertised formal debriefing clinic set up in every public hospital would allow women to engage with it when they felt ready.

The Hon. SUSAN CARTER: I suppose my concern is that, given the figures that you gave us about suicide and maternal mortality, if we are leaving women unsupported and saying, "It's here when you're ready," without any structure or signposts around that, are we actually leaving the women who follow other paths rather than find their way to a debriefing clinic unsupported?

FIONA REID: I think the establishment of a formal debriefing clinic should be well advertised within the maternity unit, but I think parking the ambulance at the bottom of the cliff is an error that is commonly made in health. We need to prevent birth trauma, not prevent suicide.

The Hon. SUSAN CARTER: I'd like to think that we were working on both, at the moment, before we get to a stage where there is no birth trauma. That is why I am interested in this debriefing clinic.

FIONA REID: I don't think we'll ever eliminate birth trauma. It's an impossible request. Birth is, on occasion, traumatic. Certainly, our attention to those unpreventable incidents of birth trauma is very important. What I would like to draw attention to is the responsibility to prevent preventable birth trauma.

The Hon. SUSAN CARTER: But in terms of the debriefing clinic, you are not suggesting that be available as part of general postpartum care, are you?

FIONA REID: I'm not sure that's an achievable resource. I think, if hospitals were to set up formal birth debriefing clinics and they had dedicated staff and the clinic was run to accommodate a proportion—30 per cent—of the known births in any given year, it would be quickly up taken by women who wanted to debrief. There is

a percentage of women who never want to talk about their birth again, or they want to talk about their birth 10 years down the track. I think part of the problem with top-down medical servicing is that, when we require women to do anything, we are not going to achieve the result we want, which is self-determining health care and a provision of appropriate support that women access when they are ready and when they want to.

Dr AMANDA COHN: I have two questions. The first one is also about the debriefing clinic. We have had a number of submissions from people across the State who have told stories where the inability to debrief was an exacerbating factor in their trauma. So I was particularly interested to hear about your formal birth debriefing clinic as part of the solution. My first question is about the practicalities of the clinic. How is it staffed? How is it funded? Who is actually providing the clinical service? What are the skills of those people? Can you explain to us how it works?

FIONA REID: I was very fortunate to be working in an organisation that valued the innovation of a formal birth debriefing clinic, so I was supported as part of my role. I had a very big job but part of my role, and part of what I saw was extremely necessary as part of that role, was to provide debriefing. I became increasingly aware of the number of women who were re-entering the system, or who were refusing to re-enter the system, or having difficulty re-entering the system, absolutely terrified about what would happen. They had no-one to guide them through the system and to ensure that they had appropriate support to negotiate what would happen in their pregnancy and at the time of labour and birth.

We know that women who have experienced birth trauma subsequently have a higher rate of terminations of pregnancy, have a higher rate of permanent contraception, have a high rate of miscarriage and of preterm birth. They have a higher rate of late booking antenatally, refusal of care and management, declining care and management investigations, and can have a higher rate of repeated poor outcomes for both the mother and the baby. For women to re-engage with the service became a very big motivator for me to help them navigate a way back into the service and to afford them some sort of support while they were pregnant and then at the time of labour and birth. Sorry, it's a long answer.

I established the clinic and women were referred. I would ring them and establish what they wanted. They would be referred or they would contact the hospital. I would ring them and then make an appointment. If they were from out of area I would ask them to get their notes—their partogram, which is the record of labour, and operation report if they'd had surgery—and to bring a copy of those notes with them to the appointment. If they were from within the system I would access that material with their consent and then I would read everything associated with the birth.

When they came in we would try and keep waiting times for the appointment to a minimum. Ultimately we tried to move the clinic to an area that wasn't located in the antenatal or the postnatal unit because of the distress that re-entering would cause. We tried to not make them wait in the waiting room for any period of time. The admin staff were unbelievably supportive. They would let me know as soon as the woman arrived and we would usher her into a private room. The room would be set up in a non-confrontative way. I would have a doll and pelvis, because I am physiologically birth trained, so describing and manipulating the baby through the pelvis and talking about her progress of labour was very much a frequent facet of the interview.

The interview would start just quietly, "I've read all your material. Would you like to tell me your story?" Part of the problem with debriefing—again, the top-down model is that, as clinicians, we tend to tell women. This was the reverse of that, where the woman gets to tell someone, in an uninterrupted way—so a quiet room and privacy guaranteed. She speaks for as long as she likes to. I would advise her that I would make some notes while she's speaking. It's not that I'm inattentive; it's that there are things that I need to remember so I am just going to make a couple of notes while she's speaking. And then she speaks until she's said everything she wants to say.

Then, because I've already read the information prior to her appointment, I have an idea in my head of what the issues may have been. Sometimes they were correct. Sometimes they weren't. Sometimes I was surprised. Then we go back, "What questions would you like answered?" When I made the initial phone call for the appointment I would always ask them to think about what they wanted from the appointment and actually to write it down. Then, because the appointments were made a month out, I would ask the woman to keep a list on the kitchen bench where she just made notations about things because, once she knew the appointment was made and she was going to be talking about her experience, things would bubble up. So I would ask her to capture those by keeping a list.

Quite often women didn't bring a list. They knew. There was one, two or three things only that they wanted to know or they wanted to clarify or they wanted to understand. The appointment ran for one hour. At 50 minutes I would say, "We've been talking for 50 minutes and I'm just letting you know that a lot has been said." There's often been some distress. I think an hour is long enough for an appointment; probably 50 minutes is better. If we

needed more time, I would rebook her for a second follow-up appointment. If the appointment was to her satisfaction and she didn't have any further questions or issues, I would not see her again.

If it was someone who had a lot of distress—a lot of women would like to come back and see me at 36 weeks to top up, to perhaps write a plan, which we used a format of one page, three to five dot points only and an opening paragraph about what their distress was at their last birth. We labelled it NBAT: next birth after trauma. I was in the process of printing that on very fluoro orange paper at the time I left the position. It was very clearly identified—this woman is an NBAT and requires a member of staff who is sympathetic to working with women who are carrying trauma and who is motivated to take care of any issues that she's identified in her point form on the plan and will be alongside her as best as possible. Some staff felt that they could and some staff felt that they couldn't or didn't have capacity to work with women who were traumatised. Some staff on short-staffed shifts had no option. Alongside that I did education with the birthing staff and the antenatal staff and the postnatal staff to talk about trauma.

Dr AMANDA COHN: That's led nicely into my second question. In your opening statement you talked about psychological screening or screening for past trauma at intake or booking in.

FIONA REID: Yes.

Dr AMANDA COHN: I wanted to read something to you from the NSW Health submission to this inquiry. They've stated:

> Universal psychosocial screening (SAFE START) has been a core component of antenatal and postnatal health care in NSW Health services since 2009. This screening incorporates questions regarding symptoms that have been associated with psychological birth trauma, for example feeling anxious, miserable, worried, depressed and emotional problems. This provides maternity clinicians with an opportunity to identify psychological birth trauma and ensure appropriate care is provided.

FIONA REID: No, I don't agree with that.

Dr AMANDA COHN: That's what they've stated is happening. I wasn't going to frame it as a yes/no question, but can you describe to us from your experience what actually happens in maternity services that you've worked in? Can you articulate how what you're suggesting is different from that?

FIONA REID: Yes. SAFE START, of course, is well utilised. There is a SAFE START assessment done for every woman. There are two questions in the SAFE START assessment that relate to anxiety, but it's not associated with birth trauma. It's generalised anxiety. So it's not identifying birth trauma and it's not related to a specific incident. Of course, when I say that a validated tool should be used to help identify women with previous trauma, I understand that the burdening of midwives at the book-in appointment is something that we don't want to do. I do suggest that a validated tool, if used—and I did use the City Birth Trauma Scale, which is a validated tool to assess birth trauma. There are about five internationally used validated tools. I chose that one because I was also in contact with Alysha Fameli, soon to be Dr Alysha Fameli. She was using that in her research and it suited my needs for the clinic and it also provided me with a data resource. Sorry, I forgot the second part of your question.

Dr AMANDA COHN: That's all right. It was about that SAFE START process and how that's different from what you were proposing.

FIONA REID: Yes. It is very different. As you can see, SAFE START is about psychosocial lifestyle and any risks. It identifies risks in the woman's life, but it doesn't identify previous birth trauma or flag for clinicians the fact that this woman is re-entering the service with a significant amount of history that is related to her care and management at the time of pregnancy, labour and birth in the last pregnancy.

Dr AMANDA COHN: Can I leave you with a question on notice? I'm very interested in the validated tools that exist to evaluate previous birth trauma. If it's possible to send that through to the Committee, I'd be very interested.

FIONA REID: Yes, I will.

The CHAIR: I have a few questions as well. Did I hear correctly in your opening statement that you had some experience with the Birthing on Country model?

FIONA REID: Yes.

The CHAIR: Could you tell the Committee a little bit about the model and how it's working. I've read a little bit about it in the submissions, but it's not something we've heard much about.

FIONA REID: I'm afraid I can't. I'm sorry to decline. I can't speak about cultural issues because I'm not Indigenous. I've been employed as a consultant in that role, but I can't speak to the cultural issues. I'm sorry.

The CHAIR: That's fine. I'm also going to quote the NSW Health submission because I want to give you the right of reply to something that has been written in there as well. I'm not saying that this is my belief, but I will quote directly. They said:

> … there is a lack of evidence of the clinical benefit of universal postnatal debriefing …

Can I get your thoughts around that statement?

FIONA REID: Yes. I know it's very confusing. When you read the literature, there are so many models that have been employed. Australia adopted an English model where the obstetrician and attending midwife at the time of birth would sit with the woman, usually at her request, at a postnatal appointment, and they would explain why whatever happened happened. When you read the literature, it's not very satisfactory, partly because it was seen as a medicolegal responsibility to avoid litigation, and it was the hospital taking responsibility and justifying management. This inquiry has the ability to not go down that line but to listen to the women. That's the beauty of asking the women.

In the debriefing model that has been the most utilised in the English-speaking countries, women are very dissatisfied with debriefing. That, of course, has skewed the feedback, because women were unhappy with debriefing. You have to really drill down to understand why, because they left, having a doctor and a midwife who were—I hesitate to use the word "perpetrators"—instrumental in the trauma telling her that it was necessary and that she had to learn how to cope with her experience rather than criticise the management and care that the hospital afforded her at the time of a critical incident. So you can see the fallout of that is that women were not happy with the experience. That just distorts all the data from then on, because when you bring women in and you're telling them, not asking them, and you're not checking what they want or what is most important to them but you are deciding what you want them to understand or know, they leave most dissatisfied and often more disrupted.

The CHAIR: I think that in your opening statement you also mentioned that you had experience in rural areas as well. As we are putting some recommendations together, that's something, I think, that the Committee hasn't heard a huge—we have discussed it a little bit, but it's not something we have really gone deep into in regards to whether there's differences in the recommendations that we make as part of the report for regional and remote areas where women are giving birth. What do we need to be aware of for those areas, and are there additional recommendations we need to make sure are in the report?

FIONA REID: It's really interesting, actually, because when you look at the Mothers and Babies reports over the years, and the most recent one, intervention—as you will have gleaned, intervention is responsible for a lot of trauma. High rates of intervention are directly related. Rates of intervention are associated with affluence, so where you have more affluent areas, you have higher rates of intervention. Rural and remote areas have lower rates of intervention and correspondingly lower rates of birth trauma. If formal birth trauma debriefing was to be implemented at a rural or a remote level, it still needs to be done expertly. It still needs to be offered. It will still exist, birth trauma, but you're probably going to have a much lower incidence.

The CHAIR: Interesting. Thank you.

The Hon. EMILY SUVAAL: Thank you, Ms Reid, for appearing today. You have referred to your previous role a couple of times. Were you at one time employed by Illawarra Shoalhaven Local Health District?

FIONA REID: Yes, I was.

The Hon. EMILY SUVAAL: When did you cease working in that role?

FIONA REID: In February of this year.

The Hon. EMILY SUVAAL: Thank you. I also wanted to clarify with you—and my colleague, the Hon. Emma Hurst, has touched on this somewhat already, in terms of there being no "gold standard", as I think you referred to it in your opening statement, around debriefing and that the research is confusing to an extent. But you also said that you, yourself, don't undertake the formal debriefing prior to 12 weeks. In evidence we heard on Monday in the hearing, it was suggested that even waiting until the six-week mark was quite stressful for some women because of that space that was there. What would you say to that?

FIONA REID: I think it's a very good point. In recognition of that, and something I had actually forgotten—where staff, very generously, would flag a woman with me, either from the birth unit or from the postnatal unit, they would often email me or ring me up and say, "Look, I think you'll need to see this woman." What I would do is I would put her in the calendar for a three-week or four-week phone call. I would call her and say, "This is why I am not offering you a debriefing appointment now, because the hormones of pregnancy and the hormones created at the time of your labour and birth are affecting your ability to process and to understand

and to be calm. You're dealing with so much in these first few weeks that it's going to be much better if you can hold the line and know that we're going to bring you in and we're going to provide you with a very deep opportunity to debrief completely, but we just want to give your brain time to recover from the pregnancy, labour and birth." That phone call was very helpful because it meant that they didn't feel abandoned.

Women are leaving the postnatal unit two days after giving birth. They are not surrounded by family. They have to construct their own supports. Their brain is disrupted. They are dealing with intense physical pain. They may have urinary and fecal incontinence. They may not be able to walk properly. They may not be able to sit for longer than 15 minutes. They may be struggling with feeding. All of these things—you can't debrief a woman while she is in such physical distress or while she has psychological distress. I take Susan's point. What is the safety net we can provide when they are waiting for debriefing? I'm not sure what the answer to that is. But I know that interim phone call was helpful in providing an element of hope, I guess.

The Hon. EMILY SUVAAL: You spoke in one of your previous answers about the rates of intervention and the correlations with that. In terms of intervention more generally, that's something that we heard a bit about on the first day of the hearing but haven't heard so much about today. Is it true that some interventions are necessary? What's your thoughts on that?

FIONA REID: This is like a four-day workshop.

The Hon. EMILY SUVAAL: We don't quite have four days—but just a summary?

FIONA REID: I'm very available, if you ever want that. This is a very important part of this discussion. It's a very important part because, of course, maternal and infant safety is why we are all working. That's what we are all working towards. However, in an effort to make birth safe, we have utilised medical interventions at the expense of good midwifery care. We now have a change in midwifery that's becoming evident where we have more midwives working in hospitals who are very good mechanics—perhaps less good one-on-one midwives, but they can run an induction. They can assist at an instrumental delivery. They can resuscitate a baby at a caesarean. We are creating a culture that is increasingly medical, at the expense of patient satisfaction. We haven't improved maternal or infant outcomes, and that is the crux of it, regardless of the rate of interventions. Our caesarean rate is now 500 per cent of what it was in the 1970s. Our rates of induction are 40 per cent. These sorts of figures, which we know are associated with birth trauma, are not supported by evidence that shows that maternal and infant outcomes are improved; they're not.

The Hon. EMILY SUVAAL: Is it true that the overall demographic of women that are giving birth or expecting has also changed over time?

FIONA REID: Yes. Women are older and they're fatter. Ninety-two per cent of babies who are born are within normal weight range. When we villainise women who have a BMI of over 30, and we start to treat them as though they themselves are the risk and they are the house of the risk, and they have the baby and we need to relieve the risk by getting that baby out in whatever way we see fit, we are not only undermining her right at the booking visit, but we are setting her and the baby up for serious intervention that will create trauma. Ninety-two per cent of babies are normal birth weight.

I have spoken with women. There is now an increasing tendency to document at an eight-week-dating ultrasound that the baby is larger than normal. What you are seeing is the domino effect of when we start to intervene. When we have medical knowledge, it's a "more is better" kind of attitude. We have the knowledge; we need to use it. But in actual fact, we need to put the brakes on that. We need to look at the quality of care, not the rate of interventions. We are not improving maternal and infant outcomes, and in fact we are breaking mothers.

The Hon. MARK BANASIAK: Just picking up what you were saying in answer to Dr Cohn's questions, I think you mentioned a two-day period of women feeling abandoned after leaving the hospital. It seems strange to me that we boot women out of the hospital after two days, going through such an ordeal. I think in the private health system it's probably about five days, on average. Do you think there should be a minimum standard of stay to maybe do some of those necessary checks with women to make sure they're coping after the birth? Is two days too short? I know you probably wouldn't want to mandate a specific time period, but do you agree two days is too short and it needs to be longer?

FIONA REID: It's a very good point. I think you raise a very important issue. Just as you say, some women will want to leave hospital—some women opt to leave hospital four to six hours after the baby is born. They feel well; they have other children and other responsibilities. That is wonderful. But the pressure on the hospital system is such that we have—and this is part of the problem with intervention. We've become addicted to throughput: "Get them in, get the baby out and get them out because we need the bed. Not only do we need the bed but we need women not to linger because we've got a staffing crisis, so we need a quick turnover. We need people not to be hanging around or being dependent on staff, because we can't support it."

Women in hospital for two days will not necessarily get the kind of support that you're alluding to. Regardless of whether they stay two or five days, our staffing shortage means that they will still need to struggle with breastfeeding, they will have delayed pain relief and they will have inadequate assistance up to the shower following a caesarean. We will have women who are provided with medication but very little one-on-one midwifery care for the first 24 hours. This sort of thing means that the support given to women—they're better off at home, where they have someone with them 24 hours a day or they can recruit family or bring in support. Because we are currently unable to provide adequate support, even though it is the ideal.

And, of course, you're looking at women trying to establish breastfeeding. We know the long-term health benefits for babies and children with breastfeeding, yet our breastfeeding rates are deteriorating. That's largely because women are going home at two days, before their milk has come in. Who's with them to assist with the early breastfeeding issues that normally arise? So women are stopping breastfeeding much sooner than is ideal. Then we have a reflected deterioration in the health of infants and young children as a result of allergies, asthma, gut problems and this sort of thing.

The CHAIR: As there are no further questions from members, I thank you so much for coming and speaking to the Committee. That was extremely helpful and useful. Committee members may have additional questions after this hearing. We have resolved that answers to those questions, along with the question that was taken on notice, be returned within 21 days. The secretariat will be in contact with you about those questions. Thank you again.

Applause

(The witness withdrew.)

(Short adjournment)

Ms MARGOT MAINS, Chief Executive, Illawarra Shoalhaven Local Health District, affirmed and examined

Ms MARIA FLYNN, Executive Director Nursing Midwifery and Clinical Governance, Illawarra Shoalhaven Local Health District, affirmed and examined

Dr ANDREW WOODS, Senior Clinical Advisor Obstetrics, Health and Social Policy Branch, Ministry of Health, affirmed and examined

The CHAIR: I now welcome our next witnesses: Ms Margot Mains, Ms Maria Flynn and Dr Andrew Woods. Before I begin this session, I remind witnesses to avoid referring to specific names, hospitals or medical facilities in their evidence and to speak generally about the issues raised in the terms of reference. Does anybody have a short statement that they'd like to give?

MARGOT MAINS: Thank you for the opportunity to participate in this hearing and to make an opening statement. Firstly, I would like to acknowledge the traditional custodians of the Dharawal and Yuin nations, whose land we are meeting on today, and pay my respects to Elders both past and present and to all Aboriginal people who are joining us today. Our local health district is very committed to listening and to learning from women about their experiences of maternity care, and we welcome this inquiry into birth trauma. Today's hearing is an important opportunity for us to hear directly from local women—as we have—and representatives about their experiencing, accessing or working with our maternity services. I sincerely thank all of those women who have been willing and bravely come forward to share very personal stories to help contribute to making improvements to our services.

As the local public health service, we are passionate about providing a maternity service that we are proud of and that not only suits the needs of women and families but is a service that our community wants to access during such a significant and important time in their lives. We deliver maternity services across a number of hospitals, community settings and in the home, and we provide care to women and families throughout the Illawarra. On average, we see 3,500 babies born in our service each year. Maternity care is provided by highly trained, skilled and dedicated multidisciplinary teams, including midwives, obstetricians, shared care with general practitioners, allied health professionals and Aboriginal health workers.

Our staff work incredibly hard to deliver quality and safe services. Many women who use our service report a positive experience. However, we acknowledge strongly that some women experience birth trauma, whether it is physical or psychological. We also very much acknowledge that that trauma may have lasting effects on a woman's mental, physical, social, emotional or spiritual wellbeing for her and her family. Providing access to postnatal debriefing is a key feature in both supporting women and learning from their experiences. Shoalhaven maternity service is currently providing a formal debriefing service, and that's something we are also reintroducing at Wollongong this year, following our recruitment of a new clinical midwifery consultant.

The stories I have read in submissions and those that have been shared at today's hearing, I personally find challenging and very difficult to hear. They have a profound impact on me as a chief executive, but not only as a CEO, as a mum and about to be a grandmother in two weeks' time. On behalf of the local health district, I sincerely apologise to any woman whose care did not meet their expectations. I acknowledge that we need to do absolutely everything we can to ensure that birth trauma does not occur in our hospitals and services.

We know midwifery continuity-of-care models are shown to have improved outcomes for mothers and babies, as well as highly positive experiences. We also know midwives enjoy working in this way, as these models foster ongoing, nurturing relationships with the women they care for and enable midwives to work to their full scope of practice. We currently provide midwifery continuity-of-care models through our MGP in Wollongong, which also provides the option of a publicly funded homebirth, and midwifery antenatal and postnatal services in the Shoalhaven, for which we get very positive feedback from women.

And at Binji and Boori, our Aboriginal maternal and infant health service is providing culturally appropriate antenatal and postnatal care for Aboriginal women and families in the Illawarra and Shoalhaven. We are also working with Waminda on the South Coast, with the Waminda South Coast Women's Health and Wellbeing Aboriginal Corporation, to support them in implementing a Birthing on Country initiative, the first in Australia. In the first stage of this, we are seeing the Waminda midwives providing birthing services at Shoalhaven Hospital.

We know we need to do more to expand access to continuity-of-care models. We have been working on that. I acknowledge that this has taken longer than anticipated, and I'm happy to explain why in questioning, and I apologise for this. It has been due to several barriers—workforce has come up, and other things—but I am happy to leave that until after I have completed this. We are refocusing our efforts with renewed energy to enable the number of women to access Wollongong MGP and further explore access for women in high-risk categories. We

are working to establish the Shoalhaven MGP, which in the first instance will see up to 120 women, as well as further develop the Wollongong MAPS model of care and increase the numbers at Wollongong Hospital MGP.

We are committed to ensuring that all women receive culturally respectful, evidence-based and equitable maternity care and we do this through a range of dedicated services for our population groups that require greater support, including our First Nations people, our LGBTIQA+ families and our culturally and linguistically diverse [CALD] communities. We are always learning, and enhancing these services to meet the individual needs of each consumer. An example of that is our multicultural and refugee health service is currently partnering with our maternity service and consumers on a project to inform and improve care for refugee and migrant women and children.

No-one comes to work with the intent to cause harm, and I believe our staff share our goal of making a positive difference to women and families. However, there are areas that we need to improve, and work has already begun. We will continue working closely with consumers and also with Better Births Illawarra, from who you've heard today. I would like us to build on this partnership, which has seen improvements with the work that they've done with us to enable us to redevelop the Wollongong Birthing Unit, for which we gained government support for $2.2 million of expenditure—which has done work closely with us to enhance skin to skin and is also a group I would love to continue to work with to co-design, in partnership with co-chairing on, service improvements and access to publicly funded birthing options.

We are expanding breastfeeding support in our hospitals, with the recruitment about to commence for a new role at Wollongong, based on the successful lactation model role at Shoalhaven hospital. We are reviewing and strengthening our clinical policies, with a focus on optimising what is best practice and limiting risks. We are participating in the preterm birth collaborative, which aims to safely lower the rate of preterm birth across Australia. And planning is underway for our next-birth-after-caesarean clinic at both Wollongong and Shoalhaven hospitals to ensure that we are providing consistent advice to women.

We have also implemented a range of new services and support for women with hyperemesis gravidarum. We are supporting the growth of the midwifery workforce with ramped-up recruitment advertising, strategies such as GradStart and MidStart, as well as the Mentoring in Midwifery program, which aims to build midwives' skills in teaching and supporting students and early-career midwives. We also will be working to implement the Blueprint for Action.

We understand that services provided are much more than the clinical care that people receive. It's also about how people are treated and the way that they are made to feel. I had the honour of attending a workshop this week on consumer, carer and community engagement we are developing further in the organisation. The quote on the power of partnerships stuck with me as I prepared to speak today. We must make sure decisions that impact consumers, carers and communities are informed by them. We acknowledge historic and current power differences between organisations in community. We must partner in the planning, the design, the delivery, the measurement and the evaluation.

We are continually working to develop our maternity services to meet the diverse needs to women and families. We are committed to working in partnership with women, to listening, to learning from their experiences in order to help guide our decisions. Finally, to those women currently receiving care through our maternity services—we want to assure you and your family that we remain focused on ensuring you receive the very best care. Please reach out to your midwife or doctor if you have any questions about this inquiry or your care. Thank you. I look forward to the questions today.

Dr AMANDA COHN: Before I ask my questions, I just wanted to acknowledge your apology as part of that statement and the profound impact that that had on the gallery behind you. I thank you for the apology that you've made to the people that have experienced birth trauma in this local district. My first question is the one that you've anticipated, which is what are the barriers to expanding the MGP program?

MARGOT MAINS: Can I first of all say up-front, because there was a question about our commitment, I have come from New Zealand, where I was involved in the change to very strong midwifery-led models. I was a part of the oversight and implementation and working with organisations to do that. I strongly believe in midwifery-led care and continuity of care and also in the appropriate level of care where it's required for the woman and their needs. I am proud, firstly, that we do have MGP in our organisation and that we get a lot of really positive feedback from our consumers, from the women who use MGP. There certainly has been a lot of discussions about the need to improve this and extend it. We've heard that today from Better Births Illawarra. So we have had a lot of discussions within the organisation, with an absolute desire to extend this service. There is no doubt whatsoever: We want to extend MGP.

There had been a lot of debate throughout circles about the nature of the model of MGP. I'm not a midwife, so I'm not an expert. We agreed and it was commissioned—a document was undertaken by an organisation—and there were discussions that occurred in 2018. At that time, there was the start of a real midwifery shortage. There also was discussion amongst some midwives that some wanted to do on call and some did not wish to do the on-call system. It certainly did delay, and I acknowledge that. But then when we got into the discussions—and there was also a discussion on the type of model it should be and also about the consistency and equity of access between the two different teams. This debate was going on within the circles.

We did not reach resolution of that and then COVID came along. I have to say, COVID refocused us—with fires and other things as well—for the next three years. That did cause a considerable delay as well. I can understand the frustration at what has actually happened. However, we are in the process of re-looking at the whole MGP model. As I have said, we are committed to starting that at Shoalhaven. That is where we will commence. We will basically be able to have the MGP model of care for up to 120 women in the first instance. We are also working on how we can extend that same service at Wollongong, using some of the vacancies that we currently have to initially do that.

With the new midwifery leadership we've got, with the new divisional director of midwifery, and Angela and also with Maria with extensive midwifery background from the UK, we are also looking at the risk rated model to ensure that we can actually see women that are of a higher risk factor. I would like to say that we very much are committed to MGP and we are moving to increase it. We are looking at the nature of the flexibility of the model that will enable us to use the vacancies that we've got. We are also looking at the risk factor and also recognising that, at times, when we have high clusters of women presenting, which we sometimes can do—and post-COVID we certainly saw a significant rise in births—that we may also need people to help us in the delivery suite as well from time to time.

Dr AMANDA COHN: My follow-up question, which is either to yourself or perhaps to Dr Woods, is regarding the high-risk clinic for pregnancies that have been identified as high risk. We have heard from a number of people this morning about the trauma caused by seeing different people at every appointment, and it's been well argued that high-risk pregnancies probably would benefit the most from continuity of care. I am interested in the rationale behind the high-risk clinic being staffed in such a way that people see a different obstetrician or obstetric registrar every appointment and the barriers to someone seeing the same doctor throughout a high-risk pregnancy.

ANDREW WOODS: I can take that. Thank you for the question. I think first and foremost it's important to ensure that any model of care is woman centred, acknowledging the importance of midwifery-led care, midwifery models of care and the benefits that that has been shown to give women in pregnancy. From a risk perspective, I think we also need to acknowledge the importance of collaborative care models where the skills and expertise of different craft groups are valued, and that women have exposure to both midwifery, medical and allied health care as part of high-risk care and that that care also adopts a continuity model where there is, where possible—and I'm sure we can achieve this—a named obstetrician who a woman gets to know during the course of her pregnancy and supports the information she's provided, the choices she's supported to make and the care delivered through pregnancy, birth and afterwards.

Dr AMANDA COHN: Further to that, what are the barriers currently to being able to provide that? We've heard from a number of people today that it's not the case that there is currently continuity in this area. What are the barriers that we need to be addressing?

MARGOT MAINS: I think I need to answer that. I think that's something we need to take away from having listened, and actually explore locally what we can actually do to reflect what women are saying about seeing a number of obstetricians. I'd like to take that away, and we will be looking at it within the organisation.

The CHAIR: You've talked a little bit about some of the barriers and the reasons for a longer time period before we can see a full rollout of this MGP. I'm wondering what sort of time line you may have planned going forward and what barriers you're still facing.

MARGOT MAINS: I would like to think that at Shoalhaven we could move. There needs to be discussions internally and also with women involved in shaping that service. Equally, we need to work together at Wollongong to actually take that forward and resolve some of the issues that are there. I would like to think that we will definitely do it, if not by the end of the year, by early next year.

MARIA FLYNN: We've got a number of long-term strategies. Margot has given some examples of why it has been challenging with COVID. We do know that during COVID there was an increase in the pregnancy rates of our own workforce. We do know, being a predominantly female workforce, there were a lot of challenges with furloughing. There were a lot challenges with the midwifery workforce. The Australian data is that we've got 40 per cent of midwives who are over the age of 50, so we had a lot of retirees. We knew we were coming to the

baby boomer years anyway. There were a number of factors that came in, if you like, to cause the perfect challenge with regard to workforce.

There are short-term, medium-term and long-term strategies for increasing that workforce. We have to, obviously, invest in the midwives who are within the service and ensure that they're developed, that they can work to scope of practice and that they're supported during their novice-to-expert continuum when they become midwives. And then there's the issue around investing in students who are going to become midwives of the future. I've noted that there's been quite a lot of interest with regard to some of the other models around supporting some of the backfill of those models of care with the use of registered nurses or assistants in midwifery. The current registered nurses—that program is aimed for those nurses. I'm a MidStart midwife, so I did nursing before I did midwifery. There's lots of expertise with those nursing roles. I was actually an intensive care nurse before I did midwifery, so I was very clinically competent in my own field.

Those nurses that we have working, we endeavour to have those as midwives in the future. We have to risk assess where those midwives are to be placed and we risk assess that the birthing unit is where you definitely need that expertise. Those registered nurses are the nurses that we're investing in to become the MidStart—so the nurses that then train to be midwives of the future. I would like to acknowledge their support, and I would like to thank the midwives who work with them and invest in them, because their experience is really important. A number of them will be mothers. Clearly, most babies can be cared for by people who have become mothers themselves.

Then there's the long-term strategy. We've increased the student numbers quite considerably. It's difficult to increase them much more than it is because you do need to get the birthing experience. With the support of our new co-director, Ange, we're looking at different models around the experiences of those students so that they get to MGP models. I was a midwife in the UK. I have over 25 years of experience as a midwife, and I was essentially an MGP midwife in the UK. So I'm very committed to nurses being supported with that transition, but also midwives to work to their full scope. There is nothing more privileged, in my experience as being a midwife, than touching a baby for the very first time. Being with a mother and their partner and delivering a baby is the most privileged role in my career. It is literally being with somebody when they pass away and being with a mother. They're both very personal and powerful roles to be in.

They do have some impact, and we do have to acknowledge that there is a lot of research about compassion fatigue and moral distress as a result of COVID. Our midwives are doing a phenomenal job and I'd like to say that we're completely behind them, and that we're doing what we can to reinvest in that workforce. We are actually seeing some improvement. I know that it's been articulated that there are some challenges, but we run our own digital platform. We engage with a digital platform person. I said that when I go onto Facebook, I want to see, like I see WA advertising, us advertising. That's realised lots of benefits. We've done a lot—Shoalhaven is one of the few midwifery units that's fully established, and we have a strong belief that we can get there with Wollongong as well.

The CHAIR: I've also got a follow-up question about high-risk women not going into the MGP model. I understand you're working towards changing that, but I'm just wondering, going back, what was the decision? Looking through a lot of these submissions, it suggested that the research said that high-risk people giving birth are the ones that are most likely to benefit from something like this. I'm wondering why the decision was made to focus on women who weren't identified as high risk?

MARGOT MAINS: The model was developed some time ago, and I might need to take that on notice to go back to the previous decision.

MARIA FLYNN: I can probably answer a little bit. The full-time equivalent midwives you need to manage a case load—you need more midwives to manage a more complex case load. If we started with the women—and there's lots of moves away from calling them high risk; it's women with additional care needs, or babies with additional care needs—it requires a bigger full-time equivalent. If we focused on the high risk—albeit that would be wonderful to do—it means that we wouldn't have it for the women that actually don't need to see an obstetrician probably at all. Again, on a balance of risk, it's where you can provide most of that service. The MAPS model and continuity-of-care model can be provided in slightly different ways. We are looking at a long-term vision of providing support to medium-risk or medium-care-needs women. It requires a slightly different FTE, so as we start to gain those numbers of FTE then we will be looking at that model.

With regard to the issue around trying to encourage midwives to do it—as I said, it is the most fantastic job from a scope of practice point of view and the relationship that you build with mums and partners. We do offer flexible working, and some of those models and some of those full-time equivalents will be offered in pairs or teams, because it is a big commitment for one midwife to be on call over all of that period of time. As we work through the re-establishment of the workforce, the models we take on will be taken on based upon a risk and safety

based approach for where we need to do it. That will be our endeavour, but the start has to be with the women with the reduced care needs, being the women who probably only need to see a midwife.

The CHAIR: If you could take that question on notice—just for some more detail. This might be one to take on notice as well, but you mentioned the balance of risk that was considered. Could we get a bit more information about that? From an outsider, it sounds like it would be better to focus on the high-risk women, even if that means less women go through the program in those early stages, because they're the ones with the greater risk of birth trauma and greater risk of complications. It sounds like they would benefit more than women who are potentially low risk. If you could give me a bit more information on the decision-making around that, and where the balance of risk was given to the larger group of women that could be covered by the program but who had a lower risk of complications, that would be really useful. Something else that came up as well was concerns around being able to have a private midwife in the hospital room during birth. I wanted to get some information around whether that's an insurance problem or a policy problem or what actually happened there.

MARGOT MAINS: With the work we've been doing with the Ministry of Health, with the organisation and with Waminda, and certainly enabling access for the midwives from Waminda to come to Shoalhaven to care for the woman and be with the woman that they are assisting in supporting with birthing, we've been able to make some changes around access agreements. That is work that we will now be able to take forward, and I am hoping we will be able to start discussions within our local community shortly.

MARIA FLYNN: It did begin, really—it's the indemnifying practitioners to be in the sites. So, actually, the conversations we are having with women have enabled NSW Health to look at the NSW Health policy. And we really endeavour—and we welcome that review—to be able to give access. But I think, also, we're already having conversations about, if the woman would like to have the independent midwives and would like to have the doulas at those birthing experiences as a support person, what's to stop that? We've also started conversations about the numbers. Obviously, during COVID, the numbers of partners or the numbers of attendees with the mother was reduced because of the 1.5 metres and the size of the rooms. But we've already started as that now has taken a step back again in that the risk rating is being reviewed. Certainly, I've also been having conversations around what we do for the mothers who have to experience a birth by caesarean section.

MARGOT MAINS: I think this is also a very good area where it's important that a number of people come together. Having worked in the system within New Zealand, with private midwives coming into the public system, we really need to get together a group of private providers, local midwives, obstetricians, gynaecologists and consumers to actually shape what will create a good service, because you do need to work through relationships, handovers and a whole range of things.

The CHAIR: Do we have a time line for those sorts of changes?

MARGOT MAINS: We are focused very much at the moment on working with Waminda and enabling that to get up. That's our key priority because we think this is an extraordinary and very special development for women. Then we will be focusing, next year, on working with private providers, but there is nothing to stop us meeting now to actually start to get things in preparation.

The CHAIR: Do you think that by sometime next year you might be able to have that happening.

MARGOT MAINS: Yes.

ANDREW WOODS: May I make two comments? In relation to the high-risk continuity-of-care models, I am aware of successful and sustainable models within New South Wales, and I am happy to work with the district to understand the barriers and challenges to introducing those and what's made them sustainable. Also, in answer to your question regarding endorsed midwives and access agreements, if you'd like me to take that on notice, I'm happy to provide more information to the Committee.

The CHAIR: Yes, please.

Dr AMANDA COHN: You have offered to provide the successful continuity models to the local health district. Could those also be provided to us on notice?

ANDREW WOODS: Of course. Forgive me for being too local. I am happy to provide that to the Committee too.

The CHAIR: I have another question about a report that was mentioned when we were speaking with Better Births Illawarra. I believe that report is not public. Is there a reason that report is confidential?

MARGOT MAINS: Sorry, I was unaware that the report wasn't public, so I'll take that on notice.

The CHAIR: Can you table that report to the Committee?

MARGOT MAINS: Yes.

The CHAIR: In regard to the action points on that, I think there were eight recommendations, and they were made public. Can I get an understanding of where we are up to on those? That might be something to take on notice, if you or not able to provide it now.

MARGOT MAINS: Yes. I'll take that on notice too.

The Hon. EMILY SUVAAL: Thanks so much for appearing today. I want to reiterate the acknowledgement at the start—it may have been Ms Mains or Ms Flynn—around the work of our midwives, our obstetricians and everyone else that works within the system currently, particularly during some very trying times in COVID. I am not sure who particularly to direct this to, but what are the demographics of women currently giving birth in Illawarra Shoalhaven LHD?

MARGOT MAINS: I have a whole range of figures here. Just bear with me. I think it's really important—and I think it's come through—that if we are promoting and committing to totally women-focused care, that we actually understand our community, because that impacts on the models. One of the things is that, for example, at Shoalhaven Hospital 12.1 per cent of women birthing are First Nations people, so are First Nations women. That's had an incredible impact in looking at the Birthing on Country development which will actually occur. It's the same at Wollongong—7.3 per cent of women are First Nations. When we also look at our demographics, 17.5 per cent of our women that birth are CALD community, so therefore that's one of the reasons that we very much focused on the development because, after some issues—and there was some work done—that we actually looked at the improvement just so that we used the demographics to shape what we needed to do.

That's where I just very briefly shared about how our multicultural and refugee service and our maternity services have come together with the School of Health and Society and the Early Start centre at the University of Wollongong and local consumers to enhance care for women from refugee and migrant communities. What they're doing is they're informing maternal care service improvements through evidence, and developing health services responses which looks as—they're shaping up and they're building on the work that's been done in the organisation on health literacy, and there's been considerable work working with communities on health literacy. Also they're co-designing a training package focusing on a culturally responsive care service. They're also looking at delivering low-literacy antenatal education and early support pilot sessions for refugee families in Arabic, Swahili and Burmese, and they're looking at also delivering education programs, which have started, to support refugee families in early attachment and child development. So they're very much coming together to recognise the population.

I think we also need to recognise that we need to think about how we deliver our services when we look also at the nature of the challenges that our population here faces, which needs particular solutions to working together that are relevant. For example 48 per cent of our total population exhibits social disadvantage and 52 per cent of women who give birth at Wollongong come from socially disadvantaged regions, and there are real distinct social risk factors in that. It's actually how do we actually promote our services in a way that people can attend and in a way that is geared to their situation rather than standardised, so therefore we can enhance the attendance of people at antenatal care within the first 10 weeks of their pregnancy. I'm not sure if that answers your question; my apologies.

The Hon. EMILY SUVAAL: It certainly paints a picture in terms of the average woman presenting and the social disadvantage that may also be prevalent throughout the community, and whether this then has an impact on the care that they receive, for example, due to their own interaction with the service. Just further to that, what is Illawarra Shoalhaven currently doing to improve maternity care?

MARGOT MAINS: So there's a number of developments that we're undertaking, and certainly I've expressed the need to speed up with MGP in the developments. We are, as I said, going to expand the midwifery group practice at Wollongong and at Shoalhaven. We've going to strengthen the MAPS program at Wollongong. That's been based on the successful MAPS program in Shoalhaven which has been established, with the addition of our new head of department working with our midwives, and we've certainly been getting very successful feedback. We are participating in the preterm collaborative group.

That's really important because that collaborative is looking at the Timing of Birth document and to bringing that into our practice, and it's looking at the Induction of Labour policy document, which is currently being reviewed and revised to provide consistency over when women are induced. As I've said, we've also brought in the lactation consultant at Shoalhaven and we've also brought in and we're going to now roll that out to Wollongong. I've just been speaking with the lactation consultant around that. We've also been looking at extending what Shoalhaven can do with the service capability assessment in terms of the length of time mums can actually deliver there and also stay there.

We have done a whole range of other changes as well in terms of a consumer advisory group at Shoalhaven. We are, as I've said, going to be looking at the privately practising access agreements and the collaborative agreements once they've been finalised for Waminda, and we'll certainly appreciate external advice and support for that. We've got planning underway at the moment for the next birth after caesarean clinic for consistent advice and informed consent at both Shoalhaven and Wollongong. We also are doing education, so we're coming together with South Eastern Sydney LHD to undertake education on trauma-informed care workshops for all the staff throughout maternity services. I'm also proud to say that at Shoalhaven we've now reached our first full-time staff specialist workforce, which is fantastic, and we've got a new leader, who brings a lot of experience. I've talked already about the debriefing clinics. That's just an overview of some things that are happening.

The Hon. EMILY SUVAAL: That sounds like a lot and the achievement around staff specialists is certainly something that's no mean feat, particularly in the current workforce complements. How can Illawarra Shoalhaven Local Health District assure women in the region that are currently pregnant that it is safe to give birth in these public hospitals?

MARGOT MAINS: We have sent out a letter to women throughout the district because, understandably, when there's an inquiry on and there's been a lot of discussion and debate, that does erode the confidence further in services. We do believe that we provide safe services and we look at our indicators constantly. We look at our neonatal outcomes as well. We do believe there are issues and would agree there are issues around the experience that women have. There are some areas that we definitely need to work on and that's what we're working on—reviewing our policies to look at inductions and so on. But I'll just ask Dr Woods to add that. Thanks.

ANDREW WOODS: Thank you, Margot. I agree. The maternity services within the district are safe. We have teams working together as we speak across New South Wales and within the district that are providing, I believe, safe, effective and respectful care. I think we have a responsibility to ensure we understand our services—the strengths and limitations. We have rich data sources that help us with that. I'm interested to follow the evidence we heard earlier in the week relating to patient-reported measures that I think will increase the richness of that data. I think, where limitations are identified, improvements can be looked at involving all the necessary stakeholders to develop actions to generate meaningful, sustainable and locally relevant positive change.

MARIA FLYNN: If I could add to that with regard to the outcomes, with regard to the experience, we have got evidence to suggest that the experience—we absolutely acknowledge the experiences that we've heard today are not where we want to be and we always want to consistently improve and listen. But we have actually got very good skin-to-skin rates. They're some of the best in New South Wales—obviously better for the mums who've had spontaneous vaginal deliveries, slightly better for the planned caesarean sections. The unplanned needs more work but still is above the State. We will have conversations around the model of care with regard to how our recovery areas are. It's really helpful for us to have those personal experiences given so we can ask those questions and see if we can do things differently. We do look at complaints. We do look at themes from complaints. Our complaint rate is 0.002 per cent.

We do know that sometimes complaints—that's not the only way we gain feedback. Having those conversations with the local community—as Margot mentioned, we were both at the All of Us launch of how we consult with consumers and the community. We've learnt a lot from that workshop this week that we'll be rolling out with regard to elevating the human experience work that's been done with the ministry. We have been very fortunate to be very progressive on some of those aspects, and we can look at those areas. We've reached Baby Friendly at Shoalhaven and we have aspirations to do that at Wollongong as well. So there are some really good things that we want to celebrate and some of them were mentioned earlier. It's not just focusing on what we've not done well but looking at what we have done well and how we can translate that and roll it out further.

The Hon. EMILY SUVAAL: Obviously achieving the Baby Friendly status is something, but you stated earlier that the skin-to-skin rates are above the State average. Is that right?

MARIA FLYNN: Yes, but clearly we'd like to exceed that.

The Hon. EMILY SUVAAL: Yes, of course.

MARIA FLYNN: We'll work with mothers and their partners to work through how we can do that better.

The Hon. SUSAN CARTER: This question is probably primarily to Dr Woods. I note that you indicated that you had experience or awareness of other local health districts, and you were going to be able to share information. What process exists for local health districts to share best practice with each other so we're not existing in silos?

ANDREW WOODS: Thank you for the question. I think it's important, as part of the team I work with within the ministry and the pillars, that we engage with the districts and we have networks across the State and across various different craft groups but, in particular for me, the co-leadership model involving the district medical and ministry co-leads, to allow us to share information and hear from them around the things that they are proud of within maternity care in New South Wales and the things they do well, understanding how they've achieved those results and looking at how we might be able to translate those across New South Wales so we have good bidirectional information to share, both backwards and forwards, to improve maternity care in New South Wales.

The Hon. SUSAN CARTER: How often would that information sharing take place?

ANDREW WOODS: That particular group meets three times a year, and that's face to face, although in recent times it has been hybrid as well as virtual but is now back to face to face. But in between times we have good relationships, we know one another and we can reach out to understand the challenges that we all face to provide that support and networking. And that's not the only group. There are senior midwifery groups that meet, share similar stories and work to improve maternity care in New South Wales. But I'm not part of those.

The Hon. SUSAN CARTER: Are there sufficient resources, once that information sharing has taken place, for programs that are working somewhere to be rolled out somewhere else?

ANDREW WOODS: That's the next step. It is to understand how we can resource those models and use the initiatives that you're aware of across the State to lead and drive those—

The Hon. SUSAN CARTER: So at the moment it's chat rather than do.

MARGOT MAINS: There are a number of groups. Maria can speak to this: I know the EDONs and midwives get together, and they bring back advice to us about what we need to be looking at in the chief executives' meeting. Many groups meet across the State and the initiatives are considered, but sometimes there are still some local contexts where things can be different and you need to shape that. But certainly whenever we're looking at something, we say, "What are others actually doing?"

For example, in terms of what's happening at the moment with our women's health and maternity services, we have set up a strategic group, and we'll oversight it to make sure we're seeing progress. Part of that membership is going to be our tiered maternity network, and the leads from royal women's will be involved. We've also invited the lead, Dr Andy Woods, and our lead midwife from the State to join us. This is a group that I'd very much like to be co-chaired. We need to discuss that post-this with Better Births Illawarra and consumers so that we can make progress together, learning statewide with our tiered maternity work, with our consumers together and with our clinicians together about where we need to go, but keeping the mind on the horizon about what is happening elsewhere. It is really important.

MARIA FLYNN: Certainly those communications happen. We have a monthly meeting—State executive directors nursing midwifery. Presentations are given to other areas. We collectively come together to support other organisations. There have recently been call-outs to support midwifery care in other, more rural regions where they're really struggling to get that maternity cover. We have visits. We had a visit this week, in fact, from Kelley Lennon, who is the policy lead. Those are regularly timetabled, where the statewide policies are—we talk about how we contextualise them locally. So there are lots of those conversations that occur.

ANDREW WOODS: May I come back in? Thanks to my colleagues for giving me time to reflect to provide further context to your question. There is an example that I'd like to share that is more than just chat, as you mentioned. From 2018 to now, there was a very successful NSW Health-funded supported model looking at maternal transfers and the maternal transfer redesign model, which ensured that women across New South Wales were connected with care to ensure that they stayed where they should be if they didn't need to be transferred, particularly in relation to preterm birth and preterm complications of pregnancy, but also ensuring that women got to the right place at the right time, because we know that in-utero transfer is far more beneficial for mothers and babies than out-birthing. That model is now turning into Pregnancy Connect, which is the next iteration in the evolution which, within the ministry and the maternity services, we are very excited to start to introduce. Thank you.

The Hon. NATASHA MACLAREN-JONES: From the regular meetings across the various districts in relation to midwifery care, I'm just wondering—you obviously have an agenda. Has birth trauma been on the agenda at any one of the meetings? If so, when was it first raised?

MARIA FLYNN: It underpins some of those policy documents. There are other, different experiences that bring that. If I may use this opportunity to think about other—we focus very much on births and maybe late pregnancy. We do really need to think about trauma that occurs for women who maybe have miscarriages or

ectopics, who have tubes lost during that event and the loss involved around that. The other thing is I've been with the health district for 12 months; before that I was at the Royal Children's. I would really ask the Committee to think about the trauma and how we advocate for family consultations about trauma. If you're a young child, the effects of having a mother who has been affected by this—so I would request that.

The other thing I would ask, as well, is to think about women who might be experiencing family violence, whose partners might not be comfortable with them being facilitated to access debriefing. Certainly, we need to think about how we enable women to access debriefing when they may well be in families where there is coercion or people who minimise the impact of their experiences. That's on the broader context. But a lot of the policy documents that are coming out from NSW Health have been informed by all aspects of person-centred care. We are working a lot on the person-centred care practices and how we ensure that we listen and respond to families in appropriate ways.

We talked a lot earlier about what sort of trauma debriefing we need. It really depends on what that family needs. Some women will want to go through the birth experience and need explanations for why something occurred. Others may have experienced sexual violence and so just having a normal spontaneous vaginal delivery might be quite impactful. They need a different type of debrief which might not even be with us—that might be with psychologists. And then there'll be people that—I would say, as well, we need to think about the partners. A lot of women I've worked with—and I worked in a debriefing clinic called Birth Afterthoughts in Oxford in 2004. Some of those women didn't remember the birth experience and their partners were actually experiencing trauma because they were very much—and it affected their personal relationships. They felt worried about their partner becoming pregnant again. We need to think about it in a wider context and very much about person-centred practice, both for the women and partners.

The Hon. NATASHA MACLAREN-JONES: I've just got a couple of other questions. While you are already commenting, Ms Flynn, you mentioned previously that you were looking into doing a review of mothers who have had caesareans. I'm interested to know what you're looking at in that review and when that review will be completed.

MARIA FLYNN: With regard to their experience of skin to skin—it was mentioned earlier. We're always reviewing the intervention rates—and Andy might want to come in there—around the feedback we heard around the experiences of babies being separated from mothers that have had caesarean birth. We'll look into that, around how that can be facilitated in a more appropriate way.

MARGOT MAINS: Also, we're in the process of reviewing our policies as well that influence inductions and caesareans.

The Hon. NATASHA MACLAREN-JONES: That's around skin to skin?

MARGOT MAINS: Some of it, but it's broader as well.

MARIA FLYNN: Also what constitutes the requirement.

ANDREW WOODS: I think in relation to interventions and the impact that has, acknowledging that intervention rates are rising across New South Wales, Australia and internationally, I come back to the data that allows us to provide a local context onto the figures that you see when you report the data, further informing the work we're doing to ensure that intervention rates are correct—whatever correct might be—and ensure that interventions are recommended at the right time, for the right reasons, and to support that women have the necessary comprehensive information to allow them to make informed decisions and the time to make those decisions, and, should they choose to ask if there are alternatives to the recommendations made, to support women down alternative pathways of care, to support their wishes and choices.

The Hon. NATASHA MACLAREN-JONES: Following up from my colleague's question about the demographics, you mentioned that 12 per cent of women in the area are from a First Nations background and that there's work done on birth on country. I just want to know the statistics around the number of women that are having their babies on country.

MARGOT MAINS: The Birthing on Country has been established by Waminda as the process at the moment and the first step is we've been working together to enable access agreements to get Waminda midwives into the birthing and the units there. The second phase will be about developing their own birthing unit and that has got the support moving forward.

The Hon. NATASHA MACLAREN-JONES: What's the time frame for that?

MARGOT MAINS: Currently, the access is happening now, in terms of midwives being able to come in and actually deliver. But I'll need to ask Waminda to give that information.

MARIA FLYNN: At the moment we're supporting the Waminda midwives to become endorsed. Fiona's helping them with the education point of view, but some of them aren't endorsed for birthing yet. They're coming to Shoalhaven to be able to care for women so they become endorsed to provide. The other thing is we're really excited that we've got our first Aboriginal cadet midwife at Shoalhaven, and actually we have a higher number of Aboriginal cadets from nursing in the district than some others as well. We're really focusing on that strategic plan to try and increase the workforce.

The Hon. NATASHA MACLAREN-JONES: That brings me to my next question, which is the number of midwives that you currently have in the district and, I suppose, the percentage that are CALD background or are Aboriginal as well. You might need to take that on notice.

MARIA FLYNN: I know the total number. I think we might need to take that on notice.

The Hon. NATASHA MACLAREN-JONES: If possible, could you also take on notice, looking at the budget, how much is allocated to employment of midwives within the overall budget of the midwifery services as well?

MARGOT MAINS: Of course.

The Hon. NATASHA MACLAREN-JONES: The other question is whether or not you have capacity to expand. In an ideal world where we have lots of people that want to work in midwifery, do you have that capacity to take on more midwives in the district?

MARGOT MAINS: We certainly do in terms of our vacancy rate, definitely.

The Hon. NATASHA MACLAREN-JONES: What's your current vacancy rate?

MARIA FLYNN: We're in a much better place than we have been—I knew you'd ask that question. Over the last few years it's ranged between 10 per cent and 18 per cent, but we're actually at 8 per cent to 11 per cent at the moment. We do have to, sometimes, keep some of those placements for the students that would come in because we've got to protect those places to offer those to students, so we've got some MidStarts and B-Mid programs starting. Some of those are being held for some of those rates as well.

The other thing I'd like to mention is we've been working with the universities. The State brings the deans together to see what we need to do for education and what needs to be in the curriculum. Trauma-informed care, if we advocate for that in the curriculum, might be a really good place to start. We also know that a lot of nurses and midwives leave within the first three years of practice, so being able to support each other in trauma-informed care would be really helpful. We don't have a local midwifery program but, certainly, we've spoken to the university and there's a plan to try and host. Not all establishments can host, because the numbers are smaller for midwives, but there's the ability to be able to rotate from another university and host them at the University of Wollongong.

The Hon. NATASHA MACLAREN-JONES: That brings me to my final question, about staff training. What support is provided to staff, particularly following something like a stillbirth?

MARIA FLYNN: We have our EAP, so we have the support. We also have quite a lot of wellbeing programs. People talk about the "hot" debrief—the debrief that happens immediately following the event—and then a "cold" debrief. The Mentorship in Midwifery program is obviously supporting the midwives with supervision but also mentorship, so that they can support each other locally. With regard to obstetrics, obviously they get involved in the hot and cold debriefs. Andy, I don't know if you'd want to say anything else?

MARGOT MAINS: I think there's a couple of other programs. We've also been running a maternity program called SEED, which we established at the time of the Milton bushfires. It was a program that was generated by putting support into the organisation to identify what those staff needed to be—because they were continuing to work and often they'd lost homes or whatever. That has also gone into the maternity services, and to evolve the program—it is about wellbeing and it's about things that help team development and culture development. We are also working on other areas of team and culture development as well.[1]

Dr AMANDA COHN: Ms Flynn, regarding the hot and cold debrief process for your staff, is protected time provided for that or is this happening on lunch breaks and after work?

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[1] Correspondence from Ms Margot Mains, Chief Executive, Illawarra Shoalhaven Local Health District providing transcript clarification on 24 November 2023.

CORRECTED

MARIA FLYNN: It really needs to happen following the event. People will do it as quickly as is practicably safe. It slightly depends on what the debrief is requiring and where it needs to be. They'll do it as soon as they possibly can. There are handovers in shifts—they endeavour to do it in the handover times—but it's a risk-based approach on what they can accommodate. You don't have the ability to backfill people because you don't know when the debrief will be required, so you can't timetable or roster it. You have to manage it as best you can. Sometimes services will put on a particular staff meeting to say, "We're going to have a debrief tomorrow," and people will be facilitated to try and be freed up for that. But that is a real challenge with regard to being able to protect time for whenever it might occur. It could happen at 3.00 a.m.

Dr AMANDA COHN: I ask because it was raised at our hearing on Monday by the NSW Nurses and Midwives' Association. There was an appreciation that most departments are supporting debriefs to happen but that it's not on protected time. That means that people either get called away from it or they're spending overtime at work to be able to debrief, which is not ideal.

The CHAIR: Thank you for attending this hearing today. We appreciate your time. Committee members may have additional questions, which the secretariat will send to you, and I know that you've taken some questions on notice. We have resolved that the answers to those questions be returned within 21 days. The secretariat will be in contact regarding those. Thank you again for attending, and thank you to all of our witnesses today. I also thank everybody who has come here today to join us. That concludes day two of the inquiry into birth trauma.

(The witnesses withdrew.)

The Committee adjourned at 16:20.