Lawyers for the People

AUSTRALIAN LAWYERS ALLIANCE

Reproductive, maternal and paediatric health services in Tasmania

Submission to the Select Committee on Reproductive, Maternal and Paediatric Health Services in Tasmania

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Who we are

The Australian Lawyers Alliance (ALA) is a national association of lawyers, academics and other professionals dedicated to protecting and promoting justice, freedom and the rights of the individual.

We estimate that our 1,500 members represent up to 200,000 people each year in Australia. We promote access to justice and equality before the law for all individuals regardless of their wealth, position, gender, age, race or religious belief.

The ALA is represented in every state and territory in Australia. More information about us is available on our website.[1]

The ALA office is located on the land of the Gadigal people of the Eora Nation.

[1] www.lawyersalliance.com.au.

Introduction

1. The ALA welcomes the opportunity to have input to the Select Committee on Reproductive, Maternal and Paediatric Health Services in Tasmania ('Select Committee') regarding the Select Committee's inquiry into reproductive, maternal and paediatric health services in Tasmania.

2. The ALA's submission will focus on birth trauma but also by extension the following four other Terms of Reference for this inquiry: reproductive health services, maternal health services, workforce shortages, and perinatal mental health services.

3. Studies suggest that birth trauma, defined as "a woman's experience of interactions and/or events related to childbirth that cause overwhelming distressing emotions and reactions, leading to short and/or long-term negative impacts on a woman's health and wellbeing",[2] is experienced by up to 50 per cent of women who give birth.[3]

4. ALA members report having represented clients experiencing the effects of birth trauma across Tasmania, and the following ALA submission will address:

    a. the prevalence of birth trauma and its impacts, including six de-identified case studies sourced from the ALA's member base in Tasmania;

    b. the underlying causes and factors contributing to birth trauma in Tasmania; and

    c. the ALA's recommendations for reform to ensure that trauma-informed and culturally-appropriate care is provided for women giving birth and for their support networks in Tasmania.

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[2] Julia Leinweber PhD, RM, Yvonne Fontein-Kuipers PhD, RM, Gill Thomson PhD, Sigfridur Inga Karlsdottir PhD, RM, RN, Christina Nilsson PhD, RM, RN, Anette Ekström-Bergström PhD, RN, RM, Ibone Olza PhD, MD, Eleni Hadjigeorgiou PhD, Claire Stramrood PhD, MD, 'Developing a woman-centered, inclusive definition of traumatic childbirth experiences: A discussion paper' (2022) 49 *Birth* 687, 687 <https://onlinelibrary.wiley.com/doi/full/10.1111/birt.12634>.

[3] Ibid 688.

The prevalence of birth trauma and its impacts

5. The ALA submits that, since women can feel so vulnerable when giving birth, they need to be able to have trust in medical providers and rely on those professionals to inform and advise them in the lead up to and while giving birth.

6. However, the clients of ALA members have found that medical providers in Tasmania have ignored them and/or actively dismissed their concerns or requests. When that trust between a woman in labour and her medical providers is broken, and when women giving birth are left feeling powerless and without agency, there can be – and there are – truly devastating consequences.

7. Breaches of the duty of care in birth cases can result in significant injury to women giving birth: physical trauma, psychological trauma, or (in many cases) a combination of both. The Australasian Birth Trauma Association provides the following examples of those physical and psychological injuries:[4]

Physical trauma can present as:

- Perineal tears
- Bladder damage
- Pelvic floor muscle damage
- Pelvic organ prolapse (POP)
- Infected stitches
- Incontinence/leaking of wee or poo
- Pelvic fractures (public bone, coccyx, sacrum)
- Caesarean wounds
- Pudendal neuralgia (nerve pain/damage)
- Wound dehiscence (wound breakdown/separation)
- Hysterectomy (removal of womb/uterus)
- Postpartum haemorrhage (PPH/secondary PPH)
- Other injuries that may not have been categorised here

Psychological trauma may present as:

- Postpartum post-traumatic stress disorder (PTSD)
- Postnatal depression and/or anxiety (PNDA)
- Obsessive Compulsive Disorder (OCD) (For example, obsessive thoughts that can affect our behaviour, such as checking on baby constantly or recurring thoughts that impact your enjoyment of daily life).

[4] Australasian Birth Trauma Association, *What is birth trauma?* (Web Page, 2022) <https://birthtrauma.org.au/what-is-birth-trauma>.

8. ALA members also seek to emphasise that physical trauma is usually the result of an instrumental birth, which can lead to lifelong, embarrassing and restrictive outcomes for women, such as incontinence. This is addressed further in the next section of this submission.

9. The ALA notes that trauma related to the birthing process can also be experienced by partners, family members and friends of women in labour. Further, babies can die during traumatic births or can experience injuries as a result of a traumatic birth, including but not limited to:

    a. Physical injuries (broken limbs and fractures);

    b. Hypoxic brain injuries resulting in Cerebral Palsy and/or intellectual impairment;

    c. Brachial Plexus injuries;

    d. Subdural and cerebral haemorrhage;

    e. Facial and peripheral nerve injuries; and

    f. Spinal cord injuries.

10. Finally, the ALA also notes the economic impacts of birth trauma on women and their families. ALA members report that women injured while giving birth have great difficulty in returning to work and/or education, yet incur increased expenses related to those injuries – including medication and ongoing treatments. Partners, family members and friends also need to forgo work and education to provide much-needed care for women injured while giving birth, as well as their babies (who may also be injured and require additional care). There are broader economic impacts on government systems and services, including Medicare, Centrelink and the National Disability Insurance Scheme.

Case studies

11. The ALA notes that many occurrences of birth trauma experienced in Tasmania have been covered in the media.[5]

[5] See, egs, Manika Champ, 'Rebekah had to travel more than four hours after her waters broke due to a midwife shortage', *ABC News* (online, 17 February 2023) <https://www.abc.net.au/news/2023-02-17/midwife-shortage-in-north-west-tasmania/101970692>; Bec Pridham, 'Maternity services on Tasmania's north-west coast to return to public hands from December', *ABC News* (online, 18 May 2023)

12. The following de-identified case studies have been sourced from the ALA's membership in Tasmania for the purposes of consideration by the Select Committee. Any names used are not the clients' real names, and other identifying features have been excluded where necessary.

<u>Case Study A</u>

A woman suffered a long labour and caesarean delivery was delayed significantly, despite evidence of fetal distress warranting early intervention. The child was born blue and floppy, the child received 15 minutes of oxygen therapy, spent some time in NICU and ultimately survived. Vague apologies were made by an attending anaethetist and later a doctor about the child's delayed delivery, but no proper advice about what occurred was provided. As the child grew there was evidence of delayed development and it was raised with the mother by a medical professional that this may be due to the birth. The mother sought to obtain the medical records on six occasions and was denied by the hospital. She also raised the concerns with a paediatrician who acted aggressively when the possibility of error by another doctor was raised. A second paediatrician advised there was no way they could assist in the matter due to concerns as to backlash from the particular hospital involved. The barriers placed an additional and significant burden on the mother and a delay in the child receiving treatment for what has now been diagnosed as a significant birth related developmental delay and related problems. Expert analysis includes comment that early intervention to assist this type of delay significantly increases better outcomes. The long delay in receiving records and, much later, a diagnosis resulted in significant financial and psychological burden and trauma to the mother and child, which has exacerbated an already highly traumatic experience.

<www.abc.net.au/news/2023-05-18/north-west-maternity-services-to-return-to-public-hands/102360922>; Jess Flint, 'Amanda Duncan says birth trauma inquiry is needed for Tasmania', *The Advocate* (online, 11 September 2023) <www.theadvocate.com.au/story/8343455/nurse-joins-calls-for-tasmanian-inquiry-into-birth-trauma>.

Case Study B

Obstetric care received in a public regional centre

Emma has two children both of whom were delivered vaginally.

Emma's first child sustained a fractured clavicle during the course of delivery which healed without issue. Emma received no advice as to the risks involved in any subsequent delivery at this time or at the time of her next pregnancy.

Emma's second pregnancy was managed within the same hospital as her first. There was no record of any cross-checking of her first delivery and Emma was not asked and did not volunteer any information in relation to her first delivery.

It was only in second stage of labour that Emma volunteered to the attending midwife that her first child has suffered a fractured clavicle and asked whether that was important. Emma was prepped for a caesarean section and taken to theatre.

Prior to the commencement of a caesarean section, the Registrar decided to have make one final attempt at an instrumental vaginal delivery. The vaginal delivery ensued but, in doing so, Emma suffered a third-degree perineal tear and her baby suffered shoulder dystocia.

Emma was assured her baby would recover, which was a false hope, and it was not until Emma attended a specialist children's hospital that the full extent of her child's problems was explained, namely a diagnosis of Erb-Duchenne paralysis.

Emma then sought advice in relation to her baby's Erb's palsy and, during the course of consultation, Emma was asked if she had suffered any injury. Reluctantly, Emma advised she experienced a third-degree perineal tear, pelvic floor damage and urinary incontinence, which she thought was just one of those things.

Emma's mental health has also been impaired as a result of her injury.

Legal proceedings have been commenced and the hospital has admitted liability.

Case Study C

Obstetric care received in a public regional centre.

Claire experienced a PPH of 1.8 litres and a ragged placenta during the birth of her first child. No investigation was undertaken in relation to possible retained products of conception, despite the clinical findings at the time of delivery. Claire subsequently passed a blood clot prior to her discharge. No investigations or follow up advice was provided to Claire prior to her discharge.

Six weeks later Claire presented with retained products of conception ('RPOC'). She underwent an emergency suction curettage for evacuation of the RPOC and during the course of the operation Claire's uterine lining was obliterated and her uterus was perforated. The operation was performed by a Registrar, without ultrasound control, using a large catheter and deep sutures were used to over-sew the perforation.

As a result of her injury Claire now suffers Asherman's syndrome and permanent infertility. She continues to suffer pelvic pain. Claire and her partner had planned a large family.

Claire's mental health has also been impaired as a result of her injury.

Legal proceedings have been commenced and the hospital has not admitted liability.

Case Study D

Obstetric care received in a public tertiary centre.

Alexandra was admitted for the birth of her first child. Her delivery was laboured in that she experienced a late stage first labour and a prolonged second stage labour with a cephalic presentation. Despite the prolonged second stage of labour, a trial vacuum extraction was not considered, nor was an emergency caesarean section.

Alexandra had a piper's forceps delivery, which also involved a very hard pull during the delivery. Alexandra required a right mediolateral episiotomy and, during the course of repairing the episiotomy, suturing was such that it resulted in vaginal introitus.

Alexandra required a Fenton's procedure following her delivery to correct the vaginal introitus. She has also been diagnosed with significant anal defect and obstetric pudendal neuropathy. She has undergone years of intensive pelvic floor physiotherapy and exercise and remains under the care of a colorectal surgeon. She is currently preparing to undergo sacral nerve stimulation surgery.

Alexandra's mental health has also been impaired as a result of her injury.

Legal proceedings have been commenced and the hospital has not admitted liability.

Case Study E

Obstetric care received in a public regional centre.

This is an obstetric event whereby the baby did not survive delivery.

There was a delay in investigating the mother's presenting abdominal pain resulting in a critical incident requiring resuscitation of the mother and delivery of a still born term baby.

The mother has suffered significant mental trauma as a consequence of the death.

Legal proceedings have just been commenced and further details cannot be disclosed at this stage.

Case Study F

Ms L had an unremarkable pregnancy. Ms L was reviewed at 35+0 and 37+0. She was not reviewed again until her presentation at the hospital when she was 39+3. Ms L had been experiencing contractions since the night before. She was now contracting every 10 minutes. A vaginal exam revealed that she was dilated at about 4cm and the membranes were intact. An ultrasound was performed, which showed that Baby L was in the breach position. It was not documented which breach position Baby L was found to be in nor the position of the head.

Ms L was given options for a vaginal birth or a caesarean section. Ms L preferred a caesarean section. A caesarean section was confirmed by the consultant. About 26 minutes later there was a spontaneous rupture of the membranes. Baby L's heart rate was documented at 160bpm.

A vaginal exam confirmed full dilation with Baby L's feet being located in the upper vagina, known as "footling breach." At this point a caesarean, which would have been standard practice, was abandoned in favour of a vaginal birth. Ms L was not consulted nor advised on this procedure and intervention from her husband asking that a caesarean be continued was ignored.

Further, an expert has opined that it is not widely accepted practice to attempt to deliver a singleton footling breech by traction (breech extraction) when there is no spontaneous progress of the baby down the birth canal.

Ms L pushed for about 20 minutes with no progress. Traction was applied to the feet with no effect. Baby L's buttocks were found to be palpated and high above the public symphysis. The consultant unsuccessfully sought assistance from another OB, and another OB was contacted to attend and assist. This took approximately 13 minutes. An expert has commented that it is widely accepted practice to proceed to caesarean section and not instruct Ms L to "push" for 20 minutes under such circumstances. To attempt breech extraction (applying traction to the fetal feet) in the face of no progress goes against established and widely accepted obstetric practice. A caesarean section should have been performed before this time.

About 50 minutes after admission to theatre, the decision to proceed with a caesarean section was made. Once the caesarean was commenced and the abdomen and uterus were open, attempts were made to deliver Baby L vaginally. Downward pressure was placed on Baby L. Baby L’s head was found to be deflexed and the use of forceps and ventouse were applied.

15 minutes after deciding to proceed with the caesarean section, Baby L was born with the aid of forceps. Baby L was born in poor condition. Baby L was apneic, pale and floppy. Resuscitation was commenced and was ongoing for about 15 minutes when there was the return of sudden circulation. Baby L was breathing spontaneously.

Shortly after birth, seizure activity was noticed. The prognosis for Baby L was guarded. Baby L was unable to survive without ongoing and invasive respiratory support. Baby L was intubated and treated palliatively. Baby L died approximately two weeks after their birth. The cause of death was hypoxic brain injury and injuries included the complete severing of nerves in the back of the baby’s head due to the pushing and pulling ono Baby L’s head.

Apologies were made verbally to the family by one doctor involved.

It appears clear that had a caesarean been performed at the appropriate time, Baby L would have survived.

Baby L’s family suffer significant trauma as a result of the above circumstances, which were preventable.

On the issue of consent, Ms L says nothing was said to her in advance about breech delivery and the options available, she didn’t even know Baby L was breech as no ultrasound was performed until she was in labour. It appears the relevant rural hospital did not have an ultrasound machine and relied on midwives feeling the breech between 20 and 40 weeks.

Baby L was a big baby and Ms L believes the hospital should have known earlier than labour and she could have been booked in for a caesarean. She then believes she would have been able to be appropriately consented as to the risks of continuing with the vaginal birth, etc. Ms L states that upon attendance at the hospital, whilst in active labour, staff were going to send her home; however, she refused and staff then did a scan through which it was found that Baby L was in breech position.

Ms L says it was put to her that medical staff could manoeuvre Baby L or do a caesarean. Ms L consented to a caesarean. She did not consent to vaginal birth and was not asked if she wanted the switch to the vaginal birth when it occurred. This includes no advice about any advice on the risks of pushing by her, pulling by the medical staff (and the vaginal attempt). There was no communication in the moment as to why that change was made and medical staff did not explain what was occurring.

Ms L considers that, had the procedure been performed, Baby L would be alive. Initial expert advice is that the vaginal birth should not have been attempted and, had a caesarean been performed, Baby L would have survived.

Ms L's husband, Mr L watched the birth unfolding and became frustrated seeing the rough and hard pulling the consultant was applying to Baby L and said, "You're going to fucking kill him." Medical staff tried to calm him down.

Ms L says if she had known that the staff were not experienced in this type of birth and had known there were other births in the same hospital involving both staff members which had resulted in damage to babies, Ms L would not have gone to that hospital at all.

Ms L recalls the paediatrician coming into the room late in the piece, shaking his head, looking down and that's when Baby L had pooed himself, she recalls Mr L stated they had "lost him". The paediatrician later said to Ms L that they "should not have done it" (the vaginal delivery attempt). There were other options.

Ms L is concerned that both doctors are still practising, that nothing has happened to her knowledge internally and that she has heard of more babies and mothers being injured by rough births in the same hospital, involving the same staff.

Ms L is aware that mistakes happen however when it's not a once off for both doctors involved and it is preventable, she feels it is disgusting that nothing happens. In Ms L's view: "Something needs to change".

The underlying causes and factors contributing to birth trauma

13. This section of the ALA's submission will address the underlying causes and factors contributing to the prevalence of birth trauma in Tasmania, including exacerbating factors.

14. The ALA contends that these causes and factors reflect serious systemic issues, which the ALA submits must be urgently addressed. The ALA will present our recommendations for reform in the final section of this submission.

15. The ALA acknowledges that understaffing and scarce resourcing across Tasmania's health system, including maternity care, greatly underwrites decisions and actions which ultimately lead to birth trauma and the associated injuries. **The ALA urges the Select Committee to recommend that the Tasmanian Government addresses these staffing and resourcing shortcomings urgently as a matter of priority in the interests of public health and safety.**

Lack of communication, informed discussions and education compromising informed consent

16. The ALA submits that a lack of communication between medical professionals and women (during pregnancy, when in labour and after delivery) – and by extension her support networks – is a feature in many birth trauma cases.

17. There appears to even be a reluctance generally to discussing birthing options and the likely risks and complications associated with giving birth, including in relation to the use of instruments or undertaking a caesarean section. This is putting women and their babies at increased risk before, during and after delivery, as well as robbing women of the opportunity to provide proper and informed consent.

18. Since *Rogers v Whitaker*,[6] the law in Australia has recognised and protected the individual's autonomy to make informed decisions about what happens to them and their body. The ALA submits that this is particularly important in pregnancy since the baby is being born via a mode or modes of delivery – staying in is not an option. Therefore, proper and informed consent should include a discussion of all reasonable alternative modes of delivery, and the risks and benefits (to the woman giving birth and the baby) associated with each. It is only when presented with the full suite of such options can the woman giving birth's right to make an informed choice be truly respected.

19. The ALA further submits that informed consent must not be considered as a 'one-time event' during labour and, moreover, it is not limited to signing a consent form that is often thrust upon women in a rushed and emergency situation. Pregnant women need to receive adequate information throughout their pregnancies and be involved in decision-making at all stages. That is true and informed consent.

20. As detailed in our recommendations for reform in the next section of this submission, the ALA contends that this process should commence in the antenatal period and continue through the labour and into the post-partum period.

21. Further, good documentation of care and the development of a birth plan are very important, especially when there are breaks in continuity of care (as discussed below).

[6] [1992] HCA 58; (1992) 175 CLR 479.

No continuity of care

22. The ALA contends that there is currently a lack of continuity of care for pregnant women and women giving birth, especially in the public healthcare system in Tasmania.

23. Care is fragmented and women are regularly seen by different medical professionals at antenatal appointments, even in the immediate leadup to giving birth. Those women are then assisted by medical professionals they have never met during the birth.

24. There can often be minimal, inconsistent or rushed communication between the various medical professionals caring for pregnant women and women giving birth. With regard also to reports that registrars are undertaking complex procedures in circumstances where it is not appropriate for them to do so, the status quo places those women at greater risk of having a traumatic birth. A lack of continuity of care is particularly risky for first-time mothers, who do not have prior experience giving birth.

The use of instruments during delivery

25. In the experience of ALA members' clients, the use of instruments during vaginal deliveries greatly increases the chance of the woman giving birth (and others involved) experiencing birth trauma. In 2021, 21.6 per cent of women surveyed had an instrument-assisted delivery in Tasmania when giving birth for the first time.[7]

26. Forceps and vacuum extractors during vaginal deliveries are routinely used, notwithstanding the risk of injuries. Those injuries include urinary and faecal incontinence, as well as nerve injury that can occur during instrumental delivery. The Australian Institute of Health and Welfare has noted the following about instrumental delivery:[8]

> Both vacuum and forceps assisted delivery are associated with an increased risk of injury to the tissues of the vagina, perineum and anus. This may lead to long-term perineal pain and sexual difficulties; additionally, a very small number may have urinary or faecal incontinence.

27. The literature reports that forceps deliveries are a major cause of levator avulsion injuries leading to a significant risk of symptomatic pelvic organ prolapse and incontinence –

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[7] Australian Institute of Health and Welfare, *National Core Maternity Indicators* (Web report, 13 July 2023) <https://www.aihw.gov.au/reports/mothers-babies/ncmi-data-visualisations/contents/labour-and-birth-indicators/instrumental-vaginal-birth>.

[8] Ibid.

specifically, a 40 to 60 per cent increased risk of obstetric anal sphincter injuries (OASIs) and other maternal pelvic floor injuries with forceps delivery.[9]

28. The ALA submits that the rate of birth trauma cases arising from the use of instruments speaks to the increased risk of birth trauma posed by the use of these instruments.

Exacerbating factors and experiences

Regional and rural Tasmania

29. ALA members report that there are increasing numbers of women presenting for legal assistance after experiencing significant problems giving birth in regional and rural areas. Many medical negligence claims arise as a result of maternal birth trauma experienced in hospitals or medical facilities in regional and rural areas.

30. The ALA submits that the gap between medical services offered to those in urban centres versus medical services offered in rural and regional Tasmania must be closed. The current gap in medical services provision is not in any way an excuse – and nor should it ever be used as an excuse – for the evident failures in the standard of care experienced by those giving birth in rural and regional Tasmania. Patients in regional and rural areas of Tasmania are entitled to the exact same standard of care as persons in cities. That includes medical professionals in regional and rural areas of Tasmania having the same level of skill and knowledge as medical professionals in urban centres.

31. We note that many of the case studies presented earlier in the ALA's submission were instances of birth trauma experienced in regional medical facilities in Tasmania.

32. The issue stems from the care women feel able to access from early in their pregnancy. The Australian Institute of Health and Welfare reports that women living in remote areas

[9] See, egs, Talia Friedman, *Instrumental Delivery and OASI* (IUGA annual meeting, August 2016); Hans Peter Dietz, Peter D Wilson and Ian Milsom, 'Maternal birth trauma; why should it matter to Urogynaecologist?' (2016) 28(5) *Current Opinion in Obstetrics and Gynecology* 441; Hans Peter Dietz, 'Pelvic floor trauma in childbirth' (2013) 53(3) *Australian and New Zealand Journal of Obstetrics and Gynaecology* 217.

(including in Tasmania) are less likely to have an antenatal visit in their first trimester, not receiving that care until their second or even third trimester.[10]

33. The ALA thus submits that being located in a regional or rural area is currently a barrier to receiving trauma-informed care, including in Tasmania.

34. This is directly connected to staffing levels, poor staff training and limited resourcing (including available technology and medical equipment, such as ultrasound machines), as well as the distance regional and rural residents must travel to receive medical care or specialised medical services.

Aboriginal and Torres Strait Islander peoples

35. The ALA notes that, in general and across Australia, the gap in health status between Aboriginal and Torres Strait Islander peoples and non-indigenous Australians has always been unacceptably wide.

36. Studies and reviews have demonstrated that the needs of Aboriginal and Torres Strait Islander women (including but not limited to those living in regional and rural areas) during their pregnancies and while giving birth are not being met physically and holistically.[11]

37. The ALA submits that this is particularly concerning given the pre-existing conditions experienced by Aboriginal and Torres Strait Islander peoples at higher rates than non-Indigenous members of the public means that many Aboriginal and Torres Strait Islander women will have high-risk pregnancies. Examples of those conditions are diabetes, cardiovascular disease, hypertension, and respiratory illnesses.

38. The experience of Aboriginal and Torres Strait Islander clients of ALA members reveals that the system is currently failing Aboriginal and Torres Strait Islander women before, during and after they give birth in Australia, including in Tasmania.

[10] Australian Institute of Health and Welfare, *Australia's mothers and babies* (Web report, 29 June 2023) <https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/antenatal-period/antenatal-care>.

[11] See, eg, NSW Health, NSW Government, *Continuity of Care Models: A Midwifery Toolkit* (June 2023) 7 <https://www.health.nsw.gov.au/nursing/practice/Publications/midwifery-cont-carer-tk.pdf>.

39. The following factors are currently compromising the experience of Aboriginal and Torres Strait Islander peoples in receiving proper and culturally safe care during their pregnancies and while giving birth, which exposes them to birth trauma as a result:

    a. A lack of culturally-appropriate and accessible information about pregnancy, labour and post-partum recovery for Aboriginal and Torres Strait Islander peoples;

    b. Antenatal care for Aboriginal and Torres Strait Islander women "occurs later and less frequently than for non-Indigenous women",[12] which increases the likelihood of those women having pre-term or low birthweight babies;[13]

    c. Unconscious bias and/or complacency with respect to Aboriginal and Torres Strait Islander health outcomes by some medical professionals – for example, Aboriginal and Torres Strait Islander clients report sentiments (either implicit or explicit) from medical professionals that poor health for Aboriginal and Torres Strait Islander peoples is either their own fault or inevitable;

    d. Relatedly, there is a lack of cultural competency among medical professionals – for example, a lack of protocols around 'women's business' and 'men's business', and the need to ensure the appropriate people are assessing, examining or questioning an Aboriginal and Torres Strait Islander patient to ensure that patient feels safe;

    e. An inherent distrust in government and government services (extending to hospital settings) felt by many Aboriginal and Torres Strait Islander peoples – especially those who have experienced racism directly in healthcare settings;[14] and

    f. A lack of Aboriginal and Torres Strait Islander healthcare workers available to better communicate with and support Aboriginal and Torres Strait Islander patients, which is a symptom itself of the high rates of bullying, harassment and discrimination in healthcare settings.[15]

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[12] Australian Health Ministers' Advisory Council, *Aboriginal and Torres Strait Islander Health Performance Framework* (Report, 2017) 7 <https://www.niaa.gov.au>.

[13] Ibid 8.

[14] See: National Justice Project, *Aboriginal Health Justice* (Web Page. 2023) <https://justice.org.au/category/aboriginal-health-justice>.

[15] Housnia Shams, 'Indigenous doctors call for cultural reform in health sector to address workplace discrimination', *ABC News* <https://www.abc.net.au/news/2022-05-02/indigenous-doctors-workplace-bullying-discrimination-reform/101027964>.

People from culturally and linguistically diverse (CALD) backgrounds

40. ALA members' clients who are from CALD backgrounds report a number of factors which led to their experiences of birth trauma, including:

    a. Language barriers and a lack of available interpreters (if one is even offered at any appointments or during/after labour) with adequate training in medical terminology;

    b. A lack of understanding among many medical professionals of patients' religious and cultural practices – for example, male medical professionals can be sent to undertake a physical, internal examination of a female patient from a CALD background, who would rather only be seen by female medical professionals; and

    c. Unconscious bias and/or complacency with people from CALD backgrounds by some medical professionals.

Young parents

41. While the average age of women giving birth for the first time has been increasing over time, there are still many becoming parents at a young age. In Tasmania in 2021, 1.8 per cent of women who gave birth were under the age of 20 years (noting that this is above the national average, which was 1.5 per cent that year).[16]

42. The ALA contends that it is imperative that young parents receive respectful, safe and comprehensive care before, during and after labour, since women who are under the age of 20 years and who are giving birth "have an increased risk of complications and adverse pregnancy outcomes".[17]

43. Young parents report that their concerns and wishes are often dismissed by medical professionals due to perceptions and their age and inexperience. This is putting young parents at greater risk of experiencing birth trauma, especially if they are not listened to in the birthing process and/or are not afforded the opportunity to provide informed consent.

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[16] Australian Institute of Health and Welfare, *Australia's mothers and babies* (Web report, 29 June 2023) <https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/demographics-of-mothers-and-babies/maternal-age>

[17] Ibid.

Recommendations for reform

44. In addition to our recommendation above regarding rectifying staffing and resourcing issues within Tasmania's health system, the ALA submits the following recommendations for reform for the Select Committee's consideration.

45. We contend the following recommendations for reform should be implemented in order to avoid or reduce instances of birth trauma in Tasmania moving forward.

Clear, respectful communication and trauma-informed, culturally-appropriate care

46. The ALA contends that clear, respectful communication along with the provision of trauma-informed, culturally-appropriate care will improve outcomes for women giving birth and their support networks in Tasmania. It will empower women to make informed choices and provide consent based on being informed – not based on being afraid, intimidated or guilt-tripped.

47. Understanding the birthing process from antenatal care to the birthing suite, as well as from labour care and delivery to post-natal care, empowers women and their support networks to make decisions about their birthing experience. This has been found to reduce adverse outcomes like birth trauma.

48. While many women giving birth may not be medically-trained themselves, they certainly know how they are feeling throughout their pregnancy, during labour and in the post-partum period. Those women should be listened to, given time to advocate for themselves, and immediate action taken to address their concerns.

49. **In order to generally improve the safety and cultural safety of pregnant women and women giving birth in Tasmania, the ALA recommends that comprehensive training is provided to medical professionals about all aspects of birth trauma, medical litigation, and about how to engage with a diverse range of patients**.

    a. This includes the provision of training in cultural safety and accessibility, such as in relation to the provision of healthcare to Aboriginal and Torres Strait Islander peoples and any related policies/protocols.

b. Educating medical professionals about medical litigation would be beneficial for medical professionals to understand that clients are seeking damages to restore themselves to the position they would otherwise have been in health-wise, not as a punitive measure. This is an important distinction which may affect how medical professionals currently view birth trauma litigation.

c. All of these new training initiatives must be included in the curricula of health and medical degrees and should be required as part of ongoing professional development for medical professionals.

50. **The ALA recommends that during a woman's pregnancy, the following processes and services should be standard across Tasmania as part of providing trauma-informed care which prioritises informed choice and consent**:

    a. Discussions must be initiated by medical professionals early in the pregnancy about birthing options and any risk factors and possible complications associated with natural, caesarean section and instrumental deliveries, so that women and their support networks can be prepared to make informed decisions if/when complications arise;

    b. Written material – in accessible and culturally-appropriate forms – must also be provided after those verbal discussions, so that women and their support networks can consider such material in between antenatal appointments; and

    c. Ultimately, birth plans should be developed in advance of labour (with the assistance of interpreters and/or Aboriginal and Torres Strait Islander healthcare support services, where needed), as birth plans have been found to empower women during their birthing experience. Birth plans should include:

        i. a woman's preferences regarding pain relief and instrumental/surgical interventions;

        ii. a woman's preferences regarding by which medical professionals she is (or is not) comfortable being examined or treated;

        iii. what medical professionals have explained to the woman giving birth during antenatal appointments, and what risks she understands as a result of those discussions;

iv. what decisions the woman giving birth and her support network may need to make during labour, and what their preferences are (preferences which should be considered even in an emergency or urgent situation).

51. Addressing errors and mistakes can significantly reduce the trauma experienced by women who give birth and their support network, and also allows those women and/or their child to receive the earliest possible care and treatment. **The ALA thus recommends that the following processes and services should be standard for women while giving birth and when post-partum in Tasmania, as well as for their immediate support network, as part of providing trauma-informed care**:

    a. Appropriate debriefing after the birth (including apologies, if relevant);

    b. Regular conversations and check-ins, especially with the woman who has given birth;

    c. Accessible counselling being offered;

    d. The provision of any physical treatments needed (such as pelvic floor physiotherapy and general physiotherapy); and

    e. the swift release of medical records upon request by the woman who gave birth and/or her support network.

52. **The ALA contends that the above recommendations will only have impact if they are implemented alongside processes which facilitate continuity of care for women and their support networks before, during and after those women give birth in Tasmania**.

Developing a regional and rural strategy

53. The ALA notes the Tasmanian Government's commitment to improving health outcomes and services provision in regional and rural Tasmania, as outlined in the *Long-Term Plan for healthcare in Tasmania 2040*.[18]

[18] See: Department of Health, Tasmanian Government, *Long-Term Plan for healthcare in Tasmania 2040* (June 2023) <www.health.tas.gov.au/publications/long-term-plan-healthcare-tasmania-2040>.

54. However, this document does not focus on maternal health and birth trauma in general, including the experiences of those giving birth in regional and remote Tasmania.

55. **The ALA thus recommends that a clear and detailed strategy must be developed by the Department of Health to improve outcomes specifically for those giving birth in regional and rural areas of Tasmania. Health guidelines must be updated to reflect this strategy.**

56. This strategy and the resulting guidelines must include measures like the appropriate transfer of patients for labour or treatment – including but not limited to transferring women at high risk before any risk eventuates. Patients must be referred and transported if necessary to hospitals with the appropriate treatment equipment and interventions at the earliest possible time. This includes, where needed, transfer to Melbourne.

Training opportunities and legislative solutions

57. **The ALA recommends that the Tasmanian Government requires and provides for comprehensive training on safe, trauma-informed to be undertaken by all medical professionals in Tasmania who interact with women and their support networks at any stage of a woman's pregnancy or delivery**.

    a. This would encourage adherence by those medical professionals to any current or future regulations and policy guidelines for safe and trauma-informed deliveries. In turn, those medical professionals would also be better placed to communicate effectively with patients and educate them about risks and potential injuries before, during and after birth.

58. **The ALA also supports exploring ways birth trauma could be directly enshrined in legislation in Tasmania**. An example can be found in New Zealand, where the Royal Australian and New Zealand College of Obstetricians and Gynaecologists supported amendments to New Zealand's Accident Compensation legislation "to enable more women to access the care that they need after experiencing birth injuries".[19]

[19] The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *RANZCOG supports amendments to Accident Compensation in Aotearoa New Zealand* (News, 15 June 2022) <https://ranzcog.edu.au/news/maternal-birth-injury>.

59. **Finally, the ALA also recommends that the following be considered by the Select Committee**:

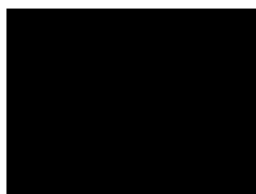
    a. Ensuring that whistleblower protections and mechanisms are available to medical professionals in Tasmania, so that concerned medical professionals can anonymously report incidents and systemic issues without fear of repercussions; and

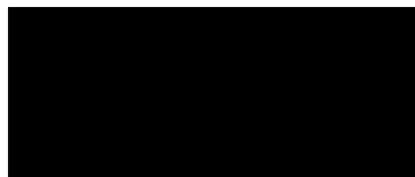
    b. Where processes fail and women and/or their support networks experience birth trauma, there must be adequate, independent and responsive complaints processes in place.

Conclusion

60. The Australian Lawyers Alliance (ALA) welcomes the opportunity to have input into the Select Committee on Reproductive, Maternal and Paediatric Health Services in Tasmania's inquiry into reproductive, maternal and paediatric health services in Tasmania.

61. The ALA is available to provide further assistance to the Select Committee on the issues raised in this submission.





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