SELECT COMMITTEE ON REPRODUCTIVE, MATERNAL AND PAEDIATRIC HEALTH SERVICES IN TASMANIA MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART ON THURSDAY 20 FEBRUARY 2025

The Committee commenced at 9.04 a.m.

CHAIR (Ms Haddad) - Good morning and welcome formally for today's hearing of the House of Assembly Select Committee on Reproductive, Maternal and Paediatric Health in Tasmania.

Thank you for the written submission you've provided to the Committee. Could I ask you to state your name, please, and the capacity in which you are appearing today?

Ms WHITE - My name is Clara Cathlene White. I'm appearing to share my lived experience of the health system in Tassie.

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

Ms WHITE – Yes I have.

CHAIR - Great. In the guide you would have read, but I'll just remind you, that the hearing is covered by parliamentary privilege, which means that you can speak freely to us, say whatever it is that you want us to hear, without fear of being sued or questioned in any court or place outside of Parliament. That protection, however, doesn't accord if you make statements that might be considered defamatory and then refer to them again outside of this parliamentary hearing. It is a public hearing, which means there may be people watching online, there might be members of the public or media attending in the gallery today.

We've already introduced the Members of the Committee. You have a mixture of every party and independents, and south and northern-based members as well.

Ms CLARA CATHLENE WHITE WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - As a Committee, we've agreed to read what's called a sensitive content statement into the *Hansard* at the beginning of each session, so I'll do that for you, people in the room and anyone watching online.

The Committee recognises 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. We encourage anyone impacted by the content matter during this hearing to contact services and supports, including Lifeline on 13 11 14, Tresillian Tasmania's parenting helpline on 1300 827 282 and PANDA’s national helpline on 1300 726 306.

Additionally, here in the building today, we have clinical support workers from Gidget Foundation Australia, and we're very grateful to have their support to the Committee for these hearings. Dr Erin Seeto and Ms Amelia Walker are available in an adjacent room if you require any assistance after today's hearing in that breakout space, and you don't need to feel at all rushed. You can stay for as long or as little as you need.

We'd love to invite you to start - if you'd like to read an opening statement or anything you'd like to start with.

Ms WHITE - Sure. I guess I think my submission largely speaks from where I'm coming from. I didn't prepare an opening statement, sorry.

I had a variety of experiences with my twin pregnancy that were challenging and some I felt that were exacerbated by the system. I was also very aware that I was one of the kind of last cohort of people who did get to go to the Mother Baby Unit. It was really distressing for me when I found that it had been closed, and so quickly. I know there was some talk - 'Oh, we'll have, like, a bed at the hospital'. From my experience that seemed not at all the same.

Being a twin parent, obviously it's different for everyone, but it is a bit of a unique experience. A lot of people do find it really challenging, and to know that people didn't have somewhere to go in that situation, I know that a lot of people ended up going to the - well, maybe not a lot, but some people go to the mainland and obviously that's pretty challenging as well. Obviously, that's really cost-prohibitive for some people. So, yes, I really wanted to share, I guess, my experience and gain something from it, particularly around the Mother Baby Unit and a few other things that happened in the pregnancy and afterwards.

CHAIR - You're right, twin pregnancies are exciting but also present their own challenges. I've got friends with twins as well. I wonder if you want to expand at all around the issue of mental health support: whether you were offered mental health support either prior to giving birth or after your stay at the Mother Baby Unit, or in between giving birth and the admission to the Mother Baby Unit. What kind of postpartum mental health support or care was provided or offered to you?

Ms WHITE - I don't think anything was really explicitly offered. I'm sure I was given pamphlets, which is something. But, you know, life was pretty busy and I didn't really have the ability to look it up and research it and call someone, and all of that kind of thing. When I found out I was having twins, I didn't get offered anything, which is difficult to talk about because, obviously, it was so wonderful, but also it is a big change if you're expecting to have one baby and you're going to have two, like the money side of things, housing, your car, like all of those things. It can also mean that your pregnancy is quite different than what you had imagined and it's not something - I did have a few people ask me, 'Oh, like, were you expecting? Were you trying for twins?' 'No, it's just something that happens.' That was a bit challenging and even when I found out, I started laughing because I was surprised and the person doing the scan just told me to stop laughing because she was trying to do the scan. I felt like that was kind of -

CHAIR - Insensitive.

Ms WHITE - Yes. It was a bit - 'Get on with it', I guess. I was lucky. It wasn't a medically complicated pregnancy, but - sorry.

CHAIR - Take your time.

Ms WHITE - During that time, I wasn't offered anything.

CHAIR - I'm sorry. I want to give you these [tissues].

Ms WHITE - So early. That was a bit difficult.

I was also - I didn't talk about this in my submission. There's always so many things going on in your life.

CHAIR - I'm sorry to have immediately started with a really tough question. I'm sorry about that.

Ms WHITE - That's okay. I also was quite sick in my pregnancy, and that was quite hard. Sorry.

CHAIR - Do you want to take a break? We can take a break anytime you need?

Ms WHITE - No, that's okay.

CHAIR - Are you sure?

Ms WHITE - Yes.

CHAIR - Okay.

Ms WHITE - I mentioned in my submission around the obstetrician because in the south, definitely, once you have twins, you're high risk so you go into the high risk clinic at the Royal. And I'm sure the doctors there are very skilled and that kind of thing but it does mean you see a different person every time.

I definitely had one difficult experience because I was really sick, throwing up most days, feeling nauseous. I had medication prescribed to me for that which I was taking and then I saw an OB [obstetrician] at the Royal [Hobart Hospital] who really made me feel as if I shouldn't be taking the medication.

CHAIR - That's terrible. I'm sorry to hear that. That's really not fair at all.

Ms WHITE - That was just one of the challenges.

Sorry, can I take a break?

CHAIR - Yes, of course.

Can we stop the broadcast?

The Committee suspended from 9.13 a.m. to 9.16 a.m.

CHAIR - Thank you. Do you want to expand a little bit about the importance of continuity of care?

Ms WHITE - Yes, sure. With my first pregnancy, I was through the Midwife Group Practice (MGP), which, you know - no system is perfect, but that was really good for me. I saw some different midwives, because someone's delivering a baby or whatever, but it worked really well for me and I really liked midwife-led care. I understand different situations call for different types of care, but it was challenging to get immediately pushed to the high risk clinic. I know some people end up seeing the same doctor there. I think it just depends. I saw two different OBs and they had quite different approaches. They also always said to me, 'Well, you're not really high risk', which was kind of annoying because I was like, 'Well, I have to be here because of the kind of twins I was having', which I was very grateful for. It was a bit like, 'We're not really sure why you're here -

CHAIR - But you didn't have a choice.

Ms WHITE - we're not quite sure what to do.'

Mr STREET - Last thing you need is to have your situation minimised.

Ms WHITE - Yes. I did feel relatively okay. I didn't feel like I was super high-risk. I wasn't super worried. It was like, 'Well, I don't really want to be here and you're telling me you don't really want to see me.

CHAIR - It would feel very disempowering.

Ms WHITE - What are we doing?

CHAIR - Do you see midwives as well as OBs through that clinic? Or is it mostly doctors?

Ms WHITE - I didn't. I had a booking-in experience over the phone and that was with a midwife. They said, 'Oh, you can see a midwife', but I wasn't really sure what I would be seeing them for. Just to say, 'Hi,’ okay? If I'm having these appointments with the OBs - but it was offered to me, but it wasn't how I would do that or anything. I think it was mostly the midwife who I did the booking on with. She was very midwife-y in her approach. She was very, 'Maybe you can have a very natural birth, maybe you can dah dah dah'.

Then the OBs, we didn't really get to talking about that in too much detail, but I did get a different vibe, which is something I experienced with my first pregnancy as well. There are obviously differences in the approach. It was really the second time I saw an OB, and she was very - maybe she was just having a hard day, but she was very, 'I don't think - if you're taking Ondansetron, that's really the last line of resort, how much are you taking?' and, 'Have you tried eating little and often?' and, 'Are you taking ginger?' and all those things that you hear a lot. That was quite difficult.

After that experience I was really lucky I was in a position, although I didn't have private health that covered obstetrics, we were in a position - and I knew from my mum that you could go and see an OB privately and then deliver publicly. That's what I ended up doing, which is a great option because it's really the birthing in a private hospital that's the expensive bit.

I was perfectly happy to be at the Royal, because that's where you would get sent anyway if things were complicated with twins. I had no issues with my experience there. I just wanted to see the same doctor and a doctor who understood me. I was really lucky I saw Dr Brett Daniels. He also works - they all work at the Royal anyway, it's Tassie, right? That was a really positive experience. We did have to pay out of pocket. I can't remember exactly how much it was. It was a bit, but for us it was worth it. It's probably still cheaper than paying for obstetric-level health insurance.

CHAIR - Health cover.

Ms WHITE - It was quite a good little - and I always tell people about that because it was a really positive experience -

CHAIR - That's really good feedback.

Ms WHITE - getting to see him through pregnancy and then, at the Royal, he was there when I delivered.

CHAIR - Okay, that's great.

Ms WHITE - It's probably a change in some of the people here. My delivery was all really positive.

CHAIR - That's really good.

Ms WHITE - It was a very good experience. I think part of the reason - I mean, you never know, but I think part of the reason it was positive was that I had Dr Daniels there who I knew and who I'd been working with through the pregnancy, and he knew - like, because one of my big issues was I was very nauseous the whole time. I was worried that I was going to be throwing up the whole time -

CHAIR - Through labour.

Ms WHITE - Through labour, and he was able to manage that.

CHAIR - That's fantastic.

Ms WHITE - That was really good and that was really positive. I do think that maybe one of the challenges with that then is that you've seen a private OB. I did get put into the public system, obviously, and have people come out to the house - the midwives. Maybe there was a little bit of disjoint. Maybe if I'd been a bit more connected to the public system I would have had more. I did go on a tour of the Royal before I gave birth and a few little things like that, but I don't know. I don't know what the experience would have been like if I'd been a truly public patient because there were a couple of times in the process where everyone was a bit confused about, 'Where do you fit?'

CHAIR - Okay. How did that compare to your MGP experience with your first pregnancy, in terms of that contact with people in the system?

Ms WHITE - Yes. Look, I don't think it - I think it was fairly similar. There were a few things with my first pregnancy as well, like I had gestational diabetes. I feel like when anything happens it's a bit confusing. I think the system is very good at dealing with you when things are really acute, which is obviously super great. The most important thing, but I think sometimes, when you're in that not really high-risk category - with my first, as well, I had a lot of experience, or not a lot, but a few experiences of going to appointments and they're like, 'Oh, we don't really know why you need this scan. I don't really know why they've sent you.'

CHAIR - That's confusing.

Ms WHITE - You're like, 'I've waited for an hour and a half in the waiting room, so -

CHAIR - 'Let's do it.'

Ms WHITE - Yes. I do think sometimes there's just kind of protocols and different people have different ideas around that. So, I don't think it was a lot worse. I guess I just don't know whether maybe there would have been a bit more wraparound care if I'd been truly a public patient.

CHAIR - Did you still have some midwife care afterwards - the visits? After you had the twins?

Ms WHITE - Yes, they came to the house, which was fine. I think it was helpful, being a second and third baby, I never know how to say it. I was less worried about things like weight gain and stuff. Also, when you have twins, they're really nice to you. It's like you unlock the next level where they're like, 'You're breastfeeding, you're giving it a go, you're doing great.' Whereas, I think with my first I felt a lot more like, 'Not gained quite as much as we would like and we're not quite happy that you're perfectly positioned when breastfeeding.' With twins they were very like different, but I do wish they were like that to everyone.

CHAIR - I would love to open it up to the rest of the Committee if anyone else wants to.

Ms JOHNSTON - Thank you for your submission. You talk in your submission about the difficulty in getting into the Mother Baby Unit. I think in your submission you've said – I think what resonates with a lot of mothers and me, because I was in the Mother Baby Unit too, 18 years ago - that sleep deprivation is a form of torture and it absolutely is and you get to that point - can you talk a bit about the process of trying to get admitted to the Mother Baby Unit and how hard that was for you in navigating that way? I recognise that it's not there anymore, but we hope that we have facilities in the future. Maybe we can learn something from the process that was there in the first place.

Ms WHITE - Sure. It was a bit unclear. I think there were a few different ways you could get admitted. Honestly, a lot of it now, probably - as it is with lots of things, there's a lot of like Facebook groups where mums are talking about, 'You need to do this, you need to do that,' which is sometimes helpful but sometimes not. Sometimes it's outdated information. Certainly, around insurance, it was a bit complicated because I knew that there was only one public bed and I didn't have the highest level of health insurance, but I was able to work out that I could access it, but I think if even that would have put off a lot of people.

It wasn't clear, exactly, what the reasons were. But I was in a good position in that one of my mum friends from my first pregnancy, from my mothers' group, she had gone in at one point, so I knew a little bit about how she'd gone in. And my mum is a retired paediatric nurse and she knew people who were working in the Mother Baby Unit. So, I think it was difficult for me, I can't imagine what it would be like for other people.

It also happened that I had randomly, in the middle of the night, when I couldn't get Ryan to go to sleep, made a doctor's appointment and the doctors - that office - and then one of the doctors I ended up seeing was working at the Mother Baby Unit. So, I can't remember, is it - like my mum was like, 'I think this is where you should go,' and then it was just a bit difficult. I had to try a few different ways. It's hard to get a GP appointment. It wasn't really clear to me whether I should be admitted because you can be admitted like the babies are admitted or you can be admitted that you're admitted. And I was admitted because one of my twins was declared 'unsettled,' so I think that makes a difference in the care you receive. It was never really explained to me. I think if it's your babies that are the problem, they're kind of just like, 'Well, you're just here to like feed them and look after them during the day.' They didn't really talk to me about how I was going with things or anything like that.

Anyway, to go back, I did call - I had to get a referral, had to talk to a doctor I'd never met before on the phone because it was just the easiest way to get an appointment. So, he did give me a referral, but, I don't know, he seemed to be grumpy about it. I don't know what he was doing. But anyway, he gave me a referral and then I called and I think I talked about in my submission, that I had a bit of a difficult experience with the first person I spoke to was kind of like, 'Oh yeah, no worries, yes, you're definitely,' -

CHAIR - And the next person was like, 'Wait your turn.' That's not fair.

Ms WHITE - So, that was a bit of a challenge. I think I ended up getting in over - like it was a different, I'm not sure - I saw - and then I did go and see that doctor, the doctor I'd met with previously, face to face, again. And he was like, 'I know you're on the list,' so Tasmanian isn't it? ‘I'm trying to’ - you know, 'You should get in soon,' but there's like this - and it was a very small facility as well. I think it was like 12 beds or something, so it's obviously very dependent on how those people are going and who else is on the list. So yes, it was just a challenging process. It's difficult because you feel like you needed to show why you needed it, but that would be quite emotional, like I am now, and so to have to do that with several different people.

Ms JOHNSTON - You didn't know the first time.

Mr STREET - The thing that I picked up from your submission was that a number of the difficulties that you had come from personal interactions that you had with people and a couple of times you've excused people and said, 'Maybe they were having a bad day.' As a semi-public person, I think probably all of us here are aware that everybody has a bad day, but I'm acutely conscious that I can't have a bad day out in public because it might be the only time that somebody ever meets me and they'll form a negative opinion of me that will never change. There are people who work within the health system who might be having a bad day, but they can't afford to let it creep into their work because it has such a negative impact on the service that they're delivering on any particular given day.

The difficulties that you've had through this process, I know this is a difficult question, but in terms of percentages, how big a problem was the individual interactions that you were having versus the systemic problems that you think exist. Do you understand what I mean? What percentage of the problems were because of the way the system is set up and what percentage of the problems that you had were because you either had problematic individual conversations or you weren't seeing the same person the whole time and so there was no continuity to the service delivery as well?

Ms WHITE - I guess it was a combination. I guess those comments - any comments you get at a time like that really stick with you. And I think one leads to the other in that when I did have difficult interactions, there wasn't necessarily a process to - I didn't feel comfortable to push back or to know, well, if this person said this, the other process is that. I think it was a combination. I have a lot of friends who've had kids and some who've had really, really difficult interactions where it's really been about that person who has made that experience very challenging for them. I don't necessarily, looking back, think that it was just that I encountered someone who wasn't good at their job or anything like that. I think a lot of it was systematic, just as far as the process around accessing extra care. I guess I personally feel like, particularly, for multiple births, you should have some kind of residential offering that you know how to access from the outset, versus the Mother Baby Unit. They were quite - I don't know, it was just weird. They seemed quite surprised to be dealing with twins, and I just kept thinking, surely -

CHAIR - Surely, it would be higher proportion of people needing support.

Ms WHITE - 'Our staffing levels mean it's quite difficult for us to deal with two babies.'

CHAIR - You're dealing on your own with two babies, and a toddler.

Mr STREET - Where it's like you would think that -

Ms WHITE - Maybe that was a personal issue. It's hard for me to judge as just a member of the public, to what degree, maybe. I don't know, but it was put to me as if it was almost a systematic issue. For example, things like bathing them, someone would have to come and help me. They were pleasant enough about it, but it was kind of like, 'Oh, we'll have to come with you', kind of thing.

CHAIR - That's why you're there, for assistance and help.

Ms WHITE - Yes. I think it was a combination of things, but I did definitely have problems. There were comments that stick with you. And it was difficult because it was a really difficult time. I think, genuinely, someone could have the best will in the world and they could happen to make a comment that upsets you. Like, sometimes you see someone at the shops and they say something like, you know, sometimes if you're carrying one twin and one twins in the pram - 'Oh, I know which one's your favourite.' Things like that. That's just a comment and you just have to -

CHAIR - Constantly people saying 'double trouble' and things like that. It's a bit frustrating.

Ms WHITE - But I think it was the systems and the way that the Mother Baby Unit was set up, and maybe a little around the staffing and their expertise, I didn't get the feeling, I didn't experience that any of the nurses there were particularly trained in mental health. They didn't talk to me about that at all. They seemed very focused on the babies, which is obviously a big part of it, but that wasn't what I'd been led to believe the experience would be like.

Ms JOHNSTON - Following on from that, it was called the mother and baby unit, not the mother or baby unit. You talked a bit about - it depends on was the baby admitted or the mother admitted - possibly, you get different kinds of level of care or intervention depending on who the patient is. Do you think if there were to be mother baby units in the future, there's benefit from having more of a holistic approach, that you are the one unit in terms of the mother and the baby, in terms of mental health support and care for the mother? All those kinds of health and wellbeing things, obviously, are good for baby. Likewise, all those things you give to a baby are good for mum as well. Is there benefit in trying to not delineate between who the patient is? Do you think that would have made a difference in your experience if it had just been you and your babies being admitted, not your babies being admitted and you're just here to provide care and support?

Ms WHITE - Yes, I think so. I think some of the challenges are just around it was a hospital setting and so you have that classic thing you have in hospitals where there's shift changes and there's always about to be shift changes, so there's a lot of times when I got admitted, we went through some paperwork, and at that point I thought - they sketched out your whole family, and I really thought that was going to be more in-depth, but that had to be done relatively quickly. The whole thing is around sleep, obviously, so there's a lot of that, like, 'We need to do this before the next thing with the sleep'. So, yes, I think that would have been helpful. I think maybe also looking at the larger family system.

CHAIR - The support around each person, yes.

Ms WHITE - Yes, and, after that week, what you would do, because there wasn't a lot of support around that.

Ms JOHNSTON - Going home can be scary.

Ms WHITE - Yes. They we’re happy to chat about it, but one of the things I did that really helped was that I got - and I was lucky I could afford this - a babysitter to come a couple of mornings a week. But there was no – I asked, 'Do you know who would be a good place to start with that?', where I should go or anything like that. There wasn't anything around that, which was a bit of a lack in the system –

CHAIR - A lack of knowledge.

Ms WHITE - it feels like there should almost have been a case worker or someone like that who knew.

CHAIR - Or someone specialising in multiple births.

Ms WHITE - Yes. Also, who knew what some other facilities were when you left, that kind of thing. It was funny because I remember when we left, they said, 'You could always come back'. My husband was like, 'I don't think we - they've been very clear. We definitely can't.' The experience was not that we could. It felt like it was a very specific intervention for a very - and it was, obviously, great in many ways, but it was just very specific and nothing was talked about as far as when you got home.

CHAIR - What's next.

Ms WHITE - Yes, exactly. And if you have older children, how do they fit into this? It's all very well to have this very strict sleep schedule. I was very like whatever works. I had no issues with that.

CHAIR - But then you've also got a toddler.

Ms WHITE - Yes. It's not practical, where you're constant - you know.

CHAIR - Did you have any contact from the Multiple Birth Association after the twins?

Ms WHITE - Yes, I did. I had a bit of contact with them before the twins were born. I went to an expectant parent session, which was useful. Then afterwards, I went to play group once or twice, but it was hard to get to. It was really good but it is all just volunteer-run, so as far as mental health support or even -

CHAIR - It's not what it's set up for.

Ms WHITE - They also all have twins, so they're all pretty stretched as well. It has been a comfort to be connected to that, but I think that there are quite a few limitations. When you have twins, everyone, including doctors, always says, 'Have you heard about the Multiple Birth Association?', which I appreciate, but it's also like, well -

CHAIR - It's not set up as a mental health support organisation.

Ms WHITE - It's not really, yes.

CHAIR - Yes, that makes sense.

Ms ROSOL - I was interested in your touch points at the end - you talked about the parenting centre being very helpful to you and coming to your house to help and give advice. Could you explain a little bit more about what that was?

Ms WHITE - Yes, sure. That's part of the CHaPS (Child Health and Parenting Service) nursing program, and it's based in New Town. I'd come across it with my first, when I had some breastfeeding troubles. It's a really good service because you call and they triage you and they book you into the system. I think partly because I had twins, they came out to my house. I only really have positive things to say about it, apart from the fact that I feel like there's not enough information about it, and they are, obviously, limited.

It's also quite difficult because you call and then it depends what day you call, because I think they triage on a Thursday. Then you have to wait to get triaged and they call you back. It's quite hard taking lots of phone calls when you're trying to sleep. There are just some challenges with that -

CHAIR - Bureaucratic challenges?

Ms WHITE - Yes, with that system. It's really helpful in some situations, but if you're in a real crisis situation, being told, 'We'll call you back in five days', or whatever, 'and we'll see if we can fit you in', is not always going to be the answer. But it is great that it has - I do think in the past they did have a residential offering, but they no longer do. I always mention it to people, and it is free as well, which I think is really good. There's a lot of things online now, sleeping courses, feeding courses, all these things that you can spend a lot of money on, and they might not be in Australia, they might not be specific to the situation, they might not be safe. I think it's really great that we do have these public systems which are staffed by professionals and that kind of thing. I just wonder if we could make people more aware of them and make it a bit more of a straightforward process. There's, like, a website. It's a very Tasmanian Government health website. It doesn't really explain things and you have to call a landline. I get it, but it doesn't feel accessible to everyone.

Ms ROSOL - Thank you.

CHAIR - It's really good feedback. Our time has rapidly drawn to a close.

Ms WHITE - No worries.

CHAIR - I'm really grateful for you having been able to share your story. I know it hasn't been easy. It's important that we hear stories like yours because it will make our report more meaningful and our recommendations more persuasive. We're eternally grateful as a Committee that you've been brave enough to come and share your story with us, both in writing and in person. I hope we haven't triggered too many traumatic memories from the experience that you've had. I'm grateful that you could do it. Thank you very much.

Did you have anything else that didn't come up in our conversation that you want us to hear?

Ms WHITE - No, I don't think so, thank you.

CHAIR – Could we stop the Broadcast please.

The Committee suspended from 9.40 a.m.

The Committee resumed at 9.45 a.m.

CHAIR - Welcome to today's hearing of the House of Assembly Select Committee on Reproductive, Maternal and Paediatric Health Services in Tasmania. Thank you for making a written submission and for appearing before us today.

Could I ask both of you just to state your names into the record?

Mrs ALLEN- Angela Allen.

Mr ALLEN - Shannon Peter Allen.

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

WITNESSES - I have, yes.

CHAIR - Awesome. You would have read it in the guide, but I'll just remind you that this hearing is protected by what's called parliamentary privilege. What that means is it's the same as if we were standing in the parliamentary Chamber. You're free to say whatever you want to say to us. You can speak freely, say anything that you want the Committee to hear without fear of being sued or questioned outside of Parliament.

The only exception to that is if you make statements that might be considered defamatory and then refer to them again outside of this chamber, for example, in the media or that kind of thing. That parliamentary privilege doesn't extend to that.

Mrs ALLEN- That's fine.

CHAIR - It's a public hearing, so there may be members of the public who attend and listen in the gallery or might be watching online. Members of the media have been watching online and attending, sometimes in person as well. We're being broadcast in that way.

Could I ask each of you to make the statutory declaration separately on the cards that are in front of you?

Ms ANGELA ALLEN, AND **Mr SHANNON PETER ALLEN** WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Thank you very much. We've also agreed as a Committee to make a sensitive, content statement at the beginning of each hearing, because people might be tuning in online just for each individual session. I'll quickly just read that in for your own benefit, but also for anybody accessing these hearings either online or reading the *Hansard* later.

As a Committee we recognise that these hearings 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. The Committee encourages anybody impacted in this way to contact services and supports such as Lifeline on 13 11 14 or Tresillian on 1300 827 282, or PANDA on 1300 726 306.

Additionally, for these hearings today, we have clinical support workers available on site from the Gidget Foundation Australia and we're grateful to have their support to this Committee. Dr Erin Seeto and Ms Amelia Walker are here in the building in our breakout room, who are available to provide support before, during, and after today's hearings.

That's all of the formalities dealt with. We'd love to just hand to you for an opening statement or anything that you'd like to start off on.

Mrs ALLEN- First of all, I'd like to thank the Committee for the invitation to speak today on behalf of our daughter, Lysithea Allen. It's a rare opportunity and we are very grateful for it. To provide some context, Lysithea has just turned four and she was formally diagnosed with global development delay and suspected autism in January 2024. We had concerns about our daughter from as young as 18 months as she was different from our first born. However, the first external person to share these sentiments was her family daycare provider due to Lysithea's obvious lack of speech and lack of social engagement. This occurred in July 2023, about 19 months ago.

As concerned parents, Shannon and I promptly acted, securing a GP appointment within two weeks to obtain a referral to a paediatrician. That's when we hit our biggest and our first, hardest roadblock. There were no paediatricians available, either public or private, in Tasmania. Due to our stable financial position, we could afford to pay for private care, but every time we contacted a paediatric clinic, whether public or private, the result was the same. They had closed their books.

We were persistent with our GP to contact every possible paediatrician and finally, after six months of trying, the Royal Flying Doctor Service in Victoria offered Dr Britt Turner's services via video conference only. The consultations with this paediatrician were very helpful, however I'm confident the interstate distance delayed the process of getting Lysithea referred to the Tasmanian Autism Diagnostic Service, or TADS for short, as Dr Turner was unable to assess Lysithea in person as all consults, which were three in total, were held via Zoom.

Dr Turner finally referred Lysithea to TADS in July 2024 and we are now on a 20-month wait list for a formal diagnosis. At this rate we will be seen by TADS in March 2026 after Lysithea enters the schooling system.

Since July 2023 we've had one, just one, appointment with a Tasmanian paediatrician, Dr Natalie Morgan, at the Royal Hobart Hospital. At this lengthy and thorough face-to-face consultation, which she was good, Dr Morgan supported Dr Britt's opinion that autism is highly likely, however, she withheld a formal diagnosis pending an assessment from TADS.

In itself, TADS is quite inaccessible as a department. When trying to speak to an actual person on the phone to find out further information regarding their processes, you were told via automated message to send an e-mail and to expect a 20-month wait from when your child is referred. The information sheets are not detailed as to what an assessment actually includes, noting that it involves a psychologist and an occupational therapist. The website also notes consultations with the child take 45 minutes to one hour and then there's a separate parent interview. Why there's a 20-month wait for a process that has profoundly less time taken than birthing a child is hard to contemplate.

In the meantime, off our own efforts, we've secured ongoing therapies for Lysithea, including speech pathology, child psychology and applied behavioural therapies. These occur several times a week and it is so that Lysithea can have the best chance of life regardless of her diagnosis.

To summarise, because I've thrown a lot of information out there, the lengthy delays of 16 months to see a Tasmanian paediatrician either within the public or private system from the date of the GP referral and after that another 20 months to be assessed by TADS from the date of the paediatrician referral have been detrimental, in our view, to Lysithea accessing the specialised kind of interventions she may need. I'll conclude my opening statement and I'm very happy to answer any questions.

CHAIR - Thank you so much for sharing that, in what has been an incredibly frustrating and lengthy process, so succinctly. It really does demonstrate what the Committee has heard about delays in accessing paediatric services both through the public and the private system. It's such a stark illustration of the difficulties that Tasmanians face at the moment.

I'm really interested if you're happy to elaborate a little bit more on TADS because I share that frustration that it's such a long wait, but also that the wait comes after a long wait to actually access that first step.

Mrs ALLEN- Yes, it's a three-year wait.

CHAIR - And you've elaborated it in your written submission around all the messages that we get around the importance of early intervention, but that Lysithea will be at school age or in school by the time those wait times are up through the public and private system. That must be incredibly frustrating.

I wondered if you'd like to elaborate a little bit more on that referral into TADS part of your journey and how that could be made easier or better for Tasmanians.

Mrs ALLEN- First of all, on the TADS website it says a referral can be made by either a paediatrician or a clinical psychologist. However, when you scroll down further into the FAQ section it then elaborates that it has to be made by a paediatrician, not a psychologist. This was something - I'm not trained in these areas - but, to me, that immediately makes the funnel into that service go from this wide to this wide because, you can access a child psychologist if you're persistent. It's hard to find one for a young child particularly for one that doesn't talk because what are they going to do, just watch? But when it is literally such a narrow criteria to get in, that is very hard for parents to be able to navigate because, immediately, it just amplifies the wait time.

CHAIR - I'm also not trained in those areas, but I wonder if there would be value in us exploring the possibilities of clinical psychologists or even GPs to be able to refer into that service. Do you have any views on?

Mrs ALLEN- I feel that would assist, simply because if you have a child who is obviously displaying signs of lack of normal development, lack of speech, lack of interest in their peers, as Lysithea does, those things are very obvious. In my case, we have a family on the maternal - on my side - with a history of autism. That, coupled with these factors, should at least open up the option that if it's suspected, let's get that child assessed sooner rather than later.

CHAIR - Into the system, yes.

Mr ALLEN - It's also not like - all the professionals have been in agreeance there. They're not under-qualified. You have Dr Britt Turner, you have multiple people there pointing in one direction, but we're still hindered from the diagnosis from someone we can't even access. There are multiple people there who have agreed to what this is.

Mr STREET - Are TADS the only people who can make a definitive assessment?

Mrs ALLEN- To my knowledge, yes.

Mr STREET - It sounds like the paediatrician that you met with at the Royal [Hobart Hospital] was relatively confident having met Lysithea that she was autistic.

Mrs ALLEN- Yes, she was. For sure.

Mr STREET - You've gone and accessed services yourself before as well?

Mrs ALLEN- Correct.

Mr STREET - What is the benefit of TADS' assessment being confirmed? Do you know what I mean?

Mrs ALLEN- I absolutely understand. This is why I noted that it's hard to get in touch with TADS. I've tried to call them. I tried to call them yesterday at 12.30 p.m. to get a bit of an understanding of what they do in their assessment process. They basically - no one picked up the phone. It was lunchtime. No one picked up the phone. It went straight to an automated message saying, 'Send an email or leave a message', which no one returned.

My understanding from TADS is that, bceasue they have people there who are specialised in the autism space, whereas a paediatrician has a very broad knowledge of many childhood ailments. Whereas TADS is quite narrow in their focus, purely autism. They would be able to offer more insight and more detailed testing. They've got the facilities there. This is something that for me too is a bit of a mystery. I still haven't been able to figure out what exactly they do there because they're very inaccessible. On their website they say that they do an assessment with the child which involves play while being observed, and attempts of the staff. So I'm assuming the occupational therapist and also the child psychologist engage with the child, which is similar to things that a childhood nurse does.

Then they also have a parent interview, which - we've had numerous parent interviews with many providers. What exactly they do is a bit of a mystery to me. Why there's such a long wait again is a bit of a mystery to me. From an initial thorough read of their website, the services they offer are OT [occupational therapist] and psychology. There's occupational [therapists] and psychologists. They're more abundant than paediatricians. Why aren't there more there pushing everyone through?

Mr STREET - You've been able to access a speech pathologist?

Mrs ALLEN- That was hard, but we did get in. I had to call about five different practices, get put on waitlists, and then finally we had Speech Pathology Tasmania. They got in touch with me and Lysithea sees them - I'd like to say weekly, but it's not. It probably works out to about once a fortnight because they have a practice of needing to redirect their staff to schools to go and test children. I've said to them, 'Well, if you're going to test children for speech delays but then your existing client load is full, what's going on there? Why are you adding more?' It seems to be a fairly consistent situation with most speech pathologies.

CHAIR - Is that a public service?

Mrs ALLEN- No, that's private.

CHAIR - Okay.

Mrs ALLEN- Public speech pathology - we didn't even go there, because the wait times were huge.

Mr STREET - But they were comfortable taking Lysithea on without the TADS assessment being completed?

Mrs ALLEN- Oh, yes. Correct. Absolutely.

Mr ALLEN - That still took the GDD [global development delay] diagnosis, did it not?

Mrs ALLEN- It helped to get her prioritised. If it had just been our word, we probably wouldn't have been seen as quickly, but we had the thing where we also - we engaged a private child psychologist who wrote a report which was then provided to the first paediatrician we saw via Zoom from Victoria. That basically outlined her very strong suspicion of GDD because when we started this process Lysithea had only just turned two, so that lack of speech, while not ideal for a child just over two, is still on the very, very, very, very fringe area of maybe being okay. However, she is four now and when coupled before the other issues it was very obvious that she was not progressing, and we have that internal torment now of 'Could more have been done?'

Mr STREET - She has essentially got her to where she needs to be in terms of the services that she's accessing by working around the system rather than going through it?

Mr ALLEN - That's correct.

Mrs ALLEN- We've had to -

CHAIR - Go through the private -

Mrs ALLEN- Exactly.

Mr ALLEN - When we say there's a 36 month wait, that's not a seamless 36 months - that is us pushing -

Mrs ALLEN- I would be getting calls.

Mr ALLEN - and spending thousands of our own dollars to get it there.

Mrs ALLEN- I'd be getting calls from the Tasmanian Health Service, too, intermittently, asking if I still needed to have Lysithea on the waitlist and asking if I needed to take her off.

CHAIR - I hear that a fair bit.

Mrs ALLEN - No.

Mr STREET - She would not have been on there in the first place -

Mrs ALLEN- Exactly. And this is - once again, no one wants harm to children. It's just, I think when you are actually working within a system and you're just trying to process information and data, it's very easy to get caught up in that. But the problem is, it's not just me, it's many people who are experiencing this. Shannon and I have been able to put our hand to getting our daughter the services she needs because sometimes paying privately is $650 a week.

CHAIR - That's a lot.

Mrs ALLEN- We finally managed to get NDIS [National Disability Insurance Scheme] funding for her, which is another story and that's separate to this Committee because that's a federal thing; but that took six months. So, on an expensive week with a child psychologist, speech pathologist and applied behavioural therapist, we're looking at about $650 to $700 a week, plus lost wages.

CHAIR - It's massive.

Mrs ALLEN- We've moved closer to town to help her get the services she needs. Many parents who I speak to, who don't have that disposable income, their little kids just wander around untreated and it's terrible.

CHAIR - And they're missing out on what they need.

Mrs ALLEN- Yes.

CHAIR - And they're starting school behind the eight ball.

Mr ALLEN - A lot of the treatment is recognised - I'm not a health professional, but to start early is better long-term.

Mrs ALLEN- For sure.

CHAIR - You've pointed to that in the written submission as well, that all the advice on the websites and the information that we received through public channels is that early intervention is key.

Mrs ALLEN- It's key.

Mr ALLEN - I would like to add, the treatment does work. It's just getting it. We have noticed a difference. It is working.

Mrs ALLEN- Just her - things like, working with her occupational therapist who does applied behavioural therapies. Things like, her getting extremely elevated and emotional when packing up toys - she now picks up toys. And Lysithea, the flip side to her is she is extremely fast, extremely strong, and very dexterous, so she has a huge amount of talent there. It's the social engagement and the speech she doesn't have. And she's getting stronger, she's 20 kilos now. I'm not a big person. It's hard to control a child and then you have fears as they get older, entering the schooling system. Are they going to hurt children? Are they going to be a danger to themselves and to their peers? What do the prospects hold? So, lack of service where you actually get a good idea of what the future might hold, is hard.

I've got Shannon here as a great support. He's a fantastic father. He's very hands-on with Lysithea. A lot of parents, single mums or parents single-parenting, they don't have that resource. I can have a time out and Shannon's - he's got it. A lot of parents don't have that. And it's how much would the early intervention help with that?

Ms DOW - I had one question. Thank you both for presenting before our Committee. A big focus of this Committee's work is around paediatric health and wellbeing and access to services. It's been great to hear from your perspective and that's why we encouraged you to present and provide us with a submission to this process.

I wondered, as your daughter approaches school, whether you have a good understanding of what services will be available to her in the education department. Whether, in fact, that's been communicated to you as a family who are awaiting that assessment process and whether the services that you're currently receiving now will continue when she enters the education system.

Mrs ALLEN- That's a really good question. From the public system, we've had nothing offered to us. Privately - our daughter will be attending a private school and they've got great interventions available and support for children with neurodiversity. And we will continue her existing privately funded treatments. But, in terms of if I received a written communication from the Autism Diagnostic Service or from Tasmanian Health Service about what might be good to assist with your child entering into the schooling system with global development delays, suspected autism - nothing's been provided. I know the resources are there, I know there are workshops and various things that people can attend. I haven't had them succinctly communicated to me. Having said that, Shannon and I also - we're quite proactive in the sense that we've kind of set our own path in motion, simply because we don't want to have Lysithea to miss out.

Mr ALLEN - We've even gone to the effort of selecting the school best for that aspect.

Mrs ALLEN- Yes, that's right. Her enrolment's in process right now.

Ms DOW - Thank you. That does highlight, doesn't it, the fact that if parents aren't well informed or proactive like yourselves that there is a significant gap there in communication and preparedness for the public education system. Thank you.

Mrs ALLEN- Once again, I just want to reiterate, although I'm a mum and I am busy, I'm not engaged in full-time work now. I work for Shannon's company several days a week. I have flexible work hours. I can be there to pivot for Lysithea and for the family's needs. Many parents don't have that luxury. Many parents have young kids and both of them are working full-time or they're single parents.

The word I would probably use is they would feel so hopeless because they have to have this, huge task added to their already very full lives. That's something that I feel probably needs to be addressed. Shannon and I, basically, although the situation has been frustrating and the TADS situation is one that we are really quite concerned with, we've been able to do what we feel is best for Lysithea.

Mr STREET - I think the reality is that a lot of people in your situation would just withdraw -

Mrs ALLEN- That's what happens.

Mr STREET - from the process out of frustration.

Mrs ALLEN- They do, they really do.

Mr ALLEN - Or just feel forgotten, I guess. You know, if it drags on for 20 months, they just think they've been forgotten about.

CHAIR - I know you've seen a paediatrician at the Royal now, but your first appointment was with someone in Victoria.

Mrs ALLEN- That's correct.

CHAIR - Do you happen to know whether or not there are any barriers to interstate people referring into the Tasmanian service?

Mrs ALLEN- Yes. I called about five or six paediatric clinics in Melbourne and a lot of them basically said that they don't take interstate children because they've got very busy books themselves.

I actually spoke to one office manager of a clinic in Melbourne and she said, in her view, basically since the lockdown, it's just exploded. They can't keep up with demand, she said. I don't have her name, the name of the practice or anything like that. I'm sure if I went back through my phone history for two years ago I'd find it, but basically - one of the reasons that was given was they don't have the working partnerships with Tasmania, with the various providers. They don't have the relationships which - look, I can appreciate that you've got colleagues who you work with, who you're happy to present referrals for because you've got confidence in their practice. This is not something that I sort of was upset about.

I guess with the Royal Flying Doctor Service, we got fortunate that they were happy to take Lysithea because they are a nationwide service and they happen to have a paediatrician who, although she was pretty much working most of the time at a hospital in Melbourne, she did have one day a fortnight that she did work in paediatrics for the Royal Flying Doctor Service and we managed to fluke it.

CHAIR - That does feel kind of like all the stars aligned.

Mrs ALLEN- Yes. I couldn't actually believe it.

Mr ALLEN - That was quite an aggressive conversation to get that -

CHAIR - That appointment?

Mrs ALLEN- Back and forth with the GP. Big toll.

Ms JOHNSTON - Can I ask about that GP interaction? Obviously, you had to have a lot of it to try to get that. How have you found that process and experience and interact? Have you had a good GP that has been in your camp or is that an issue you've found as well?

Mrs ALLEN- Our GP, noting that GPs have a very broad job description - can't expect them to be subject matter experts on everything. I think she was actually genuinely surprised at how many turn-backs she was getting. I do think she went from working full-time at the practice we were at to sometime there and sometime at another practice. That, obviously, affected her ability to look at correspondence being sent from me and answer phone calls and stuff from me. I think we did have to put a little bit of extra pressure on to get her to just keep sending out the referrals, keep trying. She was the one who basically said, 'Look, I will try the Royal Flying Doctor Service'. I would never have thought they had offered a paediatrician.

CHAIR - No, I didn't know that either until I read your submission.

Mrs ALLEN- The paediatrician through the Royal Flying Doctor Service; she's since become a mother. I'm assuming she's back on board now because it would have happened late last year, but we don't have consults with them anymore. We're more through the Royal now. I am waiting for another consult with the paediatrician at the Royal. But, to me, basically until the TADS assessment is done - and we're pending some results too from some urine and blood samples which have been taken. The bloods have been turned up, nothing. The urine was still waiting results for because it's more genetic testing. It's sort of like - well, it's nothing new to report.

CHAIR - Right. That's frustrating.

Mrs ALLEN- Even something as simple as a urine sample are to give four different samples because the pathologists at the Tasmanian pathology attached to the Royal kept rejecting them. Both paediatricians said it would have been fine, and I'm sorry if this is too much information to just supply, some samples like in cotton wool; that got declined. I then had to - because Lysithea's not toilet trained -

CHAIR - It's not easy to get a urine sample from a child.

Mrs ALLEN- Yes. We're working on it, but this is a huge battle with an occupational therapist. In itself - like she's four and she's not toilet trained. That's old and it's physically demanding now, more so for probably me than Shannon, although at the end of the day when your knees are sore it's a bit of an issue. Just to get a urine sample off her I had to provide four different samples and then there was mixed messages given about how the sample was to be collected. So it ended up being I had to squeeze out cotton wool into a little jar twice. They tried to reject the fourth sample and I was extremely disgruntled with them and I said, 'We've provided the required amount. Why isn't that sufficient?'. And they weren't able to give me a good answer. And I said, 'Well, I'm going to be talking to the parliamentary Committee about this'. So then they accepted it and I had a text message saying it had been sent off to genetics.

CHAIR - That shouldn't be how the system works.

Mrs ALLEN- It's not and that's the thing, it's like the frustration and it has an effect.

Mr ALLEN - I suppose I kick started the initial process. As a normal bloke, I guess, you come to this stuff and you know nothing, like you just go to the childhood nurse and you're like, 'There's something wrong, what do I do?'.

CHAIR - And then you're on a big learning.

Mr ALLEN - You have all these abbreviated departments, but the childhood nurses also don't really know the process, but you're splintered off into multiple different departments and ultimately it all goes through TADS, but as a parent you're very lost. If the childhood nurse is lost, you're lost. So if they should be, probably dealing with it quite often and I'm coming into it from work dragging my kid into a childhood nurse -

CHAIR - To a new system.

Mr ALLEN - to a new system that have no clue about. There's no hope. And it's fortunate that I have Ange to dedicate a significant amount of time because I don't have the time. I wouldn't have the time to do both. There's no way I could do work and then that as well and to learn it, you almost have to learn a new role just to push this through.

CHAIR - It should be much more accessible -

Mr ALLEN – steamlined.

CHAIR - especially because you wouldn't be on your own in suddenly learning a new system when you find out that you need that system and it sounds like there's a lot of systemic roadblocks and barriers to actually learning and accessing that.

Mrs ALLEN- That's the thing, I think. There's no point pointing fingers and trying to say, 'Oh, just bring in more paediatricians', or anything like that because I'm not sure what the rates of people going through university becoming a qualified paediatrician is. I'm not privy to that information. But it's a tough job. It would have a lot of sadness attached with it.

Instead of being like the only gateway to this service is a paediatrician, why not broaden it out a bit, upskill various people in the health industry to be able to identify, certainly have the checks and balances [regarding] over diagnosing and giving out services that might not be required. That's not what you want, but it's also paediatricians, like they deal with such a broad range of childhood ailments. It's like cancers, heart defects, all these things. Do they have the capacity to deal with autism on top of that, or can we make it a separate way that it gets treated? I don't know.

Ms JOHNSTON - Through all this process, you've really driven it. Has anyone actually ever offered you any assistance yourselves as parents and your mental health and wellbeing caring for your daughter? It seems to me that you've done an incredible amount of work. I was wondering if there's anyone, whether it be allied health service providers or paediatrician or GP, ever said, 'How are you both going with this process and what can we do to support you in supporting your child?'.

Mrs ALLEN- Look, the schools have been great. In terms of anyone saying these are workshops and things for parents, occasionally you'll receive an e-mail just from some group - I'm not even sure how my name would have gotten onto the list - about various workshops that are available. I think there's one next week at Sorell for children with autism. I forgot who's running that, whether it's state or federal. I would attend that if I wasn't already pre-booked out with things.

But in terms of a care provider saying to you, 'Hey look, this is actually quite rough. It's hard on parents. Can we do something to help?'. No, I haven't actually received that. In fact, sometimes the vibe you get - and I certainly feel this a bit when interacting with TADS is, 'Okay, we have our process, that's it. You get in line, don't want to deal with you until your time's up'. This is where it's, if people are dealing in a job that's difficult, because they would be dealing with people who are desperate.

Lysithea's autism is not a severe, severe, severe case where she's completely non-verbal, hurting herself, attacking other children, all the stuff. Through interventions, and I'm not sure what else because we're still waiting to be assessed, overall, she's a great - we adore her and we love her and she's able to show us affection, which I'm very grateful for. But parents of children with autism who are unable to express that emotion, and their parents are just feeling like they're giving and giving and giving over and over again to a child who is essentially unable to communicate back to them, I don't know what services are available for them or whether they get offered. I wouldn't know, but I think they would be needed.

Mr ALLEN - For me, the lack of a diagnosis is probably the biggest thing.

Mrs ALLEN- It's very hard on Shannon, yes.

Mr ALLEN - You could get one if you could get seen to, but you're not going to get one until you get seen to. The lack of a diagnosis, that does have a flow-on effect. You don't -

CHAIR - To your own wellbeing?

Mr ALLEN - Well, I'm a planner, I guess. I'd like to think that my daughter's going to be able to get a job one day. I'd like to think that. If that's not the case, that changes my life for the next 30, 40 years. That is a full-time role. I have to factor all that in.

So, that not knowing, and if we're still going to wait another 20 to 30 months for that and to know the severity of it - and there is a little bit of unknown with children. As she gets older it's more apparent and everyone is hinting at the same thing. That is an implication for us. That also takes a toll, the unknown, I guess. For me, that's the biggest thing.

CHAIR - That's understandable.

Mrs ALLEN- Even simple things, like our eldest daughter, who is actually probably borderline [progressing normally]. I'm not sure whether she would be, but she's extremely proficient in her speech, she was talking at 18 months, very eloquent. That's affected her ability to have interactions with her sibling in a normal way. It's affected our ability, well, it's made us rethink how we live life, where we locate ourselves, if we choose to extend our family.

Obviously you have these thoughts, that when you're not here, and it's your children left behind, and you've got one who may need intensive support throughout their adult life, do you have more children so that there's a tribe around them? Or do you just throw your hat in the ring and say, 'Okay, we're going to just give everything we've got to our autistic child to see whether she can progress'. Then you're still growing older, you're still getting the ailments of age. What do you do? This is where the lack of someone actually being able to commit and say, 'This is where she is on a scale, this is the trajectory we expect, this is what you can do to really help' –

CHAIR - Have some certainty in your planning, like you said.

Mrs ALLEN- Yes, exactly. That's just so missing because, until that TADS occurs, pretty much everyone we've interacted with, in fact, every single health provider we've interacted with, whether public, private, we've paid for, we've gotten through the public system - no one has committed to saying, 'This is what we think Lysithea will be like in 10 years, 20 years'.

People get those projections for things like cancer or for a range of diseases. To not have it for autism - I get the brain is a complex organ, and it's very individual and specific to each person, whereas something like a pancreas or whatever has a function, it's pretty much the same in most people. But when you have people who are specialised in this field who are inaccessible, who are preventing you from getting certainty in your life, that means that you have to modify your life on a day-to-day basis, winging it, it's very hard.

Mr ALLEN - We've even - I've altered the way that I parent based off what I've seen the occupational therapist, how they interact with my child. I've taken that home, and it's a constant battle, but that is what helps. So, without those sort of consultations, I do think you'd be flying blind. You do need a little bit of training in that regard to alter how you parent one child to another.

CHAIR - There would be lots of others who are doing that.

Mrs ALLEN- Or parents who've got multiple kids and working. What do they do?

CHAIR - Or multiple kids with additional needs.

Mrs ALLEN- Oh, yes, for sure.

CHAIR - Our time is rapidly ending. I feel like we could speak to you guys all morning. It's been valuable hearing from you. Was there anything that didn't come up that you wanted us to hear in particular?

Mrs ALLEN- That's pretty much the crux of it. I didn't want to be someone complaining and pointing their finger because, like I said, I think most people when a child is put in front of them - in fact, I would say nearly all people - want what's best for it. I just think the system needs to be - I wouldn't even say overhauled, I just think redirected.

CHAIR - Yes. Simplified.

Mrs ALLEN- Simplified a bit, yes. I'm positive that until people actually come forward and tell our elected representatives, who aren't deeply involved in the system, what's actually happening, then -

CHAIR - That's right, and that's why hearing evidence like yours is so valuable to a Committee like this one, because unless we have personal experience, we don't have the deep understanding of the challenges that you face. Hearing it directly from you is really meaningful and will lead to a better report that we ultimately deliver.

Mrs ALLEN- That's it. It's just information-gathering and then, hopefully, something good happens from that.

Mr STREET - I don't want to take this overtime, but I have one more quick question.

Mrs ALLEN - Go for it.

Mr STREET - Are there people outside of the TADS system who can make a definitive assessment who currently aren't because they are restricted by the system and by the protocols that sit within the system?

Mrs ALLEN- That is a very good question.

Mr STREET - Do you feel like you've met -

Mrs ALLEN- Everyone we can?

Mr STREET - with medical professionals with Lysithea who could have made a definitive assessment but chose not to because of risk or because it's not actually part of their formal role?

Mr ALLEN - Yes, I do think so.

Mrs ALLEN- I think so.

Mr ALLEN - What's the psychologist called, what's their name?

Mrs ALLEN- Chrysalis Psychology. I'm not sure whether we can name -

Mr ALLEN - Yes, sorry. Yes, I do feel that, very much so.

Mrs ALLEN- This person is a subject matter expert. I spend time with her interacting with our daughter and what she comes out with and what she picks up on is stuff that is just brilliant, basically. She's extremely proficient at what she does.

Mr ALLEN - But inaccessible. Booked out all the time. She is rare.

Mrs ALLEN- Yes, she is rare, she's great.

Mr ALLEN - But we actually get access to her, unlike TADS.

Mrs ALLEN - Thank you very much. We do appreciate it.

THE WITNESSES WITHDREW.

The Committee suspended from 10.28 a.m.

The Committee resumed at 10.34 a.m.

CHAIR - Hello and 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 making a written submission to the Inquiry and for agreeing to present to us in person today. Could I ask you to state your name, please, into the record? It's not that big, just your name.

Ms COWEN - Brigid Cowen.

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

Ms COWEN - Yes.

CHAIR - I'll remind you, you would have seen in the guide that the hearing is covered by parliamentary privilege, which means that you can speak freely and say whatever you want to say to us in any way that you want to without fear of being sued or questioned in any place outside of Parliament or in any court. The only exception to that is it's not accorded to statements that you make that could be considered defamatory if you then repeat them outside of these parliamentary proceedings but you can speak with immunity inside these hearings. It's a public hearing, which means there might be members of the public or media attending in person. We have had some, not a lot, over the course of our hearings and of course there might be people watching online as well.

Now is the time for the statutory declaration. Can I just ask you to make that statement on the card?

Ms BRIGID MARY ROSE COWEN, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Thank you. We've also agreed for the Committee to make a short, sensitive, content statement at the beginning of each hearing. We're doing that with each individual person who is appearing. And I'll just do that quickly now.

The Committee recognises 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 in these proceedings. The Committee encourages anybody impacted in that way to contact services and supports, including Lifeline on 13 11 14, Tresillian on 1300 827 282 and PANDA's National Helpline on 1300 726 306.

Additionally, for today's hearings, we have clinical support available on site in our breakout room, our colleagues from Gidget Foundation Australia who we're very grateful to have supporting the work of this Committee and that's Dr Erin Seeto and Ms Amelia Walker who are available here on site in the building; and you don't need to feel the need to rush off after today's session, you can stay as long as you need. They are all the formal parts done.

We'd really like to hand to you if you want to make an opening statement to the Committee, if there's anything particularly you wanted to start with or highlight for us for our knowledge.

Ms COWEN - There are a few things since I did the submission, one in particular, that is really highlighted for me and my twins is the lack of paediatricians. They have just started kindergarten and they probably both have ADHD [attention-deficit/ hyperactivity disorder], but I can't get into a paediatrician. Accessing other help is also very, very hard, like an occupational therapist, the practical support. Right now it feels like I'm never going to get in to see a paediatrician. Everyone's books are closed. Am I going to have to go to Melbourne? I don't understand. There has to be something to get more paediatricians here, and I know so many other parents in the same boat.

CHAIR - The Committee has heard that there is a lack of access in both the public and the private system. There's another committee going on into ADHD, and that committee has heard some really rich evidence around the lack of access to diagnosis and support for ADHD, so it's really important that you raise it here as well for us to hear that.

Ms COWEN - I just want them to have the best journey through school and I know that means getting help as early as I can.

CHAIR - Have you tried to access paediatric services through the public system?

Ms COWEN - I haven't been back to my GP. I have a friend who's a GP who said they won't see behavioural issues through the public system. I could get on the wait list and I may just never, ever, ever be seen.

CHAIR - So, you're waiting in the private system at this stage?

Ms COWEN - Well, I was, and then in December I got a letter from Hobart Paediatric Group - which is now -, I believe – I think there is only two paediatric centres in Hobart now-, the biggest of only two paediatric clinics in Hobart now, and Hobart Paediatric Group is the biggest – I got a letter in December to say they wouldn't be seeing any of their new referrals that they were sent last year, which were over 500.

CHAIR - Because there's just no capacity?

Ms COWEN - And their paediatricians are retiring.

CHAIR - It's scary.

Ms COWEN - Yes. My kids were born at the Royal [Hobart Hospital] so we didn't have a private paediatrician from the start, whereas if you give birth at the private hospitals, you do see a paediatrician.

CHAIR - Of course - you're referred to see someone. That's really frustrating, but it's important for the Committee to hear and add that to the work we're doing.

Mr STREET - Can I ask, in terms of the ADHD that you suspect, is that just your personal suspicion?

Ms COWEN - No.

Mr STREET - You've seen somebody who -

Ms COWEN - I have seen a psychologist at our Child and Family Learning Centre in Sorell. I'm in Sorell. It's called The Nest and it's amazing. They're providing the most amazing services. I got to see a psychologist through them and with my GP as well. Now, we're trying to get OT [occupational therapist] support.

CHAIR - But that's the next step and, not to stray into the other committees' work, but that's something that they've been hearing too, around that psychologist's initial diagnosis needing to be backed by either a psychiatrist or a paediatrician. That's the access block.

Ms COWEN - Yes, because there's another clinic in Hobart called the ADHD Clinic - I've looked it up - but they don't have a paediatrician, and a paediatrician is the only one who could prescribe medication for a child.

CHAIR - And confirm the diagnosis. They're amazing, but their waitlist's really long. We were on it for a long time.

Can I come to your written submission and just ask a little bit - it might just be a bit of a kind of practical question, but what you've described around the NICU [Neonatal Intensive Care Units] and the difficulty for twin parents. If there's some kind of practical, structural suggestions that you could make to us around the challenges you faced when they were in that unit?

Ms COWEN - I've seen the old NICU and special care unit because my sister had a prem[ature] baby. The boys were born at a time where they actually went to the old NICU unit for NICU, and that was the same week that they were then opening the new NICU and special care unit. The boys were then transferred up to the new special care unit.

CHAIR - Oh right, while they were there?

Ms COWEN - Yes. Say they'd been born three days later, they would have been taken straight to the new NICU unit. Anyway, we went in the old NICU unit, which was dated. It was fine. We went up to the new special care and each kid is in their own little cubicle, which, I mean, is great for privacy, but when you have two kids in separate rooms separated by a hard wall with a window and a blind, it made it really difficult.

Mr STREET - So there were no double rooms?

Ms COWEN - No, not in special care. I was told in the NICU there was. If we'd gone into the new NICU unit, we would have had a twin room, but in special care there wasn't. It just seemed crazy that this brand new ward isn't fit for purpose for twin parents who - so many of us have prem[ature] babies. It was difficult, very difficult.

CHAIR - How long were they in there?

Ms COWEN - Five weeks.

CHAIR - Five weeks? Holy moly.

Ms COWEN - I had a scenario one day where I was having skin-to-skin with one, and then the doctors and nurses were doing their rounds and they went and saw the other twin and they're talking about him. I'm the type of mum - I was there like all the time and I would be there for all the doctors rounds and taking in what they said. But, I was just in this other room and they were just talking about my kid and -

CHAIR - That's not good. Anyone else?

Ms JOHNSTON - Thank you for your written submission. I really appreciate it. You touched on a number of key points in time that we've heard from the Committee where there have been some problems with processes and things like that. You touched on trying to get into the Mother Baby Unit at the St Helen's Hospital when it was open there and you were unable to get it in. The feedback, I think you said, from the psychiatry registrar at the time was just to stop breastfeeding. I really get from your submission the importance of breastfeeding for yourself and your babies. Can you talk me through - did you get offered any other kind of support during that time with sleep deprivation, with your mental health and wellbeing, with sleeping for your babies? Or was it just, 'There's no other service available for you?' What was offered instead of the Mother Baby Unit?

Ms COWEN - My GP did the referral to the Mother Baby Unit stating maternal exhaustion, which I think is a very valid reason. She also gave me the number for a sleep consultant. I knew that I couldn't listen to my babies cry, so it wasn't really practical help. I've known other people who've had sleep consultants and I knew that wasn't for me. I just needed some really hands-on practical help. I knew, because I've known a lot of other mums who have gone to St Helen's. I knew that was what I needed and I couldn't get in.

Ms JOHNSTON - So, you were given a number for a sleep consultant and no other alternatives?

Ms COWEN - Yes. I called her and she said, 'You know, you'll have to make changes,' implying I would have to let them cry, and I was like, 'Okay, I'm not calling you back to book in.' I can't do it. I very much always responded to my kids when they cried.

CHAIR - It wasn't focused on you or your needs.

Ms COWEN - No.

CHAIR - It was more of a systemic kind of response.

Ms COWEN - Then the psychiatry registrar called me because I was trying to get in as a public patient. That's why - I think if you're a private patient, I wouldn't have had a phone call from this psychiatry registrar from the Royal. He was very unhelpful, but that's okay. I think he - you don't know if he was childless - I think he just wouldn't have had much idea. But that's okay.

Ms ROSOL - Can I check there, if that psychiatrist had supported your need to be in there, would you have then been able to access it?

Ms COWEN - Yes. He was deeming whether - what I got from the phone call was he was seeing whether I was very acutely mentally unwell. Obviously, it was a very busy time, in that COVID era, lots and lots of mums were accessing help. I think it was just full at the time. I think if - yes.

Ms ROSOL - It was like he was kind of the gatekeeper for your referral through to them.

Ms COWEN - Yes, I guess he was triaging us public patients.

Mr STREET - That was via phone call?

Ms COWEN - Yes it was.

Mr STREET - Not the greatest way to make an assessment either.

Ms COWEN - No. I didn't get seen face to face at all.

Ms ROSOL - You've mentioned that you had many visits with CHaPS [Child Health and Parenting Service] through that period. What support were you receiving from CHaPS?

Ms COWEN - This is bad, but - they ask - so, I've co-slept with my kids since they were young because I breastfed them. And, CHaPS would ask you, 'How do the kids sleep, or where do they sleep?' and I always just said, 'They sleep in their own cots in their own room.' It wasn't true at all. I had them with me because that's how I tried to get any sleep. So I guess they didn't really offer support because I didn't tell them the full truth.

CHAIR - That's fair enough.

Mr STREET - Are the twins your first children?

Ms COWEN - Yes.

CHAIR - You talked about going through the Midwifery Group Practice (MGP), can you talk us a bit through that process? What your experience of that was and also what kind of postpartum care was provided in those weeks after the boys were born?

Ms COWEN - Yes. I loved the MGP. I thought it would be amazing if more mums could access it. It was amazing, amazing. Loved it. My midwives were just beautiful. I had two midwives who job-shared. Because I had the boys in prem[ature], they came to visit me in special care. So, when I got home, even though the boys were still pre-term, when we went home I didn't get any home visits.

CHAIR - Those home visits had kind of been used up, for want of a better term.

Ms COWEN - Used up, because they'd come to me in the special care. Yes.

CHAIR - Okay, that's problematic.

Ms COWEN - Yes. That would have been amazing if they had been able to continue that when I actually got home, when you need that practical help. When they're in special care, they're being looked after by amazing nurses.

CHAIR - That's right; there are lots of people around. It's more about having that at-home assistance rather than just the time period after birth.

Ms COWEN - Yes.

CHAIR - Okay. That's really pertinent. Thank you.

Ms DOW - I have one question, in relation to the remarks that you make in your submission around not having access to a social worker before or during your time at NICU and the special care nursery. Could you talk to the Committee about what difference you think that might have made to your mental health and wellbeing at the time or to going home with your twins, whether that would have made a difference for you or whether you understand why that wasn't offered?

Ms COWEN - Yes. I think I wasn't offered it because I seemed very strong, you know, like mentally well. I wasn't breaking down all the time in front of the nurses or anything, and I wasn't even doing that at home. I think you just do what you do to get through and you put a really brave face on. I think maybe that's why I wasn't offered any help. It would have been lovely to have someone come and offer any help, because my husband continued working so he could have some leave when the boys came home.

I saw other mums in there being given meals, like the normal meal rounds, and they would bring a meal up for some mums, but not all mums. I was never offered them. It all adds up - the driving in, the parking - so I would have liked any help they offered, but I just saw the nurses and the doctors and that was it. There was no kind of support for my mental wellbeing.

I understand it's so circumstantial being during COVID, but I wasn't allowed any visitors, so my husband would work all day and then he'd come in in the evening and we'd both cuddle a boy. I had massive mum guilt because sometimes I would realise I was cuddling one boy and I couldn't cuddle the other at the same time. Obviously, it was a funny time. A little bit more flexibility would have been very nice. I could have had my sister come in her lunch breaks to hold a boy for me, or my mother-in-law, my mum, anyone could have come in and offered a bit of support.

Then post-discharge, again there was no offer of help or support. It was quite upsetting for a number of years afterwards. Now I don't get so upset about it, but in the probably two years post-birth it was tricky.

Mr STREET - I know it's not an easy conversation to have, but you didn't ever question why some mums seemed to be getting a different level of service within the unit?

Ms COWEN - I didn't ask, but she was like 18 so I think she was offered help because she was a young mum, but I didn't ask at the time.

Mr STREET - No, I completely understand why.

Ms JOHNSTON - You talked about the fact that it was during COVID and there were restrictions on and that kind of thing. Do you feel, though, that because of those restrictions, they should have been perhaps more acutely aware of the impact it would have on you? You talk about that mother's guilt in terms of only being able to hold boy at a time and not having someone else there to hold the other one. Do you feel that perhaps they should have been more aware of the impact on you and maybe heightened the reason why they should be offering you more support during that time, not just business as usual?

Ms COWEN - Absolutely. Hopefully in hindsight, they'll look back and think that they should have done that, but yes.

CHAIR - I haven't asked this at every hearing, but looking back on the experience that you had, either at the time that the boys were born or since, you talked about the challenges accessing paediatric support – and their four now right? If there was one wish list, magic wand kind of change you would want to see made to the system that you want us to hear about, what would that maybe look like for you?

Ms COWEN - I think it would be the support for mums in the NICU and special care and that would encompass being flexible with the visitor rules and offering any help -

Ms ROSOL - Like a wraparound support. They were so focused on meeting the medical needs of your boys, the other needs were missed.

Ms COWEN – Yes, absolutely.

CHAIR - Is there anything that hasn't come up in our conversation that you would like us to hear or think about?

Ms COWEN - There was a systematic issue that I had post-birth. We were discharged when the boys were around six weeks old. When the boys were six weeks and three days old, I got mastitis and I was shaking and vomiting. I was breastfeeding them and had my husband get me a bucket and I was vomiting over them while breastfeeding. He called the Pregnancy Assessment Unit, because you can go back in there until your babies are six weeks old, and they asked how old the boys were and he said, 'They're six weeks and three days old'. They said, 'Well, she can't be seen here' - and they were still not to their due date yet; these were still pre-term babies but they just had this six-week rule, you know, a mother can come back in for six weeks. Anyway, they also said, 'Oh, that doesn't sound like mastitis', like full body shakes.

Anyway, we have a friend who's a midwife, so in the morning, because this was overnight, my husband called her and she was like, 'That's just crazy. I'm calling the unit.' So she called them and said, 'That's absolutely crazy. These babies aren't full term yet. It's three days since the six-week mark.' It was absolutely ridiculous. And she said of course this is mastitis, so I went in and I got seen. They were amazing when I was in there.

CHAIR - But you shouldn't have to push like that.

Ms COWEN - Yes. It's just ridiculous. I know every hospital and every ward has their rules and systems, but this just seemed crazy.

CHAIR - It does seem very bureaucratic. I'm glad that you got seen, but you shouldn't have had to go through that.

Thank you very much for everything you've shared with us today. We're really grateful to hear stories like yours. As challenging as it is to share such deeply personal information, it will mean that our report is more meaningful and more informed by the experiences of families like yours.

If when you leave, and this always happens to me, you suddenly think I wish I'd said that thing or there's something else that comes up, it's not too late. Please get back in touch, either with Mary, our secretary, or any of us individually. We're easy to find and we'll be more than happy to hear from you again as we continue our work. Did you have any other final statements you wanted to make?

Ms COWEN - No. Obviously getting out of the house with little twins was very hard. CHaPS come to your house for the visit, but I just think that needs to be extended to a couple of visits. It's very daunting getting out, it's even nerve-wracking thinking what if they need a feed? You're just very new to it all, so I think a few more home visits would be amazing and I guess that extends to the MGP program. If your baby's born pre-term, they should maybe come and visit you at home when you're discharged.

CHAIR - Yes, it would be such a practical thing to do.

Ms COWEN - Yes. I'm not sure; they may not have that many babies born through MGP pre-term. There would be some but it's generally for the low-risk mothers. I was so fortunate to get to go through them because early on they realised the twins had their own placentas, so it was very low risk. I was very fortunate to be able to go through MGP. I think I'm the only twin mum I know who's done it.

CHAIR - We've heard from other twin mums who were automatically excluded from MGP, who were relatively low risks, so it's great that you had that experience.

Ms COWEN - Yes. Normally it's something you have to get in to very early on in your pregnancy. I think I was 14 to 15 weeks and mentioned it on the phone to someone and said ‘I'd love to go through MGP’, and then I got in. These days, I think, it's booked out from very early on.

CHAIR - All right. Great to meet you and thank you very much for appearing.

Ms COWEN - Thank you.

THE WITNESS WITHDREW.

The Committee suspended from 11.00 a.m.

The Committee resumed at 11.23 a.m.

CHAIR - Good morning and welcome. Thank you very much for attending the House of Assembly Select Committee on Reproductive, Maternal and Paediatric Health Services. Thank you for providing the written submission, which we've all received and read. Thank you for bringing the cutest babies to the table of the Ptriarliament. Parliament doesn't get to see enough babies, so it's great to have some little people in attendance today.

Could I ask each of you, one by one, to state your names into the record?

Ms WINGROVE - Chelsea Wingrove.

Mr STREEFLAND - Tristan Streefland.

Mr HALLIDAY - Corbin Halliday.

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

WITNESSES - Yes.

CHAIR - Thank you. You would have read in the guide, but I'll remind you. The hearing is covered by parliamentary privilege, which means that you can speak freely, you can say whatever you want here to us without any fear of legal ramifications, without the fear of being sued or questioned in any court or place outside of Parliament. The only exception to that is the protection doesn't accord to statements that might be considered defamatory if you then repeat them outside of the parliamentary proceedings.

It's a public hearing, so there might be members of the public here; people watching online and the media might be present or watching online as well. If during the hearings you want to give any information in private, if you start to go down a pathway that you think you'd prefer that not to be on the public record, that's totally fine. Just make that request of us. We make a short deliberative decision to move into an in camera session and then we can hear anything in private, and the broadcast stops. That's an option available to you if you need it.

Ms CHELSEA WINGROVE, **Mr TRISTAN SHAY STREEFLAND** AND **Mr CORBIN WILLIAM HALLIDAY** WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - As a Committee, we've also agreed to read a sensitive content statement at the beginning of each session for yourselves, but also for anybody who might be watching online. I'll just do that quickly now. As a Committee, 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. The Committee encourages anyone impacted by the content matter during this hearing to contact services including Lifeline on 13 11 14, Tresillian on 1300 827 282, or PANDA on 1300 726 306.

Additionally for this day's hearings, we also have clinical support available on the site, Dr Erin Seeto and Ms Amelia Walker, who are here with the Gidget Foundation Australia and supporting the work of this Committee. They're available, if our discussions today mean that

that would be meaningful and useful to any or all of you. There's no rush to rush off after the hearing. You're more than welcome to use our breakout room and to chat with our lovely Gidget colleagues. That is, I think, all of the formal parts dealt with. We'd love to hand over to any or all of you to make any opening remarks or opening statement that you'd like to make, if you would.

Ms WINGROVE - Thank you very much. In June last year I gave birth to these beautiful two girls, Harper and Willow, as a surrogate for their dads, Tristan and Corbin. The majority of our birth experience was filled with nothing but love and teamwork and excellent care from the midwives and the obstetricians at the Launceston General Hospital.

Today we would like to touch on two separate aspects of feedback: the first being a traumatic experience that occurred at the end of the birth of the second twin where I was placed under general anaesthetic by mistake, therefore causing an emergency caesarean for little Willow, and putting her under significant risk at the time as well. The other pieces of feedback we'd like to provide, if possible, are some improvements that are well-needed around the legislation to support surrogacy in Tasmania.

CHAIR - Sure, we'd love to hear about that, thank you.

Ms WINGROVE - And birth planning statewide, so that everyone can have a wonderful family.

CHAIR - Excellent. It's a beautiful thing that you've done.

Ms WINGROVE - Back to the birth story. The first twin, Harper here, was born vaginally with no complications. When it was time for Willow to come, she had a lot of space to start doing some backflips. The team did a wonderful job in repositioning her both internally and externally with some manoeuvres so that she ended up in a head-down position, but she still had her arm above her head. We were advised to move up to theatre just in case a caesarean was ultimately needed, but with the intention of still continuing to deliver her naturally if possible. We agreed that that was the best course of action as we didn't want anyone to be put at risk. Unfortunately, when we got up to the theatre room, the obstetric registrar was preparing to do the internal examination to check that Willow was in a favourable position to then be delivered naturally. At the same time, the leading anaesthetist, Dr Janine Stevens, started putting a mask on me for the general anaesthetic, which I tried to push away and kept saying, 'No', repeatedly.

The next thing I remember after that was waking up and shaking in the recovery room, not knowing whether myself or Willow were okay, with multiple nurses and obstetricians speaking to me about how disappointed they were that this had happened. The obstetrician confirmed that her hand was out of the way and she could have been delivered naturally with no problems.

Did you want to take over Tristan and talk a bit more? Obviously under a general anaesthetic and Tristan can probably fill in some gaps.

CHAIR - Take all the time you need, Tristan. Don't feel at all rushed or pressured in any way.

Mr STREEFLAND - I'm a medical professional; I work in the industry. I've got lots of context and it's not nice being on the other side of this, when generally I'm the one providing care and receiving care was a very different experience.

As Chelsea's explained, we were moved up to the theatre, which from my understanding, it wasn't an emergency, it was just we needed to get there as a precautionary measure for the safety of Chelsea and also the safety of Willow. And at that point in time, Chelsea was safe, Willow was safe, there was continual monitoring.

We moved into the theatre and it just felt chaotic. I think it was 2.30 in the morning, and it felt like there just seemed to be a disjointedness amongst the team as to what was going on. We had two people approach us. One was an anaesthetic nurse saying, 'So you're here for a caesarean', and Chelsea and I both said, 'No, we're not'.

And then the consultant anaesthetist came up again later and said, 'So you're here for your caesarean', and we said 'No, we're not'. She proceeded to give Chelsea some medication to calm her down without explaining what the medication was. We found out later that it was actually Midazolam, which is a sedative and can alter someone's recollection of events, and it can also alter their ability to actually give consent.

CHAIR - Was that intravenous or tablets?

Mr STREEFLAND - Yes, intravenous. And again, not explained to Chelsea what she was given, just it was something to calm her down.

We then moved into the theatre again, as Chelsea explained, with the express purpose of the obstetric registrar, who had kept us informed the entire labour of what was going on and the plan, and the plan was to do an internal assessment. And again, they've done heart rate monitoring for Willow. She was completely fine, not in distress, and Chelsea, we were anxious, but that's to be expected.

CHAIR - It's pretty normal during labour.

Mr STREEFLAND - Yes, exactly. And she had just delivered Harper and we're still having -

Ms WINGROVE - full contractions - ready to go.

Mr STREEFLAND - So we've moved into the theatre. At first they weren't going to let me go in and I said, 'Well, I would like to be in there for as long as possible. I know what a theatre is like. As soon as she's anaesthetised, I understand that I need to leave'. But the idea is, potentially, we can deliver naturally still.

CHAIR - Anaesthetic was not in the plan.

Mr STREEFLAND - It was not in the plan. And so, the next minute I look over, while standing at the head of the bed, the obstetric registrar is doing the internal and the anaesthetist is all ready, and someone's placing the gas mask on Chelsea. And the obstetric registrar looks up and says, 'What the f are you doing?'. I look down and go, 'Stop. This wasn't supposed to happen.’ But, looking at Chelsea, also in distress, going 'No, no, no', trying to move the mask away from her face is something that I will never forget.

CHAIR - I'm so sorry.

Mr STREEFLAND - But it's too late. Once the general anaesthetic medications have been administered, one of them is a paralytic agent. It stops the uterus from contracting, so, that's it, you can't reverse an anaesthetic.

So then Chelsea had to undergo major abdominal surgery for a caesarean that could have been avoided, which we found out later. Willow's arm was out of the way. She was in a favourable position. She was down the canal and it was an intervention that could have been completely and utterly avoided.

Chelsea can probably speak to this more as well, but we've gone through the process with the THS [Tasmanian Health Service], an incident report was raised, we've put in a complaint. I don't know if you want to keep talking about that, Chelsea.

Ms WINGROVE - Yes, we were brought in a few months later following the internal safety investigation, which was done extremely thoroughly and led by Kim Goss, who was absolutely fantastic. It concluded that nowhere in the process could what have happened had been avoided by the process itself, in that the individual acted outside of the scope of any teamwork, any like - they basically didn't even have a chance to do a stop and gather to say, 'Yes, we're going ahead and doing this surgery' because she went so far in advance of all of that, the option was just taken away. She's actually caused the emergency caesarean. I was down the end of the bed, wasn't prepped for surgery at all, my airway wasn't prepped, none of it.

CHAIR - That complaint process - going through that after the birth of the girls, has there been a conclusion to that? Is it still on foot? Was there any kind of formal apology made or any recognition of any kind of wrongdoing?

Mr STREEFLAND - As Chelsea mentioned, the THS has been great with their open disclosure in this process, but they've said there's no system or process because that's what - I've conducted some of these investigations and been a part of them. Usually, there's a system or process error that has led to this. They concluded, and I'm fairly sure it went to the level of the Secretary of [the department of] health, that there was no system or process that would have stopped this. It was an individual that’s made this.

Ms WINGROVE - Now it's been referred to AHPRA [Australian Health Practitioner Regulation Agency] and there's an investigation under the individual that's going on. That's still going on eight months later. They've been placed under a requirement to be supervised, which at least gives us a little bit of peace of mind, but, I mean, that is eight months later and they've been practising.

Mr HALLIDAY - The meeting was held in Hobart, at the Royal [Hobart Hospital] here, with the team. What was her name? It was Kim, wasn't it?

Ms WINGROVE - She was up in Launceston with me.

Mr HALLIDAY - When we had the meeting Joey, they were disgusted in what they heard. We didn't know, but there was actually a certain time period that you're supposed to be - Tristan knows this, I didn't know this - masked and, obviously tubed, and Chelsea and Willow both could have passed away in the period of time. That's been the hardest thing for us to ongoing -

Ms WINGROVE - Willow had to be resuscitated because of -

Mr HALLIDAY - Once Harper was born, I've had the first skin-on-skin contact. Chelsea did an incredible job, by the way, amazing. Up to that part, it was a beautiful experience.

Ms WINGROVE - It really was.

Mr HALLIDAY - Wasn't it, darling? Yes, you made an entrance and you still do. We know why.

I think, from there, it was horrible from that. It was something that we will never forget.

Ms WINGROVE - The whole teamwork and everything, it was so empowering. Then all of that was just taken away in the second of someone's wrong decision.

CHAIR - One of the things the Committee's heard a bit about is the issue of consent during labour: the difference between informed consent and validly provided consent. You've described that the medical effect of the sedative, Midazolam did you say it's called?

Mr STREEFLAND - Midazolam, yes.

CHAIR - But it sounds like even that part of what happened was done without informed consent. I wondered if you're willing to expand a little bit on your understanding of what consent could - or what wasn't sought properly from you throughout the whole experience including the caesarean.

Ms WINGROVE - Down in the birth suite, after Harper was delivered and we were starting to get to the point of needing to make a decision about whether to stay there and continue to try to reposition or wait for Willow to be alright to be delivered, the paperwork was shown to me and I signed it on the proviso that we were going up to theatre with the intention of it being a final safety measure. I was never someone who was like, 'No, I'm not having a caesarean no matter what.' Absolutely not. I was, of course, going to take advice from medical professionals and we do make decisions as a team, although I understand that it's my body at the time. I was never going to put my foot down and say, 'No, I'm staying here no matter what because I know it'll be fine.' In hindsight, I could have. However, I did sign the paperwork to go up to theatre, yes.

Mr HALLIDAY - I think also - sorry, just to butt in there as well. We were told there was a 5 per cent chance that she would have a caesar[ean] because they could manoeuvre her around. Also, there were five attempts for an epidural, which they missed each time because of Chelsea's back.

The other thing was, when I was sitting there with skin-on-skin with Harper and - I can't remember his name, sorry. I've kind of blocked out a lot of it -

Mr STREEFLAND - Ram?

Mr HALLIDAY - No, not Ram. The guy who came in and was really quite direct and rude and took you up to theatre.

Mr STREEFLAND - The consultant.

Mr HALLIDAY - The consultant.

Ms WINGROVE - The obstetrician from Melbourne who was flying in. The locum.

Mr HALLIDAY - That's when the room changed and then I was downstairs, obviously, in tears waiting and going, 'What's going on?' because Tristan and Chelsea went upstairs with Willow - to birth Willow - is what I thought was happening. And then I got a - the lady came - again, I forget her name, sorry, my mind.

Mr STREEFLAND - The anaesthetist.

Mr HALLIDAY - The anaesthetist. What is her name, Tristan?

Mr STREEFLAND - Janine.

Mr HALLIDAY - Janine came downstairs and showed me a photo on her phone, which I have in my phone still, of Willow being resuscitated with her mask on, saying that she was out - for how long was it, Tristan? How many minutes?

Mr STREEFLAND - She had six minutes of CPAP (continuous positive airway pressure) - six minutes of oxygen.

Mr HALLIDAY - Six minutes of CPAP. So, our main concern is to make sure that Willow has no intellectual problems.

Mr STREEFLAND - Ongoing.

Mr HALLIDAY - Hopefully, everything seems to be - she's meeting her milestones at the moment, but what happened is completely unacceptable. The fact that we could have lost Chelsea, who's been an incredible person to give birth to your children for you, and our daughter, is unacceptable.

CHAIR - Gosh, that's scary as well and quite insensitive to show a photo like that.

Mr STREEFLAND - Yes, and no consent was gained to take photos of our daughter. That's probably the birth section, but the rest of the surrogacy process as well -

CHAIR - We'd love to hear more about that.

Ms WINGROVE - In relation to the surrogacy process, we did receive incredible support from complex care midwives at the LGH [Launceston General Hospital], specifically Susan Gee and Kylie Burns.

CHAIR - I think we met Kylie yesterday actually. We had a tour of the LGH. She was great.

Ms WINGROVE - Yes, they really were able to develop a surrogacy birth plan in hand with us that really was patient centred. In speaking with Susan afterwards, she said, 'Surrogacy is the ultimate in patient-centred care and what we should be doing with everyone'. Because, obviously, every surrogate team is different. This isn't a standard practice, it's an ad hoc process that Susan and Kylie have developed because there are more cases like this coming through, and it would be amazing if something like that could be developed statewide and built in, particularly in terms of the resourcing. Even up until the day of the birth, we didn't know whether the boys would be able to stay in a room there with their girls.

CHAIR - Practical things that you need to have answers to.

Ms WINGROVE - We were very adamant that I'm being treated as the patient. These guys are the parents. I'm not a parent. I really appreciated the way that the whole time we were admitted, even during labour and thereafter, no one ever referred to me as the mum. I was so glad that they treated me as a patient, used my name and no one ever came into my room and said, 'How come you're in here by yourself, where's your baby?' or anything like that, which was wonderful because, as far as I was concerned, it was -

CHAIR - Creating a family.

Ms WINGROVE - a direct handover. We were there to support each other, but it was your time to be parents and that was fantastic.

Mr HALLIDAY - The level of care from the midwives in LGH was absolutely outstanding. In fact, after the incident happened, we had most of them in tears coming into the room saying they had never seen anything like it before.

CHAIR - Wow, okay.

Mr HALLIDAY - Some of them had left work, I think, over it. There was a particular - I don't know, the lady who was it, Frances? One of the ladies looking after us, who was amazing; and she was distraught. It has affected a lot of people.

Mr STREEFLAND - Obstetric registrar.

CHAIR - It obviously had a wider impact on their mental health as workers, on your mental health as parents. Not necessarily through the complaint process, but obviously you've quite correctly taken that pathway, but have you been offered or referred into supports for yourselves after going through something that traumatic through the system in any way?

Mr HALLIDAY - No, not really.

Ms WINGROVE - Not through the system.

CHAIR - But you have had to seek that privately yourselves?

Ms WINGROVE - Strangely enough, as part of our next point around the legislative process, in order to be eligible to apply for a parentage order for the girls to have the birth certificates changed over, for Tristan and Corbin to be named as the parents, we did have to do post-birth surrogacy counselling. Part of the surrogacy process - it's very long up until even the IVF [In Vitro Fertilisation] stage where you get to, and it involves, obviously, the legal agreements and a number of counselling sessions.

So, we were able to tap back into our psychologist as a team and individually as well to sort of debrief a little bit and unpack what had happened.

It's not something that I think about now every day, but it does make me nervous in terms of ever thinking about actually going and having surgery again. It's not something that I would ever be looking forward to, given this experience now. And, honestly, the recovery from the caesarean is the worst thing that I've ever had. It was just the most painful experience. My heart goes out to anyone who's had a caesarean because now I understand. Also because I was having full contractions right up until it was done, I think that probably made the recovery a little bit more painful.

To separate it and go back to the legislative process, in Tasmania it's very difficult to access surrogacy, even more than in other states. As you know, probably, the *Surrogacy Act* is 2012 and it states that if you require a surrogate, you have to utilise somebody who resides in Tasmania, so that's a very limiting barrier, particularly for same-sex couples who would like to start their family. Going overseas and spending hundreds of thousands of dollars is one thing, but not even being able to access a friend or family member on the mainland to help is completely different. Then, obviously, post-birth, there's a huge period of time, potentially, before the parentage order goes through. That makes it very difficult to access services like Medicare.

Mr HALLIDAY - Going to hospital.

Ms WINGROVE - It was a nightmare, to be honest, for these guys.

CHAIR - Especially with premmie babies, too, because you're more likely to need immediate medical services.

Mr HALLIDAY -We did end up in the queue as well.

Ms WINGROVE - They were not necessarily classed as premmie.

CHAIR - Oh, they weren't? Okay.

Mr HALLIDAY – 37 [weeks] and 3 [days], yes, they were.

CHAIR - Okay. Wow.

Mr HALLIDAY - Yes, we did well.

Ms WINGROVE - I would have gone to 40. I got induced.

CHAIR - Incredible. Can you describe that administrative process for us? We'd really like to hear about how that can be improved as well?

Mr STREEFLAND - It was not a very nice process at all from the beginning of actually lodging the paperwork. Obviously, we need to have the parentage order filled out, all the information that goes with it. We have to say that we've given it to Chelsea and she understands it will go to court. So, they didn't have any of the forms at the Magistrates Courts and we had to use white-out on a restraining order form to hand to Chelsea.

CHAIR - That would be awful for anyone at all, but imagine if you'd had a restraining order and then had to use that form. That would be a horrible experience.

Mr STREEFLAND - I literally took it home and had to white it out myself, and there was not a lot of information from the staff there about what actually needed to happen. So, we turned up on the day and presented to the magistrates and then, one, she asked, 'Where's your lawyer?’ I was like, 'We didn't know we needed a lawyer.’ It's also an added expense. We can present. Then there was a tick-box of things we needed to present, which we presented, and then she asked for additional information.

Mr HALLIDAY - We actually questioned her because Tris and I had viewed the paperwork, something we both do in our professions, a lot of paperwork. We questioned her with one of the questions - she asked us to have [another document] present, not on the checklist or any of the paperwork. So, she had to actually go back and say, 'Okay, actually, I'm sorry about that.'

Mr STREEFLAND - But she still required it.

Mr HALLIDAY - She nearly asked us to leave and come back another day, and we had babysitters. You know how hard it is to babysit twins, so someone to look after your twins. And they were, four months, five months?

Mr STREEFLAND - Yes.

CHAIR - So, four or five months until that process was complete?

Mr STREEFLAND - You can lodge after 30 days for the parentage order and it has to be before six months. However, getting a court date was difficult. And then you're looking after twins post-birth. It was a complex process to get all the paperwork together, to then lodge it and then we turned up on the day and then the Magistrate asked for additional information, which was about - we had to do the counselling and she wanted the report. It's a bit insulting to turn up for a Magistrate to read a report to see if you're fit parents when anyone can go and become a parent and how can we -

CHAIR - It's like an added layer that's unfair to put on same-sex couples. That's completely unacceptable.

Mr STREEFLAND - Correct. It felt a bit like discrimination. Why do we, as a same-sex couple, need to prove that we are in good mental stead to look after kids, and we've been looking after them for five months?

Mr HALLIDAY - The counselling process, through Tas IVF, the years of stuff we had to go through to actually even go for the first embryo transfer, which we were lucky enough it was the first transfer split for twins. We've still got seven left. Seven left, sitting there.

CHAIR - Your body was ready to do the whole thing, yes.

Mr HALLIDAY - It was crazy. They lost paperwork. There's so many different things that happened in the process.

[To baby] You're ready for some food. Sorry, just give me a second.

CHAIR - She's got rosy cheeks. Is she getting teeth?

Mr STREEFLAND - She's also teething.

CHAIR - Yes, she's got that teethy-cheeked look, plus chewing on her hand.

Mr STREEFLAND - And the drool.

CHAIR - We would love to hear more information about how that process could be made more straightforward.

Ms WINGROVE - Even not having access to Medicare, we would hate for a family to not be able to go in and access services if they needed to.

CHAIR - That's not accessible till the parentage order is finalised?

Mr STREEFLAND - Correct.

CHAIR - And the girls were five months old by the time that administrative process was done?

Mr STREEFLAND - Yes. We were lucky we got a GP who could put our Medicare bulk-billing on hold, so we didn't have to pay out of pocket.

Mr HALLIDAY - We've been very lucky. With my previous industry I worked in, I know a lot of people in Tassie, who actually used to own IVF Tasmania. So, before he had left, we were looked after very well. Also a medical professional and good friend as well looked after us very well. For other people who don't have that access, if you don't have that kind of profession, how do you do it?

CHAIR - Others would struggle to get that assistance.

Mr STREEFLAND - Or the health literacy that we have to advocate for ourselves as well. If you don't have those resources -

Mr HALLIDAY - Or medical background, like Tristan.

Mr STREEFLAND - To the simple fact of Willow had to go into hospital when we hadn't had the parentage order yet, so we weren't listed as their emergency contact and next-of-kin. The person on triage, I knew them. That's the only reason why it never got questioned that they were our children, because I knew that person and there was no question about it.

Ms WINGROVE - And I live in Launceston, the guys are here in Hobart, so -

Mr HALLIDAY - She has to be present.

Ms WINGROVE - Willow had a bit of a reaction to the rotavirus vaccine at one month old -

CHAIR - She went into hospital at one month?

Mr STREEFLAND - Yes.

Ms WINGROVE - She got rushed in. I would have been two-and-a-half hours away if they had said, 'She needs to be here, she's the one on the birth certificate'. That would have been a real struggle.

CHAIR - Which could have happened if it hadn't just been that you knew somebody because it's a small community and you work there.

Ms WINGROVE - Yes. It shouldn't be about who you know.

CHAIR - No, it shouldn't.

Mr HALLIDAY - Yes, it is. Really, it shouldn't be like that.

Mr STREEFLAND - That's what we've found. Going back to the complex care midwives again, we feel like that's not role-specific, the job that they did. That's individual-specific. It means if there was another individual in that role, were they going to provide us with the same level of care? Possibly not. It should be role-specific.

CHAIR - It should be systematic, yes.

Ms WINGROVE - And would someone get that if they were on the north-west coast, or if they were -

Mr STREEFLAND - Down south?

Ms WINGROVE - Yes. It was very much due to their care and attention, which we really appreciated.

Mr HALLIDAY - I think the most amazing thing about this whole story, though, is that we have two beautiful healthy children, a great friendship and we've met some incredible people, the team.

Ms WINGROVE - The whole experience has been amazing.

CHAIR - Amazing team, all of you.

Mr HALLIDAY - I've been asked at my job so many times now by people who are going through it, questions, and been able to talk on TV about it. It's a fascinating process we went through. It was a long process. Four years? Four years. But there are, obviously, some negative things that really don't sit well with us still. That is going to affect us our whole life.

CHAIR - Absolutely. It is an absolutely beautiful thing that you've done, I think, surrogacy, I'm a big fan of people being able to. That's why I'm asking lots of questions about how to make the surrogacy process easier.

Ms WINGROVE - Me too. I would still say that, of course.

CHAIR - We have also heard, through the Committee, from a lot of people about exactly what you just said: 'You've got healthy babies, so just move on'. But it's not fair to treat anybody that way, and the experience that you had does need to be heard. It's very valuable to hear about experiences like your family's so that we can make the best recommendations we can to the Committee to improve the system for everyone going through it in the future. It's extremely meaningful for us to be able to hear your experience.

I am glad that the end result is these two gorgeous babies that we got to meet. I wish all the families had brought babies in for us to meet. We did see a little baby in the NICU [Neonatal Intensive Care Unit] yesterday at the LGH who was very tiny and cute.

I feel like I've hogged all of the time. There are other Committee Members here. Do either of you want to jump in with some questions?

Ms JOHNSTON - Yes, I'll start off. Chelsea, you mentioned in your submission about the impact of having a C-section and post-C-section in terms of not being able to drive for such a long time, and the enormous amount of pain following a C-section. Did they offer any support around that, given you shouldn't have had a C-section in the first place? What was the reaction of medical staff and support staff in terms of providing recognition that not only did you have a procedure that you weren't supposed to have, and that wasn't good at that particular time, but that has a lasting consequence for you - obviously, post six weeks, but also physiologically forever. You had major abdominal surgery. What's been the response to you around that, if you're if you're happy to share with us?

Ms WINGROVE - I had a home visit after a week to take the dressing off, and then it was, 'See you later. Enjoy'.

Mr HALLIDAY - It was a standard C-section patient.

Ms WINGROVE - I assume that's the standard service. I had an appointment after six weeks, I think it was, with a physio as well and she talked about scar massage and that sort of thing, which I found helpful. I didn't even have the added complication of having to lift and carry. What if I had to quickly jump out of bed and feed these babies? I just had to put the pump on - that was easy. I just thought, 'Gosh, how do people do this?' I really did.

Mr STREEFLAND - Chelsea's also a really strong person, as you can probably tell - a very incredible, strong person.

Ms WINGROVE - The background knowledge in the community is that ‘If you have caesarean, you can't drive after six weeks’, but that's not necessarily the case. I went to my GP and they were like basically, 'If you feel OK to drive, I'll sign you off'. I've heard of people who are driving a week later, but I didn't feel like I could. I guess there's not really a lot of awareness around that. I would hate for employers to be saying to people, 'You can just go get a sign-off and you should be right', although not a lot of people would be back at work after six weeks like I was, given my situation. I was very, very well supported by my workplace, which is absolutely fantastic. They actually put leave into the EBA [enterprise bargaining agreement] at the University of Tasmania to support surrogacy, which was absolutely incredible.

CHAIR - Fantastic. As a result of your surrogacy they did that?

Ms WINGROVE - Not as a result of mine; it was prior to when I fell pregnant, luckily. Yes, that was incredible because otherwise the responsibility would be on the parents to be making up for lost wages and that sort of thing, so I was glad the boys didn't incur that cost. I couldn't have thanked my workplace more for their support in terms of the system they had, and my managers directly as well. That was fantastic. It would be great if more workplaces could support diverse creation of families too.

CHAIR - I feel like we've learned a lot from you all. Thank you. Is there anything that hasn't come up that you wanted us to hear?

Mr STREEFLAND - We could talk about this for hours.

CHAIR - I feel like we could talk you guys all day as well. Thank you for being here.

Mr STREEFLAND - One thing probably post birth is parental mental health, the nine to 12 week mark was tough - twins sleeping, sleep deprivation and access to not acute [help], but when you need help, you need it now. I'm fortunate to know some people who work within the Mother Baby Unit here in Hobart, and was talking to them about looking at potentially needing an admission and what is the process? Again, when you're reaching that point, you need help now and it was not a 'you can get in now', you need a long, convoluted process to get an admission, and by that point we were fortunate enough to find our own resourcing and get help.

CHAIR - That's hard to find and navigate and also not accessible.

Mr STREEFLAND - And it's expensive and we're lucky to have the resources. Again, it's a small snippet of the big story for most people, but yes.

CHAIR - Thank you very much for appearing today. If you go away and think of something you forgot to mention, that's really common, so don't hesitate to get back in touch with any of us individually or with Mary, the Secretary of the Committee if you leave today and remember things you wanted to be heard, please don’t hesitate to get back in touch with us. Thank you again, sincerely, for sharing your family story. It's really meaningful to hear real examples of what happens in our health system so that we can do the best we can as MPs to provide good recommendations to the Government. It's been a real pleasure to meet you all and meet the babies.

Mr STREEFLAND - Thanks for having us.

Ms WINGROVE - Thanks so much.

Mr HALLIDAY - Thanks.

THE WITNESSES WITHDREW.

The Committee suspended from 12.00 p.m.

The Committee resumed at 12.07 p.m.

CHAIR - 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 submission. Could you please state your name into the record?

Ms SHARPE - Heather Sharpe.

CHAIR - Thank you. Can I confirm you have received and read the guide sent to you by the Committee Secretary? You would have read in the guide, but I'll remind you as well that the hearing is protected by what's called parliamentary privilege, which allows you to speak freely, say whatever you want, without fear of repercussion of being sued or questioned in any court or place outside Parliament. The only exception is that doesn't accord to statements that you might make that could be considered defamatory if you refer to them then again, outside these hearings.

It's a public hearing. We're being broadcast online. We know that there are members of the public watching and potentially media as well, but there might be people attending in the gallery as well. If you want to give any evidence in private, you can make that request to us. It's a very simple procedure - just to move into what's called an in-camera hearing. Please feel free to access that or if you need a break at any time, do that as well.

Ms HEATHER SHARPE, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Thank you very much. We've also agreed to just make a short, sensitive content statement at the beginning of each session, just because we know that things that we're discussing are really personal. As a Committee, we recognise that during these hearings we may discuss highly sensitive matters that have deeply impacted the lives of Tasmanians, which could be a trigger for individuals listening to or participating in these proceedings. The Committee encourages anyone impacted by this content matter to access services including Lifeline, Tresillian or PANDA.

Additionally, on site today we do have clinical workers here available, Dr Erin Seeto and Ms Amelia Walker from the Gidget Foundation Australia who are supporting the work of the Committee. That's available to you afterwards or if we need to take a break part way through that's totally fine. Don't feel the need to rush off at the end of the Committee.

Hello, [redacted]. Thank you for bringing a beautiful baby to Parliament. We don't get to see enough babies in this building. It's a pleasure to have both of you here.

That's all the formalities out of the way. Would you like to start with a bit of an opening statement or anything you'd like us to start off on?

Ms SHARPE - Yes. I have a little statement that's about this general thing that I want to talk about with you guys. Then I've got a couple of other bits that I've written down that we can refer to.

Birth is a portal. On one side of the portal, two humans exist inside one body. One suspended in liquid, air never having touched their lungs. The other is on the brink of becoming a parent. Those of us who parent know that the person we were before birth does not exist anymore. Their priorities, their concerns, their bodies, their life trajectory are all shared and transformed in the cocoon of birth.

Birth is a portal, not just because the birth giver literally is a portal through which a human passes to join their family, but also because once one passes through that portal, the world is fundamentally changed, smaller and bigger. Time moves so slow and so fast, and birth humbles us. And also when it happens in ways that position us as birth givers, as the choice makers, the experts in our own bodies, and the ones capable of mastering and surrendering to a tempest so monumental that it gives us confidence to know that no matter what we face in this life, we can do it.

Every birth giver deserves to know their power and the marvel of their bodies to do something profound like creating a human and transporting them from womb to air, however this happens, and all birth givers deserve this. The fact that birth for so many is diminishing and traumatising and filled with terror is a crime.

CHAIR - That's a very meaningful and impactful statement, and as a Committee we're really grateful to hear it. We have heard a lot through this Committee about the difference between the homebirth experience and the hospitalised experience and you've experienced both. Are you willing to just expand a little bit on the differences that you experienced?

Ms SHARPE - Yes. So, I experienced homebirth during COVID. That was a huge influence on why we chose to have a homebirth. Many factors were considered in relation to that, but really the biggest one was that I didn't want to be anywhere near a hospital during a COVID pandemic with a newborn.

The process of having a homebirth, my midwife, Annie Popelier, walking with someone who walked with you and who was so experienced in birth that she didn't need to focus on a risk to talk to you about what was happening with your body. She could find ways to talk about it without being like, 'Let's talk about all the risks right now'. You know what I mean? She would be watching what was happening and if something was sort of like, 'Well, this measurement seems wrong', then we would have gone down certain kinds of paths, but we weren't doing those things in a conversation around ‘What about all these risks’. The risks were sort of not talked about. That was her domain.

She didn't need to bring up the things that we were looking for or not looking for. And I genuinely think that is the responsibility of a caregiver in this space. Those are the things that you know about. Talk to me about the things, the choices that I'm making and phrase them as choices. That was a big factor, whenever we would talk about something that was going to happen or needed to happen or could happen, she'd be like, 'This is a thing, this is the information it gives us. Do you want to do it?'.

CHAIR - So, that was throughout the pregnancy and through labour?

Ms SHARPE - Yes. Well, for labour, because that was my second child. I knew that in labour I didn't want to talk. And to be able to give birth without medication, I needed to be not in my thinking, analytical brain because my thinking, analytical brain would panic. I needed to be in my animal brain basically, for want of an easier way of talking about that. So, we needed to have ways that were - how would I not talk? How would we ensure that my wishes were listened to and from the outside, it would look like she didn't do anything. And she just stepped back and listened to the different noises that I made and knew when the times were that I needed to have support. She really only got involved at any level of transition and she just let me do it. And because we were in our house, we knew everything was, we were relaxed, like it was a straightforward process.

I do think that what that acknowledged for me was not just to know how my body works and to understand my body and to be like this is what it takes for someone to be able to give birth without any medical intervention for pain. Medical intervention is a separate thing, but I'm not talking about C-sections or whatever.

This is what I need. I need to not have people asking me questions all the time. I need to not have anything physically on my body. I need to go into it trusting that I can do it. I need to have people next to me who believe that I can do it, and I need my caregiver to believe that I can do it. All of those things create the perfect storm of someone who can walk through that and be okay. Not everyone will. That's okay, hospitalisation during homebirth is a good thing -

CHAIR - When it's required.

Ms SHARPE - When it's required.

There's an issue with availability of homebirth midwives at the moment. I know at least six children who've been born in a car on the way from the Huon Valley to the hospital. If those people had been at home, that would have been a safer environment than trying to race to a hospital and having a baby on the side of a highway. The Huon Valley is only 45 minutes to an hour away. Nubeena's ages away, so the access issue is big in that way.

I couldn't get a homebirth midwife because there was one operating at that time and she was already booked. Basically, at that point, I had to make a decision about whether I didn't use the system at all or I went through the hospital system. I went through the hospital system for one reason: to be able to have access to the Syntocin injection at the end of labour if I required it, because I had required it for the last two.

Nothing was phrased as a choice. I will say that the midwives I worked with were amazing. They knew they had to phrase things in certain ways; they had to tell me certain kinds of information. By and large, most of our conversations weren't focused on that information. I can see everybody's doing the best job they can, but I can see how hamstrung people are by requirements associated with certain definitions of risk. I can see how those definitions of risk have caused normalised behaviours where like, these are the things we're looking for and these things are completely off our radar because we can't get sued for them.

I'm not thinking about what the risk of this person experiencing birth trauma is when I'm thinking exclusively about infant mortality. If infant mortality is my only measure and that's it, and there's a 20 per cent higher this or that or whatever, I'm going to go for something that will cause birth trauma but won't cause infant mortality. The problem is that everyone's just trying to avoid that risk.

My point, basically, was, where is the data comparing homebirths and birth trauma to hospital births and birth trauma? That data needs to exist. What about postnatal depression? After birth, how capable do they feel? I had five home visits after my homebirth. I didn't leave the house for 20 days. After [redacted] was born, I had to go back to the hospital three days later from the Huon Valley, because they don't do satellite clinics on a Sunday. Even if I was going to do a satellite clinic, it would have been in Kingston. Cool, I understand all of this. It's out of your hands. They're not being bad -

CHAIR - But it's the way the system works.

Ms SHARPE - It's the way the system works. Everybody knows that people who give birth should not be leaving their bed at that point. It's just totally acknowledged. It's acknowledged in the medical system, and yet that's the course of action because the risk of not catching something that's wrong with the baby is too high, so we have to make you come to the hospital.

CHAIR - One of the things we've heard directly from a midwife who presented to the Committee is that when they're at university they're taught about women-centred care. Then they get into the workforce and it feels like it's system-centred care.

Ms SHARPE - Yes.

CHAIR - Without trying to put words in your mouth, I just wondered if that reflection rings true for you, or if you have any comments on that.

Ms SHARPE - Absolutely. I want to talk about something. There's a document that they're trying to bring in at the hospital about consent. It acknowledges the fact that people who are giving birth can't consent adequately because they're giving birth and they're not able to make reasonable decisions. They might need a support person to say, 'Actually, are you really sure?' There's also the acknowledgement of a power imbalance. In sessions where people meet with, particularly, obstetricians, it is suggested that the obstetrician is the expert and the person giving birth doesn't know what they're doing or is inexperienced. The obstetrician is likely to - and in my experience does - talk in terms with authority, all of their knowledge of birth. First of all, it's possible that person's never given birth. There's quite a few male doctors who do that job. There's also young people and people who haven't and will never [give birth]. That's never acknowledged, in any of my experiences.

The meeting I had with the obstetrician, which was a formal meeting because I was 'declining medical care' - that's the phrase - by saying I don't want to have a Syntocin injection 10 minutes after birth. I will wait 45 minutes and I will take the risk, because they're all trying to stop -

CHAIR - That seems like a very low bar to make that assessment of declining care. You're expressing your preference, not declining care in that scenario.

Ms SHARPE - Yes - and I didn't want a monitor. I didn't want monitoring. I don't want anything on me. I know what I require to give birth. At no point in any of the process was there a discussion where people were like, 'We applaud the fact that you're attempting to give birth without any intervention or medication. We know that has better outcomes for babies in many ways - health, immunity, all of these things. It lowers a whole bunch of other risks that aren't this risk that we're looking at'. That was never talked about. It was all, 'This is going to raise the risk'. The midwives didn't talk that way, the obstetrician did.

In that room, it was her and a medical student who was male. I don't know if she's ever had kids. She was young. She didn't mention them. I was probably the most experienced birth-giver in that room and I was having to, through coercive conversation, say, 'No, no, no'. On top of that, I had filled out a form that says I am not allowed to agree to anything without a support person present.

CHAIR - Was that a birth plan form from the hospital or something different?

Ms SHARPE - No, it's a ‘maternity support person agreement’. They've got one for the baby as well. It basically is an attempt to ensure that people - it's an acknowledgement of an imbalance of power. Some people think it's annoying because they're like, 'It's one more step and it's more bureaucracy', but regardless, that's the form.

CHAIR - Was that observed?

Ms SHARPE - No.

CHAIR - In [redacted] birth?

Ms SHARPE - In [redacted] birth, we were good. [redacted] birth was fine.

CHAIR - But this was from your first labour.

Ms SHARPE - But I had a doula. This is for the lead-up. It's all the agreements in the lead-up, including what happens to me. In the meeting with the obstetrician and the medical student, they were running late. That happens, but it meant my husband couldn't come to the meeting. So, that basically meant that whatever happened in that meeting I couldn't agree to. But still, I know from her perspective - I wrote it here - it's likely to occur that she is seeing this as informing me of the risks and trying to prevent situations that they perceive as being more risky, where me being like, 'I don't want any monitoring', and them being like, 'How will we know what's happening to the baby?' I'm like, 'Yes, I know.'

But, in that room, like I said, there was never an acknowledgement of who's the person who has given the most physiological births in this room? Who's the person who's existed inside the body that's going to do this birth. You're telling me you can't have one of these around you for the whole birth while you're trying to labour and not use any drugs. Fair? Probably couldn't either. But the lack of recognition of what it actually takes to be able to give birth - it's like, 'Oh well, we'll just put this on you' or 'we'll just do this other thing'. 'Oh well, if you've got strep B, you've got to have a thing.' Now you're on a drip. Try walking around. 'Stay still for 30 minutes while we try to get the heart rate.'

CHAIR - It's not very woman-centred, what you described.

Ms SHARPE - What? And the only reason that I was such a difficult person was because I'd already done it twice and I'm 40, which by the way, makes me a higher risk.

CHAIR - I think the use of 'geriatric' in respect to 40-year old's is very hurtful.

Ms SHARPE - I was just like, I'm not taking, I'm not sitting down and being like, ‘Okay, all right, you're right. I don't want to risk the - '. You know. I think that that's the thing. It comes down to this for me: when we're measuring homebirth and hospital birth, so often homebirth is seen by the general public as a risky thing. The majority of society thinks homebirth is a risky thing. Birth-givers, I remember having to have lots of difficult conversations with other people about why I was being selfish.

CHAIR - Yes, that's not a nice feeling.

Ms SHARPE - That's fine. I did it. Those of us who do homebirths actually also know that this idea is not true. It's not actually true that homebirth is really, really risky or really, really dangerous. It's actually, if we want to look at statistics -

CHAIR - There is that evidence out there that it's safer.

Ms SHARPE - Whenever I see homebirths measured or compared to hospital births, I see them measured by hospital standards, so in hospital priorities. Risk is measured in terms of what hospitals and insurers consider to be risky, and everything relates to mortality. Don't get me wrong, mortality is an important thing to consider. But the picture of giving birth is one of nuance. It involves humans, and humans are filled with nuance. Homebirth and hospital birth are not the same thing. Only someone who measured things in a superficial or medical way might suggest it.

I would like to suggest that data and the language used around birth needs to have not such a heavy influence from a system that has such a poor track record of birth trauma. Why do we only measure homebirth in comparison to hospital birth on hospital-dictated risks? Where is the data on how likely birth trauma is in homebirth versus hospital? Where is the data on a sense of parental confidence following birth, on the nuance of parental experience, on the likelihood of postnatal depression, on the effects on siblings, on the likelihood of birth-related injury due to intervention?

Homebirths and hospital births may be two ways of achieving the birth of the baby, but birth is not a mechanical process. Again and again, in the hospital system - not with the midwives, but when I was having to justify things, that's how it felt. This perception was that it was something that was going to happen to me, and all these things were in the way to stop avoiding the risks of things that would happen to me and not something that I was going to do.

CHAIR - It's been such an impactful story. I'm grateful for you being able to share it so eloquently and so succinctly. It's really meaningful for us to hear this kind of evidence. I feel like I've hogged all the time. Were there other things that either of you wanted to raise?

Ms ROSOL - I think you expressed it really well and quite succinctly too.

CHAIR - That's what I was thinking, too. I was making notes to come back. There are lots that will be relevant for our report writing in what you've shared with us today. It's a deeply personal story to share. Thank you for doing it. If you leave today and suddenly think, 'I didn't say this thing I wish I had', it's not too late. Please get back in touch with any of us on the Committee or with Mary, the Committee Secretary, who you've heard from. We're all here to learn from your experience, so please don't hesitate to get back in touch with us if you need to.

Ms SHARPE - Thank you.

THE WITNESS WITHDREW.

The Committee suspended from 12.30 p.m.

The Committee resumed at 1.38 p.m.

CHAIR - 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 written submission that you've provided to the Committee.

Could you please state your name and the capacity in which you are appearing before the Committee today?

Dr AYTON - Certainly. Firstly, Chairperson and Committee Members, thank you for the opportunity to contribute to the Inquiry. My name is Dr Jen Ayton. I'm a midwife and an academic researcher and a senior lecturer in public health at the University of Tasmania, so I'm presenting as a researcher.

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

Dr AYTON - Yes.

CHAIR - Thank you. You would have read in the guide, but I'll remind you that you're covered by parliamentary privilege during these proceedings, which means you can speak freely with us. You can say anything you want us to hear without any fear of reprisal or fear of being sued or questioned in any court or place outside of the Parliament.

The only exception is that doesn't accord to any statements that you make that could be considered defamatory if you refer to them or repeat them outside of these parliamentary hearings.

It's a public hearing, so there are people and media watching online and we have had, at times, members of the public or the media in the gallery today, so that could happen. Hasn't happened a lot, but we have had some members of the public attending.

I'll introduce the Committee. My name is Ella Haddad. I'm the Chair of the Committee and a member for Clark. This is Cecily Rosol, who's a member for Bass. Kristie Johnston is one of my Clark colleagues in our multi-member electorate, so also member for Clark. We have two members joining us remotely online. Anita Dow is on the screen at the moment. She's a member for Braddon in the north west, and Rob Fairs, whose camera is working now. Fantastic. He's a member for Bass as well, based in Launceston. We have one apology today from Nic Street, who's a member for Franklin, but also a member of the Committee and he'll be part of the report writing stage.

We have also agreed to read a short sensitive content warning into the *Hansard* at the beginning of each session in case people online are watching specific sessions. I'll very quickly do that now.

We recognise that as a Committee that these hearings may discuss highly sensitive matters that have deeply impacted the lives of Tasmanians, which may be a trigger for people listening to or participating in these proceedings. We encourage anyone impacted by the content of this hearing to contact services including Lifeline, Tressilian, and PANDA.

Additionally, today we have clinical support workers available on site in our breakout room, our colleagues Erin Seeto and Amelia Walker from Gidget Foundation Austraia. If that's something that you would benefit from that is available this afternoon.

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

Dr JENNIFER AYTON, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Thank you. That's all of the formalities done. We can put those to rest and would love to invite you to start with an opening statement if you would like to do that.

Dr AYTON - Again, thank you for the opportunity to contribute to the Inquiry. As I said, I'm a midwife and an academic researcher. My field of expertise is reproductive and maternal health. I've been working in the field as both a midwife and researcher for 30 years, both internationally and nationally. I have a PhD in sociology which was undertaken in Tasmania and involved looking at breastfeeding and why women stop breastfeeding in Tasmania.

I lead a growing team of multidisciplinary researchers who are focusing on and dedicated to the health and wellbeing of women's reproductive and maternal health in Tasmania.

I wish to acknowledge the Tasmanian women who contributed to our study and their valuable contributions to this research. We respect and value the courage it takes to tell deeply personal experiences and those of emotional and physical trauma.

I profoundly respect and acknowledge the Aboriginal and Torres Strait Islander women's perspectives, culture, language and history, and the continued effort to fight for justice and their reproductive rights and health. Their voices to date in the study are limited.

When referring to the participants in the data collected, I will use the terms woman and/or women to mean female. I acknowledge that the data includes people who do not identify as women or mothers and that individual parents and families may use different words.

There are three key take-home points that I wish to stress for the Committee. The first is what we know. The aim of our study was to give voice to Tasmanian women about their experiences, both good and not so good, across their perinatal journey, including pregnancy, childbirth and the first 12 months of the postnatal period, and then to use this data in a positive way and create a respectful maternity care framework for Tasmania. We've achieved this and have developed a draft framework. 176 women to date have shared their experiences. This is different to - an addition to the report.

The need for improvement, the quality of maternity care and the quality of care is evident from the data. The women's experiences ranged from positive through to deeply traumatic. They've shared with our team highly sensitive and authentic experiences. These experiences appear to leave long- and short-term impacts, both positive and negative, on their and their families' health and wellbeing.

Second, what can be done? From the data, what matters to women most is that their experiences are listened to and that they are included in the solution. A recommendation is that the focus must be on quality of care. This requires effective partnerships with women, health services and government to implement the respectful maternity care framework and measure the effectiveness, most importantly, using indicators we are developing around respectful care. Further recommendations I've outlined in the report.

The final point is, why should we even care? Tasmanian women have the right to respectful, dignified care throughout their healthcare journey. Improving the quality of their experiences, irrespective of the outcome, is a priority in Australia and globally, so we're not alone in addressing this issue. Our work demonstrates how local research and partnerships can add value and create evidence to improve the quality of care, health and wellbeing of Tasmanian women. Most importantly, our research offers Tasmania an opportunity to be the leader in respectful maternity care in Australia.

CHAIR - First of all, I want to thank you and your research team for the incredible work that you have done. We are hearing very similar stories, by the sounds of it, from the women who were part of your sample. Unfortunately, as is the nature with parliamentary inquiries, we're mostly hearing stories on the severe birth trauma end of the spectrum, but we have heard also some really amazing and inspiring stories about good experiences as well. I suppose that's where I would like to start before opening it up to the whole Committee.

In your written submission you spoke about describing women's experiences of maternity care with that broad spectrum, from an amazing experience with exceptional care through to traumatic experiences. You've described it as saying the good experiences were often described by women who received care from Midwifery Group Practice, MGP, or had engaged a doula, a private independent midwife, or a private obstetrician.

I wondered if the positive stories were limited to those particular methods of care, or if there were positive stories across the board, or if you had anything you'd like to expand on in terms of the different models of delivering health care to women in pregnancy and labour?

Dr AYTON - I think for our data, it's important that the context is that this encompasses the journey, so the positive and negative experiences can happen at any time.

CHAIR - Everywhere.

Dr AYTON - Yes, so it's not just at that child-birthing period or event. Those positive experiences from the data are certainly connected with the model of care, but more importantly, when we drill into the data and have a look at where that's coming from, it's coming from the relationship that's built with the provider. For example, with the private obstetrician the woman has received continuity of care, she's built a relationship over time and they have begun to share information together. It creates an opportunity for building trust with providers such as independent midwives. It's the same scenario. It's based on that relationship that's built with the provider.

In saying that, from the data, even when that deviated, for example, for a woman who's receiving a midwifery model of care, the MGP, Midwifery Group Practice, or she's engaged a homebirth midwife, if things have deviated and she needs to change her model of care, that appears to be the intersection point where a negative experience might happen, so there's the change in the trust of the relationship, but also saying that, one person within their whole care experience can actually change the way that woman interprets and comes away from her experience.

There were many cases where women described having a negative experience, but it was one person, and it could have been just a random person coming in, it could have been a pharmacist, it could have been -

CHAIR - One experience shapes that whole journey.

Dr AYTON - That's correct. It's that one experience that can actually shape how she walks away, from or goes forward. That's a really important leverage point for frameworks to make sure that it's not just targeted at obstetricians or doctors or midwives, that it's actually a whole system that we need to actually support to do this.

CHAIR - One of the things that we heard directly from a midwife who presented before the Committee was that at university she feels like she was - she told us at university it felt like she was learning about women-centred care and when she got into the workforce it felt like system-centred care. I've asked a few others to reflect on that, if that feels like a true or accurate reflection and what learnings we might take away from your research around the difference between the two?

Dr AYTON - Yes, it is system-centred care. On one hand you can understand why its system centred, because it's a complex system, and the system is void of women's voices.

We need to understand that the system comes from a paternalistic model. It comes from - with no disrespect to men - a place of the white male gaze. So therefore, it's [health system] paternalistic. From the colour of the room, from the placing of the instruments to how people talk, is taken through that [male] lens, and often it's unrecognised.

As a system, that's the most important thing. We need to actually recognise that that's the place where we're coming from. That's the view of the world. We actually need to step back and say 'So we need to take a woman's[view]' - That's what I mean by woman-centred, but it's understanding that women's knowledge is different from that and women's knowledge during this particular period of their life is different again.

So when midwifery training - I trained in the UK, which is quite different again from Australian training, but have worked in Australia, of course. It is like that. You're taught the theory and a woman-centred approach, and then you do hit the system where it contradicts everything that you are taught.

So, if we're going to address that, we need to go to the [understanding that the] - system is part of society. Society is grappling already with gender bias and we need to respond to that in a maternity and perinatal care system and see that as separate from all other care systems.

Ms JOHNSTON - Thank you so much for your submission and your research. Just touching back on the points you're making about continuity of care. I note that you said the estimate that women may see between two to 45 different care providers through their maternity journey. That's a lot of different interactions to have to divulge really deeply personal and private information, to expect 45 providers to be able to give, as you recommended, a respectful maternity care framework.

In your experience, when you're looking at that data, I'm assuming that there are some women who have complex pregnancies or a range of issues who do need to see a number of different providers. Does your framework envisage how you can have that continuity of care with multiple providers supporting a woman-centred focus around that? What might that look like in terms of - there would be very good reasons why you might need to have a range of health professionals caring for and supporting the woman through that journey. How do you do that in a respectful care framework? What does that look like? What are we not doing now that means that many faces are not getting the best experience? Sorry, that was a long question.

Dr AYTON - Where that data has come from - we asked women to tell us how many different people did you see over pregnancy, childbirth? They would then start counting how many different people that they interacted with just once through that journey. In the whole, the data that we've analysing at the moment, it's actually two to 62.

Ms JOHNSTON - Gosh.

CHAIR - Wow, okay.

Dr AYTON - We see that as a real positive, because that shows us that we need to make sure the system - we're actually being able to [use this to] map the system then. This is the system that's looking after women in this through their perinatal period. If we're going to do any interventions or do the framework or anything like that, we need to make sure that they all are players [providers] in that framework. As alarming as those numbers sound, it does offer up an opportunity to map out where the system is and who's doing what. They are also opportunities to make a difference. Back to the data that showed us that one person, one interaction can make a difference. That's reassuring again.

Probably the second point there is that the continuity of care is paramount. In the data it's suggesting that that continuity can be provided by one person - such as a homebirth practising midwife - or a team. That team can be the solid foundation for that woman and her family to anchor to. She can interact with all the different people that she needs to interact with to manage her care. Complex cases are a really good example of that. She needs a solid foundation. She needs one - either a team or an individual who's going to be her primary perinatal care provider. That should continue into the post-natal period. When you ask questions about that, I can talk about that side of things.

Ms JOHNSTON - With that team, is there an important role for one sort of central person to be the guide through that change, to partner with the woman to assist - is that something you would recommend?

Dr AYTON - Internationally, the research, of course, time and time again has shown us that continuity of care is the gold standard, and team-based or midwifery-based models for when the pregnancy and everything is tracking without any complications. When it deviates and there are other care needs and it becomes more complicated, the care is often shared with an obstetrician, the experts in the complication. They're the models that, time and time again, have been proven across the world to be effective. When we refer back to the midwives who often feel like they're not working to full scope of practice because they're in a system that's devaluing their expertise.

This is where the partnership needs to come in, so respect of both. Respectful frameworks are about respect for each other's profession as they are about respecting the health consumer.

What is this going to look like? We've just received some funding from the Clifford Craig Foundation, where we'll be able to start the first stage of testing out and talking to health-service providers, midwives and obstetricians, and that money only gives us that little bit to do that, so we'll be able to work out what that looks like - what it would mean to obstetricians and to midwives, understanding that there are many more players in the field.

Ms ROSOL - You've started to go there already. I was going to ask a bit more about the respectful maternity care framework and if you could expand on that. You've started to do that, but I'm wondering if there are other things you'd like to share about it?

Dr AYTON - The framework is built from the voices of the women; it's built from their experiences. We've been able to measure the different forms of mistreatment. We needed to do that first, before we could flip it and ask the data, 'Well, if that's what that looks like, what is the positive?' That's why we were very keen to collect positive stories. The positive stories are about relationships. Part of the framework is the building of relationships, one of the front parts of the framework is continuity of care and making sure that we are continuing in partnership with women and their families the whole way through.

There are five components, just like there are five components to measuring the mistreatment, and those components have items that we're building indicators to, so we can actually measure whether we're actually making a difference. There's no point having frameworks in place unless we can say, 'Well, these experiences [improved for], the women, at the end of the year’ [we can only do this by] collecting some more data to see if we're meeting the indicators - that we're practicing respectful care. The last pillar of the respectful care is health system, so it has a component that includes built environment as well. The built environment is essentially as important as the other components for the women as well.

Ms ROSOL - What do you see? You said you have some funding from the Clifford Craig Foundation and you're starting to do some work. What do you see as a pathway to the implementation of the framework?

Dr AYTON - First we need to take the framework and talk to the women as well. We also need to collect a bit more data. From our data we've spoken to a lot of women, which we need dedicated time to do, [we now need] to talk to women who are culturally, linguistically, and ethnically diverse. We need more representation of Aboriginal women within the data, so it's not one size fits all. We need those voices in there because their needs, and this is equity, are going to be different. We need to do that first, so talk to them. We may end up deciding that there's a particular framework that needs to address specific needs for different population groups, young mothers as well. That's first. That's a small pool of money that will allow us to do that, then we'll start taking the framework to the health services and asking them for their feedback and then rework it from there.

We're going to need ongoing funding, so we're going to always be looking for more funding and building partnerships with the appropriate organisations - the Australian College of Midwives, Royal Australian and New Zealand College of Obstetricians and the Australian College of Rural and Remote Medicine - to work with us. It's a long-term project. It's not a quick fix, but it's the commitment to it that's really needed from, like I said, health services to government to research and it must be evidence based.

Ms ROSOL - You mentioned the Royal College of Midwives and those other organisations. Have you been able to have conversations with them? What's the openness and what's happening in that space?

Dr AYTON - They're really open. Very open to having the conversation. We're building on this work, of course. I said we're going for more money so that we can continue the implementation process. We'll be going for national funding with the NHMRC [National Health and Medical Research Counil] this year and continually trying to - that's where we're pulling in the partnerships from those organisations to partner with us and contribute to the work.

CHAIR - Leading on from Cecily's questions, do you think there would be value, or do you have any views on - 'constant' is not the right word - but regular consumer input into the structure of maternal health services and paediatric health services - postnatal, the works - and how that might best be facilitated and be adequately representative of women's experience?

Dr AYTON - That's a great question. When we talk about women-centred care - and going back to the midwife who felt disjointed when she went into the system, and doctors feel that too, they go into the system and they feel equally as disjointed - I've lost my train of thought.

CHAIR - It was about consumer input into system design, really, for want of a - I can't think of a less bureaucratic way to describe it. Basically, patient and consumer input into health systems.

Dr AYTON - It has to be absolutely built in. For the study, we have a steering group that's made-up of lots of experts and health consumers and different representations. But we also have been developing a consumer women's advisory group. Everything goes before those committees, those groups, before we finalise anything, including the questions that we ask in the interviews.

Health systems, they're a part of society. They are society, and so, it's core. One of the powerful sort of threads that went through the data was the lack of trust. That is a way - bringing in health consumers is a way of hopefully improving trust. But, again, there's no point us having these things in place unless we're actually measuring, having indicators around, whether it's making any input.

CHAIR - What about our colleagues online? Anita or Rob, would either of you like to jump in?

Mr FAIRS - No, Cecily covered what I was on. All good.

CHAIR - What about you, Anita?

Ms DOW - I do have a question that relates to the data collection. Obviously, you've talked a lot about qualitative data collection and the experiences of women and consumers. One of the things that's been portrayed to us through the work of this Committee is the lack of data collection around maternal health and paediatric health in Tasmania more generally. I wondered if you might provide some comments about how that informs your work and where you think there is an opportunity to increase that? Perhaps through the University of Tasmania or maybe the work that you're doing.

Dr AYTON - Thank you, that's a great question. There's an absolute lack of women being included in any research strategy. I've just had a look at the preventative health strategy. Women are mentioned twice in that document. Reproductive and sexual health is mentioned and outlined, but maternal health isn't mentioned. We don't have a women's health research unit here in Tasmania and we need one. Everything we do in the future needs to be evidence based. We need to build it from evidence with women at the core. I think at the University we have a wonderful opportunity to bring people together, and so I said that we're building - I'm building a team. It's taken six years, almost 10 years. I've been working towards this for a long time. I work with colleagues all around and internationally, and across the state, across Australia.

The way forward is making sure that women are named up in everything. If they're not named up, they're missing. They might be implied, but they're missing. We have to have that in there. Women's based research, like I've said before, women's knowledge isn't the same as women's generated knowledge, and how that contributes to any health outcome is not the same as other knowledge. That needs to be recognised. That's where the qualitative research comes in understanding what their experiences are.

And experiences are a health outcome. I think that it's absolutely vital that we understand, we acknowledge that. The quantitative data, I totally agree, there's a lack of dedicated strategic direction about what it is that we're wanting to understand, and what foundation we need to improve the health of women and their families across Tasmania.

We talk about first 1000 days, we talk about the early years, but we still don't name it up as women's centred research, and so, they're missing.

CHAIR - It's terrible. Yes, very illustrative of the system we're in.

Dr AYTON - Yes, it's because we live in a paternalistic society. It's just recognising that and not criticising that, but saying, ‘Okay, that's the problem -

CHAIR - How do we find the solution?

Dr AYTON - This is the solution’.

CHAIR - I think you mentioned earlier that you were hoping that we would end up speaking about postnatal care and there might be something that you'd like the Committee to hear around that.

Dr AYTON - So, the journey - we dissect women's experiences up into bits and pieces, but it's important to see, to understand, that in women's health research - and that includes access - it's not in our data, but it includes reproductive, sexual, access to abortion and termination care, everything, and particularly around pregnancy loss as well.

Women get to the postnatal period, so they've come through - they may have been beautifully supported. We've got excellent data that suggests that the care pathways have been, they've had a wonderful experience. They get to the postnatal period and they fall off a cliff.

Why we've extended our data to the first 12 months is because that first 12 months is that foundation period and absolutely imperative. We need to continue to consider the postnatal period to the first 12 months, and that's why we've referred to it as perinatal. The postnatal care is sadly lacking.

CHAIR - We're hearing that as well from individuals. In particular, just today we've heard from people who feel like everything post-birth is focused on the baby and, of course, there needs to be a focus on the baby's health, but very little focus on the mother's health, really, past the six week check, particularly around checking in around mental health, experience of birth trauma. That might take months or years to reveal itself. Sometimes it's not until a second or subsequent pregnancy that somebody might realise that a previous experience would fall into the birth trauma category. So, I agree with you about postnatal care. We're hearing that message really strongly.

Are there suggestions that have come out of your work around how that could be delivered better in Tasmania? There are some postnatal supports built into the THS [Tasmanian Health Service], for example, and through CHaPS [Child Health and Parenting Service]. We've had some good feedback on some of those supports, other than that people would like more of them and longer support. Are there other examples that have come out of your work, either here or in other jurisdictions, that we could learn from around better postnatal care?

Dr AYTON - Yes. I think recognising that postnatal care, as you've said, is a longer period. And mapping of who does what is really needed. We can do that in the data. We haven't done that yet, but it's on the agenda to do. Of course, that requires and money for us to do that.

Models of care, there's the continuity - that that care provider is then changing in the structure of funding models for that continuity so that it does include that longer period of time, so they can extend their care, that it's not cut off as soon as they leave or two weeks or four weeks or six weeks. That there's a multidisciplinary approach to this so that it's including rural generalists, GPs, that there's a clear handover point. Different models in the UK have clear delineation between, and handover times, where there's a two-week handover between one care provider and the next, so there's ongoing [care].

But also peer-to-peer support. One of our last recommendations and findings was that women - healthcare providers and professionals, they did value their care and they do value their clinical expertise. Even within the really traumatic experiences, they did really value those. The most support was achieved, particularly in the postnatal period, when they had peer-to-peer, so they had mother-to-mother support or father-to-father to support. Building those within a community and getting the community involved in the health system, how it's functioning, will be what will most likely make a difference. So then, you're meeting the needs of the community, and some communities really valued having that peer-to-peer support.

Funding models that extended the postnatal period, so allowed practitioners to have that in their care package. More inclusive peer-to-peer services that are [made] available. Also, really importantly, one of our recommendations is that we need to audit what's actually happening at the moment. We need to actually understand what are the multiple different ways women are being cared for? What are the different models of care that are actually happening here? Because they change all the time depending on funding and workforce. By doing that, we may be able to come up with some clear solutions.

We can go back into our data and ask our data that question. Our data is a repository, if you like, so we can go back into it and ask more questions and find out specific solutions to those sort of problems.

Ms DOW - I have one further question in relation to the analysis you've done and evaluation of debriefing post-birth trauma in Tasmania. It would appear from some of the evidence that we've heard that there's perhaps different approaches taken in different centres to this. Is there a recommendation from your work that you could inform the Committee of about how that could perhaps be done better or more consistently across the state, please?

Dr AYTON - Again, a really good question. The birth trauma, we're working with the Office of the Chief Nurse [and Midwife], who's now - a PhD student has just started. Sophie has just started a dedicated project using our data to have a look at that birth trauma, what it is, how it's experienced, and unpack some of that, so we can come up with some recommendations and a debriefing model that is inclusive of everyone's needs, and when that should happen. So, it's back to the research question. We don't have enough research on this that's Tasmanian-specific. There's data from other states and territories and internationally, but for Tasmania, we really don't understand what that looks like. In our data, we can pull out - that's what Sophie's going to do. She is going to pull out the childbirth data and the birth trauma data, and have a look at that.

Then we'll test different models of debriefing. At the moment, from our data, women's experiences - one of the problems was there's a lack of redress. That includes the ability to have a discussion about what happened. It could be a positive or a negative. That's a sort of routine practice, but when you have multiple different people interacting with you, that's really hard to do. It's back to let's figure out how we can implement some sort of continuity, then we will be able to understand how we can make sure what birth trauma debriefing looks like? What conversation do we need? One thing that women and their partners - partners are left out as well. Partners aren't being identified as someone who would experience birth trauma. Many of the women in the study felt like they were carrying everyone. They felt like they had to look after everyone.

CHAIR - Sounds familiar to the evidence we've heard as well.

Dr AYTON - Yes. It's really problematic for all sorts of reasons. The birth trauma debriefing or support system that needs to be built around that - just like the support system that needs to be built around pregnancy loss, including miscarriage - needs to include all of the family, if the mother wants that. When that should happen and how often that should happen for the first 12 months and then on - Sophie's going to hopefully understand this in her PhD. So, we're doing the research right now to try to understand that.

CHAIR - That's great. I feel like we could talk to you all afternoon, but our time has come to an end, very sadly. Thank you very much for presenting today. Was there any other information that we didn't touch upon that you'd like us to hear? We're available afterwards as well. We can stay in touch.

Dr AYTON - I was reflecting on - I mentioned my PhD in the beginning. I could go back - this is not a new problem. I could go back into that data and ask this question.

CHAIR - The same questions. We haven't moved far enough.

Dr AYTON - The women in our data were very clear that this wasn't something that they were complaining about. This was something that they wanted to shift. I guess reiterating that they want to be part of the solution, so embedding them in -

CHAIR - System change.

Dr AYTON - In system change, having them side by side with us. What's also important in research, any research particularly around women's health, is that we use an intersectionality lens. That's fundamental. Otherwise we're just going to generate more inequity and inequality.

CHAIR - That's right. Thank you. It's been so informative hearing from you. It's been a very short hearing and I think we'd benefit very much from meeting again. For now, let's say goodbye and thank you.

THE WITNESS WITHDREW.

The Committee suspended from 2.22 p.m.

The Committee resumed at 2.28 p.m.

CHAIR - Hello and welcome to today's hearing of the House Assembly Select Committee on Reproductive, Maternal and Paediatric Health Services in Tasmania. Thank you both for appearing and for your written submission. Could I ask you first to read your name into the record and the capacity in which you're appearing before the Committee?

Ms GOYNE - My name is Emma Jane Goyne and I'm appearing as I submitted. Sorry, there's not enough coffee in the world today. I have a teething toddler. I birthed on 3 June 2023, so I submitted my experience and I've been working with Alecia.

CHAIR - Alecia, can I ask you to state your name and the capacity in which you're appearing as well?

Ms STAINES - Sure. I'm Alecia Staines. I founded Maternity Consumer Network and I'm here to represent Maternity Consumer Network today.

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

Ms GOYNE - Yes, I have.

Ms STAINES - Yes.

CHAIR - Thank you. As you would have read in that guide, the hearing is covered by parliamentary privilege, which allows you to speak freely to us and say whatever you would like us to hear without any fear of being sued or questioned in any place outside of Parliament or in court. The only exception to that is the protection is not accorded to statements you might make that are considered defamatory if you refer to them outside of these proceedings, but you can speak freely to us in the hearing today.

It's a public hearing. We know that there are people watching online. Members of the public may appear and sit in the gallery. Similarly, the media may appear or be watching online as well.

If you want to provide us any information in a private session, you can ask that of the Committee. It's a simple process that we then agree to go into what's called in camera and we can hear evidence privately as well, if that's necessary or something you would feel more comfortable with.

I'll quickly introduce the members of the Committee. My name is Ella Haddad. I'm the Chair of the Committee and I'm a member for Clark in the south here. Kristie Johnston is a member for Clark as well. Cecily Rosol is a member for Bass. We've got two members joining us online alongside Alecia. We've got Rob Fairs, who's a member for Bass, and Anita Dow, who's a member for Braddon. We've got one Committee member away today, Nic Street, who's a member for Franklin.

Could I now ask you to make the statutory declaration?

Ms EMMA JANE GOYNE, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

Ms ALECIA STAINES, MATERNITY CONSUMER NETWORK WAS CALLED, AND WAS EXAMINED, VIA WEBEX

CHAIR - Thank you. Alecia, I'm told I don't need to swear you in because you're interstate.

Ms STAINES - Handy. I promise to tell the truth, though.

CHAIR - Great. No doubt. I'm also just going to read a very short sensitive content script into the *Hansard*. There are people who are tuning in throughout the day, so just in case they haven't been exposed to this information at an earlier hearing, I'll do that very quickly.

The Committee recognises that during these hearings 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 this hearing to contact services and supports, including Lifeline on 13 11 14, Tresillian on 1300 827 282, or PANDA on 1300 726 306, and a lot of those resources are also listed on the Committee's website.

That's all of the formalities out of the way. I'd like to start by inviting either or both of you to make an opening statement or make some opening comments that you'd like to start with.

Ms STAINES - I might, because it's actually my son's birthday, so I'm going to duck out a little bit early at the end. It's actually 16 years ago I became a mum and that's kind of a big driver for what I do, because I had such a good experience.

That aside, Maternity Consumer Network is now the largest maternity consumer advocacy organisation in the country. We are volunteers. We do it because we know that women deserve better and that birth is really the foundation of motherhood.

There is federal, state policy development we're involved in, but we know from the outcomes with a third of women experiencing birth trauma that absolutely we can be doing better by women, so a big part of what we do is really try to advocate for the implementation of the woman-centred care strategy, which we were a part of. We lobbied Greg Hunt, the previous health minister to develop that strategy back in about 2016-17 and obviously that document was published in 2019. We had COVID and it kind of got buried under a lot of other stuff, but post-COVID we're really keen on states making some headway into doing that.

Having been involved in inquiries like this across states and federally for a long time, when we have stuff that's already there, like the women-centred care strategy, a big part of what I see as the outcome of something like this is let's get some monitoring, evaluation and an implementation strategy for that document, because that was on the back of an inquiry 16 to 17 years ago federally and we're still at the stage where we're recycling and going through these processes when it's already there and done.

CHAIR - It's frustrating. Thank you for sharing that. I share that frustration. I hope that this Committee will make some good evidence-based and informed recommendations that we hope Government will adopt, and hearing evidence like yours and the individuals who presented to our Committee is really integral to that.

I want to leap into part of your written submission. You talk about the training you've developed alongside human rights in childbirth and a perinatal psychologist, and have delivered that training in Queensland hospitals and 20 maternity hospitals have completed that training to date. That's amazing. I wonder if you have any insights since that training has been delivered in those hospitals around any changes or improvements that you've seen in service delivery as a result of that training?

Ms STAINES - To put that training into context, priority 2 of the women-centred care strategy is respect. The priority or the enabler is that every maternity care professional upholds or endorses the Respectful Maternity Care Charter, but I could see nothing was being done. I think that's where private industry or not-for-profits can play a part. I sat down and thought something needs to be done, so we teamed up with a human rights lawyer and a perinatal psychologist. I'd actually been contacted by a health service, a midwifery unit manager, and she said, 'Alecia, you need to help because what's happening here is absolutely terrible to women. What do you think needs to happen?' I said, 'I think you need to hear from someone with a bird's-eye view, almost like an outside person, but also from women first-hand. How is this impacting them?'

I call that ground zero. We go there every year and unfortunately, like most states across Australia and Tasmania included, there is no good perinatal data collected on the respect women are receiving, their autonomy and their experience of that perinatal care, so I'm relying on anecdote when I'm saying this. Ground zero - they do it every year.

Even though we're in Queensland, when the New South Wales birth inquiry, started and there were over 4000 submissions, what the Queensland local health districts were seeing was an increase in women complaining about their maternity care experience. It must have been resonating. Ground zero said they were all sitting around whinging about all these complaints. She said, 'Actually, I wasn't having them', and it's because after three years we had invested - she said ‘It's never one and done’, there were other things we were doing in between, whether it's staff meetings or showing screenings of birth time, like a documentary and things like that.

Absolutely I think the respectful maternity care training is imperative, but there needs to be other elements of that as well, such as collaborative care and things like that. They book us in every single year to make sure any new staff, the new registrars who come in, are all on the same page. Alongside that, they almost have a navigation. If a woman is having a hard time or she's wanting to decline certain elements of her care or is just not happy, the midwifery unit manager will personally take on that case, so it's almost like they've created this informal navigation role. There is also the head obstetricians who will navigate those women through as well.

Only a few weeks ago, my niece was having a hard time there and as I've done for other women, I let them know she wasn't happy with what was happening. I said, 'The steps that she's relayed to me do not point to there being informed consent or informed decision-making. I'm going to leave it with you. Here's her email. I've cc'd her in. She's given permission, but obviously, she'll confirm that, and I just leave it with them’.

It's multifaceted. But what I will say, it's never one and done. Cultural change. I mean, I'm a teacher, I know you cannot just do a three-hour session and think that we're going to transform this space for women, and it needs to have management buy in. And I think even higher up as far as the health.

Over in WA they actually mandated it for all staff over there. And yes, there was a lot of pouting and carrying on, which is ridiculous from staff. But how else, if you're not having it from the top level to say - 'no more of this?' Women need to be the centre of care. Can it be led if it's not from high-level leadership?

CHAIR - I agree. How many places have you delivered that training in now across Queensland and WA or broader if I'm wrong about it just being those states so far?

Ms STAINES - We've done 11 workshops in WA, and they've actually recorded it. So there's no excuse basically for staff.

In Queensland, there's very few who haven't had the opportunity to do it. But what the Queensland Government did on International Women's Day last year was actually fund it for four years.

So, health services are just sent out the EOI [expression of interest]. ‘Okay, in this week there're five sessions available. Book your session’, and we just fly around, drive around and do sometimes 20 hours driving.

Tasmania is small. Queensland's big. So, you can imagine it's a massive road trip sometimes. But there'd be very few places that actually in Queensland now. Because when I made that submission was last September. We've since done a whole week's worth of training in Queensland, in November. And then, we're about to head around again to another lot of training in March.

CHAIR - I'll just ask you one more question about this before we open up to the rest of the Committee. With the training that you're providing, which health workers could do it? Is it voluntary or is it across the board? Is it doctors, obstetricians, nurses, other allied health staff? Who actually undertakes it?

Ms STAINES - It's open to everyone. I think when we've got good leadership that says ‘The expectation is that every staff member completes this’, it's a lot more beneficial because some places we really are preaching to the converted. You'll get a small cohort of midwives who are nodding the whole way through and you're like, 'yes, that's great', but 'yes, and take these resources to your colleagues and this information'. But, I think there needs to be a bit more buy in.

At the moment it's kind of expected, but there's not explicit instruction from Queensland like there was interstate that this has got to be part and parcel of solving the problem.

Some of the pushback from obstetricians is the word 'obstetric violence', but it's internationally recognised now. We're pretty explicit that this isn't a shaming exercise, that this is actually to solve the problem. And if we're going to get caught up on words, it's actually not going to help women.

But we've had some high-level obstetricians from Queensland Health attend and as a result it was kind of good because they were like, 'Oh, so they're actually just carrying on a bit', was their feedback? And she said, 'you know, I'd heard all this stuff' – [suggesting] it was really radical', she said. 'So I thought I'd come myself'. And she came in November and she said, 'Actually it's helping them, because this is how you help women'.

CHAIR - That's really positive. Thank you.

Emma, did you want to add anything on that part of what we've discussed?

Ms GOYNE - No. It's good to hear Alecia. I just wish that I'd have connected with her and the Maternity Consumer Network before I birthed my son, rather than post with my birth trauma.

CHAIR - Let's open it up to everybody else. Who'd like to jump in with any questions or observations?

Ms GOYNE - Obviously, the submissions that Alecia has made are a lot more stories than just mine. For me, it was quite personal because I birthed 3 June 2023. The same week I found out I was pregnant, I found out I was elected to council. So, it was a bit of a throw in the deep end, especially after I was told I couldn't have children. I was very surprised. It was a big few months for me, obviously having the capacity to advocate for myself personally because I'd had a previous motor vehicle accident and had some medical related issues with the hospital and the care that I received.

So, it was one of those things that I'm constantly aware of how important it is to provide my voice, because there are so many women who wouldn't be prepared to advocate for themselves. I think that if my birth story was as complicated as what it was, what would it be like for women who can't speak up and advocate for themselves? That's really the main reason why I thought it was important to come today, to just make sure that we keep pushing.

CHAIR - For that change.

Ms GOYNE - Yes.

CHAIR - I think change is always more effective if it is informed by real experiences that people have in our health system. That's why we've been really grateful to hear individual stories through this Committee. How many Tasmanians are involved with the network here? Have you got a group of people starting to want to be involved?

Ms GOYNE - Most of the ladies are up north, aren't they, Alecia, the ones I've spoken with?

Ms STAINES - Birth in Tasmania. Yes, we do a lot of mentoring for advocacy, and they've come to us. I guess I'd seen the media that we'd had, or helped get, as well around Launceston. Intermittently, I would say that they have done a really good job in a short period of time, Birth in Tasmania, to be able to assist us in getting 80 submissions to that survey. You've only got 6000 births a year. That, percentage wise, relying pretty much on social media, is a really good effort.

CHAIR - We're hearing from them as well, from Birth in Tasmania. We'll be hearing from them later.

Ms STAINES - Yes, absolutely. There are probably, I would say, six to 10 active women. Then you have women who if you ask them to do something like write a letter to an MP, or submit to our survey, they would do that. There are levels of engagement as well. Certainly, we have some good active members now in Tasmania.

Ms GOYNE - Obviously, I'm not a midwife or a doula or any sort of birth advocate. I more came into it from that capacity, that engaging is where my expertise lies.

CHAIR - That's very important as well.

Ms JOHNSTON - I'm interested - in your submission you talked about information regarding maternity care options prior to or during care. I think your data indicated 44 per cent responded with no, with a further 18 per cent responding that they were unsure. I suppose that goes to the issue around consent and informed consent, and women being given the range of options that are available, and knowing. One thing we're hearing quite regularly is you don't know what you don't know. For many women it's their first time in a system that at times appears to be very bureaucratic and process driven, rather than women-centred driven. Can you perhaps expand on the lack of awareness about the options, and how that's not communicated to women about the different kinds of birth experiences that they might want to choose?

Ms STAINES - I guess we have to look at women's first point of contact, and that's often with a GP. You're also now relying on a GP to provide unbiased advice on various models, which they mightn't even know about. Lot of women will also say in hindsight they wish they'd been able to access MGP [Materntiy Group Practice], but they got in too late. You have a supply issue there as well.

I think even before women get to the GP - or is it provide the GP clinics with flyers and things like that, because I think we've gotten to the stage of social media being almost information overload. Whereas something tangible with just some unbiased information – 'Here are all the different models of care', - might be quite useful. It is the state trying to collaborate with a federal or independent model with the GP clinics. That's often women's first point of call, particularly even if you don't have self-referral into Midwifery Group Practice or to the birth centre - women will still have to go to the GP.

I think trying to capture that is really important. You probably have a website that can provide some information to women too. I don't get the impression that they were looking at the Government website necessarily for models of care. It's probably peers, or once they're being spat out on the other end, on reflection, wishing they'd had a lot more information.

Ms JOHNSTON - I suppose I'm following on from that. I get a sense that women get a lot of the information from other women going through that. If you're the first off in your friendship group to have a baby, then you're the one that's going to be the font of information for other women in your friendship group. Can you reflect at all, whether you have anecdotal evidence of this, or data about how that affects people's expectations around their experiences and whether that creates fear or concerns amongst women entering into services and using services, if sometimes their only source of information is other women who've been through the process?

Ms STAINES - Well, particularly if other women have had poor experiences, absolutely. If all your peers have had trauma, you're going to be not in a great position having any confidence in that system. A lot of the survey - there was that theme in the survey responses, like 'I don't trust.' So, if I as a birthing woman has had a bad experience and I don't trust - or women who couldn't even go anywhere near a hospital so for so long, or women who couldn't be intimate for so long, you can imagine, that's almost like PTSD. But then, if you have that in your peers, it's very hard for a woman then to get past that.

Conversely, if a woman has had a positive experience, it's almost like her peers might have that unfair advantage to go, 'Okay, so you had it' - because often, and I'm just relaying the theme from our survey, most women had a really positive experience having continuity of midwifery care through MGP. There was one who felt like she'd had too many midwives, but if women are finding out through - and I would imagine they would be - from their peers, then you have a cohort of women who, just by potluck of finding out about Midwifery Group Practice or the Birth Centre as well.

Ms GOYNE - I think for me, anecdotally, is that I hadn't spoken to anybody. I didn't know anybody that had had a natural birth. Most women I'd spoken to ended up with an emergency C-section. For me, really the only reason why I think I managed a natural birth is during COVID I chose not to have the COVID vaccination, and then was obviously subjected to a lot of coercion. That was actually how I found myself kind of here. So, I learned to advocate for myself then. There was a lot of pushback and so I got very good at saying no.

During that time most of my friend group were doctors, nurses, doulas who couldn't work because they also hadn't had the COVID vaccination. Because of that, I was very lucky that when I found out I was pregnant, I was literally surrounded by medical professionals who had no job. I was their job in the end, so I ended up with a personal doula - I couldn't afford any of these things because a councillor's allowance isn't great. I couldn't afford any of those things and I just wanted to birth at home. I didn't want to go to the hospital. I'd had a really significant trauma after my car accident in the hospital and there wasn't an option here. Like it was just not on the table, unless I wanted to go off-grid and go rogue and have my doula sit at home and run the risk.

As a nearly 40-year-old woman who was told I could never birth, and I was told I'd never be able to birth naturally my whole life, because I had my car accident when I was 19, to then be in that position where thankfully for me, the doula was like, ‘Your body's designed to do this, you can do this’. So, you know, I was forced into the hospital system, and then a lot of things happened that I wouldn't necessarily do again, but at the same time, I managed to advocate for a natural birth. I birthed naturally, apparently. According to the obstetrician, I had a nice natural birth and I was very lucky. But I put in nine months of preparation for that physically and mentally. So, again, I look at the other people who don't have that kind of support. Even then there were things like -

CHAIR - Or self-advocacy skill.

Ms GOYNE - Yes. I wasn't allowed to birth in the birthing pool, even though that's what I wanted. There were so many things I wasn't allowed to do.

CHAIR - Why is that?

Ms GOYNE - Because they were concerned that I might have had some meconium in my - when my waters broke, but later they did say to me that that wasn't the case and they did apologise. By then, you know, I was exhausted and didn't want to get in the birth pool anyway. Even though that was a part of my birth plan. When I asked them, what was the risk, you know, 'Oh well, the risk is only 1 per cent higher,' than what it was if I didn't choose to use it, so I wasn't explained the risks of if I chose to get into the pool. They just said no. There wasn't even an option. I was not allowed to. I know Alecia speaks of birth centres, but as far as I'm aware there's nothing like that in Tasmania.

CHAIR - There is one in Launceston, not in the south.

Ms GOYNE - Recent?

CHAIR - No, no, it's been around 40 years. We actually toured it yesterday.

Ms GOYNE - Well there you go. I probably would have driven to Launceston if I'd known that. So, the lack of services and now we have even less, another hospital less, so it's not like you're given options. I wasn't really given an option and I couldn't afford to go privately. Not that I think my birth story would probably be any greatly different, but for me it was just what it was.

CHAIR - Were there other parts of your birth plan that you felt were followed or respected? You talked about the pool.

Ms GOYNE - No. Not really, no. They used my partner to try to coerce me into having the foetal heart rate monitor put in. When I wouldn't listen to the midwife and I said I didn't want it, she went to him. He's a veteran with some significant PTSD [post-traumatic stress disorder] and he was a medic. He kind of got - she got into his face and said, 'Your baby could die.' Then he basically told me I had to. I agreed to it because I didn't want him to have a mental breakdown in the middle of my birth.

CHAIR - That's a lot of pressure on you.

Ms GOYNE - It was. And look, in hindsight, I'm glad I agreed to it because it just shut them up and they left me alone. Up until that point they were shoving things on me every five minutes, whereas at least when they screwed the thing into my son's head, they just left me alone. I was right. I told them I was fine, I knew that I didn't need all the things that they were telling me I needed, and that we were all okay. But, yes, it was - and when I asked for a change of midwife because I wasn't happy with her, they just said no. They said, 'We don't have the staff, it's a really busy night.' When I wrote a complaint, they told me that that was not the case, that they would have offered me an alternative midwife had I requested.

CHAIR - That's not what your experience was.

Ms GOYNE - That is absolutely not my - I have, obviously, other witnesses who said that that was not the case. I told them I would not birth while she was in the room. I think it was seven minutes after she left shift, the other lady walked in, and I birthed. I knew I wasn't.

It also didn't help that she hadn't detected that my son had the umbilical cord wrapped around his head. She just kept telling me I needed to push harder, and I was like, 'I actually can't.' I'm very tough and have a very high pain tolerance and I'm like, 'I cannot push physically any harder.' And she's like, 'Yes, yes, you can, just push harder.' The other midwife walked in, stuck her finger in, flicked it off, and he just fell out. I was like, did I just spend three hours trying to push him out and he literally just fell out?

CHAIR - Oh my goodness. That's an incredible story.

Ms GOYNE - Look, my worst part of my birth story was actually coming home and the trauma after that, actually after I left the hospital. For me the worst part was the fact that they would not let me outside with my child.

CHAIR - While you were in the hospital?

Ms GOYNE - Yes. I wasn't allowed to go into the internal garden at all.

CHAIR - Why not?

Ms GOYNE - Because of COVID, they didn't let you into the garden. Even though it's how many years post-COVID and you'd think being out in the fresh air would probably be beneficial. But, no, you're not allowed to use the internal garden and they wouldn't let me outside with my child. He was property of the hospital until I discharged, so I couldn't take him outside for the fresh air. Because of my previous issues with the hospital, I didn't want to be inside the whole time. After losing over three litres of blood, I discharged myself on day two because I didn't want to stay inside anymore and I didn't feel comfortable leaving my child. So, I went home.

CHAIR - Are you comfortable sharing any of that postpartum experience?

Ms GOYNE - Yes, absolutely. That was the worst part because - I didn't receive any support in the hospital in the days post my birth, apart from having the paediatrician come and harass me because I declined vitamin K. She threatened child support services, even though when I asked her how long the treatment period was, if my son had the rare blood-clotting disorder that it was needed for, I had something like seven to 10 days to treat him. Even when I said that I was making an informed decision on that, she then said that she would, if I wanted to choose the oral option - which is what my doctor had told me to say just to get her to leave me alone - she told me she would prescribe it, go down and get it, and watch me administer it to my son. So, that was - she said, 'This is a welfare issue,' and she pushed that.

Then he'd lost weight in the days proceeding, which obviously is normal, but he lost more than the percentile. So, because I had left early they then made me come in every two days and have him weighed. At one appointment they told me they were going to forcibly admit him, or 'take him,' and put a nasogastric tube in. I asked them, because I was really dehydrated and unwell, if I could get IV fluids and they said ‘No, that I wasn't a patient and that I would have to go to the emergency department if I wanted to get IV fluids’. But yes, they were quite happy to shove a tube down my son's throat.

It actually turned out my son had an undiagnosed - even though they'd ticked the blue book to say that they'd checked - tongue-tie. I was having a lot of problems breastfeeding and they kept saying that it was thrush, and it was this and it was that, it was all these other things. Nobody once checked my breastfeeding attachment or anything like that. After - I can't even remember how many different creams they made me shove on him and in his mouth and all these things - I went to see a lactation consultant. That was pretty much all the money I had at the time, I remember. She diagnosed he's tongue-tied. So, then I had to borrow the money off my parents to have his tongue-tie revised, and at eight weeks of screaming and torture from the hospital, he breastfed like a champ. He's been in the 90 percentile since and we're still breastfeeding.

It was very traumatic having a woman in your house telling you they're going to take your child off you. On the days that I didn't have to go to hospital to have him weighed in, they would come to the house and weigh him, so it was every day. Now, to think about it, I thought that going to town to have a weigh-in was no big deal. But with a newborn, you know, immediately after I'd given birth -

CHAIR - Hard to leave the house.

Ms GOYNE - I didn't realise at the time because I was so, like, I can prove to everyone that I can do this. Like, I went to council two weeks after with my baby and all these things. I was so determined to prove that I could do it all that I didn't even really think at the time that it was just all running on adrenalin.

CHAIR - It would have had a profound effect on you and your mental health.

Ms GOYNE - Hugely.

CHAIR - If they were visiting you every other day, did they offer any support to you or check in how you were going?

Ms GOYNE - No, no. One of the midwives prescribed me Domperidone without knowing my medical history at all. She actually rang a doctor while I was there to get a prescription and told me it would be sent to the chemist and she would check to make sure I was taking it.

CHAIR - What is that? I don't know that medication.

Ms GOYNE - They do prescribe it quite commonly. It was originally developed as a mental health drug and then they found that it increased breast milk supply if you were low in prolactin. But it only works if you're low in prolactin, which most women aren't post giving birth because the body produces your prolactin. So, without any testing or anything, she prescribed that. She hadn't spoken to my doctor; she hadn't seen any of my medical records. There's a lot of contra-indications. The label actually says, the first thing it says is, 'Do not give to pregnant or breastfeeding women'. This was a woman who didn't know me who was prescribing me medication that she was going to check to make sure I was taking that wouldn't really - I did actually end up taking it because I felt like I had to. To have somebody turn up in your home and basically she's like, 'I will give you this and you will take it and I will check, and if not, we will take your child'. My child was hardly starving.

Even now, I'm constantly paranoid about whether he's hungry, and he's nearly two. He would tell me if he was hungry. I would know. But it's become like a real thing for me of making sure he's fed because it was like they were so, and everything. From the moment he was born, all they spent doing is telling me all the things that were wrong with him. You know, he's got this with his chest and he had a mild hearing loss and all these things. It just felt like that whole first eight weeks was like - this is what I thought was this perfect creature and they're like, 'this is wrong, this is wrong, this is wrong, this is wrong'. And I was like, you know - and he is perfect. It was just that constant –

CHAIR - Very disempowering.

Ms GOYNE - Obviously, in that eight weeks, my partner was trying to force formula and all of those things. And so we separated. I think I was probably a few days before the tongue-tie revision. He now tells me that I was right and he was wrong, and that it was the tongue-tie. He said good on me for trusting my instincts, but obviously that had a profound effect on us.

CHAIR - Your relationship, I'm sorry to hear that.

Ms GOYNE - Yes. I mean, he has a lot of mental health issues related to his service, but it was the straw that broke the camel's back, I guess.

CHAIR - It's tough, though. Let's open it up to others. I was going to ask Alecia about something else in the written submission, but I might not - I'll ask you, just in case you know it, but if not, we can contact back to Alecia.

Ms GOYNE - Yes, yes.

CHAIR - She's mentioned in the written submission that there are - it's something you touched on and Kristie did as well in her questioning around consent versus informed consent. We are hearing a lot of themes around that in the evidence that we've heard, and she mentioned that there are policies and guidelines in place in Tasmania that contain coercive language that preclude informed consent. I was interested to unpack that a little bit. I don't know if that's something Alecia shared with you.

Ms GOYNE - Not specifically, but I know even in my own experience, when I asked questions in regard to the information I was provided by the hospital, they provided information about the importance of Hep[atitis] B and say the leaflet says that the most dangerous time to get Hep[atitis] B is as you exit the birth canal. Once you've given birth and they immunise your child for Hep[atitis] B, obviously, the danger period's already through. When I asked my doctor about that, she then said, 'Well, yes, I guess that makes sense, but we just give it anyway'. So it's sort of that, it's not the -

CHAIR - It's the policies and procedures that are in place.

Ms GOYNE - Yes. And as soon as you question, for me, because I question those - I mean, we had all our other immunisations. They were the two that I just didn't see as necessary. Because of my experience, I'd looked into them quite heavily. There was no conversation around the reasons I'd made those decisions. They're like, 'This is the policy, this is why we do that'. There is no deviation from the policies. Even when you ask the doctors, they couldn't tell you why. That was the thing that really surprised me. I'm like, if I'm going into that room - and it was worse, probably, whilst I was birthing to a degree with things. If I'm going into that room and I'm the most informed person in that room - and I know nothing about birthing, I know nothing about children, I know nothing apart from my own experience, going into that room, I felt like I was the only person who knew what I was doing.

The only reason I probably felt comfortable being in that room at all is because Mike was a medic and I knew that he could perform medical procedures if necessary, and he'd delivered babies. My postpartum care was only him. I don't think, apart from having meals dropped off, I didn't receive any postpartum care really, apart from a lady that insisted I pee every two hours or something, and woke me up.

CHAIR - Were there visits from midwives through the hospital to you at home after birth? No.

Ms GOYNE - They were the ones that weighed and -

CHAIR - But no checking on your health and wellbeing during that period?

Ms GOYNE - No, nothing at all. And when I did write my complaint, I think I got a perfunctory letter that was, you know, 'We're sorry that you feel that way'. Also, the thing that really surprised me is when I requested my birth records - sorry, the medical records - that it cost me, I think it was $150. So, it's $27 a page and they can choose what they provide you. By the time I'd paid, I think it's about $150. I think I got three blank pages because you get the cover note and the end note and something in between.

CHAIR - They charged you $27 per page?

Ms GOYNE - Yes, per page, including the blank pages. Well, probably not blank, but they've got your name on them. Then they choose the information they give you. You can't request it. You can put in a general request form, but they can choose what they give you. So, they chose to provide me, with the money for, it was my discharge notes and that was it.

CHAIR - Was that through a Right to Information process?

Ms GOYNE - Yes.

CHAIR - It was not a specific health department form? It was a general right to information, requesting your own records?

Ms GOYNE - Gosh, I can't remember, it was such as - I had to go upstairs just down from the hospital, so it was a hospital one, through their complaints process, I think.

CHAIR - Was there anything else that didn't come up in our conversation that you'd like us to hear, or any other questions from members online or at the table for Emma?

Ms DOW - Thanks very much, Emma, for sharing your experience. I had a procedural question, Chair. I had a question for Alecia around the recommendations of separating the chief midwife and nursing role into two, so, being a chief nurse and a chief midwife. Is there the opportunity to put that question to Alecia or to Network more formally?

CHAIR - I think we can do that. We can resolve, as a Committee, in a deliberative meeting. We can follow that up with Alecia. We can make that decision in a deliberative meeting and write to her again.

Ms DOW - Thank you.

CHAIR - Emma, thank you very much for attending today and for the involvement that you have with Alecia's Network. I've met with Alecia before and seen how passionate she is around these issues and particularly around women's health. It's great to see she's built a national network of passionate women looking at advocating for maternal health. If you think of something after you've left today that you wish that you'd mentioned, then get back in touch with Mary or any of us. We are easy to find. Often, I think, when you leave something like this, you'll think, 'Oh, I wish I'd mentioned'.

Ms GOYNE - I think I said to Mary when I did my initial submission, and I'm sure she included it at a later date, she said that she would. My partner said that the birth room was more stressful than active service medic duties, and he'd watched a guy get two legs blown off and he was the only medic attending. So, that did say a lot. I did lose a lot of blood, so there was obviously a lot of blood that was unexpected. He still thinks it's worse than his service time in Afghanistan, while I still think it was a relatively wonderful experience, so obviously the perspectives are different. Again, so many people probably couldn't advocate for themselves in the ways that I did, and that's the thing that concerns me particularly.

As I said, everybody that I've spoken to has had an emergency C-section, probably apart from myself. Most people I speak to also say that they weren't able to breastfeed. I think something we're really lacking here is lactation support, because for me that was really important, and that was something that was definitely missed at the hospital.

CHAIR - Thank you.

THE WITNESSES WITHDREW.

The Committee suspended from 3.10 p.m.

The Committee resumed at 3.18 p.m.

CHAIR - Good afternoon and welcome to the hearing today of the House of Assembly Select Committee on Reproductive, Maternal and Paediatric Health Services in Tasmania. Thank you for both your written submission and for appearing online to the Committee today. Could I ask you please to state your name and the capacity in which you are appearing before the Committee?

Ms CATHERINE BELL WAS CALLED, AND WAS EXAMINED, VIA WEBEX

Ms BELL - Catherine Bell, and I'm appearing as a researcher.

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

Ms BELL - I have.

CHAIR - Great, thank you. You have read in the guide, but I'll explain again. The hearing is covered by what's called parliamentary privilege, which allows you to speak with freedom to us and tell us anything you want us to hear without the fear of being sued or questioned in any court or place outside of Parliament afterwards. That protection doesn't, however, extend to any statements you make that might be considered defamatory if you then repeat them outside of these parliamentary proceedings. It is a public hearing. We don't have any members of the public here in the gallery right now, but we have done at other times, so there might be some people coming in or out, including media. We know that there are members of the public and media as well watching the web stream on the parliamentary website.

I'll introduce the Committee. My name is Ella Haddad. I'm a member for Clark in southern Tasmania. My colleague, Kristie Johnston, is also a member for Clark. We have a multi-member Lower House Parliament in Tasmania, which has been unusual. So, Kristie's an independent member for Clark. Cecily Rosol is a member for Bass. We've got another member for Bass on the screen, Mr Rob Fairs, and Anita Dow, a member for Braddon in the north-west of Tasmania. So, you've got all political parties and independents in every part of the state represented on this Committee.

We've also agreed to make a short sensitive content statement at the beginning of each hearing, just because we know people online might not be watching the whole day's session. So we've been doing that at the beginning of each session. So just bear with me while I do that as well. It's quite short.

We recognise as a Committee that during these hearings 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. We encourage anyone impacted in that way to contact support services, including Lifeline, Tresillian and PANDA, and those resources are listed and available on the Committee's website.

Could I invite you just to make an opening statement to us, Catherine, if you'd like to start off with what you'd like to talk about most?

Ms BELL - I would like to tell you about my research. It's the abstract for my research. The concept of the birth plan was introduced over 40 years ago, in recognition of women as the decision makers in maternity care. The intent was to provide a sense of agency to women in an increasingly medicalised maternity care system in which the cultural messaging and power imbalances would dismiss women's experiences.

Birth plans are intended to improve communication between women and their care providers. However, birth plans need a woman led structure and a process supported by the system to ensure that women are seen and heard. With collaborative and supportive birth preparation, women report greater satisfaction, a greater sense of control and more aligned expectations. In the absence of collaboration and support, women are less satisfied and at greater risk of trauma, and the validity of consent is drawn into question.

In response to these issues, the Birth Map was developed from a consumer perspective to be a woman led, collaborative and structured approach to birth preparation. The Birth Map acknowledges the importance of communication and enables confident decision making for women. In the form of a book, the Birth Map provides an overview of the Australian maternity system with question prompts to assist women to engage with care providers and suggested resources to aid in knowledge building. The evaluation was framed around the question, does the Birth Map facilitate communication, enhance experience and aid decision making?

This was explored using a realist evaluation methodology with self-selected participants from various models of care across Australia. The participants were asked to record periodical reflections throughout pregnancy and after birth and a cross section of those participants provided in depth interviews postpartum. Short postpartum surveys also provided quantitative information on their experiences about respect and decision making. The participants gave valuable insights into the Birth Map, and these were instrumental in shaping the resulting theory. The evaluation found that the Birth Map facilitated communication, enhanced experience, and aided decision making for the women in the study. However, barriers included short appointment times and dismissive care providers which impacted their experience negatively and impeded their decision making. The Birth Map did help alleviate this impact, but it does not negate the need for effective communication and relationship based care.

The refined theory presents an informed, supported and confident maternity journey with a guideline for how to put this into practise. Women must be acknowledged as the decision makers with an understanding that the context of each journey will differ. This context includes the woman's background and circumstances, the care providers skills and the facility provisions.

Women need to go through a process of sense making during pregnancy where they place the information they receive into their own context and come to understand what it means for them. This helps them to recognise gaps in knowledge that they can then seek to fill, build a support network, which ideally includes a relationship with the care provider, and then they can make confident decisions as their birth unfolds. This process is underpinned by effective communication, which is the cornerstone of informed consent.

Embedding this approach into the maternity system involves two critical aspects which address the systematic barriers that were identified in particularly standard and obstetric models of care. The first is to provide women with a comprehensive overview and prompts for questions in early pregnancy and the second is resourcing the care providers towards relationship-based care, effective communication and supported maternal decision making. This may look like training and support for practising care providers and inclusion in curriculums for emerging practitioners.

Systemic change would shift us from a consent seeking process to a decision supporting one that recognises women as capable decision makers regarding their own experiences. So the Birth Map approach has the potential to lead to this effective communication, supported maternal decision making and enhanced experience for women accessing maternity services.

CHAIR - That's great. Thank you very much, Catherine, for a very succinct snapshot of what I know would have been years of research. Thank you very much for allowing us the opportunity to learn from your research.

What we've heard from you touches on a lot of what we've heard from individual women who have presented to this Committee. One of those things being around birth plans generally and how they are received or adhered to, but also around continuity of care and short visit times and the challenges that health services have in terms of consumer experience around those things. I wondered if you, in your research, would like to elaborate on the experience that women have shared with you around those birth plans. We've heard both really positive and really negative stories from women who feel like they had written a collaborative birth plan and it was absolutely adhered to and they had an amazing experience right through to people holding out their birth plan and medical professionals refusing to even look at it or take it from her hands.

We heard another example at the Committee of a woman who was labelled as refusing medical care, but the basis upon which that decision was made, or that label was put on her, was that she asked that the Sintosin injection could be 45 minutes after labour instead of 10 minutes after labour. I'm not a medical professional, but it didn't seem like she was asking for something too outlandish and yet she was then told that she was refusing medical care and that was an issue. What kind of stories have you heard around people's experience with the existing system in hospitals?

Ms BELL - Very similar ones. A lot of the motivation for starting this study in the first place was my own experiences as a mother, starting 18 years ago and it took four pregnancies to kind of go, 'We really could do better here'. I happen to have a scientific background that helped me to develop a resource that I felt would work for me. So I felt I wish this had existed with the first pregnancy because a lot of it was that you don't know what you don't know.

What the Birth Map does that the usual approach to birth plans doesn't do is give us that overview of what you may not be aware of, hence the term ‘Map’. So, like let's have a look at the whole landscape and then the question prompts. What I've found that is particularly crucial is those conversations with the care provider and in the absence of continuity of care that looks like asking different care providers within the same facility, are you getting consistent answers? Is there different answers? A lot of women do find that there is some inconsistency there.

Legally, women are allowed to make any decisions they need to, even if it results in death or injury. That's a hard place for care providers to sit with if a woman is making a decision that goes against recommended care. At the moment, the way we approach a woman who is declining or questioning recommended care is - often there's an undercurrent so women will talk about how it's not an actual thing that's happening, but a feeling of something that's happening.

So, in my study, I had two different women talk about how they didn't pursue their questions even though they were getting dismissive responses from their care provider because they were very conscious that they had 20 minutes allocated for the appointment and that the next person would be out there waiting. What they did find, however, was when they did push to get answers to their questions, the care providers didn't actually rush them out of the room. But there was that air of, 'I've been given my allocated appointment time and I must move on'.

So, there was a little bit of a theme around an undercurrent rather than an actual perception - and actual thing that's been spoken - 'You must not ask questions beyond your appointment time'. It wasn't something that was said, it was felt.

CHAIR - That's really interesting. That is a theme we're hearing as well around self-education and the importance of people being given access to the resources to inform themselves of options and understanding.

I'll ask one more question before opening it up to the rest of the Committee. Obviously, it's been a little while since we first communicated with you as a Committee and today's hearing and I know that you wrote that last November you were going to be meeting with Westmead Hospital around embedding the Birth Map into their practise. I wondered how that went and if there are any reflections you'd be happy to share with us.

Ms BELL - Yes. Alongside the book, I've developed a game that helps to understand the statistics behind what happens in birth and it's based on the 2018 Mother Baby Report. So, you roll a 20-sided dice and it gives you a scenario that's statistically based and then the kind of decisions you might be able to make. So, what are your options in that scenario? Westmead has asked me to create a Twister-sized version of this game that they can use in antenatal classes, which encourages engagement. You can play the game in about 10 minutes and it helps participants, which will usually be the pregnant woman and her partner, to really understand that there are several decision points in this journey. What if your birth does actually end up going down a medical pathway where interventions are necessary, how do you recognise what's going on and understand how one intervention can lead to another.

For example, with an epidural, understanding that it does require a catheter and a drip and monitoring. There's a bit of a package deal that goes together with an epidural, which is often not discussed. A lot of women are in the moment where it's past the point of saying no. That's not where the consent discussion should happen because we're past the point of saying no, so if you hear the risks of induction in that moment, you don't care anymore. It's now unethical not to give that relief that's been requested. So, that discussion is best had in pregnancy where it's a hypothetical and being able to walk down different pathways and understand what you might do if you are confronting a more difficult labour can reduce the stress and then, hopefully, minimise any trauma.

In my study, I found that women who did end up on difficult pathways reported that the outcomes were acceptable in that they understood why their birth went in the direction that it did and they felt involved in the process. They talked about having had those discussions in pregnancy being the difference between it potentially having been a very traumatic experience because once things do start to become critical, things happen very fast and that's when you consider your fear.

So, having sat in that difficult scenario in a hypothetical, when it is happening, you can recognise it for what it is and feel a bit safer. The game helps you to sit in those trickier spaces as well and it can be helpful for partners who are thinking, 'Oh yes, I don't really have a role in here', to see how they can actually fit into the team and work with the care providers to make a really positive or acceptable experience for the mother.

CHAIR - Sounds really innovative and very exciting work and it does stray into another thing we're hearing a lot about which you've described clearly is around that consent question and we're hearing a lot from people who have given evidence about that challenge between consent and informed consent, and how women who have ended up in an emergency situation and have later gone on to feel that informed consent wasn't given, wasn't able to be given, that that preparation and that knowledge base at the beginning or during pregnancy, before being in an emergency situation, would have made all the difference for them being able to prepare for those eventualities or possibilities and consider those outside of an emergency situation. Have you come across that a lot in your research as well, the difference between consent and informed consent during labour?

Ms BELL - Yes. Probably a bit more of a passionate area for me, the difference between consent and the decision as well, and the language around that. Whilst consent is an important word for being able to move forward with an intervention, before that comes a decision. Before that decision comes this sense-making process where a woman needs to integrate that into her own context, which is why two different women facing the same circumstance may make two very different decisions because they have to bring in different elements into that decision.

When we talk about informed consent and the focus on informed consent, we have this consent-seeking process rather than a decision-supporting process. I think a big part of that is that care providers and policies that sit around care providers are not structured to support them in a decision. There is quite a lot of pressure on the midwives and probably the obstetricians as well, to gain consent and move forward in the framework of recommended care, rather than what a woman's decision might be.

One of the women in the study followed the approved processes, met with care providers at each appointment, had fragmented care, but didn't agree with the recommended course of action. She wanted to talk about different alternatives, but rather than having good conversations, she kept finding walls that she kept coming up against. She did end up birthing outside of the system, had an absolutely amazing birth experience, was very proud of herself, did the right thing and let the hospital know that the baby had been born, and then was police escorted into the hospital for assessment on the baby. Which now means that if she has another child, she won't engage with the system at all from day one because of that disrespectful care. She'd done all the right things and the engaging point, she'd done nothing illegal or wrong, the outcomes were fine, but then they interrupted them when there should have been skin-to-skin postpartum. Mum was happy, baby was happy, they were feeling really good and proud of themselves. It had been a very short, straightforward birth, and then to be interrupted and forced to go to the hospital. One does question why that was enabled to happen when she hadn't done anything wrong and an assessment could have been made, perhaps via telehealth, rather than forcing them to the hospital. Of course, that meant she now won't engage with the system at all.

CHAIR - That's a terrible story. Thank you for sharing it.

Ms JOHNSTON - Thanks very much, Catherine, I appreciate your submission. You talk in there about your theory of an informed, supported, and confident maternity journey. One of the things I was reflecting on this afternoon is, we've heard a number of times from individuals who've submitted, who've talked about their birth experience and that, where their wishes weren't listened to, they knew that their baby was okay. They had that sense of confidence within their own bodies and what they could do, what they needed to do. Can you talk a bit about what confidence means in your theory in terms of empowering women and giving them agency in that? Is that part of it, appreciating that women know their bodies best and they are intimately aware of what's happening to their bodies during that birthing experience?

Ms BELL - Yes, absolutely. Each of those three elements - informed, supported, and confident - all intertwine. They can't be separated. And, they all form around effective communication. Effective communication fits in each of those categories, but the informed part is about that sense-making. This is about her integrating the information into her own context. That includes then being able to let the care provider know who she is, what's important to her and what she needs from the care provider, and coming to understand what the care provider can give to her.

That might look like early on in her care realising she's not aligned with the right care model, and she may need to switch to a different care model. But most women don't realise there's different models of care in that first birth experience. With the supported part of that, that's where relationship-based care really sits. Women all talked about continuity of care being important to them. But when they were talking about it, what they really mean is relationship-based care, not just continuity of either seeing the same person or same group of people throughout and having good handovers. They really wanted to build a relationship, an understanding of their care provider and have their care provider understand them - that feeling seen and heard was a critical part of what continuity care looks like. That's why I used the phrase 'relationship-based' very poignantly because that's what it meant to the women.

That then, in turn, builds into that confidence. They feel confident that they're being heard and supported. They feel confident that they understand the skill base of the clinician and what is available in their facility, so their expectations align with reality. That can help them to accept some of those difficult scenarios if they arise.

All three of them are very intertwined. I've got a beautiful image I can send to you now that the thesis is submitted. If you want to see the final stuff, I can send that through.

Ms JOHNSTON - That'd be lovely, thank you.

Ms ROSOL - I've got a bit of a logistical question. In your covering letter with the submission, you said that you'd been asked to share it with us by consumers in Tasmania. Where's the Birth Map up to? I understand you've been doing the research. Is it a tool that women can take and use now, or is it something that you're doing more research on? What's the process for women being able to access it and use it?

Ms BELL - It is absolutely available now. I have a website where women can access it for free and there's a version of the game. It's very rudimentary because I haven't had an influx of dollars. There may also be a requirement to outsource some of the technical aspects. I do have a brilliant vision for where I can take the digital side of it, but at the moment it's available in its book form. You can read it for free online or you can purchase it as a book or a digital book. I would like to develop it further but, in the meantime, it is currently available.

Mr FAIRS - In your research, Catherine - and we've heard a lot of it in this Committee, with the health officials and hospitals and things like that, obviously they have to cover themselves legally. They're afraid of getting sued or things like that. Is that why, in your experience, that we have a lot of this? We've heard severe cases of people not doing their jobs properly and things like that, but the fact of the matter is that police escorting mum and baby to hospital and stuff is to cover their backsides?

Ms BELL - Yes, that was a big undercurrent that came up repeatedly within the literature, that one of the biggest concerns was around liability and fears around - insurance-driven birth might be the phrase that has come up in that space. This is why, in my recommendations from my study, I think we absolutely need a systemic change that supports care providers to be able to support the women in the way that they want to support them as well.

CHAIR - I think you've kind of answered it already, but for the success of the Birth Map to really flourish and be given its best chance, how vital is it that there's significant support and buy in from health professionals individually but also from health systems more generally, in terms of heads of hospitals, people who coordinate university courses for medical students, midwifery students and allied health professionals who might be involved in something holistic and broad like the Birth Map is? What are the barriers or the challenges to getting that buy in at the system level, from health system heads, individual practitioners and universities and training facilities?

Ms BELL - When I started out the study, I really did hope that the book on its own would be the problem solver. Yay, you give women a copy of the book, problem solved; communication runs freely. It's all good. But the barriers that they came up against show that we do need to build a bridge from both sides. The resourcing of the women takes us halfway across the harbour and we need to bring the care providers across with the other half. That really does look like embedding it within curriculums, putting it into policy, making sure that it is part of every aspect of the care or the education and practice that they're going through. It doesn't necessarily have to look like a module in one class, but something that's embedded as a procedure, a protocol, a credo, if you like, throughout their education and practice.

The biggest barrier is the logistics of getting the resources to women en masse. What I have found is that for a lot of very motivated women, they'll seek out the book and do the work and be quite happy. But there's a lot of women who are waiting for the care provider to give them permission. Even in the study, women who opted to be in the study were waiting for the care provider to engage. That often didn't happen until the 36-week appointment, and even then it was fairly limited. So, it needs to be written in as a protocol that we're going to walk together on this journey, ask some questions and build that map together. We really do need to resource the practitioners in some way.

I would love to see buy in by the health system. That's the bit where I don't know how that bit works, whether it's at the top, in the middle or whether it has to happen in the sporadic one-conversation-at-a-time way.

But the research is done, the product or the solution is there and it can be developed to meet the needs. Westmead has indicated that one of the biggest challenges is going to be translations. That's a very expensive process. They put the figure of about 150 - probably about every language on the planet is represented in western Sydney. In order to do it with cultural sensitivity, you translate it. But it also needs to be placed into the context of those different cultures that we're working with, which is a beautiful opportunity to enrich that multicultural background that Australia now has where care providers can then actually step into the context of those families they're working with and perhaps understand a bit better where they're coming from because the communication will hopefully be facilitated in a more welcoming way, which the framework is designed to do.

If it's not embedded within the system, we do potentially run the risk that the Birth Map won't gain the power that it could potentially have, and it could be similar to birth plans: it's only as good as the care provider is willing or able to engage with the process.

Ms ROSOL - I'm just thinking through the Tasmanian consumers, the women who know about the Birth Map. Were any of them included in the research you did?

Ms BELL - No. Tasmania was the one - oh, there were Tasmanian participants but not in the complete follow-through, so I can't share a specific Tasmanian experience with you.

Ms ROSOL - Okay, because I was going to ask if you have any indication of how many women might have downloaded it and what their experience of it has been?

Ms BELL - I could get that information for you from my website. I should be able to give you some numbers about the number of Tasmanian women who have engaged with.

Ms ROSOL - That would be really interesting to hear about what it's been like here.

CHAIR - Catherine, was there anything else that we haven't touched upon in our conversation that you'd like us to hear or that you think we'd benefit from hearing about?

Ms BELL - We've covered everything that was in my statement and submission. Suffice to say that, as is in the original submission, the Birth Map protocol does meet the strategic directions of the National Maternity Services Plan. I know that it fits with several of the New South Wales blueprint recommendations and the recommendations from the New South Wales Birth Trauma [Committee]. It fits in with the different policies and strategies in other jurisdictions. That may be of interest or relevance, I'm not sure.

CHAIR - Thank you again for allowing us the opportunity to learn from you and to benefit from your years of research that go into a PhD. Congratulations on the submission. I look forward to referring to you as Dr Bell next time we interact with one another. I know what a massive amount of work goes into a PhD, so congratulations on that huge milestone and thanks again for allowing us to benefit from your research and knowledge.

THE WITNESS WITHDREW.

The Committee suspended from 3.52 p.m.

The Committee resumed at 4.16 p.m.

CHAIR - Hello, all three of you and 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 written submission you've provided, which members have received and read. Could I just ask each of you to state your names and the capacity in which you are appearing before the Committee?

Ms WERNER - My name is Monica Werner. I'm a Branch Councillor for ANMF (Australian Nursing and Midwifery Federation) and registered nurse at the Royal Hobart Hospital in cancer services.

Ms SHEPHERD - Emily Shepherd, ANMF Tasmanian Branch Secretary.

Ms TIEFHOLZ - Astrid Tiefholz, Branch Councillor at the ANMF. I'm also a registered nurse, midwife, and mental health nurse.

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

WITNESSES - Yes.

CHAIR - You would have read in the guide, but I'll just explain again that this hearing is covered by parliamentary privilege, which means that all three of you can speak freely. You can tell us anything that you want us to hear in any way that you want to without fear of being sued or questioned in any court or place outside of Parliament. The only exception to that is the protection doesn't extend to statements that you may make that might be considered defamatory if you refer to them or repeat them outside of the parliamentary process that we're in today.

This is a public hearing, so we are being broadcast. We know that there are members of the public watching online. We have had some people observe in the gallery. We haven't got any right now, but people could arrive and similarly media might attend or be watching online as well.

I will introduce the Committee. I'm Ella Haddad. I'm a member for Clark in the south here and I'm the Chair of the Committee. Cecily Rosol is a member for Bass. Kristie Johnston is a member for Clark. We have two members joining us online: Anita Dow, who's a member for Braddon, and Rob Fairs, who's a member for Bass. Nic Street is an apology today. He's a member for Franklin. So you have all political parties and independents represented and all areas of the state represented on this Committee. We're very keen for it to be a very apolitical and productive Committee.

Could I ask each of you to read the statutory declaration that's in front of you on the cards?

Ms EMILY SHEPHERD, TASMANIAN BRANCH SECRETARY, and **Ms ASTRID TIEFHOLZ**, TASMANIAN BRANCH COUNCILLOR, and **Ms MONICA WERNER** ,

TASMANIAN BRANCH COUNCILLOR WERE CALLED, MADE THE STATUTORY DECLARATION AND EXAMINED.

CHAIR - Thank you. There's only one other formality which is we've agreed to read a sensitive content statement into the *Hansard* at the beginning of each session, just recognising that some people are tuning in for individual segments of the day and might not have had access to this information at a previous session. As a Committee we recognise that during these hearings we may discuss highly sensitive matters that have been deeply impactful upon the lives of Tasmanians. This may be a trigger for individuals listening to or participating in these proceedings, and the Committee encourages anyone impacted in that way to contact service providers including Lifeline, Tresillian and PANDA, and those resources and others are listed on the Committee's website.

That's all the formalities. I invite you to start with an opening statement if you would like to.

Ms SHEPHERD - Thank you for the opportunity to attend today and thank you for accepting our late submission, which is appreciated.

The ANMF represents nursing and midwifery. We have over 8000 members across the state and predominantly are the industrial body representing midwives in Tasmania and, of course, branches across Australia.

In addition to our written submission, we wanted to highlight that we are incredibly concerned about the future for women in the state of Tasmania, both from a reproductive maternity service and also in terms of women's health care generally - and in support of women's role in caring for children. Since 2016, we have seen what the ANMF would describe as a degradation of health services and reproductive services, as well as maternity services. We have also seen significant challenges in the child health and parenting space, inclusive of mental health services in that, and also challenges in actually seeing school nurses implemented across the state as well.

Those concerns relate to the loss of training and education for midwives in Tasmania with UTAS ceasing to offer the postgraduate diploma of midwifery in Tasmania. We believe that has contributed to perhaps less uptake of midwifery in Tasmania with those wanting to train as midwives having to access that course through interstate universities. We also are concerned about the approach to maternity services across the state. Since 2018, we have had midwives raising concerns about maternity models, particularly on the north west coast, which is when concerns were first raised by our members about the integrated maternity service down there and requested at that time for an independent review.

Whilst that independent review was undertaken, the independent chair was obvusiouly interviewing staff with a senior member of the THS [Tasmanian Health Service] sitting in those interviews, so members felt they couldn't speak freely about the concerns. Unfortunately, that didn't result in a recommendation of maternity services to return to public hands, particularly the birthing aspects. There was a whole degree of concerns raised around that time around the safety and quality of care for women and babies and the disjointed communication between the public and private service. We are very pleased that that has now returned to private - sorry, public service, the birthing aspects, but there are still considerable issues from a staffing perspective.

Following from that, we are also concerned about the loss of the Mother Baby Unit at St Helen's Private Hospital, which we strongly advocated that the Tasmanian Government take over that site and continue those services for Tasmania. For reasons articulated at the time, due to the age of the building, that wasn't possible, but that has meant a significant loss of services to women and babies both from the care of a baby in the early stages, settling feeding, et cetera, but also with mental health concerns and also those mental health services. Obviously, there are those beds at the Royal Hobart Hospital in the south of the state, which we do not believe is adequate to meet the need, and Astrid might touch on that a little bit more in a moment, in terms of what was offered at St Helen's versus what is being offered at the Royal Hobart Hospital. We understand the commitment to the beds in the north of the state under a Tresillian model, which we welcome, but that doesn't address the ongoing issue and lack of services in the south of the state, both from the Mother Baby Unit but also in terms of those specialised perinatal mental health perspective.

Before I get to present issues, I will just touch on the concern that we have around staffing and recognising the importance of appropriate resourcing of services within maternity services, child health and parenting services, school nurses and paediatric mental health services - there are significant vacancies across all those services. It is having an impact on the safety and quality of care delivery. We are very concerned that when our members raise concerns in relation to staffing, often they are dismissed, which is really similar to the way in which we hear from community members who are women having their care and their health concerns minimised when they're trying to seek medical care. These are highly skilled professionals. They are advocating for women and for children and yet the concerns that they raise are not listened to. Obviously, the North West Integrated Maternity Service is one of those examples where we had really experienced midwives who'd worked for years in midwifery, had worked across multiple models in other states, saying, 'This is just not safe', and yet their concerns were not listened to.

We are concerned about the existing workload model in place for maternity, which is Birthrate Plus, which doesn't capture the workload associated with babies. I should qualify that to say that the model does capture tasks. If a baby has to have a nasogastric tube inserted or a blood glucose level inserted, then that 15-minute window is captured under the model. What isn't captured is that when that baby has a low blood glucose level and that midwife has to then go and either get formula or work out a plan of care, talk to the mother, do the counselling, et cetera, that whole episode of care is not captured under the model. That can sometimes be a huge workload and is an increasing workload that isn't captured.

That has given rise to some recent issues in relation to the Royal Hobart Hospital, which is why we called for the review, independent inquiry. Obviously, that has resulted in numerous recommendations and again highlights the fact that our members had consistently raised concerns at the Royal Hobart Hospital, through management, through us. It took us to go to the media to have their concerns heard and acted on. We do thank the [then] minister, Mr Barnett, for taking those concerns seriously and actually agreeing immediately to that independent inquiry, but there is a lot of work that needs to be done. It needs to be resourced and the midwives in that maternity unit and more broadly need to be supported.

The Midwifery Group Practice model, I just wanted to touch on that. It's a fantastic continuity model, but again, it's a model that isn't well supported in terms of resourcing. In the north of the state there is effectively an entire service run in the community in a continuity model of care. But, that particular program isn't recognised industrially with a nurse unit manager - who is effectively doing the job of a nurse unit manager but isn't recognised for the work that they're doing.

One of the recommendations out of the review - I talk in the submission about how the feeding challenges that many of our members report to us is extremely time consuming. Obviously, as midwives they do provide that support and guidance to women to commence their breastfeeding journey, but sometimes because of staffing constraints, they aren't able to spend the time that women need.

I had an example given to me by a community member, who was with her daughter in the North West Private Hospital just recently. She was offered some support and some instructions were written up on the whiteboard. Of course, when that baby was trying to feed and then the baby subsequently became unlatched, the mother couldn't get the baby to latch again appropriately and they waited for some time and couldn't get a midwife. Then that young woman chose to switch to formula. Whilst fed is best, and I absolutely recognise that, there are lots of reasons why people choose formula. At the same time, for women who do want to breastfeed, they absolutely should be supported to. We know the enormous health benefits that that means for both the baby and the mother, and they are lifelong. We should be investing in more lactation consultants and supporting people to actually breastfeed where they want to.

That leads me to the Child Health and Parenting Service [CHaPS]. Obviously, they do amazing work, but unfortunately, they too have struggled with staffing deficits for many, many years, particularly on the north west coast. Of course, they've suffered a major blow during the pandemic when a lot of the staff within the Child Health and Parenting Service were redeployed to vaccination clinics. That's meant that a lot of children during that period missed out on checks, perhaps not the initial checks up to the six-to-eight weeks, which were considered the critical checks, but a lot of these children have missed out on those checks. It's absolutely pivotal to have those early screening measures in place, because if these issues are not picked up for children in those checks, then it means that they may get missed, or they're attending school with hearing issues or whatever it might be that hasn't been picked up.

We're keen to also consider that a lot of those checks that have been missed – that school nurses are now required to pick up on those gaps. A lot of school nurses only work part-time and they're shared across schools. I think that if we are going to be relying on school nurses to be picking up, particularly the four-year-old checks - which often are not being conducted due to staffing - then we should be making sure that we have school nurses in every school, to ensure that those children are having those checks, and that any issues in relation to hearing hip issues, or whatever it might be, are actually picked up by school nurses.

Finally, I wanted to touch on the news today that Healthscope has chosen to withdraw maternity services from Hobart Private Hospital. This comes two years after they chose to withdraw services at St Helen's Hospital, including the Mother Baby Unit and those mental health services. It's incredibly disappointing for our members, some of whom were redeployed to the Hobart Private Hospital from St Helen's, and are now facing a similar scenario at the Hobart Private. Not only our members, we're also very concerned about what this means for women generally and their children, their babies, and their families and the broader southern Tasmanian community. I think it reflects a very worrying trajectory in terms of the vision for women and for maternal and reproductive services in this state.

In addition to our recommendations, we'd like to suggest to the Committee that there needs to be an urgent review of the long-term vision of the delivery of health services in Tasmania for women, including the reproductive, maternal, and support of our children in the early years, the first five years in Tasmania. It's clear that the state Government has for too long relied on private providers to deliver these critical services for women and children.

What we understand from today's announcement is that yes, there will be every effort made to ensure that women who are needing to birth will be able to access services, but it is a further removal of choice for these women. It represents a risk that if there is not a contingency in place for these groups, which are very vulnerable, they're a minority in terms of numbers, but they're also a minority in terms of gender and their age. We absolutely need to be sure that there are plans in place for the state and public health services to meet the needs of this population going forward.

We know that this is the opportunity to actually set up our communities to be healthy. If we don't start from conception or preconception to have discussions about what you do for a healthy pregnancy, what you do to have a well-supported birth, how do we provide appropriate education and training to families with young babies and children on healthy eating, et cetera - if we don't start here, we will continue to see the troubles that we have in terms of the enormous chronic disease burden and the over-reliance on acute health services moving forward. This is where we need to start and this is where the investment needs to be.

I'll just pause there. I know that both Astrid and Monica have experiences that they'd like to share.

CHAIR - Thank you for such a succinct description and so eloquently covering the entire field basically of the terms of reference of this Committee as well, from reproductive health right through to paediatric health.

I'd really like to hear from both Monica and Astrid with opening statements as well, so that we don't miss out on hearing the insights that you'd like to share before we move into questions, if you'd like to go that way. What works for you guys?

Ms WERNER - I work in cancer services. My role is a breast cancer nurse, which I've had for nearly two years now, but I've had a good 25 years within cancer services. What I've noticed, even though I'm not within the paediatric or the obstetric field, I'm still working primarily with women. The women who would come through, although we've made some ground with diagnostic breast imaging in terms of breast screening and the new diagnostic breast imaging service that's been set up, there's a cohort of women who are not within the public health service who are out of pocket. This is a barrier for them to have any abnormalities checked out. The two other private places that are within Hobart and provide that service, which are I-MED and Women's Imaging at Moonah, have out-of-pocket expenses. They're quite substantial expenses and they're a barrier to women.

What we're finding now is women are now presenting later in a breast cancer journey than they should have, which is impacting on their lives, their survival, their family, the mental health of themselves and their family. It's something that could be very easily addressed. Early breast cancer has 97 to 98 per cent chance of survival if caught early. We are now looking at some women who have metastatic disease, which is incurable, before it's picked up.

The simple issue of cost is the barrier. Opening up public health to women who aren't at a breast screen age, which is 40 to 75, you don't even have to have a family history. But say you notice an abnormality under the age of 40, so you're not breast screen age, you have to be out of pocket.

Ms SHEPHERD - I guess to highlight too, often you're seeing women with younger children or even babies -

Ms WERNER - Those are in fact often young women with young families. Some of them are of breastfeeding age. Some of them have kids who are at school. They may be single mothers. They have to look after their children during their breast cancer journey.

CHAIR - So tricky.

Ms WERNER - Again, there are no services for these women while they are having their treatment to support them. Because they don't have a healthcare card, I can't get transport for them. I can't get housework for them because they're outside that criteria.

CHAIR - Gosh. That's so hard.

Ms TIEFHOLZ - I'd like to add my perspective from a perinatal and infant mental health point of view. I have previously worked as a nurse at the Mother Baby Unit at St Helen's Private. I've also previously worked for many years as a midwife and lactation consultant at the Royal Hobart Hospital, and Calvary as well. I'm not currently in those roles. I work for a national NGO that provides perinatal mental health services for families across the nation, but we are purely telehealth.

From the experience I've had in those sectors, but also the conversations I have daily with families, there are a lot of recurring themes that I'm noticing. One is that with the staffing shortages in the acute maternity service setting, we're finding that a lot of the time midwives are so run ragged that they're able to attend to the basic caregiving needs of helping babies get born, making sure no-one bleeds to death, making sure that there are no critical incidents. But what’s really being eroded is the sense of midwife being able to provide that nurturing care, to help families become established, to help establish the breastfeeding journey and to take care for people in their mental health journey as well, both antenatally and postnatally.

This is particularly significant for women who are experiencing traumatic birth events, where debriefing, if it occurs at all, happens very early on in the piece when people are not neurologically capable of going through that trauma processing effectively. Further to that, it is often a very quick debrief from a purely obstetric point of view without that psychological follow-up that is often required. Those women are coming to us to try to get support. The support that we are offering them is often based via telehealth interstate. They're not able to get that support locally. If they are, it's often a significant out-of-pocket cost.

We are seeing some positive steps forward. I don't want this to be all doom and gloom. Some of the great things that we've seen happen in Tasmania in the last few years are the opening of the Gidget House out at North Hobart as part of the Gidget Foundation [Australia], which has been terrific. But again, the word is out now and the waitlists are growing and growing. It's a terrific service but we need more of it and we need it more embedded.

We have the Child and Family Learning Centres throughout the state in areas of identified socio-economic need. Those services are terrific where they exist. They are well-appointed, they have one-stop-shop approaches to child and family health, early childhood development and learning, particularly in the remote parts of Tasmania. They have wonderful spaces where visiting allied health professionals, paediatricians and others can come and meet with clients there. It's a very holistic way to approach child health, which is great, but we need more of them. That is something that would be really helpful to prevent the need for people to escalate into acute care settings.

However, when acute care settings are needed, we're limited in what we're able to offer people. We went from having an eight-bed Mother Baby Unit at St Helen's, to a two-to-three bed unit at the Royal. The news that Tresillian is opening a facility in Launceston is, of course, very welcome. Again, that's still only four to five beds statewide where we previously had eight. There are considerable limitations regarding the admission criteria for people to access those services here in Hobart.

There is a lot of work to be done. I would hope that we can look with optimism towards the things that we've achieved and how we can grow and improve upon them,but also recognising that so many of these aspects of care have become eroded over time. They're getting shifted either to the NGO or to the private sector, or people are just going without.

In particular, too, I think it's really important that when we're looking at infant and family mental health, it's not just the person who is biologically carrying and bearing the child. It is that person's partner, whether a male partner, female, or non-binary. It is about having regular check-ins with partners and families as well.

In an ideal situation, women during the childbearing journey are being assessed for their mental health throughout - antenatally, to a much lesser extent, postnatally - but it is a standard part of the care planning protocol. But no-one ever checks in with fathers or non-birthing parents. If they do, it's usually in such a way as to just go, 'Are you alright there?', but without any formal way to follow up or to actually sit down with that person in an appropriate fashion to actually get a sense of how they're going and knowing what to do if that's required.

That's a really important aspect. It shouldn't just be about being mother-baby centred care. It really needs to be family-infant centred care, parent-infant centred care, and recognising that there is a huge contribution of all members of the family towards the mental health and wellbeing of the mother and the baby and the family as a unit.

CHAIR - Thank you so much, all three of you for your insights. The information you shared with us today accords very closely with the evidence that the Committee's been hearing over several hearing sessions now. The themes that we're hearing reflect the challenges that you've described in the system, even with the very positive aspects that you've mentioned as well, Astrid, and some of the positive things that have happened. We are hearing those themes around women being equipped and having the information that they need to make decisions, what happens during birth events, what happens after birth trauma, debriefing, access to mental health support for all members of the family, access to paediatric health down the track. These things are coming out very strongly from the evidence that we've heard.

I suppose, one of the key challenges across all of those things - even when we are hearing really positive stories, for example, we've heard amazing stories about people's birth experiences, we've had great stories about CHaPS - but overall people are saying that the bits that they like we want more of.

It comes down to staffing challenges. You touched on it, Emily, around the challenges of staffing across the entire spectrum of the health system when it comes to maternal and family health. We know there's been an increase in an over-reliance on local agency staff across the public system, which costs the system more financially and makes services more stretched across the system.

I know there isn't a magic bullet, but I wondered if you have some observations that you'd be happy to share around what the solutions are to solving those really drastic staff shortage questions that we've got across the health system.

Ms SHEPHERD - More broadly, I suppose, in relation to solving that very big question, I think we focus a lot on recruitment. Rightly so, because we have a lot of vacancies currently across the health sector. That's not just public sector. It is public and private. That has obviously intensified since the COVID pandemic. We know it's not isolated to Tasmania; it's also nationwide. In fact, it's across the world in terms of nursing and midwifery.

We are very focused on how do we recruit, but I think we also need to focus on retention. We need to focus on valuing our existing staff.

Unfortunately, what our members would say is since the COVID pandemic and since everybody's thanked them for the work that they've done, that exhaustion, that moral injury and the consistent moral injury that they incur on a daily basis in not being able to provide the care that they want to provide to their clients, patients, families, et cetera, is having an enormous impact. They're exhausted and burnt out. Many, across all sectors, are reducing hours just in terms of self-preservation to protect their own health and mental wellbeing.

Our advice is that - and we have met, obviously, with the department and the minister about this - we actually need to focus on supporting existing staff. It was great that there was an allocation in this year's state Budget in relation to peer support programs. For many public sector nurses and midwives, there is currently no peer support program. There's an employee assistance program, which, when you're talking about maternal health care in a birthing setting, child health and parenting, these are really traumatic - they can be really traumatic episodes of care, and care of those in accessing those services. There's not appropriate mental health support for those individuals who might need specialised care from a mental health perspective.

We also need to support the workforce from the perspective of flexibility around workforce. Unfortunately, what we've seen is - almost a big stick approach is how we would describe it to existing staff, about these punitive measures around the use of agency staff, for instance. You can only employ them for three months even though there are significant vacancies. It's adding workload to our managers trying to staff services, having to do consistent applications and job cards to put in an agency staff member when they might have 10 FTE vacant.

We need to think about how we support existing staff. It may be that we need to be thinking about those workloads. We know, across the state, in maternity, obviously, in CHaPS, there's an expectation that our members in these settings continue to provide services to the community, and they do that because that's why they become nurses and midwives. They want to care for people. Ultimately, that care, that passion and that drive to serve others is consistently -

Ms TIEFHOLZ - Eroded?

Ms SHEPHERD - Eroded, but also, too, I would say, taken advantage of, to an extent, because we say, 'You need to provide care to this amount of this population or community group. We're now going to add in this as well. We want you to do this too. We're going to add this on as well'.

CHAIR - There's an expectation that people will just put up with that extra work.

Ms SHEPHERD - 'We're going to take it on despite the fact we haven't adequately resourced the services that we're trying to provide from the outset.' I think there's a lot of work to be done in that space around how we support existing workforce. I do believe if we can support staff in these settings that people who have reduced hours will increase their hours again. People want to come back and work, but we need to work on the culture. We need to work on trust.

Again, as we've said in our submission, we need to work in an environment where staff who are speaking up on behalf of their patients and their colleagues are actually heard and listened to. The Commission of Inquiry [into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings] was very clear around that. I feel that there is still a long way to go in terms of building that culture and that trust of our members. If we continue to see the types of protocols and policies that are coming out that are punitive and punishing existing staff, we will not make headway in that space. We have to turn that around.

CHAIR - With the time remaining, I'd like to open it up to the rest of the Committee as well.

Ms JOHNSTON - Just following on from that, Emily, in terms of - just keep adding to the workload and not extending resources to do it. Reflecting on today's announcement and recognising that, already, the workload at the Royal is stretched, and you've highlighted that you've been doing a lot of advocacy around that most recently. Calvary [Lenah Valley Hospital] has a limited capacity. Can you perhaps elaborate on the way forward in terms of the announcement today? Six hundred babies from Hobart Private - trying to squeeze those 600 babies into an already stretched public system here in the south, and at a small capacity at Calvary, what that means for your members in terms of their mental health and wellbeing right now and today, and moving forward and how that is supported? I can only imagine as a midwife it's like a big wave of tsunamis coming towards you.

Ms SHEPHERD - Absolutely. Aside from the personal toll, as I mentioned before, some of the midwives at Hobart Private have gone through the exact process at St Helen's. They're now facing it again at Hobart Private. It takes an enormous toll. Many midwives have become a midwife and worked at the Hobart Private for many, many years. That is where they want to work. They want to work in the private sector, but it is true that Calvary won't be able to pick up the entirety of that cohort of birthing.

Again, that means limited options for women. Obviously, in my opening comments, when I talked about the vision and the strategy to support women moving forward, we have to think more broadly about how we support women generally. But, in terms of birthing options, in my discussions with the Secretary [of the health department] around this, thinking about expansion of continuity models, but also thinking more flexibly about the state actually extending indemnity to privately practising midwives, which is currently not afforded to those midwives. I think that's a whole other discussion around the risk, but also the benefit, the enormous benefit that that could provide if we were to think more holistically about maternity care delivery.

CHAIR - We've heard from a number of Privately Practising Midwives [PPMs] and, also, a number of women who've experienced positive birthing experiences by using PPMs, and we've heard a lot about the insurance issue. My understanding is we're the only state that doesn't provide publicly funded homebirths. Do you know much about how that would work if it was implemented here? I think it used to be offered here until the early 2000s. I think there was a short period of two years where publicly funded homebirths did happen in Tasmania; they don't now. Whether or not there are models we can learn from in other states, if that was something the Government could look at.

Ms TIEFHOLZ - There certainly are hospitals on the mainland where they have - they're not privately practising midwives, they're homebirth midwives but they're employed by hospitals, so their care is administered under the auspice of that hospital. During the antenatal care that's done in the home, for some visits they'd be done in the clinic, particularly when there are ultrasounds and other procedures needed. Further to that, if there is an emergency situation during the homebirth episode, the transfer into the hospital is quite smooth because the information's there, the person is known to the hospital. The midwives are working as employees of the hospital but attending a low-risk homebirth, assuming all goes according to plan. Those models have been very well regarded and very well accepted by consumers in the community, but also by the midwives practising in that model. It gives them that opportunity for professional autonomy, but also a back-up plan if they need it.

Ms SHEPHERD - It's also about choice for women.

Ms TIEFHOLZ - It's absolutely about choice for women.

Ms SHEPHERD - There are limited choices and soon to be further limited choices for women.

Ms JOHNSTON - I think you said, Emily, one of the final recommendations was around a review of birthing services provision. Is that what - I can't quite remember what your wording was, it was a final recommendation.

CHAIR - The review that Guy Barnett agreed to.

Ms JOHNSTON - No, I think it was - you were talking about all birthing services in terms of model of delivery, I think. I'll have to check the *Hansard*.

Ms SHEPHERD - I think in that opening statement, there needs to be that broader review. There was a review done in 2018 regarding the North West Integrated Maternity Service -

Ms JOHNSTON - But a broader one.

Ms SHEPHERD - Yes, certainly. A broader one, and, as I say, a vision around including of birthing services. Thinking more holistically about how women can be afforded greater choice and how we actually meet that moving forward because, at the moment, it's really just - it's almost like a crisis response in terms of, we have our public services and we're really reliant on those other private providers. But, I think moving forward, there has to be that confidence that women have the option to birth how they choose to and not have the rug pulled out from under them because a private provider decides to shut up shop on the turn of a dime.

Ms JOHNSTON - To alleviate the vulnerability that we have at the moment in the existing service provision.

Ms TIEFHOLZ - I think it's also really important that we learn from the closure of St Helen's. We lost a lot of psychiatrists at that time. We had psychiatrists who left the state, who retired, who are just no longer practising psychiatry with the local community. That was a huge loss to the mental health services community, both public and private. It also meant that there was this need to be able to absorb the consumers of those services in other services that were themselves already quite overstretched.

I'm very concerned that following on from this closure of Hobart Private, we might also see an exodus of obstetricians and gynaecologists as a result of that. That would just further exacerbate the skills shortage that we so desperately need.

CHAIR - Especially if people start cancelling private health insurance policies, which they may well do after decisions like this from private providers.

Ms TIEFHOLZ - For sure.

Ms WERNER - We're not training our own midwives here.

CHAIR - Yes, we'll have to come to that as well, but I think we're running out of time. I had a big list of questions. I feel like we need to keep talking all evening.

Ms WERNER - I think when it comes to staffing, we've got to make nursing and midwifery attractive again. At the moment, it's not. We're burning out our new grads. We've got new grads crying and saying, 'I hate my job,' and they're leaving. While we're being told that there's active recruitment, we're not keeping up with the exodus.

CHAIR - Numbers who are leaving, that's right.

Ms WERNER - We get contracted staff from outside of Tasmania. They come in because they're told it's a beautiful state and it is, but when they hit the floor and start working -

CHAIR - The working environment's very challenging.

Ms WERNER - where our conditions are inferior to anywhere else in the country and they're getting flogged and -

CHAIR - They're exhausted.

Ms WERNER - they're burnt out. We're not retaining our grads. We're probably not even recruiting into UTAS for registered nurses. We're not even conducting a midwifery course here within the state to keep our own at home.

CHAIR - We are hoping to be able to hear as a Committee from UTAS. We've written to them. If there's time in the Committee's hearings, we'd love to hear about what possibility there is of reintroducing a midwifery course.

Ms WERNER - We really need to look after the kids coming out. As Emily said, retention is so important and we should be able to keep our own.

Ms SHEPHERD - Just on the training aspect, I don't want to sound critical with the University of Tasmania withdrawing the course because I certainly understand with the changes in curriculum and the enormous amount of work that does need to go into developing a course like that. For a very small cohort and small numbers, it is a lot of cost and expense. But, we need to think more broadly about how do we make that viable for the University of Tasmania -

CHAIR - And what it means for the future of the workforce.

Ms SHEPHERD - Exactly. As well as thinking about our child health qualifications for child health and parenting, other opportunities that might be part of a suite of courses that could be offered as an adjunct to that. Because, certainly, curriculum changing regularly and having to rewrite courses for a small cohort would be very difficult. I think, again, that comes down to that vision and strategy and planning about how we make the education and training, the service delivery, sustainable.

CHAIR - Thank you very much for everything you've shared with us today. I wish we had more time because I feel like we could benefit very much as a Committee from continuing to lean on your experience. Thank you for the time you have given us and for the written submission as well.

We'll stay in touch if there are other things as we reach our report writing stage. Equally, if there are other things after you leave today that you would like the Committee to hear, please get back in touch with us individually or through Mary. We're easy to find.

THE WITNESSES WITHDREW.

The Committee suspended from 4.58 p.m.

The Committee resumed at 5.04 p.m.

CHAIR - Hello and 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 time appearing today, and thank you, also, for the written submission that you've provided to the Committee.

Could I ask each of you just to state your name and the capacity in which you're appearing before the Committee?

Ms GREEN - My name is Emma Green. I'm the chair of the Australian Physiotherapy Association Women's, Men's Pelvic Health Tasmania branch.

CHAIR - Great, that's a mouthful. Thank you, Emma.

Ms BARNES-KEOGHAN - I'm Lizzy Barnes-Keoghan. I'm the chair of the Australian Physiotherapy Association Paediatric Tasmanian Committee.

CHAIR - Also a mouthful.

Ms BARNES-KEOGHAN - Not as much.

CHAIR - Thank you for that. Can I confirm that you've received and read the Committee guide that the Secretary sent you?

WITNESSES - Yes.

CHAIR - Just to remind you from the guide, the hearing is covered by what's called parliamentary privilege. What that means is you're free to speak to us and say anything that you want us to hear without any fear of reprisal or being sued or questioned in any court or place outside of Parliament. However, the protection doesn't extend to statements that you might make if they are considered defamatory and you repeat them or refer to them outside of these parliamentary proceedings. Within these proceedings you can speak freely and tell us whatever you want us to hear.

It is a public hearing, so we haven't had many members of the public here today, but we have for other hearings. It's not impossible that some could arrive and we know that there are members of the public and the media potentially watching online as well.

I'll just introduce the Committee. I'm Ella Haddad. I'm a member for Clark and the Chair of the committee. Kristie Johnston is also a member for Clark. Cecily Rosol at the table is a member for Bass. We've got another member for Bass online, Rob Fairs, but he may have just had to take a call that he was mentioning, but he's online and he's also a member for Bass. Anita Dow, who's online joining us from Burnie, is a member for Braddon. Nic Street is a member for Franklin, and he sends an apology for today. You've got all parties and independents represented and you've got a lot of the state covered as well. It's a pretty broad Committee.

Could I ask each of you to make the statutory declaration on the card in front of you?

Ms EMMA GREEN, CHAIR OF THE AUSTRALIAN PHYSIOTHERAPY ASSOCIATION, WOMEN'S, MEN'S PELVIC HEALTH TASMANIA BRANCH, and **Ms LIZZY BARNES-KEOGHAN**, CHAIR OF THE AUSTRALIAN PHYSIOTHERAPY ASSOCIATION PAEDIATRIC TASMANIAN COMMITTEE, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Thank you. Lastly, I'll read a short statement in that we've agreed as a Committee to read at the beginning of each session, just recognising people accessing the *Hansard* afterwards or those watching the online streaming might not have heard this information at the beginning of each other session. It's just a sensitive content support statement.

As a Committee, we recognise that during these hearings 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, and we encourage anyone impacted in that way to contact support services, including Lifeline, Tresillian, and PANDA. Those services and information contacts are listed on the committee's web page.

With those formalities completed, I just wondered if either or both of you would like to start with an opening statement.

Ms GREEN - On behalf of the Australian Physiotherapy Association, I would like to thank the Tasmanian Select Committee for its review of our submission and the opportunity to appear before you today.

Physiotherapists are committed to working with the Tasmanian Government to improve the health of Tasmanian women and children. Every mother and child across Tasmania deserves access to vital health services, including physiotherapy. In Australia, physios are the fourth largest group of registered primary healthcare professionals working across hospitals, private practices, and community health centres. However, many communities, particularly those in rural areas, have limited physiotherapy services, particularly specialist physiotherapy services such as women's health and paediatrics. This contributes to disparities in health care.

The APA supports a high-value, evidence-based, equitable and integrated model of care from prenatal care on the maternity ward, postnatal care, and early childhood care. Stronger investment in publicly funded physiotherapy and integrating prevention and early intervention into the management and delivery of care will help address health disparities. Targeted investment and realignment of funding priorities is critical to enable inclusion of physiotherapy services in the delivery of multidisciplinary care. To address entrenched inequities, we need to find innovative models of care encompassing physiotherapy to enable fully integrated care.

One in two Australian birthing parents experience some form of birth trauma. Appropriately trained and skilled pelvic health physiotherapists offer great value in the prevention, assessment, and treatment of conditions common in the pregnant and postnatal population, such as urinary incontinence, faecal incontinence, pelvic organ prolapse, pelvic girdle pain, and pain with sexual intercourse. There is strong evidence to support intensive supervised pelvic floor muscle training and perineal massage during pregnancy to reduce the risk of severe perinatal trauma and postnatal complications such as incontinence and pain.

Despite this, access to publicly funded pelvic health physiotherapy in the childbearing years in Tasmania is limited and becoming further restricted. Pregnant women in Hobart are offered a group education session to learn about pelvic floor muscle training, but numbers are capped, access is an issue as classes run during the city in business hours and access to one-to-one appointments is limited to those already experiencing severe symptoms.

When it comes to the inpatient setting, there are regular days where no physio is allocated to the maternity ward at the Royal Hobart Hospital. Physios are a vital part of the team on the board, especially with midwifery staffing and skill-mix issues. Physios are increasingly picking up on potential safety events such as mismanaged trials of void, where a woman is unable to empty her bladder properly. Physios also play a vital role in educating patients who've sustained physical birth trauma such as anal sphincter tears on how to optimise their recovery. Just this week I was contacted in my private practice by a woman who'd given birth at the Royal last Wednesday. She, unfortunately, sustained a third-degree tear and she was not seen by a physio prior to her discharge on Saturday. She was having bowel accidents up to eight times a day when she contacted me and was understandably distressed by this.

When it comes to postnatal care, up until last year, any woman who gave birth at the Royal Hobart Hospital could opt-in to a physiotherapy assessment at six weeks postnatal. Now, women must be referred by another health professional, such as midwife, child health nurse, or obstetrician, and only women with severe symptoms are allocated an appointment. These appointments were a valuable opportunity for women to discuss symptoms such as incontinence that they may not have disclosed to anyone else or that they may not have realised are common but not normal. The restriction of these appointments means many women are missing out on vital care and education at a particularly vulnerable period of their life. I'll hand over to Lizzy.

Ms BARNES-KEOGHAN - Paediatric physiotherapists work with families to support their child's development, especially in the first five years of life. The most common state-funded pathway to paediatric physiotherapy in Tasmania is via referral from CHaPS [Child Health and Parenting Service] or GPs. Parents are also able to self-refer to access paediatric physiotherapy services and there are a growing number of private practice paediatric physios, although most of those are in Hobart, a few are in Launceston and there are very few in any of our rural or regional areas.

As paediatric physiotherapists, we are often the first person to identify and discuss in detail a developmental delay with the family. There is simply not enough time or skills that our CHaPS nurses and our GPs have to have those conversations. This is a really challenging time for families, especially the birthing parent who - as Emma, and I'm sure you're fully aware, had spoken about - is processing the birth and likely physically and emotionally recovering.

These families are prepared to transition to parenthood or welcome a new baby into their family. They'd bought the books. They'd followed the Instagram accounts. They'd downloaded the apps that they thought would help. But, as their baby starts to grow, they realise that they're on a very different journey to the one that they had planned. There's a beautiful poem that equates it to, 'You plan a holiday to Italy and you end up in Holland.' It's beautiful, but it's very, very different. Paediatric physios are there. We're in Holland with those families, with the rest of the multidisciplinary team when appropriate, to provide that critical early intervention that supports motor delays, and identifies those longer-term developmental needs, including childhood-onset disability like cerebral palsy, autism, among many others. Most importantly, we walk alongside families, especially in those early years, as they navigate a journey that they never expected to navigate.

It is critical that fully state-funded physiotherapy services for early childhood screening and interventions are easily accessible to Tasmanian families. St Giles currently holds funding for state-funded paediatric physiotherapy in Hobart and Launceston, and North West Regional Hospital holds it in that region. There is a huge demand on the state-funded service with wait times currently upwards of four months for paediatric physiotherapy. For example, a colleague in private practice recently recounted her experience with clients seeking private input due to being quoted excessive wait times, upwards of six months. In this instance, it was for a nine-month-old, despite not having the means to then pay for adequate intervention.

Paediatric services should be well integrated into the new Commonwealth foundational supports model, which is under development. There is significant wait time for Commonwealth-funded services such as the early childhood approach of the NDIS [National Disability Insurance Scheme], with families waiting at least six months and often more from referral. As such, there is a state-funded gap therapy program to try to fill that gap between public and the NDIS, but it is limited to really strict inclusion criteria due to trying to balance the waitlists with the need for intervention. And, while it fills some of that gap, children and families who need physiotherapy support are forced to seek private options or just simply go without. For example, this beautiful baby boy who I was working with just before I went on maternity leave had waited for over 12 months for NDIS funding. The family didn't have means to access private supports. Though we made attempts to fill the gap through state-funded services, but, ultimately, this child, this poor little boy missed out. He didn't have a single book read to him until after his first birthday when a physio could visit his house, figure out how to get him to sit up, and suggest to mum and grandma that now would be a really good time to read a book. His mother could have been supported at so many points during her parenting journey due to difficulties through almost every step from pregnancy planning, conception, pregnancy itself, the postpartum period, and now through her matrescence and her journey into parenthood. But, unfortunately, because of massive gaps throughout the funding process, she just didn't have that support.

I think this case really highlights the importance of women's care throughout transition to parenthood and, in particular, how paediatric physios are a vital piece of that puzzle in optimising outcomes for children and families. Thank you. We'll take questions.

CHAIR - Thank you, both. That was so illustrative of the importance of your sector and the effect on families right from pre-perinatal through to early childhood.

You both touched on the services available in the public system. You mentioned that there used to be appointments that stopped about a year ago in the public system and now a referral is required. Can you just talk us through, in a bit more detail, when and why those changes happened in the public system?

Ms GREEN - I have a surface-level knowledge of it. It happened while I was on maternity leave myself. I went off on maternity leave in October last year and we were still offering those appointments. I returned last week and we are no longer offering those appointments. It was a decision that happened outside of my time.

CHAIR - Were they previously offered through the public health system or did the public health system purchase them, for want of a better word, through your private practice for public patients?

Ms GREEN - No. Those appointments happened either at the Royal Hobart Hospital or Glenorchy Health Centre. We have a physio who works there one day a week. Any woman who'd given birth, and it could be within the previous 12 months - it didn't have to be at that exact six-week mark - could access - we call it the six-week check, but it doesn't have to happen at the six-week mark.

Lots of women would come to us just to get checked because they're wanting to get back into sport or they value their health and they want to know what's going on. Other women would come with troublesome symptoms. Sometimes they'd come with a symptom that was just like a little bit niggling, and we'd say, 'Okay, come back in another six weeks,' and it either got worse or it got better, and we could guide them through return to exercise, through return to work, through dealing with a baby who used to weigh 3 kilos and now weighs 10 kilos. All those sorts of things.

Now, those appointments are only reserved for people who get referred to us -

CHAIR - With significant symptoms?

Ms GREEN - Yes. Usually, by six weeks-ish, people have lost contact with their midwife, so we're not really getting referrals from midwives. They often do see the GP at six weeks, but often that appointment is more focused on the baby than on the mum. Lots of women still go through years of motherhood thinking, 'Oh, it's just normal to leak urine after I've had a baby'.

CHAIR - That was my next question. How often the patients that you see through your practice put up with what could be results of minor or major birth trauma just thinking that's part of motherhood?

Ms GREEN - It's increasingly common, especially in my private capacity. I see a woman who's maybe six or 12 weeks postpartum, and then a few months later I see her mum or her sister or auntie because they're starting to talk about these things now, but that's privately. We can't offer that publicly.

CHAIR - I had one other question that I wanted to come to before we open it up to the whole Committee. It comes out of your written submission. You've provided in the third section a really useful definition, I suppose, of physical birth-related trauma that can and does happen to women. In the information that we've received so far from the Department of Health - and we haven't had them at the Committee table yet, we will later, but we've had some written correspondence with the department. They also provide a written definition of physical birth trauma. I won't go near psychological birth trauma because they have provided a bit more information about that. They define physical birth trauma simply as, 'a third or fourth degree perineal tear'. I wondered, from your professional experience and from your written submission, obviously, you've provided a lot more examples of what can constitute physical birth trauma. If you can just talk us through what you think the Committee would benefit from hearing around how we might arrive at a suitable definition of physical birth trauma.

Ms GREEN - Certainly a third- or fourth-degree tear, or obstetric anal sphincter injury is it's other word, is a type of birth trauma. But people can have a third- or fourth-degree tear and have no symptoms and get on with their lives. People can have a first- or second-degree tear and be really disabled. So, I guess the things that we see are a lot of are urinary incontinence, when people are leaking from the bladder; faecal incontinence; pelvic organ prolapse, where people feel a sense of dragging or heaviness or bulging around the vagina.

Pain is another big one that we see. Either perineal pain, people might find they can't wear skinny jeans or tight undies anymore because there's something rubbing against their perineum, or they might have pain around their coccyx. Some people can fracture their coccyx even, giving birth, which is certainly a type of physical birth trauma. Pubic symphysis dysfunction, so at the front of the pelvis where the bones join together, that can become separated or the ligaments can become damaged, either during pregnancy or during childbirth. Pain with sexual intercourse is another big one that we see as well.

There's certainly more to it than just third- or fourth-degree tears. That's the easiest one to capture within the statistics because you know at the time of birth if somebody has had that.

CHAIR - The others might take longer to present.

Ms GREEN - Yes, exactly right. Even today in my work, I saw two women who were two years postpartum and had only just started having issues in the last couple of months. Sometimes these things take months, years, or even around the time of menopause or post-menopause to present. We know that there are certain risk factors associated with birth, like if women are pushing for a long time, that is associated with risk of prolapse or levator avulsion, where some of the pelvic floor muscles come away from the bone. Certain positions that people birth in can create risk as well.

The thing for us as physiotherapists that we can offer is that we know that doing pelvic floor exercise that's supervised and intense during pregnancy can reduce the pushing phase of labour, so we can reduce the risk of the sequelae. The other thing is perineal massage, which is the technique that we can teach women in the later phase of their pregnancy. That reduces the risk of third- and fourth-degree tears and reduces the pushing phase of labour as well.

Ms ROSOL - I was going to ask, you talked about how there are the group sessions available. Is there any other space? I'm thinking if women are going to antenatal classes, in general, anyway, what's your interaction like with midwives, and where are the other spaces or places or ways that you could contribute in a woman's antenatal journey?

Ms GREEN - From our discussions with midwives, a lot of them don't feel qualified to give advice about pelvic floor training. They say ‘Ask the physios’. We do have handouts that they can give women, and our information is included in the maternity information package or the MIP - I'm not sure if you've seen that - that women get when they become pregnant. We also know that just verbally instructing pelvic floor muscle training, about half of women will be doing it incorrectly. You really do need that supervised assessment, or that individualised assessment, to know that your technique is correct.

Ms ROSOL - I had another question on a completely different topic. We have heard a lot about staff vacancies being a significant issue that's putting pressure on the system and meaning that services aren't available. What's it like with physiotherapists in terms of availability of physios?

Ms GREEN - For us, it's more that our positions are filled but we just don't have enough capacity to service what we would like to. It's not that there are positions vacant. We have the skill mix here in Hobart to fill the positions if there were more positions offered. Women's, Men's Pelvic Health is the fastest growing national group in the Australian Physio Association. There's huge interest from physios out there to take part in this area of physio, but we just don't have the FTE.

Ms ROSOL - So the need's there, the interest of physios is there, but the positions aren't there?

Ms BARNES-KEOGHAN - The same to be said for paediatric physiotherapists. Particularly in the past three to four years we've really been able to consistently fill spots and we just don't have the FTE. That's why we're seeing more private practices open, which comes with its own issues in terms of making sure staff is appropriately supervised and things like that. It's exactly the same as women's.

Ms JOHNSTON - Going back to Ella's point before about what's classified as physical birth trauma. Is that limiting then the referrals that are now being provided? If you have to now be referred to the system, is the public system relying just on their limited, narrow definition of what a birth trauma is to be referring for a physio?

Ms GREEN - Fortunately not. We do see more than just third- or fourth-degree tears. Those people do get an automatic referral from the moment of birth because we know that doing physio in that early period is so beneficial for them. But then there are those other presentations that may not show themselves until further down the track. That's when women would have to see their child health nurse or their GP to get a referral. You know what it's like in that newborn period, where so much of the focus is on the baby when it comes to child health appointments and GP appointments. Women often do put themselves second and then it's not until two years down the track that they think, 'Okay, I have the headspace to actually focus on myself,' whereas, when we didn't have the barrier of having to get a referral to come and see us, it was one less barrier.

CHAIR - Yes. It seems strange to put a new barrier in place when one didn't exist.

Ms GREEN - Yes, I mean, it's a capacity issue. I guess as pelvic health physios, it's not just pregnancy, maternity, postnatal that we do, we see a lot of other bladder dysfunction, pelvic floor dysfunction. We do paediatric continence, so lots of other areas to cover as well.

Ms DOW - I have a question. I've just taken my camera off because I found that the reception wasn't very good, so I'm sorry about that.

Thank you very much for your submission. It's really comprehensive. The question that I have is that you make reference to a model of care which includes lactation consultants, pelvic floor physiotherapists and paediatric physiotherapists as being a wraparound model of care for women and babies postpartum. I wondered if you could tell us if there are examples of a model like this in other jurisdictions across the country, and what you would see as being the benefits for that. I think they're pretty self-explanatory, but for the purpose of our Committee, if you could just outline that for us, that would be very useful.

Ms BARNES-KEOGHAN - I can't think of anything off the top of my head other than there's one private practice - I don't know its name, it's in Melbourne - and they're working on that kind of model, where bringing, as Emma just alluded to, so much of the focus in that newborn phase is on baby, but trying to bring services for baby and mum into the same setting. That's really what the benefit of combining lactation consultants with pelvic physios, with paediatric physios, GPs, CHaPS nurses, whoever we can in the one building so that you can have your six-week check for mum and also have a six-week check for bub and also get them immunised and do a weigh and check your pelvic floor, and all of those kind of things in one kind of space.

CHAIR - It would make life a lot easier.

Ms BARNES-KEOGHAN - That would be fantastic.

Ms GREEN - I guess for people who are not close to Hobart, at the moment options are so limited. We offer services at the Royal [Hobart Hospital] but who wants to bring their six-week-old baby and try to find a park on Argyle Street? We do one day a week at Glenorchy Health Centre and there are some appointments offered at the Community Continence Service in Rosny as well. What we would love to see is more outreach into community health centres in the northern suburbs or down the Huon Valley or down the peninsula, to further reduce those barriers for people seeking care at such a vulnerable point in their lives.

Ms DOW - I wanted to ask one more question that follows on from that, Cecily, which is about the availability of your services in the north west, whether there are outreach services.

Ms GREEN - My understanding is they're offered at the North West Regional Hospital. There is a pelvic health physio up there who I went through my training with. I'm not sure what the FTE is up there, but it is available.

Ms DOW - Thank you, sorry Cecily.

Ms ROSOL - No, that's okay, I was thinking about the Child and Family Learning Centres (CFCEs), because we've heard quite a bit about them being spaces when we have had some conversation about paediatric health support and services, about them being a space. From what you're saying, physio is not available in those spaces yet. Have there ever been conversations about that and could you comment on that?

Ms BARNES-KEOGHAN - Because St Giles - the way that the paediatric physio works here, it's contracted to St Giles. St Giles runs outreach in some, and some of them are Child and Family Learning Centres, some are the national ones as well. There are a couple across the state. We have New Norfolk, Sorell, Huon Valley, I think are the three main ones where St Giles provides services. That's not really that many in comparison to all the people in Tasmania - providing services there. St Giles is always just trying to stretch its FTE that it's allocated as far as it can. It has to try to fill all those gaps and meet the NDIS where it's at and that kind of stuff as well.

I think there is scope to use the CFCEs much more than is currently being used for physio paediatric, but potentially also women's. We know that the midwives and CHaPS, they practise out of there and it's a beautiful space, and you start that journey of motherhood before you've given birth and you can continue it through, which I think could be potentially very powerful.

CHAIR - Anita or Rob, did you have any other comments or questions?
Ms DOW - No, thank you, Ella.

CHAIR - Is there anything that hasn't come up in our conversation that you'd like the Committee to hear or be aware of?

Ms GREEN - Probably the only other thing that I haven't mentioned is that there's been a lot of discussion around both the public and private and physios in Hobart on training for trauma-informative care. I'm not sure if that's come up in the midwifery chats, but we do deal with lots of different types of trauma, whether that's the physical birth trauma or the psychological trauma of birth. We've been crying out for that sort of training for years now. I guess our management hasn't been that supportive of providing us with that. I think it would contribute a lot more to our ability to do our job well and to do our job looking after ourselves as well, because we are exposed to a fair bit of vicarious trauma, which you would have been through this Committee as well.

CHAIR - Is there a clinical supervision built into your practice generally, like there is for mental health workers and some health workers?

Ms GREEN - We don't do it formally, but certainly informally, we have sort of quarterly case discussions and meetings and things as well.

CHAIR - Thank you. If you do think of other things after you've left today, which is very common - you'll go home, be cooking dinner and think, 'Oh, there's something that we wish we'd mentioned' - please get back in touch with us individually or through Mary, our Secretariat. We'd love to keep in touch and hear other information that you would like the Committee to be aware of.

THE WITNESSES WITHDREW.

The Committee adjourned at 5.32 p.m.