THE HOUSE OF ASSEMBLY SELECT COMMITTEE ON REPRODUCTIVE, MATERNAL AND PAEDIATRIC HEALTH SERVICES IN TASMANIA MET AT THE CRADLE COAST AUTHORITY, BURNIE ON TUESDAY 18 FEBRUARY 2025.

The Committee commenced at 9.26 a.m.

CHAIR (Ms Haddad) - Welcome to today's hearing of the House of Assembly Select Committee on Reproductive, Maternal and Paediatric Health Services in Tasmania and thank you for your written submission. Could you please state your name and the capacity in which you are appearing before the Committee?

Ms MARSHALL - Yes, I am Kaylia Marshall and I am here to give my story.

CHAIR - Can I confirm you have received and read the guide sent to you by the Committee Secretary?

Ms MARSHALL - Yes, I have.

CHAIR - This hearing is covered by parliamentary privilege, which means you're able to speak with freedom and without fear of being sued or questioned in any court or place outside Parliament based on anything that you say here today. That protection doesn't attach if the statements that you make could be considered defamatory and you repeat them or refer to them outside of today's hearing.

It's a public hearing, as you know, but we're not being broadcast, but members of the public if they've heard that the inquiry -

Ms MARSHALL - They're all stuck in traffic.

CHAIR - The media might appear, but we're not actually being physically broadcast. I will now ask you to make the statutory declaration.

Ms KAYLIA MARSHALL WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Thank you. Additionally, we recognise that during these hearings we may discuss highly sensitive matters that have deeply impacted the lives of Tasmanians. This may be a trigger for individuals listening to or participating in these proceedings.

Here comes Rob Fairs.

I'd encourage anyone impacted by the content matter during this hearing to contact services and support such as Lifeline's helpline 13 11 14.

Welcome, Rob.

Mr FAIRS - So sorry.

CHAIR - This is Kaylia. Don't worry, you're not the only one that has been stuck in traffic; it's almost everybody.

Mr FAIRS - Crazy.

CHAIR - This is Rob Fairs, who is a member for Bass.

Mr FAIRS - Hi, sincere apologies.

CHAIR - Also PANDA's National Helpline on 1300 726 306, which provides support Monday to Friday from 9 a.m. till 7.30 p.m. and 9 a.m. to 4 p.m. on Saturdays and public holidays.

We also have clinical support workers in the room today from Gidget Foundation Australia. Dr Erin Seeto and Ms Amelia Walker are available to provide support to you before, during or after your appearance and we have a breakout space available to you to use for anything you require.

Additionally, if there's anything that comes up during today's proceedings that you would prefer to be heard in camera - which basically means in private - you can make that request of the Committee and we have a short deliberation to agree to that and then we can move to in camera. Ordinarily, that would mean it stops the broadcast, but what that means procedurally is that it would still be recorded, but it wouldn't become a public transcript.

That's all the formalities. I invite you to make an opening statement if you would like to do that.

Ms MARSHALL - I guess I made a submission because I knew that from my experience speaking with other women and men, but predominantly other mothers in the Tasmanian community, that my story is quite, almost unfortunately, unique because I've had two really positive birth experiences for where I've had physiologically and psychologically really healthy births. I know very few women who have, in recent times at least, gone through that to have two positive births. I wanted my story to be on record with a little context around the things that helped to make that. There are a lot of decisions that lead to having a positive and healthy [birth], and setting us up as a family, a really positive experience. I don't think it happens magically. I think those things led to that.

CHAIR - I am glad that you did make that submission because you're right, the majority of what we've heard have been pretty traumatic birth experiences. It is good to have some positive stories on the record also. Would you like to elaborate about your experience of using a privately practising midwife for your births?

Ms MARSHALL - I didn't know anybody who had homebirth or, particularly, contracted private midwives within the health system or to birth at a hospital. I'd always, in the back of my mind, wondered when the time came whether that might be something I would want to consider. I have a family history of very capable birthers, not a lot of complications, and physically I don't have any reason to consider that I'd have issues. I'd always wondered about it. When I spoke to my doctor about it, I found out that she'd actually had homebirths herself. When your doctor, who is a highly trained medical professional, has had that experience that made me go, okay, there's a bit more to this.

We started to explore that and by fortune, I guess, a friend of mine who is also pregnant, her auntie is a privately practising midwife. Therefore I had a contact to be able to find

somebody who, by extension, I trusted to have an initial conversation and move in that direction.

That is part of the story. I believe definitely that my doctor who had homebirths, helped my husband to wrap his head around it a bit because his initial reaction, I imagine a lot of men also, was hesitant. He is as much of an advocate for having that choice of homebirth now as he has had a positive experience himself.

CHAIR - That was your GP who'd had that experience?

Ms MARSHALL - Yes, two out of her four births, I believe, were homebirths on the north west, I believe.

CHAIR - I had another question about your submission on being sent for scans and blood tests and feeling like there was undue pressure - that's my words paraphrasing yours - on induction. Could you talk us a bit more through that experience?

Ms MARSHALL - Our midwives are not hippie midwives who are doing everything outside standard protocols; there's scientific backing to a lot of these things. They wanted us to have scans and appropriate blood tests to help us monitor. I was fine with that. That gave us all confidence, my husband, myself and our midwives too, to birth at home because we understood more about what was going on in my body. That was really good.

We were still engaging with the public system in Burnie, going to the obstetrician appointments as normal, again making sure we were ticking off that everything was looking okay, and getting that well-rounded support and feedback on how the pregnancy was progressing. I can't remember exactly where, but my 20 week scan with my first pregnancy - the size was suggesting a little bit larger. From memory I don't know whether it was 70th or 90th percentile, but the scan was really a bit larger.

We went back for another scan based on obstetric suggestion and our midwives were supportive of that to have another scan at approximately 35 weeks, I believe it might have been. There was suggestion of a larger baby from the scan and that's the only evidence. Our midwives would be visiting us regularly and feeling my stomach. They have felt hundreds and hundreds of babies and it wasn't adding up for them. They could not feel this baby as a big baby.

When I went to the appointment - and this was during 2020, so in the throes of COVID - my husband couldn't come in. The obstetrician, who I had never met before, basically said, 'Well, your scan reads large. You should not be having a homebirth, and we should be inducing you in x amount of days'.

CHAIR - What week were you during that?

Ms MARSHALL - I think I was 38, 38-and-a-half maybe. They didn't even want us to go beyond 40. I certainly didn't understand what I understand now, but again, with the secondary resource of information as our experienced midwives, they were saying, 'Look, it's not adding up. Even if it's a big baby, it's not going to make a lot of difference between now and then and the baby's probably going to come when the baby is ready'.

The way that it was presented to me was, 'The scans are saying this, therefore this. Would you like me to book you in for Tuesday?', was essentially how that conversation went. No real discussion about what the risks of induction were, what the choices would be if I didn't or the potential implications if I did not book in. I said to the gentleman obstetrician that I would speak with my husband and we would ring and book in. We never booked in, and my baby came when my baby was ready and came at 49th percentile.

We all had a bit of a laugh about that afterwards, the experienced midwives. After having a look into it more and during that time, but also afterwards, there's a lot of evidence that late-term scans actually don't give you very good, reliable reads on size. They give you a lot of other information that's valuable, but not on size. That's been my understanding.

CHAIR - Thank you. That's really informative. I'll open it up to the Committee.

Ms JOHNSTON - The GP visit you had, the very first one, was really critical in giving you the confidence to choose a homebirth. Can you reflect on if the GP had been a bit hesitant, or hadn't had that experience themselves? Where would you have gone for resources to find out a bit more on this? You felt like you were really quite interested in doing - how would you have navigated that? You had your friend, obviously, but the GP sounded critical in that kind of confidence moving forward.

Ms MARSHALL - It was important for me to get my doctor's feedback because I trusted her from my experience with her. She explores options and I was interested in what her thoughts were. I did think she would have a positive view on that decision, that option. If she had shown hesitancy or suggested otherwise, I actually just might have been a bit surprised, but I probably still would have pursued a discussion with some midwives to see whether we felt like it was a good fit and looked perhaps more at the literature around some of it. Yes, I'm not sure what I necessarily - I think it helped me give me confidence, but I think I was already starting to explore that for myself. It wasn't make or break for me.

Ms DOW - I was going to ask you - obviously, you mentioned in your submission around the shortage of private practising midwives on the north west coast. You said that you were able to contact one through a friend of a friend. Are you aware of exactly how many there are here on the north west coast?

Ms MARSHALL - There are two, and they work together as a pair. Having one midwife to see you through your pregnancy has huge implications for your birth experience and your whole experience. There's so much evidence, and you guys have probably heard a bunch of that, around Know Your Midwife programs. Knowing two midwives and having the option of which one to pick up the phone to was amazing too, because sometimes you gel with some people and not so much with others. There are two on the north west coast; they work together as a team and they have a limited capacity.

They are constantly turning people away. They cannot - they can only - they service an area; they service people from Stanley to Birralee. I know they've done Launceston in the past, but now there's a few more in the Launceston area starting up. They turn people away quite frequently and that leaves people to end up in the hospital system, where they may not have the experience that they want or that's just not the option that they want. I know that there's an increase in freebirth rate from what I've understood from various conversations as well.

Ms DOW - You talked a bit about the feedback that you've had from other women across this region. I just wondered whether you were comfortable elaborating a little bit on that - what some of those key issues have been for those women who you've spoken to that differed vastly from the experience that you had?

Ms MARSHALL - There are so many different ways that - every person's story is so unique. I'm trying to think back to some specifics. I think because we had people we could pick up the phone and talk to all the time, we had that support throughout the pregnancy. When you don't know somebody or you're picking up the phone to ask a question of somebody who you've never spoken to in your life - often that can be quite an intimate question that you've got to ask. It probably means that we just got care that we may not have got - or a lot of women may not have got because they wouldn't have felt comfortable asking for their support.

I'm trying to think of some specifics. I know women who felt pressured into inductions and have ended up going ahead with those inductions. Often, that results in a - statistically, there's that trajectory towards a caesarean section.

I am, as I understand it from speaking to people within the homebirthing community, one of the few who goes for a homebirth as their first time birth. It's quite a high frequency that women have a traumatic experience in the health system and then turn towards homebirth, or at least privately practising midwifery, to provide that support and that secondary opinion on the status of the pregnancy.

I have a lady who I did know at the time; she birthed with - our second-borns were birthed within 30 hours of each other by the same two midwives. They had two very busy nights on one weekend in September. Her first birth was one thing to the next thing to the next thing. She had a caesarean and a very challenging time out of that and did not want to repeat that experience.

Without speaking to real specifics on people's stories, I don't know anybody else who's had, bar one person, all their children as homebirths and had great experiences.

I hope that helps answer that. That's a big question.

CHAIR - I suppose it would be good to hear from you about the experiences that you've had subsequent to your babies being born, whether you've witnessed very much change in the medical system or just anecdotally amongst other new parents in the north west. You mentioned that you've heard anecdotally about an increase in the number of freebirths, which is worrying, and that's down to lack of availability or, potentially, experiences in the hospital system. Is there anything you'd like the Committee to hear about those kinds of experiences or conversations that you've had?

Ms MARSHALL - I think there are some really excellent midwives in the north west coast. I think they're doing everything that they can do for the women and families in the north west coast. I think that they are finding it very hard with the system currently set up and some of the changes that have occurred here in the north west coast with the hospital.

There's, from what I've heard anecdotally, an element, a strong element of, within the health system, obstetricians bullying midwives.

Certainly, whenever I've said, 'we had a homebirth' to somebody like a child health nurse or a midwife, they've been predominantly and overwhelmingly supportive and said, 'Oh, that's great. I bet you had a great time.' Had a chat about it. Whenever I've mentioned that to somebody who is in an obstetric role, it's with hesitation with, 'That's dangerous'. There's no - and the evidence is not there in the literature.

The evidence for homebirth in itself being positive and actually leading to physiological and psychologically positive outcomes is really strong. It concerns me a great deal with that, and it makes it unattractive. The north west coast people talk. It makes it unattractive for people to want to go into the health system here and work in midwifery. I have considered it myself. To work in an environment where the incredible skillset that that midwives have is reduced by a small few obstetricians who are playing power games. That is something that will continue if there is no change. I hope that the changes up here around the shift out of the private into public management of the births - I hope that that leads to that, but I don't know. I know people who have had really great experiences up here birthing too. It is not a 100 per cent for sure, but I also know people who have had really challenging times.

It is really concerning that there are not more privately practising midwives. I think part of that is because of the amount of grit that you have to have to relate to people within the system when you do need to transfer, and they do transfer when they need to. One of my births was looking at a transfer at one point until the baby's heart rate settled down again and we were fine. They will transfer, but that relationship - they do everything they can to support women, but it does not seem to be across the board, that that is at the heart of the team necessarily at the hospital.

Another thing that I can think that I would like to say is that on the mainland, there is a number of hospitals that have been trialling and having great success with publicly funded homebirth. It's not hard. There needs to be frameworks around it, but I think the year before last there was a study around the economics of it. It's actually cheaper for the health system.

CHAIR - I think we are the only state without publicly funded homebirthing.

Ms MARSHALL - I heard once that Hobart actually was the first place to do publicly funded homebirth years ago and then it closed. You would have to fact-check that. I have heard that we did have it and then we have moved away from it. We're a small state. We're spread out, but we also have good hospitals to support.

CHAIR - And we're well connected.

Ms MARSHALL - We're well connected. The difference for me in birthing at home; we just snuggled down. We stayed in our space. We didn't pick up diseases. People could come and visit us. We had the support we needed. I wish with all my heart that more women, more families had that experience. It set me up really well for breastfeeding. I've breastfed both of my babies, still now two and a half years with my son and then 17 months in now with my daughter. These are really great things that are supported by the experience that I have had.

CHAIR - The Committee has heard lots of positive evidence around that connection; the positive evidence that we have heard from privately practising midwives around the post-birth experience and higher rates of longer-term breastfeeding and lower rates of postnatal depression.

Ms MARSHALL - Yes, I can believe it.

CHAIR - It's really great to hear of a personal experience like yours that really backs up what we have heard as a Committee regarding that method of birthing.

Ms MARSHALL - I think there is a lot we can do for women in this space and some of it looks like homebirth. Not everybody will want a homebirth. Some people I have spoken to are like, 'Really? Okay, wow'.

CHAIR - It's about having the choice.

Ms MARSHALL - Yes, it is about choice and we are not giving women the choice. If we hold ourselves up as being a developed nation and a developed state, we are not giving women who are half the population - and a critical half in terms of families being healthy and strong. We need to really think back to the beginning and this is where it begins.

Ms JOHNSTON - I had a quick question. You mentioned beforehand about how you are aware of increased numbers of freebirth on the coast. Do you think that's predominantly because of the traumatic experience they might have previously had or the lack for someone who's wanting to homebirth but can't get into a PPM [Privately Practising Midwife], or is it a bit of both?

Ms MARSHALL - I would suggest it's both. From things I've seen in online forums, particularly, but also in speaking, our privately practising homebirth midwives will not accept families who will not let them do the work that they need to do. If they say, 'We were transferring', we were transferring, we put our lives in their hands. If women are not wanting to let them do what they will do, then they will not work with them, and that's completely fair. They've got a whole lot of insurance and everything around what they need to adhere to. There are women who just don't fit. They want that support, but they don't want - yes. It's very greyscale, I guess.

From what I've seen, it's women who've had a really negative experience that, overwhelmingly, want a midwife. They want midwives at their births; they just can't get them, they just can't get them because they're not available. Women are booking Airbnbs in Hobart or Launceston to travel, to have privately practising midwives and homebirths. That's Australia-wide, but it is happening here in Tassie. Yes, it is both, definitely. If we had two, three, four more midwives on there, they would be booked out. I'm confident of it.

Ms JOHNSTON - And it's only available to those who can afford it, obviously. It's not publicly funded, so it's an expensive exercise to go through.

Ms MARSHALL - Yes, financially. It is an investment, definitely.

Ms JOHNSTON - And then to travel, if you had to book an Airbnb on top of that for however many weeks you need because babies come when they're ready.

Ms MARSHALL - They do. They do. That's right. It is a very privileged position. I'm aware of that, that we've been able to. We saw that as an investment because we knew that the likelihood that that would be a positive setup for us as a family was really strong.

Mr FAIRS - Just a quick question because I've never gone through it, never experienced homebirths. I'm just curious, midwives, what if something goes wrong? Do they have all the equipment and training to adapt to that and deal with that?

Ms MARSHALL - My dad was a 30-year ICU nurse here in the north west coast. His response to me homebirthing - and my mum would have homebirthed if she'd been offered the option too. I trust a medical professional because I trust my dad and he's - talk to somebody at the north west coast, they know my dad. I've got a lot of respect for the profession, but yes, he was the same sort of like, 'Okay, well what happens when things go wrong? Things can go wrong'.

Mr FAIRS - And I'm glad it didn't by the way, obviously.

Ms MARSHALL - And it didn't, but I know people who have had to transfer and have had tears or had to transfer because they've had issues with getting baby up.

Our midwives put a limit on how far from the hospital, so they won't serve at Zeehan down the west coast; it's too far from the hospital. Within about a 45 minute and also, if they're heading to a birth, they'll pick up the phone to ambulance service and let them know, 'We're just letting you know we're heading to a birth in Forth and this is what's going on', so the ambulance service is aware, should they need to know, then they've just got a bit of a briefing on that. There's a limit as far as distance goes. They set things in place with the ambulance service, just as a courtesy. Again, trying to work with the system.

They also carry critical supplies. They carry oxygen, so if the baby comes out and baby needs oxygen. They carry synthetic oxytocin. I didn't need it for second stage of physical labour, where you birth the placenta. It's fairly standard to be given a shot of that. It's not necessarily necessary, but if there's a bleed they can administer that and that helps to stop any bleeding. They've got a number of other supplies that they carry. They don't typically ever need to use them, but they are there if they need to. Yes. Does that answer your question?

Mr FAIRS - Yes, it does.

Ms MARSHALL - Yes, that was what my husband and my father needed to hear. My mum and my dad and my younger brother all were at my second birth and making us cups of tea. They all speak of that experience. My dad was amazed at the skill level of our midwives and how they just got about it. They operated in the space. There was some discussion about hiking boots falling apart while I was giving birth. That, for me, was lovely because it meant that nobody was stressed out, we were all just in it together. My brother, who's a rock climber, was shocked at how strong my grip is, because I was grabbing his hand.

Having that support solidifies a family. It's a very special thing, but it has some really - people who do - I'm sure that there's been midwives in Australia who like to operate in a much greyer zone but the ones that we have here in the north west coast are high quality.

CHAIR - It's highly regulated.

Ms MARSHALL - Yes, it's highly regulated. Exactly.

Mr FAIRS - Thanks.

Ms MARSHALL - No worries, Rob, great question.

CHAIR - I haven't asked at every hearing, but if you had a magic wand to make one critical suggestion that you would want to see for change or enhancement or a magic wand moment. What would that be?

Ms MARSHALL - For the health system?

CHAIR - Yes. A key recommendation that you want the Committee to hear to put into our report writing.

Ms MARSHALL - Every woman needs a midwife. I'd love for them to have the option of a homebirth midwife. Every woman needs to know their midwife and they need someone they can relate with and trust and to follow them through. Not enough women have that opportunity. I believe that has made a huge difference to a lot of the women and to myself.

CHAIR - That's a great recommendation. Thank you. Is there anything else that you'd like to share with us before we finish up?

Ms MARSHALL - No, I think we've covered it well. You have a very important role in helping to reshape some things that need a bit of reshaping.

CHAIR - It's been a very rewarding Committee for all of us. We've had nearly 200 written submissions, which is a very high response rate for a parliamentary committee. As Committee Members – correct me if I'm wrong on anyone - but we're all feeling quite positive that the now Health Minister was previously on this Committee until she became Health Minister. We know that this is front of mind for her. She's read all the submissions as well. We're hoping that the report that we eventually provide to the Parliament will be taken seriously by the department, certainly by the Minister who is very keen to see the recommendations that we make. Your evidence is critical in that. Thank you very much for sharing your physical story.

Ms MARSHALL - I decided to make a submission because I would like to see my daughter and my son - who's already said he wants to be at my daughter's birth - I would love for them to have that option to have a better system in another 20 years' time, if or when that time comes, that they can have that option. The options that I've had within the public system would be great.

CHAIR - Thank you.

Ms MARSHALL - Thank you everybody for your time, I really appreciate it.

THE WITNESS WITHDREW.

The Committee suspended from 10.23 a.m.

The Committee resumed at 10.30 a.m.

CHAIR - I welcome you again to the hearing of this House of Assembly Select Committee on Reproductive, Maternal and Paediatric Health Services in Tasmania. Thank you for the written submission that you've provided and for attending in person today.

Could I ask you to state your name please, and the capacity in which you are appearing before the Committee?

Ms HARDING - What does capacity mean?

CHAIR - Just your name, just as a member of the public, I suppose.

Ms HARDING - My name is Kimberley Grace Harding. I'm here as a member of the public.

CHAIR - Can I confirm that you have received and read the guide sent to you by our Committee Secretary, Mary?

Ms HARDING - Yes, I have.

CHAIR - Thank you. This hearing is covered by what's called parliamentary privilege. What that means is you're free to say whatever you want to say without fear of being sued or questioned in a court or any place out of Parliament. The only attachment to that is that the protection doesn't extend if statements that you make are defamatory and you repeat them outside of this parliamentary hearing.

It is a public hearing. We're not being broadcast, just because we don't have those facilities when we travel, but it is a public hearing. I think there may be a member of the media here and members of the public might come. That said, if there's anything during your evidence that you would like to be heard in private, we can move into what's called an in camera session. You can just make that request of us during the evidence that you're giving. We have a short deliberative meeting to agree to go what's called in camera and then we proceed privately. There'll still be a transcript recorded, but it won't be a public one at the end of the process.

I will introduce you to everyone on the Committee. My name is Ella Haddad. I'm a member for Clark in the south; Kristie Johnston is one of my member for Clark colleagues in the south; Anita Dow is member for Braddon, based up here in Burnie; Cecily Rosol is a member for Bass, based in Launceston; and Rob Fairs is a member for Bass as well.

There is also a sensitive content statement that we're making at the beginning of these hearings, just recognising that we may discuss highly sensitive matters that have deeply impacted the lives of Tasmanians which may be a trigger for individuals listening to or participating in these proceedings. The Committee encourages anyone impacted by the content matter during hearings to contact services and supports on the lists available in person from the Committee Secretary or on the Committee's webpage. We do also have clinical support providers here in the room today, Dr Erin Seeto and Amelia Walker from Gidget Foundation Australia who are here to provide any in person assistance that you might need. We have a breakout room available for that purpose as well.

Could I ask you to make the statement that Max is very -

Ms HARDING - It's a fun toy.

CHAIR - Definitely, including as a toy. He's welcome to do that, but mum just needs it for one minute.

Ms KIMBERLEY GRACE HARDING WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED

Ms HARDING - Do we have backups of these?

CHAIR - Yes, we do. Thank you. All those formalities are now done and dusted. Did you want to make a short opening statement?

Ms HARDING - I do. I have one in my pocket.

CHAIR - Excellent.

Ms HARDING - It's not very long. Max is probably going to be very interested.

CHAIR - He's very patient.

Ms HARDING - Hi, my name is Kim. This is Max who was born last May. I suspect you have heard and will hear more stories involving traumatic birth stories and a broken system. I'm very blessed that my story is positive and empowering.

I've found that being an instinctual mother during childbirth has helped me to be an instinctual mother as I raise Max. I fully believe that, as mothers, we know what's best for our babies, and that includes while we're pregnant, as we give birth, and in the postpartum period and as we raise them.

Much of our system, it seems wants to go against these instincts by following what doctors tell us, even if it goes against our instincts. As a part of MGP [Maternity Group Practice], I was allowed to make decisions for my own care without judgment. My midwife empowered me and allowed me to put confidence in my own body. I'll be forever thankful for that.

I'm thankful for the opportunity to speak with you all today. Thank you for your attention towards the maternity system. Though I've had a positive experience, I know that the huge majority of my friends who have had babies have ended in traumatic interventions and lack of communication from doctors and midwives. I'll watch in the coming months to see the outcome of your inquiries.

CHAIR - Thank you very much. It is really lovely for the Committee to hear a positive birth experience because, you're right, the Committee has heard really traumatic evidence and I believe we all have friends who've had similarly negative experiences as you've described your friends having.

I just wondered if you would be happy to expand a little bit on your experience with the Midwifery Group Practice (MGP) and the importance of that in your experience with Max?

Ms HARDING - Of course. I kind of knew a little bit about MGP when I got pregnant. They offered it to me on my first midwife intake on the phone session, and I said, 'Please, I really want to be a part of that'. They put the application in at every meeting I had with the midwives. I was bugging them, 'Have I gotten in? ' They said, 'We do not know yet, you do not find out until later.' I was really pushing for it. I do not know if that was the reason that I got in, but I know that it is quite hard to get in being overweight. I do not know why I got in because I have had friends who have been rejected saying, 'You are not allowed in because of your weight'.

CHAIR - I've heard that too.

Ms HARDING - Yes, which is stupid.

Mr FAIRS - Can I ask why is that an issue?

Ms HARDING - I do not know. I am not really sure. Sorry.

Mr FAIRS - No, that is fine.

CHAIR - I think that in other states, it is the opposite. If somebody agrees with what you wrote, the BMI [body mass index] is an outdated - I think you wrote that, didn't you? BMI is an outdated way -

Ms HARDING - I cannot remember, probably.

CHAIR - In other states that's a reason to admit somebody into an MGP program but I could be wrong. I have heard that anecdotally. How many weeks were you when you found out you were accepted into the MGP?

Ms HARDING - About 20 weeks.

CHAIR - At 20 weeks? Wow.

Ms HARDING - Yes, I was pretty far along. That is what I was told that I would not find out until then.

CHAIR - How did your care compare before and after admission into the MGP?

Ms HARDING - I think it was really just having that constant person to talk to. They were all different people until I was in MGP and then you had the same midwife every time. She knew what I wanted. The biggest thing with me, because I did have gestational diabetes, was that I did not want to be induced. I was very adamant on that. She wrote in all the notes for the doctors that, 'She does not want to be induced. Don't do it'. It was really great to be able to go in and know that she was accepting of my choices and I didn't have to explain myself or defend myself, but she knew exactly what I wanted. Made it so much easier. I think that continuity of care was the main difference before and after.

CHAIR - After Max was born, what are the interactions postpartum through the MGP?

Ms HARDING - I was meaning to read this, this morning before I came but I didn't. My midwife was actually sick on the day of delivery so they sent two MGP midwives who I hadn't met before to the hospital for me and they were incredible.

They were the ones who visited me postpartum because my original midwife was hospitalised so she was not able to come to see me postpartum. I had two weeks of postpartum, as much as I needed, so that if I needed it, they would have come every day to my home. I didn't need that because I had such a smooth transition to motherhood. It was amazing to have them there, and the same ones. There were two who came when they were rostered and to know who was coming to your house and they would message and say, 'Is it okay if I come at this time?' I do not know if that is what happens normally without MGP, but it was incredible.

CHAIR - I will ask one last question before I open it up to the rest of the Committee as well. You explained that your midwife respected your wishes not to be induced, but then you did actually end up with an induction. Can you just talk us through that? It sounds like, from your written submission, that it was something that you felt was necessary at the time and that you consented to. Can you just talk us through that transition?

Ms HARDING - Of course. When we talked about it, she told me all the risks and she explained why they do induce at a certain time. At that time, I had in my gut if it goes that far, I will be induced. I was not induced until 41 and five. I was nearly 42 weeks. I'd always had that in my mind that if it happens, that's when it's going to happen. For friends, I've said the same thing. ‘Maybe if there is a date of about 44 weeks, will you be induced? When is the time that you are happy to be induced?’ For me, that was just that time.

CHAIR - That you felt comfortable with?

Ms HARDING - Yes. That was my decision.

Ms JOHNSTON - You talked about how your midwife was a really strong advocate for you and how important that was in terms of all your medical notes. Did you get a sense that they were getting pushback from the hospital or doctors in terms of how they were advocating for you, or were you aware of that sort of interaction between them? They sound like a pretty strong advocate for what your decisions were.

Ms HARDING - I know that because I did have the diabetes, I did have to have a few visits with the obstetrician. Before I had them, my midwife was kind of hyping me up and saying, 'You need to stay strong, you do not have to do what they say, stay strong with what you want to do'. Does that answer the question? I don't know if that does.

Ms JOHNSTON - So, just anticipating the sorts of issues that you might be presented with, informing you along the way.

Ms HARDING - Yes, and she'd say, 'They are going to push this. Just be aware that you're going to go in and they're going to want to induce you'. She was kind of giving me forewarning, I suppose.

Ms JOHNSTON - That made you feel that you had the capacity to make decisions fully informed in terms of what your choices were. You'd heard from the obstetrician, you had the trust relationship with your midwife and you were free then to choose what you wanted to do.

Ms HARDING - Yes, absolutely.

Ms DOW - Thank you so much for coming and presenting to us today. It's a big ask to come in and share your experience, so we really appreciate it.

I wanted to ask, you've talked about the importance of a birth plan and you've talked about the contrasting experiences of your friends and the traumatic births that they experienced. Did they have birth plans or understand the importance of a birth plan? Is there anything else that you'd like to leave with the committee around the importance of birth plans?

Ms HARDING - Absolutely, that's actually something that I've found really frustrating when I talk to friends and they say, 'I don't have a plan, I'm just going to go in and wing it.' For me, having a birth plan meant that I understood everything on the birth plan. It wasn't actually about having a birth plan, it was about knowing my choices and my options.

When they came in and would say, 'You need an episiotomy,' and I'd go, 'What does that mean? What are the risks?' Because I already know the risks, because I know why I didn't want one and I've really seen a trend of people saying, 'I'll just go in and wing it, I'll see what the options are.' It's like - I think you mostly have children - you know those hormones are running like crazy. You do not want to make a decision when you're pushing a baby out. It is not the time.

Ms ROSOL - Can I add a follow up question on that? When you prepared the birth plan with the midwife, what was that interaction like? Who was making suggestions and how did you build it together?

Ms HARDING - We had a few drafts. I did a lot of my own research. I went home and there's a really good podcast called *The Great Birth Rebellion* and it gave me so much information and I built my own plan from that. I also did the breastfeeding program by Dr Robyn Thompson and that had a few really good options, suggestions for birth plan, and how that would transition to breastfeeding.

I've had a few drafts and a few things I'd go in and she'd say - I originally had three hours skin to skin before weighing and injections, and she kind of said, 'Look, it's a little bit long, but that's fine if you want that, but you might want to consider maybe changing to two hours', and I did do that in the end, which was fine.

CHAIR - And then you had that time?

Ms HARDING -Yes, we actually had two-and-a-half hours in the end and it was incredible. So, she kind of fine-tuned things and suggested things. She also suggested, I'm trying to remember what I even had on my birth plan. I should have brought it, shouldn't I? She suggested warm compresses, which I hadn't heard about, for the perineum to prevent tearing. I hadn't heard about that and so, of course, then I went and researched it and put it on my birth plan. It was one of the best things that was on my birth plan. It was very much a communal thing, back and forth, me suggesting things, she suggested things. Did that answer the question?

Ms DOW - Yes, so you came with your ideas of what you would like it to be and then she, from her experience, was able to say we could tweak it here for a better experience or a safer experience and so you built it together that way.

Ms HARDING - Yes, absolutely and there were a few silly things I had on there like I was just understanding so much about oxytocin and being happy and relaxed. One of the things that relaxes me, really silly, is the Vicks inhalers and so I put that on my birth plan. I was like, 'If I'm really stressed, that might just help to ground me, you know, just breathe it in' and so she was like, 'Oh, okay, sure'. A big part of her kind of teaching me was, have a toolbox on your birth plan, of things. You might not use them, but if they're there, you can choose to use them in that moment because you really don't know what you're going to want in that moment. If you want to do an inhalation, you can.

Ms ROSOL - So, it's about being really well prepared, like you said before?

Ms HARDING - Yes, absolutely.

CHAIR - Do you know whether the medical professionals involved with Max's birth, as in your experience, had read the birth plan as well?

Ms HARDING - They were incredible. Everybody who entered that room, except the doctor, read that birth plan before. They introduced themselves and then the first midwife would say, 'Here's the birth plan, have a read'. I was so respected. I had on my birth plan to not have Syntocinon for delivery of the placenta and, at that time, when I was pushing out, the midwife said, 'You've got on your birth plan about the no Syntocinon, are you still happy for no Syntocinon?' I said, 'No, just give it to me'.

CHAIR - That's really interesting. That's really good to hear.

Ms HARDING - They were so respectful. I was really pleasantly surprised with how respected my birth plan was.

CHAIR - That's really good because one of the things the Committee has heard at previous hearings, and in some of the written submissions, is the fine line between consent and informed consent during labour. You described it really well: the hormones are intense and if there is a critical incident during labour, some of the submissions we've heard is there is that grey area between consent and informed consent. I don't want to put words in your mouth, but it sounds to me like, having had that process of being able to learn about the different things that could happen in labour and make some pre-emptive choices, was an important part of what led to a positive birth experience. Is that a reasonable way to characterise?

Ms HARDING - Absolutely. Yes, definitely. I completely agree, yes.

CHAIR - And was it easy to find that information out because it feels like, from your written submission you did a lot of personal research as well as being guided by midwives?

Ms HARDING - Yes.

CHAIR - Was it easy to find that information out?

Ms HARDING - Would you mind if I put him [Max] on the floor?

CHAIR - Is he mobile yet?

Ms HARDING - Oh, yes. Super mobile. Now, what was that last bit? I'm so sorry; kids.

CHAIR - I wanted to know how easy or hard it was to find out that extra information to inform the decisions you put in the birth plan.

Ms HARDING - The main thing was that podcast I mentioned, *The Great Birth Rebellion*, because it's a few midwives who are challenging the system and going after evidence-based research, that's right. That's what I found, is that a lot of things in our system are not actually evidence-based now and so, that gave me a lot of information. Mainly that and the breastfeeding course I mentioned. Yes, I found it really had to be me taking on [research]. That's how I felt about my birth leading up to it, it was me going this is my birth, this is not the midwives, this is not the hospital's birth, this is my birth and it's going to be what I want it to be.

CHAIR - What an experience, it's a great way to put it.

Ms HARDING - And owning it has to be you finding the information. As much as I hope that, in the future, that can be midwives. Because I was so well-informed by myself, I don't know what it would have been with MGP if I wasn't. I wouldn't know what that would feel like.

Ms JOHNSTON - You've talked to other mums who've gone through difficult experiences. Can you talk a bit about how you see that both experiences and the pressures put on those mums to not have that choice or to have their choices limited, and how you find that impacts them postpartum in terms of your experiences in supporting other mums?

Ms HARDING - Yes, I mean - I think that - as physiological as you can be with birth, there's less complications in postpartum. If you can avoid tearing - there are things you can do to minimise your chances of tearing - you're going to heal better if you can have a better breastfeeding journey, if you're hoping to breastfeed, which means less drugs, it's all connected together.

Not having the information, you can't make a good choice if you don't have the information. One of the main things I saw with two of my friends was that they both had gestational diabetes. I think one of them had other problems. The baby had some kidney issues. So, they never saw a midwife. I saw one of them a week before her induction date and she still hadn't seen a midwife, she still hadn't been given the opportunity to write a birth plan.

CHAIR - And that was through the public system here?

Ms HARDING - Yes. She had a really traumatic birth. It ended in a C-section after a horrendous birth because the baby wasn't in the right position. I talked to her afterwards and she was completely traumatised by it.

Ms JOHNSTON - In your submission, and it might be the same person, your sister-in-law it was actually, had such a traumatic birth and doesn't want to go back and have another one after that. Particularly, about your brother who doesn't talk about the birth because he was

so fearful he was going to lose his wife and baby. That's obviously a huge impact and very different to your experience.

How have you found the support networks on the north west in terms of other mums talking about their experiences and supporting one another? What's been your experience postpartum of mother's groups? That mental health well-being postpartum experience in the north west?

Ms HARDING - I went to a Bub and Me Group. I went to the one run through East Devonport Child and Family Learning Centre. That was for first-time mums with babies under the age of 6 months. That was great to go along and talk about birth stories and what was going on with the babies. We didn't really keep in contact a lot. I know that sometimes they do stay as a mother's group. I didn't, but it was nice to go along to that. There was one particular doctor that everybody had and everybody had issues with, which was funny.

Somebody once said, I won't say the doctor's name, 'Oh, did you have such and such?' and we all went yep. Then we all said, 'What did he do to you?' which was an interesting thing because I thought it was just me and it wasn't. I mentioned that there was one doctor that - [to Max, seated on the floor] sorry, he's going for the cords. What was I saying or was somebody else saying?

CHAIR - You said there was one doctor, and I know the bit you mean, you said there was one person who made you feel disrespected in the whole experience.

Ms HARDING - Because I was so well informed, I knew exactly what my choices were and he made me feel like it wasn't my choice.

Ms DOW - You were a public patient or a private patient?

Ms HARDING - Public.

Ms DOW - The other question was about your antenatal pre-care, you've talked about how you didn't get that opportunity until 20 weeks. I asked you a little bit about that as well. Is there anything else that you want to leave with us about the level of support you had, prior to that point in time and what services were available? You're obviously very well informed because you did your own research, but had you not done that, it would have been a very different scenario for you. Is there anything you wanted to leave with us on what's required up here?

Ms HARDING - I don't think so**.** I hope that more people can get a place in MGP. My best friend is very similar to me, did a lot of her own research and didn't get into MGP. She knew I was coming to this Committee and she said make sure you say, 'I wish I had got into MGP' and she would have been an amazing person to be in MGP. I hope that in the future people who want MGP, because it is the best standard of care for maternity care, I hope that everybody who wants a place can get a place.

Ms DOW - Was she provided with an explanation as to why she wasn't eligible for the program? Do you know?

Ms HARDING - No, I don't think she was.

CHAIR - How different was her birth experience?

Ms HARDING - She had a good birth.
CHAIR - That's good to hear.

Ms HARDING - I must say that all the midwives were incredible, regardless of if they were MGP or not. They were fantastic. She had a good birth.

CHAIR - I think you've already answered the next question in response to Anita's but, if there was one magic wand moment you could have of how you would like to see maternity services delivered, one big change or one main thing you want the Committee to take away from today, what would that be?

Ms HARDING - I'm thinking because I want to give a good answer.

CHAIR - I feel like you've given us a lot of good answers already.

Ms HARDING - I believe that women should understand the risks of their choices and that they are not, [only] given the consequences. It's so easy to say yes to all the easy things like an epidural, but people are not aware of the risks of dural puncture that increases risk of C-sections. If you don't want a C-section and the cascade of interventions, people don't understand what it is.

CHAIR - That's a great way to describe it. Thank you. Any other last questions or comments? Is there anything else you didn't cover you'd like us to hear?

Ms HARDING - I don't think so, no.

CHAIR - Thank you for sharing your story. It is invaluable for the Committee to hear direct experiences, both positive and negative, to inform the work we do. We are all very glad we got to meet Max. He's the first baby to have attended the Committee. Thanks for bringing him along. He's been so patient.

Ms HARDING - He's got a one-on-one babysitter down here.

CHAIR - Yes, he's got Mary.

Ms HARDING - Amazing, thank you, guys.

CHAIR - It's really good to meet you.

Ms HARDING - Lovely to meet you guys.

CHAIR - I forgot to read this at the end of the last session, but just to remind you that what you've said today here is protected by parliamentary privilege. Once you leave the table, you need to be aware that that does not attach to comments you may make to anyone, including the media, even if you're just repeating what you said to us. Does that make sense to you?

Ms HARDING - I think so. I just won't talk to anybody.

CHAIR - It's more so if anything might be considered defamatory, parliamentary privilege doesn't attach, but I don't think anything that you said has strayed into that territory, so it's fine.

Ms HARDING - Great. Thank you very much.

THE WITNESS WITHDREW.

The Committee suspended from at 10.55 a.m.

The Committee resumed at 11.08 a.m.

CHAIR - First of all, formally, welcome to today's hearing of the House of Assembly Select Committee on Reproductive, Maternal and Paediatric Health Services in Tasmania. Thank you for the extensive written submissions that you've shared with us. Could I ask you to state your name and the capacity in which you are appearing before the Committee?

Ms RAMSEY - My name's Amy Ramsey, I submitted an individual story with recommendations.

CHAIR - Sam, do you mind stating your name just for the written record as well?

Mr THOMAS - Of course, Sam Thomas, here to support Amy.

CHAIR - Thank you. Could I confirm that you have received and read the guide sent to you by our Committee Secretary?

Ms RAMSEY - I have read it, yes.

CHAIR - I'll just remind you that the hearing is covered by parliamentary privilege. What that means is you can speak freely and say whatever you want to say to us without any fear of being sued or questioned in a court or place outside of Parliament. That protection doesn't extend to statements that might be considered defamatory that you repeat or refer to outside of the parliamentary proceedings.

The hearing is public. It's not being broadcast, as I said, because we don't have those facilities when we travel, but there will be a written transcript of the hearing. It's a public hearing and that members of the public might appear and sit in the gallery and we do have one member of the media who's here listening to today's proceedings as well.

Ms AMY RAMSEY and **Mr SAMUEL THOMAS** WERE CALLED, MADE THE STATUTORY DECLARATION, AND WERE EXAMINED

CHAIR - The Committee has also agreed to read a sensitive content statement before the hearings that we've got today, it's a lot of what Mary's already talked about beforehand, but we've been doing it at the start of every session, recognising that during these hearings we may discuss highly sensitive matters that have deeply impacted the lives of Tasmanians, which might be a trigger for individuals listening to or participating or later reading the *Hansard* of these proceedings.

The Committee encourages anyone impacted by the content matter during this hearing to contact services and supports. There are lists available in person from the Committee Secretariat as well as on the Committee's webpage and as you know, you've already met our clinical support workers who are here from the Gidget Foundation Australia today to provide support on site. Dr Erin Seeto and Ms Amelia Walker, who are available in the breakout room, which you've already experienced as well and just to remind you that if at any point you need a break, that is totally fine. We're all here to be in your hands.

If you want to move into a private hearing, we can easily do that as well. What that means is members of the public are asked to leave, there's still a transcript recorded, but it doesn't

become a public one at the end of the hearings and also anything that's said in those private, called in camera sessions, can't form part of the report writing stage of the Committee's work. That's totally up to you whether you want to go into a private session at any time, just make the request and then we'll do those formalities and away we go. So, really it's over to you if you'd like to start with an opening statement.

Ms RAMSEY - Yes. I didn't realise that a 30 minute timeframe was negotiable, so it's actually a closing statement that I was just going to read first, to make sure I got to it.

Straight into the heavy stuff. Instead of acknowledging abusers in maternal healthcare as criminals, victims are forced to be second class citizens and not be worthy of justice. I'm hoping that one day I'm going to see true actual justice for what happened to me.

CHAIR - Take your time.

Ms RAMSEY - I want to see the guilty parties publicly held accountable and accordingly punished, as well as national policy and law change. That would be enough of a stepping stone to move forward and salvage what's left of my cognitive capacity. It's the catastrophic damage that has been done to the only life I have. It might not be for nothing if that change to Australian society could happen.

There's a research paper out of, I think, the University of Sydney. Nursing, midwifery researchers, it's quite good and I think it came out in 2022. It is called *Dehumanized, Violated, and Powerless: An Australian Survey of Women's Experiences of Obstetric Violence in the Past 5 Years*. The study conducted really, well, a massive survey. It is qualitative, but they quantified it. If you read it at some point it will speak for itself. They also pulled together a lot of information about how obstetric violence is criminalised in other countries and how that has worked to reduce it, because healthcare workers know that there's a punishment if they cross the line. They don't get to come back tomorrow with the promise to do better. That is my opening statement.

CHAIR - Before we leap into conversation, I want to thank you for being here today. It's a lot to share your personal story, and it's invaluable. It's very important for the Committee to be able to hear personal stories like yours. We're very keen as Committee Members for this just to be a conversation. We've all got and read your written submission, but we're not going to kind of formally interrogate you with questions. We really just want to hear the parts that you feel you want us to hear most pertinently. All of it is available to us obviously in our report writing stage. I suppose if we were to start somewhere, you've made a series of very valuable recommendations in the second half of your written submission. I wondered if there were any that you would like to talk us through in more detail from your experience.

Ms RAMSEY - I guess I'll start from the bottom. I frequently check and recheck and deep-dive the internet, and the registrar doctor who delivered my daughter doesn't exist. Well, she does. I found her in a few student papers here, there and everywhere and I looked through AHPRA (Australian Health Practitioner Regulation Agency). Not AHPRA registered. There is no one named Annie or any variation of Annie Rose who was AHPRA registered. Getting information out of Burnie is a no – communication with the hospital is not an option to me with everything that has happened. The same as the midwives who were involved. I was told I would get to talk to them and then I was barred from speaking to them.

CHAIR - Beforehand or afterwards?

Ms RAMSEY - Afterwards. In many meetings, the open disclosure and following meetings, everybody hid behind the excuse that they could not answer those questions because they had not been there on the day to make the decisions. They did not know why the junior midwife made up her own pain scale. They had no idea why my records were so far from what happened. Then when it came time to meet with them, they said it wouldn't be possible anymore. Then, later, I think it was Paula Hyland, in writing said that it wasn't possible because the contract had changed and they were no longer private hospital employees. Those people still exist. They still could have met with me.

Anyway, they never are going to have the chance to recognise in their own practice the subtle ways that they took my rights away. They never are going to sit across a table with me and hear me say, 'Don't ever tell another woman she's wrong about her pain. If I say that I'm in pain, then I'm in pain. If I say I want an intervention, that's it. I'm not just someone saying something'. The doctor who delivered my daughter is never going to know that she had the chance to act correctly and in the scope of her practice and be present when I was begging for help and begging for suicide. She went home, patting herself on the back. Job well done.

Even at the very inappropriately late six-week debrief - debriefs need to be within 72 hours. That's what evidence tells us to avoid set-in PTSD [post-traumatic stress disorder]. There's another recommendation. She was still patting herself on the back, really, and didn't realise - because practitioners can register under whatever name they feel like and practise under a different name, that shields them from ever having to face that moment.

CHAIR - Did AHPRA give you any answers around why that is? That people can be registered under one name and practise under another?

Ms RAMSEY - It's just their policy that - it's written on their website, even. You have to bear in mind that the name under which someone is registered is not necessarily the name under which they practise. A travelling student doctor might just go by their first name, they might go by -

CHAIR - Their married name or their maiden name.

Ms RAMSEY - Or you might never hear their last name at all. You can never track them down. In fact, some of - I don't think she ended up making a submission. A friend of mine, one of them, named Amy, tried to work out who the locum midwife was that left her to push for eight hours. Veronica Zupan said that they have no way of searching the records and finding out who that might be. That's not - that can't be true. That can't be true.

CHAIR - Do you mind - if there's anything you'd like to share or feel comfortable sharing about your experience in the health system prior to going into labour. Had you met any of the health professionals who were involved with your care beforehand?

Ms RAMSEY - There's no continuity of care, no. Antenatally, whoever's on the schedule that day for antenatal care will see you, and they all have a different piece of advice. In fact, it was post-COVID, so there were no antenatal classes even allowed. They just point you to the Royal Women's [Hospital] sort of videos, which they're not -

CHAIR - Not the same.

Ms RAMSEY - No scope to ask questions, or they ask you to go pay for like a Tummy Talks seminar, what have you.

The first consultation I had was via telehealth with a lovely midwife called Courtney at the Mersey [Community Hospital], who I did later meet in person. She was delightful, but she was of that same culture of, 'Patients are the second class. They don't know as much because I've got the letters behind my name'. When I wanted some kind of genetic testing to know the options, she secretly wrote and - she kept telling me, 'We'll test for those things 24 hours after birth', which really circumnavigated the fact that I was making a choice to not proceed. She didn't ask why this was such a worry to me, and it was because I had experiences growing up having to directly care for cousins who were never going to walk or talk again, and another cousin who had a pretty severe genetic disorder.

She didn't dig for any of that. She just kept saying, 'We'll test 24 hours after birth', which was like shaming me for saying - I had to come out and say, 'You're missing the point, I want to know now'. I don't think I'd be a very good parent to a severely disabled child based on how I handled that when I was 16 with my own family. She secretly wrote in my medical notes, for other people to read, 'Note: Amy has a mental health history', to invalidate what I was asking for. She thought that I was just being a bit extra, I suppose, and she thought that I was being overly anxious and that it was an invalid question.

CHAIR - Did you end up being able to do any of that genetic testing?

Ms RAMSEY - I did. I found a company, a geneticist lab out of Victoria called VCGS [Victorian Clinical Genetics Services], which had a much better NIPT [Non-Invasive Prenatal Testing] than the one pushed on everyone here on the coast through Sonic. So, Sonic at the time, I think they might have changed and there might be some genetic stuff available now. I think that has been updated somewhat following meetings I had out at Burnie, telling them that, across a whole maternity service, not one person knew about this option. I told them it was a massive professional development issue if no-one knew that this was available, given that this region of Australia has such a high-level -

CHAIR - Of conditions.

Ms RAMSEY - Yes.

CHAIR - So, you accessed that at your own cost, found out about it and at your own expense?

Ms RAMSEY - I did. Not everyone can pay for that, I acknowledge that, but for less than $1000, I got their version of NIPT, which also checks for a few additional conditions that the Sonic [Healthcare] one offered here on the coast does not. For example, q22 deletion syndrome and also they check across the 23 chromosomes for anything visible like duplications and such. I also, for that same price, accessed a genetic counsellor to speak with me and carrier screening for the two of us, where they basically just crossmatch to see if there's any crossover nasties. I was made to feel, on the coast, that what they wrote, that I was being crazy.

So, that happened and there were a few issues with an obstetrician, who is no longer with the service - I think he might have been hired back, but I'm unsure - of him being quite rude.

CHAIR - About this issue?

Ms RAMSEY - Yes, similarly dismissive. I think I wrote it in my paper that I needed him to sign the form for the second NIPT. The genetic screening, for whatever reason, I actually didn't need his signature, but he chose to have input on that anyways and share his opinion. He asked me, while we were sitting there why I would want to be testing for things like cystic fibrosis (CF) if I have no known family history. And I had to reiterate, 'I don't really know my dad's family, not well'. I told him that everyone in Australia who has CF and suffers with that has it because their parents didn't know if they needed to test and I made the decision to worry about that and test for that.

Having a close friend with CF and seeing the struggle she had gone through, and her advising me to make sure you test for that - and during that meeting with him, we stood up as we walked to the door, he had his hand on the doorknob, opened the door, so he was between me and the door and then he shut it and said 'what would I do now anyways, if I found out about a genetic condition? At this stage, it would be about management'. It wasn't that late. Termination within Australia, I'm pretty sure, is 25 weeks, 20 to 25? I wasn't there and I had to tell him thanks for his opinion, but I'd be making a very different decision. I want to be clear, I don't have anything against the disabled, they are included in society as they should be. I just think I wouldn't be a good parent for someone of such high needs.

CHAIR - Thank you for sharing that. It's deeply personal and we're grateful for you sharing it. I'll open it up to our Committee Members if anyone has anything they'd like to talk to about?

Ms DOW - Thanks so much for presenting to our Committee today, to both of you. It's still incredibly traumatic for you, even now. I want to thank you very much for the comprehensive submissions that you made to our Committee as well. Each of us has read them and that will go a long way to informing the work of this Committee, so thank you.

I wanted to ask you, in your recommendations you talk about, and throughout the body of your submissions, the follow-up for many women like yourself who experience traumatic births at the North West Private Hospital and the complaints process, and there's one particular area there, where you speak about women's complaints being lost or mishandled, I wondered if you might provide some more information or context to that for the Committee, Amy, please?

Ms RAMSEY - Yes, so when myself and a few of the other mums were lobbying and meeting with Jeremy Rockliff to ask for a change in support and to end that contract early, that the private hospital had, it was eventually very, very late in the stage negotiated that the victims were going to receive counselling with a bespoke package through the Gidget Foundation [Australia].

A lot of them never received it because their complaints, even though they'd had meetings and submitted written complaints, their complaints got lost and Sarah Sheehan, now Sarah Marshall, as well as Amy McLachlan, [received] no treatment for PTSD because the complaint process essentially stopped for them because their complaints - I don't know how it happens - but got lost and they were not then entitled to any Gidget [Foundation Australia] support either.

Mr FAIRS - Did they say why?

Ms RAMSEY - The hospital said 'sorry, we've lost them, we do remember you, but we've lost your complaints', and they said that the package was for the existing number of complaints, not for any new submissions. So, if they submitted then they would be considered a new complaint submission and they'd already been through so much re-traumatisation with meetings that they just couldn't.

CHAIR - It seems pretty unreasonable.

Ms RAMSEY - I mean, Sarah Sheehan, after a pretty terrible birth that she wasn't really able to tell me all about and haemorrhaging and such, they told her partner she's possibly not going to make it through the night and they wouldn't let Dennis stay and made him leave and he said 'but there's a private room, there could be' and they said 'not unless you pay for it' and forced him to leave. And they didn't tell Sarah they were watching to make sure she didn't code. So, he's, imaginably, pretty traumatised by it as well. Thinking he's leaving his fiancée to die and they led him to the door and shut it behind him.

Then, Amy McLachlan is the one where there was a locum midwife. She was in a birth pool and she kept saying that something was wrong, she felt like the positioning was wrong and the locum yawned, put a mirror down in the water under her, looked at her husband and said, 'I'll be in the staff room, call me if you see a head'. I think she said, 'I've got three hours or so left of my shift', and she left. Amy's husband is, I'm fairly certain he is a miner of some capacity. He's not got medical knowledge, so he was rather frightened.

When the next midwife came on shift Amy had been pushing by herself in the bath for four hours plus - it was eight hours in total that she ended up pushing and worked out that her daughter was malpositioned and she was stuck, rather tightly stuck, and got her out. They tried several times to get an epidural in and blackened her back, couldn't get it in, took her to theatre, no local anaesthetic, no warning, no consent, episiotomy, said, 'We're going to do a vacuum'.

She and her husband, Brady, were screaming for a C-section and they said, 'Well, we've already tried the epidural, we're going to do the vacuum.' He screamed at them and stood and said, 'You've got one pull.' They got Macie out on the one pull, she had - mostly resolved now - nerve damage down her left side, and they positioned the vacuum wrong in a way that pulled her fontanelle nearly closed, I suppose. She was having to get a lot of additional follow-up care at their expense. At one point they were told they'd have to go to Melbourne to have her skull broken. I think there was a lot of natural resolution to it. Last I spoke to her, Macie had 70 per cent use and it was looking up, but her husband's fly-in fly-out, he's two weeks in, two weeks off, so when she has a flashback and she's home alone with her daughter it's rather terrible.

Sorry, what was the question?

Ms DOW - I was interested, which follows onto that very well -

Ms RAMSEY - The ones that got lost.

Ms DOW - Yes, the perinatal support that was committed to be provided to that group of women that the Government was working with.

Ms RAMSEY - Amy McLachlan in one of her meetings with the hospital, I think, she got quite heated and said she'd take it to court or she would sue them. One of the people in the meeting said, 'I'd like to see you try'. It was quite a hostile shutdown, apparently.

Ms DOW - The other thing that I was going to ask just before we move on was that you alluded to a little bit speaking about the experiences of other women and their partners, and the configuration of the current maternity service facilities as well. I wondered if there's anything that you wanted to add there about what could be improved. I understand that there are some plans put to make some improvements to that.

Ms RAMSEY - About the group rooms?

Ms DOW - More about just the actual physical aspect.

Ms RAMSEY - Everyone needs a private room, everyone needs to be able to sleep. No-one should be hearing other women labouring or babies screaming. Everyone needs a private room and their partners need to stay. If not their partners, like if he [Sam] needed to go home and sleep or go up to the units on the hill that they've got, someone needs to swap out with him. I mean, especially first-time mums and people who've come through obstetric violence. Even if I had another baby and it was a great birth, I would never want to be alone in the hospital. I would want another person there that I could trust witnessing and seeing what was happening.

The group room situation is - I mean there are animal stalls that are more spacious. There are no doors to shut, so midwives and nurses are joking and laughing out in the hall and they're trying to sleep. It's shared toilet and shower facilities, which I understand can be at a limit, but I suppose I thought there would be a space to -

CHAIR - Have some privacy.

Ms RAMSEY - Wash the baby or like a shower stall with a chair maybe, or soap, any of those things.

For whatever reason - I have heard this from another woman called Crystal, whose child will be six soon - the midwives play these mind games where they push the baby in the little plastic bucket as far away from the bed as possible so that you have to call them and wait for them every time. You can't - if you're unable to get up. You're not supposed to get up. It's just a power game. Partners need to be able to stay for safety and -

CHAIR - And to be able to bond with their baby.

Ms RAMSEY - Be able to bond, be able to help. We have short staffing here anyway. A partner around that could go get the maternity pads. That would halve the work of the midwives who are trying to keep up with everything - assuming goodwill.

There should never be a shared room in maternity. I know budgetary limitations, but the woman across from me for much of my night there, she wasn't due to deliver. I think she was

there due to pain or some ongoing issue. She was weeping all night and having a terrible night and lots of people coming in and speaking to her and saying, 'We need to get you right, don't we? Not just bub'.

I don't know what the rest of facilities were like because we left as soon as we could. Even when I went back for that meeting where Keith Cock growled at me and told me I was a liar; it was so hot in there and they even gaslit me about the climate and said that it was just the drugs leaving my body and that I wasn't hot. Comfort and privacy.

Mr FAIRS - I just want to clarify. You said the midwives pushed, I assume, the baby crib. Is that what you are talking about? They push them away from you?

Ms RAMSEY - Yes.

Mr FAIRS - As a game.

Ms RAMSEY - Yes. They didn't tell me, 'You're not going to be able to get up. You need to ring the bell if you want to pick up the baby, we'll get her for you'. They didn't say that. It was me asking as they were arranging everything in the room, to bring her closer. They said, 'No, you push the bell to get us to get her'. It turns out that's what they do to everyone. If you have had an epidural or catheter and you are not meant to get up, they push the baby in the plastic bucket over by the window, so probably the distance of, if this is the edge of the bed from me to Ms Rosol. There is no possible way you could even put your hand in to see -

Mr FAIRS - Your own child.

Ms RAMSEY - It seems that they have been doing that for quite a long time, so at least six years. It's a power game. Everything you say is met with why you're wrong.

Mr FAIRS - Thank you.

Ms RAMSEY - There was never a policy requiring midwives to abuse patients. So, there is not ever going to be a policy to stop them from abusing patients. What's going to stop that kind of disdain for women, I guess, is the threat of prosecution for obstetric violence. It needs to be criminalised.

When I say doula, I actually mean intrapartum patients need a bodyguard with them at all times. I don't mean the partner because they steamrolled him [Sam]. He had no voice, no power either. He thought that there was only one way to get through it. He was also wondering if I was going to die. I tried to read through the other submissions. It didn't go well. I didn't get far, but I did read, I think it was - there was one I did an interview for and they made a submission - I can't remember.

CHAIR - It could be Birth in Tas[mania]. They've got a lot of personal stories attached to their written submission.

Ms RAMSEY - They had made a recommendation that an advocate be embedded in the unit. I like that vein of things where the advocate isn't there for the midwife's assistance. If that advocate could have, I suppose, on call, on duty, extra doulas. But, the other problem with that

is if a patient is begging a midwife to please get the advocate, is she going to do it? Will they do it? Probably not. There needs to be, I suppose -

CHAIR - They have the ability to move around freely.

Ms RAMSEY - A buzzer on the bed for the advocate. The same with care call. That wasn't a thing when I gave birth. There's no such thing as care call in the private hospital.

Even if a woman didn't want to work with a doula prenatally, if they could have the option of having someone immediately come into the room and back them up. Without having to ask and beg the midwife and negotiate and try to convince her that she was of sane mind.

CHAIR - Do you have any questions?

Ms ROSOL - It sounds like a lot of this is coming back to being listened to.

Ms RAMSEY - Yes. Continuity of care, I think, would help with that. People tell me, 'Well, you should have gotten a student midwife to travel through it with you. We did that together.'

A student midwife that I met for a few antenatal appointments - I saw her the day I left hospital and she came to my house with one of the extended care visits. I don't think she knew, but she was lying to me. Ashley, she's really sweet, but she - when I asked, antenatally, 'What would happen if they were full? If I showed up in labour and they were full?' She said, 'I've never seen the unit on bypass.' Now, I know that's not true. I said, 'What if it's full and I'm really wanting some water therapy to get through this?', and she said that there were plenty of assessment rooms that they can turn into birthing suites and you can stay in the shower in there.

No, there's not. There are no showers. I don't know that she knew the system that she was part of. Even when we were there and being assessed, Amber, the first midwife - she was saying they didn't want to admit me now and we could go up onto the group units on the hill. I really wanted to get in the tub early on and she said, 'There are tubs up there'. There are not. She seemed so confident, so she must have not known she was lying, which makes it not a lie, I suppose.

CHAIR - A lack of informed knowledge.

Ms RAMSEY - It was such a letdown. I was already completely incontinent and having a lot of bladder pain and I didn't realise - I shouldn't have been allowed to leave with bladder pain like that. Getting up to that unit and walking in and no tub was really gutting.

CHAIR - How long were you there in the end?

Ms RAMSEY - Only a few hours and then it was too painful. I came back and then Pam started telling me - what's that?

CHAIR - You were 10 centimeters not long after you returned to the hospital.

Ms RAMSEY - No. My daughter, turned out she was asynclitic, so head a little off kilter. That's why I was in level 10 pain at one centimetre and for the day -

Mr THOMAS - It was over a day. We got there at 5 p.m.

Ms RAMSEY - Pam standing in front of me and telling me that I could not be in that much pain. This is early labour.

CHAIR - Denying your experience.

Ms RAMSEY - It made it so much worse later finding out that no-one knew about her very questionable work history and disciplinary action. AHPRA doesn't keep that publicly available anymore, not ever. I found out about things Pam had done based on what Pam wrote on various websites and social media.

CHAIR - Is your AHPRA matter concluded?

Ms RAMSEY - It is.

CHAIR - The Health Complaints Commissioner?

Ms RAMSEY - That's completed as well. They've all decided to do no more because the hospital reported they had conducted their own investigation, which consisted of Veronica having a side chat with Pam and with Jordan and them doubling down on their stories and that was it; that was the investigation.

I tried to reach out to the HR, Healthe Care, website and I couldn't get a hold of anyone. The Healthe Care website, their upstream website is some kind of bizarre landing page out of China that sells other things and has links to other stuff and has no contact details.

CHAIR - What's the website?

Ms RAMSEY - I cannot remember. I was so rattled when I was trying to go upstream and go above Keith Cock to find out if the HR department would agree with him not calling them and there's no one upstream. I never got any response. There is meant to be Healthe Care out of Sydney. I couldn't get anyone but that website links in there, in legal language, to a higher up one. I have never seen anything like it and I used to build websites for corporations for a living.

CHAIR - That seems really strange.

Ms RAMSEY - It was it was like a hacker landing page, and I sent emails.

CHAIR - That was the HR page for the hospital?

Ms RAMSEY - They do not have a HR department. They rely on being able to, as Keith Cock and Veronica Zupan say, you learn HR through their parent company Healthe Care when required. You can't get in touch with them to let them know. I don't know if there's really an HR department with Healthe Care. But Healthe Care seems to be owned by an upstream shell of a company that owns other healthcare-esque stuff globally but their website was, I think red might have been in the name, some disjointed landing page. It still had dummy text in it like Lorem Ipsum.

CHAIR - How bizarre, they have published a draft page.

Ms RAMSEY - When I emailed a few people around, the advocate that I was mainly working with at the time, she thought that I might be having an episode because it sounded that crazy.

Mr FAIRS - You're experienced with building websites and stuff; you don't think that was hacked or anything like that?

Ms RAMSEY - No, someone put that up. They'd have to enter the back-end code and there would have to be an open source like a WordPress site and that's not.

Mr FAIRS - Okay.

CHAIR - Our time has rapidly come to an end. I didn't realise quite how far over schedule we've gone, but we've been very grateful to hear your insights and recommendations you've made to us both today and in writing. Before we do finish up, is there anything else you would like to share with the Committee?

Ms RAMSEY - I meant to cover so much. All my recommendations are pretty clearly laid out. My point, I guess, the main angle is that everybody, every organisation, group that I have been directed to for complaints for this process, everyone says 'We don't do punitive action; we're here for future improvement' and that's fantastic. We should all try to do better, but justice and punitive action is missing from the Australian healthcare landscape, full stop. For fear of losing healthcare staff, or for fear of not attracting talent into the industry, we unconditionally pardon any cruel or torturous behaviour and we just warn them to improve future practice.

So, a midwife who intentionally causes catastrophic devastation is told to just come back tomorrow and try to stop ruining lives, please? And I need to know where to go with this because - I think I said what I need to say, but where do I go? Do I need to push for a federal inquiry? I mean -

CHAIR - I think you said you've taken through AHPRA and the Health Complaints Commissioner are supposed to be those avenues, but you're not the first person we've heard from who - without straying into territory that's outside our terms of reference - it's not uncommon to hear dissatisfaction with AHPRA processes. I suppose I can say - as a health consumer, as well as in this role on the Committee - it's not good that you've been let down by those processes that are supposed to be able to hold practitioners to account.

Ms RAMSEY - The AHPRA person I worked most with, I think he was named James, called me on a Friday evening to say we finally wrapped up the investigation and he wanted to make sure I had a support person with me and just said 'We made the decision to take it no further' and I said, 'Does that mean you don't believe me?' He said 'No, no, no, it checks out. We investigated, we believe you, we understand what Pam did, there's no question about it', he said, 'But our guidelines specify that because there's not evidence to suggest she'll repeat the offence in the future, we can't do anything else.'

And the OHCC [Office of the Health Complaints Commissioner] similarly said the hospital investigated, but you can't - we don't let murderers investigate themselves and, yes, I tried to check myself into an inpatient unit.

CHAIR - I'm sorry.

Mr FAIRS - Are you getting the right support now?

Ms RAMSEY - As much as I can do. The Gidget [Foundation Australia] support is being cut off, which I've been trying to space those out quite a lot anyways because I knew that. So, that was supposed to be as much as we need, as long as we need. But I think I put it in my updates that what was promised in writing was not initially what was provided. It was not as anonymous as Ruth King had suggested that it would be. When I raised concerns about that, that seemed to all become a lot more in line with what it was supposed to be, which was just the Gidget practitioners basically putting forward 10 more sessions, please, no questions asked, instead of being asked to submit a clinical summary which removes anonymity. It was supposed to always be a 'tack-on 10' type of model, but I have been sent a letter to say this is your last 10.

I have Ros back here in the public gallery. She is my CHaPS (Child Health and Parenting Service) social worker and that is another piece of the puzzle. I think if we could recruit for more Ros's. CHaPS is the best service in the THS as far as anything to do with maternal and child health, across all CHaPS aspects, any role, nurses, social workers, speech pathologists, allied healthcare. Whoever is organising them and structuring that is killing it and give them more money to do more of that. Sorry for not writing that one out well.

CHAIR - No, that's good. You have given it to us today and that is probably a positive note to finish on after what has been a really traumatic time in your life. I am sorry for that and I am really grateful that you have the strength to come and present to us today. Thank you very much to both of you for being here. There's ongoing support for the rest of this afternoon if you want to take a break, do not feel you need to rush out of the building. You can hang out for as long as you need with our amazing Gidget [Foundation Australia] friends here and we are really glad that you could share your story with us. Thank you.

Ms RAMSEY - What is the likelihood of the recommendations, if the recommendations to Parliament did have wording about looking for a prosecution angle for future obstetric violence, what is the power within Parliament to push that?

CHAIR - The report that we provide, like I said in the room before, it will provide written recommendations that will go to the Parliament and then there's an expectation that they'll be considered and hopefully acted on by the Health Minister and the health department. If we end up with recommendations around potential criminal sanctions, it would be a Government decision that would have to then involve the Attorney-General who has oversight over the Criminal Code, if we were to be recommending new offences be inserted into the Criminal Code, for example. If that ends up in our recommendations, it would be a Government decision for them to potentially bring a bill to Parliament to achieve that outcome.

As I said before, I am confident that the Health Minister would not mind me sharing on the record that we know that this is an area of passion for her, maternal and reproductive health. We, as Committee Members, are feeling quite fortunate that she was on this Committee when

she was still a backbencher and attended the first day of hearings, has read all the written submissions, and is awaiting our report. That is as much power as we have really as a Committee in terms of providing a written report. In the background, we do know that we have a Health Minister who has maternal health as a priority in her planning.

I hope I have not overstepped any boundaries to speak on, I cannot speak on her behalf, but certainly I know that she was a very active participant in the Committee until becoming Health Minister. Procedurally, she had to step off it for that reason. It is a small Parliament. We all know each other and she knows that we are continuing this work and she is eagerly anticipating the work that we are doing. It is not an ironclad guarantee. I cannot give you that, but that puts the Committee on a fairly positive footing in terms of potentially being able to influence some change.

Ms RAMSEY - All right, let me know if I can do more.

CHAIR - Thank you, will do. You have Mary's contact details. We are all very easy to find as well if you want to be in touch with any of us after today's session, that's totally fine.

Ms RAMSEY - As far as paediatric stuff, more Circle of Security classes for free for everyone.

CHAIR - Yes, it's a great program.

Ms RAMSEY - People on the coast, I do a few volunteer action groups, they want it. It just needs to be at available times for working people. I think it needs to be grandparents and other carers too, because people want to upskill. People want to improve their parenting on the coast, but it just needs to be accessible.

CHAIR - Will need that resourcing. Great to meet you. Thank you very much for being here.

THE WITNESSES WITHDREW.

The Committee suspended from 12.04 p.m.

The Committee resumed at 12.10 p.m.

CHAIR - There are just a few procedural things that we need to do at the beginning to start the hearing formally. Formally, welcome. Thank you for your patience with running slightly overtime. Welcome to today's hearing of the House of Assembly Select Committee on Reproductive, Maternal and Paediatric Health Services in Tasmania. Thank you for your written submission that we've all had the chance to read. Could I ask you to state your name and the capacity in which you are appearing before the Committee?

Ms ARMSTRONG - Jacinda Armstrong. I'm the CEO of Playgroup Tasmania.

CHAIR - Great. Thank you very much. Can I confirm that you have received and read the guide sent to you by the Committee Secretary?

Ms ARMSTRONG - Yes, I have.

CHAIR - The hearing is covered by parliamentary privilege, which means that you are able to speak with freedom, say whatever you want to say to us without any fear of being sued or questioned in any court or place outside of Parliament. That protection is not accorded to you if statements are made that are potentially defamatory and you repeat them or refer to them outside of these proceedings.

It is a public hearing, although we're not being broadcast because we don't have those facilities when we travel. There was a member of media before; I don't know if he's coming back in. Technically, members of the public could attend, sit in the gallery if they wish to. If during the course of today's evidence, you would like anything to be heard in private, you can make that request of the Committee and we'll do a short procedural agreement to move into what's called an in camera session. That's totally fine. That's completely there and available to you if you wish to do that. There will still be a *Hansard* transcript recorded, but it won't become a public one.

Could I ask you to make that statutory declaration that's in front of you on the card, please?

Ms JACINDA ARMSTRONG, CEO, PLAYGROUP TASMANIA, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED

CHAIR - Thank you. I'll introduce the rest of the Committee. I'm Ella Haddad. I'm a member for Clark and the Chair of the Committee. I'll go this way, I've gone that way every other time. We've got two members for Bass, Rob Fairs and Cecily Rosol. Anita Dow, who's a member for Braddon, based here in Burnie, and Kristie Johnston, who's another member for Clark with me down in the south. I'd like to invite you to make an opening statement.

Ms ARMSTRONG - I thought I'd open with who we are. Playgroup Tasmania has been supporting children and families across the state for over 50 years. We do this through capacity building and organisational support for volunteer and community-led playgroups. We also deliver a range of targeted playgroup programs that support families, such as PlayConnect+, which supports families with children with a disability. We also have our Baby Village program, which is funded through the Child and Youth Wellbeing Strategy, which is obviously aimed at parents and families who have very young children, pre-walkers.

In developing our submission - we actually saw the advertisement quite late. I was on leave at the time. I spoke with my team and I said I think this is really important because we hear a lot of stories from families every day about their experience in accessing services that suit their family. We opened up a survey that we had open for one week. We had over 120 responses, which is phenomenal. What we took from that is that families really do want to tell their story, and they trusted us to share their story with us.

The key themes that we heard, as in the submission you'll see, is around availability and access to services, and their confidence in engaging with services, and the significant isolation that families face, whether that be geographical isolation or social isolation. Some of the data that came through that survey indicates that more than 63 per cent of respondents indicated that they were concerned at times around their mental health and that they weren't always confident [knowing] where they could access the appropriate services.

Given that this survey was open 12 months ago - and I apologise that we didn't actually go back and have the survey updated when the Select Committee reopened - through our programs we are hearing about things that have maybe improved for them, but we're also hearing a lot of stories around things that are still not meeting their needs.

My staff have gone through the submission and they've actually made some notes for me so that I can bring the most current stories as well. The submission, I don't think any of those key themes have really changed. There have been some service improvements I think over the last 12 months that families are responding to, but there are still some significant challenges, including, of course, the cost of living and the pressure that that is placing on families. I think now I'm happy to take questions.

CHAIR - Thank you. I should have said at the outset that this is as non-adversarial as possible for a parliamentary hearing. We're really keen just to have a conversation with you. So, it won't be kind of a formal interrogation style by any means, but we really want to lean on your experience.

First of all, I want to thank you for being so proactive as an organisation and gaining, like you said, you were surprised by 120 submissions. That's incredible. We're really grateful to be able to learn that evidence base that you've collected as a result of this Committee being established. Thank you for doing that, especially in such a short timeframe, and then obviously the election meant the Committee dissolved and was re-established.

I might start off before opening it up to the Committee, asking a little bit about - obviously most of your interactions are with families with little ones. Are you hearing mostly, around those service access issues that you mentioned, are they mostly about access to services to support them with young people, or are you hearing stories about prenatal care and services as well?

Ms ARMSTRONG - There is feedback around the inconsistency in terms of availability for some maternal and antenatal services. Birthing classes and the like aren't always available on an equitable basis. I understand there is obviously workforce challenges within the sector, but this is what we're hearing. There is also some lack of engagement, I think, from families when some of those services are available, just through fear of judgment.

CHAIR - Really?
Ms ARMSTRONG - Mm-hm.

CHAIR - Okay.

Ms ARMSTRONG - Whether that's through previous experiences or what their community might say. Obviously, when there's been negative experiences they are quite often shared more broadly than what a positive experience will be, but yes, there is still some inequitable access to antenatal services.

CHAIR - Regionally, or in terms of social isolation as well?

Ms ARMSTRONG - What we're hearing is mainly regionally in terms of the geographic availability for some of those. I think some of the - this is a bit of a consistent theme actually, the availability of some of these services, when these services are placed in Child and Family Learning Centres mean that some of the community is locked out of that. What we're seeing is that services going into the Child and Family Learning Centres leave gaps in areas where families can access them in a more universal way, because of the fact that Child and Family Learning Centres do have a geographic boundary put around them, essentially.

CHAIR - Interesting, right. That's very important feedback. Thank you.

Ms DOW - I had a question which relates to what you've just said about geographic disadvantage and whether you could highlight some of those areas where you think that's - from the feedback that you've had is that that's more pronounced in this state?

Ms ARMSTRONG - The west coast is, and I'm sure that you've heard, it's extremely problematic. In terms of being able to maintain a workforce on the west coast - which is the ideal situation because we know that drive-in, drive-out service delivery is not ideal. It's around creating those trusting relationships with the community. That's often really difficult if you're not spending prolonged periods of time [there] or [not] from the community.

The west coast in particular is - and I can't even imagine what they're experiencing now, but we work really closely with existing services there like the neighbourhood and community houses, Child and Family Learning Centres, rural health. Trying to work in partnership to leverage some existing strengths is the way in which organisations like ours will work there, but to maintain consistent service delivery, it's problematic.

Ms DOW - You said that there had been improvements perhaps in the last 12 months. Are there a couple of those that you could provide examples of to the Committee?

Ms ARMSTRONG - Yes, definitely. The Child Health and Parenting Service over the last 12 months, what we've seen is a real increased engagement with families and an increase in positive stories from families on their engagement with the service.

For us, that's really important, they are always the service we would first refer families to if they are indicating they are having any challenges with their early parenting. Sometimes, that experience hasn't been positive for families. The Service has done a great job, particularly over the last 12 months, but there's been a lot of work in the lead up to that. We're seeing that

in the availability of additional services and more of their community engagement and working in partnership with organisations like ours.

Ms DOW - In your submission, you talk about the availability of improvements to the blue book and introducing an app in Tasmania. Is there some more feedback you could provide to the committee about that?

Ms ARMSTRONG - I believe that needs to be part of a really kind of a holistic solution that has a platform for families like a one-stop shop because it really is challenging for families to try to navigate. We've all tried to do that at some point. There is an example in Victoria, a maternal child health app, which links to a broader kind of platform. We could examine some things like to ensure the information people are seeking is available, evidence based and accessible.

CHAIR - One of the things highlighted in your written submission is people don't know where to go for support, what services are out there and that's universal across every area of the health and community services system. Does that Victorian app link people into those?

Ms ARMSTRONG - My understanding is that it does. It has the ability to highlight or identify in the available services if you're experiencing this, then this is what is available to you.

CHAIR - I have a background working in community services before this job. I know in Tasmania there's been so many attempts to do service directories. They're so challenging because most organisations do outreach and it ends up being difficult to provide, say, a teacher in school or somebody running volunteer play group session, something tangible to actually be able to refer people into. Have there been any improvements in that area, in the time since this written submission and now, when you've highlighted that lack of knowledge of people struggling to know where to go for services?

Ms ARMSTRONG - No, I don't. I do know there are a range of service directories out there. The challenge is on ensuring they're up to date. We know as an organisation ourselves with over 60 playgroups registered with us, just us maintaining our information to make sure it's current is challenging. But even though it's challenging, it doesn't mean there's not a solution to it. If we look at how we can have better governance and owned as a joint ownership by the government and the sector then we all have the responsibility for maintaining it.

CHAIR - I believe Find Help Tas is jointly managed by TasCOSS (Tasmanian Council of Social Services) and the Government.

Ms ARMSTRONG - Yes, it is but it's not extremely -

CHAIR - Very broad.

Ms ARMSTRONG - Yes, it's not user friendly. It's not very intuitive. It is a service delivery map. It doesn't have all the other nice things there that could just be some information sheets or the link. Whether it's something that looks more like a - I don't really want to describe it as a gateway, but that kind of thing. Somebody has to have responsibility for it; an organisation, humans need to be able to fund it. It has to be funded, of course, but there is a lot of goodwill also that needs to be leveraged.

CHAIR - I wanted to ask, on access to paediatric services you've touched on, because that's one of the areas that the Committee hasn't heard as much evidence about in written submissions or in the hearings that we've had so far. We've heard a lot about perinatal and maternal services, but we'd love to hear more feedback around paediatric services.

Ms ARMSTRONG - It's not positive.

CHAIR - That's okay, we're here to hear whatever we need to hear.

Ms ARMSTRONG - At the moment books are closed. You cannot access a paediatrician. The changes to the NDIS are going to create even more challenges for families, in being able to access the services they need. Again, we understand there's workforce shortages in paediatric services, particularly in and around allied health as well. So if you have a child who you may be concerned that there is development delay or any other kind of disability you're observing, there's no pathway that's open for you.

The information around paediatric services is also really inconsistent. Families don't know how they can access, their books are closed anyway, but private services and the cost of private services is out of reach of most families. There's an argument or a discussion on ensuring - we included it in our submission - that 18 month check. I do believe through the lifting literacy recommendations that 18 months actually has been implemented, so that there's a screening, but there's nowhere for families to go once the -

CHAIR - If it's picked up something up once the screening there's no -

Ms ARMSTRONG - Yes. St Giles has currently closed their books to pre-kinder referrals and you cannot get a paediatrician. The books are closed, which means that they've also closed waitlists, so there's not even a system in place where families can be flagged or understand when a waitlist might be open or books might be reopened.

CHAIR - Scary.

Ms ARMSTRONG - And it's real. We speak to families about it every day and the angst that creates for families. It's heartbreaking, some of the things we hear. We work a lot with families and we know there are a lot of community organisations like ours that are doing some early inclusion, early intervention work. But we don't deliver therapeutic models and even if we do build in brokerage into all of our program budgets so we can bring in services and they will do some group work for families, helping them to set up strategies on whatever they need, but then to be able to access their service, yes.

CHAIR - There's no availability.

Ms ARMSTRONG - No.

CHAIR - Are families predominantly going without, or are they seeking interstate services in your experience?

Ms ARMSTRONG - Online services aren't preferred; we do also have conversations with families about them. We can support them to access online services and they can do that from Playgroup Tasmania, but it's not their preferred, which you can understand. It's hard for

children to engage with online services, so it's definitely not the preferred option. What was the question?

CHAIR - Whether people are going without.

Ms ARMSTRONG - Yes, they are. What we're seeing is kids are hitting kindergarten and they haven't had any early intervention. They haven't had their assessments. Schools haven't had the opportunity then to make reasonable adjustments. It's just getting pushed into the schooling, yes.

CHAIR - Into the education system.

Ms ARMSTRONG - Yes, and I think that's what we know that it is.

CHAIR - Also, it puts those children at a disadvantage -

Ms ARMSTRONG - It certainly does.

CHAIR - Because early intervention would have put them on a better footing to begin those schooling years.

Ms ARMSTRONG - That's right. There are some children where early intervention will mean they may not need further intervention down the line, but we're not set up. Our workforce isn't set up, the services aren't accessible and so that opportunity is being missed. I do have concerns about how the changes to the NDIS [National Disability Insurance Scheme] will impact that.

We've also concerns with foundational supports. We are a provider of foundational supports and we are concerned if families aren't being able to access therapeutic supports once they've received diagnosis, then we will be seeing them coming back into our programs, which of course we do not say no, but often we will see families with children who have higher complexities than what our staff are trained to work with. So, it is challenging.

It is probably one of the biggest issues that we see in the birth to five [years of age] space at the moment. I cannot underestimate just how important and how challenging this period is for families.

CHAIR - It is, we're hearing that a lot, just as a local member as I am. I am sure others are as well. Are those families who have lost funding in their NDIS plans?

Ms ARMSTRONG - Well, they do not know yet because of course they are not - the communication still is not clear about what impacts these changes will have, and there has been a position by the Federal Government. The changes are on the way but then they have been really lacklustre in how they have explained what those changes will mean for families. They are left in the dark thinking the worst and facing that extreme uncertainty.

CHAIR - There's still uncertainty around what those foundational supports will look like too and how they'll be funded.

Ms ARMSTRONG - Yes. Given that 1 July is not that far away, we have just received confirmation that one of our programs will receive a two-year extension because -

CHAIR - As a foundational support?

Ms ARMSTRONG - Yes.
CHAIR - With federal funding?

Ms ARMSTRONG - With federal funding, because they do not have anything else in place. So, I do not think that they are in a position to not extend funding to existing programs and services.

CHAIR - That's one tiny glimmer -

Ms ARMSTRONG - It is.

CHAIR - That's extended across other services. There is so much uncertainty now.

That is valuable information for us. If anything else comes to mind after today's hearing when you are back with your team specific to - well, not just specific to paediatric services, but anything else that you would like us to hear, please get back in touch with Mary or with any of us.

Ms DOW - I have two questions. You've talked about the transition away from ECIS (Early Childhood Inclusion Service). In your experience, how has that changed when ECIS was provided by the state in the early intervention centre for families, particularly across regional areas to what exists now, with a lot of that being pared back and transferred to the NDIS? What is the distinct difference between that? In your opinion, is there a role still for the state to play in providing those services?

Ms ARMSTRONG - Yes. Tasmania is one of the only states that kept their contribution to ECIS. It went out to the sector in most of the other states. We are probably one of the only states that actually has that service as a state service. It is a very valuable support for families. The changes that have happened have meant that it is being taken out of the community settings and put into education settings. Not every child will go to a public school and the families have found that it is increasingly difficult for them to access or feel like it is the environment that they want to engage with ECIS in. In a launching into learning program that can be quite confronting for a family who has a child with additional and complex needs. When it is taken out of that specific community setting that ECIS was working in previously, I think it has created some barriers for engagement.

Ms DOW - My final question. In relation to what you have spoken about the closure of books for paediatricians, but some of the things that we hear as local members is about long wait times to see, for example, ear, nose and throat specialists and the impact that has on children's development and preparation for school. Is there anything more that you can provide to the Committee about that?

Ms ARMSTRONG - I have said about paediatricians but we know that across the board that accessing those higher-level interventions and those services for children, it is the wait lists. Unless you are a private [patient] and even with privates, it does not happen instantly.

Ms DOW - Are you aware of any other models in other states? You spoke about the blue book and the app in Victoria, but are there other jurisdictions across the country that are trying to deal with the shortages across specialty areas, looking at new models of the way that those assessments are provided? Is there anything that you could leave with the Committee around that?

Ms ARMSTRONG - I think that what we are seeing is that, in terms of early screening for our children, there is acknowledgement that it doesn't have to be done by a health professional. Some of my team are highly trained and they can do early screening as well. I think that what we will say is more of that happening in community, in natural settings where families are at. Again, we can do the early screenings, but then where are the families going?

I think that it's twofold because, of course, my view is around primary prevention, early intervention. But then if we don't have the appropriate services to refer onto then we're stuck between a rock and a hard place because we want to work with the families. We will continue to do the work that we have capacity to do. There's only so much when some families do actually need that more highly skilled intervention work.

Mr FAIRS - The early service intervention and assessments and things like that you spoke about, was there a time when it did all work? Has this change come about because of Government policy changes, or has it become the sheer demand on health professionals across the board? How long has it been?

Ms ARMSTRONG - I think it's a wicked problem. I think it has had times when it has worked okay, but there's always people who are excluded from that. I do find it interesting that the Tasmanian Autism Diagnostic Service (TADS) will only accept referrals. It's the, I guess, Government diagnostic service will only accept referrals from a paediatrician, psychologists and psychiatrists. A GP can't even refer into, or CHaPS [Child Health and Parenting Services], can't even refer into that service.

It was last week, I think, that we received the letter from St Giles saying that, currently, their intake will be closed for pre-kinder.

Mr FAIRS - So, they could wait? GPs and -

Ms ARMSTRONG - I don't know.

Mr FAIRS - Okay. Yes, gotcha.

Ms ARMSTRONG - But I find it curious that it's so limited, particularly if you cannot get into a paediatrician or a psychologist or a psychiatrist, that they are the only referral pathways for TADS.

CHAIR – There are huge waitlists for those services. So, a child could potentially be missing out on that diagnostic service for years.

Ms ARMSTRONG - They are. We hear from families who - I'm not just talking about, I guess, families who have low levels of literacy. We're not talking just about families who have other circumstances that may limit their capacity to advocate. We're talking about families

with capacity to advocate who cannot access services even though they know exactly what they should be doing to try to access them.

CHAIR - Even in the private system, if you were waiting for a referral from one of those three professions, you'd be waiting years.

Ms ARMSTRONG - And paying an awful lot of money to get to it. I think what we need to maybe look at is why. Why is there that blockage?

CHAIR - Is it a bureaucratic reason? Is there some clinical reason? That's really pertinent information. Thank you. Is there anything else - you said your team had given you some updated notes.

Ms ARMSTRONG - Let me just let me just double check my notes.

CHAIR - I don't want to miss anything that you would like to share with us.

Ms ARMSTRONG - One of the things that we are hearing, and we didn't actually hear a lot of it through - there were elements of it through our survey, but around birth trauma. Since establishing our Baby Village program and obviously giving mums in particular a safe space to come together to talk about their experiences, we are hearing more. It is prevalent in most of the groups that we're working with. Of course, we refer on to specialist services, Women's Health Tasmania, for when - generally, our staff aren't necessarily equipped to have in-depth conversations about birth trauma. We are hearing more about that.

What we are also hearing, interestingly - so Tasmanian Multiple Birth Association and Down Syndrome Tasmania have both let us know that they are not introduced to families in the prenatal or postnatal period.

CHAIR - Really? They used to be. I'm sure they used to be.

Mr FAIRS - Did they say why?

Ms ARMSTRONG - No. Obviously you know you're having multiples, it's not a surprise.

CHAIR - Usually. Sometimes it's a surprise, but normally, no.

Ms ARMSTRONG - But they're not introduced to them in the antenatal period in particular, they're not introduced to them then. I think there's some kind of fragmented pathway postnatal. With Down Syndrome Tasmania there is not any pathway from antenatal or maternal health services.

CHAIR - In the public system?

Ms ARMSTRONG - In the public system. Well, the interesting thing about the conversation with Down Syndrome Tasmania is obviously with screening, they're seeing a huge reduction in births of children with Down Syndrome, so their services I guess are not as broadly accessed anymore as what they were previously. Yes, I just found that really curious when they started talking to us about it. I don't understand why that wouldn't be flagged.

CHAIR - It would make sense to have information available through the public system.

Ms ARMSTRONG - Because we talk about making sure that families have their village, right, and that should come from the antenatal period, but the flow of information doesn't seem to be -

CHAIR - There's blockages everywhere.

Ms ARMSTRONG - Yes. I think that's pretty much all they told me to say. Cost of living, we hear about financial barriers around accessing services, and that even comes down to travelling and appropriate transport options.

CHAIR - Even accessing public services, there are still financial barriers.

If there's other things that when you leave here, it's just Murphy's Law that you're driving back across the coast and you think, 'There was that thing', so please don't hesitate to get back in touch with Mary or any of us to provide other information.

Thank you so much for presenting today, for the written submission, and for the work you did with families. It is a really rich evidence base and we're grateful as a Committee to receive it. Thanks for travelling for today's hearing. Even though we're going your way tomorrow, it's just the way it's worked out.

Ms ARMSTRONG - It's totally fine I've been able to catch up with some people today. But same, if there are any questions you guys have that you don't think that you've received enough evidence or responses for, we -

CHAIR - Come back to you.

Ms ARMSTRONG - Yes. We've got access to over 1000 families. Like I said, it seems like they're very open to having their stories heard.

CHAIR - We are really grateful for it, thank you. Great to meet you.

Ms ARMSTRONG - You too, nice to meet everybody.

THE WITNESS WITHDREW.

The Committee adjourned at 12.44 p.m.