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THE HOUSE OF ASSEMBLY SELECT COMMITTEE ON REPRODUCTIVE, MATERNAL AND PAEDIATRIC HEALTH SERVICES IN TASMANIA MET IN ROOM 3, HOTEL GRAND CHANCELLOR, LAUNCESTON ON WEDNESDAY 19 FEBRUARY 2025.

The Committee met at 9.03 a.m.

CHAIR - Formally, welcome to today's hearing of the House of Assembly Select Committee on Reproductive, Maternal and Paediatric Health Services in Tasmania. Thank you for your written submission and the information you've provided us. Could I ask you to state your name and the capacity in which you are appearing today?

Ms SMITH - Yes, my name is Jaimee Smith, I'm an endorsed, privately practising midwife based here in Launceston, so I'm just here to share my perspective on the maternity services in Tasmania.

CHAIR - Great, thank you. This hearing is covered by parliamentary privilege, which means that you are free to speak and say whatever you want to say to us without fear of being sued or questioned in any court or place outside of Parliament. That protection doesn't extend, though, if you make statements that may be defamatory and then refer to them outside of these proceedings today.

As I said, the hearing is public, so media and public could come. We did have a journalist attend yesterday, but yes, technically this is a public hearing, so there might be people that join us, but no one's watching online.

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

Ms JAIMEE SMITH WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Thank you, and just for the sake of anybody reading this *Hansard* later, we have decided as a Committee to provide a sensitive content statement at the beginning of each hearing and I'll just read that in for the record.

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 and supports on the lists available on the Committee website. We also have clinical support available here from Gidget Foundation Australia on-site, just next door in our adjacent room.

So, that's all of the formalities out of the way. We'd just really love to invite you to start with an opening statement.

Ms SMITH - Great, thank you. Yes, I guess my perspective is that I wanted to show the positive side of maternity care and how it can be done really well in Tasmania because that's my experience.

I'll just briefly go through some of my submission. I'm a privately practising midwife, I'm endorsed. What that means - I'm not sure if you're aware of all the ins and outs that midwifery -

CHAIR - It'd be great for you to explain, thank you.

Ms SMITH - So, midwives in Australia are registered and can technically practise in any setting, but to practise outside of an employment setting or to be self-employed, we have to have insurance. The only way we can be insured to work privately in Australia is to have an extra qualification called endorsement. So, you go back to university for six months, study pharmacology, do a prescribers, you have to have 5000 hours experience across the spectrum and then you can apply to our registration board, AHPRA (Australian Health Practitioner Regulation Agency), and get our endorsement. That enables us to get the insurance that we need to set up privately and to have Medicare access so we can offer rebates, antenatal and postnatal.

So that's what I am. Until a couple of weeks ago, I've been the only endorsed midwife working in Launceston for the last several years. I work out of the Launceston Birth House. It's Australia's oldest independent birth house. The model of care I offer women is full continuity from as soon as they want to book in with me, right through their pregnancy. I'm on call for their labour and birth and for six weeks and six days postpartum, and that's usually a home visit. So, it's really your gold standard continuity of care model.

We are really experts in normal physiology, where nursing and medicine, the underlying philosophy of that would be looking after sick, unwell, injured people. Midwifery's underlying philosophy really is we're looking after well women. Pregnancy, birth and postpartum is normal physiology. That's the perspective I come from.

CHAIR - That's a great way to describe it.

Ms SMITH - Yes, and I think that gets missed because midwifery gets lumped in with nursing so often. I'm also a remote area nurse.

In terms of how we offer service provision, it's night and day. I think that's where we're having so many issues, where women are ending up so upset and traumatised. The system is set up to get people in and out, and to keep women and babies alive. It's doing its job in that way, but it's not meeting women's needs, their emotional [needs], physical safety, their sense of wellbeing. That's where private midwifery really ticks those boxes.

Often we think it's unsafe to birth outside of hospital because that's our cultural narrative, and I used to think that too. However, we don't go to hospital to do a poo, or we don't go to hospital when we have our period if everything's well, and pregnancy and birth is often the same. Of course, physiology can turn into pathophysiology and then there's a problem and I'm so grateful that we then have experts and specialists when things go wrong.

I work really collaboratively with the hospital and the wider maternity network in Launceston. I've worked really hard to build trusting relationships and I feel they respect and trust me. I'm grateful for their backup when it's appropriate.

Midwives, but especially endorsed midwives, are really good at recognising when something is now not normal physiology and then bringing in the team of care providers, whoever that might be; it might be an obstetrician, it might be a paediatrician, it might be a physiotherapist or an osteopath or a haematologist. That's how I work. I would then invite people into the team to address that issue. I can still, then, offer good continuity of care, woman-centred care, individualised personal care to that woman and support her when she's engaging with other healthcare providers that she doesn't have a relationship with until that point. That really sums up what I do.

I was also going to say, I think I mentioned in my inquiry - letter or the submission - about the insurance issue. While I said we do have insurance, it only covers us for antenatal and postnatal care.

CHAIR - Not the birth event.

Ms SMITH - No. The [Federal] Government recognised that there is no insurance product for birth outside of the hospital. Therefore, they gave us an exemption back in 2010 to operate without insurance if the woman understands that, and as long as we tick all those other boxes for our endorsement. It is a bit of a problem. It keeps coming up every so often.

Back after the federal budget was announced, they obviously announced that they were committed to providing an intrapartum insurance product for us, which seemed like a really great idea, except I was immediately alarmed because it was really not fit for purpose.

CHAIR - We'd heard that as well from other practicing midwives and from the peak body.

Ms SMITH - It was really looking at kind of like a hospital homebirth program, which we don't have in Tasmania but in other states of Australia. The problem with that is it's very risk-based rather than woman-centred. Everything about midwifery is meant to be woman-centred, offering continuity and that trust and that relationship. If you tell a woman when she gets to 42 weeks, 'Sorry, you're out of the program,' her whole plan was to birth at home and suddenly she's - so that was the problem. I did jump up and down about it. I welcome an insurance product. I think midwives and women deserve that safety net but -

CHAIR - It needs to be fit for purpose.

Ms SMITH - It needs to be fit for purpose. That was my interest.

CHAIR - I'm showing my lack of detailed knowledge here, but I know that there was an announcement post-budget about an insurance or maybe a change to that, a recognition, I suppose, from the Federal Government that what they had proposed wouldn't be fit for purpose. Do you know if there's been any update since the time that you wrote your written submission?

Ms SMITH - Yes, this was before the update and the update was that they listened to us and said, 'Right, we'll extend your exemption now till the end of -' I think it's December 2026. They're hoping within that time to have more time to develop the right product, but we haven't heard anything about what -

CHAIR - Since then?

Ms SMITH - Since then.

CHAIR - I've got lots of questions but can I just keep on what you're talking about? Because one of the concerns that we've heard from other privately practicing midwives is that the insurance product that was recommended or suggested, I suppose, was a risk-based formula. It was explained to us that that's not fit for purpose because that risk category could change throughout a woman's pregnancy, even throughout labour.

Can you just talk us through why that wouldn't work so that the Committee is aware - obviously, it's federal government, but it's not impossible that we could at least make some comment about that in our report.

Ms SMITH - Absolutely. I actually had an example that I thought might help, like a case that I could share that shows exactly how that would play out where they came up with the risk categories based off the Australian College of Midwives Guidelines for Consultation and Referral. It's a big mouthful, but it's a little book that pretty much categorises anything that could come up in pregnancy, birth or postpartum as Category A, B or C.

Category A is low risk: midwives can care for that just fine. Category B suggests that we consult with someone else: it might be another midwife to get another opinion. Category C suggests that we - they are guidelines not rules or policies - bring in someone else or refer the woman to a more suitable care provider whilst - this is what got missed - staying as part of her care team. I believe that's what was misunderstood maybe at the Federal Government level. They seemed to think we would have to hand care over for that woman.

They were saying the insurance product would only cover low risk category A women and therefore no one else would be eligible for private midwifery care. I know private midwives from all around Australia, I mentor a lot of midwives and I contacted them. A lot of them sent their statistics in to me, because I thought how many of our women are only category A? It was less than 15 per cent. That would put us all out of business. We could not run our practices with only 15 per cent of our current load.

As an example, last year I had a woman, she's 36 years old, having her second baby with me, healthy, normal weighted woman, with a normal BMI [body mass index]. She had a homebirth with her first baby in 2020. It was a 4 kilo baby, but all was well. In this pregnancy she had her 20 week scan, which is called the morphology, and they discovered placenta praevia. The placenta was over the internal opening of the cervix, which means you cannot birth vaginally because the placenta is in the way. That would be a Category C. The baby was on the 90th percentile, considered a big baby, also a Category C.

At 28 weeks she developed iron deficiency anaemia, which is a common thing to happen in pregnancy. Babies start to suck up all that iron from the mum and she was symptomatic with that. That's also caCegory B/C. She also developed thrombocytopenia, which is an issue with her platelets that some women just have happen in pregnancy and her platelets were dropping. The way I manage those things to date, I sent her to see a haematologist to give her an iron infusion or excess and she ended up having an iron infusion and to monitor her thrombocytopenia.

I booked her in for a tertiary ultrasound at Women's Imaging in Hobart because we don't have tertiary scans in Launceston and often placentas move away from the cervix, so we did that. At 30 weeks, her baby was sideways so babies can't be born sideways except via caesarean and she had an irritable uterus where she looked like she was going into premature labour from 30 weeks.

At 32 weeks, she developed gestational diabetes -

CHAIR - What a rollercoaster.

Ms SMITH - This woman on paper looks like a very high-risk woman. She has a lot going on. She was highly motivated and she had had GDM (gestational diabetes mellitus) before. She managed that beautifully with diet and exercise. She knew what to do and didn't require insulin for that.

She still had an irritable uterus at 36 weeks when she had the tertiary ultrasound in Hobart. The placenta had moved well away from the internal opening of the cervix. Her baby was still in an unstable lie: it kept flipping from sideways to head down, and it was still measuring above the 90th percentile, a big baby.

A woman in the hospital system, if she'd had MGP (Midwifery Group Practice) or any sort of continuity of care model would have been shafted out of that. She would have been put in a high-risk clinic and she would have been offered or pressured to have an induction. Her birth and pregnancy experience would have been very different.

I manage all those things safely with appropriate care providers. We could not have had a homebirth if the baby was unstable or sideways and we had a plan for that. We had engaged with the hospital. She was happy with the plan, but at 40 weeks and two days, she went into spontaneous labour. Her baby was head down and she had a quick normal water birth at the birth house, which is a homebirth.

You look at someone's history on paper and say, 'Okay, she's really high risk'. Under that intrapartum insurance model I wouldn't have been able to keep caring for her.

CHAIR - From 20 weeks?

Ms SMITH - Yes, from right back then.

CHAIR - You would not have been able to continue to have her in your care. That is a great illustration.

Ms SMITH - Showing how the guidelines would be misused, they are meant to guide us and help us, to be an indicator. Okay, bring in someone else, manage this, don't just ignore it. When done well, it works really well and women can be really satisfied. It really addresses safety, not just physical but emotional, cultural, spiritual. She had her three-year-old son in the room when she had her baby and it was just a really beautiful birth.

That is an example of the risk categories and how they should be utilised and why, as private midwives, we do not want to be limited to risk-based care, we want to be able to offer

woman-centred care – when women do not get traumatised by having things imposed on them that they have not wanted or even necessarily needed.

CHAIR - That is a really great illustration of that issue regarding insurance and also explaining the way you operate as a midwife.

Another thing we've heard is women often opt for seeking the services of a privately practising midwife or homebirth options after having had a negative experience in the hospital system for their first birth. It might be their second or subsequent labours that they seek something different. Is that what you observed in your client base?

Ms SMITH - Very much so. Especially during COVID, it just skyrocketed. Without stereotyping people, we would have a particular cohort of people who would naturally always seek outside of the system care, such as private midwifery care. During COVID, we saw a lot of women. There was another midwife working with me during COVID. We saw a lot of women who would never have even considered looking for alternatives because their experience was so unsatisfactory and limited. Partners could not attend any appointments with them, children could not visit their babies in hospital, all sorts of things.

I know that was a big unknown for all of us. We were all trying to navigate that situation, but around Australia, women looking into alternative options skyrocketed.

I will sit down - I used to offer free meet and greets for any woman. I don't now because I am too busy. The stories I would hear over and over again were heartbreaking and do not need to happen. That's my motivation in being here.

I do not know exactly what it costs to have a baby. I do not know what it costs the government to have a baby in hospital. A normal birth I think is around $30,000 and private midwifery is approximately $5,000 to $6,000 and I would love to see more funding. At the moment, there is no Medicare rebate for homebirth. There is only rebate if a midwife has admitting rights, which no midwives in Tasmania have yet. It has not happened in Tasmania. I would be keen to see that happening because, at the moment, if I transfer a woman to a hospital, as soon as I step inside the hospital doors, I am not her midwife anymore. I am just a support person because I am not employed by the hospital. If we have visiting rights like some other states have, I could retain authority if you like, or I could be her midwife similar to what a private obstetrician does. They have their own private practice and they birth in hospital. We transfer women in and it is just -

CHAIR - An unknown.

Ms SMITH - A bit more challenging. Women cannot afford or access private midwives when they want to either. It is not affordable for them or there is just not enough of us.

A part of that is because there is no insurance. Midwives are too scared. It is a risk. I risk my house every time I go to a birth. I am passionate about it and relationship-based care makes me feel fairly safe because I do have a really trusting relationship with my clients, but they would have the right to sue me if I was negligent or I missed something and I did not care for them and there was an adverse outcome. I would love to see it be more accessible because it just eliminates so much of the trauma and the issues. This personalised, individualised care and it meets women's needs.

Ms JOHNSTON - On admitting rights, at the moment if you have to transfer a mother to hospital during labour, you said you can only go in as a support person. You have no rights as a midwife or no control. What has been your experience in those circumstances of how the hospital has responded to trying to meet the needs of the mother and to address issues like birth plans and wishes and things like that and how it might proceed? What has been your experience?

Ms SMITH - Hugely varied, and I will say the LGH has been incredibly supportive. When I first started in private practice there was a bit of a divide between homebirth midwives and the hospital. I worked in the hospital for years so I know what they would say about homebirth midwives. They would only see the problems coming in. They wouldn't see the 90 per cent of women who just had happy normal births at home. I understand their clouded perspective of that.

It took a little while but I feel like they're very supportive of me. They do trust me now and know that I work safely. I have deliberately worked hard to communicate with them even when there wasn't much in return to let them know of all the nice normal births we've had, just to help build that trust so that when I transfer a woman in we're not going in on guard and having to fight for what she wants. It's friendly. It's not like that in most places in Australia. Most midwives have a very difficult time with the transferring.

I would say, obviously some midwives and doctors are more receptive to a woman's preferences than others. Sometimes it's just that they don't know. I work closely with some private obstetricians too. They say their clients do need to do birth classes and obviously they're all planning to birth in hospital, because I don't try to convince everyone to have a homebirth. It's about what does that woman want. If she wants and needs a plan, booked caesarean, then I support that wholeheartedly. It's not that everyone needs to have an au naturel, Kumbaya homebirth.

I've had obstetricians call me and have a chat like they have had awful experiences having to pick up the pieces in other parts of Australia from homebirths that have gone wrong or freebirths where there hasn't been a care provider. I totally understand their bag of tools is to deal with things when they go wrong. They've probably never seen a homebirth. They don't trust it because they're not experienced in that and I appreciate that too. I try to go in with that respectful attitude of them and I let the women know ‘They really want to support you.’

I know in some areas private midwives are really anti-the-hospital, and vice versa. I don't think that serves anyone. I'm grateful to the hospital and I always say they will support you as well as they can. They don't necessarily have the same experience that I do. I can advocate for a woman in that environment. I'm familiar with hospital systems and why they're offering what they are, and I can help the woman understand that and then help her - she makes a choice that feels right for her.

Usually that's well respected here in Launceston. I'm really grateful for that because I know it's actually unusual. I think this is the best place in all of Australia to work as a private midwife. We have a beautiful house across the road from the hospital that women can birth in if they want, rather than at home or if they're too far away, and a really receptive hospital if we need them.

Ms JOHNSTON - I can't remember when we heard it, we had a lot of hearings here, but I think we heard someone suggest that they had never seen a normal, relaxed, happy birth until they'd seen a homebirth, a midwife who'd been practising -

Ms SMITH - A privately practising midwife, yes, we've heard that story.

Ms JOHNSTON - That's it. Do you think there's benefit in training the old midwives to provide that opportunity for them to experience multiple homebirths and to be participating in that?

Ms SMITH - Absolutely.

Ms JOHNSTON - As I understand it, training at the moment is very hospital-centred.

Ms SMITH - You have to do 5000 hours in the hospital before you can even apply to be endorsed and work privately. You could work as a second midwife. We have to have two midwives at every birth in a homebirth in case mum and baby need attention at the same time. The second midwife does not have to be endorsed, they can be any registered midwife, as long as they're up to date with neonatal resource. I haven't had endorsed midwives to support me, so I have just utilised hospital midwives for that role for the last several years. Lots of them are in the wings now, motivated and interested in doing their time and their training. So yes, I would love for students to be able to have that opportunity too.

CHAIR - That was my next question. I know students have to observe a certain number of births before they can complete their studies. Do students ever observe homebirths?

Ms SMITH - Yes, I've had lots contact me, even from as far as Germany. German midwives contact me all the time, 'Can I come and do a placement?' The insurance is the issue. Some universities are not willing, or able, to insure their students for - I don't know why, but they're not actually hands-on. Often it's not as easy as in the hospital, because the women have to agree to have someone extra there and they've often chosen private midwifery care because they want minimal observation. But absolutely, yes.

CHAIR - So technically, just anecdotally, a friend of mine who's now a privately practising midwife observed my second birth because she was studying at that time, and it was a hospital birth. Would her insurance have been provided through the university or through the hospital?

Ms SMITH - Yes. It depends if she's paid. They've introduced some paid prac for midwives who are training. When I went through, our prac wasn't paid and so our insurance came from the university. I'm guessing once the hospital's paying the midwives then they must have some insurance that covers them, but it's not for anything outside of the hospital. The uni would probably be better able to cover the students for that setting.

CHAIR - For students to observe a homebirth, that would be a university issue in terms of providing that insurance?

Ms SMITH - I think they could come and observe, but if they wanted to have it as one of their follow-throughs, students have to follow women through. That means they're actually providing some clinical care under supervision. I think that would be the issue. I think if it was

just observing, they could - of course, anyone, if a woman's happy, can observe a birth if they're not hands-on.

Ms JOHNSTON - Thank you.

Ms ROSOL - A couple of questions. You've written in your submission about the prescribing issues. Thank you for that. I guess just broadening that out a little bit, are you able to request tests and scans and things? You're endorsed for that?

Ms SMITH - Yes.

Ms ROSOL - They don't have to go to their GP?

Ms SMITH - No. We used to have to have GPs refer women to us and then we could book them in. That got dropped from 1 November [2024]. Women can self-refer to us now, which is fantastic. We've always, as long as you're endorsed - that's what the Medicare provider and prescriber number does. I have a script pad. I can write prescriptions, order all ultrasounds and blood tests. Obviously, I'm responsible then for following them up and acting on anything that may be different.

I think I mentioned the formulary in my submission. In Tasmania, and I think it was in other states, we're the last state to drop it. Each state's legislation - ours is the *Poisons Act 1971* - has a list of things that they determine that privately endorsed midwives are able to prescribe. It's kind of odd. I don't know how or who chose what's on it. There's morphine on that list. I would never prescribe morphine in a home setting. If a woman required morphine, we'd be going to hospital. But then there's some really other important things missing off it that we would prescribe regularly. Every other state and territory has now dropped that list that says we can only prescribe these things. They say that midwives can prescribe according to their scope and experience. I would love to see that dropped in Tassie as well.

Ms ROSOL - Do you know how long it's been since that's been reviewed?

Ms SMITH - I don't know if it has ever - I don't know in Tasmania if it has been reviewed.

CHAIR - We've heard through another Committee that a review is imminent.

Ms SMITH - Oh, great.

CHAIR - I hope that's true.

Ms SMITH - The Australian College of Midwives - I spoke to Alison Weatherstone who is Chief Midwife of Australia. She said that the college wants to work closely in Tasmania to help address some of these things this year and moving forward to kind of bring us up to speed with everywhere else in Australia.

Ms ROSOL - I'm curious about what your thoughts - I think you briefly referred to this happening in other states - but publicly funded homebirths. Are you able to share your thoughts on that?

Ms SMITH - Yes, absolutely. It's interesting. I've been speaking in a lot of midwifery conferences around Australia in the last couple of years. I was just at the HomeBirth Australia conference on the Sunshine Coast a couple of months ago. They have just introduced a publicly funded homebirth program up there. They had two people on the program to speak. It seems appropriate to speak at a homebirth conference on publicly funded homebirth. They were really shot down, the audience was very unhappy with the program. I felt sorry for the speakers because they were just the representatives of something that people have worked really hard for.

I don't know how I feel exactly. I see the benefits of both. It's a two-sided coin. I love that it makes homebirth accessible to women who can't afford private midwifery care. I would probably struggle to afford a private midwife. Certainly in Victoria, you're looking at ten grand plus. I love it for that reason. I love that hospitals are - and I guess it's a government thing - recognising that women can birth at home quite well and safely with good support.

The problem with it comes back to that risk-based, all the criteria that come with it. That's why people are upset in this audience because they saying women would get to 42 weeks and one day. A full term pregnancy isn't 40 weeks. It's 42 weeks, officially. Up until 42 weeks, that's considered a normal length pregnancy. In the hospital, they try to induce women before that because the induction process can take a few days. They will start an induction at 41 plus three or so, but up there, women would get to 42 and one day and they're suddenly off. They can't have their homebirth that they were hoping and expecting and planning for and then their options are to freebirth, which is to just birth at home without a care provider, or to birth in hospital, which they obviously desperately didn't want to do for whatever reason. Then they're ringing around all the private midwives, saying please can you look after me, and that's actually not safe for us either.

A big part of homebirth safety is we know the woman so thoroughly; we've spent nine months with her. I feel conflicted about it. I want to see homebirth much more accessible. I want to see midwives supported in that and hospitals aware and accepting of it. But I don't like the risk-based aspect of it. Up there, the sentiment was we're better off without it because it's just causing more trauma to women. Hardly any women end up getting to stay on the program. When they presented their figures, a lot of women suddenly were risked out - they developed gestational diabetes, or have had a previous caesarean. The caesarean rate in Australia is like 39 per cent, so lots and lots of women have those sorts of histories. A history of COVID - we've all had COVID - there's some funny things that, depending on the hospital and their policies, that women get risked out of that.

CHAIR - And is that the case in other states? The Committee has heard we are the only state without publicly funded homebirth.

Ms SMITH - Yes, we are. I know that it's also recently been expanded in Western Australia. I actually think Queensland do it best of anywhere. They seem to have been doing it longest and best. They have visiting rights for midwives a lot more easily than any other state, but yes, I think that's the problem. You hear that come up over and over, especially my perspective and interaction with private midwives, that's what I'm hearing, that they're sort of getting last minute calls from women.

Ms ROSOL - In theory, it's good to have publicly funded, but there's still too much regulation around it that goes against the theory.

Ms SMITH - Yes, and I get it. The hospital has the right to then determine the policies that the midwives operate under because they're employed by that, but ideally they would use guidelines like we have instead. The woman and the midwife can determine together what - it's hard. I know hospitals are actually businesses and they're looking at risk from a different perspective than women and midwives are. Yes, I feel mixed about it.

CHAIR - That's really interesting.

Ms DOW - You've talked a little bit about it, but one of the things we keep hearing as a Committee is about the attraction and retention of midwives across Tasmania and there being significant shortages. You've obviously had the experience to work in both private practice and in a public health setting. What are your thoughts on what it is that are barriers to people wanting to take on midwifery? Is it the structure of the course? Is it the fact we don't have a course provided by the University of Tasmania? Just some thoughts and reflections on that from you.

Ms SMITH - Yes, I was one of the last groups to go through UTAS for midwifery. That reminds me, I was going to say when I was speaking to you, our training is very woman-centred. Universities are really good at teaching midwives to be woman-centred and then we get out and practice and its system-centred. There is a culture that we have to fit into or we get bullied, or policies that actually aren't woman-centred and are outdated. We know it takes about 17 years for research to end up in hospital policy, so there's a massive lag there between best practice, evidence-based practice and the outworking of that in reality and so, I've actually started another business called the Midwives' Midwife.

Midwife means 'with woman' and midwives are burning out and leaving at a rate of knots, we're a million midwives short worldwide at the moment. I can't remember what the Australian number is, but we say it's the best job in the world. If you're a midwife, every midwife is like, 'I've got the best job in the world.' Yet, why aren't we keeping midwives? I think it's because of that mismatch between we do this as a profession because we want to be with women, we want to support women's autonomy and positive birth and pregnancy experiences and then, we're forced to work in a system that, like, 97 per cent of women in Australia birth in hospitals.

Most of us are birthing in hospitals and most midwives work in hospitals, but it doesn't support woman-centred, personalised, individualised care. The system has to run as a system. It's en masse. It's get you in, get you out, keep you alive. But that should be the bottom rung of the ladder. There's a lot more to what we offer them than just keeping mums and babies alive. I believe that's the problem. We have this cognitive dissonance where how we want to work and function doesn't align with our employer and the system we're working in. After a while that burns midwives out and makes them feel like they're being forced to work at odds to their own conscience. They're traumatised by what they're seeing and having to participate in, and decide to leave.

Ms DOW - Are you aware, maybe in other states or across the world, of different models of care delivery put in place to deinstitutionalise or de-medicalise maternity and postpartum?

Ms SMITH - A little bit. I know in England and probably in Australia most women used to birth out of hospital and then gradually the shift went to hospital. I've looked after a few women from the Netherlands and they say, over there, that everyone assumes you birth outside of hospital, unless there's a problem and then you go to hospital. That is how it should be; that

makes sense to me. That's how I operate too and that's what hospitals, doctors and obstestrician specialists are for. They're there for when something is wrong and there is pathology. A healthy, well woman doesn't need to birth in hospital. I like that model.

I know New Zealand is much more supportive and set up to offer homebirth. All midwives in New Zealand are trained, and I believe in England, I don't know if it's still the same, but certainly historically were always trained that you worked in home and hospital. You could be on a hospital shift and someone's having a birth at home and you're the one carrying the on-call phone, so you go out and support her at home. Having said that, New Zealand midwives don't get paid very well. We find they come over here because being on-call is hard and that model of care is really hard.

I've been on-call day and night for the last five years, basically without a break. I've just taken six months off because I was also burning out. It's hard because our job gives us such huge job satisfaction, especially in private practice. We know we're making a massive difference to women's lives, how they start their family, and you ignore your own needs because of the job satisfaction until you suddenly can't anymore. There are the two sides to that.

CHAIR - We could talk to you all morning, but our time has raced to an end much faster than I would have liked. It's been such a delight to meet you and hear your insights. Thank you. I can see why you were awarded Midwife of the Year. You've just encapsulated so much of what the Committee has heard so succinctly and to our benefit. We're hoping the report we provide to Parliament will be full of really implementable recommendations that will improve maternal health in Tasmania. Thank you very much.

Ms SMITH - Thank you.

CHAIR - Thank you for providing us with so much information and if things come to mind after you've left you think I wish I'd said that thing, please get back in touch with any of us or with Mary, our Secretariat, directly.

Ms SMITH - Likewise, if you have questions or as things progress, please get in touch with me too. I'd love to support what you're doing. I think it's wonderful and I am really grateful for the time and attention you're giving this.

CHAIR - Thank you very much. We're hoping to tour the birth house later unless there's someone giving birth.

Ms SMITH - No, she's not in labour and she's a primigravida- it is her first baby. She is unlikely to go into labour. We are all good. I'll see you then.

CHAIR - We'll keep our fingers crossed that we get to come through. Thank you so much, Jaimee. Great to meet you.

THE WITNESS WITHDREW.

The Committee suspended from 9.41 a.m.

The Committee resumed at 9.44 a.m.

CHAIR - Please start the recording. It's just a written transcript. There are microphones to create an audio recording that Hansard will use to provide a written transcript. If you want to give evidence to us in private, if during what you tell us, you suddenly think, 'Oh actually, I'd prefer not to have this on the public record', you can do that. Just request that of us at the time. There's a short formality that we need to go through to move into what's called in camera. Then we can hear that in private. There'll still be a transcript, but it won't be public.

We formally welcome you to today's hearing of the House of Assembly Select Committee on Reproductive, Maternal and Paediatric Health Services. Thank you for your written submission that you've provided to us. Could I ask each of you to state your name into the record?

Ms MARSDEN - Kate Marsden.

Mr MOHR - Timothy Mohr.

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

Ms MARSDEN - Yes.

CHAIR - This hearing, as you would have seen in the guide, is covered by what's called parliamentary privilege, which means you're free to say whatever you want to say to us without any fear of being sued or questioned in any court or a place outside of Parliament. The only exception to that is the protection does not extend if you make comments that might be considered defamatory and then refer to them outside of these proceedings. You can make the comments, but if you refer to them outside of the Committee in the media, for example, then that parliamentary privilege wouldn't extend.

It's a public hearing, as I have described, but we're not being broadcast online. There might be members of the public or the media that might attend. Could I ask each of you to make the statutory declaration that's on the card in front of you?

Ms KATE MARSDEN and **Mr TIMOTHY MOHR** WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - We also recognise as a Committee that the content of what we're discussing as a Committee can be highly traumatic and is highly sensitive and might trigger for individuals listening to or participating in these proceedings some pretty strong emotions. If anyone reading this in *Hansard*, or if yourselves need any support, we have lists of support available through Mary, the Secretariat, but we also have some clinicians onsite next door: Dr Erin Seeto and Ms Amelia Walker, who are from Gidget Foundation Australia. If you feel like you need that support afterwards, please don't hesitate to seek that support from us in the next room. That's all of the formalities done. We would like to invite you to make an opening statement.

Ms MARSDEN - Yes, I have something on my phone. Thank you for inviting me to take part in today's hearing. I gave birth to my first baby 14 months ago. What should have been an exciting time in my life has left me with permanent, physical damage as well as mental and

emotional trauma. This all resulted from the inadequate care I received at the LGH [Laucneston General Hospital].

When it comes to pregnancy, labour and birth, women are told to trust and listen to their bodies and to speak up if something doesn't feel right. My experience within the Tasmanian Health Service was that if you're a first-time mum, you basically don't know what you're talking about and so if you do speak up, your concerns will be minimised or ignored.

I was told several times to 'remain poised' and that if I was in labour I wouldn't be able to speak at all and that I just wasn't using the heat pack correctly. These comments were in response to me communicating escalating pain, increased contractions and increased fluid leakage prior to birth. Ultimately, I was left on my own without monitoring on me or my baby until it was not only too late for my scheduled C-section, but too late for any pain relief other than the gas. This meant that I was left to endure severe birth injuries with no pain relief on board, leaving me with a very traumatic birth experience on so many different levels.

Navigating motherhood for the first time itself is challenging, and to do this while trying to heal and find my way through a very broken health system has added a significant amount of stress and despair. At times I had been in a very dark place of shame, guilt, anger and hopelessness, as well as grieving the many special first moments of bonding that I missed with my son and my husband.

I wrote my submission with the intention of raising awareness of birth trauma and to support other women in sharing their stories, and to also bring attention to the painfully obvious gaps of care within the Tasmania Health Service. I hope that my submission might contribute to improved support and guidance for women post-birth, especially for women who have sustained severe birth injuries. I hope that my submission can also provide evidence on the coercion that can happen to women at their most vulnerable time.

Unless there is a threat to life, medical professionals should not be allowed to try to talk a woman out of her birth plan, especially when this birth plan has been made with past mental or physical health issues at the forefront. The Tasmanian Health Service needs to introduce significant change to ensure that women are heard and respected during all parts of their pregnancy journey.

CHAIR - I want to start by thanking you for sharing what is a deeply personal and traumatic experience. I can only imagine how hard it is to put that down in writing and to share it with us today. It is deeply impactful for us to hear it, and it will lead to us being able to make more informed recommendations as a Committee in the same hopes as you that we can actually make recommendations that lead to systemic change.

You've described very succinctly in your written submission that you had a very clear planned C-section, and then nothing went to plan. Are you able just to talk us through, as far as you're comfortable, those steps that happened where - you mentioned the word 'coercion' once you arrived in hospital and things didn't go to plan. Can you just talk us through that experience in terms of the different decisions that were made or that you felt that you didn't maybe have a voice in during that time?

Ms MARSDEN - Yes. It all kind of started three weeks prior. I had a bleed and we went to hospital. We had the same obstetrician who was there for the birth. Even three weeks prior,

she was very heavy on trying to convince me that I shouldn't have a C-section. It was a lot of using - like I said in my submission - things like, 'You'll likely send your baby to NICU [neonatal intensive care unit] because if he doesn't come out the vaginal canal, he won't expel the fluid and this is why babies end up in NICU'.

That was all three weeks prior, but he didn't end up coming early. Went home. Plan was still C-section three weeks later. When I first got there, again, she said all the same things and it was, 'No, I'm set on this'. She said, 'Think about it some more, I'll go away and come back'. Tim was like, 'Don't let her talk you out of it', because he could see that I was starting to think like, 'Am I doing the wrong thing?' When she came back and I said, 'No, C-section is what I wanted', basically, her reasoning was, first, that she didn't think that it was fair to ask staff to stay back because I wasn't in an emergency situation. Then I said I had actually eaten, because I wasn't due to start fasting until that night. It was like she was kind of a bit happy. She literally was like, 'Oh, well, you definitely can't have a C-section now and I don't think it's likely at nighttime because, again, it's not right to ask staff to stay back for you'.

Then I said, 'When will it happen?' and she said she didn't know, but she had lots to do now because I want a C-section. 'I have calls to make'. I kind of felt like I was being a pain, basically. Then I did ask her, 'What will happen if I don't get to that time and I start going into labour before then?' and she said ‘That's not going to happen. First time, mum, you don't have anything to worry about.’ Didn't get a chance to discuss anything.

Basically, I just sat there. She told me to go home. We went home and then I started leaking more and I was getting really bad pain, so I went back. I didn't see her again until I was in the birthing suite. I had a midwife who I saw lots of times, but there's no note of her in my medical records at all. I had told her contractions were increasing, requested pain relief, but she was the one who said, 'If you're in labour, you wouldn't be able to talk to me'. Kept telling me to remain poised over and over again, even though I was pretty calm.

CHAIR - That's a strange request of a woman in labour.

Ms MARSDEN - Yes. It was weird.

Literally, just nothing happened. That's why I wanted to make it obvious in my submission and in my complaint to the hospital as well that I understood I couldn't have the C-section. I would understand if there were emergencies getting in the way of that. That's fine. But I should have at least been able to have pain relief. By the time I had a midwife who actually listened to me and was like, 'Oh, this woman's in labour', it was too late. I was literally pushing in the hallway. It shouldn't have been too late for pain relief.

In one of my questions to the hospital, that I still haven't got answered was, why? Why did I not get any pain relief? There was no monitoring. I had the foetal monitor on me at 11.30 a.m. that morning and then not again. Not again until after my water's fully broke and I had to be taken to the birthing suite.

CHAIR - I'll open it up to all the Committee in a minute.

After your son was born, you said you've had questions to the hospital that you haven't had answered. Was there any support given to you after his birth postpartum in terms of the

fact your birth plan hadn't been adhered to, that you had experienced, obviously, significant birth trauma? Was there much support provided to you or offered to you in postpartum?

Ms MARSDEN - No. I literally had - the two doctors came in to me while I was like on my knees like pushing and screaming, trying to apologise to me. I just was like -

CHAIR - Too late.

Ms MARSDEN - get out of my face. I had that apology, I guess if you'd call it that.

Then, two days later, the obstetrician came and got me and said she wanted to discuss what had happened, but it wasn't really an apology. She said that she was sorry I couldn't have my C-section, but that was due to staff availability and the theatre was full. Then it was this long five-minute spiel about how she wasn't saying that the midwives weren't experienced, but if someone else was there then maybe I wouldn't have got such a bad tear. It felt like she was blaming me that I had a really good pain threshold and nobody would have known I was in labour, even though I was repeatedly asking for pain relief.

CHAIR - And saying you were in increasing pain.

Ms MARSDEN - I remember at one point I even googled the signs of labour and [it said] if you are getting around and walking does not relieve it. I got up in the room, I was walking, it was making it worse. I told that to the midwife and then that was when she said I should not be able to talk if I was in labour.

CHAIR - They were not checking for dilation at that point?

Ms MARSDEN - No. Nobody checked me apart from 11.30 a.m. that morning, and Philip was born at 10 p.m. that night. Nobody checked me again until -

CHAIR - You were literally -

Ms MARSDEN - I think one of the things that frustrates me so much is when I arrived, I was already dilated because I started dilating three weeks prior.

CHAIR - You were potentially at 10 centimetres at 11.30 in the morning.

Ms MARSDEN - Could have been.

CHAIR - Wow, but they didn't check?

Ms MARSDEN - No. After 11.30 a.m. they did not check. They did check when I arrived. Support wise, I had one really nice midwife who told me if these feelings last, you should contact a GP and see a psychologist. Again, that is really putting it on you. There was nothing. I ended up being referred to Walker House by my CHaPS [Child Health and Parenting Service] nurse at Philip's like six week check, and from there I got really good support. That was a shame that could not have happened from the beginning.

CHAIR - Thank you for sharing all of that.

Ms DOW - I was going to ask you more about that and you've touched on it a little bit and of having talked about your eating disorder in the past and obviously, the impact that's had on your life. Were there ever any conversations in the pre-maternal care you received about additional support after you had had your baby or what you thought you might need or nothing like that?

Ms MARSDEN - The first ever midwife that I had, she was great. We went through such a detailed history of everything and she asked me if I would like to be put in touch with, I forget what it was called, it was a post-birth group to get confidence and support for mums. I said absolutely. I forget what it was called though, but I joined that, signed all the stuff and then it was about a month beforehand they cancelled it due to there not being enough people and that was it. That was the only thing that I got. It was not actually anything.

Ms DOW - Your appointment with the physiotherapist that was meant to occur through the THS. I understand that it never did. Can you tell the Committee a little bit more about that?

Ms MARSDEN - The day after Philip was born, the physiotherapist came and she gave me an information handout and told me the importance of pelvic floor physiotherapy given the type of tear that I had and that she would call me two weeks post-birth to chat, which she did. Then she booked the six week appointment so she could have a good look and everything. I was really keen for that appointment because the day before was where I'd seen the LGH gynaecologist who gave me nothing. He told me like, 'Oh, you can discuss all of this with the physiotherapist because that's what she does.'

I was really hanging out for that and then the next morning got a text saying it was cancelled and I would get a new appointment in the mail and that just never happened. I did get a response from the hospital in December and they offered me a priority appointment a year later. Their reasoning was - administration issues were why I didn't get my appointment. I went and saw a private physiotherapist, which I'm really glad that I did. That was that.

Ms JOHNSTON - You said that once you got to your sixth week of waiting with Philip that you finally got some supports put around you at that six week point in time. As a first-time mum, you were sent home with a new bub, some horrific injuries to yourself. How did you - did you try to reach out to any organisations? You seem really confident at googling and things like that. You did that in labour, which is incredible. I don't think I could have done that. Can you talk about how hard that time was? As a first-time mum taking home a newborn bub, they don't come with instruction manuals and you're not well yourself. Can you talk more about how you experienced that six-week gap until you finally got in touch with someone who could offer some support?

Ms MARSDEN - I didn't really know where to look, to be honest, especially when I had that group that had been organised and then cancelled - that was the only thing that I had heard of. I really hung out for the CHaPS appointments, because she was so lovely. At the CHaPS appointments they do the mental health testing and all of that. It was at the review at the six week one and I mentioned that I still wasn't sleeping even though Philip was sleeping and then she suggested sending my details to Walker House.

I don't know, during that time - I was really lucky I had my mum come and stay from Sydney and I had a friend come and stay. I didn't know what to do. I felt like a lot of people in our family circle are quite cagey about discussing birth stuff, and I mentioned that in the

submission. If I would try to say this is how I'm feeling, it was very much like, 'Oh, don't say that, you might have something wrong with you'. That's why I was so relieved when the CHaPS nurse referred me to Walker House. I still meet with them monthly now. They've been the best support.

Ms JOHNSTON - It really highlights for you how important it was for the hospital to have followed up with you immediately, given they knew what the situation was and how things hadn't gone to plan. That immediate follow-up, straight after.

Ms MARSDEN - Yes, even at the two and the six day midwife visits, no-one really checked in with me. I mentioned how much pain I was in and I was still obviously hunched over. I couldn't walk very well but it was very much 'weigh the baby, look at the baby, how's breastfeeding?' Lots and lots of advice on breastfeeding and what to do and what I shouldn't have been doing but that was about as far as it went.

Ms JOHNSTON - Do you think the midwife or whoever came to visit you at those two and six day appointments, would they have had all the information about your birth, do you think?

Ms MARSDEN - One of them did, because they had my file from the hospital. Yes, I don't know whether it was just that that's not what they're for. It always felt very like in and out.

Ms JOHNSTON - And not focused on you?

Ms MARSDEN - No, definitely not.

Ms ROSOL - Hello. I've been looking through the submission you gave us. Thank you for that. I remember you writing something in there but I just can't find it about classes before.

Ms MARSDEN - Like the birthing classes?

Ms ROSOL - I wonder if you could comment more on how planning for a C-section impacted on the preparation that you had beforehand.

Ms MARSDEN - I was happy to prepare for everything in case what happened, happened. Even though I knew I was having a C-section that had been approved, I still said yes to the birthing classes. I was signed up for them because - and the first midwife that I had agreed with that. She's like, 'Totally get it, I'd be the same. I'd rather know than not know', so signed me up for that. I mentioned - I then never had her again. It was someone different each time. I don't know, if I did have her the whole time, she probably wouldn't have pulled me out of that class because she agreed it was a good idea.

I had a different midwife. I think it was the week before the birthing class, and she was going through C-section risks and I was like, 'I'm fine with all of this. I'm also signed up for the birth class as well next week', and I was asking her where do I go for that. She was like, 'You don't need to do that because you're having a C-section.' I said, 'Well, I wanted to do it just in case.' She's like, 'I wouldn't bother. It's not worth your time. I'll sign you up for just a one-on-one C-section class with a midwife instead.' I was like, 'I really wanted to do it just to be safe', and she was like, 'Oh, haha, no, you don't need to do that. Don't worry, you're definitely

having a C-section.' Took me out to reception, cancelled that, put me in with this class which, when I got there, it was literally me sitting in the same room with a midwife clicking through a PowerPoint on a computer, reading what was on the PowerPoint to me about a C-section, which was everything that I'd already read in the brochure that they gave me. That was it.

I think, as well, because they were so confident that I didn't need to know anything else I was like, 'Okay, well, if that's what they're telling me then that's it'. Essentially, because I've never had a baby before and people don't really talk about the details that much, I had no idea. When everything started in hospital and I was in with the two lovely midwives who were there for the birth, I just had no idea what I was doing. Because I, obviously, hadn't practised breathing or anything, it was very rushed. It felt very rushed and forceful. I don't know whether that contributed to tearing the way that I did. I know that there's information on how you can reduce tearing, but obviously I didn't know any of that. That's why I also said in my submission, there just seems to be such a focus on - I felt like I was constantly being scared out of having a C-section but -

CHAIR - And yet not provided the support you needed to learn about vaginal birth.

Ms MARSDEN - Everything else that can go wrong that I didn't even know was a possibility.

Ms ROSOL - They emphasised the risks of a C-section, but no-one went through the risks and how to manage them?

Ms MARSDEN - No.

Ms ROSOL - I know we've talked about it not being a risk-based model, but you didn't get the information you needed.

Ms MARSDEN - Even when we had the doctor who was trying to tell me that I shouldn't have a C-section, it was like, 'You know, some women tear a little bit, but it's a couple of stitches and you'll be right.' Nothing about everything else that happened.

CHAIR - You've got the right to be informed of those things so that you are prepared.

Ms MARSDEN - At the end of the day, I feel like everything was just like one failure after another that led to what happened. It probably still would have happened that way, but, I don't know.

CHAIR - You would've felt more confident having had those classes. It seems really cruel to have pulled you out of them.

Ms MARSDEN - Yes.

CHAIR - You said just now, but also in your written submission about the fact that you saw a different person each time. That's something that we've heard a lot from people working in the system as well as people having babies in the system, that continuity of care would have been better for them. Can you just talk us through whether you feel that way? Whether continuity of care might've made a difference?

Ms MARSDEN - I definitely do. My understanding - I was in team midwives and my understanding was that you might see lots of different midwives but one of them would at least be at your birth. That wasn't the case at all. So not one person knew anything about my history or, even though I'm sure it should have all been on the system, but no-one would have looked at it. So I strongly feel like if one person there knew me, I don't know, one thing could have changed. Even again, if I didn't get to the C-section in time, there would have been someone who knew, if I was to have a vaginal birth, I wanted the epidural and then that might have actually happened.

Ms ROSOL - Did you have a written birth plan? I know that your plan was to have a C-section and you made that clear and you communicated it. Was that in writing or did you share that verbally and they wrote it down?

Ms MARSDEN - Because I was having a planned C-section I had to have an appointment with a doctor instead of a midwife, like a couple of weeks out, so it could be approved and signed paperwork. So I had signed something saying I consented to all the risks and I understood XYZ and the surgeon who did it had signed off on it.

But, no, in terms of like a birth plan thing I was told I didn't need one because I was going to get a C-section. So again, I didn't get the opportunity to tell anyone my alternative birth plan because it was like a 'Oh, well, no, that won't happen.' That's again, just another part where I just think it all went wrong.

Ms JOHNSTON - Following on from not having that opportunity to have that birth plan, when you filled out the paperwork for the C-section, did that include what would happen immediately after you had your little boy in terms of skin-on-skin contact? Did you get a say in how that might play out immediately afterwards?

Ms MARSDEN - They told me that they try to do skin on skin as best as they can, but it was an - if that can happen, that would happen.

Ms JOHNSTON - They didn't ask what you would like?

Ms MARDSEN - No, no.

Ms DOW - In your submission, you talk about the fact that obviously you weren't able to access the services that were really promised to you after having your little boy through the THS so that you had to seek care. Did this come at a significant cost to your family. Would you like to talk a little bit more about that and the financial impact this has had?

Ms MARSDEN - Yes, so obviously the private pelvic floor physios aren't cheap and that is covered a little bit under health insurance but not much. So there were those appointments and all of the additional - I feel like I was at the GP every week for a while because I also had a couple of the emergency admissions and this was all ongoing from the gynaecologist appointment where I basically was misdiagnosed and given the wrong medication and all the pain relief I was taking, all the ibuprofen that I could, so I gave myself gastritis as well.

And all my GP appointments, like none of them is bulk billed so they were quite expensive and what else was there? Oh, and well in future now because of what happened, obviously, I'm absolutely terrified that this could happen again. Because of the cause of the tear

that I had, the colorectal surgeon said that there is a very big risk of becoming fecally incontinent if I was to have another vaginal birth. So there's no way I'm going to risk that.

But going through what I went through. I know there's no guarantee that the LGH is actually going to honour that. So we've, yes, increased our health insurance to the highest that we can and I've been seeing a private obstetrician as well who's also a gynaecologist so she's been working through other stuff with me too. This is going to be an ongoing cost until we do have another baby because there's no way I'm leaving that risk again.

Ms DOW - Thank you. The only last comment that I wanted to make was I thought that the quotes that you had at the end of your submission resonate so much with all women and families when it comes to childbirth. I want to thank you very much for putting those in there. The thing that I like the most was:

> It frustrates me that during pregnancy, so many people (strangers or not) feel entitled to touch your pregnant body, talk about your pregnant body, discuss your bodily functions and ask very private details - yet once the baby is born, it is a different story.

There are no truer words spoken. So, thank you, and then the other things that you go onto say about how your world changes, but you're just told to be grateful that you've got a healthy baby.

Ms MARSDEN - Thank you.

CHAIR - I think the sentiment is shared by all of us, that sharing a personal story like yours is really important for committees like this. Thank you again for your strength in being able to do that. If there's anything else that you do want to share with us down the track - you might leave today and think, 'Oh, why didn't I say that thing?' - there's every opportunity to get in touch with any of us or Mary directly through the secretariat. Was there anything else that you didn't mention that you'd like to?

Ms MARSDEN - Oh, the only thing was just the update that I did hear back from the hospital in December. The response was that a lot of my questions about what happened were very - they couldn't comment because the doctor that I had no longer works there, so that was basically where those ended. They just left out huge portions of my complaint that they didn't even comment on, but it's been taken up by the Health Complaints Commission now, so I've got someone. I've sent them a whole list of every point that wasn't answered. So, that's where that stands.

CHAIR - Have they given you any expected timeframes?

Ms MARSDEN - They said it will be a long time. They said it would be quicker if I wanted to meet with the hospital in person, but I said 'No, I want everything in writing'.

CHAIR - Yes, that's fair enough.

Ms MARSDEN - I said I waited over six months for the first response, I'm happy to wait another six months for the second one, but, yes, that's the only update that I had.

CHAIR - Great. Thank you so much for being here, both of you. We really appreciate it, and yes, if this has stirred up anything, then just remember that we've got our amazing colleagues here from Gidget, so please don't feel you need to rush off into your day. There's plenty of time to sit and reflect before you go.

Ms MARSDEN - Are we allowed to listen to the others?

CHAIR - Yes, but we've got a bit of a break, actually. The next people had to cancel last minute, so the next person won't be here till 11.05 a.m.

Ms MARSDEN - Okay, alright.

CHAIR - It's a public hearing; it's technically as if we're sitting in the Parliament in Hobart, when we have these Committee hearings. Stick around. Thank you so much and good to meet you both.

THE WITNESSES WITHDREW.

The Committee suspended from 10.23 a.m.

The Committee resumed at 11.10 a.m

CHAIR - So, formally, welcome to the hearing today in Launceston of the House of Assembly Select Committee on Reproductive, Maternal and Paediatric Services in Tasmania and thank you for the written submission that you've provided and for agreeing to attend in person today and share your story with us. Could I ask you to state your name for the record?

Ms LILLEY - Georgia Lilley.

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

Ms LILLEY - Yes.

CHAIR - Thank you. In the guide you would have seen this hearing is covered by parliamentary privilege, which allows individuals to speak with freedom, say anything that you want to say to us without the fear of being sued or questioned in any court or place outside of Parliament later. The only exception to that is it doesn't extend if you make statements that might be defamatory and then repeat them or refer to them outside of this hearing. That parliamentary privilege protection doesn't extend to future statements made in the media or in public settings.

It's a public hearing, as I said, but we're not being broadcast. It will just be a written transcription. Could I ask you to do the statutory declaration that's in front of you?

Ms GEORGIA LILLEY WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED

CHAIR - Thank you and the Committee has also agreed to make a short, sensitive content introduction for anybody in the room or anyone reading the transcription later, which is just recognising that the hearings that we're having discuss highly sensitive matters that have deeply impacted the lives of Tasmanians, which can be a trigger for individuals listening to or participating in these proceedings.

Anyone affected in that way, we encourage them as a Committee to contact services and supports that are listed on the Committee's web page. We also have onsite here clinical support from Gidget Foundation Australia from Dr Erin Seeto and Ms Amelia Walker, who I believe you've already met. They'll be here on site after we finish today's hearing, so you don't need to feel the need to rush away if you don't need to. They're here to provide whatever support that you need this afternoon.

That's all the formal stuff done. Would you like to start with an opening statement to us?

Ms LILLEY - What should I include?

CHAIR - Whatever you would like to share. We've all received and read your written submission, but if you would like to start by sharing whatever you would like with us as a starting point, we can then move to a conversation or we can move straight to a conversation, whatever suits you.

Ms LILLEY - I'll just move straight in.

CHAIR - First of all, thank you for writing your submission. I know that you have done that before and it must take a lot of personal and emotional toll to write down what's happened to you in that way. It is deeply impactful for us as a Committee to hear stories like yours. It's very important for us to hear stories like yours. Our recommendations will be better informed as a result of hearing from members of the public who have had these experiences. So, we sincerely thank you for taking the time to do that.

I had an overarching question, and it's something that we've heard from quite a few practising midwives who say that they feel like at university they're taught to provide women-centred care, but once they're in the system, it feels like it's much more system-centred care. Your experience that you've shared with us in your written submission definitely feels like that. You've talked a lot about mistakes that were made throughout your experience with your daughter and that the focus didn't really seem to be on you as a woman and as a mum. I wondered if you'd like to elaborate on that experience any further?

Ms LILLEY - Yes, I pretty much felt the whole way through, just like a description on a sheet of paper. Every time I went into an appointment at the antenatal clinic it was a different doctor so I never got to have any continuity of care.

I was supposed to meet with the midwives but nobody ever seemed to bring that up and eventually it got to the point where it was quite late in my pregnancy and I asked like, so when am I supposed to meet with the midwife? And they were like, 'Oh, that hasn't happened yet?' Things just sort of slipped through the cracks. So I only got to meet two midwives, neither of whom were present at any point of the labour or birth. Every time I came in, it was a reintroduction.

CHAIR - Going through history again and starting from scratch.

Ms LILLEY - Yes, trying to help them get an understanding of who I was because I think the biggest barrier was just a general misunderstanding of who I was based on how I looked.

CHAIR - That's very unfair.

Ms LILLEY - Yes, it was extremely frustrating. I felt like because I'm plus size and don't wear designer brands and I don't know, maybe I don't speak eloquently, I don't know, but I just felt like maybe they thought that I was uneducated and that, because I'm plus size, maybe I didn't care about my health, or that it was automatically going to be a high risk pregnancy. There were a lot of assumptions made about who I was that were not based on anything real.

CHAIR - You've talked a lot through your written submission about feeling coerced into various procedures. Something that the Committee has heard about through some of our other hearings, and through other written submissions, is the difference during labour of people being able to give consent versus informed consent. Your submission really points to the fact that even if you were consenting to those procedures at the time, it didn't feel like you were given the right information to provide informed consent to all of the stuff that you needed to know. Correct me if I'm wrong, I don't want to put words in your mouth, but that's the kind of sense that I got from reading your submission.

Do you want to elaborate as far as you are comfortable with some of those different interventions that were made during your labour with your daughter and how those decisions were arrived at for you?

Ms LILLEY - I felt going into the hospital that night that I was as fully informed as a person could be. I knew that I had a right to say no to any procedure that I didn't want to participate in, but I was operating under the false assumption that that would be respected.

By the time I got in, it was around midnight and I was immediately sat down by the doctor and midwife, which, it was just odd from the get-go - that it felt like we were having a negotiation instead of me being supported in labour. We sat down and they immediately started trying to pressure me into having a - is it a hep-lock? I think that's what it's called.

CHAIR - We've got two former nurses at the table who are probably better informed than me.

Ms LILLEY - They immediately wanted me to put that in just in case. When I said 'No, I didn't want that', they didn't drop it. They persisted with why they thought it would be a good idea. They wanted to do the continual monitoring with the band. I explained that I wanted to be free to move around. The times that I had done CTGs [cardiotocography], the band just moves around. They're not very plus-size friendly, so I didn't want it. There was just a lot of back and forth and this general feeling they thought I was making silly choices and they were going to try to convince me to make better ones. They kept looking over at my partner as if they were trying to get him on side. Like, you're listening to this, right? This is a bit crazy.

CHAIR - So patronising.

Ms LILLEY - Yes, it really did feel patronising, like they were hoping that he would convince me since their coercions weren't working.

Meanwhile, I was having contractions every two minutes and having to pause the conversation, so I had to fight really hard for two whole hours in labour just to have the care and support that I needed. I didn't get it in the end. I had to compromise just because they weren't letting it go. I wasn't able to just move on.

Even to the point that I'd been advised by a private midwife that the hospital had no legal right to stop me from accessing one of the baths, and that I should say that if they tried to coerce me. I did say that. I told them that I've been informed, that you have no legal right to stop me. When I said that, they just sort of stared at me blankly, like well, we're still not budging. They weren't going to show me where they were, they weren't going to assist in any way for that to happen, even though they clearly knew they had no legal right to stop me as well because they didn't deny it.

Essentially, from the moment I arrived in labour, again, I felt like there was a misunderstanding about my character where it was assumed I was a troublemaker who was going to make things difficult for them, when really I just wanted to be left alone to labour.

CHAIR - You mentioned earlier you went into the hospital that day feeling like you were as informed as you could be about all the likely outcomes and you've mentioned in your written

submission you did have a birth plan. You've said that wasn't respected or adhered to or taken seriously. Can you tell us a bit more about that?

Ms LILLEY - I tried to hand it to them because it was a printed birth plan. When we first arrived they asked about - I don't remember if they specifically asked for the birth plan, but they asked if I had any idea of the sort of path I've chosen, I guess, or you know what type of labour I wanted. At that point I said, 'Yes. I have a birth plan. I've written it all out. These are my wishes', and tried to hand the doctor or the midwife the birth plan. Neither of them took it. They just stared at me blankly. It was a little bit awkward. I held it out for a second and nobody took it, so I just sat it down next to me and moved on. It was strange. They never looked at my birth plan and they asked me the questions verbally instead, which I thought was strange because I've already written it all out for you.

Then the next day when I was - by that point I had an epidural and was resting, and my partner said that he overheard two staff members having a conversation on the other side of the curtain. He heard one of them say, 'No, there's no birth plan, just a verbal birth plan', which wasn't true.

CHAIR - That's really very sad to hear. I'm sorry to hear it.

I've got other questions, but I'll open it up to everybody else on the Committee too, if anybody wants to jump into the conversation.

Ms ROSOL - I read in your submission you undertook Eye Movement and Desensitisation Reprocessing therapy in 2023 at your own expense. I was curious what support and what mental health support were you offered formally through Government services after your birth?

Ms LILLEY - Nothing. Yes, I never spoke to any sort of counsellor or any sort of support. In fact, the staff on the maternity ward didn't even seem aware of how my birth had gone down. A few times, I would struggle to get out of bed because I was still pretty sore and I would have midwives asking me like, are you okay? Like they didn't know why I was struggling. I would have to explain I had an epidural and unwanted forceps delivery and I'm sore.

At one point, there was a midwife who came in and I was crying because I was still in shock - this was the next day after the birth - and she wanted to comfort me and asked why I was crying and what had happened. At first I didn't want to talk about it, but she convinced me. I told her about everything that had happened and how I was feeling and that it was a non-consensual procedure. At the end of it all, she was just very dismissive. She basically said, 'Oh, but I'm sure the doctor had a very good reason for doing what she did and wasn't the cord around her neck.' I just basically was like shoo, leave me now. That was the only person I spoke to, though I'm guessing she didn't pass it on because nobody was sent to talk to me. Nothing was offered. Any mental health care I sought out myself later.

Ms DOW - Georgia, you talked about the fact you didn't get any sort of continuity of care in your first birthing experience and obviously went onto have a very successful freebirth later for your twins. Do you think if you'd received continuity of care for your first and it had been vastly different experience, would you have continued on with having a freebirth for your second pregnancy?

I know you wanted to originally birth at the birthing centre and that wasn't made available to you. I wondered how what happened to you influenced that second decision and whether that would have been any different had your experience been different.

Ms LILLEY - I think it probably would have been different. I can't say for certain, but, ultimately, I think I'm the type of person who still would have preferred to birth at home because if it had been successful at the hospital and if I'd felt safe and supported, I think I would have felt more confident of my ability to birth and assured that my body can do it on its own at home, but I definitely would have felt safer with the idea of going to the hospital in case of an emergency.

It definitely would have been an option I considered, like I definitely would have considered just going back to the hospital if I'd felt supported. If it had been a positive experience and if people had supported me in the way I wanted to be supported, I don't think I really would have had any reservations about going back.

Ms JOHNSTON - Thank you for your submission and, following on from Anita's questions on your freebirth experience, you talked a bit in that answer about the confidence to go back and whether you'd feel supported in an emergency situation. Can you outline or elaborate a bit more on that decision to freebirth given your concern about going back to a hospital, either for a delivery or an emergency situation and how that played out in terms of the support you had around you at home for that freebirth decision?

Ms LILLEY - The idea of having to transfer during or after my freebirth to the hospital was definitely a fear that I had to work through. I was scared to go back, under any situation, even an emergency.

Ms JOHNSTON - How did you work through that fear? What kind of support did you put around yourself, or how did you manage that?

Ms LILLEY - I talked about it a lot with my partner and I came to the realisation that as long as I was in control of all the decision-making - what's the right word? Sorry, my mind's gone a bit blank. Oh, consent - as long as I was consenting to any stage of the plan, if I was in charge of all decision-making then that would be an empowered birth. That's what helped me work through the fear, that if I was in control of when I say I need help, then I will still feel empowered. That was the biggest difference with my first birth - I did not feel in control of certain decisions. As a result, I felt very disempowered.

Ms JOHNSTON - Do you think that sense of losing control impacted on your physical wellbeing? In terms of delivery and ability to deliver, both in your first birth and then reflecting on your second birth, the difference in feeling that control actually had a physical change in you?

Ms LILLEY - Yes, absolutely.

Ms JOHNSTON - To get your body able to do what it needed to do?

Ms LILLEY - Yes. I felt infinitely safer at home with just my partner present.

Ms JOHNSTON - You talked a couple of times about the experience your partner, I know. In your submission you talked about the significant impact that it had on him during the first time. You indicated he was crying during the delivery. Are you able to elaborate on the impact that that had on your partner in terms of the second birth and the concerns that he might have felt the first birth, moving to the second birth, and those conversations? If you're comfortable.

Ms LILLEY - Yes. He was wholeheartedly supportive. I feel very lucky that he is potentially the one person in the world who doesn't question my ability to make decisions for myself. He basically was of the opinion that it's my body and my birth and I should be in charge of the decision-making and he would follow.

At the time of my daughter's birth, I think he felt very disempowered as well. He did tell me that in that moment he regretted not doing anything, but he also knew that being a man, if he was to try to interfere or stop anything that was happening, he would have just been taken away. He would have been treated as an angry male, potentially violent. He also wasn't sure if it would even be the right decision because nobody informed him of what was happening or why either, so he didn't know if it was a true emergency. He was torn between trusting what the doctors were doing or listening to my requests for it to stop.

CHAIR - Has there been a long-term effect on his mental health as well as your own from that experience, would you say?

Ms LILLEY - That's harder for me to say. He would say no. I suppose it's not for me to say.

Ms ROSOL - Can I ask a question around your second pregnancy? You had a freebirth - what was your antenatal care through that period? You chose to have the freebirth so you had control. What did you feel comfortable engaging with during the pregnancy?

Ms LILLEY - The whole way through I was basically tuning into my own needs. I hadn't ruled out any sort of care. If I wanted an ultrasound, I would get one, and at no point did I want one. I have a very superb GP who I trust wholeheartedly, thankfully, so I knew that I could see her at any point if I wanted that kind of support. I did see her once and that was mainly just an obligatory visit to make the birth certificate process a bit easier to create a bit of a paper trail. I didn't particularly feel like I needed any sort of care. She confirmed the pregnancy.

CHAIR - Did you know it was twins at that point?

Ms LILLEY - No. She wanted to do a quick Doppler [ultrasound] to confirm it because she said that would be quicker than a blood test. I was very reluctant. She said that she would be very quick, that she would just check for a heartbeat and a head-down position and that was all. I figured that I would rather do it with her than anyone else, so I agreed to it. She was very quick. She confirmed what she needed to confirm and that was it, so she didn't have time to see the second, which was very fortunate for me.

CHAIR - So it was during labour that, after the first one was born, that's when you found out it was twins?

Ms LILLEY - I didn't find out it was twins until I looked down and saw the second baby. I thought it was my placenta.

CHAIR - Wow. How incredible. That's an incredible experience.

Ms LILLEY - Yes. It was awesome.

Ms ROSOL - Because you did need to go into LGH afterwards - you've said that that was a vastly improved treatment, but what was that experience like, going in from having had a freebirth to going in for that treatment? What was the experience like for you?

Ms LILLEY - I was surprised at how respectful all the staff were. A couple of times I maybe got the feeling that there were certain midwives who maybe didn't approve, but they never said anything.

That's all I ever asked for, that you keep your opinions to yourself if you don't agree. Everyone was very respectful. Nobody said anything negative or judgmental. I actually had a few staff members who expressed that they actually support freebirth, and they enjoy supporting women who have come in after freebirth and that they hope to create a culture where women feel safe to do that. That was really positive to hear.

I did wonder, as well, if it was maybe different because it was twins and because it was such an exciting story that created a bit of buzz. Maybe that might have made everyone a little bit more positive - just the sort of ripple effect that it had. I did wonder if it would have been different if it was just a normal, boring singleton baby.

Ms ROSOL - Just around the freebirth, what preparations did you make beforehand in terms of planning around if something went wrong? What did you do to prepare for it?

Ms LILLEY - Mostly just talking with my partner and having that sort of - a lot of discussions around the type of support I would need from him. Essentially, my request of him was that he just hold the space and be there, be present if I had any requests, and that he not bring any fear into my space even if he was concerned, because I didn't need that near me. I just wanted to be able to tune into my own needs - just to follow my lead. The only time he had permission to call the ambulance for me was if I passed out for any reason and wasn't able to make that call myself. We'd agreed about that beforehand.

Aside from that, the other preparations were pretty minimal. It was just ordering a pool to birth in and some tinctures that might have supported the labour, that kind of thing, some towels. It was really pretty simple.

CHAIR - How long after the birth of the twins did you make that decision to return to the LGH? You said there was retained placenta?

Ms LILLEY - I think it was about an hour after the second boy was born, so I had still been feeling blood leaking that whole time and I was lying horizontal and everything was very calm and happy, so there was no external influence to contribute to any sort of haemorrhaging.

Then, when I stood up close to about an hour after the second boy was born and I tried to get the placenta out again and instead some quite large clots came out and I thought maybe

it was bits of my placenta. I wasn't really sure, so that was when I decided I'm not really sure what's going on anymore, so I think we should transfer. It wasn't a decision made out of fear. I felt very like I was able to trust my own judgment in the moment, yes.

Ms DOW - With postpartum care, you presented to the LGH and had your follow-up after your freebirth treatment and then, obviously, were discharged home, but did you have follow-up care from the hospital or postpartum care or you managed things? I'm trying to understand whether you then had midwife contact afterwards or -

Ms LILLEY - They offered and I said that I didn't feel I needed it. They did also, ironically, a support worker was sent in to ask about our mental health and whether we felt okay after that transfer and -

Ms DOW - But you hadn't been offered that before - after your birth trauma with your daughter?

Ms LILLEY - No, and I had to say to her, I feel incredible. I feel like the most powerful woman in the world. I feel great and then she tried saying, 'But how does your partner feel? Is he okay' and I was like, 'He's much better than he was last time, we're both great.' So, we could have used her the first time.

Ms DOW - It was good they did offer that service after having your birth; that's what I was trying to understand, whether they would provide you with ongoing service delivered at the LGH.

CHAIR - Is there anything that hasn't come up in our conversation you'd like to share with us or have us hear?

Ms LILLEY - I'm not sure. Yes, there's probably one thing actually. I felt it was ironic during my antenatal care there were, with my first pregnancy, a lot of signs around the ward -

CHAIR - Actually, that jumped out at me in your written submission.

Ms LILLEY - Lots of little signs reminding women that they are the experts of their body and nobody knows their baby like they do and if you feel like there's something wrong, to come in and speak up about it. I felt the whole way through that every time I spoke up and said I feel fine, my baby's telling me she's fine, pretty sure I'm the expert of this, that was continually questioned and disrespected.

CHAIR - Thank you for being here today and for what you've written. You've also provided us some really good recommendations that you've called takeaways in your written submission. As I said at the beginning, hearing stories like yours is really powerful for us in developing the recommendations we'll provide to Parliament.

If you do think of anything after you've left today, don't hesitate to get back in touch with us through Mary, who you've been in touch with, our Secretary of the Committee. We'll be continuing to hold hearings in the south, so there's lots of time to get back in touch with us before we reach the point of finalising the report.

If there's anything else you want to share with us afterwards, we'd be very happy to hear from you again. Thank you for being here and for your written submission.

Ms LILLEY - Thank you.

CHAIR - Have a good rest of your day with the twins.

THE WITNESS WITHDREW.

The Committee adjourned at 11.45 a.m.