REPORT ON PROCEEDINGS BEFORE

SELECT COMMITTEE ON BIRTH TRAUMA

INQUIRY INTO BIRTH TRAUMA

CORRECTED

At Wagga RSL Club, Wagga Wagga on Tuesday 12 December 2023

The Committee met at 9:10 am

PRESENT

The Hon. Emma Hurst (Chair)

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

PRESENT VIA VIDEOCONFERENCE

The Hon. Anthony D'Adam

The CHAIR: Welcome to the fourth hearing of the Committee's inquiry into birth trauma. I acknowledge the Wiradjuri people, the traditional custodians of 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.

I ask everyone in the room to turn their mobile phones to silent. 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. Parliamentary privilege applies to witnesses in relation to the evidence they give today. However, it does not apply to what witnesses say outside of their evidence at the hearing. I urge witnesses to be careful about making comments to the media or to others after completing their evidence. In addition, the Legislative Council has adopted rules to provide procedural fairness for inquiry participants. I encourage Committee members and witnesses to be mindful of these procedures.

Ms LAURA JOHNSTON, Individual, affirmed and examined

Ms CARMEL BIDDLE, Individual, sworn and examined

The CHAIR: Welcome to both of you and thank you for giving your time to give evidence here today. 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. Mrs Biddle, do you have an opening statement that you would like to give?

CARMEL BIDDLE: I do, yes. I have had eight births, six of those in New South Wales hospitals. I am well acquainted with what bad and good maternity care can look like. My submission focused on three of those births: the first, in which after birthing I was injected without my consent and treated as though I had no idea how to care for my baby; and the second, which was a twin birth, when during labour I was forced to argue with the obstetrician instead of concentrating on birthing my children and giving them the safe, natural twin birth I knew my body was capable of.

My experience of birth trauma centres on the lack of empathy and understanding displayed by health professionals in the maternity field towards the woman in their care and the power imbalance that occurs in that very first antenatal appointment, where they tell you how you will birth your baby. At every single appointment for my twins, I had to restate my case for a natural labour and an unassisted birth. I was laughed at, told it just didn't happen that way, told I wouldn't be able to cope with the pain, and even on the day I arrived in labour I was asked why I hadn't turned up for my scheduled induction—an appointment I repeatedly told them that I didn't want made but I was just ignored.

The fact that I had had five children already made no difference to the way I was generally disrespected in 90 per cent of my appointments. The lack of trust in the mother to make her own birthing choices about her own body and her capability to bring her own children safely into the world is the root cause, I believe, of many of the problems and incidents occurring in New South Wales maternity wards. I would like to add that I recently celebrated the birth of my eighth child and there has been some real positive change, which proves that changing the culture around the treatment of mothers before and during the birth is definitely possible. However, there were options not available to me, which I believe it is the responsibility of the health department to make available to all mums, the most important one being to allow midwives to be on call to mothers who want a homebirth. This, I believe, would be a huge step forward for New South Wales maternity care.

LAURA JOHNSTON: I'd like to start by acknowledging that there are really incredible, dedicated and supportive health professionals, midwives and allied health et cetera. I hope this inquiry leads to more support and resources for those who we rely on to give the best care available for women. Going into my birth I felt I was educated. I'd done the hospital courses online, lots of reading. I was flexible going into birth. I knew my preferences, but I also knew that I had to be very flexible. I knew the risks and the benefits. However, the system did not allow me to enact my autonomy, my knowledge, let alone my preferences. I was continually dismissed, ignored and coerced during labour by staff. I was coerced into accepting an intervention—morphine—that I'd repeatedly said no to for three hours. Over 12 hours the poor care and refusal of staff to listen to me, to believe me when I said I was in active labour led to a cascade of interventions and the baby born with a low heart rate. I was also administered Syntocinon, had a vacuum used, given an episiotomy and had forceps used all without any attempt to gain any consent. The OB said to me, "I'm giving you an episiotomy now", as I was being cut.

The birth was clearly traumatic to me, but it's the way I was treated during the labour that really sticks with me—this is two years later. Some months after the birth, I again felt dismissed when I was raising my concerns and complaints to management. There was some validation that my treatment had been fairly sub par and I had been dismissed and coerced, and there was acknowledgment that there had been a serious breach of practice in my care. However, there was a refusal to talk to individual staff, to take seriously the lack of women-centred care. I felt, frankly, some comments made to me by management were just shocking. The complaint process left me feeling like the issues are systemic and so prevalent that they're now cultural.

The personal cost of birth trauma to me has been significant. I've struggled with postnatal depression, which I believe my birth trauma has been a factor for, to the point that I've had a couple of months off work this year. I feel really lucky and privileged that I was able to afford to do this, and that I've been financially able to afford private psychologists and women's health physio. I know that's a privilege not many can afford. I do believe in my case that continuity of care with a midwife would have made a huge difference to my experience. Women have no real choice in birth provider. No private midwives practise here. Despite the evidence for this model of care, the hospital having talked about it for a really long time—for years—there's no midwifery continuity of care or midwifery group practice in Wagga.

The CHAIR: Thank you both for coming here today and for your bravery and strength in coming forward to speak up. As a Committee, we really appreciate it. Even though this feels like a really formal and strange set-up, this is going to be more of a casual chat, even though it does feel like we're miles away from each other. The process now is that we're going to ask some questions. If you don't feel comfortable with any of the questions, feel free to let us know. We'll move between ourselves asking different questions about your opening statements but also your submissions, which we've read. I'll start with a question to you, Ms Johnston. In your opening statement, you talked about the complaints process and the problems you had there and that it led you to feel that it was systemic. Can you give a bit more detail about the complaints process and the problems there, and also if you've got any advice on what you would have hoped to have seen from that complaints process?

LAURA JOHNSTON: I contacted the hospital; I think it was almost eight months after the birth. I hadn't received any follow-up from them in the meantime, despite it being an obviously traumatic birth and my child ended up in special care. I think, even at that point, some offering of a debrief or support services or further things would've been important. Then I had a birth debrief—people at the maternity ward—and I think a debrief is a stretch because they obviously hadn't read my notes or anything. It was a conversation. When I was followed up on the phone later, when they rang back to talk through some of the things I've raised once they'd read my notes, it was very—I felt like in the same breath there was an admission that actually some of the things that'd happened had been worse than I thought. There were some significant breaches. But in the same breath it was like, "But we're not going to do anything about it." There's no point talking to the individual staff. The response was, "We'll resend the memo to all staff." And I think we all know what we do with those emails.

The week before, I'd been there, kind of crying and talking about what the experience was like for me and seeing the interventions my baby received after the birth. I was really shocked with some of the comments that were made to me in that phone call about, "Well, you know, if it had gone really wrong, it's fine, we can fix it. We just would've needed a little injection, and everything would have been fine."

It was not a very trauma-informed attitude at all. I felt like my main concerns about the lack of women-centred care weren't taken seriously at all. There was, like I said, a refusal to talk to the individual staff, which I don't understand because that's not going to make the next woman's experience any better or make them less likely to make similar mistakes. I just felt, again, quite dismissed.

The CHAIR: As part of this inquiry we're able to make a wide range of recommendations to the Government. To both of you, what sort of recommendations would you really like to see in that report? I might start with Mrs Biddle.

CARMEL BIDDLE: That's a really big question. There's a lot of recommendations, or a lot of things that I think need to change. Definitely the complaint process—I also put in an official complaint after the first birth in my submission. You just get fobbed off, really. The biggest thing that I would like to see improve here in the Riverina is there needs to be an option for homebirth. We currently have no midwives here. There's a midwife who comes from Goulburn, but I personally have four friends in my small group of friends who have had homebirths. It's not safe, because the midwife can't come in time for the birth and Wagga doesn't even know about it.

There should be a midwife supplied by our local hospital for those women who want to birth at home. I don't know what that would look like practically. Maybe it's because their first child they birthed in the local hospital and it was very traumatic so now they want a birth at home, but there are many mothers who want that option—who see birth as a natural process, not a highly medicated process—and it isn't here. There should be that option here. That's probably the number one recommendation that I would really like to see put before the Government and something, hopefully, to come of it.

The CHAIR: Ms Johnston, did you have anything to add?

LAURA JOHNSTON: Yes, lots of things! I do agree with that—more access to different models of care, including homebirth; to make private midwives more financially accessible through Medicare. I think it's really simple that we just need evidence-based care in our maternity system. The evidence is there—the decrease in birth trauma for having a continuity of care model, for empowering midwives to help women. I think it's really quite simply just listening to women and following normal practices around informed consent, which I feel like—and from other people I've talked to—as soon as we're in a maternity ward, it just goes out the window. We would expect that in other areas of medicine. Bringing it back to birth being a normal process that only needs intervention when required, not going in with an assumption that an intervention will be needed.

Dr AMANDA COHN: I have a question that follows on from your question, Chair. You would probably know that we've been doing this inquiry for months now. I have lost count of the number of stories from people who have told us that the complaints and debrief and follow-up process has actually made things worse or been

re-traumatising. I was really interested in your submission, Mrs Biddle, that you talked about receiving an apology after the birth of your twins; you used the word "healing" to describe that. I was wondering if you could tell us in more detail what that interaction was like to help us understand what a good follow-up process is like.

CARMEL BIDDLE: That made a huge difference. I would have put in a formal complaint after my twins' birth if I hadn't received that apology. To explain that birth a little more, I went in with the twins. They were already on the back foot because I hadn't turned up for my apparently scheduled induction appointment, which I never wanted and had never actually booked in. I also had a birth plan where I very clearly said, "I'm having these babies naturally. If there are problems, I'm happy to go with whatever needs to be done, but I don't want to talk to the obstetrician unless it's necessary—unless there's a problem. Me and the midwives will birth the babies."

I went in—I was already in active labour. They didn't think I was, which is always the case. I started having my baby. I called them in and said, "The first baby's being born now." The obstetrician just stood in the doorway and was like, "She needs to be on the bed. We need to be monitoring the second baby. We can't see what's going on", telling my husband to get me off the floor. The only reason I was able to sit there and argue with him while the baby was literally crowning was because the midwife was supporting me. I presume she got told off afterwards, but she was on the one hand saying, "Yes, doctor, I'll get her to", and on the other hand saying to me, "Carry on, you're doing great. Stay where you are." That midwife made all the difference in that birth. As soon as I'd had the baby it was like, "Okay, come on, we've got to get the second baby out. Move, move, move." Again, I had to argue through all of that.

After the birth—about four hours afterwards—he came back and explained that it was literally the first time. He was quite an older obstetrician—I'm sure he'd seen many twins' births—but it was literally the first time he'd ever seen a mother-led twin birth, a natural twin delivery with literally no interventions. He felt out of his depth and he was sorry that he didn't trust me; I looked very young. It was an honest apology and it just made a huge difference. For me to understand that he was out of his depth and he was unsure himself—and that's why he was trying to get me up on the bed and all that kind of thing and get all the monitors in place—it just helped me see that he was a doctor out of his depth. It was all new to him, having a mother telling him how she was having her twins, so I didn't put in a formal complaint. I felt that closed the case and, yes, I could understand why he acted the way he did.

Dr AMANDA COHN: I have one more question. Mrs Johnston, in your submission you talked about the really great experience you had with physiotherapists. I was hoping you could expand a bit more on the kind of care you received and how you had to go through accessing that. We've heard a lot of evidence from midwives, GPs and obstetricians and not as much about physiotherapy. I'd be interested in exploring that.

LAURA JOHNSTON: Because I had some chronic pain during my pregnancy, I was engaged through my GP with a women's health physio at, I think, what was a significant cost—$100-plus an appointment. After birth, I'd already booked in with her to be seen. I did have a post-birth injury, likely from the forceps. She was really fantastic; all my friends who have seen physios have said the same thing. It is a matter of being able to afford it but also to know that they're even there. At no stage after birth or through the pregnancy care clinic at the hospital had anyone talked about a women's health physio at all.

I think it should be something that all women have access to. It took a massive toll on the body. Even in the best circumstances, there's likely to be an impact for women's bodies. I believe we don't know enough about it to know, not seeing a physio, what the effects might be much later on in life and the prevalence of birth injuries and that kind of thing, because not a lot of women can access the service. The physio provided me a lot of education pre- and post-birth. It was incredibly helpful. It helped with pain and functional issues. I saw her sometimes weekly, fortnightly, monthly for quite a long time.

Dr AMANDA COHN: One quick follow-up: I suspect the answer is fairly obvious, but can you just clarify for the record that it wasn't possible for you to see a physio through the public system or at a lower cost?

LAURA JOHNSTON: No, it was definitely something that was never offered or mentioned. My understanding is that people who have a 3C tear, for example, might get some physio follow-up. There are certain criteria that people might be able to access through the hospital, but the waiting lists are huge. People aren't seen in a timely manner and it's very limited, at least at the hospital I birthed at.

CARMEL BIDDLE: Just to follow on from that, I was never offered any kind of physio. I had a third-degree tear with one of the babies and they just don't tell you that there is an option. Unless you go searching for it—and it is very financially difficult to cover—you're not going to end up getting that care that you need. Many births, I think, people would need physio afterwards, but it's not available and it's too expensive.

The Hon. SUSAN CARTER: Thank you both for being here. If I may, Mrs Biddle, congratulations on the birth of your most recent child. You've said that you've noticed some changes. I wonder if you could talk about the changes, especially as it might inform recommendations we may want to make.

CARMEL BIDDLE: Not so much for the obstetricians. I'm sure they've done some PD, but I didn't notice too much change there. But amongst the midwives I noticed it was much more consistent care. All of the midwives seemed on board. They asked me before anything. If they were going to touch my stomach to feel where the baby was, they actually asked, which is really nice. They don't have to, but they did. And they never did before. So it's just simple things like that. They asked, "Do you want to be weighed?" Instead of, "Go get on the scales." It's just little things but it made such a difference because, unlike previously, if I met a great midwife, it was like, "Well, great, you're probably not going to be there for the birth." This way, I was very confident that it doesn't matter who's there. They're all listening to me and they're all respecting me.

I felt I was checked with everything. They actually went through the birth plan with me. They actually have a whole new form that they give parents now at Wagga for you to fill out your whole birth plan, which they didn't have before. You had to bring in your own at labour, but they didn't have it before. It's just little things like that that just made a huge difference. You came away from those antenatal appointments feeling really confident that the midwives were actually going to help you to have the birth that you wanted, rather than coming away feeling pretty down and unsure of yourself because they didn't agree with what you had said or whatever. So it was a big improvement.

The Hon. SUSAN CARTER: Did the antenatal changes follow through to your experience of giving birth?

CARMEL BIDDLE: Yes. I was actually really pleasantly surprised. When I came in for that birth, the midwife just said, "There's the button. Call me when you need me. But, if you want to have your baby here in the room all by yourself, you can." That was amazing because I'd never been approached that way with birth. She told me where everything was and she said, "We'll be outside and ready if you need us." And I did need them and it was great, instead of being told "do this, do that". Even with previous births, the fact that they are there in the room waiting for you to have the baby can be very stressful. You're in labour and its progressing as it will progress in its own time and you have two people tapping their foot. So it's little things like that that make all the difference.

The Hon. SUSAN CARTER: You are obviously a very experienced mother. Do you think their attitude was because they knew that you were very experienced at giving birth or do you think it's been a change in approach to all mothers?

CARMEL BIDDLE: No. I think they've done some PD or something to change. I've never noticed that anyone pays any attention when you say you've had X amount of babies before. Every birth is different. This birth was very different to my other births; it was really long and the others were short. I think they kind of discount all that, really, in general. Not that I specifically noticed it this time, but I got the feeling that everyone had been spoken to and they were just changing the whole way they did things. I felt very well supported this time around.

The Hon. SUSAN CARTER: Ms Johnston, do you think if you'd been approached like that it would have changed your antenatal and birth experience?

LAURA JOHNSTON: Yes, completely. If I had been given any respect to have some bodily autonomy and had been asked what I wanted and had those wishes respected the first time—they are really quite simple things. To feel like I was being supported and not told what to do would have made the world of difference.

The Hon. SARAH MITCHELL: Firstly, thank you both for coming and for sharing today. It would be fairly daunting to have a bunch of politicians that you've never met asking you questions about the birth trauma that you've been through. Thank you for being so open and honest because it really does help us with the deliberations that we will be having as a committee. My question kind of picks up on something you said, Mrs Biddle, but I think you both talked in your submissions about that continuity of care. I know, Mrs Biddle, that you said that you had to repeat to multiple midwives and doctors your birth plan throughout.

One question is what are your views on how you can improve that continuity of care? We've heard in other hearings about having a relationship with a couple of midwives or one doctor that you've got that implicit trust to understand what your wishes are, but obviously there can be workforce challenges with that. I was interested when you just said then that when everyone was following the same mode—whether it's policy—or how they were with you, regardless of the midwife, that gave you that consistency that you needed, as opposed to it necessarily being the same person. When we talk about continuity of care, do you think it's the individuals that matter or the overarching policy of the hospital and how they treat birthing women?

CARMEL BIDDLE: I don't want to slam the continuity of care model. I think it can be great. But I think it'd be much better if there's just consistency of care across the hospital. I've had continuity of care in other States and what happens—which is what happened with me—is that you then get to the labour and that midwife is not there. If you've changed the culture of your whole hospital and the way it deals with women and the midwives and the obstetricians are on board with that, it shouldn't matter if it's the same midwife or not because they are all going to actually read your notes before the appointment and they are all there to support women, not to tell them how to have the baby.

I think, for me, I did have the continuity of care model but there was always that risk that that midwife wasn't going to be there. I thought what happened with my last baby, where all the midwives were on board, was probably better and a little bit easier for the hospital to manage as well. It can be a really good model, but I think a better model is where you just have all of your midwives properly trained to deal with women and your obstetrician is also on board. I did find with my last birth that the midwives and everything had obviously done a little bit more PD. They had changed their views a little bit and things and it was great, but that hadn't filtered through to the obstetricians. I did think that that was a problem. But, yes, the continuity of care model is still good though. I think it can be a really good option if retraining your entire staff is not possible.

The Hon. SARAH MITCHELL: Did you want to add something, Ms Johnston?

LAURA JOHNSTON: Yes. Can I just add that, ideally, women would have a choice of which model of care. For some women, continuity of care might be really important—with a team of midwives, for example. There are also a lot of women who might be okay having different midwives as long as they were consistent, like Carmel said. I think that is really important. Some women are really happy with obstetrician-led care. I think it's about women actually having a genuine choice in their model of care.

I just wanted to add too that I did have shared care with the GP, which I think is considered a continuity of care model because I had that GP consistently. I would in no way think that that was a continuity of care. I saw different midwives at the hospital every time I went. No-one ever discussed a birth plan with me. A lot of things were probably missed. There was a rush to get through appointments and that kind of thing. And then, with my GP, things that were very concerning to my GP the hospital didn't even register on their radar. They were like, "No, that doesn't matter." And the opposite happened as well. Things that my GP was like, "Oh, that's fine", the hospital was really concerned about. So they weren't even on the same page and that really added to confusion for me.

The Hon. SARAH MITCHELL: Yes, especially as a first time mum.

LAURA JOHNSTON: Yes, and I was trying to advocate for things but what the doctors saw as important didn't meet thresholds for the hospital. I was like "What do I advocate for?" There seemed to be a complete lack of communication between the two.

CARMEL BIDDLE: Just to follow on, I did actually also have that model with the last baby, the shared care thing, and it totally doesn't work. It's exactly as Laura said. That doesn't work. The GP—I don't think—didn't know enough about birth or maybe about the services at the hospital. The connection between the hospital and the GP clinic was bad and they didn't send the same staff. So that's not an answer anyway.

LAURA JOHNSTON: I feel like you're a bit passed along like "We'll just make that the other person's problem."

The Hon. SARAH MITCHELL: Can I also ask, Mrs Biddle—and, again, I only want you to share what you are comfortable with—obviously from your submission I take it that you live outside of Wagga. I live in a country town too and a lot of people will go to their major regional centre for some of these services if there are complications and the like, so I'm certainly very well aware that that happens. But you were talking about not even having the chance to have a clinic or anything where you live so, presumably, you had to travel into Wagga for that. How was that experience and what would you advocate for in terms of those women who live regionally but maybe not in that major regional centre?

CARMEL BIDDLE: I only live half an hour outside Wagga but it's a real problem because, in my case, I have a number of small children. I can't necessarily afford babysitting when you don't know how long you are going to be waiting at the hospital for. So for every single appointment I have to allocate about three hours to come in, to wait around, to eventually get seen and to drive back. Particularly with my last baby, it got to the point where I just couldn't make appointments. It just didn't happen. That wasn't safe. It was only because I'd already had eight kids that I knew what was going on. If I was a first time mum, it's not a safe way to go through your first pregnancy. I just had to miss the appointments because it was too expensive to find a way to get care for the kids and wait around.

Being only half an hour outside Wagga, there should be something in place where a midwife comes out to where I am once a fortnight and has a day where she sees all the babies in the town and all the mums in the town who are pregnant. It shouldn't be a hard thing to organise, and it would make so much difference to the mums in that town. They wouldn't have to drive in. It's very difficult. I don't think there's an understanding of how difficult that is, when you're there, you're waiting and you're looking at the clock. For those mums who work, they're taking time off work. For those who have babysitters, every half hour is another—and there's a lot of appointments you're supposed to make. I think that would be a pretty simple thing to put in place—that in the outlying towns of Wagga, on a certain day, a midwife is there and sees the local pregnant ladies. It shouldn't be difficult, but it would make a huge difference.

The Hon. EMILY SUVAAL: Thanks so much to both of you for making the time to be here today and for your submissions to the inquiry. I wanted to ask you some questions around maternity care in particular. We've heard a number of different things in this inquiry about maternity care in terms of making sure the care is respectful. What actions do you think need to occur to ensure that maternity care is respectful? I note that you've given a really good example, Mrs Biddle, about respectful maternity care that you received.

CARMEL BIDDLE: I'll let you take this one.

LAURA JOHNSTON: It's going back to basic principles of informed consent. It's just respect—listening to women and believing them, supporting them in their decisions and talking about the risks and benefits of everything. I was told I had to have an induction. Never once did anyone mention any of the risks with having an induction. We know there are risks and benefits. Even being really up-front and clear around what is policy and the reasons why some things are denied, as opposed to just leaving people feeling like they're not being understood or heard, and an awareness of people who have had traumatic births being supported post-birth as well—I had whole shifts where I didn't see a midwife at all, only on the handover points. I think there was also some really non-trauma-informed things that were said to me without any understanding that I had had a traumatic birth. There were some pretty bad attitudes—pretty dismissive. I was going to say something else. It's really just basic respect and a belief in a woman's ability to birth and that she does know her own body.

The Hon. EMILY SUVAAL: Do you have suggestions around what we could do to better ensure that occurs, recognising that we've heard in other inquiries about the fact that health professionals, for the large part, don't go to work intending to do harm? What sort of actions and measures can we take to ensure that respectful maternity care is provided?

LAURA JOHNSTON: Do you have anything?

CARMEL BIDDLE: I think a birth plan—actually giving mothers a form and saying, "Fill out your birth plan. Bring it in at the next appointment and we'll have a discussion about it." That was a new thing, and I thought it was really good. It's really a cultural thing. It's changing the way they even view the mother. One thing that was quite obvious to me in a couple of the births was that the goal for the health professionals seems to be a healthy baby. You get a healthy baby out of this. It should be a healthy and happy mum and baby. Some of the options that are given to you—for example, in my last birth, I was talking to one of the obstetricians. Straight up, he was like, "Do you want a caesar for this one?" I was like, "Why on earth am I having a caesar? I'm not high risk. There's nothing wrong." It was just sort of, "Well, you've had a lot of births and you could haemorrhage." There's all these risks going on with caesars as well.

With my twins, there was an obstetrician I refused to see. Unfortunately, she ended up being there for the birth as well. After seeing her two times, I didn't want to see her again. For the second twin, she was like, "When you have twins, the second baby needs to be extracted." I went, "What the heck is extraction?" She said, "We stick our arm up inside you and pull the baby out." I was completely horrified, and she was talking about this like it's like having a cup of tea. For me, talking about a woman's body that way is really bad. As you say, she never went into work attempting to be offending in any way, but it was totally fine for her to suggest it to me like it was like having a cup of tea. I was horrified and was like, "No way am I doing that." Eventually I stopped seeing her because she kept saying, "That's just what happens with twins; the second baby needs to be extracted for the baby's safety." That's not evidence based. It doesn't need to be extracted. I think that it's a cultural thing. There needs to be a bit more focus on the mother. We all want healthy babies as well, but there are two patients. It's not just one patient. There are two patients, and a healthy, happy mother after the birth should also be a main goal.

LAURA JOHNSTON: I agree. There isn't a mother that doesn't want her baby to come out safely and healthily. There should be people there also supporting the mother to make sure that she's also healthy and safe. It did absolutely feel like I wasn't even in the room. There was a lack of information as to what was happening, for both me and my partner. That's really important as well. And ongoing consent—as things change in birth, consent needs to be rechecked.

The CHAIR: We did start a couple of minutes late, so is it all right with you guys if we go over a couple of minutes? Thank you.

The Hon. MARK BANASIAK: Thank you for appearing. Both of you spoke about problems with the shared GP-midwife model. If we were to make some recommendations about improving that as a model of care, what do you think those recommendations would look like? I think both of you spoke about the lack of communication between the midwife and the GP. Would mandating some joint case conferences or joint case meetings assist in that?

CARMEL BIDDLE: To be honest, I think it's a bit impossible to make that work, just because the GP is a GP; they're not an obstetrician. They're not quite as clued up about how maternity care works and all of that kind of thing. The midwives, on the other hand, have all the stuff that they're doing. It seemed to me an extra lot of work when you could've just—it's the same amount of work just to have a shared care system at the hospital with the same midwife. I can't think of any way that that system would actually work—the shared care with the GP. I just don't think it's working.

LAURA JOHNSTON: My only recommendation would be that the GPs that are engaging in the shared care are very aware of the hospital policies and the hospital's risk points and things so that they're actually on the same page. Potentially, it works better with GP obstetricians who also work at the hospital or have a history of working at the hospital and would be really aware of how those systems work. Case conferences might be ideal, but it's probably a little bit unrealistic with stretched resources. There probably has to be a way to make that model work better for people who live out of the main centres that is a way for them to access care in their own town. One thing I did like about seeing the GP was I felt like they had a holistic approach. It wasn't just focused on the baby and the growth of the baby but more broadly around the general health of the mother and mental health and that kind of thing. There are elements of the shared care model that are probably worth keeping, but they need to be on the same page.

The CHAIR: Thank you, both, so much for coming in today. We really appreciate you coming forward and sharing so openly and honestly with us. It will go towards helping us put this report together and make recommendations, so we really appreciate everything. We appreciate that you've come here today and your bravery in coming and sharing something so personal. If we have any further questions, the secretariat will be in contact with both of you. Thank you again. We really appreciate it.

(The witnesses withdrew.)

Mrs FRANCESCA MALE, Individual, sworn and examined

Mrs BELINDA ALEXANDER, Individual, affirmed and examined

Miss STEPHANIE POLL, Individual, sworn and examined

The CHAIR: I now welcome our next witnesses. Thank you all for being here today and giving us your time. 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 you have opening statements?

FRANCESCA MALE: Yes. I speak today on behalf of myself and my husband, Evan, with whom I welcomed my daughter in March 2023. What was meant to be the happiest moment of our lives ended up being a traumatic experience due to many factors. However, today I will only speak on the most impactful. This statement is not to discount the amazing support we received from the many midwives who attended us. We opted for shared care between our GP and hospital. We received amazing support from our women's health clinic, which identified our daughter's reduced growth rate at 30 weeks. Due to this I was admitted to the hospital's complex care program but was disappointed in the lack of continuity of care as well as a lack of consideration for the plans developed by our GP obstetrician.

At each hospital visit I saw a different doctor. One doctor advised induction at 39 weeks. The next week it was moved forward to 37 weeks. When I questioned this change I was told that there was concern of potential fetal demise despite no reported changes in my ultrasound findings. The lack of inter-clinic communication, collaboration and individualisation of our plan left us worried and confused. Our induction was underpinned by more disagreement between hospital staff, which occurred right in front of us and left us feeling doubtful. We were left alone to labour as staff argued around my CTG monitor. Ultimately we were rushed to theatre for a caesarean. I raised concerns surrounding my spinal block, due to my scoliosis, directly to my anaesthetist and was brushed off. The resident was allowed to attempt my spinal block without my consent. The initial placement was incorrect and resulted in severe pain, but I was told that the second placement was textbook. However, when I could still feel both the ice test and the towel clamps, my concerns were dismissed twice and the surgeon was given the go-ahead.

I will never forget the pain and fear I felt in the minutes that followed. I was crying out but was dismissed for a third time, told that feeling pressure was normal and offered gas. My husband was stunned, unable to advocate for me. When I was still vocalising from pain, I was given a general anaesthetic. My husband was escorted out and made to wait alone with no idea what was happening. I was well informed of the failure rates for spinal blocks. Requiring a general anaesthetic, whilst unfavourable, is not what led to our trauma. It is the fact that I was not believed that I was in pain, and this led to fear, unnecessary pain and distrust. As a veterinarian, with the inability to verbally communicate with my patients, it's hard to fathom the dismissal of this direct communication. I also know that unfortunate mistakes can happen; however, the lack of accountability by the hospital has made this a difficult experience for me to process. My daughter Charlotte was born with an Apgar of three, contributed to by the delays in surgery and the need for general anaesthesia. Waking up in recovery on my own and missing her birth were devastating but, soon after, Evan was required to leave the hospital as no private rooms were available—an unfortunate reality faced in our public hospitals.

The support I received from my appointed midwife that night was a godsend as I could not even get out of bed, let alone care for my baby on my own. Sharing my story, including with those in the profession, prompts the reply, "She's here safely and that's all that matters." Of course we are grateful to have Charlotte here and healthy. However, this does not diminish the trauma we experienced nor negate the necessity for improvement. A delayed initial bond with Charlotte, difficulty looking at my scar and flashbacks to the surgery are just some of the after-effects I have experienced. Evan has been equally affected, although in different ways. Initially I thought my anaesthetic experience was a freak accident; however, I now know of a friend who went through the same thing just three months prior at the same hospital. It absolutely horrifies me that this is happening to other people. My motivation for speaking today is simple: I do not want anyone else to experience what I have experienced. So thank you for allowing me the opportunity to speak and for your desire to incite change.

The CHAIR: Thank you so much for sharing that. Mrs Alexander?

BELINDA ALEXANDER: Thank you for giving me this opportunity to speak. As per my submission, I, like so many other first-time mothers, was induced. I was not educated in detail on what exactly this would include—namely, the medications used and how they would work or the risks associated with induction. I was told about the risks to my baby if I waited for spontaneous labour. My first birth ended in an emergency caesarean after a long labour with what felt like every medical intervention and analgesia available. It took me a long time

to process exactly what happened that day and the overwhelming disappointment that I did not get the natural, empowering birth that I envisioned.

After educating myself, I was very fortunate to have my second birth, going into spontaneous labour and delivering my girl with no medical assistance or intervention and only gas at the end. My third birth—I was extremely lucky to have an obstetrician on staff who involved my husband and I in the decision-making process. I had experienced heavy bleeding during labour and was literally on the operating table ready to have another caesarean when she, thankfully, assessed me and told me her opinion and asked my husband and I what we would like to do. She asked whether we would want to continue and have a caesar or try for another VBAC. It was a completely different experience to my first birth. Four hours later I had another successful intervention-free birth with the help of an amazing midwife.

Because of my caesar I was confined and restricted to what I could do during labour and the birth of my last two babies. This caused me a lot of frustration and disappointment, especially with the evidence and research available out there today. Due to the large number of inductions performed here in Australia, I believe women should be properly sat down and educated on what it involves and what it looks like to be induced—the risks. The cascade of interventions needs to be acknowledged so women have a better understanding of what they are consenting to when interventions are performed.

The CHAIR: Thank you very much. Ms Poll?

STEPHANIE POLL: I didn't write a statement this morning; I didn't know how to start. I am scared that my daughter is going to see this when she is older. I had my baby in the hospital. I had gone into labour and was five centimetres dilated. The midwife told me that there was nothing else that she could do. She couldn't find the landmarks. I didn't know what the landmarks were. So she sent me home. For five days I stayed at the size of a lemon—my cervix open, labouring. I was exhausted and I feared I was going to birth on the side of the road. I was then induced in the hospital and within seven minutes my daughter arrived. That's not the traumatic part though. The midwife grabbed my daughter, as I was bleeding heavily, and walked out of the room. About an hour went past and she returned—laughing that she had just given my baby to another woman. She had no tags on. She thought it was funny, that this other woman couldn't be the mother because she was clearly labouring still. But my daughter was in the arms of somebody else.

My daughter is older now and I still look at her and think, "I'm not sure. What if?" It could have been any family; it could have been given to anybody. And they just thought it was funny and they laughed in my face. The trauma doesn't stop there, though. You have to entrust your body to people. You have to entrust your children to people and nobody listens to you. All of that trauma doesn't stop. You then have to trust them when you send them to day care. You've got to trust that these people will look after them. The hospital couldn't look after me; they couldn't look after her. You've got to trust them at school. They're not trusted; they're not safe. Injuries are happening and then it's not reported. It doesn't matter; it's all brushed off. When is somebody going to listen to us and say that enough is enough? My girl is going to grow up and she's going to have to go through birth. She has a disability just like her sister and if they don't listen to her there is a really strong chance that both of them will die. I don't want my children to have children—not in Australia.

The CHAIR: Thank you all for those statements. Miss Poll, please don't feel that you have to share anything you don't feel comfortable with today. As we move into the next section where we ask questions, if there are any questions that any of you don't want to answer, please just let us know that you're not comfortable with that question and we can move on. I might begin with one question to all of you. As part of this inquiry, we will be making recommendations to the Government in regard to legislative changes or funding changes, and I just wanted to understand from all of you what you think are some of the top priorities. What would you really like to see in that report?

FRANCESCA MALE: I have a list just from our experience. I said that I'd like to present the following recommendations: more collaboration between practices and hospitals providing shared care services, particularly in complex cases. In my case I was sent in between my GP obstetrician and the hospital with a little yellow card. It mainly just had objective data, so just my temperature, my heart rate, my baby's heart rate, my fundal length. There wasn't actually any proper conveyance of important information, most importantly what the plan was for our birth. My GP obstetrician and the hospital had two completely conflicting ideas on what the plan for our birth should be, and essentially my husband and I were just left to decide what we thought was best. It's good to be able to make that decision but more guidance was definitely needed. We were left completely distraught at that time because we just felt the weight of the decision.

Other recommendations include further education on the appropriateness of conversations occurring in the delivery room and more effort to involve parents in the decisions surrounding their baby; and the inclusion of poor birth experiences, poor anaesthetic experiences and poor surgical experiences in morbidity and mortality

rounds at hospitals. There was certainly no acknowledgement of what happened to us at our hospital. Like I said, it was pretty much just, "Oh, well, she's here, and that's just what happened to get her here", which I don't think is appropriate.

Other recommendations include further education for maternity staff on identification of birth trauma and its effects on parents—we certainly weren't identified as a couple who had experienced a significant trauma—and routine post-birth mental health check-ins for parents followed by provision of further support if required. I think the support that we received to actually take care of Charlotte was fantastic, but I definitely felt like I was not treated as a patient and especially not my husband—he was not even considered. Our mental health was really something that if someone had asked us, "How are you feeling?" after the birth, we would have really gotten a lot out of that. We sought our own mental health support but it would have been really great—that was private and it did come at a cost. It would be really great if that was routinely offered in the public system.

BELINDA ALEXANDER: I feel like it's a hard one because it's all resource based. You need more staff that can have the time to be with you and education on both sides. I think first-time parents—I'm not sure the classes that are provided at the hospital are enough, especially if there are any kind of complex issues in your pregnancy or if you're looking like you're going to be induced. I feel like there are so many induction stories. People aren't prepared for what it involves, being induced—just education and time spent around that.

I feel like all the evidence out there is all about midwifery-led care. Having that person with you that you trust the whole way through, I had, like I said, a totally different experience with my third birth. The midwife was incredible and I only met her that day, but it makes a huge difference. My husband and I both noticed with our third—he was only born 12 weeks ago—that there was a big shift in the hospital. After the birth, they asked us how we thought it went and if we had any questions. There was a totally different feel compared to our first birth, so even that makes you feel like you're seen and what you feel matters. Just that shift of—I don't know what they've done up there—some education, I guess, as well.

STEPHANIE POLL: I just think that every patient—we don't want to be referred to as a textbook. We want you to actually read our notes. We want you to listen to us and what our body wants to do. If they had have listened to me when I said, "I'm five centimetres. Please don't send me home. Please help me." My previous two pregnancies, I had to have help to get my waters broken to produce naturally, and as soon as my waters were broken, seven minutes—that seven minutes could have been life or death. It's not just her health; it's my health. It's every parent's health. I don't want anyone to have to have a baby that's not tagged. I think there should be at least two people in that room: one that has eyes on that baby and one that has eyes on the mother at all times. Do not let that child go unless it is marked with who it belongs to. No mother should ever have a fear that that is not hers.

The CHAIR: I'm so sorry. I just want to personally say sorry that that ever happened to you. I can't imagine what that was like.

The Hon. EMILY SUVAAL: Thank you so much to you all for appearing today, for your submissions and for your opening statements. They're really valuable for this inquiry. My first question is around education that's provided to people. I note a couple of you have sort of canvassed the education or the gaps in the education that is provided. If we were to improve the education that's provided to women and families, do you have suggestions around what the best mode is for us to do that? Online, fact sheets, face to face.

STEPHANIE POLL: Everything is technology based. There should be an app where we can look at different options, open up pages of what a C-section could look like, what outcomes are different, the induction, what different inductions there are. You have to talk to other women. Some have had a stretch and sweep; some have had balloon. Women that are going in for their first time haven't heard those terms until it's actually happening, and sometimes they don't even get that choice. If you could see it all and it's all black and white with little diagrams, everyone reads different, everyone interprets the stuff differently but then at the end of the day we go to the hospital because we're entrusting people that have got that knowledge. If they could just be like, "Look, this is an app that is generated with a lot of information. There are quick little videos of what it could look like."

The Hon. EMILY SUVAAL: Do you have anything to add?

BELINDA ALEXANDER: That's a good idea, I think. I find that really hard as well. There are so many resources out there and people can go down a lot of different avenues. It's just so hard because you don't know what's happening until you're in that situation, sometimes. Yes, that's probably the easiest way to do it—have it as an online resource or something that's easily accessible for people. We get a lot of pamphlets and paperwork during our pregnancy clinic visits. There are always those standard ones that I think they are required to give us, but they're usually quite broad and not very specific. Maybe, once decisions are made during your pregnancy,

that's when they can home in on, "This is what you need to look into. This is what could happen." Maybe they just need those resources to tap into for women.

STEPHANIE POLL: The baby brain is really strong around then, too. I would have preferred to watch a video about how it was going to happen and listen to it rather than have to look at the booklet. Nobody is glowing at the end of the pregnancy. It's a lie. Just tell it as it is. It's going to be scary. Lay it out there, and let us dive in as deep as we want to go.

The Hon. EMILY SUVAAL: Did you have anything to add, Mrs Male?

FRANCESCA MALE: I was just going to say I think giving more time to explain things in depth—importantly, particularly at the hospital—would be really valuable. In comparison between the obstetrician I saw at the hospital and the anaesthetist I saw prior to the birth—a different anaesthetist—I had a really good one-on-one chat with one of the anaesthetists at the hospital. They ran through all the analgesic options available to me and all the risks associated with them. That's why I felt like I went in knowing what the percentage of failure rates for spinal blocks were and that sort of thing. I felt really well informed. But in terms of my induction, even though I felt equally informed, that information had come from me asking for that information and talking with my GP obstetrician, who I was very fortunate to have. None of that came from the doctor at the hospital who actually recommended the induction. I think at the time that recommendation was made, there needed to be a thorough discussion as to what was going to occur.

The Hon. EMILY SUVAAL: Which leads to my next question around the timing of it and striking a balance between providing too much or not enough. Would it be your suggestion that sufficient time, if possible, is allowed to give that education when it's needed or in advance?

FRANCESCA MALE: Yes. I think you're right: It is a fine line, because you can leave those appointments feeling quite overwhelmed, particularly if you have gone on your own. My husband is always a lot better at asking questions than I am, but it needed to have been addressed before I was admitted into the hospital to have the induction.

The Hon. EMILY SUVAAL: Thanks. Did any of you have anything to add? My next question is to you, Mrs Alexander. I was really pleased, and also quite amazed, to hear that you've given birth some 12 weeks ago. Congratulations. I think it's extraordinary that you're here. As someone who has two young children, I struggled to make it out of the house for about the first four months, with both of them, so well done.

BELINDA ALEXANDER: Thank you.

The Hon. EMILY SUVAAL: I think you've got a really unique perspective having just had a baby recently. Could you talk the Committee through what it was that made things different this time around and whether there were specific examples that were really beneficial?

BELINDA ALEXANDER: Definitely. With the induction, it was the same thing. I was admitted to the hospital. It all started straightaway. Nothing was really explained. It was more, "This is what happens next." It never felt like my body took over properly. It was always, "Okay, this is next. We have to do this." It was never, "This is what we're going to try. Is that okay? This might happen. This is what you'll feel." The drip is horrendous. I wasn't prepared for that at all. It just felt like a whirlwind. It was the same as what the girls were saying before. It was a different attitude with the midwives as well. They were sitting in the corner just watching me. I didn't feel like I was supported at all, or they weren't advising.

The Hon. EMILY SUVAAL: This is previously?

BELINDA ALEXANDER: Yes, the first birth.

The Hon. EMILY SUVAAL: Thanks for clarifying.

BELINDA ALEXANDER: You feel like you're a number taking up a bed in a regional hospital. It's important for them to move you along; I get that. But it also feels like you're not doing enough. What can you do? Whereas the last one could have easily turned into another traumatic experience. I had the heavy bleeding at home. That was pretty horrible in itself. As soon as we got into the hospital, the midwife was the one who took me in and the girls straightaway started prepping me for a caesar, so I knew what was happening. But they were very good about it, trying to keep me calm. It felt like a more—not relaxed. They were trying to keep things calm. They were listening to me, talking to me and trying to keep things as calm as possible. Then, even though I was down in the operating theatre, on the table, ready to go, the obstetrician still gave me the chance to try, which I felt so thankful for. I did not want another caesar.

Especially coming from an obstetrician, I feel like they're very time restrained so for her to take that time and explain it all to us—and she actually asked us what we would like to do. She explained the risks and there

were, of course, restrictions. I had to be very closely monitored, and if anything looked bad I was straight back down for the caesar. But I just had a totally different vibe from the staff that time, with the last baby, around how they could make us feel more involved in the decision-making. And the midwife was totally, totally different. I was in the shower and she was down on her hands and knees in the shower with me. She was doing everything she possibly could to make me feel more comfortable and do things to let me labour how I wanted to labour. I don't know what they've done, but it was good.

Dr AMANDA COHN: Thank you so much for being here today. I want to thank Miss Poll especially for the call to action that you've given us today. If this Committee, the Parliament, the Government and the House department all do our jobs, I hope that we're going to build a future where you feel safe for your daughter to also have a baby. The question that I want to ask, particularly of Mrs Male but of all three of you, is about the logistical or the non-medical bits of the hospital experience. Mrs Male, in your submission you talked about your husband not being able to stay with you overnight and that he was kicked out of the operating theatre and left to wander. Miss Poll, as well, there was that experience of the baby being taken out of the room where you couldn't see them or where a support person wasn't with them. I'm interested in your suggestions around those practical nuts and bolts of how the hospital runs and how we can do that better.

FRANCESCA MALE: It's really hard because at the time we had Charlotte it was a very busy time on the ward, so it's one of those situations where unfortunately I feel like it just comes down to resources a little bit in terms of the rooms in particular. We fully understand why Evan was not allowed to stay that night. We were in a shared room. That's understandable. But I just wonder if there had been any thought to—not that we were owed a preference, but if there is any thought to prioritising those sorts of situations. Even just going through an event like that and then going into a shared room is quite confronting. I think with the dads who do have to leave the operating room, they shouldn't have to wait on their own. My husband was literally just put in a room on his own with no-one and wasn't told what was going on so he didn't even know if we were okay. Then he was taken down to meet my daughter separately, and then I was brought down later. I think just being a little bit more empathetic to people in that sort of situation—having someone wait with them, even putting them in the nurses' station or somewhere where they don't have to wait on their own and they have someone there to support them—would make a big difference.

Dr AMANDA COHN: Did either of you want to add anything?

STEPHANIE POLL: I think having a social worker come and check on the mums and the dads, especially after what she's gone through. I had something similar happen like that with my second daughter that was born. I had nobody with me and my partner couldn't come into the theatre room because he was sick so he was told to go home. If he had been given an option to sit and wait somewhere in the hospital with somebody who could've checked on him and see his mental health—he was told beforehand, "Who's coming out, her or the baby? Because we can only save one," and then told to go home. That's a strong topic.

Then after I'd expressed to the midwife that it's not funny to laugh about giving my baby to someone else, I asked, "Can I talk to somebody about this?" Why was there no social worker offered? It shouldn't be that once you leave you have to go and get your own mental health support only if you can afford it. There are plenty of people looking for jobs. Even if it was a volunteer position, I would happily sit there with another mother that just wants to sit there and hold onto me while I cry. Or my partner sit there and have somebody just sit with him and talk with him—have a cup of tea or something so they're not alone. Like, make it a roster. I'm sure people would volunteer for that sort of position. I would.

The Hon. SARAH MITCHELL: I also, again, wanted to say thank you to all three of you—very different experiences, but all obviously very traumatic. It's emotional and please don't ever feel you have to apologise. I think with what you said, Miss Poll, about your daughter—I'm sure when she's old enough she'll be very proud of what you've been able to do today. Unless we hear from people who have lived experiences like the three of you, we can't make suggestions around improvement, so don't underestimate the power in what you're doing today and what that will mean for many other women who have written to the Committee, who have appeared before us and who have also shared similar circumstances. It is really powerful, so thank you for that.

I wanted to ask—and it picks up a bit on what Emily asked before but around that education piece, because it is something that we've heard fairly consistently across other hearings—about the role of birthing partners there with you. Some of the evidence we've received before has been around when you're in that moment as a mother going through that process—having had two children, you're not always at your most switched on if you've been labouring for a long time—and there's certainly a bit of relatability with some of your stories and my own, can I say. What is the role that you see of the partner in terms of helping you give that informed consent and how much they can be more involved in that process? It obviously depends on individual circumstances but do you think that there's a gap in terms of how we can make sure that the dads, the birthing partners and the support

people are also part of that to actually make it a little bit more seamless for the birthing mother? Are there any thoughts on that from your own experiences?

FRANCESCA MALE: I think in our experience—especially when the father is the birthing partner—they have such a big emotional investment in the situation. It's their wife or their partner and it's their baby. I feel almost, in some cases, they're actually not able to advocate for the patient. That was our experience. Everyone was going through as much stress as I was and he wasn't in a position to be able to say, "Hey, stop. She said she can feel that. Stop." Again, it comes down to resources but I feel like it needs to be someone else there, whether that's a doula or the midwife—just someone who is removed from the situation but is there to be an advocate for the family as a whole. It's too much to put onto the birthing partner. We didn't want any of our other family members there at the time but I often wonder whether our experience would've been different if we had had someone else there with us who was able to look from outside and say, "Hey, that's not right."

The Hon. SARAH MITCHELL: Do either of you want to—it's up to you.

BELINDA ALEXANDER: I agree. After the first birth, when I was educating myself on how to go with the second birth and how to approach it differently, that was a big focus on—what I learned is teaching your partner how to advocate for you because sometimes you can't. You're in a different world when you're labouring, I feel like. We spent a lot of time educating him because he's got no medical background at all, and I even toyed with the idea of asking my sister to be there because she's a nurse and I know she's a very strong person. She would be one to stand up for me. My husband was overwhelmed with what was happening. I agree that having that person, even if it were a doula or someone employed by the hospital that is available in those situations because it is—I'm not sure how many times the MET call emergency button was pressed with our first birth, but it was multiple times and every time there are 10 or 15 people running into the room. The partner or husband is in the corner having no idea what's going on or what's going to happen next. Just having that extra resource—because sometimes it doesn't matter how much you can educate them and get them to be advocate, they're in a situation and it's their loved one. Their mind is also not thinking straight in a time like that. I like the idea of a doula or something.

STEPHANIE POLL: I agree. I think it's really important. When I was giving birth to my daughter, if I had been induced on the day that the hospital would've put me in—but then I was rescheduled and just made to hold again—I would've had my best friend there and I would've had my partner. I just got pushed in the system—"Oh, you can just wait another day," or "We've had something else come up and we can't do it because of staffing issues. We'll just wait another day. You'll go Friday. It'll be fine." So I had no one. My partner had just left for work and then I birthed my daughter and before I even knew it, I had to ask the midwife, "Can you grab my phone so I can take a photo of this baby on my chest because I've just birthed the baby." Then the worst thing happened and nobody was there. If there had been somebody else—the doctor didn't even make it in time to help with the birth because it was so quick so it was the midwife. She was amazing but the other midwife that was there was the one that took her. Just having somebody in that moment that could have said, "Okay, it's all alright. I'm going to go off with her." This is what they're asking you to do and you can't think in that moment.

The Hon. NATASHA MACLAREN-JONES: Again, I also want to thank you all for coming today and sharing your stories. I particularly understand how challenging that can be. One of the questions I'm interested to find out a little bit more about is the postnatal care that you were provided, and also things that could be improved and some of the recommendations that the Committee could look at as well.

FRANCESCA MALE: We didn't have what you would normally get with postnatal care because our daughter was small for gestational age but was able to be looked after by us. We went home but she was still a patient so we actually got extra visits from the midwife and that—honestly, I don't know how we would have done it without that. I think we had three visits by the same midwife, which was really important. That was just fantastic. I think that should be standard. I couldn't imagine not having that, to be honest.

The Hon. NATASHA MACLAREN-JONES: Anyone else want to comment?

STEPHANIE POLL: My son was born in a smaller hospital and I received care every two or three days. A midwife was checking in on me, which was really nice. At a larger hospital, where both of my daughters were born, I didn't receive aftercare. I think I only seen them once and that was just a routine check. My daughter was born with clicky hips—my middle child—so that was quite concerning. I had to follow up with a GP with that so it would've been nice to have a little clinic or something that you could go into. Unless you're looking for community places, there's not really much around that can help you with that. Then to check the weight of my baby, I was going into the chemist to make sure that she was feeding correctly because my youngest daughter was also tongue-tied so she wasn't feeding correctly. I had to get her tongue snipped and those sort of things. It would've been nice to have the same care given by the small hospital, for my son.

BELINDA ALEXANDER: I agree. I had a good aftercare. They were supportive. I felt like they listened to me. I didn't have any issues so that might've made it a bit easier. I didn't feel like I needed to ask for extra help at that time. I felt supported.

The Hon. SUSAN CARTER: My question is principally to Mrs Male but I'm interested in other ideas as well. You clearly had a difficult decision point in terms of the 37 week/39 week. Do you think that more information would've helped you and your husband make that decision? Or do you think that you needed to have a trusted medical companion through your birth that would make those decisions for you? Can you talk about that a bit?

FRANCESCA MALE: I didn't go into depth too much in my statement, but we did have a lot of information available to us because, pretty much, once we found out that she wasn't growing properly, we had weekly checks between the hospital and my GP obstetrician. They were doing extra ultrasounds, checking her blood flow measurements—everything like that. I think the issue was more that those two things didn't really come together.

My GP obstetrician, who was doing the ultrasounds and who we had amazing continuity of care with—we were seeing two practitioners, but they were working very closely together. They, in hindsight, were coming from a very individualised approach. They were using what they were seeing on the ultrasound to make the recommendations. They recommended we wait until 39 weeks. The hospital, using the same findings, basically saw a small baby and pushed for induction at 37 weeks, basically expressing concerns that something was going to happen to her if we left it any longer.

There wasn't any communication between those two parties, and so my husband and I were faced with do we go early. We were told it's going to be safer for her, but then, on the other hand, our GP obstetrician was saying, "Well, actually, waiting longer is going to be better for her in terms of less risk of needing special care, less risk of needing nutritional support"—all these other long-term things. There was a lot of conflict there, and it just felt bad to be—in the end we were, like, "Well, we're not going to risk her life." That's why we decided to go for the induction at 37 weeks, but it sat badly with us that we were going against the advice from this amazing clinic that had given us such individualised care.

The Hon. SUSAN CARTER: Do you think there's any education or any other support that would have made that easier for you to resolve, or do you think it's just a communication problem?

FRANCESCA MALE: It's communication, yes. I think if they had just worked together and presented us with, "This is the gold standard plan; these are the other plans", we would have felt a lot more comfortable going into that situation.

The Hon. SUSAN CARTER: Mrs Alexander or Miss Poll, do you have any comments on that?

BELINDA ALEXANDER: No.

STEPHANIE POLL: No.

The Hon. SUSAN CARTER: Thank you very much.

The CHAIR: Thank you, all three of you, for coming here today, being so vulnerable and sharing your personal stories with us. I echo what was said by my colleague the Hon. Sarah Mitchell: Your coming forward and sharing your stories will really help us and help other women. We've had over 4,000 submissions to this inquiry, and obviously we will only be able to hear from a few women face to face. Thank you for putting your hand up and being willing to come here today and give evidence. We really appreciate it. If there are any further questions on notice, the Committee will be in contact with you.

(The witnesses withdrew.)

Mrs HANNAH EISING, Individual, affirmed and examined

Mrs EILIS SHEAHAN, Individual, affirmed and examined

Mrs COURTNEY SIGNOR, Individual, affirmed and examined

The CHAIR: I now welcome our next witnesses. Thank you for appearing here today. We really appreciate your time and your bravery. 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 any of you like to give an opening statement? We might start with you, Mrs Eising.

HANNAH EISING: My statement is called "A mother's instinct". On this exact day, 12 December, four years ago I gave birth to my first daughter. The events that unfolded in the week after left me utterly traumatised and completely disappointed, and give me the right to have a voice that speaks for myself and many other women in saying that when we become mothers we are given one of the most powerful tools known in the biological world—instinct—and it's not being heard.

I had a high-risk pregnancy due to an underlying heart condition. I was induced at 38 weeks, and my birth plan was delivered to me without my consideration by someone I'd never met. I was told to have an epidural, which failed. It resulted in the complete loss of sensation in one leg and being completely numb from my belly button down. My baby girl was born healthy, and the attending obstetrician sutured my four first-grade tears—the result of a fast delivery and the complete inability to feel my baby crowning. She removed small fragments of my placenta from my uterus and displayed them on the tip of her finger for the whole room to see.

All the expected checks on baby were performed with no troubles, and we were constantly encouraged to "Go home before day three so you can get the home care nurse visit." Within 48 hours of the birth I began feeling unwell, with readings of high blood pressure. I told every staff member that entered the room throughout the day that I wasn't feeling well and that something wasn't right. It was all shrugged off as "You just gave birth. Are you drinking enough water? It's lack of sleep. It's from breastfeeding."

Despite the continued high blood pressure, I was discharged on day three. At the home care midwife visit on day four, I explained I was still extremely nauseous, had no appetite and felt horrible. Despite my cardiac history, she had nothing to do with me at that visit and just checked the baby. By day five, I felt horribly ill and knew something was terribly wrong. On discharge from the maternity unit, you're provided a sheet of paper that says if you have any symptoms of headache, swelling or nausea to call the midwifery unit. So I did, and was encouraged to attend the unit for a check.

I attended with a high blood pressure reading of 170/90. I was told I could have a stroke or a seizure at any moment and that I might have to be separated from my newborn. I was readmitted overnight and I was discharged again the next day, informing everyone present in my care that I still didn't feel right. By day seven, 19 December, we again called the midwifery unit and I was told to reattend the birthing suite again for an exam since I was showing no signs of improvement. I was monitored during the day. They reported my blood pressure was again too high but appeared stable. They were organising my discharge that same day. During assessment I had a midwife see me, who shut us away from everyone else and said not to listen to the obstetric staff but to go immediately to emergency to be seen. That midwife saved my life.

I was seen promptly in emergency, with a high blood pressure of 160/100, and immediately admitted as I was presenting with a well-known but rare postpartum complication called postpartum pre-eclampsia. I was admitted to the critical care unit for four days before finally being discharged, now well, for the third and last time on 23 December. While I should have been at home for the first two weeks of my life as a mother, loving our beautiful miracle baby, I was in and out of hospital and disregarded by staff who consistently brushed off my medical concerns to the point where I was discharged and readmitted three times in a week.

There was never any follow-up; I never saw or heard from anyone in the obstetric and maternity ward ever again. I had to make my own six-week follow-ups for myself and present my experience myself. I had to seek my own mental health review and trust my own instinct that how I processed these events may not be normal. From this experience, I was counselled for a year and medicated for postnatal anxiety and PTSD. I experienced severe panic about the whereabouts and safety of my daughter constantly, and experienced nightmares that reiterated that I was told that I may be separated from my daughter for the first two years of her life.

I experienced my first ever panic attack related to postpartum high blood pressure two days after the birth of my second daughter, three years later, because of the hell that I went through after my first birth. It's said that you should always trust a mother's instinct, but what about when it's about the mother herself? From these experiences, my recommendations for reducing the incidence of birth trauma are as follows: scheduling

postpartum health and wellbeing check-ups, occurring simultaneously to a newborn six-week growth check; a reminder service to be sent out in the simple, same format that you receive for a reminder about the baby's first vaccination; and genuine continuity of care, especially in rural areas, where many women opt for GP shared care for affordability and ease of access—but as soon as the babies are born, the process stops.

Why aren't there scheduled follow-ups for the mother in this extremely vulnerable time? Hospital follow-up—hospitals have the resources and social worker staff to support the rollout of a simple follow-up for women whose births resulted in adverse events. This could open up a conversation that a mother suffering deeply in the trenches of postpartum mental health issues desperately needs help with. And then, simply, home care nursing visits to include taking vitals. What if I trusted the opinions of healthcare staff overseeing me? What if I hadn't trusted my instincts and repeatedly returned to hospital? This simple inclusion could save someone's life.

EILIS SHEAHAN: Firstly, I appreciate the time and the platform you've created for myself and others in a similar situation to have a voice. To summarise my experience, I have two main points to make that myself and my husband feel are the major contributors to the New South Wales health system failing me. Communication that includes consultation time frames and informed discussions—my post-surgery consultation was delayed by 14 hours. The impact of this was uncertainty between midwives, their management and time lines. As a result, for nearly two days I remained covered in remnants of placental expulsion and meconium, and I wasn't even offered a sponge bath. When discharge from the first hospital was directed, I was made to feel I had no choice but to leave the major hospital because of a bed shortage.

I was given the option to drive myself or use patient transport. Being in no condition to drive, I opted for patient transport, which arrived five hours after the allocated time, with no explanation. As a result, I arrived at the next hospital late at night. The impact of this was utter exhaustion, isolation and immense pain. This brings me to my next point: continuity of information between midwives and between hospitals. Among other things, I was on a complicated treatment regimen. Before leaving the major hospital, I had to ask the midwives to develop a spreadsheet so that I was up to speed. When I arrived at the second hospital, it came to light that both hospitals had not communicated the details around my case clearly. As a result, I did not have access to medications required.

I had to prompt the nurse to dispense my next treatment. After much resistance, she retrieved my allocated dose of antibiotics and locked the rest away. I was refused analgesia throughout the night, and with no discussion of ongoing pain management or any other aspect of my treatment plan. The impact was utter exhaustion, isolation and immense pain. The lack of care had a flow-on effect that resulted in being readmitted to hospital five hours after discharge. The lack of care is a direct result of staffing shortages and bed shortages. The lack of continuity could be curbed by allocating midwives to patients, much like doctors to patients. Over four days I never saw the same midwife, and everyone had changed my routine. I'm positive this will ensure more engaged employees and deliver better patient care.

As a first-time mother with a fourth degree perineal tear, I don't think it is appropriate to transport any patient to another hospital, especially late at night. If the regional hospitals are unable to support a woman who is about to give birth, then staff the major hospitals accordingly. Supply an appropriate number of beds to support the continually growing population. The physical and emotional stress had a direct impact on my milk production and hormone production, and I feel this could have been avoided had I had the support, guidance and informed discussions required for a successful discharge and recovery.

COURTNEY SIGNOR: After three years of trying to fall pregnant, fertility treatment and surgery, I finally fell pregnant with our miracle. But due to my BMI and a health condition that I had under control, I was automatically classed as high risk and I was unable to do shared care. This meant that I had to travel three hours return for every appointment to the closest high-risk clinic. Instead of seeing my GP, who knew my history and who I trusted, I instead saw a different doctor every time and continually got told I was healthy and did not need to be classed as high risk. For this and many other reasons, I would strongly recommend that shared care should be allowed for all women, especially those who live rurally, and that your BMI should not be a factor in the way a pregnant woman is treated or classed. It is an inaccurate and outdated method that many midwives and doctors do not agree with.

The way we were spoken to and treated from the time we arrived at the hospital was horrendous, to say the least. I understand that for the medical personnel it may be the end of their shift, but it is important to remember that you are dealing with people's lives. You are there for them on some of the happiest, scariest and sometimes saddest days of their lives, and this is not something to be taken lightly. But, sadly, we were just treated as another one to be pushed through as quickly as possible. I was put on a Syntocinon drip to speed up my labour, despite feeling confident in how I was progressing and coping with contractions. This led to me requiring an epidural,

and my baby's heart rate started dropping only after the drip was started, and I ended up having an emergency C-section.

I strongly believe and recommend the time frames should not be put on women labouring. The Syntocinon drip should not be unnecessarily used to speed up labour. As was clearly explained in the antenatal classes we attended, medical intervention leads to a cascade of medical intervention, which was something I experienced. In the World Health Organization's *Recommendations for augmentation of labour* in 2014 it states:

> Augmentation with synthetic oxytocin may result in uterine hyperstimulation, with adverse effects such as fetal asphyxia and uterine rupture, and thus increase the risk of a cascade of interventions during labour and delivery. Besides, such unwarranted clinical intervention deprives women of their autonomy and dignity during labour and may negatively impact their childbirth experience.

Once our son was born, he was resuscitated as he had the cord wrapped around his neck. However, this is not information I was told. I only found out by reading a chart and then his blue book. He then spent six hours on oxygen in the special care nursery. At 24 hours old, he contracted a severe MRSA infection, which is a staph infection that is difficult to treat because of resistance to antibiotics—once again, information I was not told by anyone at the hospital. It was a doctor in our home town who explained the seriousness of this infection he had. This infection led to my newborn baby needing a cannula and high-dose antibiotics, which has contributed to his ongoing medical issues. I was also not checked by a doctor before getting discharged and was sent home with a severe infection in my uterine lining that required two courses of strong antibiotics to treat. When I got discharged, I was just told that they really needed my bed.

I would highly recommend that there are single rooms only in maternity wards so that women can have the support and get the rest they so desperately need after giving birth. I was placed in a double room, which meant I was unable to rest and I could not have my husband stay with me. I would also recommend that parents should be given a rundown of the birth and any complications that resulted once the mother is stable and recovered enough to comprehend what is being discussed. Enough resources need to be allocated so that women and their babies can all be given the time to be fully checked and reviewed by doctors, and simple hygiene practices should be reviewed regularly.

Sadly, due to the way we were all treated, we have spent the first year of our son's life dealing with issues and conditions that would have been avoided had we been given the time and attention we deserved, and the joy from the experience of becoming first-time parents has forever been robbed from my husband and I. It is my hope that by telling our story and by, hopefully, the implementation of some of these recommendations that will be made, that women will be able to feel safe and in control when giving birth and that the mothers, babies and families are treated with the respect that we all deserve.

The CHAIR: Thank you all again for coming in today. We will move between members and ask different questions. If there are any questions you don't feel comfortable answering, please say so, or if there is any additional information that you think we have not asked for, please direct us in that direction as well. I might just start with a couple of questions myself. You've all touched a little bit on experiences of giving birth in rural and regional areas in your opening statements. I want to hear a bit more around the unique situation of giving birth in a regional or rural area, but also what we really need to focus on specifically for women so that they feel safe giving birth in a rural area. I'm happy to throw to any of you.

EILIS SHEAHAN: At the time I lived at Gundagai, so that's a little over an hour from here, and there is a hospital in Gundagai. It's really small. I went in at 36 weeks with a kidney infection and they, for lack of a better term, freaked out. They said, "I can't deal with you here. You need to go to Wagga." I was in Wagga for only a few hours. They gave me some fluids and sent me home. That was fine. There were no complications after that. It was a little bit scary because anything could happen in that hour, me driving—for some reason, if I'm by myself, I'm heavily pregnant, and just the distance alone and them not being able to support me while I was there. During the time that I was—sorry, post birth and had to change hospitals because of the bed shortage, that was a little bit, obviously, more traumatic because I absolutely did not feel like I could travel at all—that was horrible—let alone being offered to drive myself with a birthing injury. So that absolutely needs to be addressed.

Yes, the regional hospitals are really great. They're a lot smaller. You do feel like you get a little bit more personalised care when you are there—not when I arrived, but the midwife that I had, the second one, on the next day, was a bit better. I think if these hospitals are going to be like satellite hospitals around, they need to be better equipped with mostly staffing—I don't expect to have a midwife at every one, but definitely people who know what they're doing. I know Wagga in particular has to service such a large area, all these little towns around, because you can't give birth at these little towns. If they're going to have to deal with that extra population pressure, then they need to be able to service it accordingly, in my experience.

The Hon. SARAH MITCHELL: Just to clarify, because I was interested, Ms Sheahan, when you mentioned it before, after being in Wagga for a few days, you went to Tumut?

EILIS SHEAHAN: Tumut, yes.

The Hon. SARAH MITCHELL: But you lived in Gundagai?

EILIS SHEAHAN: I lived in Gundagai, yes. Gundagai could not handle—there's no way. I don't know their bed situation. It's attached to a nursing hospital. They've got an emergency area, and the nursing hospital is on the other side. There are no beds that are—

The Hon. SARAH MITCHELL: But in Tumut there is a maternity ward with midwives, but you can't actually give birth in Tumut, is that—

EILIS SHEAHAN: I don't know.

The Hon. SARAH MITCHELL: I can ask the health district this afternoon.

COURTNEY SIGNOR: I'm from Tumut. You can give birth in Tumut, and it is a beautiful maternity ward. I would have loved to have given birth there.

The Hon. SARAH MITCHELL: Is it a risk factor thing?

COURTNEY SIGNOR: Because I was automatically classed as high risk, I wasn't allowed.

EILIS SHEAHAN: I might clarify because I worked in Wagga at the time, so the triangle was just too hard. That's where I had all my—

The Hon. SARAH MITCHELL: You wouldn't have chosen to go to Tumut, it's just that you—

EILIS SHEAHAN: No, because I worked in Wagga. I had all my appointments in Wagga because I could just duck off work to have doctors and things like that here. So going to Tumut wasn't an option for me.

The Hon. SARAH MITCHELL: But then you had to after you'd given birth because they needed to put you somewhere. Is that what's happened?

EILIS SHEAHAN: They needed the bed, yes, so they transferred me to Tumut. Back then—I don't know what year you gave birth in, but it was the old hospital then. So it was little bit different to what it is now. It was so dated and massively uncomfortable. It was built in the twenties or something. That in itself was a little bit different again. The facilities just weren't up to scratch.

The Hon. SARAH MITCHELL: Sorry to hijack your question.

The CHAIR: No, that's all right. Mrs Eising, did you have anything to add?

HANNAH EISING: I think an important feature that most women in rural areas will have that's quite consistent is the GP shared care program. Obstetricians come with their own out-of-pocket expenses that people in rural areas aren't always equipped to be able to supply. With that, the lack of communication between these departments is embarrassing. I personally was juggled between three departments as a high-risk patient with the maternity shared care program—went through my GP, went on the cardiac ward, went to the maternity ward. I had a different person every time. No-one had a cohesive plan. Every person generated their own opinion. So a level of communication—again, in the previous discussion, there was the mention that you just walk in with the yellow card that's got your baby's heart rate and your weight on it. It's useless. There needs to be a more detailed sharing of information that's personalised, so that you can get a personalised approach.

The CHAIR: Mrs Signor, did you have anything to add around the experiences of regional and rural women?

COURTNEY SIGNOR: I've only had one child. So my only experience was that I was not allowed the shared care. I haven't experienced what that is like. I would've loved shared care because my GP knows me in and out. She knows my entire history. She's a family doctor. I had to take excessive amounts of time off work because it was a three-hour round trip. When you're heavily pregnant, you need half the day, easy. It's hard to go back to work in the afternoon. Then when I was at those appointments, I mean I got told I was healthy, "You don't need to be classed as high risk." They were never longer than 10 minutes. I just didn't see the point in that at all and why I couldn't have that shared care, why I couldn't go to the local hospital for checks, why I had to travel that distance.

The CHAIR: Thank you. One of the strong themes that has come up in this inquiry is about being informed and having information. There's discussion about whether that is best received from the healthcare professionals directly or whether it's information on an app or more flyers, but we're also hearing that a lot of people are overwhelmed by the information on flyers and the reading that's available. Is it something that you feel would be better to come from a healthcare professional and to have more time with somebody who would talk

you through potential situations that could happen during birth? Or is it something that should be a written piece of information to take home?

HANNAH EISING: I think both. A simple way to involve it would just be with—at a regional hospital, you have the opportunity of two birth classes that is a very small, personalised group. You spend a whole day with a couple of midwives. At no point do they discuss anything adverse. They have a really dated video that shows the first few days with the newborn. They don't talk about any kind of things to look out for with baby's health and the mother's health as well. So what would be a really easy implementation is to update that video with something that gives more information to parents.

EILIS SHEAHAN: You don't always have questions on the spot when you're in the room. I always get them when I'm in the shower, do you know what I mean? And maybe post birth I YouTubed myself to death—to the point where I was crying, sitting on the bed trying to breastfeed because it was so hard, and it drove me nuts. Yes, having it in your hand is just as important as having it in your consultation, I think.

COURTNEY SIGNOR: I think both. You need to be able to have that conversation with somebody who has the time. When you're being rushed through, you know, "This is your weight. This is your baby's heart rate. This is your baby's growth—cool, you're good. We'll see you in a couple of weeks." It's not very conducive to any conversation around what might happen, and it's not really until the last few weeks that they start talking about what will happen at the birth or what could happen at the birth. Yes, it is important to be able to go home and read these things and look at it, but to have somebody who has the time to have that conversation with you, where you don't feel in a rush and you don't have to have these questions pre-prepared because you're not going to. Baby brain is, as was mentioned, a very really thing. Yes, just having a doctor who has the time, even half an hour, would've been great.

The Hon. SUSAN CARTER: Thank you all for being here. We're very grateful that you're here sharing with us. This is a question to all of you, perhaps starting with Mrs Eising, then Mrs Sheahan and then Mrs Signor. What difference would it have made if you would have had somebody to talk with or follow up or support you after the birth? What would that have looked like? Would that have been helpful, or were you just too busy that it wouldn't have been helpful?

HANNAH EISING: It would have been completely helpful. I think it may shorten the length of time it takes to make your own intervention. It reduces the severity of it; as things progress, they get worse. If it was addressed sooner, mental health issues specifically, then I think the opportunity for intervention would be much easier to initiate—some kind of support system that extends beyond, "Are you okay?" Every mother is going to go, "Yes, I'm good." It needs to address certain questions. In the thick of it, nobody knows what to look for. "Are you having nightmares? Are you worried about your baby's health?"—things like that. It needs to be a broader conversation and a more personalised approach, as well.

EILIS SHEAHAN: I think so. Once I left the hospital—this is the benefit of living in a country town—my child maternity nurse lived directly across the road. I didn't know that until the end, but it was lovely. But I had one visit from her and that was a few weeks afterwards. Yes, it was really great, but I think in the immediate future after leaving hospital, absolutely. Whether it's daily or a couple of times a week, maybe three times a week or something, absolutely. Especially if the number of beds is a problem in your hospital and they're trying to kick you out early like you're a number, you need to increase the amount of care that goes on after hospital. I feel like I was kind of a person who was not sick enough to be in hospital but too sick to go home. That transition period really needs a really strong support system and in-home care, when you are in your own environment and you do get to relax and do things a little bit better but you still have somebody at the other end of the phone or somebody who you know is going to be there at nine o'clock the next morning. That would be amazing.

COURTNEY SIGNOR: I don't think there was enough after-birth support. I was the same: I got the one home visit after going home six days after giving birth because my son was in the special care nursery fighting off this horrible infection, sent home on high-dose antibiotics and told, "Follow up at home. Follow up with your GP. Go into the hospital at home if you're worried." Looking back now and knowing the things I know now, there were so many things that were going on with him that, if I had the support and someone who cared enough to follow through, I wouldn't have had to fight for as long as I had to fight just to get him the help he needed. It would've made the world of difference to us.

The Hon. SUSAN CARTER: If I could ask a follow-up question, and if any of you have any views, I think what I'm hearing is that there are post-birth mental health needs, there are post-birth caring-for-your-child needs and post-birth mother needs. Can the one person address all of those, or is it best if the one person is trying to address all of those because that provides continuity of care and you don't have lots of different faces that you're talking to?

HANNAH EISING: Yes, I think the continuity of care is key. I think the one person—and you need to be skilled in multiple areas, obviously. One person regularly in home—you can always cancel the service if you want. If you find you're flying high, great. But I think I, especially, had problems with my baby afterwards. My husband was a great support person, but he also was like, "Oh my God. I'm here for you, you're here for him"—do you know what I mean? I think somebody needs to be there for us as a family.

The Hon. SARAH MITCHELL: First of all, Mrs Eising, happy birthday to your daughter today. I hope you get to go and do something more fun after this that involves celebration. Mrs Sheahan, you attached a copy to your submission of the letter that you wrote to the health district outlining the experience that you had. Could you tell us a little bit more? I think you said you did get a call from someone at some point to talk through that—obviously not naming names—and then you haven't really heard much in terms of follow-up. What were you expecting out of that process? What would that have looked like for you in an ideal situation in terms of that feedback post you making that, I will say, complaint, but raising the issue—

EILIS SHEAHAN: Yes, it was a complaint. I do remember having that conversation with her. It was sometime afterwards. She was lovely. She made the time to go through every single paragraph with me, so I did feel like I was heard then. She did ask me the same question; she was like, "What do you want out of this?" I said, "I don't really understand how the system works as far as what should happen after this and what other people have done, but I just want to make it clear that not everyone has the same background as I do, and the medical background—I know it's not human, but it's still within the same realm. If I wasn't educated enough to ask the questions that I did—somebody in the same situation without that background would have had a much worse experience than what I would have done. I feel for those people and I just don't want that to be replicated in other families."

My husband was—he still is. He hates speaking about everything that happened to us because in his mind, he was just as traumatised as what I was, if you know what I mean. I think there needs to be the support for those people as well. What should happen here? Ultimately it's happening now, and I think that's—not that I expected a parliamentary inquiry from my submission, but I think that it's important that we see that you guys hear us, that these recommendations are going to be put forward and that something's done about it. We want the system changed, ultimately, to support us.

Dr AMANDA COHN: I had a question for Mrs Signor, but please jump in if other witnesses have thoughts as well. I was particularly interested in your written submission when you talked about having to pay to board when your baby was in the special care nursery. I know you were sitting in the audience earlier today when we were talking about other people's experiences with family members not being able to stay in the hospital with them et cetera. This seems like something relatively straightforward to fix. Can you tell us about that experience having had to board, but also what a perfect version would have looked like?

COURTNEY SIGNOR: My son was born at 8.21 p.m. It was 9.30 by the time I got out of surgery. Both my husband and my mum were there with us. I got told I was going into a shared room so my mum had to, late at night, drive home to Tumut. I was on the phone in the special care nursery, laying in a bed next to my baby, trying to get my husband accommodation after just having this major surgery. I was in the double room and I got him—it was horrible having to say goodbye to him.

Then I think it was maybe day three, day four that I just got told, "We really need your bed. But if you're willing to, you can pay to board." So, "We need your bed, we need you to leave" but "You can pay to stay here," which just made absolutely no sense to me. Later that day they said, "Actually, no, you can't. We need you to go." The option was Ronald McDonald House. We were fortunate enough that then they found the family room in the special care nursery was free. They said, "Both you and your husband can stay there and stay close to your baby," which was fabulous. But I didn't really understand why that hadn't been an option from the beginning, considering we were not only first-time parents but from out of town and had no family living in town. It sort of just added insult to injury.

Dr AMANDA COHN: I'm just trying to understand, in terms of recommendations from us, what a better model would have looked like. Is it being able to stay in the hospital in the room? Do we need to be looking at carer accommodation that's adjacent to hospitals that have patients coming from out of town?

COURTNEY SIGNOR: I think what would have helped most is just a single room. They don't need to be huge; you need a bed and a chair for your partner and somewhere for your baby. A shared bathroom—fine. Giving birth is so difficult. Going into a room with another woman who has just given birth and her newborn baby and your newborn baby means you can't rest. I had a midwife tell me, "You need to rest. You need to sleep." But how? It's just doesn't work. The rooms don't have to be huge and full of all this amazing stuff. Cut the rooms in half. If I had my husband stay with me, the rest I would have gotten would have been amazing.

EILIS SHEAHAN: I agree. I was in a similar situation. I gave birth at six and didn't get out of surgery till midnight and my husband then had to drive back to Gundagai, over an hour away. Even just for that first night or even just for the support to hold the baby sometimes when you can't or you need just another half an hour's sleep, to have the husband in the room is a monumental relief. We ended up back on the paediatric ward a few days later and they had—even just a fold-out. It was a giant couch but it was like a sofa. Just a single sofa—even something as basic as that. It doesn't take up much room. It doesn't have to be a whole bed for dad. It's just something that he can roll out until the next day and then go home and get himself freshened up and come back. I went into labour at five in the morning, so we had been up for nearly 24 hours. Driving that distance in the night along a major highway was just dangerous for him. Having that little couch would have been amazing.

The Hon. EMILY SUVAAL: Thank you all for being here today and for the evidence you have given to the inquiry. It's really welcome. Obviously, we write a report that has some recommendations after the conclusion of all our hearings. In terms of positive maternity care that you may have had—and that may not be the case—I am particularly interested what you think it was that made it positive and how we can encourage or create more of that.

HANNAH EISING: With the birth of my second daughter, I opted for obstetric and private midwife care. Keeping the same face present throughout the whole thing and the same faces even on the ward makes the world of difference. Resource wise, it's obviously not always possible. But I think some level of familiarity in any domain possible makes a huge difference.

EILIS SHEAHAN: I agree. Like I said earlier in my statement, the midwives should be allocated in a similar fashion to the doctors. The amount of times there was a shift change and I heard, "You're doing it wrong. You should be doing it that way", just increases the anxiety and things like that. I understand that, yes, there are shift changes and you are in there for multiple days sometimes. If there are a couple of people that are allocated to this wing of the ward or something like that, absolutely.

COURTNEY SIGNOR: I experienced something very similar where every new midwife that came on came with new suggestions and telling me that the way the last midwife had told me to do it was actually wrong. "You are trying to breastfeed? No, you don't do it this way; you do it this way." I was very fortunate that I did have one amazing midwife. I think it was her calmness and understanding and the fact that she really listened to me. Everything I said to her she just listened to and she was ready to help how I wanted and how I needed, not how she thought it needed to happen.

Another midwife came and they wanted to take my baby for a couple of hours so that I could rest because I wasn't. But the way it was said to me the first time just broke me into tears and I said, "You're not taking my baby. You're not going anywhere near him." And then another midwife came in and she knelt beside my bed and she listened to me cry and she said, "I will bring him back the minute he wakes up for his next feed and I won't leave his side." It was just her understanding and her care. Those two midwives I will never forget because that's all I needed; I needed that bit of care and that love and that understanding. That was all I needed.

The CHAIR: Thank you to all three of you for coming forward today. As we have said to other witnesses this morning, we are so grateful for everybody that has come forward and for your bravery in sharing such personal stories. It's so important for us to actually hear individual experiences as a committee to help us to make those recommendations. You are really paving the way forward. If we have any further questions, the Committee will be in contact with you about those. Thank you for your time today.

(The witnesses withdrew.)

(Short adjournment)

Dr TRUDI BECK, General Practitioner, Nova Health, affirmed and examined

Dr CARL HENMAN, GP Obstetrician, O&G Sonologist, Nova Health, affirmed and examined

The CHAIR: I now welcome our next witnesses. Before we go into 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 either of you have an opening statement that you'd like to give?

TRUDI BECK: I would like to acknowledge the traditional owners of the land on which we meet, the Wiradjuri people. As a mum of three, I have frequently reflected with gratitude on the three safe and empowering births I have experienced, the second and third of which were under a GP obstetric model of care at our local public hospital. I am a GP obstetrician and provide intrapartum care at our local hospital and community-based care in a private multidisciplinary women's health clinic. Our clinic's mission is to empower women and their families with knowledge as they embark on their journey into parenthood, and then to provide a safe, supportive space for them to find their new normal. It has been a privilege to sit with over 400 women in the last two years since we opened as they have told their stories of pregnancy and childbirth. We offer coordinated medical, pelvic physiotherapy, perinatal psychology, dietetics, exercise, parenting and peer support services.

This inquiry elicits many complex thoughts and emotions for me as I walk the line of knowing the empowerment of birth and understanding the principles of women-centred care but also witnessing the inherent uncertainties and dangers of the physiological process of birth. Australia has one of the lowest perinatal mortality rates in the world, particularly intrapartum. My professional experience of this is that, as a clinician, we are trained to hold safety as one of our guiding principles. In holding safety as a core value, I witness the conflict that arises between what a woman and her birthing partner ideally would like for their birth and the interventions that often occur. While I think effective communication, a known provider and informed consent go a great way towards protecting from trauma and optimising outcomes, I still have difficulty reconciling the challenges that exist in simultaneously providing a nurturing maternal experience alongside exceptional maternal and neonatal outcomes.

I am mindful of and humbled by the opportunity women and their partners give us to be involved in their journey to become a family. Pregnancy and birth are biologically and physiologically normal processes, and we should take immense joy in the privilege we're afforded in witnessing matrescence unfold. I believe this inquiry comes at a time when both families and those working in the birth space are seeking a trigger for cultural evolution in this realm. I welcome the recommendations of this process and hope that they can constructively point the way forward.

CARL HENMAN: Good morning, Chair and Committee members. Thank you for inviting me to speak. First of all, I'd like to share something. During my time working as an intrapartum clinician at my local regional hospital, the overwhelming majority of clinical interactions that I witnessed between midwives and patients were conducted with expertise, compassion and the utmost professionalism. Furthermore, I imagine that the majority of those patients would not only agree with my sentiments but would state that they did not suffer any long-term physical or mental birth trauma. Most patients' birth experiences are good ones, conducted in a healthcare system that, by international standards, we are very lucky to have available. But that doesn't mean it can't be improved. That being said, I recognise why we're here today and that there have been a number of women who have suffered significant birth trauma and prolonged negative sequelae secondary to their experiences within our health services. I'm happy to offer my insights in order to reduce the frequency of these events in the future.

Prior to writing my own submission and attending today, I read through many other submissions and transcripts of recent hearings. It is of no surprise to me that the vast majority of these submissions detailed a lack of one or more of the following: continuity of care, individualised care and a trusted lead care provider. There is anecdotal and literature-based evidence that continuous individualised care is associated with improved outcomes and a better patient experience. Unfortunately, our healthcare system, particularly the public one, is decreasingly likely to facilitate a model in which this care type can be offered. Much is made of multidisciplinary teams, medical sub-specialisations and clinic-based care. While these entities have their value—and each health professional within them, no doubt, has best intentions—they are, by their very well-intentioned nature, causing ever-increasing fragmentation of care. This leads to less continuity and time to establish a therapeutic relationship and a lead care provider—exactly the opposite of what these women and their partners want at one of the most vulnerable times in their lives.

My number one recommendation is that significant time and resources are put into promoting, encouraging and facilitating longitudinal models of care under a trusted lead care provider that cross the threshold of the hospital foyer. There is more than one model that can satisfy these criteria, but on the background of many of my own wonderful, profound clinical experiences, the barrier to the obstetric GP model in regional centres should be dismantled and this care type reinvigorated and prioritised.

The CHAIR: Thank you, both, for being here. I also recognise that the local member, Dr Joe McGirr, is here with us today. He has been with us this morning. We appreciate him coming here today and spending his time with us. At this point, we're going to ask questions to either of you about your submission or your opening statements. I will start with Dr Amanda Cohn.

Dr AMANDA COHN: My first question is for Dr Henman. In your opening statement, you mentioned barriers to GP obstetricians being able to provide intrapartum care in hospitals. We've heard this morning, and in every other hearing so far, about the value of continuity of care and, particularly from other witnesses this morning, about the preference of some women to have GP shared care. Can you expand on what some of those current barriers are?

CARL HENMAN: Unfortunately, it seems to be a reflection of the way the obstetric profession is going overall. There are less and less GP obstetrician opportunities, particularly in regional and metropolitan centres. GP obstetricians are utilised well in more rural locations but, without them, they would have no-one. This inquiry is not about my situation in particular, nor should it be, but the barriers to me continuing that care are still somewhat confusing to me as well. I don't really understand why, after seven or eight years of providing service myself, it was abruptly terminated without clinical reasoning or explanation. You will probably find that some explanation would be under the guise of a narrowing scope of practice guideline that seems to be reflective of a very risk-averse culture and medical administrations on the background of an ever-increasing concern over medicolegal implications and being less inclined to want to have people involved in care who they don't view as specialists in the field.

We are reducing a scope of practice at the expense of continuity. I think, the vast majority of the time, we can't avoid all risk. When we try to do so, we raise the possibility of other problems. The first one, and the one being repeated in this inquiry not only today but in the other hearings that I've read transcripts of, is that there is a disruption in continuity and almost an inability to establish a relationship through all of the pregnancy, which includes the intrapartum environment. I suppose I wish I had all the answers. Some of those answers should probably come from other people.

Dr AMANDA COHN: I am happy for Dr Beck to jump in as well. Do you have any constructive suggestions for us in terms of how we can improve the continuity that is provided in public hospitals?

TRUDI BECK: I guess I am in a unique position in that I do straddle the private and public systems in our region, because I have an ongoing contract to provide intrapartum services at the hospital, not in a GP VMO role, but I'm happy in the contract that I'm in that it fits the demographics of the patients that I look after. I guess I walk a careful line there, because my main priority is to maintain excellent working relationships with the midwives. I really value and trust their friendship and their collegiality, and I think that there is a very healthy relationship in our particular hospital between both medical and midwifery staff.

I guess, from the outsider perspective, referring into a hospital, I would think that my experience would be similar to all other GPs in that we have been used to being the point of reference for our patients and, over long periods of time, we've developed, I hope, trustful and caring, mutually beneficial relationships with our patients. And we don't ever claim to know everything; I think GPs are very good at recognising the limitations of their scope of practice and then seeking specialist advice beyond that. But it's an unusual experience, I would imagine, for some of our patients—when we do the referral to hospital, it's almost as though the patient then belongs to the hospital. I don't know that that's the hospital's intention. However, my experience of it from both inside and the outside is that, regardless of the pre-existing relationship I may have with a patient, the hospital then takes ownership and, in doing so—I believe, probably—they do that knowing that they also take on the large load of the medico-legal responsibility of it.

But I think that then comes back to the idea that—my belief, from working in the system, has been that safety and the minimisation, wherever possible, of risk has potentially come at the expense of true collaborative care. I can't criticise that fully, because I understand that it's well intentioned. However, I believe that the patient experience of that may look like fragmentation, and I guess that all of us who are here are here with the hope of decreasing that fragmentation because we all have seen and witnessed the unavoidable nature of some women's experience of trauma in childbirth. But if we can increase the lines of communication and the shared responsibility for patients then perhaps we can provide a more seamless pathway to patients feeling held when they are returned to their previous primary caregiver, which, in both Dr Henman's and my instance, would be general practice.

Dr AMANDA COHN: You touched on the communication issues between GPs and the hospital. I am particularly interested in the experiences of your colleagues who are not GP obstetricians but who are GPs that a patient has chosen for shared care. What are the practical opportunities to influence that communication? How can we improve that so that we improve the patient experience of GP shared care?

TRUDI BECK: I think I'm coming back later in the day to be in alignment with the PHN that coordinates our local shared care pathway. I certainly think that the shared care in this region is highly valued, and I think that there is a good program that exists in place to do that. I guess that there's limited opportunity for an external provider to comfortably access advice through the hospital system if they're not familiar with the system. The pathway that Dr Henman and I provide means that at any one time we will probably be providing some form of shared-care arrangement for maybe up to 150 or 200 women on our books at any one time between us.

So I feel really comfortable with picking up the phone and knowing who the appropriate person at the hospital is to call for advice, and I frequently do that because, as we've all mentioned, continuity and consistency of care is really key. But, I guess, if you don't have as much to do with the hospital system, sometimes, in the pressures that exist within normal general practice consultations, the idea of picking up the phone, calling switch, maybe getting through to someone that's in a theatre case, and then you'll get called back later and, by that time, the patient—you can see the difficulty that can exist just trying to logistically coordinate something. I know New South Wales hospitals have done a lot of work on the idea of GP liaison officers and things like that, and I certainly think that it would be, again, allocation of resources. How do you have a touch point of a senior clinician, whether it be doctor or midwife in the hospital, that is easily accessible to outside providers?

The Hon. SARAH MITCHELL: Thank you both for your submissions and for being here today. My question is directed to you, Dr Henman, because it has come out of your submission, but I am also happy for Dr Beck to provide some insights. It was interesting when you talked about women being aware of reasonable expectations of what may happen, and I think one of the things we have found through this process is that it can be very subjective. Women can have very similar birthing experiences but have very different emotional and physical responses to them. We had some women talking about wanting to have better information and, in a prenatal sense, really understanding what the risks and complications are, whether it's through induction or assisted delivery. From your experience, do you think there are ways that process could be improved?

Obviously, you have that unique, one-on-one relationship with that GP model of care. As someone who lives in a regional area, I had that too; it was wonderful. But I know that is not everyone's experience. Do you think, across the system or across the board, there are things that we could recommend in that space to help women feel as if they are more empowered and informed before they reach the point of being in labour? What would you suggest?

CARL HENMAN: Do you mean specifically when they're attending public clinics or separate to—

The Hon. SARAH MITCHELL: Either/or—anything that you think would be useful for us.

CARL HENMAN: I suppose the first thing is to hark back to the previous point that if we encourage, to use that example, GP obstetric models of care, then I think those models of care are more likely to be associated with a trusted care provider who is more likely—and, I'll say, more able, in the sense that the GP obstetrician gets to make the decision about how long they spend with them. I have a bit of a caveat there, I suppose, because in private land we're not really more able, somewhat, in the financial sense, because it's quite difficult in the private setting to spend a long time each time, but that would be ideal.

If a woman isn't choosing or is unable to choose that particular model and they were seeing the public antenatal clinic, for instance, and if we're going to model it on how I do it now or specifically did it when I knew I was going to be the intrapartum carer, at about the 36-week visit—and it doesn't exactly matter when it is—I made sure I spent time talking through what I thought were the more likely possible scenarios that might occur in labour and getting an idea at that time what that woman's preference was as to how she would like her birth managed. Sometimes that's, "I want you to do everything that you think is safe, right up to the point of being maybe not safe, in order to get a vaginal delivery." And other times it's like, "If you think it's going badly early, then I'm happy to have a caesar really early." That allows you then the opportunity in the labour ward to make those decisions, knowing that you've essentially already had somewhat of a consent process occur.

The consent that we are able to do in an intrapartum setting, I would say, makes a mockery of consent. Doing it in that setting, I don't think—I mean, you've got to do it because if you don't do it at all you're in trouble. But I don't think it really amounts to a good time to give them information. I think, probably, establishing a system or a particular appointment time where those types of things could be discussed would be a reasonable way to go about that and/or in the education surrounding those people who are likely to be involved, even if it is in an intermittent sense, through that woman's journey, to remember to talk about those things.

It's simple. Sometimes it's just asking, "What is your expectation?" If she's got a complete placenta praevia and breach and she says, "My expectation is to have a vaginal delivery", I hope that I will be able to reset her expectation. If she's had three previous normal vaginal deliveries and her expectation is a vaginal delivery, I'll say, "That's extremely likely." But without that education, we shouldn't necessarily assume that the woman sitting

in front of us will know why something is unreasonable. If we go into something with an unreasonable expectation and then we don't get what we want, as humans we're just inherently disappointed. But we didn't need to be that way if we were otherwise well educated about what might be in front of us. As I say, it harks back to having a trusted care provider who you feel as though you can ask those questions of or knows you in such a way that will raise those topics appropriately.

The Hon. SARAH MITCHELL: Did you want to add anything, Dr Beck?

TRUDI BECK: I think I agree with Dr Henman that the process of consent is inherently difficult during birth, particularly in the pressure points where you're having to make decisions in a rapid way. The approach that I take, which everyone is slightly different in how they would manage these kinds of expectations in the different models of care we use, I use the resources that are already out there and I think that are getting quite widely acknowledged. I like to have other women tell their birth stories. *Australian Birth Stories* is a podcast that the hospital recommends in clinic, and I do as well because I think that I can explain to you as many ways as you are willing to listen about the things that could happen to you in childbirth, but hearing it from another woman's perspective—we know that storytelling is a huge part of birth, and so I am grateful to the resource that she puts out there in that podcast. I encourage all of my women to listen to that.

The hospital does a really good job with their—it's done over two days usually—antenatal education days in terms of just going through what the possibilities are and what to expect. I guess when I think about what things I would like to see come out of this is the idea that birth planning's actually really important, and even in the women that I see who are generally often quite well educated, have good health literacy, I say to them the same as Dr Henman would in their third trimester, "Have you started to think about the birth?" What I guess, as healthcare providers, I think we should be railing against is the idea of paternalistic style medicine where they say, "I'll just do whatever seems right because I just want a healthy baby." I actually don't think that facilitates change.

So I encourage them in between visits to think about three questions that they would like to put to their care providers in birth, and the first thing is "What we would like you to know about us." It could be, "I had a previous traumatic birth and I'm looking to try and heal some of those old wounds", or, "I have abuse history and I would like trauma-sensitive care", or, "I really know that my personal feeling is I don't like pain and I'd like an epidural." So the things that get rapport with your care provider quickly so that you don't have to spend a lot of time explaining those things, things that they'd really like for their birth and things that they'd like to avoid if possible because once they've thought about those things, I say, "Discuss it with your birthing partner and then they're points for advocacy for your partner to say."

The other thing, which I think we could do a better job of because we don't necessarily learn it in midwifery school or in medicine, is patient-centred communication. I think when it comes to consent, a lot of the time we, even ourselves, might not fully understand what that process entails, and it shouldn't be driven by our inherent biases about what we think is safe or what we think the right thing is, that we almost always have time to say to a woman and her partner, "Hey, this is what the situation is at the moment. We're at this kind of fork in the road. These are the options I can suggest to you. These are the pros and cons of each. What do you think?"

I think that when it has come down to it, we've talked a lot about continuity of care but you can have, in my opinion from what an external perspective would be, what looks like a traumatic birth and I think if they've gone into it with an idea of what to expect, that they've had clear communication and a feeling of autonomy in decision-making, they can come out the other side and be like, "That was a wild ride", but don't carry with them that sympathetic overdrive ongoing that that was trauma. Their brain is able to process it in a different way. I know that the Committee's goal is not to eliminate birth trauma altogether, because I think that we all accept that that's potentially not the goal of this, but I guess that that's my anecdotal observation that women can experience and undergo things that we can be vicariously traumatised by by witnessing it but if they feel safe and held and understand the rationale behind things their brain processes it in a different way.

The Hon. SARAH MITCHELL: Just picking up on the consent piece, I think that's a really interesting point because obviously it is something that has come up in other hearings that we've had and from other witnesses about sort of making those decisions in the moment. When you're having your baby, you're maybe not at your most eloquent in terms of processing things, and so I think that idea of having conversations and really kind of knowing beforehand the ideal, and I think those three questions are excellent examples of what we could do because I think the Committee is quite conscious too of not adding extra barriers. We don't want to have less people being able to have babies, particularly in regional areas. We want to support our workforce, and I think that's really important that we don't get too tied up in kind of medico-legal issues that make people not want to come and work out here. I just wonder what the piece is around that earlier support, which I think you've covered

quite articulately, because I wouldn't want us to recommend anything that would actually make it harder for people like you and your colleagues to do your jobs, particularly in the regions. Is there anything we should avoid?

TRUDI BECK: I think we should acknowledge that NSW Health does make an attempt to facilitate this. Women will receive a birth preferences sheet at one of their third trimester visits. However, my feeling around that and the women's experience of that is most of them look at the form and they're like, "I don't know what to do with this", not because they're not informed but because how can you explain to someone the need for some of those interventions antenatally.

I would like to be a midwife in lots of ways—I just think I'm not patient enough—because midwifery is an art. Midwifery is not a tick box process. The process of being with a woman in birth, it's not like you feel. You can't learn it from a textbook. It's something that you do because you have a deep desire to sit with women. My friendship with the midwives that I work with means they don't need a tick box. What they want to know is how can I develop a quick rapport with this patient so that I can take them through this really challenging day of their life. I guess that we're always on a slippery slope in medicine of more medicalisation, I suppose, and one of the things that we try to do in our private practice is say, "This is a choose your own adventure. This is an amazing and exciting and incredible part of your life, and how can we make this about your story more than about your statistics?"

CARL HENMAN: If we talk about consent in the sense of consenting to someone looking after you, when we have a trusted care provider, I would say that, with the babies that I delivered, those women throughout the journey said, "I consent to you, Carl, looking after me. I consent, essentially, to you making the decisions." In an environment where the person making the big decision and doing the big thing at the pinnacle moment is someone who they've never met, I think they look back on it and say, "I didn't consent to you making that decision." And I think that's a difference. The woman feels like, "Okay, I said yes but I didn't consent to you making that decision for me."

Whereas you've got a trusted long-term relationship with someone, most women, the vast majority of women, get it. They get it's dangerous. It can be really difficult and they want to be safely looked after, but they want to be safely looked after on the background of feeling that the right decisions were made, individualised to them. I think that's where it falls over a little bit when the first time they see the person who's going to put the forceps on or make that decision is when they're at the end of the bed. The person putting the forceps on, I'm sure 99.99 per cent of the time has got 100 per cent the best intentions, but it's about more than best intentions.

As Trudy says, it's about that sense of what's the right thing to do for that woman in that moment, and how will she look back on that?

It wasn't uncommon for me when the situation was not acute, in the sense that you could give the labour a bit longer to go on, for instance. For example, I would say, "You can have another half an hour or an hour and we'll see how things go." Not uncommonly, looking back, I would be thinking to myself, "I know how this is going to go. I know how this baby is coming out." But I also know that—and this is not uncommon—I've walked up from my rooms that morning, having seen a woman at a six-week or two-week check and having done a similar process in her labour, and she had said to me, "I'm glad you gave me that extra hour. I really feel I had that opportunity. And then once the caesar was done, I felt that I was given the best opportunity to at least try to achieve."

I think another advantage of a longitudinal, trusted care provider is that they're there two, six or eight weeks later as well. There's nothing like having been there at the bedside to know what really happened. I recognise that we're not going to magically develop thousands of GP obstetricians who are going to work in regional and rural areas. They could work in metropolitan areas too. I just want to make that point. We seem to have pushed GP obstetricians—

The Hon. SARAH MITCHELL: We'll take them in the regions.

CARL HENMAN: It's not going to happen metropolitanally. I know that. The public system is going to have to try to take some of these recommendations on, in order to address these issues, and try to fit these types of suggestions into their model of care, because people like Trudi and me aren't just going to magically appear and fix this problem. That's probably a secondary recommendation to the continuity of care-type argument.

The CHAIR: I want to do a follow-up to Dr Henman around that whole idea of, "I haven't consented to you making those decisions", or the idea of broad consent when you know the healthcare provider. Some of the women who we've spoken to have talked about feeling trauma from individual informed consent. Suddenly they're getting a vaginal exam when nobody said, "Do you mind if I do this?", "This is what we're going to do now" or "This is the safest thing to do now. Are you okay with that?" Do you think that there's also a need for that informed consent throughout the process so that the woman still feels like they're part of that entire process?

CARL HENMAN: Definitely. I think those examples—and I read similar things in some of the submissions. When I was reading those submissions, I thought to myself, "I can see that from the doctor's perspective." This looked like it was turning south quickly and they wanted to know, for example, what position the head was in because they thought, "We're going to have to deliver this baby quickly and I need to know the position for that." The consent in that particular setting is, like I said before, probably not ideal consent. But I think if you had explained to that lady prior to labour that this might have to occur for these reasons, she's a bit less likely to say, "I felt assaulted because I didn't really feel as though I gave that unknown face specific consent to do an internal examination." You're never going to address every last trauma that comes from that, because the situations are emotionally charged. But I think if you've prepared her emotionally for what might happen in labour, it will go some way to addressing that.

The CHAIR: Absolutely. In your submission you said that we currently have a self-sabotaging healthcare system that's ill-equipped to provide education. Is that related to that true continuity of care or is it something more? Can you help me unpack that?

CARL HENMAN: Mostly, that's what I'm referring to there. There are so many people involved that it's very difficult for a woman to feel as though their care is being individualised. Multidisciplinary care is great but multidisciplinary care is not continuity of care. It's interesting, actually: I read a transcript from a hearing a few hearings ago—I don't know when it was—and the witness was asked, "Tell us about continuity and what your view is of general practice continuity and GP obstetric care." The next couple of paragraphs in the transcript were talking about the multidisciplinary approach and all the different people who the women see in that particular person's clinic. I just thought, "That's not continuity." That's not allowing that woman to feel as though she has been well educated by one person who might be able to bring together all the different views that were put to that woman by all those different multidisciplinary teams. Again, every person in that group is very well-intentioned, but the more you fragment care, the more generalised care ends up being.

As I alluded to before, the public system does have significant constraints on it in relation to time. It's not uncommon for me to hear that a woman might wait two or three hours to be seen in a clinic. That's not because people are sitting around having coffee; it's because they're really busy. We've heard a number of times, even this morning, and plenty of times in previous submissions and transcripts, about resource allocation. I think that essentially contributes to this self-sabotaging, if you like, because you feel as though the system has to see a certain number of people in a particular clinic at a certain time. There are only so many hours in the day.

Part of this is resource allocation and part of it is not necessarily putting someone in those places who is charged with the responsibility of being the lead care provider for a group of women. It has fleetingly occurred to me that that could be a way in which you could address some of this. It's unreasonable to expect the O&G director of any particular unit to be charged with the responsibility of all the patients in that unit. That's just not how it's going to work. But you could have a situation where for a certain number of women the final antenatal decisions were made by a particular, for example, non-GP specialist obstetrician, if we're talking about public systems.

The CHAIR: Dr Beck, in an interview earlier this year, you talked about informed consent and that it isn't mainstream enough. Can you talk a little bit further about this and how we make informed consent mainstream through the system?

TRUDI BECK: My experience of this—and, again, this is only my personal experience—is that I can't actually recollect, at any point in time in my obstetric training, ever having specific training around informed consent. I'm aware, just through keeping up with my CPD, that RANZCOG is doing lots of work around incorporating more modules in their mandatory training around communication, and I expect that the outcome of committees like this will be to add informed consent as a specific topic. But I think sometimes we feel time pressure where it's actually really important to spend the extra 30 seconds on something. It might feel like you don't have time at the time, but one of my interests has been how I can focus on more women-centred care. And I certainly think, personally, that to practise in alignment with my values would be that each patient I spend time with believes that I am truly present with them. In doing so, what information would I want conferred to me if I was to make an important decision?

We talk about consent, but consent is not just doing a NSW Health checklist saying, "We're taking you for a caesar and you could have these complications." Consent is what I said before: "This is the fork in the road that we're at. This is, in my clinical opinion, what I think is going on. My training would lead me to believe that these are the options that are available to you. The pros and cons of each of these options are these. What do you think?" I am lucky enough to spend a lot of time with really great junior doctors, and even pick them up on the nuances of their language around how they say, "I'm going to do this. Is that okay?" That's not informed consent. Informed consent is saying, "Because of this reason, I would like to offer you a cannula. How do you feel about that?" It's not what you say; it's how you say it. When you look back at how far all medical practices, but particularly

obstetrics, have come in the last few decades, it's incremental change that has to occur and picking each other up on when we say something to our patients, recognising that there is an inherent knowledge and, therefore, power differential. How do we be humble clinicians? It's not shared decision-making. I think that that's a thing of the past. It's actual true, informed consent.

The Hon. EMILY SUVAAL: Thank you both for appearing today and for all your ongoing work in advocating for women, in the regions in particular. I wanted to build on these questions around consent. In our first hearing we heard some evidence from the chair of Human Rights in Childbirth, who described the consent that should occur for a woman that was required to have an unplanned forceps birth. In this evidence they stated that someone should ideally come into the room 10 to 15 minutes beforehand and say, "This is something that we need to do. Or the alternative is that we would recommend you have a C-section." Then you step out and give her five minutes to think about it and talk with her partner or her support person. Is this an appropriate and realistic way for gaining consent, would you say?

TRUDI BECK: I guess that this is a kind of scenario that I am expecting to be dealt with at any time on any given shift, as would be anyone working in a birth suite. Yes, that is the ideal situation. Even when it comes to things like caesarean sections, there are very few emergency situations where there isn't time for the patient, their birth support people and the midwife looking after them to reflect on it. My personal feeling is that if, when I go into a room, it's not a resounding, "Yes, let's go," then I will always say to them, "I'm going to give you some time to think about this." In other circumstances it conflicts with RANZCOG's own guidelines around this in instances of things like fetal bradycardia where the time line is such that there just isn't the opportunity for that style of informed consent. They say that within six minutes, you should be making a plan to expedite delivery, and within that 12-ish minute mark, the baby should be born.

You can see the time frames for that are much tighter, particularly when often we're not alerted to a deteriorating situation until it's already at the point of potential crisis. I would say that in that circumstance it's inherently difficult to have a true process of informed consent. Going back to what Dr Henman said, I think if, in an ideal situation—which in a lot of cases it is an ideal situation—the patient already has formed a rapport with the midwife and the midwife has already alerted them to the increasing urgency of the situation, often by the time you arrive that process of verbal consent is almost on the way to theatre, unfortunately. Again, I, as I alluded to earlier, grapple with walking the line of safety profiles and what our kind of standard of care is in Australia to the trauma that obviously occurs if you have a poor maternal or neonatal outcome.

CARL HENMAN: Yes, I think that's eloquently described by Trudi. I think there are times where that would be—sometimes or a rare number of times, really—entirely inappropriate because five-minute bradycardia at 50 beats a minute could have lifelong sequela, but most of the time we probably have got opportunity for that. I used to have something called my postcode speech, which was, "Okay, this is not really acutely a major issue right now but it's not going that well. It's 10.00 p.m. and we are in a regional hospital and I know theatre is going home and I know how long theatre takes to get back. In this postcode it's going take me an hour to get knife to skin when none of them are here." For example, at Royal Randwick, the theatre is where you are and the woman is where I am and it takes one minute. That makes a difference. So it's not only about reasonable expectation of clinical outcomes and opportunity; it's about reasonable expectation of where that occurs and what resources you have available to you. So recommendations that come from this Committee will probably need to keep that in mind—that some will be very appropriate for certain settings and some will be less appropriate for other settings.

The Hon. EMILY SUVAAL: Thank you. That's really very good for us to keep in mind in terms of forming the recommendations as well. If it's clinically identified or indicated that the intervention is required in a time-critical nature—and you've given some examples around that sort of time-critical nature of some of these interventions—is it appropriate to then offer a woman the choice of an emergency caesarean or a forceps birth? Is that an appropriate thing to do or—

TRUDI BECK: I think that when you were asking before about antenatal education around birth choices and what might occur, I feel like—I am not a senior clinician but I would probably not class myself as a junior clinician anymore either—every year my knowledge bank builds around patterns of behaviour and what you might be expecting to occur or if you see or feel something that doesn't feel right, that your antenna goes up and you're like, through previous experience, "This doesn't seem right." I think that that's where the whole idea of trusted providers is so helpful because I can't, hand on heart, say that I can consent antenatally any of my patients to what could or couldn't happen in labour. Sometimes it's not even until the last minute that you know yourself what's going to be the most desirable outcome.

So again, just like midwifery, I think obstetric medicine is an art. There's a degree of human error in there, which we will continuously self-reflect on. In the middle of the night sometimes you're still up thinking about things where the patient might have had a great experience but you're taking that uncertainty or "Did I do this

right or did I do not do that right?" I think the day that I stop questioning that would probably be the day that I would stop doing this because we're all always looking for best outcomes for the woman, physically and emotionally. That decision often is made under extreme time pressure.

The Hon. EMILY SUVAAL: Dr Henman, did you have anything to add to that?

CARL HENMAN: Not to that but can I go back to—you asked about my comment about self-sabotaging the health system in relation to individualised care. Another thing that occurred to me sitting here is about what seems to me often a rigid adherence to certain guidelines. I can't remember who, but a senior person once said to me, "Guidelines are for the advice of wise men and the adherence of fools." If we have a system which won't allow us to work on the edges of guidelines in order to individualise care, we then work in a self-sabotaging system because those women won't be happy that they weren't given the opportunity to have something on the edge of a guideline.

Now we've been talking about intrapartum stuff here—I'm not even really thinking about that. I'm thinking something as simple as giving someone an iron infusion that doesn't necessarily fit with the Red Cross guidelines about when that should be done, because of that woman's particular circumstances of when she might be able to have it and how long away from town she is. Is she already here? But if she's going to have it at a certain gestational week she'll have to travel to Hay and back, for example. I think we need to pay some attention to the fact that guidelines are reasonable and they're there for safety but stepping outside the guidelines, on the background of individualised care, doesn't equate to it being unsafe, necessarily.

The Hon. EMILY SUVAAL: Just a final question from me to you, Dr Henman. Earlier in today's hearing you mentioned that multidisciplinary care is not continuity of care. I'm just keen to understand what evidence you have to support that idea or where that's come from?

CARL HENMAN: I would say that it's evidence from my own experience, I suppose, rather than being able to quote a particular author to you. Just because lots of people are involved in one woman's care doesn't mean that she will feel as though she is being managed in a continual sense throughout. I suppose I'm saying that a continuous care model allows that woman's journey to be individualised to her, whereas many multidisciplinary inputs will find it more difficult to individualise care because they all have their own idea about what is best for that particular woman. But when that woman has an essential care provider who she can discuss those ideas with, we're more likely to be able to individualise that care to her, maybe after due consideration and not taking on the advice of one of the members of the multidisciplinary team. I'm not deriding multidisciplinary care overall; I just think that the more providers you put into any care, the more likely you are to fragment that care and the more difficult it will be for that woman to feel that her decisions, in particular, about her journey are really taken into consideration.

The Hon. MARK BANASIAK: We've heard from a lot of witnesses today and throughout the course of this inquiry that they feel dismissed as individuals. In your submission, Dr Henman, you talked about embracing the imperfection and embracing individualised care. How do we do that at scale, given that obviously it's a stressed situation in terms of resources? Picking up on what you said, Dr Beck, about it not becoming a tick-a-box exercise, how do we do that without it becoming a tick-a-box exercise and maintain the authenticity of actually engaging with the patient as an individual? Is it purely resources or are there some practical things?

TRUDI BECK: That's a really good question because that's the practical application of everything that you are listening to. I think it's actually the language that we use. Language is one of our most powerful tools. Yes, our medical knowledge and our hospital resources, in terms of our physical resources, are really important. But language is insanely powerful. The things that women take home with them—I would say that, as a general rule, the things that you've heard haven't been about the physical location; it's been about how they were communicated with.

The very first thing for me is that the birth and the pregnancy belong to the woman; the birth and the pregnancy do not belong to NSW Health. If that could be culturally something that we put out there—because as soon as we do that, it means that we automatically default to consent. We say to them, "This is what we think. What do you think?" Yes, continuity of care is certainly one of the pillars of what we've talked about. But if you as an organisation automatically assume that the pregnancy belongs to the woman—and so anything that we do to that pregnancy, we have to gain consent for—we can still practise within guidelines within that kind of approach to women-centred care. It's not the guidelines that are the problem; it's the way that we implement the guidelines.

CARL HENMAN: I think part of it will go back to some definitions we use. Commonly, you hear the term "normal birth", and people probably automatically assume that that means a vaginal birth. I'm not quite sure we should be saying that because if a woman feels as though the best birth for her, for example, is an elective caesarean then that's her expressing her individual views on how that should occur for her. We've addressed the

individual nature of humans by asking her about that and asking her what her definition is of the perfect birth. Secondly, I go back to what I alluded to before about guidelines. We need to individualise our care and take into consideration the imperfections of humans. Guidelines, as you've alluded to, can't be set up about individuals; they're set up on groups of people. But some of that group will exist on the edges, so they need to be treated differently. That requires resources and education and everything that Trudi just alluded to that we need to be thinking about in recommendations from today.

Dr AMANDA COHN: In all of this discussion of guidelines, we've been skirting around the edge of discussing the medico-legal environment that you're practising in. Earlier one of you mentioned risk aversion within hospital systems. I was hoping you could comment on the medico-legal environment as it stands, the impact that that's having on practice and if there could be any useful changes to it.

CARL HENMAN: It has a massive impact on practice. I don't think you can overstate it, to be honest. I have almost no doubt that for almost every submission that involved a criticism of one of the healthcare professionals involved, that healthcare professional was worried about what would happen if they didn't do the intervention that they did. Overall, it may be outside the terms of reference of this inquiry, but the medico-legal system has a lot to answer for here because I doubt you'll find a doctor, full stop—let alone a doctor or a clinician involved in obstetric care—that isn't somewhat fearful of what will happen if there isn't a perfect outcome. But, of course, there are no perfect outcomes, so it's a perfect storm for medicine and a perfect situation for the medico-legal community.

But, that being said—and I struggle with this myself every day—I try not to let that, as best I can, influence the care that I provide, even if it is at the edge of guidelines. Because many times acting at the edge of guidelines—obviously I do think it's the best thing to do for that particular woman. Overall, if we genuinely strive to do the best thing that we can possibly do for the woman sitting in front of us, we should, you would think, leave ourselves less open to medico-legal problems. That's not actually the case, but it doesn't mean we shouldn't strive for that. But the summary to your question is the medico-legal environment is a minefield, a treacherous one, and unfortunately marching in a direction that is very sad.

TRUDI BECK: I guess we talk about this frequently at work. At the hospital I work in, there's a healthy culture within the department. I have never felt that there was an attempt at blaming or finger-pointing. I think that it deals with complications in a really healthy way because we know that in this process there will be complications for some women. The medico-legal side of things is at the back of all of our minds all the time. The healthcare system is risk averse from that perspective, and so we're inherently encouraged to adhere strongly to guidelines so that there's less room for interpretation of clinical decision-making. But I agree with Carl that the problem is that, in the submissions that I've read and the hearings that I have listened to, that's actually one of the features of the care that women don't like. That's what I alluded to in my opening statement. I think that it's an inherently challenging area to work out how we provide individualised care—perhaps, like Carl says, on the edge of guidelines—but still be able to assure people safe outcomes for both mothers and babies.

I know that there's been allusion in previous submissions to the idea that the World Health Organization recommends 10 per cent to 15 per cent caesarean section rates. That's just never going to occur in Australia. That is not going to happen because who is the clinician who is going to sit back and be, like, "Well, we've already hit 10 per cent caesar rate this month, so I'm going to have to sit on this really average CTG for a bit longer and hope that you're the one that's going to prove me wrong"? That's just not going to happen, and I don't think any clinician would be expected to function under that model. Like I said, that's one of the things. When I've listened to what you're all having to listen to, I just think it's the wicked problem of how do we give the safest care we can give with the best patient outcomes, with the least—justly allocated—medico-legal interventions? How do you do that?

CARL HENMAN: I think we can address some of the likelihood of ending up in a medico-legal fight by some of the stuff we've mentioned in relation to continuity, particularly after the event. There are a number of cases where it seems that the meat of the case is, "I wasn't followed up appropriately," and then of course the woman becomes increasingly disgruntled about the trauma that she has suffered because there was inadequate follow-up and inadequate debriefing. We can address part of it by aspects of what we're discussing today. There are parts of it we are never going to address and, in that sense, I recognise what you're saying or maybe what you were alluding to—that guidelines are in part, at least, there for a reason. But they're there for the majority of the middle of the bell curve. They're not designed for the edges of the bell curve. I did say in my submission that what's right for one woman will be catastrophic for another. That is true both emotionally, mentally and physically, so individualise your care.

The CHAIR: Thank you both for coming in today, and thank you for all your advocacy in this space as well. We really appreciate it, and we appreciate the evidence that you've given us today. I don't think any questions

were taken on notice, but if the Committee has further questions then it will be in contact with you about those questions. The Committee will now break for lunch and will return at 1.15 p.m.

(The witnesses withdrew.)

(Luncheon adjournment)

Ms LESELLE HERMAN, Midwife, Leeton Midwifery Group Practice, affirmed and examined

Ms REBECCA QUIRING, Clinical Midwifery Educator, Leeton Midwifery Group Practice, affirmed and examined

Mr ANDREW HEAP, Senior Manager, Primary Care Engagement, Murrumbidgee Primary Health Network, Murrumbidgee Region GP Antenatal Shared Care Program, affirmed and examined

Dr TRUDI BECK, GP Obstetrician, Murrumbidgee Region GP Antenatal Shared Care Program, on former affirmation

The CHAIR: Good afternoon and welcome to our next 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. Does anybody have a short opening statement that they would like to begin with?

LESELLE HERMAN: Ours is twofold, beginning with Rebecca.

REBECCA QUIRING: We work in a standalone level 2 birthing service where midwives are the primary care providers, caring for women throughout pregnancy and for up to six weeks postnatally. We provide local care close to home for women of all risk, consulting and referring to higher level services as required. Women with no or low identified risk factors may choose to plan to birth with us or at a higher level facility. Women with identified risk factors plan to give birth at higher level facilities. We provide a 24-hour on-call service, where two midwives are on call for planned birthing and unexpected presentations. To better explain continuity of midwifery care and its impact on outcomes, we've got some documents to table.

We'd like to table Sandall et al, which is a Cochrane review focusing on outcomes; Tracy et al, focusing on outcomes and cost effectiveness; Forster et al, focusing on women's experiences; Tafe, Cummins and Catling, focusing on the next birth following birth trauma; and the *Continuity of Care Handbook* and New South Wales midwifery toolkit, both focusing on implementing continuity models of care. There are numerous barriers to providing continuity of care and to women accessing their chosen model of care. In early pregnancy, women attend a GP to confirm their pregnancy and refer to a maternity care provider. This immediately undermines a woman's innate ability to trust her body and tells her that the provider knows what's best for her and her baby. This can limit options available to the woman, as the GP may only refer to their preferred provider, even when multiple options are available.

Many clinicians and the wider community don't understand what continuity of care or the full scope of practice of a midwife is. The ethos of clinicians vary widely, with some believing in the physiological process of birthing only needing intervention in select circumstances, versus seeing pregnancy as a pathological state to be managed, only occurring without risk retrospectively. As the tabled evidence demonstrates, the philosophy of a care provider directly impacts on a woman's outcomes and how she feels about her birth. Women have been exposed to traumatic accounts of birth from a young age and carry that with them throughout their journey. There is a perception that intervention is needed just in case, and trust in the birthing process is often a journey from a high intervention first birth to seeking like-minded care providers and a physiological subsequent birth.

Our maternity care system is provider and organisation centric, with rural women expected to travel long distances at great financial expense for appointments that could be done virtually. Our community of more than 10,000 people doesn't even have basic ultrasound facilities available. Fundamentally, a woman's experience is seen as secondary to physical, measurable outcomes. Continuity of care is not seen as core business in Australia but, rather, as a luxury alternative to fragmented care.

LESELLE HERMAN: To follow on from Rebecca, I'd like to offer some possible solutions to some of these barriers to woman-centred care and midwifery continuity of care. Access to the majority of maternity care options and/or Medicare funding for these in Australia is via GP referral, which can be limiting due to lack of knowledge or potential bias. We propose that women and pregnant people should be able to self-refer to a care provider of their choice for their pregnancy, birth and postnatal care. In terms of options available in the public health system, midwifery continuity of care should be the primary option, as evidenced by the documents tabled earlier, which demonstrate the improved outcomes offered by this model of care.

In order for this model to best respond to women and pregnant people, the governance surrounding the care needs to be consumer focused. For example, many women have reported risking out of their chosen model of care as a contributing factor to their trauma. This focus on risk assessment often takes priority over the woman's choices and does not consider that risk assessment is subjective in nature. We propose governance that places women and birthing people's autonomy as the highest priority. Improved clinician education around legal liability

is also required, as fear of litigation is often cited as a reason to enforce procedures. However, this is not necessarily reflected in current legal practice.

An additional barrier to midwifery continuity of care is the procedural reliance on medical oversight for care that is within the midwifery scope of practice. Organisational acknowledgement and governance for midwives as primary care providers as well as increased support for endorsed midwives within public health will assist with this. When additional consultation or referral is indicated and accepted for medical or allied health services, we suggest rostering practices that support consistency of these practitioners. In rural communities, access to virtual care options will also reduce the financial burden of travelling for consultation, as indicated. With regard to funding, the current scheme involves activity-based funding, which incentivises intervention and therefore overtreatment. We suggest bundled funding to reduce this risk.

We also suggest a process by which a woman or pregnant person can utilise funding to access care of their own choice. We also suggest that this concept is applied to education to offer the opportunity for families to seek education from a broader range of options. Finally, we would both like to offer sincere thanks for this opportunity. We cannot stress enough that the most important voices in the room are the women, pregnant and birthing people, and their families, and we hope to amplify their voices. We also humbly acknowledge that our perspectives will not always align with the lived experience of every consumer, and we are here to listen, learn and respect the choice of every individual.

ANDREW HEAP: This joint statement is on behalf of myself and Dr Trudi Beck in relation to the Murrumbidgee Antenatal Shared Care Program, facilitated by the Murrumbidgee Primary Health Network, or MPHN. We would like to table two documents as part of this statement: The first is a brochure for women who are pregnant, to understand their options for antenatal care in the region; and the second is the 2023 GP checklist for antenatal shared care. To begin, I'd like to say that general practitioners are well positioned to care for women who are identified as a low-risk pregnancy. Often GPs already care for these women as part of their practice, or have been involved in preconception care and advice. In the postpartum period, they will continue to care for both mother and baby as part of their regular routines.

When GPs are caring for women in the shared care pathway, they will have at least seven interactions with a pregnant woman during her pregnancy, alongside three interactions with the hospital antenatal clinic. These are at the 14- to 18-week period, at 28 weeks and, finally, at 36 weeks. Postnatal checks under the shared care pathway include four mother-baby appointments in the 14 months after birth. As you can see, caring for low-risk pregnancies in the GP setting provides many benefits, including continuity of care and integration with the hospital to prepare for birth. Our GP Antenatal Shared Care Program orientation and update workshop has been hosted annually since 2011. The pathway option provides choice, continuity of care and greater accessibility for women by seeing their general practitioner during pregnancy. MPHN has led the development of the program and associated workshops in collaboration with the Wagga Wagga Base Hospital and local GP obstetricians, of which Dr Trudi Beck is one.

Across the region we have 20 GP obstetricians, and while they do not have to attend the workshops, many of them do attend annually. The workshops are designed to provide GPs with the relevant information and training to deliver a high standard of antenatal shared care, which includes referral pathways when low-risk pregnancies deviate from normal. GPs and GP registrars must qualify to be listed as a provider of antenatal shared care services and are listed on our brochure, which is the first tabled document. That is updated annually following the workshop to ensure GP listing is accurate. GPs who do not fulfill the eligibility requirements are taken off the listing. Our current brochure as tabled includes 69 GPs and GP registrars listed as shared care providers. In addition to the Antenatal Shared Care Program training, MPHN also leads the work on providing localised information through the Murrumbidgee HealthPathways platform. This online platform contains 11 clinical and five referral pages, localised, relating to pregnancy, lactation support and maternal postpartum checks.

The Hon. EMILY SUVAAL: Thanks so much to you all for appearing today. My first question is to the Leeton midwives—thanks so much for your opening statements. In previous hearings we've heard that some midwives struggle to fulfill the requirements of the 24/7 on-call roster in terms of that midwifery continuity of care which you provide. How do you propose that we respect midwives' personal caring commitments and their own circumstances that may preclude them from working those on-call requirements as part of the MGP, but also ensure that we provide that enhanced ability for women to access midwifery group practice if that's what they desire?

REBECCA QUIRING: I can start with that one. As a non-parent, I was a caseload midwife and I chose to leave that position when I had my own child. The colleagues that I was working with all had young children, and the difference between them and myself was support from their families, their partner, their wider community. They all indicated to me that they were more available for their children than they were in standardised care, or

working the floor, and working standard shiftwork. The flexibility that comes with midwifery group practice means that, yes, you are on call, but your availability is completely different, and it is negotiated with the woman. A woman may prefer to have appointments at 6 o'clock in the evening because that's more convenient for her because she works and that's when her partner is home and that could be facilitated. I think the key for any program is flexibility. It can't be a one-size-fits-all approach. When you're flexible to the needs of the woman and flexible to the needs of the midwife, then we can all succeed.

LESELLE HERMAN: I'd like to add a couple of things to that. Additional ways to support staffing within midwifery group practices—a lot of job advertisements out there for those positions require three minimum years' post-grad experience. That is certainly not necessary within a team that has a culture of support and supporting those earlier career midwives. There is a body of work related to—I think it's called the WHELM study that looks at midwifery satisfaction, burnout and working in continuity model. I would like to take that on notice to be able to provide some of that information as well, if that's okay.

The Hon. EMILY SUVAAL: Sure, that would be great.

LESELLE HERMAN: It's probably beyond the scope of our sphere of influence here, but I'd just like to highlight the continued reference to staffing concerns. Referring to midwives as a predominately woman-based profession does highlight our broader societal views on womanhood and expectations of parenthood. There's a whole broader cultural thing going on there where we go, "It's women who are midwives, but they have kids to look after." There's a lot more that as a society we could be doing about that, but I acknowledge that's beyond the scope of what your power of influence would be.

The Hon. EMILY SUVAAL: Thank you very much to you for providing these tabled documents to us today. My question is to you, Mr Heap or Dr Beck. The Murrumbidgee GP Antenatal Shared Care Program that you have provided us mentions the childbirth education classes that are available, which usually run from 28 weeks and are held, I presume, in Wagga—it references the PCC. In terms of those classes, we heard some earlier evidence today about a video being quite dated. I wondered whether that was the same education class. Is there a fee for people to attend? How is the education provided? Is there anything more you could tell us about those education classes?

TRUDI BECK: Yes, those would be the same classes that are run by Wagga Wagga Base Hospital on a regular basis, usually in the third trimester. I think they're continuously working on updating those and trying to keep them clinically relevant. Beyond that, it would be up to the family's choice and within my private practice, and I'm sure the MGP, or midwifery group practice—I would generally encourage people to go beyond that. That would be the minimum level of education for someone who is wanting to know more about birth and then look to other private providers that the woman would seek out themselves, like other well-known birth classes that are accessible locally.

REBECCA QUIRING: Do you want us to share what we do?

The Hon. EMILY SUVAAL: Yes, from your perspective. That would be very helpful.

REBECCA QUIRING: We did offer classes as part of an MGP and found that they weren't very well received or very well attended by women. COVID kind of gave us a break, a bit of a circuit breaker. I did some research on women's expectations going into antenatal classes. I also spoke to about 12 women who were seeing us who were attending classes at other facilities and sought their feedback. As a direct result of that, we actually don't run classes at the MGP. We do individualised one-on-one discussions around labour and birth. Our antenatal appointments are a little bit longer than what's considered standard. We do lots of talking about labour, birth and the postnatal experience. We have an identified appointment at around about 32 weeks that is longer. Hopefully it's in the woman's home if she'll welcome us into that space, but some women do prefer to come into our clinic rooms. We encourage their support people to be there, and it's completely individualised to that woman, her expectation, her prior experience and her clinical journey.

LESELLE HERMAN: To add to that, I want to highlight some personal concerns of mine. There seems to be a lot of discussion around standardising education and putting programs in place. Firstly, I want to acknowledge that there are broader ways of knowing and seeking information that Dr Beck has rightly pointed out—that families are seeking information from a broad range of sources. That does include knowledge that comes from outside of traditional education programs, so enforcing a standardised education program may interfere with women's options in that respect.

Another concern is that standardisation of clinical care has been implemented to the point where the policies are often overriding the individual's choice and autonomy. We've heard that repeatedly in the submissions that have come from women and families, so further standardisation does feel concerning to me based on that. Another idea I want to highlight is that when we're talking about discussing certain interventions ahead of time—

and, again, I'm here for individualised discussions around what may or may not transpire in the pregnancy, birth and postpartum period—occasionally it can have the undertones of conditioning women and birthing people to accept these interventions if they're suggested later in time. It's a very nuanced and balanced thing to do, but it's just a concern that comes up when we keep referring to things like, "If we talk about forceps birth here, that will improve the consent process later." I'm not denying that education is important; it's just that nuance of it not being in a conditioning space.

The Hon. EMILY SUVAAL: Yes. My final question, likely to the PHN again: With this document in terms of the 2023 checklist, I notice that the version history there is that it's from 15 October. This is quite a recent document. It's also quite a thorough document; it's very clear. I invite you to perhaps advise the Committee of what's gone into this, particularly anything around the "My Birthing Plan form" that is highlighted in there.

ANDREW HEAP: There is an antenatal shared care committee that meet together. It is made up of representatives from Wagga Base, from the MLHD, from the PHN, GP obstetricians and GP shared care doctors. That information is pulled together by that committee through liaising with their various departments and that is how the document is put together. Trudi might be able to—

TRUDI BECK: I think the important thing is that, again, along the same lines as the Leeton midwives, my interpretation of documents like this is that this is a minimum standard. This is ensuring that, for the clinician who may not have the breadth of experience that, for instance, a midwife or a GP with frequent interactions with women of child-bearing age would have, this is a safety net document that makes sure that those women are identified, any risk factors are identified and that they know what their options are in terms of birthing choices. I don't think that this should be looked at as a way to standardise health care, because certainly I don't think for any of these documents that's the aim. I think it's more a safety net for those who are, in the GP world, maybe infrequently coming across pregnant women.

The Hon. SUSAN CARTER: Thank you all for being here. I was very interested, Ms Herman, when you were talking about practical things that we could look at, the idea of virtual care. I wonder if you could explain that a little bit, especially in the context of—what we've heard from a lot of women is the importance of them being heard and, I think, respected by time being spent with them. I'm just wondering whether virtual care would be an aid or a hinderance in developing that relationship with a woman.

LESELLE HERMAN: Yes, absolutely. Thank you for that question. That suggestion has come from, I guess, experience working rurally, where we don't have any onsite obstetric medical practitioners for women and birthing people to see. They do have to travel if consultation is indicated, and they accept that. It would be a very individualised approach, so basically just having it available. For some women, they don't mind travelling the either 45 minutes or an hour and a half, depending on where they're going, one way—so an hour and a half and three hours round trip. Some people don't mind that. They have abilities to have their children looked after. They're financially able to take the time off work and that face-to-face interaction is important to them—fantastic. Of course they can go attend the clinic in person. But all of those factors can be really restrictive for families that don't have access to that support. Being able to simply just come into their local midwifery clinic that is only, say, 10 minutes from their home and then have a dialled-in videoconference with whatever practitioner is involved would obviously save them a lot of time and money in that respect.

REBECCA QUIRING: We've actually had women accessing our service who have not attended those appointments because logistically it's just not possible for them, but they're quite happy and able to come and see us. Even taking it a step further, we actually do antenatal care in the home as well for women who can't come in and see us. I guess, from a practical standpoint, if we need to consult with an obstetrician, if we're in the room with a woman and the obstetrician needs a physical assessment that requires laying hands on a woman, we can do that for them in the room and then communicate that virtually. It's about accessibility. It's about making it woman centred rather than practitioner centred and organisation centred. I think we have the facilities and the technology available to do it; it's just getting everyone on board.

The Hon. SUSAN CARTER: If I understand it, the proposal is that it would be used as part of multidisciplinary care. It would be not in the woman's home, but it would be in the group practice. How does that address issues like, I think you said, access to ultrasound, other issues with access to blood tests or other medical needs?

REBECCA QUIRING: We have pathology in our local community; ultrasound, we don't. I did read something somewhere about—Ms Herman, was that you telling me about—

LESELLE HERMAN: I've worked at a hospital that was a bit larger than the one that we're currently based at. They were able to offer a maternal fetal medicine outreach, so they utilised local sonography services, which, again, won't apply to where we're working because we don't even have those. They utilised the local

sonographer but then teleconferenced with the MFM specialist in the tertiary centre, who was able to review those images, and they did a consultation with the lead midwife, the MFM specialist and the woman or pregnant person so the women were not travelling eight hours return to get a tertiary-level scan. That's not specific to us, but an example of how it can work to look after women in rural and regional communities.

The Hon. SUSAN CARTER: This is a very practical question. If we were looking at something that we would roll out across New South Wales or recommended be rolled out across New South Wales, are there communities where—I imagine you need pretty good internet for the type of scanning and image-reading. Are there practical difficulties in some communities, where we'd be offering something that actually wouldn't work because of internet issues?

REBECCA QUIRING: My understanding is that the facilities that we have access to have got good internet access, but we can certainly investigate that further and get back to you.

The Hon. SUSAN CARTER: No, I'm just raising it. If it's working in Leeton, that's great. I'm aware of other regional and rural communities where there are issues, that's all. I don't want to set up something that looks good but build barriers into that, is all I'm suggesting.

Dr AMANDA COHN: My question is to the PHN. We've had more discussion of GP shared care models today than any other hearing that this Committee has held. I suspect that's because we're in Wagga Wagga, and that's in part to the work that you've done. I'm interested in understanding what are some of the attractors or some of the barriers for GPs to sign up as shared care GPs. Do you get that kind of feedback from them?

ANDREW HEAP: I don't work in a clinical capacity, but my understanding is that this is an area of medicine that's quite complex and quite time consuming. They are possibly two reasons why more GPs don't sign up.

TRUDI BECK: I think people self-select to this. The same as there'll be GPs who don't find their niche in dermatology, there'll be other GPs who don't find their niche in obstetrics. We have the luxury in our area of being able to easily refer to another practitioner who is more comfortable with that field than we might be ourselves. Perhaps the MLHD can talk to more the issues around some of the things that you were referring to earlier, but I think the reason why GP obstetrics does come up in this MLHD is because once you go beyond the hubs of the regional centres, your care is entirely reliant on midwives and nurses working at the top of their scope and GPs who have sub-specialty areas.

I think the resources to keep all of the services running in the smaller communities is a constantly evolving challenge. Probably COVID, to a certain extent, in my opinion, has helped us with service provision because it has pushed the envelope on what is accepted delivery of care. I don't know if that's been a shared experience with Leeton, but certainly we've noticed even our access to education has improved in regional areas in the obstetric space, purely because of the push for making more things online.

Dr AMANDA COHN: As a follow-up, I am interested in whether you have any sense of the numbers of supply and demand. If someone's preference is to have GP shared care, can they usually get into that kind of model?

TRUDI BECK: I don't think there is an issue in Wagga with that kind of model. Certainly I know, from speaking with my GP obstetric colleagues in the smaller communities, that there are high pressures of on-call ratios and frequent issues that then become a challenge for resource provision in Wagga, as the referral hub. The wellbeing of the rural midwives and GPOs is critical to the success of the central units. It might not seem like a lot if a rural hospital goes on what we call COSOPs, where they can't provide safe provision of services. It might not seem like a big deal if it's one hospital having three or four births a month, let's say, for instance, but if five hospitals in our catchment area are doing that then it puts the central referral hospital under intense pressure. So it's to all of our benefit if upskilling and support can occur to peripheral sites to enable them to provide consistent service provision. From my perspective, working on the floor at our regional hospital, we are frequently put under intense pressure when peripheral locations are unable to work at the top of their scope of practice.

The CHAIR: I have a couple of questions for the Leeton Midwifery Group Practice. I am wondering how many birthing women you are able to accommodate each year within your own practice and if you find that there is a demand that is higher than what you are actually able to accommodate.

REBECCA QUIRING: We provide care to about 120 women a year, which has been consistent over the years. Most of those women, however, don't birth with us for various reasons. These are women that we might be seeing from 14 weeks antenatally. In our community, getting into a GP is becoming more and more of an issue. We are talking about fit, healthy women that don't often become unwell. If they are not on the books with a known GP, they may not actually even be able to get in earlier than that. So we have been providing consultation to

women earlier than that 14-week mark and then we will continue to look after them postnatally and then support them as they go and birth in a high-level facility.

We do have a number of women that, in terms of risk assessment, could safely give birth with us but choose not to because they would prefer and feel more comfortable to birth in a higher level facility. Currently, we can provide the service that we are doing, but that is only due to the sheer tenacity and dedication of the midwives that work in our practice. Without them, it would not be possible. You can't pick our model up and put it somewhere else unless you also take the dedicated midwives with you.

The CHAIR: We have also heard a little bit this morning and in other hearings about staff shortages, particularly shortages of midwives in regional and rural areas. I was hoping that you could talk a little bit more about the impact of that and how that translates to women's experiences giving birth in regional and rural areas.

REBECCA QUIRING: Trudi actually alluded to that when she used the word COSOPs. In our facility, if we have unplanned leave or even planned leave and we can't fill the vacancy with an agency midwife, then we have on occasion needed to go on what's called COSOPs, which means that we are downgrading our service, which means that we are not providing an on-call service. That is definitely an issue. I think it's an issue universally across the world that we are short of midwives. I don't know what the solution is. Who would want to be a midwife at the moment?

LESELLE HERMAN: That leads into what I was going to suggest. This is only anecdotal but, in speaking to midwives, there are midwives who are either leaving the profession altogether or leaving the public health system because they can't tolerate working in a culture that disrespects and abuses women and birthing people. It affects midwives too, and they leave the profession. I guess it becomes this self-fulfilling thing. And then there's a staffing shortage and the culture deteriorates. Although, I also would suggest that being understaffed is not an excuse for care that undermines a woman's bodily autonomy and respectful care, even under a lot of staffing pressures.

The CHAIR: We also heard at one of our other hearings that some women had been able to get their own midwife, however the hospital wouldn't allow that midwife to actually be there during the birthing process. Is that something that exists in your experience as well?

REBECCA QUIRING: Are you talking about a privately practising midwife?

The CHAIR: Yes.

LESELLE HERMAN: Full disclosure—I am planning on leaving the public health system and working as a privately practising midwife. There is some governance that does allow endorsed midwives to have visiting rights in public health services and there are certainly midwives who have been able to do that successfully, which obviously is far better for the continuity of women and birthing people who either want to or need to birth in a facility rather than at home. However, again, anecdotally, using those pathways to get visiting rights can prove quite difficult, depending on what facility you are inquiring at. It certainly is a big barrier to really enhancing that continuity.

The Hon. NATASHA MACLAREN-JONES: I have a couple of questions. I might start with the midwifery group. You mentioned in your opening statement about being more consumer or client focused and the risk assessment versus choice. How do you find that right balance?

REBECCA QUIRING: I don't think it's up to us, necessarily, to find the balance because a woman's perception of her own risk is the most important thing. Myself as a practitioner or the facility that I work within may say, "This is high risk", but that's all in a matter of perception. What you may consider to be too risky may be different to the next woman. It's not that we shouldn't be looking at risk; of course we should. But this is all about communication with the woman. This all comes back to informed consent, which was discussed before, where the autonomy and the decision-making is with the woman. No-one is more invested in that woman's outcome and the outcome of her baby than that woman herself. The decision is hers.

The Hon. NATASHA MACLAREN-JONES: In relation to the shared GP model, how do you reach the women? Is it purely based on engagement through the hospital or through midwives? How do you tap into them to say, "These are the services that are available"?

TRUDI BECK: Essentially, women will mostly self-refer. Because of the breadth of the number of clinicians involved in the program, most practices will have a GP shared care provider within the practice in the main practices in the area and then the practice will triage the women to those particular clinicians. And then my practice would be that when I see them at one of those initial appointments I will offer them the models of care that are available within our area. Unfortunately, midwifery group practice is not one of those. Then they will

choose to either have the GP as their primary care provider or they will choose to go with one of the other models of care.

The Hon. NATASHA MACLAREN-JONES: Are you at capacity at the moment with the number of clients or what scope do you have?

TRUDI BECK: Do you mean me personally?

The Hon. NATASHA MACLAREN-JONES: Across the whole program. How is it managed?

TRUDI BECK: Across the program I think we would have similar challenges to Leeton. I would say that those are challenges that exist across the entire rural health network. The difficulties that women will come to us with are "I can't see a shared care provider at this particular practice", because that practice's books are closed. Andrew would probably know how many practices within the region would have their books closed, but it would be the same situation as Leeton. So, unfortunately, for some women that does mean that they are left in uncertainty for a period of time while they find a clinician who is capable of pointing them in the right direction, so to speak. But I would say that that's probably a challenge that exists across all the regions, not this one in particular.

The Hon. SARAH MITCHELL: My question is to the ladies from the Leeton group. I'm sorry if you touched on this before, but I don't think you did. I am curious as to the genesis or the origin of having that midwifery group practice in Leeton because obviously it's a smaller regional community. How long has it been operating? What was the reason why? Why do you think your community has been able to set that practice up? What led to it?

LESELLE HERMAN: Because of the community.

REBECCA QUIRING: Yes, because of the community. The Leeton midwives started in 2016. It started because there was a complete closure of the maternity unit. They were functioning as a level-three service under GP obstetric-led care, and it completely closed overnight. The service was completely driven by the dedication of the original four midwives working at the Leeton hospital at that time, the local manager, the MLHD midwifery manager and the Leeton facility manager. We also had intense community support from the local mayor at that time to establish any service. Geographically, we are 45 minutes by car to the next facility that's offering maternity services. At two o'clock in the morning, that's a very long way. It has been running successfully since then. I came into the service in 2019. Not shortly thereafter—and it wasn't because of me, I hope!—we had 75 per cent of the workforce retire or resign. Filling those positions has been a long process, and it is a credit to the midwives working in the service that we've been able to keep it going despite all of that. We're still short one midwife.

The Hon. SARAH MITCHELL: How many have you got?

REBECCA QUIRING: We've got myself and three others. That is providing a 24-hour service, seven days a week with three midwives and myself. It is a big ask.

The Hon. SARAH MITCHELL: That's what you were talking about before in terms of how you manage that as well.

The CHAIR: Thank you, all, for coming today and for all the work you're doing to advocate for women in this space. There were a couple of questions on notice, I believe. The Committee will be in contact regarding those. There may be further questions from the Committee as well, which the secretariat will be in contact with you about. Thank you again for your time today and for the information you've provided us.

(The witnesses withdrew.)

Ms JILL LUDFORD, Chief Executive, Murrumbidgee Local Health District, sworn and examined

Professor LENERT BRUCE, General Manager, Wagga Wagga Base Hospital, sworn and examined

Ms CARLA BAILEY, Executive Director Operations, Murrumbidgee Local Health District, affirmed and examined

Ms SANDRA FORDE, Midwifery Manager, Murrumbidgee Local Health District, affirmed and examined

The CHAIR: I now welcome our next witnesses. I begin by reminding witnesses in this session 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 an opening statement they'd like to begin with?

JILL LUDFORD: I have a statement that I'll make on behalf of all four of us. Thank you for the opportunity to participate in this hearing and to make an opening statement. Firstly, I'd like to acknowledge the traditional custodians of the land on which we're meeting today, the Wiradjuri people. I pay my respects to Elders past and present and extend that same respect to emerging leaders and to Aboriginal people here with us today. I acknowledge the courage of the women who have bravely come forward to share their personal stories through this inquiry and the impact birth trauma has had on their lives. I appreciate that there are others who have experienced or witnessed birth trauma who have not engaged in this inquiry. We also respect your feelings and experiences. Sharing your personal experiences is making a difference by contributing to strengthening maternity services so that more women can have a positive birth experience, with better communication and engagement throughout their care.

On behalf of the Murrumbidgee Local Health District, I sincerely apologise to the women who have accessed our maternity services and found that their needs or expectations were not met. I'm sorry we let you down, and I acknowledge the legacy birth trauma can have on a woman's mental, physical, social and emotional wellbeing and the impacts on their family. As a chief executive, a previously practising midwife, a child and family health nurse and a mother, the experiences you have shared with us have significantly impacted me and many of my colleagues as well. Women have united to have a voice in seeking meaningful change to show that maternity services now and into the future can change. We are committed to listening and learning from what each person is telling us to build woman-centred maternity services that support holistic trauma-informed care.

In 2022 the Health Care Complaints Commission informed me of complaints received from the Maternity Consumer Network. I took these complaints very seriously and, at my request, the Clinical Excellence Commission completed a resilience assessment at Wagga Wagga hospital. The assessment was undertaken by experts in birthing, accountability, and clinical care and safety. The experts found that the maternity service was well prepared for when things go wrong; however, the service could be improved and made 11 recommendations to the district. The district has accepted all of the recommendations and is implementing all of these that will strengthen maternity care services to ensure that they are collaborative, equitable and woman-centred.

I am going to give you a brief update on the recommendations: enhanced oversight, with a governance structure at board, district and hospital level; the appointment of a clinical director in obstetrics and gynaecology at Wagga Wagga Base Hospital in April 2023; and the establishment of a consumer group to co-design a continuity of care model at Wagga hospital. Further engagement will be progressed with a diverse range of community groups, including Aboriginal and culturally and linguistically diverse women. Follow-up after discharge—a four- to six-week midwifery-led postnatal follow-up service has been established to discuss with the woman follow-up and support. Capturing feedback—the hospital has established a consumer feedback survey for antenatal and postnatal care, and results are shared with the consumer group. Mapping the consumer journey in the prenatal clinic—we have recently had a whole group of people come through to map the consumer journey to inform immediate improvement and recommendations that can be considered by the consumer group.

There is also the implementation of alternative birthing models and birthing education; the introduction of a new hyperemesis gravidarum model of care for pregnant women to maximise their time at home and at work; building capacity to care for women who have experienced trauma—staff from the hospital maternity units have attended a trauma first aid course in November and are active participants in the mentoring in midwifery program; progressing pathways for women who identify childhood or adult trauma in the prenatal period; and, finally, environmental improvements and enhancements are being made to the parenting room in the postnatal ward.

We acknowledge we have a lot of work to do. We recognise that pregnancy and childbirth are momentous events in the lives of women and their families and that this represents a time of intense vulnerability. The steps we are taking are with the understanding that it is not just clinical care we are providing. Our care must encompass respect for the woman's basic human rights, including respect, autonomy, dignity, choices and preferences. These include working collaboratively with women and other providers such as doulas, birth keepers, private providers

and clinicians from other jurisdictions. Essential to this is ensuring that the woman is placed at the centre of her own care.

Our staff across the Murrumbidgee region deliver maternity services in a number of hospitals, community settings and also in the home. Care is provided by a highly skilled, multidisciplinary team, including obstetricians, GP obstetricians, midwives, counsellors, allied health professionals, and by other specialised teams, including mental health, alcohol and other drug clinicians and an Aboriginal health team. Our health service delivers approximately 2,200 babies each year, and our staff are committed to providing safe, high-quality care. We know midwifery continuity of care models are desirable for women and their families, with improved outcomes for mothers and babies as well as a highly positive experience. Our midwives tell me they have much greater satisfaction working in this way where they develop ongoing, nurturing relationships with the women and their families they care for. The district provides a maternity continuity of care model in Leeton, as we have actually just heard. We are committed to creating woman-centred models of care for our maternity services, and we are doing this in collaboration with local women.

In partnering with the Wagga Birthing and Babies Support Group and representatives from the Maternity Consumer Network, the Wagga Wagga maternity consumer group has been formed to co-design a continuity of care model where women have known carers. There will be no exit point for women should complexities arise during their pregnancy, and there is also a commitment for this group to go beyond co-design of this new model and to continue to play a part in how the services are provided to ensure we improve experience and quality. There is much to learn. NSW Health's key policy—connecting, listening and responding—is a blueprint that has been developed to guide us on our collective journey. We would like to reassure the women who are currently accessing our services that we are entirely committed to providing you, your family and your carers with the highest quality care. I would like to thank and recognise our dedicated and skilled staff, our volunteers and our carers, who all play a vital role in the service we provide to our community. Thank you, Chair. I look forward to answering your questions.

The CHAIR: I might start with a few questions myself, and then we will move around the Committee. You mentioned Maternity Consumer Network. Has either the hospital or the LHD met with Maternity Consumer Network?

JILL LUDFORD: I have met with the Maternity Consumer Network on a number of occasions, and they kindly provided me with some names of women who had made complaints about our service. I can advise that each of those people has been contacted by the local health district to offer support and also to ask them if they would like to have their concerns investigated by a completely independent expert obstetrician and midwife from within the New South Wales health system. Those women have appreciated the call. We also invited them, if they would like, to join our consumer group which is doing the co-design of our continuity of care model. I am pleased to say that a number of women said they are interested. Some of them were a bit busy but contributing in different ways. Some of them have helped with particular projects. One of them is actually on the co-design group.

We will share with each of those women, when we get back, the feedback around their individual complaints. We have also asked for those complaints to be themed because we think that there is a lot that we can learn broadly across the system from the themes around what we are hearing from people's experiences. Generally, they obviously go beyond safe clinical care. The majority of what we are hearing is all about what we heard from our gracious women today. It's about their experience in the system. It's about us being able to look at them with a deep sense of respect and to understand their vulnerability. Those are the themes that came through, along with communication as well.

The CHAIR: You mentioned that you offered individual investigations. Did any of the women take up that opportunity? If so, how far are you along with those individual investigations?

JILL LUDFORD: Yes. All of the women are pleased for us to have those complaints looked at independently from the health service, and that is well underway now. In fact, we expect to hear something by the end of the year. I would just like to appreciate that, for these women, it's been a long journey. That in itself is really traumatic for them as well as they relive some of the experiences that we've heard today.

The CHAIR: You also said that you would offer these women support. Can you detail what support has been offered to them?

JILL LUDFORD: We offered a range of options for people. The first thing was if they already had a counsellor who was providing them with support we offered some payment for that service. Also, we offered a range of online supports that we know are evidence-based, trauma-informed support.

The CHAIR: Is that psychological support?

JILL LUDFORD: Psychological support, yes.

The CHAIR: It has been mentioned that, in response to the complaint, the hospital was going to recruit a clinical director of obstetrics and gynaecology. Has that occurred? If so, what changes have been implemented since that person's appointment?

JILL LUDFORD: Yes, that was one of the first things that we were able to complete once we received those HCCC investigations. In fact, we did it beforehand. That occurred in April 2023. We have a new director of our obstetrics and gynaecology service. I think, too, Chair, it's about what we've invested in that person being a leader, obviously, as we go through significant change and cultural change within the organisation. The director is receiving support from the New South Wales clinical lead in obstetrics, and Dr Andy Woods has been down to Wagga Wagga. She is also going to go through some leadership training with the Clinical Excellence Commission and HETI, and she is receiving some great mentoring as well.

The CHAIR: What is being done within the changes that have been implemented to ensure that every woman that comes to the hospital to give birth is given the opportunity for informed consent in respect to procedures or interventions throughout birth?

JILL LUDFORD: We've heard a lot about consent as we have listened to our various people who have put in submissions to this inquiry. Consent is around the conversation that we have with women and how we appropriately allocate time for people to have that conversation with their midwife and obstetrician, if they have one. Some of the work that we've done around looking at the mapping of how people go through our clinic to make sure that we can streamline their time and allocate them with a known carer is really going to help us to allocate that time, where we can give people appropriate time for conversations and education.

The other thing that we've done is making sure that people are aware of their obligations under the New South Wales consent manual. But, really, consent needs to be given after informed information has been given, and that has been I think the biggest change—where we understand that the woman is the final decider in giving her consent. It's about asking for her decision in what she wants to see in the options of her care and also completely understanding that there are processes if she decides that she wants to have a look at another option which is outside of the clinical recommendations. So it has completely changed from giving that decision back to the woman and making sure that the service providers are able to provide enough information for that woman to be able to make some decisions. It's not about the blunt approach, which goes into the hazards and the risks; it's a conversation.

The CHAIR: Obviously that information is so important and then obviously that leads to that informed consent, and it is one piece. How are you making sure that that's actually taking place on the ground in the hospital? Are there any sort of surveys or questionnaires or anything to make sure that these aren't just discussions but it's actually being implemented through that whole process?

JILL LUDFORD: Chair, I might ask Sandra Forde to answer that question because as a chief executive I'm that level above the service delivery. So I think Sandra and Len could probably provide further information.

SANDRA FORDE: Thanks for the question. We have implemented antenatal and postnatal surveys for women. A lot of the questioning around that is around respect, whether the women actually felt respected during their care, whether they felt that they had appropriate involvement in the decision-making process and around those sorts of questions to actually get the person's experience as opposed to what actually happened. We have had good feedback from that that women have felt that they are being treated with dignity, that they have felt that they are being respected and that they have felt that they have had appropriate discussion and involvement and were the decision-makers in their care.

The CHAIR: Did you find any change through that survey? Did it begin one way and then sort of start to shift as those changes were being implemented?

SANDRA FORDE: The survey, we have had in place probably for around six months now, and I think we had probably made some changes prior to introducing the survey. I don't think there has been a lot of change in the survey responses. It has been six months since we implemented it, and then we will go back and review the questions and see what further information we can get out. But it's the woman's experience that we want to get out of the surveys. We've also implemented the four- to six-week follow-up phone call with women; that is every woman that birthed within the hospital setting and we have identified that, as has probably been mentioned earlier, it's not about the traumatic birth, meaning the woman had an emergency caesarean section, that causes the trauma for women. The touchpoint at four to six weeks is to enable us to have some further conversation with women and to identify if women actually require any further follow-up.

The CHAIR: One final question from me. I understand that you've started implementing a whole range of changes, and I'm just wondering if there has been a mechanism to get feedback from the healthcare professionals that are working in the space and what feedback they have in regard to changing the way things are done. Obviously quite a large number of changes are being made in quite a short period of time. Has there been feedback and what is that feedback generally?

JILL LUDFORD: What we've really looked to change is our culture and the way that we see women in terms of their clinical care as well as their whole experience in receiving the care. We've really done that by trying to embed that culture of deep respect. It's almost a charter, if you like. I think there has been a number of mechanisms through the M&M meeting, which is a morbidity and mortality meeting where staff come together and are talking about the change. I think in that forum they are also looking at the data, and we are very fortunate in New South Wales to have what we call the QIDS MatIQ. I don't know if you've heard about that through the hearing, but every week it's information from our electronic medical record, which is extracted and gives clinicians almost real-time information about some of the things that we're doing in terms of rates of induction, emergency caesarean and a whole range of factors. Together with the feedback that we are receiving from staff and from the women themselves, coming together and having those conversations is really, really important. But, Professor Bruce, you might also want to comment, particularly around the processes for staff to give back.

LENERT BRUCE: The M&M process in the end leads to feedback to the hospital national standard on the clinical governance committee, if there are any particular recommendations. There is also feedback to a quarterly perinatal M&M meeting, and they will also provide feedback to the hospital executive and also to the district clinical governance meeting. Clearly this has been a significant time of change for us as a facility and as a health district, and there has really been significant consultation and collaboration with our staff, regular rounding, regular meeting. Probably the main area where we're currently providing support to the senior obstetricians is in regard to patients who would like to choose a different pathway than what is medically recommended.

A lot of it exposed in New South Wales that there is no New South Wales policy, which is different to Queensland. There is also no college document. A lot of time you spend supporting the clinicians to make sure that they can support women that have a different care pathway and make sure that we look after them and also look after the clinicians. But there has been lots of feedback, regular meetings. The clinical director has got regular feedback with the director of medical services and, in his absence, with myself as executive director of medical services. Our feeling is that the clinicians are actually embracing the choice. It's obviously very disappointing for us when the community that we serve don't have a positive experience when we look after them. That has been distressing for all staff, and for us this is a tremendous opportunity to learn.

The Hon. SARAH MITCHELL: I just want to thank you all for attending, not just your session this afternoon but I also note you have all been here throughout the day. If I say that, it will all be recorded by Hansard so people who aren't at the hearing will be aware of that, because I know that you and a number of your staff have been here and I think that's really important in terms of the respect for this process but also hearing firsthand those stories from this morning. Thank you for your attendance. I just wanted to ask a couple of questions. One is a little bit more broad in terms of continuity of care, not just here in Wagga but across the health district. It's something that has come up today but also in previous Committee hearings that we've had—witnesses talking about, in whatever model works, how you can have that sort of trusted relationship.

In terms of workforce challenges or pressures more generally, what are some of the ways that your health district is supporting—whether it's more midwives or the health professionals that we need? What are some of the positive things that you are doing and maybe what are some of the challenges around that personnel level of support that we need for continuity of care? I know it's a big issue but anything that you could offer in terms of that would be useful. I am happy for any or all of you to answer.

JILL LUDFORD: I'll get Sandra to talk about the continuity of care planning. Obviously something very dear to our hearts is the Leeton midwives who presented today. I was chief executive at that time when the last doctor left Leeton and we were looking at how we were going to continue to provide services for the community. It was essentially a decision of close and have people travel or do something differently, and we didn't have any midwifery group practices at that time. So it was the tenacity of the midwives to engage the community and their ability to work flexibly to really set up our first midwifery model. But Sandra might want to talk about that, because it's not the same in every community. We've got a number of midwives who are at different stages of their own family journey and their flexibility to work in that way, as we've heard throughout this inquiry.

We are particularly committed in the larger centres to creating a continuity of care model. We're doing that with that consumer group. It's really important that we develop that trust and time, because the model will be different. It will be a model where there is no exit point if complexities arise during the pregnancy, which is very

different to other models where people get bumped out of a model and into the traditional model if they have a complexity in their pregnancy. We're also going to make it available for everybody. I want to reiterate, it should be the woman's choice around continuity of care and models of care.

Before Sandra answers—I'm hogging the floor—I want to say the GP shared care model can be a really good continuity of care model if everybody is aligned. We heard today that doesn't always work if there's not good communication, but there are examples where it does work really well. In some of our towns we have just a couple of GP obstetricians and a small group of midwives at their local hospital who they get to know. If they do have to go across to a bigger centre for a specialist consultant appointment, they've still got those known carers back in their home town. Many women might birth in the bigger centre but will nearly always choose to go back home straightaway so they can have their visitors and family and that whole celebration in their home town. So it is almost a continuity of care model, and we're fortunate to have that relationship with the Murrumbidgee Primary Health Network where we have come together collaboratively to make it work, because unless we have that annual review and that conversation about how we need to improve it, it's never going to work. So we're very fortunate. Sandra, you might want to talk about the work you are doing more generally.

SANDRA FORDE: It was interesting—and we heard from one of the consumers this morning. I think there's a bit of clarification that we need. We can have continuity of care, which is a philosophy of care, and we did hear from one of the consumers this morning around the philosophy of care. She felt that the philosophy of care was the same through whether she was in antenatal birthing or the postnatal period. Or we can have continuity of carer, which is where you do have a small group of clinicians providing care. You may have a named midwife who provides the majority of the care but the women are introduced to the other midwives so that they work within a small team. Because, as you know, we're not on duty 24/7, and we also have to have time away from the work environment.

Within our rural birthing sites, we do have GP obstetricians and the women quite often choose continuity of care with their GP obstetricians. It's their GP obstetricians who follow them through their children's immunisations, their childhood and their illnesses along the way. So we do have continuity of care with GP obstetricians. We also have the smaller numbers of midwives in those rural sites so that when the women do see the midwives, they do know the midwives. It's a small community. Their children go to school together. They play soccer together. They do have that familiarity with the midwives.

In the larger sites, like we've alluded to, a continuity of care model is really important. I know we've heard a lot about risk and people being risk assessed out of models of care or continuity of care. But in a larger site where you have a wider and a broader multidisciplinary team, there's really no reason for women to be risk assessed out. Leeton is a little bit different because it is a standalone midwifery unit, so they don't have access to GP obstetricians. It is a matter of transfer to a higher level of care when that woman has identified risks associated. Within a midwifery scope of practice, we have the Australian College of Midwives consultation referral guidelines and they identify to us as midwives what sort of complexities we need to consult with the medical officer about and what sort of complexities we need to refer on. So I think there's an opportunity for lots of different models of continuity but, for me, it's about the philosophy. It's about having the woman in the centre. It's about that partnership. It's about that trusting relationship, and it's about that culture through all our maternity services.

The Hon. SUSAN CARTER: Thank you all for being here. Professor Bruce, could I ask you a bit of a perhaps technical question, and you may need to take it on notice. I was interested when you were talking about practitioners being open and supporting women who wanted to take alternative pathways and some of the difficulties around that. I think you flagged the fact that there wasn't a college document and there wasn't a policy document the way there may be in other States. I wondered whether this creates any difficulties with respect to the Civil Liability Act in New South Wales and whether we need to be looking at, for example, the definition of professional negligence in section 5O, where there is the need to have some peer recognition of this as a pathway, or even issues around the *Rogers v Whitaker* duty to warn and whether this creates issues for professionals supporting women wishing to take individual pathways.

LENERT BRUCE: This is probably one that I'd take on notice, to discuss the details.

The Hon. SUSAN CARTER: Ms Ludford, I want to acknowledge that some of the evidence we heard today indicates that the recommendations that have been developed and that are being implemented appear to be making a difference in women's lives. I also wondered if you could perhaps identify obstacles that the health services met in trying to implement some of those recommendations and ways around them. I think it's especially important to the extent that this may be something that informs what happens in other places in New South Wales.

JILL LUDFORD: Yes, thank you. There are probably four areas where we need to have a look at more system-wide change. The first one I think we've already touched on, which is that informed decision-making and valid consent that you've just touched on and also ensuring that we do have a guideline to guide clinicians when

women choose care outside of the clinical recommendations. You can put those things together to say we really need a system-wide approach to how we can do this better for women. The second one is around how we debrief women after birth, because it's not just a matter of having a conversation. We talked about the fact that we are doing post-delivery phone calls with women, but that's not quite the same as the debrief.

Debriefing requires training for the person who's undertaking it and certainly not determining who is someone who might have had a traumatic birth, because people have had all sorts of previous experience in their lives where they've had trauma that they may not have shared with us. Just the experience of birthing can bring back all sorts of really difficult things to make those people particularly vulnerable. So we can't judge. We can't have an unconscious bias about who is or isn't offered a debrief. I believe debriefing should be offered universally to everybody, and midwives can do this but they will need some specialised training.

The other thing is, in that debrief, if there is information around the system that is important, there probably needs to be a way that we can pick up that as feedback and take it back into all of the things that we're getting in terms of feedback, whether that's compliments, complaints or information coming through the data. It needs to be fed back in so that we can continue to make improvements. It's all about making improvements. If women share their experience and there are issues in there, as we heard with one of our women this morning, who felt that it didn't go anywhere, then women will feel dismissed. So part of that debriefing is around offering the immediate support for women, that mental health support and whatever support they need, but the second thing is for us to learn from that debriefing around what the system has done to perhaps contribute to their experience.

The other one is trauma-informed care. Again, as a system, we need more education for our midwives and probably our early childhood nurses as well. I've heard one of the women today talk about the fact that she received a visit. We have universal home visiting, as you know, where they receive a visit from the child and family health nurse a week after birth. What a great opportunity for a debrief conversation. It's not just about how the baby is feeding or whether the baby is gaining weight, it also needs to be about the woman and how she is going and how her partner is going—as well as the whole broader family. There's a real opportunity there to leverage from that to really be able to broaden that scope of debriefing and trauma-informed care.

Dr AMANDA COHN: I have a couple of questions but I first wanted to acknowledge a couple of things from your opening statement. The first one is your apology on the public record. I think that is a really important part of healing for the people who have made submissions to this inquiry so I thank you for that and acknowledge that. I also wanted to acknowledge the work that is being done to implement those 11 recommendations from the HCCC. It's not ideal that it took a collective complaint to the HCCC for that work to happen but I acknowledge that that work is underway. We have heard evidence this morning that that's already having an impact. My first question is about the experience of patients in outlying communities. We heard from Leeton specifically this afternoon but obviously Murrumbidgee has a large number of smaller communities as well. Has there been any work done to do outreach to those communities, whether that's with midwives, with an obstetrics registrar or with any kind of virtual care models to try and minimise that travel burden on people that are coming into Wagga Wagga for care that's led by the LHD?

JILL LUDFORD: What a great question because we have eight different maternity services across our region. They all are tiered and networked together. Sandra has started some really great work on how we might be able to provide that virtual support. Sandra, I'm going to get you to talk to the work that we've done. There's more work to do, could I just acknowledge.

SANDRA FORDE: We do have one outreach midwife clinic out at Hillston, which is actually Rural Doctors Network funding. I have a midwife out there that provides antenatal and postnatal care one day a week for that small community. That does help women who are birthing in Griffith—the tyranny of distance—so they can have the majority of their antenatal care with a midwife and then postnatal follow-up with that midwife. We heard earlier today about the woman's experience, which is always really important, and the use of virtual care in that area. What we're looking at and what we're trialling with one of our sites at the moment is to have the woman with the midwife in the site and do virtual care in to the obstetric specialist at Wagga so that there is a midwife there providing hands-on care with the woman by listening to things like fetal hearts because it is a little bit difficult to do virtual care.

During COVID we did have some guidance from the ministry around what we could do virtually but, of course, because we do things like psychological screening and domestic violence screening, we never do that screening unless it's face to face. There are reasons why we do do face to face but we're trialling to have a maternity care provider or midwife with the woman so that then the woman comes into the hospital at her community. We're trying to decrease technical issues that might happen or women not being able to get on to the internet for the virtual appointment and they can then have contact with the specialist obstetrician virtually to try and prevent that process.

Dr AMANDA COHN: That's very interesting work. Is there a time frame for the trial you've got underway?

SANDRA FORDE: We're hoping to commence in January.

Dr AMANDA COHN: Fantastic. My second question is about the communication with GPs. We've heard earlier today that for the GP obstetricians who provide intrapartum care in the hospital they feel very well connected to the hospital providers but that for GPs who either don't provide intrapartum care or aren't GP obstetricians, they feel like there's a lack of communication or collaboration with the hospital. What work is being undertaken that space?

JILL LUDFORD: I'll get Len to respond to that in a moment but I want to start by saying we—there is considerable risk with the declining numbers of GP obstetricians, as you probably know. I guess when we're looking to the future, the numbers of GPs are declining at an alarming rate in regional and rural areas but the number who are choosing to do obstetrics as their advanced training is an even greater risk. I think since we've introduced our new Murrumbidgee GP training pathway, where we've employed them as registrars—I think that we've only had one that's actually done and completed his advanced GP training. He's up in Young and doing fantastic work there. We really need to think about that because that is a really big risk to future models and those continuity models. We need to really understand that, in the next few years, those numbers are going to be so low. We've got quite a few now who are operating on their own. What does that look like in terms of their work-life balance? It's a problem area.

I think there's probably more work to do in the communication with non-GP obstetricians and generalist GPs. In Murrumbidgee I have appointed a director of primary care who is a GP himself, Dr Alam Yoosuff. There's probably some work that we could do with Alam in his community of practice with his GPs. I think we need to go and ask them what it might look like. Just thinking aloud, Len, is whether or not we have some regular open days where they come in and meet the director of obstetrics and gynaecology and get to know some of the consultants and the midwives—equally as important—because there may be times when they need to call a midwife rather than a registrar, I suspect.

LENERT BRUCE: The challenge that we have is that the electronic medical record doesn't allow for non-NSW Health employees to have access. That makes it really easy for our GP obstetricians because they access it the same way I access the medical records. We are currently working with our health information team to actually see if it's possible for us to create access for our Aboriginal medical centre medical practitioners as a particularly vulnerable group because the easiest way to share information is through access to their electrical medical record. That yellow card that's been in place since I was intern is still there. At least it's some information but clearly we're very excited about the option of the single digital patient record where we can see GP records and they can see ours. It is challenging. It has improved over time.

I'm still doing some perioperative medicine—my background's anaesthesia. I spoke to a patient the other day, and just having records scanned in and me not having to go through five paper files to find information is really a tremendous improvement. Clearly, there's lots of anxiety about cybersecurity and providing more access to the hospital network but we are working with our health information team to see if that's possible because that would be the easiest way to have up-to-date information. There are some open days—I think at least once a year—between the shared care group where they can get together. That's also an opportunity to share the newest guidelines and for people to get to know each other. There are opportunities, but it is tricky. I think the other bit that has helped is having the health pathways. That's available for all GPs and we have a number of services that MLHD provide that form part of health pathways.

JILL LUDFORD: And wouldn't it be great if we had that yellow card, that antenatal card, combined with the birth plan for the woman and available digitally for—there are doulas and others too that we need to think about for that collaborative approach for the woman.

Dr AMANDA COHN: Thank you. I think that's really interesting information. I have one very cheeky follow-up on behalf of my GP colleagues. The open days where they can come in and meet the maternity staff, are the GPs compensated for their time to attend those?

LENERT BRUCE: It's a first question. It's definitely something that we'd consider because, in the end, it's looking about after patients, and the more engaged they are, the better care our patients will receive.

JILL LUDFORD: It's probably something we can talk about with the primary health network around practice incentive payments. Something like that, yes.

SANDRA FORDE: Those days also carry CPDs for the GPs. It is organised by the primary health network; however, it's Health, midwives and obstetric teams—we provide that education and the clinical scenarios and participate in that day as well. I do know that they actually can get CPD points for the education.

The Hon. MARK BANASIAK: I guess my question is to you, Ms Ludford. Today you have spoken a lot about cultural change. We all know cultural change is quite difficult, especially in a large organisation such as a health district. What steps are you taking to make sure that that cultural change sticks and keeps evolving, given that our midwives and our doctors are obviously in a very busy, high-paced and highly stressful situation and aren't necessarily always thinking in the front of their mind, "This is the new way of doing things." How are you maintaining that ever-presence?

JILL LUDFORD: That's a great governance question, actually. I know in conversations with our board, who also took this whole experience very seriously, it is how do we make sure that this doesn't happen again, where we get these voices coming forward that we needed to hear sooner? In terms of cultural change, it's about making sure that it's not person dependent. It doesn't matter if I'm not here or Professor Bruce isn't here; the process that sits behind it needs to be entrenched and it needs to be really clear. The other thing around culture is we really need to engage with the hearts and minds of the staff so that they own it but, along with that, there needs to be accountability. So we have processes in place.

We have a culture change program, which has helped in this process, called Our People Our Future. It is about having aligned goals, aligned behaviours and aligned systems. Every year we all have the same aligned goals, and our behaviours help us to deliver those goals. We have particular coaching mechanisms where we can coach teams through periods of change, because these things are very hard to implement, but they're even harder to get them to stick because there's a tendency for people to go back to the status quo. In this case, because women sit at the centre of it—when I visited the midwives recently at our big hospital, they told me how much they admire the women for coming forward, because it's what they want too.

It is about making sure that we align all of our goals and that we own it, but we also need to hold ourselves accountable. So that's at a hospital level; then at the district level, where we've got a new maternity quality and safety governance council that is looking at all of these things, particularly around the consumer feedback and the improvements; and then right up to the board, monitoring it through their committee. One of our board directors is here today, who will oversee that process at the board level as well. I hope that answers your question. It is around governance.

The Hon. MARK BANASIAK: It does, thank you.

The CHAIR: Before I move on to the Hon. Emily Suvaal, I have two quick follow-up questions. Do you know how many individual investigations were happening?

JILL LUDFORD: I will take it on notice, but I know it's approximately 30.

The CHAIR: And that's being funded by the LHD?

JILL LUDFORD: Yes.

The CHAIR: And those roughly 30 women will receive a report, you said, hopefully by the end of this year?

JILL LUDFORD: Yes, we should have the recommendations back from those independent experts. We'll ask the women how they would like to receive the feedback, so we'll certainly offer them a meeting, but we'll also offer them written information as well. I think that's important.

The CHAIR: You said that some of the support that was provided was a reimbursement of the costs for psychological care or counselling. Was that a full reimbursement or a percentage of the cost?

JILL LUDFORD: I'll take it on notice, Chair. My understanding is it was a full reimbursement, but I will check and make sure that is accurate.

The Hon. EMILY SUVAAL: Thanks to you all for appearing today. My first question is likely to you, Ms Ludford. In your opening statement you mentioned the work the consumer working group is doing. I invite you to give the Committee some more information about the group if you are able to—how often they meet, what the make-up of the Committee is, what they're working on and all that sort of stuff.

JILL LUDFORD: I can, and I'll also go to Sandra because she's a member of that group. But there are five consumers currently in the maternity consumer group. Joining them is Sandra, who, as you've heard today, is our midwifery manager for the district; and also Jill Reyment, who's here today, who is our director of clinical governance. She co-chairs that committee with our consumer representative. It is really important that we offer

consumer representatives reimbursement for their time, and so there has recently been—and it is welcomed—a New South Wales policy to enable us to provide remuneration to consumer representatives when they're doing this really important work with us. Professor Bruce is also a member, because I think it's also important that the hospital takes ownership because, at the end of the day, they're going to need to do the implementation.

They were formed in September of this year and my understanding is they've held three meetings. We have put the time frames very much in the hands of the committee, because we want to get this right. At the first few meetings it was very important that we got to know each other and developed the rapport and the trust. I think some of the information that's coming back, which Sandra can talk to—those important elements around it being eligible for all women and for there being no exit point if complexities arise, but also them continuing their work after the co-design. The continuity model of care is designed, but there's a lot more work to do, as we know, through implementation to make sure that we look to see how it's working and what further improvements we need to make.

For me, being able to run through things like a new app or information that comes through and get that consumer feedback as we go through this continuous change process around the improvement with the consumers is really fantastic, also acknowledging that the Ministry of Health have set up two expert groups at a State level. One of those is the expert consumer group, which we have invited two of our local consumers to join so that they can have that greater conversation around the system change as well as their local change. The second group that the Ministry of Health have set up is the expert clinical advisory group, which is going to have a look at the continuity of care models, the consent guidelines for women who choose care outside of the recommended clinical pathway, debriefing and trauma-informed care. I think those are really great topics for the system to have a look at and that we're going to help to feed into. Sandra is a member of that group. She is pretty busy. Sandra, what else is our consumer group doing locally?

SANDRA FORDE: Our consumer group—also a member is our director of obstetrics—

JILL LUDFORD: Sorry, that was a terrible omission.

SANDRA FORDE: —and the midwifery unit manager from the local site. There are five consumers. We do have co-chairs, as Jill mentioned. The other co-chair is a consumer. It has been a process around getting to know each other, getting to trust in the organisation, getting to trust that we are very open to suggestions and we really want this consumer group to be led by the consumers, not by guidelines or by any other process. We've looked at terms of reference. Of course, terms of reference were developed in collaboration and in partnership with the consumers, with feedback.

We've looked at information brochures. When we looked at the themes from the complaints or the feedback that had come through the consumer group, we identified things like pain relief medication and information about induction of labour, which I know came up earlier today. We have drafted a patient information brochure on that, with diagrams, because it can be quite a long process and I don't think we communicate that very clearly with women when they're going down that pathway. So we've got some brochures out there.

At the last meeting, one of the consumers gave a presentation around continuity of care, and what continuity of care could look like and what it might look like. We talked about things like philosophy of continuity of care as opposed to continuity of carer and as opposed to named primary lead carer. Then I gave a presentation around different models of care. So we can talk about midwifery group practice and we can talk about midwifery antenatal and postnatal continuity of care. There are lots of different models out there. We wanted to explore and provide people with information so that when we do our co-design, it's a model that the consumers think would be a best fit for our communities.

The Hon. EMILY SUVAAL: My next question might be best directed to you, Ms Ludford, in the first instance. You've touched on the work that you're doing with GPs locally, but is there anything else that you can add to describing that work that's occurring locally and in recent months, indeed, in terms of helping with the local GPs here in Wagga to best support consumers with maternity services?

JILL LUDFORD: I might ask Carla Bailey to talk about our sonography service that we've recently established here with one of our GPs in the region.

CARLA BAILEY: Before I talk about that, I might just add that with the patient mapping journey through the antenatal clinic that Jill referred to earlier, part of that process is actually looking at that collaboration with the GPs and how we can strengthen and improve the sharing of information and actually, indeed, that case management-type approach with the GP and the actual service at Wagga because we've recognised that that is a gap and something that we definitely can work on. I think that process will give us some clear ideas about how we might go about that. We are in the process of establishing some interviews and discussions with local GPs to

understand, from their frame of reference, their experience and how they think we could actually improve that with our service at the hospital.

In terms of the fetal ultrasound service, we've heard a lot today about travel and people having to go large distances to access care. We are part of a tiered maternity network with the Canberra Hospital and their specialist Fetal Medicine Unit. We have local expertise here in Wagga and we've established a fetal ultrasound service through that provider. That allows women to have scans and ultrasounds here locally, which saves them time and also allows them to go on with their day-to-day business. Many women have more than one child and have other family commitments, and going long distances to access ultrasound services is problematic for these women. So that's something that we've put in place most recently, in the last six months. It's working well, and the feedback we are getting from the women is really positive and encouraging. I think that's a really great step forward.

The Hon. EMILY SUVAAL: My final question—although I've got many more—is around progressing care pathways for women who've identified previous trauma. That was something you mentioned I think in the opening statements as well. I'd just be curious as to what work is going on there also.

JILL LUDFORD: I think we've talked briefly about the importance of doing domestic and family violence screening for women early in pregnancy and then again in the postnatal period, and also the psychological screening as well in terms of prevalence towards anxiety and depression, which is called the Edinburgh Postnatal Depression Scale screening. At least one in 10 women experience a level of anxiety or depression either during their pregnancy or after birth, so it's very important that we identify people early in the process, before they really start to get that terrible impact on their lives.

We already had the mental health perinatal network established. That has been well established in our district and, in fact, has been part of some research that we are doing. We've recently realised that we need to broaden that out to be more than just mental health. So we've recently got a working group going around having a really multidisciplinary approach, not for all of the clinicians caring for the women, but just working out what is the unique plan for that woman. That includes social work, and social work came up a lot today because sometimes there are actually things happening in people's lives were social workers are absolutely ideally positioned to be able to assist and haven't necessarily been included in the past.

That is also for women with culturally and linguistically different backgrounds, it's also for interpreters and it also brings in counsellor services, particularly around our priority populations area around domestic violence or people who have experienced previous sexual assault. So all of those people have come together, but the idea is how we can develop a unique plan for women that is individualised to them. So they have started work. They've had a couple of meetings now to make sure that early in pregnancy, when we do this screening, that something happens with the results and that it is obviously discussed with the woman around what her needs and referrals might look like.

Dr AMANDA COHN: Would you be able to table the terms of reference of your consumer group either publicly or confidentially to the Committee?

JILL LUDFORD: Yes, I'd be happy to. Thank you.

The CHAIR: Wonderful. That brings us to the end of today's inquiry and this session. Thank you for spending time with us and taking time out of your very busy workloads to give evidence today. We appreciate that. I believe there were some questions taken on notice. The secretariat will be in contact with you in regards to those. The Committee may have further questions as well, which they will contact you about. Thank you all again for attending today. I know it has been a difficult one to address, but we really appreciate that you've been able to come here today.

(The witnesses withdrew.)

The Committee adjourned at 15:05.