LEGISLATIVE COUNCIL

SELECT COMMITTEE ON BIRTH TRAUMA

Birth trauma

May 2024

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Select Committee on Birth Trauma

Birth trauma

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Birth trauma

"May 2024"

Chair: Hon Emma Hurst MLC

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Table of contents

Terms of reference

1. That a select committee be established to inquire into and report on birth trauma, and in particular:

   (a) the experience and prevalence of birth trauma (including, but not limited to, as a result of inappropriate, disrespectful or abusive treatment before, during and after birth, also referred to as "obstetric violence")

   (b) causes and factors contributing to birth trauma including:
      (i) evaluation of current practices in obstetric care
      (ii) use of instruments and devices for assisted birth e.g., forceps and ventouse
      (iii) the availability of, and systemic barriers to, trauma-informed care being provided during pregnancy, during birth and following birth

   (c) the physical, emotional, psychological, and economic impacts of birth trauma, including both short and long term impacts on patients and their families and health workers

   (d) exacerbating factors in delivering and accessing maternity care that impact on birth trauma generally, but also in particular:
      (i) people in regional, rural and remote New South Wales
      (ii) First Nations people
      (iii) people from culturally and linguistically diverse (CALD) backgrounds
      (iv) LGBTQIA+ people
      (v) young parents

   (e) the role and importance of "informed choice" in maternity care

   (f) barriers to the provision of "continuity of care" in maternity care

   (g) the information available to patients regarding maternity care options prior to and during their care

   (h) whether current legal and regulatory settings are sufficient to protect women from experiencing birth trauma

   (i) any legislative, policy or other reforms likely to prevent birth trauma, and

   (j) any other related matter.

2. That the committee report by 3 June 2024.[1]

The terms of reference for the inquiry were referred to the committee by the Legislative Council on 21 June 2023.[2]

[1] The original reporting date was 1 February 2024 (*Minutes*, NSW Legislative Council, 21 June 2023, pp 208-211). The reporting date was later extended to 3 June 2024 (*Minutes*, NSW Legislative Council, 12 September 2023, p 435).

[2] *Minutes*, NSW Legislative Council, 21 June 2023, pp 208-211.

Committee details

Committee members

Hon Emma Hurst MLC	Animal Justice Party	*Chair*
Hon Susan Carter MLC	Liberal Party	*Deputy Chair*
Hon Mark Banasiak MLC	Shooters, Fishers and Farmers Party	
Dr Amanda Cohn MLC	The Greens	
Hon Anthony D'Adam MLC	Australian Labor Party	
Hon Stephen Lawrence MLC*	Australian Labor Party	
Hon Natasha Maclaren-Jones MLC	Liberal Party	
Hon Sarah Mitchell MLC	The Nationals	
Hon Emily Suvaal MLC	Australian Labor Party	

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* The Hon Stephen Lawrence MLC replaced the Hon Greg Donnelly MLC as substantive member of the committee from 16 May 2024.

Secretariat

Jessie Halligan, Principal Council Officer
Julianna Taahi, Senior Council Officer
Kara McKee, Senior Council Officer
Tina Mrozowska, Council Officer
Shaza Barbar, Director

Chair's foreword

The NSW Legislative Council Select Committee on Birth Trauma marked a significant milestone as the first time a parliamentary committee examined and reported on birth trauma. This undertaking and the unprecedented scale of evidence received reflected the growing recognition of the importance of addressing this form of gendered violence.

The catalyst for this inquiry was the growing awareness of birth trauma and concern about its impact on parents and families across New South Wales. The Australian Birth Experience Study (BESt) from Western Sydney University, published in December 2022, revealed that 28 per cent of women experienced birth trauma and more than one-in-ten experienced some form of obstetric violence. In addition, in 2022, Maternity Consumer Network lodged a complaint with the Health Care Complaints Commission on behalf of 30 brave women who alleged that they had endured traumatic birth experiences at Wagga Wagga Base Hospital.

The committee received over 4000 submissions, reflecting the depth of community engagement and concern regarding birth trauma. The committee held six public hearings: four at Parliament House in Sydney, one in Wollongong, and one in Wagga Wagga. During these hearings the committee heard from a diverse range of organisations, healthcare practitioners, researchers, subject matter experts, representative bodies, government agencies, and most importantly from individuals who shared their stories of pregnancy, childbirth and early parenthood. Hearing these experiences, it was clear to the committee that there are a significant number of individuals who have suffered preventable birth trauma in New South Wales and the experiences of the people who gave evidence to this inquiry are unacceptable. We also found that urgent efforts must be made to address avoidable and preventable factors that contribute to birth trauma.

The evidence highlighted a number of factors contributing to avoidable birth trauma which the committee believes must be urgently addressed, such as lack of continuity of care, lack of trauma-informed practices, inadequate antenatal education, inadequate informed consent practices, a lack of respect for women's birthing choices and experiences, and a lack of inclusivity and culturally-appropriate services within in maternity care. We also heard that some of these issues are exacerbated by maternity workforce shortages and resource constraints.

The committee therefore made 43 recommendations to the NSW Government that we believe will go a long way in addressing preventable birth trauma, including a primary recommendation that all women have access to continuity of care models with a known provider. Midwifery continuity of care was identified as the 'gold standard', which is why the report also recommends the NSW Government invest in and expand midwifery continuity of care models, address midwifery shortages and appoint a standalone Chief Midwifery Officer.

The report also makes important recommendations regarding the need for comprehensive antenatal education, reviewing laws around informed consent and requiring maternity health practitioners to undergo informed consent training, supporting women's birth preferences, the need for improvements in mental health support and postpartum services, and adopting trauma-informed care practices in maternity care.

On behalf of the committee, I extend our deepest gratitude to all who contributed to this inquiry, especially the brave individuals who shared their experiences of birth trauma. We also acknowledge the dedication and hard work of the maternity healthcare professionals who work tirelessly to deliver excellent care in challenging circumstances.

I thank my fellow committee members for their commitment and engagement throughout the inquiry. I also thank the committee secretariat (and in particular, Ms Jessie Halligan) for their hard work, dedication and capable assistance.

We take pride in the significance of this world-first inquiry, which has even inspired efforts globally. We commit to ensuring this momentum continues, fostering reforms that ensure all parents receive high quality healthcare, along with respect and support throughout pregnancy and childbirth.

Our hope is that the evidence documented in this report will not only inform the NSW Government's consideration of these matters, but more importantly, prompt action across Australia and the world with the hope that every birth is met with dignity, respect and compassion.

The Hon Emma Hurst MLC

Committee Chair

Glossary

The following terms are commonly used throughout the report. For convenience to the reader, the below definitions have been collated directly from the Australian Institute of Health and Welfare glossary, unless specified otherwise.[3]

Antenatal	The period covering conception up to the time of birth. Synonymous with prenatal.
Apgar score	Numerical score used to indicate the baby's condition at 1 minute and at 5 minutes after birth. Between 0 and 2 points are given for each of 5 characteristics: heart rate, breathing, colour, muscle tone and reflex irritability. The total score is between 0 and 10.
Caesarean section	A method of birth in which a surgical incision is made into the mother's uterus via the abdomen to directly remove the baby.
Congenital abnormality	A condition that is recognised at birth, or is believed to have been present since birth, including conditions inherited or caused by environmental factors.
Doula	A doula is a non-medical birth person who can help you before, during and after childbirth.[4]
Epidural	An epidural is an injection of local anaesthetic or pain-relieving drugs (or both) into the lower back to block the nerves that come from the uterus and the surrounding muscles. These are the source of the pain felt during contractions in labour.[5]
Episiotomy	An incision of the perineum and vagina to enlarge the vulval orifice.
Freebirth	The practise of birthing without the care of a registered health practitioner.[6]
Gestational age	Duration of pregnancy in completed weeks, calculated from the date of the first day of a woman's last menstrual period and her baby's date of birth; or via ultrasound; or derived from clinical assessment during pregnancy or from examination of the baby after birth.
Homebirth	Some women may choose to give birth in their own home, with appropriately experienced professionals, as an alternative to inpatient hospital care.[7]

3 *Mothers & babies: Glossary* (15 August 2023), Australian Institute of Health and Welfare, https://www.aihw.gov.au/reports-data/population-groups/mothers-babies/glossary.

4 *Doula factsheet* (January 2024), Hunter New England Local Health District / Women's Health and Maternity Network, https://www.hnehealth.nsw.gov.au/__data/assets/pdf_file/0004/460525/HNELHD_FACT_24_01_Doula_Factsheet_1.pdf.

5 *Epidural Pain Relief (Maternity)* (16 March 2017), South Eastern Sydney Local Health District, Royal Hospital for Women, https://www.seslhd.health.nsw.gov.au/sites/default/files/groups/Royal_Hospital_for_Women/docs/epiduralmaternity.pdf.

6 Submission 242, NSW Nurses and Midwives' Association, p 18.

7 Health and Social Policy, *Public Homebirth Services in NSW* (September 2020), NSW Health, https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2020_022.pdf, p 5.

Incontinence – urinary and faecal	A term that describes any accidental or involuntary loss of urine from the bladder (urinary incontinence) or bowel motion, faeces or wind from the bowel (faecal or bowel incontinence).[8]
Induction of labour	Intervention to stimulate the onset of labour.
Instrumental birth – forceps and vacuum	Vaginal delivery using forceps (handheld, hinged obstetric instrument applied to the fetal head to assist birth) or vacuum extraction (assisted birth using traction or rotation on a suction cap applied to the baby's head).
Intrapartum	Occurring or provided during the act of birth.[9]
Intervention	In some circumstances, intervention (such as induction of labour, use of forceps or vacuum extraction, or caesarean section) may be required.[10]
Labour – first, second, third	The physiological process by which a vaginal birth occurs that commences at the onset of regular uterine contractions that act to produce progressive cervical dilatation, and is distinct from spurious labour or pre-labour rupture of membranes.
Lactation	The secretion or formation of milk.[11]
Levator avulsion	The main group of muscles of the pelvic floor is called the 'levator' muscles. Levator avulsion occurs when these muscles are overstretched or sometimes torn off the bone during vaginal birth.[12]
Medico-legal	Of or relating to both medicine and law.[13]
Midwife	Health professional who specialises in caring for women during pregnancy, labour, birthing and the postnatal period.[14]
Miscarriage	A pregnancy that ceases prior to 20 weeks gestation.

8 *Continence Clinics* (29 June 2021), Mid North Coast Local Health District, https://mnclhd.health.nsw.gov.au/community-nursing-services/continence-clinics/.

9 *Merriam-Webster.com Medical Dictionary* (online at 1 May 2024) 'intrapartum'.

10 *Connecting, listening and responding: A Blueprint for Action – Maternity Care in NSW* (March 2023), NSW Health, https://www.health.nsw.gov.au/kidsfamilies/MCFhealth/professionals/Publications/maternity-care-in-nsw.pdf, p 40.

11 *Macquarie Dictionary* (online at 1 May 2024) 'lactation' (def 1).

12 *Pelvic floor muscle damage* (2020), Australasian Birth Trauma Association, https://birthtrauma.org.au/physical-birth-trauma/pelvic-floor-muscle-damage/.

13 *Merriam-Webster.com Dictionary* (as at 26 April 2024) 'medicolegal'.

14 Health and Social Policy, *Maternity - Towards Normal Birth in NSW* (29 June 2010), NSW Health, https://www1.health.nsw.gov.au/pds/ArchivePDSDocuments/PD2010_045.pdf.

Neonatal	The neonatal period is exactly four weeks or 28 completed days, commencing on the date of birth (day 0) and ending on the completion of day 27.[15]
NICU	Neonatal intensive care unit
'Normal' birth	According to the now rescinded policy, the term normal birth relates to birth with minimal intervention or no medical intervention.[16]
Obstetrician	An obstetrician is a doctor with specialist qualifications. Obstetricians are trained to provide medical care during pregnancy (antenatal care), labour and birth, after the birth (postnatal care). Obstetricians have the skills to manage complex or high-risk pregnancies and births, and can perform interventions and caesareans.[17]
Pelvic floor	The pelvic floor muscles are a supportive basin of muscle attached to the pelvic bones by connective tissue to support the vagina, uterus, bladder and bowel. [18]
Perinatal	Pertaining to or occurring in the period shortly before or after birth (usually up to 28 days after).
Perineal tears	A perineal tear is a laceration of the skin, muscles and other soft tissues that separate the vaginal opening and the anus (back passage) also referred to as your perineum — the area between the vagina and anus. During labour, the skin and muscles between the vagina and anus stretch so the baby can be born. Sometimes the area gets torn, which results in a perineal tear.[19]
Postnatal	Pertaining to the period immediately after the birth and lasts for 6 weeks. The terms postpartum and postnatal are often used interchangeably, however, 'postnatal' refers to the baby.
Postpartum	Pertaining to the period immediately after the birth and lasts for 6 weeks. The terms postpartum and postnatal are often used interchangeably, however, 'postpartum' refers to the woman.
Prolapse	A falling down of an organ or part, as the uterus, from its normal position.[20] Pelvic organs (uterus, bladder and rectum) can prolapse when the tissues that hold them in place are stretched or weakened.[21]

15 *Neonate,* (2024), METEOR Metadata Online Registry Australian Institute of Health and Welfare, https://meteor.aihw.gov.au/content/327284.

16 Health and Social Policy, *Maternity - Towards Normal Birth in NSW* (29 June 2010), NSW Health, https://www1.health.nsw.gov.au/pds/ArchivePDSDocuments/PD2010_045.pdf, p 3.

17 *What does an obstetrician do?* (February 2023), Pregnancy birth & baby, Department of Health and Aged Care, https://www.pregnancybirthbaby.org.au/the-role-of-your-obstetrician.

18 *Pelvic floor muscle damage* (2020), Australasian Birth Trauma Association, https://birthtrauma.org.au/physical-birth-trauma/pelvic-floor-muscle-damage/.

19 *Perineal tears* (June 2023), Pregnancy birth & baby, Department of Health and Aged Care, https://pregnancybirthbaby.org.au/perineal-tears.

20 *Macquarie Dictionary* (online at 1 May 2024) 'prolapse' (def 1).

21 *Prolapsed uterus* (September 2023), Healthdirect Australia, https://www.healthdirect.gov.au/prolapsed-uterus.

Spontaneous labour	Onset of labour without intervention.
Stillbirth	The loss of a baby after 20 weeks is called a stillbirth.
Vaginal tears	See **perineal tears**.

Findings

Recommendations

- providing additional financial support for parents traveling from regional, rural and remote areas
- implementing the recommendations of the 2022 inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales.
- upgrading equipment and increasing accessibility for people with disabilities in maternity care spaces
- increasing access to antenatal education and postpartum support services for fathers and non-birthing parents, including online support groups
- ensuring fathers, non-birthing parents and nominated birth partners are keep informed throughout birth, to enable them to advocate
- ensuring access to professional interpreters with medical training and, where possible, continuity of interpreter
- investigating any allegations of racism and discrimination within maternity care in New South Wales
- providing appropriate education and training for maternity healthcare practitioners to address concerns around racism and discrimination.

Recommendation 35 **113**

That the NSW Government ensure dedicated spaces are available for parents experiencing miscarriage or stillbirth in all healthcare settings, including private waiting rooms separate from pregnant women, new mothers and babies, and that all maternity healthcare practitioners are provided training on bereavement support.

Recommendation 36 **113**

That the NSW Government improve psychological support for parents managing grief following pregnancy loss.

Recommendation 37 **114**

That the NSW Government review and revise guidelines for informing parents of fetal anomalies and genetic conditions ensuring that clinicians:

- present unbiased options
- offer ample time and support for decision-making
- provide trauma-informed assistance and psychological support to aid parents in coping with the emotional impact of such diagnoses.

Recommendation 38 **114**

That NSW Health liaise with peak and parent bodies representing parents, children and families with members who have fetal abnormalities or genetic conditions and arrange with them to provide information on a website about support and education for expectant parents with a child diagnosed with these issues. This website should be circulated widely among expectant parents.

Recommendation 39 **122**

That the NSW Government undertake consultation to consider legislative change to protect health practitioners when delivering individualised, responsive maternity care, and ensure that consumers' birthing decisions and preferences can be supported and respected.

Conduct of inquiry

The NSW Legislative Council inquiry into birth trauma was the first time a parliamentary committee examined and reported on birth trauma in New South Wales.

The terms of reference for the inquiry were referred to the committee by the Legislative Council on 21 June 2023.

The committee received over 4000 submissions and supplementary submissions. Due to the large quantity of submissions received, the committee prioritised the publishing of submissions from individuals residing in New South Wales and resolved to keep submissions from individuals residing outside New South Wales confidential.

The inquiry comprised of six public hearings: four held at Parliament House in Sydney, one in Wollongong, and one in Wagga Wagga. Representatives from NSW Health provided evidence at four of these public hearings.

Inquiry related documents are available on the committee's website, including submissions, hearing transcripts, tabled documents, answers to questions on notice, answers to supplementary questions and correspondence.

Procedural issues

Prior to the first public hearing, the committee held a private briefing with four experts: Adjunct Professor Michael Nicholl, Obstetric Advisor to NSW Health and Chief Executive, Clinical Excellence Commission; Dr Hazel Keedle, Senior Lecturer of Midwifery, Western Sydney University; Dr Athena Hammond, Counsellor and Psychotherapist; and Mr Steven Collins, Senior Aboriginal Liaison Officer, NSW Parliament. This confidential briefing was an opportunity to understand fundamental aspects of birth trauma and current practices in obstetric care in New South Wales. Additionally, it facilitated discussions on trauma-informed approaches for engaging witnesses who have firsthand experiences of birth trauma.

Recognising the sensitive nature of birth trauma experiences, the committee made a number of adjustments to standard practice, particularly for committee hearings.

Firstly, the committee invited witnesses with lived experiences to meet with the committee members before public hearings, allowing them to acquaint themselves and have an informal conversation before the proceedings commenced. Furthermore, the committee passed a resolution to have two mental health clinicians from the Gidget Foundation attend public hearings to provide emotional support, counselling and to debrief with witnesses who shared their personal experiences of birth trauma.

The committee also passed a resolution for the Chair to include a warning regarding the sensitive content and themes at the start of each public hearing. In addition, a statement was placed on the inquiry webpage including a list of mental health and support services for people to contact if they felt distressed by the inquiries content.

Seeking support

The below resources are available to those who may feel distressed as a result of this report's sensitive content and themes:

Lifeline 13 11 14 (24/7) or text 0477 13 11 14. Lifeline is a free 24/7 telephone crisis support service.

Mental Health Line 1800 011 511. Mental Health Line is a NSW 24/7 statewide phone services which links people with NSW mental health services.

PANDA National Helpline (Monday to Saturday) 1300 726 306 or visit the website for more information: https://panda.org.au/ PANDA's National Perinatal Mental Health Helpline is Australia's only free national helpline for people affected by changes to their mental health and emotional wellbeing during the perinatal period. Support is available throughout pregnancy up until the baby is 12 months old.

Domestic Violence helpline 1800RESPECT or 1800 737 732 is available 24/7 to support people impacted by domestic, family, or sexual violence. Or visit the website for more information: https://1800respect.org.au/

Chapter 1 Introduction

This chapter sets the scene for the report, providing contextual information on the establishment of this landmark inquiry. The chapter then highlights the significant contribution and insights offered to the committee by consumers and health practitioners through their lived experiences of birth trauma.

Context leading to the establishment of the inquiry

1.1 The Select Committee into Birth Trauma was established on 21 June 2023 to inquire into and report on birth related trauma for women in New South Wales.[22]

1.2 The committee was established following increasing attention on the issue of birth trauma in 2022 and 2023. In December 2022, a study by the Western Sydney University found that 28 per cent of women in New South Wales reported their most recent birth was traumatic.[23] In June 2023, the ABC reported that a maternity advocacy group, Maternity Consumer Network, had heard from more than 200 women with allegations of mistreatment before, during or after childbirth. Thirty of these women were supported by the Maternity Consumer Network to bring their complaints before the Health Care Complaints Commission.[24]

1.3 Soon after, Committee Chair, the Hon Emma Hurst MLC, brought the issue of birth trauma before the NSW Legislative Council.[25] In her motion to the House, Ms Hurst spoke to specific reports of consumers' experiences of birth trauma in the New South Wales maternity care system.[26]

1.4 The House subsequently established the Select Committee to inquire into:

- the potential causes and contributing factors to birth trauma
- the impact of birth trauma
- the barriers to providing and receiving continuity of care
- methods of delivery and access of educational information on maternity care
- what steps could be taken, if any, to improve the maternity health care system within New South Wales to help reduce the prevalence of birth trauma.[27]

22 *Minutes*, NSW Legislative Council, 21 June 2023, pp 208-211; *Hansard*, NSW Legislative Council, 21 June 2023, p 7900 (Emma Hurst).

23 Submission 232, Western Sydney University, p 5.

24 Kathleen Calderwood, *Investigation underway after 30 women complain about maternity experience at NSW hospital*, (7 June 2023), ABC News, https://www.abc.net.au/news/2023-06-07/wagga-wagga-base-hospital-hccc-investigation/102444994.

25 *Minutes*, NSW Legislative Council, 21 June 2023, p 211.

26 *Hansard*, NSW Legislative Council, 21 June 2023, p 7900.

27 *Minutes*, NSW Legislative Council, 21 June 2023, p 211.

Personal experiences of birth trauma: themes and case studies

1.5 The inquiry garnered significant public interest, receiving over 4000 submissions from individuals with lived experience across the country, organisations and advocacy groups. The majority of submissions focused on the personal experiences of those who had given birth, as well as health practitioners who had experienced vicarious trauma.

1.6 The committee held six hearings and heard from 28 individuals with lived experience as well as numerous health practitioners, academic researchers, and subject matter experts within the field.

Overarching themes

1.7 Many women shared with the committee that they felt dehumanised during their birthing experience. To this end, some common themes emerged as contributing factors to this, including that:

- continuity of care would have made a significant difference[28]
- there was a lack of trauma-informed care with little consideration of past trauma[29]
- informed consent was not a priority[30]
- there was lack of antenatal education and respect for birth plans and preferences[31]
- there were high rates of medical interventions actioned without explanation or, in some cases, medical necessity[32]
- there were workforce shortages and lack of resources[33]
- the focus was solely on the result of the birth and did not consider the health or birthing experience of the mother[34]
- there was a lack of cultural competency and inclusivity[35]

28 See for example, Submission 101, Mrs Courtney Castles, pp 1-3; Submission 107, Ms Mary van Reyk, p 1; Submission 242, Nurses and Midwives Association, p 9; Submission 402, Name suppressed, pp 1-3; Submission 351, Name suppressed, pp 2-3.

29 See for example, Evidence, Ms Carly Griffin, Individual, 7 September 2023, p 10; Evidence, Mrs Amy Mageropoulos, Individual, 9 October 2023, p 6; Submission 1013, Name suppressed, p 1.

30 See for example, Evidence, Ms Laura Johnston, 12 December 2023, pp 2; Submission 73, Mrs Attaya-Rose Peters, p 1; Submission 407, Name suppressed, p 1.

31 See for example, Submission 983, Name suppressed, p 1; Submission 275, Name suppressed, p 1; Submission 594, Name suppressed, p 1.

32 See for example, Evidence, Mrs Carmel Biddle, Individual, 12 December 2023, pp 2; Evidence, Mrs Francesca Male, Individual, 12 December 2023, p 9; Submission 895, Name suppressed, pp 1-3; Submission 964, Mrs Emily Ma'umalanga, p 1; Submission 257, Name suppressed, pp 1-2.

33 See for example, Evidence, Ms Carly Griffin, Individual, 7 September 2023, p 10; Submission 242, NSW Nurses and Midwives' Association, p 10; Submission 415, Name suppressed, p 1.

34 See for example, Evidence, Ms Fiona Reid, Clinical Midwife Consultant, 7 September 2023, p 29; Submission 268, Name suppressed, pp 1-2.

35 See for example, Submission 1042, Name suppressed, pp 2-3; Submission 1077, Veronica Smith, pp 5-7 and pp 10-12.

- there was a lack of compassionate care for those experiencing challenging outcomes such as pregnancy loss or genetic diagnoses[36]
- there was a need for improved support services after birth to support both mental health and physical birth trauma[37]
- complaints were not dealt with adequately.[38]

1.8 Below is a sample of evidence from individuals with lived experience representing these themes:

- 'Having access to continuity of care with a known midwife (and birthing in a stand alone birth centre) has had extraordinary effects on my transition into motherhood, my confidence as a woman and I truly believe led to me not experiencing interventions and avoiding birth trauma. As a midwife, I was desperate not to birth in hospital as I knew that birthing woman are often "on the clock" and can be coerced into interventions'.[39]
- 'I could not join the Midwives program because I was 'high risk'. But that meant I spoke to a new person at the hospital every time, and every time I had to tell them about my miscarriages, and my surgery, and my trauma. I wish so much that there was a program for me which was led by modern concepts of 'tell your story once' and that I had been able to work with a single person, a midwife, all the way through. I could not afford private options'.[40]
- 'I still remember the sinking feeling watching my baby get paler and bluer on my chest instead of getting pink and crying. During these few minutes, I was not aware that they had proceeded to administer the injection to deliver the placenta and had delivered my placenta using traction. I advised that I wished they had asked me first and she said "it's just the placenta, it doesn't even matter. I wanted to hurry it up so I can stitch this up and move on to my next job. My to-do list today is very long." I had a grade 2b tear, and required internal and external stitches, which were being stitched before I was even aware there was a doctor at the end of the bed'.[41]
- 'It is the more insidious features of everyday practice within the hospital system that I believe contributes to the majority of birth trauma. This includes women lacking a sense of agency when navigating the maternity system, and the frequent absence of genuine choice, informed consent and individualised care. Without these, women cannot leave hospital feeling that they had an empowering experience'.[42]

36 See for example, Evidence, Ms Naomi Bowden, Individual, 7 September 2023, pp 2-3; Evidence, Ms Emily Caska, Chief Executive Officer, Down Syndrome NSW, 11 March 2024, pp 52-53; Submission 945, Down Syndrome NSW, pp 16-25.

37 See for example, Submission 70, Mrs Bronwyn Ford, pp 1-2; Submission 78, Sarah Tang, p 1; Submission 1164, Dr Oscar Serrallach, pp 5-6.

38 See for example, Submission 24, Ms Fiona Reid, p 1; Submission 1114, Mrs Anna Cusack, pp 1 and 4; Evidence, Ms Laura Johnston, Individual, 12 December 2023, pp 2-3; Evidence, Mrs Tamara Leetham, Individual, 11 March 2024, p 5.

39 Submission 402, Name suppressed, p 1.

40 Submission 107, Ms Mary van Reyk, p 1.

41 Submission 407, Name suppressed, p 2.

42 Submission 1042, Name suppressed, p 1.

- 'I feel that the antenatal classes provided to my husband and I were vastly (almost ridiculously) lacking. Although they explained the physical progression of labour, I don't feel they remotely prepared us for being in actual labour'.[43]
- 'I, like so many other first-time mothers, was induced. I was not educated in detail on what exactly this would include—namely, the medications used and how they would work or the risks associated with induction. I was told about the risks to my baby if I waited for spontaneous labour. My first birth ended in an emergency caesarean after a long labour with what felt like every medical intervention and analgesia available … After educating myself, I was very fortunate to have my second birth, going into spontaneous labour and delivering my girl with no medical assistance or intervention and only gas at the end'.[44]
- 'My birth plan indicated that due to vaginal exams not being accurate or backed by research I didn't want any. I was subjected to 4 in the span of 30 minutes'.[45]
- 'Waters broke naturally at home we went into the hospital prepped and ready for a natural birth. However this didn't fit with the obstetricians timeline who had a holiday and recreation to attend. So after my wife not being on a single painkiller, no distress with the baby we were labelled failure to progress after only 15 or so hours after waters broke. We were rushed in for an emergency C section and whisked away and on a operation table within 25 minutes. No notice, no explanation, nothing. Being our first child we kind of felt like we had to go along with it because you don't know the process. And it all happens so fast'.[46]
- 'There were no birth suites available and there were already two women labouring on the ward so despite a junior [registrar] standing in the door way and telling me, "if we don't induce tonight, my baby could die", the O&G team finally agreed that since it was already 8pm, breaking protocol and inducing me there and then was not the ideal scenario. There was one remaining induction spot two days later. Suddenly it was no longer so emergent'.[47]
- 'Midwives often face time constraints due to poor staffing, skill mix and high workloads. This can limit the opportunity to engage with women to identify trauma, discuss emotional concerns, and individualised care plans'.[48]
- 'My son survived and is now a happy, healthy two-year-old. However, I need to see psychologists regularly and struggle to seek medical attention when needed for myself. I made a complaint to the Health Care Complaints Commission, and an internal review at my hospital was conducted. I received an apology. My biggest message I want to get across today is: Women are just as important as the babies we birth. Please hear us'.[49]
- 'I didn't have any support during pregnancy. I wasn't offered any support or any information in my own language. I had to listen to everything in English and, because I was very new and listening was so hard for me, it was so hard to understand everything.

43 Submission 101, Mrs Courtney Castles, p 1.

44 Evidence, Mrs Belinda Alexander, Individual, 12 December 2023, pp 9-10.

45 Submission 275, Name suppressed, p 1.

46 Submission 967, Mr Andrew Helin, p 1.

47 Submission 1162, Mrs Kathleen Chilton, p 1.

48 Submission 242, NSW Nurses and Midwives' Association, p 8.

49 Evidence, Mrs Rachelle Edwards, Individual, 9 October 2023, p 10.

It was the first thing—the first trauma. And also I had no-one. I had no friends and no family here… They asked me to sign the papers. Even when English is your first language, when you are stressed, when you are under pain, it is hard to understand medical things. They asked me to sign the paper. I even didn't know what I'm signing. I asked them for an interpreter and the interpreter over the phone was explaining for me—she was telling me the wrong thing. I was an ICU nurse in my home country. I could understand that she is telling me the wrong thing. I had a little bit of medical experience and I could understand. Imagine people in that hospital without any English background'. [50]

- '[My spouse] was left alone with our new baby not knowing what was happening while they gave me two blood transfusions without consent or consultation with my legal spouse. I'm not sure if this is because we're in a queer relationship but they didn't seek consent and I know this is illegal'.[51]
- 'Recalling the events of his prenatal diagnosis is always difficult… Retrospectively, when I think about it, it wasn't the diagnosis that was upsetting. It was having someone speak about your growing child as if they were a burden. Diagnosis or none, the baby was always wanted'.[52]
- 'Miscarriage is a traumatic experience in itself. We need more support for women to ensure that this experience is kept as quiet and as intimate as possible. The majority of the time, I was kept in emergency. Why wasn't I given a private space!?'[53]
- 'I was told I needed a blood transfusion when I moved to the wards. I did not receive one until the next day, when I collapsed next to my husband. I was told it was not done because doctors and nurses did not pass on information to the staff replacing them after their shifts had ended. I received no debrief of what had occurred. I received no mental health care after my first child. I suffered from nightmares for months afterwards… I suffered PTSD and perinatal and postnatal anxiety. I cried all the way through my second pregnancy.… I was diagnosed shortly after [giving birth] when I struggled to find joy being a mother. I underwent 14 months of mental health care to recuperate'.[54]
- 'Unfortunately, the one thing that many of these birth-traumatised women have in common is that nearly no one from the birthing system (whether that be the hospital or community-based facilities) has followed them up in the months after childbirth. Often I am the first health professional they have talked to about their birth trauma experience and this can be years afterwards. The range of emotions expressed to me on a regular basis when mothers share their stories range from rejected despair and deep disappointment to apathy and ambivalence. They have often been left to self-assess their situation as well as seek appropriate health support without informed guidance'.[55]
- 'I did seek legal action and, during this period, the hospital openly admitted that they were actively trying to avoid a caesarean, none of which was discussed with me at any point during my pregnancy journey. Without my knowledge, they were enforcing the now-

50 Evidence, Ms Elahe Yazdani, Individual, 9 October 2023, p 11.

51 Submission 1181, Mrs Tamara Leetham, p 2.

52 Submission 945, Down Syndrome NSW, p 21.

53 Submission 1077, Veronica Smith, p 1.

54 Submission 78, Sarah Tang, p 1.

55 Submission 1164, Dr Oscar Serrallach, p 5.

rescinded NSW Health policy of Towards Normal Birth and trying to avoid increasing their caesarean rate'.[56]

- 'The formal complaints process was inadequate and appeared disingenuous often reassuring complainants that they had received the best care at the most appropriate time. The process was designed to mitigate the risk of litigation and for the organisation to take no responsibility for a woman's traumatic experience that resulted in either or both psychological harm and physical injury. Women did not feel listened to or heard. They were not offered any ongoing support and they were not provided with a plan of care for their next pregnancy that was motivated to re-establish trust in the Hospital's clinicians or improve her experience and outcome. Women felt humiliated by the process'.[57]

1.9 In addition to the experience of women, the committee also heard about the impact of birth trauma on health professionals. The following extracts provide insight into some of the personal challenges health professionals face such as navigating the maternity system while trying to support the mother's choices and experiencing vicarious trauma from witnessing birth trauma:

- 'There is pressure to follow medicalised and out-dated policies and procedures and instructions from those in charge, even when you know it's not evidence-based, in the woman's best interests and against the woman's wishes. When I try to speak up, I'm often patronised in front of my colleagues for being sensitive or dramatic. Every day I see misleading information being presented to women and their families. Some of the things I have witnessed include lack of informed consent. For example, "I'm just going to do a little cut" in regard to an episiotomy. Or one woman who was saying to the doctors "Please this is traumatic" while having forceps applied to her baby's head and the doctor replying "No, it's not, it's not traumatic"'.[58]

- 'I do advocate on their behalf…but it doesn't come without fear or anxiety. Often, I'm left with a feeling of despair or 'letting women down' when I'm not listened to. The only thing I could then do was internalize and blame myself'.[59]

- 'I could write pages and pages of experiences where I have been yelled at, dismissed, locked out of theatre, complained about, and abused verbally for standing up for women. I have witnessed staff being rude to women and rough with babies because the woman dared to make a different choice (and birth at home), when transferred to hospital'.[60]

- 'At times when I have been involved in a traumatic event there has been no support …no debriefing… the midwives are forgotten…I am carrying a lot of trauma…and I don't feel it's recognised or acknowledged'.[61]

- 'I witnessed women experience birth trauma and obstetric violence very early on in my career, right from the beginning in fact as a student midwife. The weight of these women's

56 Evidence, Mrs Amy Mageropoulos, Individual, 9 October 2023, p 3.

57 Submission 24, Ms Fiona Reid, p 1.

58 Submission 402, Name suppressed, p 2.

59 Submission 242, NSW Nurses and Midwives' Association, p 10.

60 Answer to questions on notice, Homebirth NSW, *Birth Trauma and Homebirth Poll – Midwives*, 16 April 2024, p 7.

61 Submission 242, NSW Nurses and Midwives' Association, p 11.

experiences only hit me years later as I gained confidence and began to question the toxic work culture in which I worked'.[62]

- 'The repeated exposure to trauma, the disempowerment of the midwife in the clinical environment that supports unequal power structures and medical dominance, the experience of being complicit in trauma-causing care and the inability to have validated professional autonomy when caring for women in the system is degrading the midwifery workforce. The effects of contributing to and witnessing repeated trauma affect our clinicians' brains, and the recurrent triggering of their own trauma experiences accumulated during their working life creates a compassion deficit associated with their need to repeatedly survive shifts where the workload is too heavy and the staffing is too underskilled. The repeated stimulation of the sympathetic nervous system, and the requirement to comply with duties, procedures and policies protective of interventions that increase the likelihood of trauma or will result in injury reduces a clinician's ability to think, listen, ask questions, feel, express compassion, be authentic or advocate to be and remain woman-centred'.[63]
- 'I was 3 days into my training to become a midwife when I was called in overnight to 'witness a birth'… after some time the midwife decided she needed an episiotomy. It may have been clinically indicated. I don't remember. I only remember the senior midwife saying you need an episiotomy and handing me the scissors. I said 'no, I am not comfortable and it's only my third shift'. I remember her mumbling 'useless' and then proceeding to take them herself to the bedside. I do not remember her providing education. I do not remember her gaining consent. I remember the woman crying. I remember her saying no. I remember the midwife demanding she stay still. I do not remember any local anaesthetic provided. I remember the sound the scissors made and although there were cries before and after I remember how that noise cut through everything else. I remember her partner covering his head with his hands and the woman searching his face for comfort. I remember feeling like I wanted to vomit, cry and run away. The baby was born. Alive. The mother was alive. The Dr was called, and the episiotomy repaired. No complaints made. No questioning of practice from the people that were in power. Just a mother, a baby and a traumatised dad. I will never forget that woman. I will never forget that midwife. I will never forget that sound'.[64]

Case studies

1.10 Overall, the committee heard that the act of giving birth has the potential to be traumatic in itself,[65] however, there are other factors that can contribute to the long-standing effects of trauma.[66] The committee also heard that there are ways to prevent and avoid birth trauma.[67] The case studies below provide insight into the factors that can contribute to birth trauma and the ways in which birth trauma can be avoided.

62 Submission 964, Mrs Emily Ma'umalanga, p 1.

63 Evidence, Ms Fiona Reid, Clinical Midwife Consultant, 7 September 2023, pp 29-30.

64 Submission 351, Name suppressed, p 1.

65 Submission 718, Dr Carl Henman, p 1.

66 Submission 862, NSW Health, p 6.

67 See, Submission 254, The Australasian Birth Trauma Association, pp 33-34; Evidence, Ms Amy Dawes OAM, Cofounder and CEO, Australasian Birth Trauma Association, 4 September 2023, p 23.

1.11 For example, Mrs Francesca Male shared with the committee the contributing factors that resulted in a traumatic birth for her and her husband, including 'traumatic' medical interventions, conflicting health advice, and inadequate pain management.

Case study – Francesca Male[68]

At 25, Mrs Francesca Male had a planned pregnancy with her husband, Evan, welcoming their daughter in March 2023. However, she stated 'what was meant to be the happiest moment of our lives ended up being a traumatic experience due to many factors.'

Francesca expressed her disappointment with inconsistent communication between healthcare professionals working in the New South Wales maternity system. Francesca told the committee she received conflicting advice throughout her pregnancy:

> There was disagreement between my women's health clinic and the hospital as to when the induction should occur … they [the women's health clinic] had advised they were happy with my daughter to stay in until 39 weeks. However, the hospital … recommended induction at 37 weeks. My husband and I felt a lot of pressure from this decision.

The lack of inter-clinic communication and the ongoing disagreements between health professionals left Francesca and her husband 'worried, confused' and 'feeling doubtful' prior to entering labour.

During labour, Francesca experienced a series of medical interventions that culminated in a traumatic birthing experience. Some of these interventions included: her waters being broken at 1cm dilation which she described as 'excruciatingly painful', the induction of labour using medication that was administered at a much higher dose than Francesca and her husband had agreed to, and the lack of pain management available due to hospital resourcing and a failed spinal block:

> The initial placement [of the spinal block] was incorrect and resulted in severe pain … I could still feel both the ice test and the towel clamps, my concerns were dismissed twice and the surgeon was given the go-ahead. I will never forget the pain and fear I felt in minutes that followed. I was crying out but was dismissed for a third time, told that feeling pressure was normal and offered gas. My husband was stunned, unable to advocate for me.

Francesca compared her birth experience with her professional experience as a veterinarian, stating that when she considers her professional responsibility to advocate for the animals she treats, 'it is hard to fathom how a medical professional can have a patient directly telling them that they can feel pain, and yet treat them as though that pain isn't real'.

This experience has affected Francesca and Evan deeply and equally, 'although in different ways'. The intimate birth moment they had hoped for was instead replaced by 'memories of being anaesthetised in excruciating pain as [she] felt surgeons ripping through [her] abdomen' and her husband unable to help.

68 Submission 796, Mrs Francesca Male, pp 1-6; Evidence, Mrs Francesca Male, Individual, 12 December 2023, pp 9-15. This case study is based on the content of the submission and the evidence provided during a public hearing.

1.12 Ms Carly Griffin provided the committee with insight into how hospital policies and mistreatment by staff can have a traumatic impact on the birthing experience.

Case study – Carly Griffin[69]

Ms Carly Griffin expressed that she had experienced mistreatment by hospital staff, reporting instances of bullying, enduring verbal humiliation regarding her physical appearance, and suffering long hours of pain after being consistently denied pain relief as her intense pain was mischaracterised as drug-dependency.

> The OBs [obstetricians] I dealt with were cold and dismissive… I was forced out of bed less than eight hours after an emergency C-section. I hadn't even held my own son yet but was told I needed to get up and get in the shower… sobbing hysterically, with blood running down my legs… with no pain relief or assistance from the midwives, is a nightmare I'll never forget.

Carly's desire for a natural birth was disregarded when she was rushed into an emergency caesarean section under the pretext of her son being in distress. She claimed that there was no explanation or evidence to prove that there was distress, leading her to question whether it was a genuine emergency or a result of birthing room shortages. She explained:

> I got to 10 centimetres and I was ready to push… and then the OB came in, did an examination and said, "No, we're going for a C-section. This is an emergency. Your baby is in distress… My son was born with perfect Apgar scores. I don't believe he was in distress at all… I feel that they wanted my birthing room. I had been in there for so long, and there were so many women in labour, that they needed to get me out as fast as possible… I wasn't given any evidence.

Carly also spoke about the lack of opportunity afforded to her to bond with her newborn son after delivery, having to wait several hours after he was born before a visit was arranged. 'I didn't even see my son for 10 hours after he was born. I was able to touch him through an incubator; that was it.'

Two days following her discharge, Carly returned to hospital with surgical complications. Due to hospital policy, no support was provided to her to have her newborn baby stay with her in hospital, leaving her to be separated from her son for a week.

Through her experience, Carly emphasised the need for 'compassionate, supportive, and trauma-informed' midwives, and highlighted the importance of adequate staffing and resources to ensure pregnant mothers receive the care they need and deserve.

[69] Evidence, Ms Carly Griffin, Individual, 7 September 2023, pp 9-17. This case study was based on the evidence provided by Ms Griffin during a public hearing.

1.13 Mrs Carmel Biddle gave insight into the importance of providing woman-centric service through respect, consultation, and consideration to the woman's needs. Mrs Biddle's evidence provided the committee with real examples of how changes in hospital policy and culture can greatly improve the birthing experience for its patients.

Case study – Carmel Biddle[70]

As an experienced mother who has had several pregnancies, Mrs Carmel Biddle was 'well acquainted with what good and bad maternity care looks like'. Carmel shared that three of her births within the NSW maternity system were traumatic and attributed this trauma to the lack of trust between patient and staff, and the lack of respect for mothers to make choices about their own bodies.

Carmel said that her preference for a natural labour and unassisted birth was 'laughed at', her desire to avoid induction was 'ignored', and she was forcibly injected by a hospital worker after explicitly declining the injection.

> I was injected without my consent and treated as though I had no idea how to care for my baby…I was forced to argue with the obstetrician instead of concentrating on birthing my children and giving them the safe, natural twin birth, I knew my body was capable of…At every single appointment for my twins, I had to restate my case for a natural labour and an unassisted birth. I was laughed at, told it just didn't happen that way, told I wouldn't be able to cope with the pain, and even on the day I arrived in labour I was asked why I hadn't turned up for my scheduled induction—an appointment I repeatedly told them that I didn't want made but I was just ignored.

Carmel revisited the same hospital for the birth of her eighth child since hearing the hospital had made some changes to its work culture and policies. Carmel reported these changes brought a shift in attitude that made her feel 'well supported', especially when compared to the birth of her twins.

She said she saw improvements around the provision of consistent care and greater respect for the mother's choice.

> They asked me before [doing] anything. If they were going to touch my stomach to feel where the baby was, they actually asked… They don't have to, but they did. … They asked, "Do you want to be weighed?" Instead of, "Go get on the scales." … They're all listening to me and they're all respecting me. I felt I was checked with everything. They actually went through the birth plan with me. They actually have a whole new form that they give parents … to fill out your whole birth plan…You came away from those antenatal appointments feeling really confident that the midwives were actually going to help you to have the birth that you wanted … it was a big improvement.

Carmel articulated that her experience 'proves that changing the culture around the treatment of mothers before and during the birth is definitely possible'.

70 Submission 111, Mrs Carmel Biddle, pp 1-2; Evidence, Mrs Carmel Biddle, Individual, 12 December 2023, pp 1-9. This case study is based on the content of Mrs Biddle's submission as well as the evidence provided during a public hearing.

Approach to this report

1.14 A glossary of common technical terminology has been provided in the initial pages of this report to assist the reader.

1.15 Chapter 2 provides an overview of the maternity care landscape in New South Wales, including statistical information on birth, models of maternity care, NSW Health policies intersecting with the maternity system. Chapter 2 also discusses what birth trauma is and its impacts, causes and associated factors of birth trauma, obstetric violence, and support services available to consumers and their partners.

1.16 Chapter 3 explores the contributing factors in the healthcare system contributing to birth trauma. The Chapter discusses the importance of continuity of care, education and informed consent practices within health services, interventions in the birthing experience, and the effect birthing environments and resourcing can have on the birthing experience.

1.17 Chapter 4 considers other contributing factors to birth trauma including the lack of inclusivity in maternity care and challenges associated with pregnancy loss and genetic diagnoses.

1.18 Chapter 5 discusses the medico-legal environment and reviews existing complaints mechanisms available for the consumer, both internal and external to hospital facilities.

Committee comment

1.19 The committee first and foremost acknowledges the women who were the catalyst of this inquiry, who bravely reported their traumatic experiences not only to seek justice for themselves, but to both help others who have also experienced birth trauma, as well as prevent others having the same experience of birth trauma that they did. We express our deep gratitude to the thousands of individuals from across the country who wrote to us as part of this inquiry. The experiences shared, the research provided, and the advocacy exhibited were invaluable in shaping the committee's understanding of birth trauma and will undoubtedly contribute to improving the New South Wales maternity care system, and other maternity care systems throughout Australia and overseas.

1.20 The large scale of submissions received speaks to the impactful and complex nature of birth trauma for the individual giving birth, their support people, the health practitioners involved, and the broader community. The committee recognises that birth trauma encompasses more than just physical injury and that not all physical injuries lead to birth trauma. The committee heard evidence from individuals who experienced childbirth where the physical outcome was positive, but the overall experience was still traumatic. Conversely, the committee also received evidence from women who had negative outcomes, such as injury or pregnancy loss, yet received sufficient support and resources, enabling them to cope without enduring trauma.

1.21 The committee also acknowledges and thanks the health care professionals, allied health care workers, and the public servants of New South Wales who tirelessly commit themselves to providing the best care possible. We received many accounts of health care professionals experiencing vicarious trauma, either through helplessly witnessing the mistreatment of women during their birthing experience, or not having the time, the energy or resources to provide a high standard of care. We deliver this report with the intention to also help improve the

workforce challenges faced every day by healthcare professionals in order to be there for the parents who need them.

1.22 The committee wishes to acknowledge that the experiences of the individuals who gave evidence to this inquiry are simply not acceptable, and in many cases, were shocking and disturbing. We must do better.

Finding 1

There are a number of individuals who have suffered preventable birth trauma in New South Wales and the experiences of the people who gave evidence to this inquiry are distressing and unacceptable.

1.23 The committee understands that giving birth can be a traumatic experience in and of itself. While we do not anticipate our recommendations will eradicate that experience entirely, it was clear to us throughout this inquiry that there are avoidable and preventable factors unnecessarily contributing to birth trauma that must be addressed and will significantly reduce the prevalence of birth trauma in the state. This is the focus of our report and recommendations.

Finding 2

That urgent efforts must be made to address avoidable and preventable factors that contribute to birth trauma.

1.24 The United Nations has recognised that certain cases of birth trauma can be considered gendered violence. Considering many of the harrowing stories heard firsthand by this committee, we too recognise that cases in New South Wales involve abuse. In some cases, we recognise that women have recounted that they experienced birth trauma as a form of violence.

Finding 3

That in some cases of birth trauma, women have recounted that they experienced this as a form of violence.

1.25 Being the first of its kind, this inquiry received national and international attention, so far as inspiring the UK Parliament to also inquire into birth trauma within its jurisdiction. We encourage this momentum and hope it continues to help deliver reforms in the maternity healthcare space to give all women the respect they deserve to have the birth they choose in a safe and supportive system.

Chapter 2 Overview of the maternity care system and birth trauma in New South Wales

This chapter provides an overview of the maternity care system in New South Wales, including birth rate statistics, models of care and NSW Health policies and strategies. The chapter also explores the broader issue of birth trauma, including prevalence, causes, preventable factors, and its impacts, along with a review of support services currently available in the state.

Overview of the maternity care system in New South Wales

2.1 Maternity care in New South Wales is delivered through public and private services, by a range of health care professionals, including midwives, obstetricians and general practitioners in collaboration with allied health professionals and Aboriginal health workers.[71]

2.2 Some of the key statistics, models of care and NSW Health policies and strategies are outlined below.

Statistical overview

2.3 This section presents an overview of relevant statistics from the most recent NSW Mothers and Babies report. This includes insights into birthing environments, modes of delivery, mortality rates, pain management techniques, as well as the occurrence of tears and episiotomies.

2.4 The NSW Mothers and Babies 2021 report was released by the Centre for Epidemiology and Evidence in June 2023 and provides statistics on maternity care and outcomes in New South Wales. The report outlined that in 2021:

- 90,574 (92.4 per cent) planned birth in a hospital labour ward
- 3,011 (3.1 per cent) planned birth in a birth centre
- 3,185 (3.2 per cent) planned birth centre-hospital admission
- 502 (0.5 per cent) planned homebirth
- 79 (0.1 per cent) planned homebirth-hospital admission.[72]

2.5 Regarding place of birth, the majority of women in New South Wales in 2021 gave birth within NSW public hospitals, with 77.8 per cent women giving birth in a public hospital, compared to 21.8 per cent of women who gave birth in a private hospital. These rates have remained stable since 2017.[73]

71 Submission 862, NSW Health, p 9.

72 Centre for Epidemiology and Evidence, *NSW Mothers and Babies 2021*, HealthStats NSW, 14 June 2023, p 18.

73 Submission 862, NSW Health, p 9.

Types of birth

2.6 Among mothers in New South Wales, the rate of 'normal' vaginal birth has decreased from 57.1 per cent in 2012 to 50.7 per cent in 2021, while elective and emergency caesarean sections have increased.[74]

Table 1 Type of birth in New South Wales in 2012 and 2021[75]

Type of birth	2012	2021
Normal vaginal	55,993 (57.1%)	49,644 (50.7%)
Forceps	4,192 (4.3%)	4,235 (4.3%)
Vacuum extraction	6,981 (7.1%)	6,910 (7.1%)
Vaginal breech	399 (0.4%)	321 (0.3%)
Elective caesarean section	18,253 (18.6%)	23,732 (24.2%)
Emergency caesarean section	12,305 (12.5%)	13,163 (13.4%)
Not stated	18 (0%)	1 (0%)
TOTAL	98,141 (100%)	98,006 (100%)

Perinatal mortality rate

2.7 In 2021, New South Wales had a perinatal mortality rate of 8.4 per 1,000 births. Of the total perinatal deaths reported, 77 per cent were stillbirths and 23 per cent were deaths within the first 28 days of an infant's life. Among the 838 perinatal deaths in 2021, 718 (85.7 per cent) occurred in planned hospital births, 103 (12.3 per cent) in planned birth centre births, and 17 deaths occurred before arrival at hospital. No perinatal deaths were reported among planned or actual homebirths.[76]

Maternal deaths

2.8 In the 30-year period from 1990-2020, there were 264 reported deaths among pregnant women and women who gave birth within 6 weeks. Among them, 28 per cent died of incidental causes not related to the pregnancy or its management, 44.7 per cent died directly due to pregnancy or its management, and 25.8 per cent resulted from pre-existing disease or disease which may have been aggravated by the physiological effects of pregnancy.[77]

74 Centre for Epidemiology and Evidence, *NSW Mothers and Babies 2021*, HealthStats NSW, 14 June 2023, p 19.

75 Centre for Epidemiology and Evidence, *NSW Mothers and Babies 2021*, HealthStats NSW, 14 June 2023, p 19.

76 Centre for Epidemiology and Evidence, *NSW Mothers and Babies 2021*, HealthStats NSW, 14 June 2023, p 23.

77 Centre for Epidemiology and Evidence, *NSW Mothers and Babies 2021*, HealthStats NSW, 14 June 2023, p 24.

Pain relief

2.9 In 2021, epidural-spinal was the most common type of pain relief provided to women during labour followed by nitrous oxide.

Table 2 Pain relief in New South Wales 2021[78]

Hospital sector	Epidural-spinal	General anaesthetic	IM narcotics	Nitrous oxide	Nil
Public	41,891 (54.9%)	2,398 (3.1%)	5,900 (7.7%)	31,592 (41.4%)	6,571 (8.6%)
Private	17,953 (84.1%)	194 (0.9%)	1,272 (6.0%)	4,239 (19.8%)	734 (3.4%)
TOTAL	59,844 (61.1%)	2,592 (2.6%)	7,172 (7.3%)	35,832 (36.6%)	7,531 (7.7%)

Perineal status

2.10 Data from the 2021 Mothers and Babies report highlights that tears and episiotomy are common for women who gave birth vaginally.

Table 3 Perineal status among vaginal birth in New South Wales 2021[79]

Hospital Sector	Intact	1st degree tear / graze	2nd degree tear	3rd or 4th degree tear	Episiotomy	Combined tear and episiotomy	Other
Public	6,879 (13.7%)	11,850 (23.6%)	15,116 (30.1%)	1,269 (2.5%)	10,264 (20.4%)	1,352 (2.7%)	3,463 (6.9%)
Private	1,494 (14.2%)	1,872 (17.8%)	3,363 (31.9%)	81 (0.8%)	2,552 (24.2%)	352 (3.3%)	817 (7.8%)
Total	8,527 (14.0%)	13,811 (22.6%)	18,574 (30.4%)	1,352 (2.2%)	12,817 (21.0%)	1,704 (2.8%)	4,281 (7.0%)

Models of care

2.11 In New South Wales, a model of care refers to how specific health services are delivered to women during pregnancy, childbirth and postnatally. There are different types of models available in New South Wales, as outlined below.

- Midwifery Group Practice (MGP) – Women receive care from a primary midwife throughout pregnancy, birth, and postpartum, with a secondary backup midwife if needed

78 Centre for Epidemiology and Evidence, *NSW Mothers and Babies 2021*, HealthStats NSW, 14 June 2023, p 46.

79 Centre for Epidemiology and Evidence, *NSW Mothers and Babies 2021*, HealthStats NSW, 14 June 2023, p 49.

and collaboration with doctors in the event of identified risk factors. According to NSW Health, this model provides a high level of continuity of maternity care.

- Midwifery Antenatal and Postnatal Service (MAPS) – Women have a primary midwife for the prenatal and postnatal period, while labour and birth care are provided by birth unit midwives at the mother's chosen hospital or birth centre. This model focuses on outpatient services.
- GP shared care – Women receive antenatal and postnatal care provided by a private GP in partnership with midwives and obstetricians, while birth and early postnatal care is provided in the hospital.
- Private Midwifery Practice – Private midwives hold an access agreement with participating hospitals, enabling them to deliver care within these facilities (Westmead Hospital is the sole public hospital offering this model of care).
- Private obstetric care – Prenatal, birth and postnatal care is provided by an obstetrician in private practice.[80]

2.12 Evidence from Western Sydney University and the Birth Experience Study (BESt) indicated that:

- private obstetric care has higher rates of caesarean sections, both during and before labour, when contrasted with other models of care
- private obstetric care and GP shared care have higher rates of instrumental births, that is births that are aided by forceps and vacuum
- MGP has higher rates of vaginal birth compared to other models of care.[81]

2.13 Models of care and how they impact on birth trauma is discussed in more detail in Chapter 3.

NSW Health policy – *Connecting, listening and responding: A Blueprint for Action – Maternity Care in NSW*

2.14 In March 2023, NSW Health published *Connecting, listening and responding: A Blueprint for Action – Maternity Care in NSW* (the blueprint). The blueprint replaces the previous NSW Health policy directive *Towards Normal Birth*.

2.15 The stated aim of *Connecting, listening and responding: A Blueprint for Action – Maternity Care in NSW* is to ensure all women in New South Wales receive respectful, evidence-based and equitable maternity care.[82]

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80 Tabled document, Leeton Midwifery Group Practice, *Continuity of Care Models – A Midwifery Toolkit*, NSW Ministry of Health, June 2023, pp 16-19; Submission 862, NSW Health, p 17; Evidence, Ms Julie Swain, Deputy Director of Nursing & Midwifery, Women's and Newborn Health, Western Sydney Local Health District, 8 April 2024, p 60.

81 Submission 232, Western Sydney University, p 16.

82 Tabled document, NSW Health, *Connecting, listening and responding: A Blueprint for Action – Maternity Care in NSW,* March 2023, p 7.

2.16 Ms Deb Willcox, Deputy Secretary of System Strategy and Planning in NSW Health told the committee that in development of the blueprint, NSW Health consulted over 18,000 women and partners through online surveys, face-to-face consultations, and written submissions.[83]

2.17 According to NSW Health, the blueprint's focus is on strengthening maternity care services in New South Wales and is supported by 10 goals.

1. Women receive maternity care that is socially and culturally respectful
2. The outcomes that matter to women, and their experience, actively inform their maternity care and future service improvements
3. Women have enough information before conception to optimise their health, pregnancy experience and outcomes
4. Women are connected to information and care early in pregnancy
5. Antenatal care reflects the individual preferences and needs of women, babies and families
6. Women are offered different care options, are actively involved in decision-making about their care and their choices are respected
7. Women with additional needs during pregnancy are connected to appropriate services
8. Women are informed of the possible outcomes of all aspects of care during labour and birth
9. Women receive safe, high quality, evidence-based care that is appropriate to their individual needs and expectations
10. Women are connected to the care and support they need after birth.[84]

2.18 Dr Kathryn Austin, Vice-President, Australian Medical Association (NSW) expressed support for the blueprint, describing it as having a 'sound evidence base'.[85] Dr Austin viewed the blueprint as an improvement on the previous NSW Health policy directive *Towards Normal Births* as the blueprint is 'well-informed' by feedback from both mothers and families, as well as those working in the health system. She noted that the blueprint 'seeks to provide options for women rather than creating the expectation of one particular maternity pathway being normal'.[86] Professor Hannah Dahlen AM, Professor of Midwifery, School of Nursing and Midwifery, Western Sydney University, said there were 'good things' in the blueprint, but said she would have preferred it to have been more 'women-centred'.[87]

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83 Evidence, Ms Deb Willcox, Deputy Secretary, Health System Strategy and Planning, NSW Health, 4 September 2023, p 61.

84 Submission 862, NSW Health, p 8.

85 Evidence, Dr Kathryn Austin, Vice-President, Australian Medical Association (NSW), 9 October 2023, p 61.

86 Evidence, Dr Kathryn Austin, Vice-President, Australian Medical Association (NSW), 9 October 2023, p 61.

87 Evidence, Professor Hannah Dahlen AM, Professor of Midwifery, School of Nursing and Midwifery, Western Sydney University, pp 37-38.

2.19 Ms Willcox advised that in the year since the publication of the blueprint in March 2023, NSW Health prioritised implementation of the following as a result of issues raised through this committee and by consumers:

- valid consent and guidance for women who choose care outside clinical recommendations
- continuity of midwifery care
- trauma-informed care in maternity care settings
- postnatal debriefing including opportunities for women to ask questions and provide feedback
- culturally respectful care within the New South Wales maternity care system.[88]

2.20 In order to implement the above, NSW Health established an expert advisory group and a consumer reference group. Ms Willcox provided an update on the progress, including the development of consent guidelines and educational materials.[89] Ms Deb Matha, Director of Maternity, Policy and Strategy, also spoke about efforts to engage consumers through a consumer reference group. She told the committee that further consultations are planned, aiming to include diverse representation including young parents, LGBTQIA+ individuals, people with disabilities, and First Nations communities.[90]

2.21 Several stakeholders, including Better Births Illawarra, called for the membership of the expert advisory group and the consumer reference group to be made public, and for minutes of the meetings of these groups available online after each meeting, as a measure to increase transparency, accountability and trust in the process for stakeholders.[91]

Comparison with Queensland maternity policies

2.22 Witnesses in this inquiry pointed to Queensland's maternity system as an example to emulate and urged the NSW Government to review and adopt similar frameworks, systems and practices.

2.23 In November 2021, Queensland Health formalised the Queensland Birth Strategy to address various challenges within their maternity care system, including declining rates of 'normal' births, insufficient evidence supporting many interventions, rising caesarean section rates, increased birth-related trauma, and no improvement in perinatal mortality and morbidity'.[92] The Queensland Birth Strategy outlined five key recommendations:

1. universal access to continuity of care,

88 Evidence, Ms Deb Willcox, Deputy Secretary, Health System Strategy and Planning, NSW Health, 8 April 2024, p 65.

89 Evidence, Ms Deb Willcox, Deputy Secretary, Health System Strategy and Planning, NSW Health, 8 April 2024, p 65.

90 Evidence, Ms Deb Matha, Director, Maternity, Policy and Strategy, Health and Social Policy Branch, NSW Health, 8 April 2024, p 66.

91 Correspondence from Ms Sharon Settecasse, Director of Community Engagement, Better Births Illawarra to the committee, 7 May 2024.

92 Clinical Excellence Queensland, *Office of the Chief Nursing and Midwifery Officer – 2023 Year in Review*, Queensland Health, p 7.

2. provision of multi-disciplinary normal birth education,
3. development of co-designed resources to facilitate informed decision making,
4. embed respectful maternity care and positive workplace culture,
5. establish a sustainable Normal Birth Collaborative committee.[93]

2.24 Stakeholders including Human Rights in Childbirth and Maternity Choices Australia noted that the Queensland Government has recognised the importance of delivering woman-centred maternity services. They urged the NSW Government to consider adopting and implementing similar strategies.[94]

2.25 However, not all witnesses viewed the Queensland model favourably. Ms Fiona Davies, CEO of Australian Medical Association (NSW) expressed 'significant concern' about maternity health services in Queensland, warning it was 'on the brink of collapse' due to a shortage of doctors. She told the committee:

> We should learn from all jurisdictions about places where there are good models, but I think we need to be incredibly careful about the situation in Queensland because it's being watched around the country as a place where people in large centres are not able to access or are running the risk of not being able to access maternity services.[95]

2.26 Dr Bashi Kumar-Hazard, Chair of Human Rights in Childbirth, responded to the views expressed by the Australian Medical Association (NSW) challenging claims that the New South Wales system would collapse if maternity care approaches similar to those in Queensland were adopted. Dr Kumar-Hazard said that claims that the healthcare system crisis was caused by staff shortages was inaccurate, attributing any shortages to the reluctance of obstetricians to work within a system perceived as 'midwife-centric'. She concluded that the medical profession needs to adapt to consumer demands and competitive pressures, rather than seeking further government protections.[96]

2.27 Ms Deb Willcox from NSW Health acknowledged the need to learn from other states including Queensland. She outlined the formal process in which the NSW Agency for Clinical Innovation evaluates the safety and quality of clinical services in other jurisdictions.[97]

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93 Jocelyn Toohill, 'Queensland Birth Strategy – Transforming Maternity Care', Australian College of Midwives National Conference – Be the Change, *Women and Birth Volume 36, Supplement 1*, September 2023, pp 17-28.

94 See, Correspondence from Dr Bashi Kumar-Hazard, Chair, Human Rights in Childbirth, to Chair, 7 April 2024, p 2; Evidence, Ms Azure Rigney, National Advocacy Manager, Maternity Choices Australia, 4 September 2023, p 19.

95 Evidence, Ms Fiona Davies, CEO, Australian Medical Association (NSW), 9 October 2023, p 69.

96 Correspondence from Dr Bashi Kumar-Hazard, Chair, Human Rights in Childbirth, to Chair, 7 April 2024, p 2.

97 Evidence, Ms Deb Willcox, Deputy Secretary, Health System Strategy and Planning, NSW Health, 4 September 2023, p 66.

Overview of birth trauma

2.28 This section examines the ongoing debate surrounding the definition of birth trauma, and how it differs from 'obstetric violence'. It also explores the prevalence and causes of birth trauma, as well as the support services currently available for people who experience it.

What is birth trauma?

2.29 The committee heard a number of definitions for the term 'birth trauma'. These definitions encompassed physical injury (such as pelvic floor damage), psychological distress (such as fear for the life of the mothers or baby, or loss of control) or disrespectful treatment (such as dismissing or ignoring the mothers birth wishes). Stakeholders identified that all these forms of trauma have the potential to have negative effects on women's health or wellbeing.[98]

2.30 A number of stakeholders including Maternity Choices Australian, the Australian College of Midwives, and Western Sydney University School of Nursing and Midwifery recognised that birth trauma is subjective and 'in the eye of the beholder' or 'whatever the woman determines it to be'. They suggested that it can only be defined and identified by the women who experience it.[99]

2.31 The Australasian Birth Trauma Association and GP Obstetrician Dr Trudi Beck, noted that while childbirth carries inherent risks of injury, it is important to discern between unavoidable experiences and trauma that is avoidable and preventable.[100]

Avoidable and preventable birth trauma

2.32 Inquiry participants argued that while some instances of birth trauma may be inevitable, the quality of care provided, along with support and resources given to women can significantly influence how they process their experiences.[101] The Australasian Birth Trauma Association noted that while birth-related trauma is not always preventable, better preparation and support can help manage it.[102]

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98 See for example, Answers to questions on notice, NSW Nurses and Midwives' Association, 5 October 2023, p 3; Answers to questions on notice, Australian College of Midwives, 3 October 2023, p 1; Answers to questions on notice, Ms Amy Dawes OAM, Co-Founder and CEO, Australasian Birth Trauma Association, 6 October 2023, p 1.

99 See, Answers to questions on notice, Maternity Choices Australia, 3 October 2023, p 7; Answers to questions on notice, School of Nursing and Midwifery, Western Sydney University, 3 October 2023, p 3; Submission 854, Australian College of Midwives, p 3, quoting H Keedle, W Keedle, and H Dahlen, 'Dehumanized', Violated, and Powerless: An Australian Survey of Women's Experiences of Obstetric Violence in the Past 5 Years' (2022) *Violence Against Women*.

100 See, Submission 254, The Australasian Birth Trauma Association, p 4; Evidence, Dr Trudi Beck, GP Obstetrician, Nova Health and Murrumbidgee Region GP Antenatal Shared Care Program, 12 December 2023, p 26.

101 See, Submission 254, The Australasian Birth Trauma Association, p 4; Answers to questions on notice, School of Nursing and Midwifery, Western Sydney University, 3 October 2023, p 1.

102 Evidence, Ms Amy Dawes OAM, Cofounder and CEO, Australasian Birth Trauma Association, 4 September 2023, p 23.

2.33 Surveys conducted by the Australasian Birth Trauma Association in 2019 and 2021 identified a range of factors that can contribute to preventable birth-related trauma. These include:

- personal circumstances, stemming from an individual's history of trauma, pre-existing mental health conditions, as well as their race, ethnicity, sexuality, socioeconomic status
- healthcare system related issues, such as the inability to access preferred model of care, instances of mistreatment, dismissal or neglect by healthcare professionals, inappropriate or abusive treatment, lack of informed consent, misdiagnosis or delayed diagnosis, and the impact of interventions
- social factors, including societal expectations regarding the 'right' way to give birth, as well as the stigma and shame associated with birth-related issues including injuries or psychological distress.[103]

2.34 The Australasian Birth Trauma Association emphasised that certain groups, including First Nations women, individuals from culturally and linguistically diverse backgrounds, and LGBTIQA+ individuals, are particularly vulnerable leading up to and during childbirth. These groups face additional complexities and risks, highlighting the importance of tailored support to prevent birth trauma.[104]

2.35 Further, evidence from the Western Sydney University School of Nursing and Midwifery highlighted that there are also strategies that can be implemented to prevent birth trauma, revealing that women who received continuity of care experienced the lowest rates of birth trauma.[105]

2.36 The factors contributing to birth trauma will be further explored in Chapters 3 and 4.

Obstetric violence

2.37 During the inquiry, the terms 'birth trauma' and 'obstetric violence' were occasionally used interchangeably. However, some stakeholders were divided on the adoption of the term 'obstetric violence', raising concerns about its implications and effectiveness in addressing issues within the healthcare setting.

2.38 Obstetric violence is a term internationally recognised by the World Health Organisation as:

> outright physical abuse, profound humiliation and verbal abuse, coercive or unconsented medical procedures (including sterilization), lack of confidentiality, failure to get fully informed consent, refusal to give pain medication, gross violations of privacy, refusal of admission to health facilities, neglecting women during childbirth to suffer life-threatening, avoidable complications.[106]

2.39 In 2019, the Special Rapporteur for Violence Against Women and Girls published a report to the UN General Assembly titled 'A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence',

103 Submission 254, The Australasian Birth Trauma Association, pp 33-34.

104 Submission 254, The Australasian Birth Trauma Association, pp 36-37.

105 Submission 232, Western Sydney University, p 15.

106 Answers to questions on notice, Maternity Choices Australia, 3 October 2023, p 7.

which recognised that 'mistreatment and violence against women in reproductive health-care services and childbirth in health facilities happen all around the world and affect women across all socioeconomic levels'.[107]

2.40 The term 'obstetric violence' and associated definition are recognised in international law as a form of gender-based violence towards pregnant women.[108] Although 'obstetric violence' is not currently recognised in Australian legislation, it is enshrined in law and criminalised in a number of South American countries including Venezuela, where the term originated.[109]

2.41 Despite 'obstetric violence' not officially recognised in New South Wales or Australian legislation,[110] the BESt study conducted in 2021 revealed that one-in-ten women reported experiencing obstetric violence, which left them feeling 'dehumanised, powerless and violated'. Examples of violence included 'coercive language, a lack of informed consent, and a lack of informed choice'.[111]

2.42 Some stakeholders, such as the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and the National Association of Specialist Obstetricians and Gynaecologists (NASOG) raised concerns regarding use of this terminology. RANZCOG expressed reservations about the term 'obstetric violence' fearing it could imply malicious intent on the part of the healthcare provider and 'hinder solutions' to address birth trauma.[112] Dr Jared Watts, Board Director, RANZCOG told the committee '… no-one goes to work to cause trauma'.[113] The RANZCOG submission further elaborated:

> RANZCOG strongly believes that the term 'obstetric violence' is incorrect and in fact may limit opportunities to reduce patient experience of birth trauma. Whilst RANZGOG acknowledges that interventions can cause harm or psychological stress to the patient, the term 'obstetric violence' implicates that the obstetrician 'intended' the harm – which is unfair and vastly incorrect.[114]

2.43 NASOG cautioned against the term's focus on obstetricians, potentially overlooking the involvement of other medical staff and members of the care team.[115] However, Professor

107 Submission 409, Human Rights in Childbirth, p 8, quoting Dubravka Šimonović, 'A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence', *Report of the Special Rapporteur on Violence against Women*, 11 July 2019, p 7.

108 Answers to questions on notice, Dr Bashi Kumar-Hazard, Human Rights in Childbirth, 7 October 2023, p 8.

109 Submission 241, Perinatal Anxiety & Depression Australia (PANDA), p 5.

110 Submission 241, Perinatal Anxiety & Depression Australia (PANDA), p 5.

111 Submission 232, Western Sydney University, p 6.

112 Evidence, Dr Jared Watts, Board Director, Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), 4 September 2023, pp 3 and 6.

113 Evidence, Dr Jared Watts, Board Director, Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), 4 September 2023, p 7.

114 Submission 238, Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), p 2.

115 Submission 858, National Association of Specialist Obstetricians and Gynaecologists (NASOG), p 3.

Hannah Dahlen from the School of Nursing and Midwifery, Western Sydney University, gave evidence clarifying the term, stating that:

> If you look at what it actually means, it is one who stands opposite the woman giving birth. That is exactly the Latin underpinning of "obstetrics". We don't have a problem with "obstetric trauma". We don't have a problem with "obstetric haemorrhage". We don't have a problem with "obstetric emergencies"; we understand that involves all of us in there, working together. Some people have a problem with "obstetric violence" because they feel that it is a direct label of a group. It is not a direct label of a group. Midwives are absolutely involved in obstetric violence.[116]

2.44 Proponents of the term, such as Ms Sally Cusack, National Secretary, and Ms Azure Rigney, National Advocacy Manager, Maternity Choices Australia, advocated for its formal recognition as a criminal offence, arguing for this change to ensure 'victim-survivors assaulted in the birth room can access the same channels for justice as women assaulted outside of hospitals'.[117]

2.45 The Maternity Consumer Network also supported criminalising obstetric violence, defining it as abuse and mistreatment during pregnancy, birth and postpartum. They stressed the importance of holding perpetrators accountable through specific laws, acknowledging the challenges in seeking justice through civil means.[118] Ms Emilia Bhat, President, Maternity Consumer Network, emphasised the necessity of criminal accountability for assaults during childbirth, including forced interventions or touching genitals without consent. She stated that medical settings should not exempt professionals from legal consequences and that criminalising obstetric violence is essential for ensuring justice.[119]

The prevalence of birth trauma

2.46 Inquiry participants shared concerns about the high rates of birth trauma in New South Wales, as evidenced by statistics and anecdotal evidence presented.

2.47 The BESt Study, a national maternity survey from 2021, revealed that 28 per cent of women in New South Wales characterised their most recent birth as traumatic.[120] Additionally, evidence provided by the Centre for Women's Health Research and Australian Longitudinal Study on Women's Health indicated that over one-third of women in New South Wales who had given birth reported having a potentially traumatic birth experience.[121]

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116 Evidence, Professor Hannah Dahlen AM, Professor of Midwifery, School of Nursing and Midwifery, Western Sydney University, p 37.

117 Evidence, Ms Azure Rigney, National Advocacy Manager, Maternity Choices Australia, 4 September 2023, p 15.

118 Evidence, Ms Emilia Bhat, President, Maternity Consumer Network, 9 October 2023, p 20.

119 Evidence, Ms Emilia Bhat, President, Maternity Consumer Network, 9 October 2023, pp 20-21.

120 Submission 232, Western Sydney University, p 5, quoting H Keedle, W Keedle, and H Dahlen, 'Dehumanized', Violated, and Powerless: An Australian Survey of Women's Experiences of Obstetric Violence in the Past 5 Years' (2022) *Violence Against Women*.

121 Submission 239, Centre for Women's Health Research and Australian Longitudinal Study on Women's Health, p 2.

2.48 The committee heard that interventions during childbirth and other factors were shown to correlate to emotional distress. According to data provided by Centre for Women's Health Research, women who experienced:

- induction were 1.5 times as likely to experience emotional distress during labour than those who had not experienced induction
- an episiotomy were 1.3 to 1.6 times more likely to experience emotional distress during labour than those who had not experienced an episiotomy
- forceps or vacuum during labour were 1.6 to 2.4 times more like to experience emotional distress during labour than those who had not experienced forceps or vacuum
- an emergency caesarean birth were 2.5 to 3.1 times more likely to experience emotional distress during labour than those who had not experienced emergency caesarean
- a labour lasting more than 36 hours were 1.3 to 1.8 times more likely to experience emotional distress during labour than those who had not experienced a labour lasting more than 36 hours
- a stillbirth were 2.1 to 3.5 times more likely to experience emotional distress during labour than those who had not experienced a stillbirth.[122]

2.49 Maternity Choices Australia corroborated these findings, citing a rise in physical and emotional trauma among women. The consumer group reported that one-in-three women experience birth trauma, one-in-four develop postnatal depression, and one-in-ten have post-traumatic stress disorder.[123]

2.50 Despite these findings, Ms Amy Dawes from the Australasian Birth Trauma Association argued that birth trauma is 'under-reported, undervalued and over-represented in the community'.[124] Echoing this sentiment, the Australian Physiotherapy Association acknowledged the historical 'taboo' topic surrounding birth trauma, often dismissed as a normal part of childbirth to be endured rather than addressed and treated.[125]

Research

2.51 While the BESt study, completed by researchers at Western Sydney University, has indicated the magnitude of birth trauma in Australia, the need for further research into all aspects of birth trauma was supported by many inquiry participants, with many highlighting gaps in current knowledge and understanding:

122 Submission 239, Centre for Women's Health Research and Australian Longitudinal Study on Women's Health, pp 2-3.

123 Evidence, Ms Sally Cusack, National Secretary, Maternity Choices Australia, 4 September 2023, p 13.

124 Evidence, Ms Amy Dawes OAM, Cofounder and CEO, Australasian Birth Trauma Association, 4 September 2023, p 22.

125 Tabled document, Australian Physiotherapy Association, *APA Birth Trauma Position Statement*, 2024, p 2.

> RANZCOG believes that the solution requires continuing to listen to women, further research and a multidisciplinary team effort to address this trauma.[126]

2.52 Ms Amy Dawes from the Australasian Birth Trauma Association agreed stating that 'there's just such a lack of research in this space and out main recommendation is that we need to start gathering research'.[127]

2.53 Ms Pieta Shakes, Executive Director, Though the Unexpected, gave a specific example about the lack of Australian research in perinatal diagnosis. This is discussed further in Chapter 4:

> Internationally there's a lot of literature about the psychosocial aspects of prenatal diagnosis. In fact, that's why Through the Unexpected came about—because we've got 20 years of other literature sitting there. What we don't track is what actually happens here in Australia…we're not talking about prenatal diagnosis. It doesn't come up on people's agendas, which is why some targeted funding of that research would be amazing.[128]

Physical, psychological, and financial impacts of birth trauma

2.54 The committee received evidence highlighting that birth trauma can have far-reaching consequences with intertwining physical, psychological and financial impacts. The connection between the physical, psychological and financial impacts of birth trauma is explored below.

Physical impacts

2.55 Inquiry participants shared that physical birth-related trauma can have debilitating impacts on many aspects of a woman's daily life.[129] The Australian Physiotherapy Association highlighted that physical birth-related trauma can include:

- perineal tears and episiotomy
- urinary and faecal incontinence
- muscle damage to the pelvic floor and levator avulsion
- pelvic organ prolapse
- bone injuries to the pelvis including coccyx fractures, dislocations, or pubic bone fractures
- problems emptying the bowel
- nerve damage
- pain or problems engaging in vaginal sex
- persistent pain in the lower back

126 Evidence, Dr Jared Watts, Board Director, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 4 September 2023, p 3.

127 Evidence, Ms Amy Dawes OAM, Co-Founder and CEO, Australasian Birth Trauma Association, 4 September 2023, p 26.

128 Evidence, Ms Pieta Shakes, Executive Director, Through the Unexpected, 8 April 2024, pp 32-33.

129 See for example, Submission 667, Mrs Claire O'Brien, p 1; Submission 674, Jasmin Bennett, p 1; Submission 944, Mrs Lyn Leger, p 2.

- problems lifting and standing
- headaches, dizziness, and gastro-intestinal issues.[130]

2.56 Furthermore, the Australian Physiotherapy Association emphasised that these physical effects can significantly limit productivity, sexual function, social and community engagement, self-esteem, work capability, and domestic responsibilities.[131] If left untreated, physical birth trauma can have long-term consequences and trigger serious mental health issues, including post-traumatic stress disorder.[132]

2.57 The Gidget Foundation raised concerns about the potential impact of physical birth injuries on the bond between the mother and baby. The organisation emphasised the importance of careful management of physical trauma and newborn health to minimise disruption to early attachment and prevent further trauma. According to the Gidget Foundation, separation of the mother and baby can impede bonding opportunities, hinder breastfeeding, and exacerbate feelings of anxiety and distress.[133]

2.58 Ms Amy Dawes from the Australasian Birth Trauma Association highlighted the interconnectedness of physical and psychological impacts of birth trauma. She explained that birth injuries exacerbate mental health challenges, as new mothers may struggle to care for their babies while dealing with their injuries, leading to social isolation and psychological distress. She stated that 'the psychological impacts and the physical impacts often go hand in hand'.[134]

Psychological impacts

2.59 Evidence to the inquiry illustrated that there is an association between traumatic birth experience and poor perinatal mental health. According to the Centre for Women's Health Research, women born in 1989-1995 who had experienced a traumatic birth were 74 per cent more likely to be diagnosed with postnatal depression and anxiety compared to those who had not experienced a traumatic birth. This number had increased from 63 per cent among women born in 1973-1978.[135]

2.60 According to the Australian Association for Psychologists, birth trauma can have severe consequences for patients and their families:

> Emotionally, women may experience feelings of fear, anxiety, or depression, impacting their ability to bond with their newborn and cope with the challenges of parenting. In the long term, birth trauma has been associated with post-traumatic stress disorder (PTSD), which can significantly impair the individual's mental health and quality of life.[136]

130 Submission 231, Australian Physiotherapy Association, p 4.

131 Submission 231, Australian Physiotherapy Association, p 6.

132 Submission 231, Australian Physiotherapy Association, p 6.

133 Submission 249, Gidget Foundation Australia, p 6.

134 Evidence, Ms Amy Dawes OAM, Cofounder and CEO, Australasian Birth Trauma Association, 4 September 2023, p 24.

135 Submission 239, Centre for Women's Health Research and Australian Longitudinal Study on Women's Health, pp 3-4.

136 Submission 245, The Australian Association of Psychologists Inc, p 3.

2.61 The Australian Lawyers Alliance and the Australasian Birth Trauma Association stated that potentially traumatic birth experiences are associated with an increased risk of postnatal depression and/or anxiety, or obsessive compulsive disorder (OCD).[137] According to Gidget Foundation, psychological trauma symptoms, like nightmares, flashbacks, intrusive thoughts, panic attacks, and excessive worrying can lead to 'isolation, loneliness and significant pressure'.[138]

2.62 The Gidget Foundation informed the committee that even without physical injury, women may face psychological challenges postpartum, and that this may be confusing for those who perceived their labour as 'normal', leading them to struggle to comprehend their feelings of trauma or anxiety.[139] Gidget stated that invalidating or conflicting messages from healthcare providers can also contribute to parents feeling confused and distressed.[140]

2.63 The committee learned about the psychological toll of birth trauma on healthcare professionals. Professor Hannah Dahlen from the School of Nursing and Midwifery at Western Sydney University highlighted that the trauma experienced by midwives and obstetricians through their work has contributed to workforce shortages.[141] The Gidget Foundation further reported that healthcare providers often endure shock, fear, guilt and shame, leading to a loss of confidence, negatively affecting decision-making and the quality of care provided.[142] These workforce impacts will be further discussed in Chapter 3.

2.64 Dr Bashi Kumar-Hazard further gave evidence about the impact traumatic birth experiences can have on people's lives and careers:

> We've had clients and women come to us who have, sadly, committed suicide or attempted suicide. We've seen situations where women have rejected their infants, and it takes a lot of counselling and support to get them back on track. We've seen women who engage in, basically, substance abuse. Relationship breakdown is a very big part of what we've been seeing. Families separate, basically, because the woman who has been subjected to the abuse feels that she's been betrayed by her partner, who was equally helpless in that space. We see a lot of ongoing diagnoses of PTSD, anxiety and depression. We see a lot of women give up their careers and also struggle to re-enter the workforce.[143]

137 Submission 234, Australian Lawyers Alliance, p 6, quoting Australasian Birth Trauma Association 'What is birth trauma' (2022), https://birthtrauma.org.au/what-is-birth-trauma.

138 Submission 249, Gidget Foundation Australia, p 6.

139 Submission 249, Gidget Foundation Australia, p 5.

140 Submission 249, Gidget Foundation Australia, p 5.

141 Evidence, Professor Hannah Dahlen AM, School of Nursing and Midwifery, Western Sydney University, 4 September 2023, p 36.

142 Submission 249, Gidget Foundation Australia, p 7, quoting R Aydin, S Aktaş S, 'Midwives' experiences of traumatic births: A systematic review and meta-synthesis' (July 2021), *Eur J Midwifery*.

143 Evidence, Dr Bashi Kumar-Hazard, Chair, Human Rights in Childbirth, 4 September, p 42.

Financial impacts

2.65 The committee heard that the physical and psychological impacts of birth trauma often make it difficult for women to return to the workforce. This coupled with the expenses related to treatment can lead to financial hardship.[144]

2.66 In evidence to the committee, the Australasian Birth Trauma Association addressed the financial impact associated with birth trauma, including expenses related to incontinence, pelvic health and physiotherapy, mental health treatment, postpartum care, and the long-term effects on a woman's ability to return to work. The association therefore highlighted the need for more research to quantify these costs. [145]

2.67 The committee heard from a number of women who highlighted the financial costs associated with managing birth injuries and seeking care. Many women shared the challenges of paying for their treatments and various support services, which have had a substantial financial burden on their families.[146] For example, Ms Yusra Metwally, Advocacy Liaison, Zamzam Mums and Bubs said that many women, especially those without private health insurance, struggle to access physiotherapy services which can significantly affect their wellbeing and quality of life, with conditions like incontinence incurring both personal and societal economic costs.[147]

2.68 The prevalence of birth trauma also has a financial impact on the state. For example, according to the Australasian Birth Trauma Association:

> A 2019 report on the costs of perinatal depression and anxiety in Australia estimated the costs to the health system economy and wellbeing of those impacted as $877 million in one year. This includes health system costs, economic costs attributable to productivity losses, and monetised social and wellbeing impacts on children and families. Beyond this are estimated lifetime impacts of $5.2 billion.[148]

Support services

2.69 In addition to the impacts of birth trauma, the committee received evidence about the support services available to support women following birth.

2.70 NSW Health confirmed that there are a number of support services currently available including pregnancy family conferencing, women's health physiotherapy, social workers in maternity care, perinatal mental health services, substance use in pregnancy, nurse-led home visits, hyperemesis

144 See for example, Submission 753, Mrs Kate Webber, p 4; Submission 254, The Australasian Birth Trauma Association, p 30; Evidence, Mrs Amy Mageropoulos, Individual, 9 October 2023, p 3; Evidence, Mrs Lyn Leger, Individual, 9 October 2023, p 14.

145 Evidence, Ms Amy Dawes OAM, Cofounder and CEO, Australasian Birth Trauma Association, 4 September 2023, pp 25-26.

146 See for example, Submission 771, Mrs Helen Muller, p 7; Submission 809, Mrs Caysey Roach, p 2; Submission 254, The Australasian Birth Trauma Association, p 30; Evidence, Mrs Lyn Leger, Individual, 9 October 2023, p 14.

147 Evidence, Ms Yusra Metwally, Advocacy Liaison, Zamzam Mums and Bubs, 9 October 2023, p 36.

148 Submission 254, The Australasian Birth Trauma Association, p 32, quoting Gidget Foundation, 'The Cost of Perinatal Depression and Anxiety in Australia' (2019) *PwC Australia.*

gravidarum support, and lactation support services.[149] In addition, families with newborns receive a 1 to 4 week health and development check, facilitating early engagement with child and family health services, covering topics from feeding, safe sleeping, immunisation, as well as mental health assessment for parents and information about parents groups and support networks.[150]

2.71 Some of these support services are explored in more detail below, including perinatal mental health support, physiotherapy and other healthcare support including breastfeeding support.

Perinatal mental health support

2.72 Turning first to the issue of perinatal mental health support, including the services providing support, the limitations of resources, and its impacts on individuals seeking help.

2.73 Two organisations currently providing specific perinatal mental health support are the Gidget Foundation and PANDA (Perinatal Anxiety & Depression Australia). Both organisations play roles in aiding the emotional wellbeing of expectant and new parents.

2.74 The Gidget Foundation told the committee that it works to enhance the emotional well-being of new and expectant parents by offering various services and programs aimed at preventing and addressing perinatal mental health issues.[151] Gidget said that it has a range of services tailored to the needs of parents, including individual psychological consultations, face-to-face interventions for those diagnosed with or at risk of postnatal depression and anxiety, as well as telehealth options for remote support.[152] Clients can access these services through a mental health care plan via GP referral with up to ten bulk-billed psychological treatment sessions per calendar year.[153] However, Ms Karen Edwards, Clinical Director, Gidget Foundation advised that in order to continue to be eligible for the Medicare rebates, individuals must 'go back through the GP for referral', a process which she says creates an 'accessibility barrier' for many new parents.[154]

2.75 This concern was echoed by registered psychologist Ms Alysha-Leigh Fameli who underscored that birth trauma is a complex multifaceted issue, requiring intensive ongoing treatment. Ms Fameli stressed the inadequacy of ten Medicare-rebate psychology sessions, stating it results in substantial out-of-pocket costs for parents seeking effective mental health treatment. She called on Medicare rebates to be extended for new mothers who need mental health treatment to 40 sessions per year, which she said this is in line with other sensitive mental health conditions such as eating disorders.[155] A similar concern was raised by the Royal Australian College of General Practitioners who noted that during the COVID-19 pandemic, there were 20 Medicare-rebated sessions that have since been reduced to ten. Dr Rebekah Hoffman, NSW & ACT Faculty Chair,

149 Submission 862, NSW Health, pp 28-30.

150 Submission 862, NSW Health, p 34.

151 Submission 249, Gidget Foundation Australia, p 1.

152 Submission 249, Gidget Foundation Australia, p 2.

153 Submission 249, Gidget Foundation Australia, p 2.

154 Evidence, Ms Karen Edwards, Clinical Director, Gidget Foundation Australia, 11 March 2024, p 38.

155 Evidence, Ms Alysha-Leigh Fameli, Registered Psychologist, PhD candidate at University of Sydney, 8 April 2024, p 25.

the Royal Australian College of General Practitioners, said the advantage of 20 sessions was the ability for patients to touch base fortnightly, allowing psychologists to assess their progress and needs.[156]

2.76 NSW Health addressed concerns about the limited access to Medicare-rebated psychology sessions. Ms Deb Willcox acknowledged that while NSW Health was in a position to make representations regarding this issue, Medicare is a Commonwealth Government insurance scheme.[157] Ms Deb Martha, Director, Maternity, Policy and Strategy, Health and Social Policy Branch, Ministry of Health, however highlighted the existing measures currently in place in New South Wales, including antenatal and postnatal screenings to identify women in need, and pathways for care including the Perinatal Infant Mental Health Services, and other mental health services across the state.[158]

2.77 In addition to Gidget Foundation, PANDA also provides perinatal mental health support services, including Australia's only national perinatal mental health helpline. The services include free access to clinical counselling and peer support.[159] PANDA reiterated that without access to comprehensive mental health support the consequences of birth trauma can be severe, including chronic illness, mental health issues, relationship difficulties, and disruption of future fertility plans.[160]

2.78 PANDA acknowledged that their service capacity was limited due to resource constraints, with support primarily available for the first 12 months after childbirth. Chief Executive Officer, Ms Julie Bornikhof emphasised the need for expanded funding and resources to meet the growing demand for this services.[161]

2.79 PANDA shared that the caller demand for the National Helpline 'consistently outstrips service capacity', with helpline staff able to pick up 20-30 per cent of 'live calls' on any given day.[162] All other callers are directed to leave a message. According to PANDA, this gap in service provision can exacerbate the challenges faced by individuals seeking support.[163]

2.80 Mrs Tamara Latham, a mother with lived experience, expressed concern about the restricted service timeframes, highlighting that many new parents may not be prepared to seek support within the initial 12-months post-childbirth. Mrs Latham shared her experience, telling the

156 Evidence, Dr Rebekah Hoffman, NSW & ACT Faculty Chair, Royal Australian College of General Practitioners, 8 April 2024, p 46.

157 Evidence, Ms Deb Willcox, Deputy Secretary, Health System Strategy and Planning, NSW Health, 8 April 2024, p 61.

158 Evidence, Ms Deb Martha, Director, Maternity, Policy and Strategy, Health and Social Policy Branch, NSW Health, 8 April 2024, pp 61-62.

159 Submission 241, Perinatal Anxiety & Depression Australia (PANDA), p 2.

160 Submission 241, Perinatal Anxiety & Depression Australia (PANDA), p 4, quoting L Biggs, B Jephcott, K Vanderwiel, I Melgaard, S Bott, M Paderes, J Borninkhof, M Birks, 'Pathways, Contexts, and Voices of Shame and Compassion: A Grounded Therory of the Evolution of Perinatal Suicidality' (May 2023) *PMID*.

161 Evidence, Ms Julie Borninkhof, Chief Executive Officer, Perinatal Anxiety and Depression Australia (PANDA), 11 March 2024, p 35.

162 Submission 241, Perinatal Anxiety & Depression Australia (PANDA), p 6.

163 Submission 241, Perinatal Anxiety & Depression Australia (PANDA), p 6.

committee that she was advised to contact PANDA for assistance, but she felt unprepared to do so due to lingering effects of her birth trauma. When she eventually attempted to contact PANDA, she discovered that the service was no longer available to her. She said she was too emotionally vulnerable during the first 12 months and suggested that these time constraints limit access to support for new parents who may not yet be ready to seek help.[164]

2.81 Both PANDA and the Gidget Foundation acknowledged the frustration felt by new and expecting parents who struggle to access perinatal mental health support and said that their service capacity was hindered by limitations including resource constraints, restricted service timeframes, and policy barriers.[165]

Physiotherapy and other healthcare support

2.82 In addition to mental health services, stakeholders identified that physiotherapy and physical healthcare support play pivotal roles in preventing and addressing birth trauma and promoting women's overall health.

2.83 Stakeholders emphasised evidence-based interventions to prevent and mitigate trauma, particularly during pregnancy and postpartum.[166] The Australian Physiotherapy Association suggested that adequate preparation during pregnancy, including tailored exercises and interventions led by trained pelvic health physiotherapists, can help reduce risks and potentially avoid severe perineal tears and incontinence, leading to overall better health outcomes.[167] This was echoed by Ms Saltanat Bora, co-founder of Zamzam Mums and Bubs. She said that by partnering with pelvic physiotherapists women learn how to prevent prolapse and the importance of focusing on a positive mindset going into birth.[168]

2.84 Personal experiences, such as Mrs Amy Mageropoulos, underscored the importance of physiotherapists to help identify and address postnatal birth injuries. Mrs Mageropoulos told the committee that a woman's health physiotherapist was central to diagnosing and treating her pelvic floor issues. She told the committee that their involvement was 'key for early intervention and treatment to prevent more invasive measures down the track'.[169]

2.85 Despite the recognised importance of physiotherapy, the Australian Physiotherapy Association argued that cost poses a barrier to accessing these services.[170] Similarly, the Australian College of General Practitioners pointed out the current limit of five physiotherapy sessions covered by Medicare, emphasising it is insufficient for women dealing with significant birth trauma. The college stated that these individuals' inevitability need to pay significant out-of-pocket costs to access the care they need.[171] They suggested that the number of sessions should be tailored to

164 Evidence, Mrs Tamara Leetham, Individual, 11 March 2024, p 5.

165 See, Submission 241, Perinatal Anxiety & Depression Australia (PANDA), p 6; Evidence, Ms Karen Edwards, Clinical Director, Gidget Foundation Australia, 11 March 2024, pp 37-38.

166 Submission 231, Australian Physiotherapy Association, p 3.

167 Submission 231, Australian Physiotherapy Association, p 3.

168 Evidence, Ms Saltanat Bora, Co-founder, Zamzam Mums and Bubs, 9 October 2023, p 34.

169 Evidence, Mrs Amy Mageropoulos, Individual, 9 October 2023, p 3.

170 Submission 231, Australian Physiotherapy Association, p 3.

171 Evidence, Dr Rebekah Hoffman, NSW & ACT Faculty Chair, the Royal Australian College of General Practitioners, 8 April 2024, pp 45-46.

individual needs, with GPs playing a central role in determining the appropriate level of support for each patient.[172]

2.86 Advocacy group Zamzam Mums and Bubs and The Still Nest emphasised that women's pelvic physiotherapy is an essential allied health service due to the significant changes affecting women's bodies during pregnancy. However, the group asserted that physiotherapy is available only to individuals who can afford private obstetric physiotherapy, leading to significant long-term issues such as incontinence for many thousands of women.[173]

2.87 Mrs Lyn Leger's personal account showcased the need for more widely available and accessible physiotherapy. She told the committee about her birth injury, a bilateral avulsion of the levator ani muscle and three-compartment prolapse, noting that she attends weekly women's health physiotherapy appointments for exercise, and strength and conditioning to manage the ongoing impacts.[174] In addition to weekly physiotherapy, Mrs Leger also attends pilates. However, Mrs Leger advised that the ongoing costs of physiotherapy and pilates are an obstacle in her recovery.[175]

2.88 The Australian Medical Association (NSW) acknowledged the crucial role of physiotherapy in educating mothers for both vaginal and caesarean births, as well as aiding in postnatal recovery. Dr Kathryn Austin from the Australian Medical Association (NSW) told the committee that collaboration between midwives and physiotherapists should be encouraged, stating 'I encourage most, if not all of my patients to see physiotherapy support'.[176] However, Dr Austin also said that physiotherapists should work in concert with other healthcare professionals to ensure appropriate care and avoid misinformation. She shared anecdotal stories where incomplete or misleading advice from physiotherapists had led to confusion for birthing women, underscoring the need for education and collaboration within the healthcare team.[177]

Breastfeeding support

2.89 Finally, the committee heard from Breastfeeding Advocacy Australian and the Australian Breastfeeding Association about the link between birth trauma and breastfeeding outcomes, and the importance of breastfeeding support.

2.90 Ms Amy Tyson representing Breastfeeding Advocacy Australia highlighted the intrinsic relationship between mother and baby, emphasising that trauma experienced by one affects the other.[178] She asserted that birth trauma can hamper successful breastfeeding, and expressed the importance of addressing the need for women who experienced a traumatic birth to receive specialised support to help assist breastfeeding.[179]

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172 Evidence, Dr Rebekah Hoffman, NSW & ACT Faculty Chair, the Royal Australian College of General Practitioners, 8 April 2024, p 46.

173 Submission 929, Zamzam Mums and Bubs and The Still Nest, p 17.

174 Evidence, Mrs Lyn Leger, Individual, 9 October 2023, p 14.

175 Evidence, Mrs Lyn Leger, Individual, 9 October 2023, p 14.

176 Evidence, Dr Kathryn Austin, Vice-president, Australian Medical Association (NSW), p 65.

177 Evidence, Dr Kathryn Austin, Vice-president, Australian Medical Association (NSW), p 65.

178 Evidence, Ms Amy Tyson, Doula, Breastfeeding Advocacy Australia, 8 April 2024, p 37.

179 Evidence, Ms Amy Tyson, Doula, Breastfeeding Advocacy Australia, 8 April 2024, p 40.

2.91 Dr Susan Tawia, Breastfeeding researcher and health professional educator, Australian Breastfeeding Association, outlined the benefits breastfeeding for both mothers and babies, including reduced risk of infections and improved mental health outcomes.[180] She also acknowledged the correlation between birth trauma and breastfeeding, quoting evidence that 'birth trauma can negatively impact breastfeeding, and breastfeeding can be a source of healing following a difficult birth'.[181]

2.92 Both Breastfeeding Advocacy Australian and the Australian Breastfeeding Association advocate for comprehensive education for health professionals on breastfeeding support, emphasising the deficiency in the current training available to midwives and doctors.[182] They also highlighted the need for accessible breastfeeding education for expectant mothers, with a focus on early interactions between mother and baby to promote physiological breastfeeding.[183]

Committee comment

2.93 The committee recognises that New South Wales has a strong healthcare system. However, we are very concerned by the prevalence of birth trauma in New South Wales as evidenced by the statistics and vast number of personal experiences shared as part of the inquiry.

2.94 The committee notes that the new NSW Health policy *Connecting, listening and responding: A Blueprint for Action – Maternity Care in NSW*, published in March 2023, received some positive responses from a number of inquiry participants. While it is still at early stages of implementation, the committee recognises that the blueprint seeks to provide choices for mothers in New South Wales without suggesting that any particular birthing method is inherently better. The committee supports the principles outlined in the blueprint and calls for its full implementation as soon as practicable. The committee therefore recommends that the NSW Government fully fund and implement programs, policies, and strategies to address all ten goals and associated objectives from *Connecting, listening and responding: A Blueprint for Actions – Maternity Care in NSW*.

Recommendation 1

That the NSW Government fully fund and implement programs, policies, and strategies to address all ten goals and associated objectives from *Connecting, listening and responding: A Blueprint for Actions – Maternity Care in NSW* as soon as practicable and ensure ongoing evaluation of the effectiveness of these programs, policies and strategies

180 Evidence, Dr Susan Tawia, Breastfeeding Researcher and Health Professional Educator, Australian Breastfeeding Association, 8 April 2024, p 36.

181 Evidence, Dr Susan Tawia, Breastfeeding Researcher and Health Professional Educator, Australian Breastfeeding Association, 8 April 2024, p 36.

182 Evidence, Ms Amy Tyson, Doula, Breastfeeding Advocacy Australia, 8 April 2024, p 41.

183 See, Evidence, Ms Amy Tyson, Doula, Breastfeeding Advocacy Australia, 8 April 2024, p 39; Evidence, Dr Susan Tawia, Breastfeeding Researcher and Health Professional Educator, Australian Breastfeeding Association, 8 April 2024, p 39.

2.95 The committee notes there is significant community interest surrounding the implementation of the *Connecting, listening and responding: A Blueprint for Action – Maternity Care in NSW*, and the work of the expert advisory and consumer reference groups established by NSW Health. The committee therefore recommends that the membership of the expert advisory and consumer reference groups be made public if possible, and that the minutes of the meetings of these groups be made available online after each meeting if permitted. In addition, we recommend that the NSW Government publish information about the Terms of Reference of the NSW Health Maternity Expert Advisory Group and the NSW Health Maternity Consumer Reference Group and provide updates on the implementation of *Connection, listening and responding: A Blueprint for Action – Maternity Care in NSW*

Recommendation 2

That the NSW Government:

- investigate if the membership of the expert advisory consumer reference groups can be made public, and that the minutes of the meetings of these groups are made available online after each meeting if permitted
- publish information about the Terms of Reference of the NSW Health Maternity Expert Advisory Group and the NSW Health Maternity Consumer Reference Group, and provide updates on the implementation of *Connecting, listening and responding: A Blueprint for Action – Maternity Care in NSW*.

2.96 The committee heard some evidence that since the implementation of the Queensland Birth Strategy there have been significant improvements in the Queensland maternity system, with many praising its woman-centred approach and calling on the NSW Government to adopt and implement a similar strategy. The committee also heard evidence from NSW Health acknowledging the need to learn from other jurisdictions. We therefore recommend that the NSW Government review and evaluate clinical practices in other jurisdictions to identify findings that could be integrated into *Connecting, listening and responding: A Blueprint for Action – Maternity Care in NSW*.

Recommendation 3

That the NSW Government review and evaluate clinical practices in other jurisdictions, including the Queensland Birth Strategy, to identify findings that could be integrated into *Connecting, listening and responding: A Blueprint for Action – Maternity Care in NSW*.

2.97 The committee heard various perspectives on the concept of birth trauma, with most definitions encompassing physical injury, psychological distress, and disrespectful treatment. However, it was noted by many that birth trauma is an individual experience and can only be defined by the women who experience it.

2.98 Likewise, the committee heard perspectives on the concept of obstetric violence. While internationally recognised as a form of gender-based violence, the committee heard concerns

about its adoption into New South Wales law, with worries about the impact on health professionals of such a punitive approach. Nonetheless, the committee recognises that proponents of this term argue for its formal recognition as a criminal offence to ensure justice for victim-survivors. On balance, the committee considers that more work needs to be done in this area.

Recommendation 4

That the NSW Government consider further research into the benefit and difficulties of legislating with respect to the birthing experience, including operating with the existing law of medical negligence.

2.99 The committee heard about the devastating physical, psychological and financial impacts that a traumatic birth can have on a mother and her family. It is therefore important that appropriate supports are provided throughout and after pregnancy to prevent birth trauma or minimise its impact.

2.100 While we acknowledge the dedicated efforts of health workers to provide mental health and physical support for those impacted by birth trauma, we also recognise the barriers that exist to accessing these services. These include cost barriers and constraints on existing service capacity due to limited resources.

2.101 Some evidence suggested that the Australian Government should increase the number of Medicare-rebatable psychological sessions available to new parents to 40 sessions and to reduce gap fees. The committee recognises there is a broad range of clinical needs where some people may only need a few sessions while others may need more than 40. The committee therefore recommends that the NSW Government improve both mental and physical health support for those affected by birth trauma.

Recommendation 5

That the NSW Government improve mental health support for women and families affected by birth trauma by:

- including psychological support in public postnatal care
- ensuring that parents have access to psychological support beyond the immediate post-partum period
- reviewing the funding needs of services currently offering specialised helplines for birth trauma counselling and committing to providing the level of funding and support required
- advocating to the Australian Government to increase Medicare-rebatable psychological support for new parents to reduce gap fees and enable access to the number of sessions clinically required.

Recommendation 6

That the NSW Government fund postpartum services, including physiotherapy and supported exercise programs, to support those who acquire a pelvic floor injury as a result of birth.

2.102 The committee recognises the importance of breastfeeding. We note that the ability to breastfeed can be negatively impacted by birth trauma, and that being unable to breastfeed can be a source of trauma for some women. We recommend that breastfeeding education be made accessible for parents, and that the NSW Government ensure education be provided to maternity health practitioners on breastfeeding support.

Recommendation 7

That the NSW Government make breastfeeding education accessible for parents, and ensure education is provided to maternity health practitioners on breastfeeding support.

2.103 The committee recognises the importance of the research already undertaken into birth trauma in Australia, while also acknowledging there are still significant gaps in the research, and in particular, around Australian specific data. Clearly more research is needed to understand prevention strategies and factors contributing to birth trauma.

Recommendation 8

That the NSW Government provide funding grants specific to research into birth trauma in New South Wales.

Chapter 3 Factors in the healthcare system contributing to birth trauma

This chapter explores how current practices and processes in the maternity care system contribute to birth trauma. It examines various factors, including a lack of continuity of care and trauma-informed care in the delivery of maternity care. The chapter also considers inadequate antenatal education, and the need to strengthen informed consent practices within health services. Additionally, the chapter explores the impact of birth interventions, such as caesarean sections, inductions, and instrumental deliveries, focusing on the high prevalence of interventions in New South Wales. Finally, the chapter assesses how improved birthing environments and addressing workforce shortages can help alleviate adverse outcomes.

Delivery of maternity care

3.1 During the inquiry, the committee heard that one of the biggest factors contributing to birth trauma was a lack of continuity of care in the delivery of maternity care. This section will examine models of maternity care, including Maternity Group Practice, GP Shared Care, and Maternity Antenatal Postnatal Service, with a particular focus on their level of continuity of care.

Continuity of care versus continuity of carer

3.2 As outlined in Chapter 2, the maternity system in New South Wales encompasses many different models of care with differing levels of continuity. Before examining these models, it is important to differentiate between continuity of care and continuity of carer models.

- Continuity of care involves a team of practitioners who work together, adhering to a shared philosophy and exchanging information to deliver maternity care.[184]
- Continuity of carer involves consistent care provided by a single known practitioner throughout the entire antenatal, intrapartum and postpartum journey.[185]

3.3 Continuity of midwifery carer is a subset of these models, where women have a primary midwife who provides care from early in pregnancy through to the postnatal period. This model was hailed as the 'gold standard' by numerous stakeholders to this inquiry.[186] These stakeholders spoke of the benefits of continuity of midwifery carer, including improved outcomes for babies,

184 Evidence, Ms Sandra Forde, Midwifery Manager, Murrumbidgee Local Health District, 12 December 2023, p 44; Tabled document, Leeton Midwifery Group Practice, *Continuity of Care Models – A Midwifery Toolkit*, NSW Ministry of Health, June 2023, p 15.

185 Tabled document, Leeton Midwifery Group Practice, *Continuity of Care Models – A Midwifery Toolkit*, NSW Ministry of Health, June 2023, p 15.

186 See for example, Submission 252, Australian Medical Association (NSW), p 8; Evidence, Ms Carly Griffin, Individual, 7 September 2023, p 10; Evidence, Ms Olivia Prain, Individual, 7 September 2023, p 13; Evidence, Ms Sharon Settecasse, Vice President, Better Births Illawarra, 7 September 2023, p 27; Evidence, Mr Steven Kennedy, Founder and Executive Director, Prepare Foundation, 9 October 2023, p 53; Evidence, Dr Maria Del Pilar Luna Ramirez, Obstetrician and Gynaecologist staff specialist, Acting Head of Department, Women's care unit, Northern NSW Local Health District,11 March 2024, p 63; Evidence, Ms Jacinta Selby, Principal Midwifery Manager, Sydney Local Health District, and Midwifery Manager, Concord MGP, 8 April 2024, p 68.

enhanced satisfaction for mothers, lower rates of interventions, and fewer instances of preterm labour or stillbirths.[187] These benefits were corroborated in the *Continuity of Care Models: A Midwifery Toolkit* published by NSW Health which included data from a systematic review of 17,674 participants.[188]

3.4 Despite the benefits, access to continuity of midwifery carer is limited, with only one in ten women in New South Wales able to access this model.[189] Furthermore, NSW Health stated that continuity of midwifery carer has traditionally only been made available to women with low-risk pregnancies.[190]

3.5 NSW Health introduced a hybrid model that provides midwifery continuity of care during the antenatal and postnatal period only, while intrapartum care is provided by midwives at the hospital or birthing centre.[191] This model is known as Midwifery Antenatal and Postnatal Service (MAPS) and will be discussed in more detail below.

3.6 It is important to highlight that for some stakeholders, the term 'continuity of care' encompasses 'continuity of carer'.

Continuity of care model: Midwifery Group Practice

3.7 As mentioned previously, continuity of care refers to models of maternity care in which a mother receives consistent support from the same practitioner or team throughout pregnancy, birth, and postnatal care.[192] These models include both private models, where private practicing obstetricians or midwives provide continuum of care across antenatal, intrapartum, and postnatal periods,[193] as well as publicly funded models, such as Midwifery Group Practice.

3.8 In 2023, NSW Health reaffirmed its commitment to implementing continuity of care and republished the *Continuity of Care Models: A Midwifery Toolkit* to support maternity managers to implement continuity of care models.[194]

187 See for example, Submission 943, Maternity Consumer Network, p 6; Evidence, Ms Alison Weatherstone, Chief Midwife, Australian College of Midwives, 4 September 2023, p 59; Evidence, Ms Sally Cusack, National Secretary, Maternity Choices Australia, 4 September 2023, p 20; Submission 252, Australian Medical Association (NSW), p 7.

188 Tabled document, Leeton Midwifery Group Practice, *Continuity of Care Models – A Midwifery Toolkit*, NSW Ministry of Health, June 2023, p 7, quoting J Sandall, H Soltani, S Gates, A Shennan, D Devane, 'Midwife-led continuity models versus other models of care for childbearing women' (2016) 4 *Cochrane Database of Systematic Reviews 2016*.

189 Submission 253, Maternity Choices Australia, p 6.

190 Tabled document, Leeton Midwifery Group Practice, *Continuity of Care Models – A Midwifery Toolkit*, NSW Ministry of Health, June 2023, p 43.

191 Tabled document, Leeton Midwifery Group Practice, *Continuity of Care Models – A Midwifery Toolkit*, NSW Ministry of Health, June 2023, p 43.

192 Submission 252, Australian Medical Association (NSW), p 8.

193 Tabled document, Leeton Midwifery Group Practice, *Continuity of Care Models – A Midwifery Toolkit*, NSW Ministry of Health, June 2023, p 19.

194 Submission 862, NSW Health, p 17.

3.9 Stakeholders including Transforming Maternity Care Collaborative and Australian Midwifery and Maternity Alliance, and the Australian Medical Association (NSW), acknowledged the importance of continuity of care, specifically its role in fostering trusting relationships and facilitating informed decision-making for mothers.[195] Australian Medical Association (NSW) stated that these models create more opportunities for patients to discuss options and better understand the associated benefits and risks.[196]

3.10 According to evidence provided by Transforming Maternity Care Collaborative and Australian Midwifery and Maternity Alliance, continuity of midwifery care saves lives, reduces morbidity and enhances the health of women and babies compared with other models of care.[197]

3.11 Midwifery Group Practice (MGP) is one continuity of care model providing comprehensive maternity care, encompassing antenatal education, labour and postpartum support. Under this model of care, a primary midwife provides continuous care through every stage, with a secondary midwife on-call for back up and support.[198]

3.12 Stakeholders, including Western Sydney University School of Nursing and Midwifery, the Australian College of Midwives, and Better Births Illawarra, supported the MGP model considering it to provide the best outcomes in maternity care.[199]

3.13 The committee heard that despite its advantages, many women were either unaware of the program, were not able to secure one of the limited places or were excluded because they were classed as 'high-risk'. [200] This is despite the fact that witnesses like Dr Bashi Kumar-Hazzard, Chair, Human Rights in Childbirth, argued that women labelled high risk 'are more vulnerable and they probably need more continuity of care than anybody else'.[201]

3.14 The NSW Nurses and Midwives Association agreed that midwifery-led continuity of care must be accessible for all birthing women, 'especially those who are deemed 'high-risk'', noting that right now there are simply not enough places available in these models of care:

> Despite being the gold standard, only a small fraction of women in NSW who birth are able to access this model of care and access is almost always contingent on the woman possessing a high level of education and awareness that the model of care exists and

195 See, Submission 252, Australian Medical Association (NSW), p 7; Submission 248, Transforming Maternity Care Collaborative and Australian Midwifery and Maternity Alliance, p 5, quoting J Allen, S Kildea, & H Stapleton, 'How optimal caseload midwifery can modify predictors for preterm birth in young women: Integrated findings from a mixed methods study' (2016) *Midwifery*.

196 Submission 252, Australian Medical Association (NSW), p 7.

197 Submission 248, Transforming Maternity Care Collaborative and Australian Midwifery and Maternity Alliance, p 5, quoting J Sandall, H Soltani, S Gates, A Shennan, D Devane, 'Midwife-led continuity models versus other models of care for childbearing women' (2016) 4 *Cochrane Database of Systematic Reviews 2016*.

198 Submission 862, NSW Health, p 17; Tabled document, Leeton Midwifery Group Practice, *Continuity of Care Models – A Midwifery Toolkit*, NSW Ministry of Health, June 2023, p 77.

199 See, Evidence, Professor Hannah Dahlen AM, School of Nursing and Midwifery, Western Sydney University, 4 September 2023, p 32; Evidence, Ms Alison Weatherstone, Chief Midwife, Australian College of Midwives, 4 September 2023, p 51; Submission 880, Better Births Illawarra, p 3.

200 Submission 854, Australian College of Midwives, p 28.

201 Evidence, Dr Bashi Kumar-Hazard, Chair, Human Rights in Childbirth, 4 September 2023, p 48.

> early booking (at 4-5 weeks) is necessary as well as being sufficiently 'low risk' to be eligible for a place.[202]

3.15 Ms Leselle Herman from Leeton Midwifery Group Practice highlighted the stress many women feel at having 'risked out' of an MGP program:

> Many women have reported risking out of their chosen model of care as a contributing factor to their trauma. This focus on risk assessment often takes priority over the woman's choices and does not consider that risk assessment is subjective in nature. We propose governance that places women and birthing people's autonomy as the highest priority.[203]

3.16 Personal reports from women such as Ms Olivia Prain show the distress and disconnection experienced when women have been excluded from this model due to risk factors.[204] Ms Prain was initially accepted into MGP and then later excluded. She told the committee that she 'had felt really safe in the program' and was disappointed to no longer be part of it. She was mostly worried about seeing a multidisciplinary team of doctors and midwives as she feared issues could be missed and she could 'slip through the cracks' of the public health system. In the end, Ms Prain chose to pay out of pocket for a private practicing midwife to ensure continuity of care.[205]

3.17 Ms Jessica Holliday also expressed her frustrations of being unable to apply for an MGP program, as she was considered too 'high risk':

> If you have a high-risk birth, you are immediately not even able to apply for MGP. You see obstetricians, but you don't have the one obstetrician…It's hard. I never, ever saw the same obstetrician—not once... If I am high risk, then why am I being given—there is so much evidence of continuity of care. Why am I being given almost, to my mind, the worst type of care—no continuity at all?[206]

3.18 Ms Sharon Settecasse, Vice President, Better Births Illawarra, argued we need to rethink what is meant by 'high risk', noting the term is no longer used in the UK.[207] Ms Alyssa Booth from Better Births Illawarra also expressed the view that it is possible for midwives to deliver care to 'high risk' women:

> I think it's quite possible for midwives to look after high-risk women. They know their limits. They know when to refer to an obstetric team. So, if you have a midwife caring or a midwife as part of a high-risk team, they're going to consult with an obstetrician when they need to and you still get that continuity of care. If it comes down to it where she can't see a midwife, she could at least see the same obstetrician the entire way through. We know that that continuity of care improves outcomes and you are increasing the risk for these women by putting them in fragmented care.[208]

202 Submission 242, NSW Nurses and Midwives' Association, p 3.

203 Evidence, Ms Leselle Herman, Midwife, Leeton Midwifery Group Practice, 12 December 2023, p 33.

204 Evidence Ms Olivia Prain, Individual, 7 September 2023, pp 9-10.

205 Evidence Ms Olivia Prain, Individual, 7 September 2023, pp 9-10.

206 Evidence, Ms Jessica Holliday, Individual, 7 September 2023, p 4.

207 Evidence, Ms Sharon Settecasse, Vice-President, Better Births Illawarra, 7 September 2023, p 22.

208 Evidence, Ms Alyssa Booth, Secretary, Better Births Illawarra, 7 September 2023, p 22.

3.19 Conversely, Ms Aimee Keating's positive experience within MGP exemplifies its potential. She told the committee she was 'one of the lucky ones' as she was accepted into the program. Despite experiencing a traumatic birth where her daughter was born unresponsive after a 'very fast and intense' second stage of labour, she was separated from both her husband and daughter as her daughter was resuscitated and taken to NICU. Ms Keating found support and comfort from her two known midwives. She told the committee that the midwives were a 'familiar hand to hold' and they provided explanation and debriefing throughout her ordeal.[209] Ms Keating also praised the MGP program for helping the midwives heal from the traumatic birth as they were able to visit the baby afterwards and see her 'thriving in her home environment'. [210]

3.20 Ms Keating highlighted that her experience in the MGP prevented further trauma:

> I still struggle with the events of my daughter's birth and always will, but not because of the way I was treated. In fact, the way I was cared for and supported through my pregnancy, birth and early postpartum by a knowledgeable and incredible midwife saved me from further trauma and mental health decline and will be something I am always grateful for. I truly believe that this should be the standard of care every woman in Australia is entitled to.[211]

3.21 However, the committee heard claims there are some challenges within NSW Health to grow and support the MGP midwifery workforce due to workload demands and on-call requirements. These concerns will be explored in more detail later in this chapter.

A hybrid model: Maternity Antenatal Postnatal Service

3.22 NSW Health has introduced the Maternity Antenatal Postnatal Service (MAPS), which provides a continuum of support during antenatal and postnatal periods only.[212] The model was described by Ms Julie Swain, Deputy Director of Nursing and Midwifery at Western Sydney Local Health District, as a 'hybrid-style' approach to continuity of care as it provides midwives with more work flexibility and adequate work arrangements.[213] Under this model, antenatal and postnatal care is provided by a known midwife or team of midwives, while intrapartum care is provided by midwives at the birth unit or hospital.[214]

3.23 NSW Health informed the committee that MAPS addresses the workforce challenges seen in continuity of care models as staff do not have the same workforce demands or on-call requirements. This, according to NSW Health, is particularly beneficial in regions where continuity of care models face limitation due to staffing restraints. According to NSW Health, women accessing the MAPS model felt 'connected and safe' and experienced more quality time with their midwife.[215]

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209 Evidence, Ms Aimee Keating, Individual, 7 September 2023, p 9.

210 Evidence, Ms Aimee Keating, Individual, 7 September 2023, p 9.

211 Evidence, Ms Aimee Keating, Individual, 7 September 2023, p 9.

212 Submission 862, NSW Health, p 17.

213 Evidence, Ms Julie Swain, Deputy Director of Nursing & Midwifery, Women's and Newborn Health, Western Sydney Local Health District, 8 April 2024, p 67.

214 Tabled document, Leeton Midwifery Group Practice, *Continuity of Care Models – A Midwifery Toolkit*, NSW Ministry of Health, June 2023, p 78.

215 Submission 862, NSW Health, p 18.

3.24 However, the committee heard that MAPS also has limitations, particularly concerning intrapartum care. While continuity of care is maintained through outpatient services during pregnancy and postpartum, the involvement of different midwives during labour can hinder consistent support and personalised care. Better Births Illawarra raised serious concerns about the MAPS model, arguing that it is not 'evidence-based' care and the absence of a familiar midwife during labour could lead to increased stress and inadequate support for birthing individuals at the time they are most at risk of experiencing birth trauma:[216]

> How is it that we can have a midwife supporting a person in pregnancy and then postnatally, but isn't actually there for—dare I say it—the main event. It seems illogical. And the physiology of birth means that your hormones are different in that space. Women should not be advocating for the birth room. They should just be focusing on having a baby. So if a midwife is not there with them, who knows them and trusts them, and that person is in the unit for 12, 18 or three hours and they have a midwife change—shift changes. There is simply no evidence.[217]

3.25 Better Births Illawarra went on to say that the 'myth that most midwives do not want to work in these models needs to be dispelled. MAPS is upholding the fragmented system that is a systemic cause of avoidable birth trauma'.[218]

3.26 Despite these concerns, NSW Health expressed support for the MAPS model, arguing that it can have a positive impact on maternity care. NSW Health argued the need for flexibility in intrapartum care to adapt to workforce dynamics while ensuring optimal support for mothers.[219]

Multidisciplinary approach to maternity care

3.27 In addition to continuity of care models, various stakeholders expressed support for a multidisciplinary approach to maternity care, highlighting positive outcomes for mothers and babies.

3.28 According to Australian Medical Association (NSW), a collaborative multidisciplinary approach enables the early identification of risk factors that could lead to pregnancy and birth complications. The organisation advocated for a multidisciplinary model where doctors and midwives work together in a team, rather than being 'pitted against' each other, which can foster mutual respect and diverse perspectives.[220] Unlike some stakeholders who called for a 'midwife-led' model of care, the Australian Medical Association (NSW) argued that the most successful outcome is achieved when a 'doctor-led' and 'team-based' model of care is implemented with 'each profession supporting and respecting the opinion and approach of others.[221]

216 Evidence, Ms Sharon Settecasse, Vice President, Better Births Illawarra, and Ms Alyssa Booth, Secretary, Better Births Illawarra, 7 September 2023, pp 20-21.

217 Evidence, Ms Sharon Settecasse, Vice President, Better Births Illawarra, 7 September 2023, p 20.

218 Answers to questions on notice, Better Births Illawarra, 10 October 2023, p 2.

219 Evidence, Ms Deb Willcox, Deputy Secretary, Health System Strategy and Patient Experience, NSW Health, 4 September 2023, p 64.

220 Submission 252, Australian Medical Association (NSW), p 5.

221 Submission 252, Australian Medical Association (NSW), p 5.

3.29 Australian Medical Association (NSW) told the committee that New South Wales public hospital maternity care predominately follows a multidisciplinary approach, with the involvement of midwives, obstetricians and other professionals. According to the Australian Medical Association (NSW), in 2022, 52.6 per cent of expectant mothers used this model.[222] However, despite its prevalence, some stakeholders raised concerns regarding the level of continuity of care. GP Obstetrician Dr Carl Henman argued that while multidisciplinary care has its value, it does not inherently ensure continuity of care. He highlighted the potential drawbacks of fragmented care, stressing the importance of consistent management throughout a woman's pregnancy, labour and postpartum.[223]

3.30 Dr Henman's sentiments were echoed by other stakeholders such as Maternity Choices Australia, who told the committee that women in Australia often see more than 20 care providers throughout pregnancy, labour and postpartum. They contend that this prevents women from building a relationship with their care provider.[224]

3.31 Board Director at the Royal Australian College of Obstetricians and Gynaecologists (RANZCOG), Dr Jared Watts, emphasised the need for a shift towards patient-centred care within multidisciplinary teams. He stressed the importance of providing antenatal counselling and information to expectant mothers, ensuring they are familiar with all members of their care team to prevent traumatic experiences during emergency situations.[225]

GP Shared Care

3.32 One version of the multidisciplinary approach that stakeholders referred to was the GP Shared Care model, a traditional model of care where women typically self-refer to participating GPs who have an interest and expertise in obstetrics.[226] These GPs work alongside midwives and obstetricians, allowing for shared decision-making and coordinated care throughout the pregnancy.[227]

3.33 According to inquiry participants, GP Shared Care offers several benefits for women, including convenience and the opportunity to receive care from a known healthcare provider in a familiar setting.[228] Dr Kathryn Austin from Australian Medical Association (NSW), however, noted that

222 Submission 252, Australian Medical Association (NSW), p 8, quoting *Maternity models of care in Australia, 2023: Major model category* (22 July 2022), Australian Institute of Health and Wellbeing, https://www.aihw.gov.au/reports/mothers-babies/maternity-models-of-care/contents/what-do-maternity-models-of-care-look-like/major-model-category.

223 Evidence, Dr Carl Henman, GP Obstetrician, O&G Sonologist, Nova Health, 12 December 2023, p 28.

224 Submission 253, Maternity Choices Australia, p 6.

225 Evidence, Jared Watts, Board Director, Royal Australian College of Obstetricians and Gynaecologists, 4 September 2023, p 6.

226 Evidence, Dr Trudi Beck, GP Obstetrician, Nova Health and Murrumbidgee Region GP Antenatal Shared Care Program, 12 December 2023, p 38.

227 Submission 862, NSW Health, p 17.

228 See for example, Evidence, Mr Andrew Heap, Senior Manager Primary Care Engagement, Murrumbidgee PHN, Murrumbidgee Region GP Antenatal Shared Care Program, 12 December 2023, p 34; Evidence, Dr Rakime Elmir, Senior Lecturer, Deputy Director Clinical Education Midwifery, School of Nursing and Midwifery, Western Sydney University, 9 October 2023, p 32;

this model requires additional investment to ensure adequate resources and funding for GPs to provide this care. Despite this, Dr Austin expressed the view that GP Shared Care is a valuable option for women who may fall into a higher risk category than those eligible for Midwifery Group Practice but do not require a specialist obstetrician. [229]

3.34 An example of GP Shared Care is the Murrumbidgee Antenatal Shared Care Program, facilitated by the Murrumbidgee Primary Health Network. Mr Andrew Heap from the Murrumbidgee Antenatal Shared Care told the committee that the program provides a structured pathway for pregnant women to receive care from a GP in collaboration with the hospital antenatal clinic. The program lists 69 GPs and GP registrars qualified to provide shared care services in collaboration with the Murrumbidgee Primary Health Network, and Wagga Wagga Base Hospital.[230]

3.35 According to GP Obstetrician Dr Trudi Beck, the program's success lies in the close collaboration between GPs and the local healthcare system. She emphasised the importance of easy access to advice from hospital professionals, stating that the current shared care pathways facilitate smooth communication and decision-making. Dr Beck suggested improvements to the program such as establishing a GP liaison officer in hospitals to enhance accessibility for external providers.[231]

3.36 Dr Beck acknowledged that while access to GP shared care is adequate in Wagga Wagga, smaller communities may face challenges due to pressure on rural midwives and GP obstetricians, impacting resource provision and placing strain on central referral hospitals.[232] Better Births Illawarra also raised concern about this model, suggesting that it did not provide genuine continuity of care as it often does not include continuity of carer during the actual birth, which is where the highest risk of birth trauma occurs.[233]

3.37 In many rural communities in New South Wales, GP Obstetricians provide antenatal, intrapartum and postpartum care as well as longitudinal and holistic care for patients and often whole families. This is a preferred model of care for many people in these communities and may not meet demand as insufficient medical practitioners are trained and retained as GP Obstetricians.[234]

Evidence, Dr Kathryn Austin, Vice President, Australian Medical Association (NSW), 9 October 2023, p 63.

229 Evidence, Dr Kathryn Austin, Vice President, Australian Medical Association (NSW), 9 October 2023, pp 63-64.

230 Evidence, Mr Andrew Heap, Senior Manager Primary Care Engagement, Murrumbidgee PHN, Murrumbidgee Region GP Antenatal Shared Care Program, 12 December 2023, p 34.

231 Evidence, Dr Trudi Beck, GP Obstetrician, Nova Health and Murrumbidgee Region GP Antenatal Shared Care Program, 12 December 2023, p 25.

232 Evidence, Dr Trudi Beck, GP Obstetrician, Nova Health and Murrumbidgee Region GP Antenatal Shared Care Program, 12 December 2023, p 37.

233 Answers to questions on notice, Better Births Illawarra, 10 October 2023, p 2.

234 See for example, Evidence Dr Carl Henman, GP Obstetrician, Nova Health, 12 December 2023, pp 23-25; Evidence, Dr Rebekah Hoffman, NSW&ACT Faculty Chair, The Royal Australian College of General Practitioners, 8 April 2024, pp 46-48; Evidence, Dr Trudi Beck, GP Obstetrician, Nova Health and Murrumbidgee Region GP Antenatal Shared Care Program, 12 December 2023, pp 37-39.

3.38 Dr Rebekah Hoffman representing the Royal Australian College of General Practitioners explained that Medicare rebates for antenatal care by GPs are insufficient to cover the cost of care to the standard that both practitioners and patients reasonably expect, and that the Medicare Rebates Schedule incentivises shorter appointments.[235]

Lack of trauma-informed care

3.39 Regardless of the model of maternity care chosen, stakeholders emphasised the need for trauma-informed care to be practiced by the entire maternity care workforce. This approach acknowledges the impact of past trauma and strives to create a safe and supportive environment.[236]

3.40 One individual shared her personal account of childbirth and the way past trauma impacted her experience. In November 2017 she attended hospital for an induction, only for the onset of labour to happen quickly and contrary to her expectations. Despite seeking help from hospital staff, her requests were disregarded. She was routinely denied an epidural which added to her sense of panic and loss of control:

> As a victim of trauma this immediately sent me into panic as I suddenly realised I was not in control of the situation and the people who were supposed to support me were not going to…I began to spiral as I knew something was wrong and no one was going to listen to anything I said…I had spiralled into a complete trauma response and was pacing around the room like an animal. My husband had to keep me in the room as I was so distressed. I kept wanting to run away and locked myself in the toilet trying to keep away from these women. Eventually a young anaesthetist came in and after seeing my distress promised me things would be much more manageable very soon. At last, someone was going to help me.[237]

3.41 She recounts being coerced into a forceps and episiotomy delivery by the obstetrician. She said: 'At this point I left my body. I was laying there but I was watching myself from above and could not speak'.[238] Even after the baby was delivered her body continued to shake as the obstetrician 'pushed open' her legs to stitch her. She further stated that her husband's inability to intervene compounded feelings of guilt and put strain on their relationship. These experiences prevented her from bonding with her newborn:

> There was no connection at all. Postnatal depression began immediately. Yet all these professionals were praising me for my 'amazing birth'. It was like being in the twilight zone.[239]

3.42 The trauma permeated every aspect of her life, affecting her relationship with her husband and her ability to consider future pregnancies. The experience and subsequent miscarriages further compounded her distrust of the healthcare system. It was not until she sought alternative care, a compassionate midwife, and immersed herself in education that she finally felt the trauma

235 Evidence, Dr Rebekah Hoffman, NSW&ACT' Faculty Chair, The Royal Australian College of General Practitioners, 8 April 2024, pp 47-49.

236 Submission 242, NSW Nurses and Midwives' Association, p 7.

237 Submission 1013, Name suppressed, p 1.

238 Submission 1013, Name suppressed, p 2.

239 Submission 1013, Name suppressed, p 2.

'wash from my body', as she described reclaiming control over her body and the birth experience.[240]

3.43 NSW Health told the committee it is committed to providing trauma-informed care. To achieve this, NSW Health introduced the Integrated Trauma-Informed Care Framework: *My story, my health, my future*. According to NSW Health, this framework brings together elements of trauma-informed care and integrated care to improve the experience of individuals accessing NSW Health services.[241]

3.44 The framework is based on four key assumptions:

1. realising the impact trauma can have on families, carers, organisations, communities and individuals, and understanding that all clients and staff may have their own experiences of trauma
2. recognising the signs of trauma, that relationships can be the basis for healing, and that service-delivery setting plays a role in facilitating the foundation for trauma-informed care
3. responding appropriately and effectively by applying the principles of trauma-informed care
4. seeking to prevent re-traumatisation of clients as well as staff.[242]

3.45 According to NSW Health, 'effective trauma-informed maternity care ensures women are supported to feel physically and emotionally safe. The care promotes trust, is collaborative and ensures women are empowered to make informed choices about their care'.[243]

3.46 In a similar vein, the NSW Nurses and Midwives' Association argued that integrating trauma-informed care throughout all stages of pregnancy, childbirth, and postpartum is crucial for fostering positive birthing experiences, facilitating healing, and promoting emotional wellbeing of mothers.[244]

3.47 Australian Medical Association (NSW) highlighted that both diagnosed and undiagnosed mental health issues can significantly influence a woman's birth experience. Traumatic childhood experiences and mental health history such as post-traumatic stress disorder can contribute to adverse pregnancy outcomes.[245] Australian Medical Association (NSW) argued that trauma-informed care can be tailored to address labour-related needs using themes such as:

- need for control
- difficulties with disclosure

240 Submission 1013, Name suppressed, p 4.

241 Evidence, Ms Deb Willcox, Deputy Secretary of Health System Strategy and Planning, NSW Health, 4 September 2023, p 62; Submission 862, NSW Health, pp 6 and 14.

242 Evidence, Ms Deb Willcox, Deputy Secretary, Health System Strategy and Planning, NSW Health, 4 September 2023, p 62.

243 Submission 862, NSW Health, pp 14-15.

244 Submission 242, NSW Nurses and Midwives' Association, p 7.

245 Submission 252, Australian Medical Association (NSW), p 6, quoting M Sperlich, J.S Seng, Y Li, J Taylor, C Bradbury-Jones, 'Integrating trauma-informed care into maternity care practice: Conceptual and practical issues' (2017) 62(6), *Journal of midwifery & women's health*, pp 661-672.

- struggling with dissociation
- hoping for healing
- coping with remembering
- discomfort that comes with vulnerability.[246]

3.48 While NSW Health stated that it provides trauma-informed training to all healthcare clinicians,[247] the committee heard that, many healthcare professionals, including obstetricians and midwives, stated they lacked adequate training in trauma-informed care. In a survey conducted by the Nurses and Midwives' Association, 48 per cent of members said their understanding of the concept of trauma-informed care was fair or poor, and 83 per cent said they had not received any professional training on how to care for someone who has previously experienced birth trauma.[248] The Nurses and Midwives' Association claimed that without proper education on how to recognise trauma, communicate effectively and provide trauma-informed care, maternity care professionals may inadvertently contribute to the re-traumatisation of women.[249]

3.49 Moreover, the Nurses and Midwives' Association said there is a tendency in maternity care settings to prioritise medical interventions and protocols over individualised, trauma-informed care. The Association therefore advocated for policy changes that prioritise trauma-informed care and emotional wellbeing in maternity care.[250]

3.50 Ms Deb Willcox, Deputy Secretary, System Strategy and Patient Experience for NSW Health, emphasised the importance of trauma-informed care by stating that NSW Health conducts psychosocial screening of women during pregnancy and postpartum. This screening helps identify experiences such as domestic violence, migration-related trauma, or previous abuses, allowing the midwife to tailor care accordingly and be vigilant for signs of distress. According to Ms Willcox, over 95 per cent of women utilising maternity services in New South Wales undergo screening to ensure they receive appropriate care.[251]

3.51 Ms Willcox highlighted the universal psychological screening tool SAFE START, which has been a component of antenatal and postnatal health care in New South Wales health services since 2009. The tool includes questions addressing symptoms associated with psychological birth trauma. According to NSW Health, this tool helps clinicians identify risks and directs them to appropriate care.[252]

3.52 However, clinical midwife consultant Ms Fiona Reid acknowledged the limitations in the tool's ability to identify previous birth trauma or signal clinicians to a woman's history related to her

246 Submission 252, Australian Medical Association (NSW), p 7.

247 Submission 862, NSW Health, p 15.

248 Submission 242, NSW Nurses and Midwives' Association, p 8.

249 Submission 242, NSW Nurses and Midwives' Association, p 8.

250 Submission 242, NSW Nurses and Midwives' Association, p 8.

251 Evidence, Ms Deb Willcox, Deputy Secretary, Health System Strategy and Planning, NSW Health, 4 September 2023, p 62.

252 Evidence, Ms Deb Willcox, Deputy Secretary, Health System Strategy and Planning, NSW Health, 4 September 2023, p 62.

past pregnancy or birth experience. Ms Reid suggested that there was a need for improved screening tools.[253] Ms Reid also highlighted the need for continuity of carer, in addition to the use of these screening tools, noting the re-traumatising effect of telling (and retelling) a story and their experience to multiple health providers.[254]

3.53 Ms Amy Dawes from the Australasian Birth Trauma Association highlighted the need to 'work with women and families to give them an environment where they can disclose information safely with their caregiver about things in their history that may influence their birth experience'.[255] Ms Alyssa Booth from Better Births Illawarra also highlighted the link between continuity of carer and trauma informed care:

> If you choose to go through your local hospital because you can't financially output thousands of dollars for a midwife and a doula, then you should be able to access the same face and not have to tell your story over and over, particularly if there is a history of trauma. You're retraumatising women by making them go over their notes because you didn't have five minutes to sit down and read it, and you don't know her. All the consistent messaging is continuity of care.[256]

Adequacy of communication and education in maternity care

3.54 According to inquiry participants, another aspect of maternity care that can help prevent birth trauma is informed decision-making. The committee heard that many women receive inadequate information regarding their maternity care options. Stakeholders highlighted several factors causing women to feel uninformed during childbirth, these include insufficient antenatal education and receiving biased information from clinicians. Stakeholders called for these issues to be addressed to ensure women can make informed choices about their maternity care.

3.55 This section explores the landscape of antenatal education, emphasising how accurate, unbiased information can support informed decision making in maternity care. It also examines the importance of adequately preparing expectant parents for pregnancy, childbirth, and parenthood.

Antenatal education

3.56 The committee heard that antenatal education plays a role in preparing expectant parents for pregnancy, childbirth, and parenthood. However, evidence provided by Childbirth and Parenting Educators Australia (CAPEA), estimates that less than 50 per cent of first-time parents in New South Wales attend formal antenatal education programs, with the rest opting for alternative sources of information or no information at all.[257]

253 Evidence, Ms Fiona Reid, Clinical midwife consultant, 7 September 2023, p 33.

254 Evidence, Ms Fiona Reid, Clinical midwife consultant, 7 September 2023, p 31.

255 Evidence, Ms Amy Dawes OAM, Co-founder and CEO, Australasian Birth Trauma Association, 4 September 2023, p 23.

256 Evidence, Ms Alyssa Booth, Secretary, Better Births Illawarra, 7 September 2023, p 23.

257 Evidence, Ms Alison Summerville, Engagement Officer, Childbirth and Parenting Educators of Australia (CAPEA), 8 April 2024, p 12.

3.57 According to NSW Health, consumer feedback showcased the necessity for antenatal education, covering various topics from labour to early parenthood preparation, and parental mental health and wellbeing.[258] NSW Health also highlighted other benefits associated with antenatal education including reducing anxiety, increasing the use of coping strategies, increasing partner involvement and improving self-efficacy and psychological preparation, which they state can have positive impacts.'[259]

3.58 NSW Health advised that the NSW Local Health Districts offer tailored programs catering to a diverse range of needs, including for specific demographics such as young parents, fathers, grandparents and LGBTQIA+ families. NSW Health stated that they have made efforts to ensure inclusivity by providing education in languages other than English and addressing the needs of diverse communities.[260]

3.59 Even with these programs in place, stakeholders highlighted obstacles to achieving widespread access to antenatal education in New South Wales. The NSW Nurses and Midwives' Association reported that approximately 90 per cent of their members expressed concerns regarding barriers faced by birthing women accessing educational programs. According to these members, this leaves people unprepared for potential emergency procedures and interventions.[261] They recommended the introduction of free hospital antenatal classes, extending clinic appointment times to improve educational support and the use of more accessible resources in maternity education – such as visual presentations – to remove some of these barriers.[262]

3.60 Mrs Belinda Alexander shared her personal experience with antenatal education. As a first-time mother, she expressed feeling unprepared for the complexities of childbirth, partly due to the limited hospital-based education she received, which she said consisted of generic pamphlets not tailored to her specific needs. As a result, Mrs Alexander underwent an induction without adequate knowledge of the procedure and its associated risks, leading to a traumatic birth experience. However, with her second child, Mrs Alexander said she felt more informed. She credits her obstetrician for involving her in decision-making by presenting all available options. Mrs Alexander said this promoted a sense of control which resulted in a successful intervention-free birth.[263]

3.61 GP Obstetrician Dr Trudi Beck acknowledged that NSW Health makes an effort to educate women on possible interventions. She told the committee that typically women will be provided with a birth preference sheet during their third-trimester visit. However, in her experience, women often receive the form but do not know how to navigate it. According to Dr Beck, the issue was not a lack of information but how it is communicated.[264]

3.62 CAPEA and the Australian Medical Association (NSW) advocated for competency standards for antenatal educators and the incorporation of discussions on potential childbirth

258 Submission 862, NSW Health, p 23.

259 Submission 862, NSW Health, p 23.

260 Submission 862, NSW Health, p 23.

261 Submission 242, NSW Nurses and Midwives' Association, p 7.

262 Submission 242, NSW Nurses and Midwives' Association, p 7.

263 Evidence, Mrs Belinda Alexander, Individual, 12 December 2023, pp 9-11.

264 Evidence, Dr Trudi Beck, GP Obstetrician, Nova Health and Murrumbidgee Region GP Antenatal Shared Care Program, 12 December 2023, p 27

complications into education programs including interventions that may be needed such as forceps, vacuums, emergency caesarean sections, and episiotomies.[265] Australian Medical Association (NSW) councillor and neonatal intensive care physician Dr Eveline Staub stated 'if parents are armed with this education before such time it is needed, they are less likely to be traumatised when issues occur'.[266]

3.63 The Australian Medical Association (NSW) specifically advocated for 'a significant injection of funding to increase education regarding the prevalence and range of potential birth impacts, the frequency of and necessity for medical intervention and the rights of prospective parents throughout the process'.[267]

3.64 Stakeholders including Prepare Foundation and Dr Rakime Elmir from the School of Nursing and Midwifery at Western Sydney University, stressed the importance of tailoring antenatal education for fathers, to ensure fathers are engaged during the early stages of pregnancy. They underscored the significance of addressing barriers to education, including availability, cost, and traditional beliefs around gender roles.[268] Dr Elmir suggested ways to improve access, including after-hours education sessions and the involvement of male facilitators.[269] Prepare Foundation shared Dr Elmir's concerns, stating, 'we need targeted, father-inclusive, antenatal education and specialised information, including pregnancy, birth and postpartum complications'.[270]

3.65 Prepare Foundation founder and Executive Director Steven Kennedy acknowledged the limitations of traditional hospital-based education, especially in engaging modern fathers. He highlighted the need for online platforms, allowing parents to access information conveniently from their home and at their own pace.[271]

3.66 Dr Beck stated that expectant parents can gain valuable insights hearing about other people's experiences and perspectives. She mentioned 'Australian Birth Stories', as a recommended podcast which offers firsthand accounts of childbirth experiences.[272]

3.67 Despite the challenges, there was consensus among stakeholders regarding the crucial role of antenatal education in empowering expectant parents and improving birth outcomes. By addressing barriers to access, enhancing inclusivity, and promoting evidence-based education,

265 See, Evidence, Dr Kathryn Austin, Vice-President, Australian Medical Association (NSW), 9 October, p 66; Evidence, Ms Karen Logan, National President, Childbirth and Parenting Educators of Australia, 8 April 2024, p 11.

266 Evidence, Dr Eveline Staub, Councillor, Australian Medical Association (NSW), and Neonatal Intensive Care Physician, Royal North Shore Hospital, 8 April 2024, p 50.

267 Submission 252, Australian Medical Association (NSW), p 9.

268 Evidence, Dr Rakime Elmir, Senior Lecturer and Deputy Director Clinical Education Midwifery, School of Nursing and Midwifery, Western Sydney University, 9 October 2023, p 27.

269 Evidence, Dr Rakime Elmir, Senior Lecturer and Deputy Director Clinical Education Midwifery, School of Nursing and Midwifery, Western Sydney University, 9 October 2023, p 30.

270 Evidence, Dr Alka Kothari, Associate Professor Obstetrics and Gynaecology, 9 October 2023, p 53.

271 Evidence, Mr Steven Kennedy, Founder and Executive Director, Prepare Foundation, 9 October 2023, p 57.

272 Evidence, Dr Trudi Beck, GP Obstetrician, Nova Health and Murrumbidgee Region GP Antenatal Shared Care Program, 12 December 2023, p 26.

stakeholders were of the view that all parents could receive adequate support and education ahead of their childbirth and parenting journey.[273]

Informed consent and coercion

3.68 The committee heard about the importance of informed consent to help prevent birth trauma. The Nursing and Midwifery Board of Australia defines informed consent as 'a woman's voluntary agreement to healthcare, which is made with knowledge and understanding of the potential benefits and risks involved'.[274]

3.69 Human Rights in Childbirth viewed informed consent as a basis of ethical healthcare practice, underpinned by the fundamental human rights to bodily autonomy and bodily integrity.[275] Despite this principle, Human Rights in Childbirth noted instances where healthcare providers operate under the assumption that they 'do not need' to obtain informed consent for routine or minor procedures, causing pregnant women to feel that they do not have a right to refuse treatment.[276]

3.70 The organisation also highlighted that hospital guidelines, policies and protocols are frequently written in ways that 'mandate' routine interventions and invasive procedures during labour and birth', such as repeat vaginal examinations at least every 4 hours, fetal monitoring, anal examinations, strict time limits on labour, pitocin induction of labour and VBAC 'bans'.[277] Human Rights in Childbirth expressed frustration that these routine processes and procedures are also not routinely made public or disclosed to women prior to birth.[278]

3.71 The NSW Nurses and Midwives' Association expressed similar concerns about where the 'policies and recommended guidelines for care are used to coerce women into making decisions without being able to have informed choice in relation to that decision', stating further that:

> The prevalence of birth trauma is inextricably linked to the patriarchal medical model in which the majority of women in NSW birth. The relentless subjugation of women in our society combined with paternalistic policies and attitudes that suggest birthing women are incapable of making reasoned and rational decisions has created a culture whereby women are expected to comply with any recommended intervention. This expectation is framed around what is best for the baby, i.e. prioritising foetal wellbeing ahead of maternal wellbeing.[279]

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273 See for example, Evidence, Dr Eveline Staub, Councillor, Australian Medical Association (NSW), and Neonatal Intensive Care Physician, Royal North Shore Hospital, 8 April 2024, p 50; Submission 862, NSW Health, p 23; Evidence, Mrs Belinda Alexander, Individual, 12 December 2023, pp 9-11; Evidence, Mr Steven Kennedy, Founder and Executive Director, Prepare Foundation, 9 October 2023, p 57.

274 Answers to supplementary questions, NSW Nurses and Midwives' Association, 5 October 2023, p 4.

275 Submission 409, Human Rights in Childbirth, p 8.

276 Submission 409, Human Rights in Childbirth, p 9.

277 Submission 409, Human Rights in Childbirth, pp 13-15.

278 Submission 409, Human Rights in Childbirth, p 16.

279 Submission 242, NSW Nurses and Midwives' Association, p 6.

3.72 Informed consent entails a thorough understanding of the options, risks, and benefits of medical interventions, yet a large number of women shared their personal experiences of procedures being performed without proper consent.[280] To illustrate this, the NSW Nurses and Midwives' Association shared an example of a doctor who conducted a medical intervention without the woman's explicit agreement:

> I had an incident where a doctor felt he could do anything to a woman because she had signed a consent form for instrumental birth … At the time the woman was clutching on to me and screaming for me to help her, while the doctor was cutting an episiotomy, applying vacuum and forceps, all without communicating to the woman.[281]

3.73 Other stakeholders gave evidence about health practitioners playing the 'dead baby card', putting pressure on women to consent to interventions or else their baby would not survive. As Maternity Consumer Network stated:

> There are many alarming stories published of lies and threats being used to bully women into complying with interventions in childbirth. When women attempt to exercise bodily autonomy, have researched what they want for birth, or want to refuse certain medical treatment, they are often met with threats These include "shroud waving" or the "dead baby card": "Do you want a dead baby? Your baby will die unless [you comply]". Women may be threatened with being reported to children's services.[282]

3.74 Mrs Jessica Nash, gave evidence that she had 'heard the dead baby card played' more times than she could count.[283]

3.75 Maternity Choices Australia cited a recent survey which revealed that a significant portion of women did not feel adequately informed about procedures during their maternity care. The survey stated that '1 in 3 women who experienced birth with forceps or vacuum extraction and 1 in 5 who had a caesarean did not feel adequately informed'.[284]

3.76 Maternity Consumer Network stated that despite the legal and ethical imperative for informed consent, maternity care providers often have a poor understanding of their legal responsibilities, which can further exacerbate problems.[285] Maternity Consumer Network said that as a result women report receiving insufficient information and biased guidance from their maternity care providers.[286]

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280 See for example, Evidence, Ms Carly Griffin, Individual, 7 September 2023, p 15; Evidence, Mrs Amy Mageropoulos, Individual, 9 October 2023, p 2; Evidence, Mrs Carmel Biddle, Individual, 12 December 2023, p 2; Evidence, Ms Laura Johnston, Individual, 12 December 2023, p 2; Evidence, Mrs Francesca Male, Individual, 12 December 2023, p 9; Evidence, Mrs Tamara Leetham, Individual, 11 March 2024, p 4; Evidence, Mrs Jessica Hipsley, Individual, 11 March 2024, p 10.

281 Submission 242, NSW Nurses and Midwives' Association, p 5.

282 Submission 943, Maternity Consumer Network, p 2.

283 Evidence, Mrs Jessica Nash, Individual, 11 March 2024, p 4.

284 Submission 253, Maternity Choices Australia, p 10, quoting Maternal Health Matters, 'The Mother's Tale: Women's Experiences of Maternity Care in Australia', 2021 Digital Survey.

285 Submission 943, Maternity Consumer Network, p 2.

286 Submission 943, Maternity Consumer Network, p 2.

3.77 The Australasian Birth Trauma Association highlighted a trend where women find themselves without adequate information and consent is not sought until they are already in the process of labour. The association stated that this lack of proactive communication can lead women to feel 'blindsided' by their birth experience and unable to advocate for themselves effectively.[287]

3.78 According to evidence cited by PANDA (Perinatal Anxiety and Depression Australia), one of the major barriers to informed consent is the time sensitive nature of the childbirth, as well as women's exhaustion, pain and distress, 'compromising their capacity to provide informed consent'.[288] Australian Medical Association (NSW) acknowledged this barrier and outlined the complexities of decision-making in an emergency situation, stating that it is difficult to conduct those discussions and obtain informed consent quickly and effectively in time sensitive emergencies.[289]

3.79 Other stakeholders gave evidence about the need to distinguish between genuine emergencies, and more standard care or interventions where there is time to obtain informed consent. For example, in relation to caesarean sections, Ms Sally Cusack from Maternity Choices Australia gave evidence that:

> There are occasions when birth can suddenly take a very different course. We're familiar with the term "emergency caesarean"; it's used a lot. However, we have found—and it's not just us, but through the international research—that most of these procedures happen over a period of hours and sometimes even days in the lead-up to these caesarean sections. The better term is "unplanned".[290]

3.80 Ms Carly Griffin told the committee about her experience of being told she needed an 'emergency' caesarean section because her baby was in distress, only to be told she would have to wait until the doctor had gone on a dinner break to undergo the 'emergency' caesarean section:

> I had a midwife come in and examine me and say, "Great. Okay, we're ready to go." And then the OB came in, did an examination and said, "No, we're going for a C-section. This is an emergency. Your baby is in distress. But I'm just going to go to dinner first before I take you up." My son was born with perfect Apgar scores. I don't believe he was in distress at all. I don't want to assume, but I feel that they wanted my birthing room. I had been in there for so long, and there were so many women in labour, that they needed to get me out as fast as possible. That's what I believe. I wasn't shown the CTG tracing. I wasn't given any evidence. Further to that as well, I couldn't really give informed consent because I wasn't explained to how a C-section worked, what it involved, who will be in the room. All I did was sign a form to agree for blood product. That's it. They went for dinner; they came back. Next thing I know, we're in surgery.[291]

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287 Evidence, Ms Amy Dawes OAM, Cofounder and CEO, Australasian Birth Trauma Association, 4 September 2023, p 27.

288 Submission 241, PANDA, p 12, citing T Djanogly, J Nicholls, M Whitten, A Lanceley, 'Choice in episiotomy–fact or fantasy: A qualitative study of women's experiences of the consent process' (2022) 22(1) *BMC Pregnancy and Childbirth*, pp 1-7.

289 Evidence, Dr Kathryn Austin, Vice-President, Australian Medical Association (NSW), 9 October 2023, p 67.

290 Evidence, Ms Sally Cusack, National Secretary, Maternity Choices Australia, 4 September 2023, p 18.

291 Evidence, Ms Carly Griffin, Individual, 7 September 2023, p 14.

3.81 Dr Bashi Kumar-Hazzard from Human Rights in Childbirth also raised concerns regarding what constitutes an 'emergency' within the emergency care context:

> We do concede that there are times of genuine emergency, and there are, but for the most part, certainly for the hundreds of complaints that we see, what constitutes a genuine emergency is not necessarily there. What is seen as an emergency in the facility is that they're short staffed, the doctor is running out of time, they've only got a few minutes and they're bolting from room to room, and they need to get things done. They need to sort out one woman before they get to the next, and so there is a sense of urgency and immediacy that's pushed on her. She doesn't know that this is the context in which she's trying to navigate her labour and birth. This is not actually something that we're making up. In the special rapporteur's report on violence against women in the context of facility-based childbirth, so the obstetric violence report, the special rapporteur said that there is quite a significant abuse of the doctrine of medical necessity—medical necessity being emergency procedures—and that, because providers get to decide what constitutes an emergency, they tend to pretty much declare as much as possible, and that's not intentional. They're responding to a system that is under pressure.[292]

3.82 GP Obstetrician Dr Trudi Beck similarly acknowledged the challenges of obtaining informed consent in emergency situations but stressed the importance of allowing patients time for reflection and discussion wherever possible. She also discussed the role that rapport-building and communication can play to facilitate informed decision-making, recognising the complexities of balancing safety protocols with patient autonomy. [293]

3.83 Ms Amy Dawes from Australasian Birth Trauma Association argued that much more needs to be done to prepare women before they end up in emergency situations in labour, and that conversations with women around risk 'need to occur long before they're in the birth suite':

> I think we need to stop infantilising women and we need to actually empower women with information. We know statistically that one in five women are going to end up with an unplanned caesarean section. We know that one in four first-time mothers are going to end up with an instrumental delivery. So why aren't we talking about this before women are in the birth suite? That is the biggest thing. As we've touched on earlier today as well, birth-related trauma is not always preventable, but there is hope and there is preventable trauma. A lot of that can be done with informing and providing women with knowledge and resources and information and tools to prepare effectively for birth.[294]

3.84 Dr Beck also distinguished between consent and informed consent in maternity care, and the importance of thorough communication and understanding between healthcare providers and patients. She highlighted the need for practitioners to offer comprehensive information about all available options, including the risks and benefits, and to actively involve patients in decision-making. [295] She provided the following example of what seeking informed consent looks like:

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292 Evidence, Dr Bashi Kumar-Hazard, Chair, Human Rights in Childbirth, 4 September 2023, p 44.

293 Evidence, Dr Trudi Beck, GP Obstetrician, Nova Health and Murrumbidgee Region GP Antenatal Shared Care Program, 12 December 2023, p 29.

294 Evidence, Ms Amy Dawes OAM, Cofounder and CEO, Australasian Birth Trauma Association, 4 September 2023, pp 22-23 and 25.

295 Evidence, Dr Trudi Beck, GP Obstetrician, Nova Health and Murrumbidgee Region GP Antenatal Shared Care Program, 12 December 2023, pp 28-29.

> We talk about consent, but consent is not just doing a NSW Health checklist saying, "We're taking you for a caesar and you could have these complications." Consent is … "This is the fork in the road that we're at. This is, in my clinical opinion, what I think is going on. My training would lead me to believe that these are the options that are available to you. The pros and cons of each of these options are these. What do you think?"[296]

3.85 Dr Beck shared anecdotal observations that women can experience traumatic events during labour but if they feel safe and understand the rationale behind clinical decisions 'their brain processes it in a different way'.[297]

3.86 CAPEA highlighted the importance of informed consent in maternity care and suggested the application of the BRAIN acronym (Benefit, Risk, Alternatives, Intuition, Nothing) to facilitate decision-making. The organisation advocated for comprehensive education programs led by experienced educators, which empower women and their partners to make informed choices throughout pregnancy, childbirth and postpartum. [298]

3.87 On a related note, some stakeholders highlighted concerns with coercion in maternity care, with some women stating that felt pressured into procedures without adequate information or choice. Maternity Choices Australia shed light on the subtle forms of coercion that sometimes takes place during pregnancy and childbirth, such as presenting an induction as the only viable option, leading women to make decisions that may not align with their true desires. Ms Sally Cusack, National Secretary at Maternity Choices Australia stressed the importance of providing information to women and allowing them the time and space to make decisions that best suit their needs, rather than imposing decisions upon them in non-emergency situations.[299]

3.88 NSW Health noted that it has a manual titled *Consent to Medical and Healthcare Treatment* manual, with section 10.2 covering 'information and consent requirements for pregnancy and birth related tests, procedures and interventions'.[300] However, according to Maternity Consumer Network, many clinicians, midwives and nurses are unaware of this resource and do not use it.[301]

3.89 Dr Maria Del Pilar Luna Ramirez also gave evidence that many healthcare practitioners are not properly trained or educated about obtaining genuine informed consent:

> I think that's another area that we have never been properly taught as clinicians: What constitutes an actually valid informed consent? Having a signature on a paper, it is not informed consent. That is the pervasive belief in the medical culture: You have a signature on a piece of paper, that's it—this is informed consent. It is absolutely not. This is a legal concept. You have had time to assimilate what you have been explained. You have made your questions. You understand the risks that you have been explained

296 Evidence, Dr Trudi Beck, GP Obstetrician, Nova Health and Murrumbidgee Region GP Antenatal Shared Care Program, 12 December 2023, p 28.

297 Evidence, Dr Trudi Beck, GP Obstetrician, Nova Health and Murrumbidgee Region GP Antenatal Shared Care Program, 12 December 2023, p 26.

298 Evidence, Ms Alison Summerville, Engagement Officer, Childbirth & Parenting Educators of Australia (CAPEA), 8 April 2024, p 12.

299 Evidence, Ms Sally Cusack, National Secretary, Maternity Choices Australia, 4 September 2023, p 17.

300 Submission 862, NSW Health, p 24.

301 Evidence, Ms Emilia Bhat, President, Maternity Consumer Network, 9 October 2023, p 17.

> and you agree or disagree to have the procedure that you have been offered. Again, the lack of time and the lack of continuity makes it that that is actually, most of the time, not possible. To have a proper and valid informed consent, you have to have access to the whole information—the data, the space for questions—which most of the time does not happen.[302]

3.90 Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) also expressed the view that 'maternity care providers need continuing education in ethical and legal concepts of 'consent' in maternity care'.[303]

3.91 Australian Medical Association (NSW) called for a funding model which allows 'medical practitioners time for what can be difficult and ongoing conversations with parents about the realities of birth'.[304] Both Australian Medical Association (NSW) and RANZCOG argued there needs to be a review of the Medicare Benefits Schedule, to reflect the 'time and effort needed to council women regarding birth options and consenting/education for possible emergency interventions, if required'.[305]

3.92 Finally, the Australian Lawyers Alliance suggested that informed consent should not be treated as a one-time event but rather as an ongoing process that involves adequate information-sharing throughout pregnancy, birth, and early parenthood.[306] PANDA expressed a similar view, stating decision-making and informed consent should be an 'ongoing dialogue' between patients and healthcare providers to explore care options thoroughly.[307]

Informed consent laws in Queensland

3.93 Stakeholders including Dr Bashi Kumar-Hazard from Human Rights in Childbirth acknowledged the changes to the Queensland *Human Rights Act* which mandates true and proper informed consent for medical treatments. Dr Kumar-Hazard stated that this has led to a cultural shift in maternity care facilities in Queensland. She added that when women have not given proper informed consent, they now have avenues to seek justice such as the Ombudsman or the Human Rights Commissioner.[308]

3.94 Other stakeholders such as Maternity Consumer Network also noted improvements in antenatal care since the changes were made in the Queensland *Human Rights Act*.[309] Maternity advocacy

302 Evidence, Dr Maria Dep Pilar Luna Ramirez, Obstetrician and Gynaecologist staff specialist, Acting Head of Department, Women's care unit, Northern NSW Local Health District, 11 March 2024, p 70.

303 Submission 238, Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), p 4.

304 Submission 252, Australian Medical Association (NSW), p 4.

305 See, Submission 238, Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), p 4; Submission 252, Australian Medical Association (NSW), p 9.

306 Submission 234, Australian Lawyers Alliance, p 26.

307 Submission 241, Perinatal Anxiety and Depression Australia (PANDA), p 12, quoting J Nicholls, A. L David, J Iskaros, & A Lanceley, 'Consent in pregnancy: A qualitative study of the views and experiences of women and their healthcare professionals' (2019) 238 *European Journal of Obstetrics & Gynecology and Reproductive Biology*, pp 132-137.

308 Evidence, Dr Bashi Kumar-Hazard, Chair, Human Rights in Childbirth, 4 September 2023, p 43.

309 Evidence, Ms Emilia Bhat, President, Maternity Consumer Network, 9 October 2023, p 17.

groups and individuals expressed support for the changes to consent laws in Queensland and highlighted the absence of a *Human Rights Act* in New South Wales.[310]

3.95 Adjunct Professor Michael Nicholl from NSW Health noted the structural and legislative differences between the jurisdictions, stating that while Queensland has specific consent requirements for individual procedures, New South Wales takes a more 'holistic approach'. Regardless, he told the committee that NSW Health were monitoring the developments in Queensland for potential best practices to adopt.[311]

3.96 Queensland Health has also developed a guideline on 'Partnering with the woman who declines recommended maternity care' which provides guidance on working with women who decline recommended care. These measures were praised by stakeholders including NSW Nurses and Midwives' Association, who said:

> Women must have access to facility-based care without the fear of coercion or interventions being carried out without their consent. One mechanism that has been trialled in Queensland is the Personalised Alternative Care and Treatment (PACT) framework [outlined as the *Partnering with the woman who declines recommended maternity care* guideline] which creates a structured approach to communication and documentation where women wish to decline recommended care. This allows women to access care of health practitioners in a facility and preserves the therapeutic relationships that may be negatively impacted when women decline recommended care in labour.[312]

3.97 The Australian College for Midwives also called for the Queensland 'Partnering with the woman who declines recommended maternity care' guidelines to be implemented in NSW.[313]

Birth plans

3.98 Many stakeholders described birth plans as valuable tools in the consent process as it allows women to communicate their preferences regarding their maternity care including, pain management, interventions, and clinicians involved.[314]

3.99 Human Rights in Childbirth, however, noted that conflicts can arise when healthcare providers prioritise institutional policies over individual rights. They further explained that birth plans often face resistance within healthcare settings, reflecting a broader issue concerning provider authority versus women's autonomy.[315]

3.100 Ms Carly Griffin expressed a similar view:

> We need to support women in their right to have a birth plan. We should be encouraging women to educate themselves on birth, empower women to know their options and

310 See for example, Evidence, Dr Bashi Kumar-Hazard, Human Rights in Childbirth, 4 September 2023, p 43; Evidence, Ms Emilia Bhat, President, Maternity Consumer Network, 9 October 2023, p 17.

311 Evidence, Adjunct Professor Michael Nicholl, Chief Executive, Clinical Excellence Commission, NSW Health, 4 September 2023, p 66.

312 Submission 242, NSW Nurses and Midwives' Association, p 18.

313 Submission 854, Australian College of Midwives, p 13.

314 Submission 234, Australian Lawyers Alliance, p 34; Submission, Human Rights in Childbirth, pp 15-16.

315 Submission 409, Human Rights in Childbirth, pp 15-16.

> their rights, and we need to do our best to facilitate those preferences. Every woman that goes into labour with a birth plan understands that things change and that we have to adapt as our labour progresses.[316]

3.101 Other stakeholders acknowledged the tensions surrounding birth plans. For example, Dr Jenny King, Head of Department of Urogynaecology, Westmead Hospital, noted that childbirth is unpredictable and that 'there is no way you can be fully prepared for everything that might happen'. Dr King argued that doctors will sometimes perform procedures that do not align with a woman's expectations in order to protect the health and wellbeing of the baby.[317]

3.102 While acknowledging the importance of safety, stakeholders such as Better Births Illawarra urged hospitals and medical professionals to respect a woman's right to self-determination. Better Births Illawarra characterised birth plans as a means for mothers to take responsibility and understand the birthing process. The organisation argued that birth plans are not about setting unrealistic expectations but rather about informed decision-making.[318]

3.103 Ms Alyssa Booth, Secretary, Better Births Illawarra pointed out a significant issue with the implementation of birth plans in local hospitals. She said that while birth plans are discussed during antenatal education, there is often a disconnect between what is discussed and what happens during labour. She shared anecdotal instances where hospital staff disregard the birth plan due to perceived high-risk factors or operational issues, leading to a sense of disempowerment among mothers. [319]

3.104 RANZCOG argued that more work should be done to provide women with 'evidence-based birth plans', as part of improved antenatal education and increasing the amount of information women received before they are needing to make decisions during labour.[320] RANZCOG also acknowledged that continuity of carer is important in ensuring health practitioners are aware of a woman's birth plan and how to support them:

> They get to know you throughout the entire pregnancy, so they can realise when things are looking different because they will know what you were like last time; we've got their ability to pick up mental health conditions more readily and quickly if they've seen you before; they will get to know your medical history in a lot more detail, rather than seeing a different provider at every antenatal appointment; and then in labour they'll have had so many conversations with you that they'll know what you wish to have in that birth plan and what you'll wish to have in birth, so they'll be able to try to help you do that.[321]

316 Evidence, Ms Carly Griffin, Individual, 7 September 2023, p 10.

317 Evidence, Dr Jenny King, Head of Department of Urogynaecology, Westmead Hospital, 11 March 2024, p 31.

318 Evidence, Ms Sharon Settecasse, Vice President, Better Births Illawarra, 7 September 2023, p 23.

319 Evidence, Ms Alyssa Booth, Secretary, Better Births Illawarra, 7 September 2023, p 23.

320 Submission 238, Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), p 4.

321 Evidence, Dr Jared Watts, Board Director, Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), 4 September 2023, p 11.

Refusal of pain relief

3.105 Numerous women gave evidence to the committee that their pain before, during or after birth was ignored or downplayed. Many women indicated that the refusal of pain relief, and the dismissal of their pain, contributed to their birth trauma.

3.106 The Australasian Birth Trauma Association gave evidence that 'women who experienced prolonged physical pain due to misdiagnosis or delayed diagnosis of birth injuries, report increased mental distress. This lack of proper medical attention and understanding contributes to ongoing feelings of frustration, helplessness, and uncertainty. Many women and birthing people describe feeling like "they are going crazy" or that their concerns are "all in their head" when they are not taken seriously by health professionals when they report their symptoms and complaints about pain'.[322]

3.107 Mrs Francesca Male gave evidence that the failure to provide adequate pain relief was a cause of her birth trauma:

> I will never forget the pain and fear I felt in the minutes that followed. I was crying out but was dismissed for a third time, told that feeling pressure was normal and offered gas. My husband was stunned, unable to advocate for me. When I was still vocalising from pain, I was given a general anaesthetic. My husband was escorted out and made to wait alone with no idea what was happening. I was well informed of the failure rates for spinal blocks. Requiring a general anaesthetic, whilst unfavourable, is not what led to our trauma. It is the fact that I was not believed that I was in pain, and this led to fear, unnecessary pain and distrust. As a veterinarian, with the inability to verbally communicate with my patients, it's hard to fathom the dismissal of this direct communication.[323]

3.108 Ms Carly Griffin similarly expressed concern about the way she was treated by healthcare professionals when seeking pain relief:

> I was called a junkie by an OB. I was told by midwives that I was showing drug-seeking behaviour. And I was denied pain relief on more than one occasion, as I was told, "You can't possibly be in that much pain." As you can imagine, these comments are not only hurtful but they are embarrassing, and I was left to suffer until I was discharged two days later while also trying to care for my son as a first-time mother.[324]

3.109 A number of individual submission authors shared their experiences of having pain relief either refused or delayed:

- 'I was having quite intense contractions and he laughed at me and said I was not in labour although he never checked me.…I called the midwife in again, where a different nurse attended and was rude to me saying you're not in labour but as I was having a contraction she told me to breathe through it…I sat on the bed screaming…I was in the most unbearable pain screaming as loud as I could, the nurse then came in and I told her my

322 Submission 254, The Australasian Birth Trauma Association, p 27.

323 Evidence, Mrs Francesca Male, Individual, 12 December 2023, p 9.

324 Evidence, Ms Carly Griffin, Individual, 7 September 2023, p 10.

baby's head was coming out, I was then told I had to push and it was too late for any pain relief, I pushed twice and after delivering my son I received a 3b tear'.[325]

- 'I had had no pain relief during this labour and it was excruciating, I was screaming in pain and not one doctor or nurse though to give me any pain relief. The bleeding stopped and I was taken to the suite. I asked for pain relief after and was offered Panadol which I refused as it doesn't even ease a headache'.[326]
- 'I had to wait 2.5 hours after the birth before having the surgeon come to do my stitches, in this time I was not given any pain relief even though I was in extreme pain. I had a haematoma unnoticed the size of an orange just inside my vagina which was found by the doctor doing the stitches. There was lack of care/compassion and any bedside manner from him and as I cried and asked him to be more gentle as I could feel the stitches being done and his reply was look I can be done in 10 minutes or you can go to theatre'.[327]
- 'I had made it clear throughout the 10 months I wanted an epidural and also since checking in to give birth the night before. The midwife told me she needed the bloods back to order an epidural …I wanted an epidural and was continuously told by the two midwives I had that I didn't need one and they knew I could do it without one. My needs were dismissed and I felt pressured'.[328]
- 'When I was discharged, I was told to take Panadol for pain relief and was looked at like a junkie when I asked if she was serious…I left the hospital feeling so traumatised and unsupported'.[329]
- 'The Dr put local anaesthetic into both sides of the tear then tested for numbness. I said I could still feel pain on the left side. She put more local in, waited a moment then tested again. I said I could still feel pain on the left side. The Dr then said "Oh you can't feel that" and began to suture. I endured the suturing with no pain relief to the left side. At one point I asked how many more sutures and was told "only a few more". I then counted the needle go in and out many times before she was finally finished. The bottom line is that I didn't feel heard'.[330]

Interventions during birth

3.110 Stakeholders highlighted that another key factor contributing to birth trauma is the use of medical interventions during birth. The committee heard that childbirth has become increasingly characterised by medical interventions. Some justified these interventions for the safety and wellbeing of mothers and babies, while others expressed concern about the rising rates and potential impacts on health outcomes and the overall birth experience.

325 Submission 26, Name suppressed, p 1.

326 Submission 49, Ms Hayley Gibbons, p 1.

327 Submission 58, Ellie Sullivan, p 1.

328 Submission 735, Mrs Abby Fitzgerald, pp 1 and 2.

329 Submission 799, Alysse Simington, p 2.

330 Submission 910, Mrs Emma Hamilton, p 1.

3.111 This section explores childbirth interventions, including caesarean sections, inductions, and instrumental deliveries with a focus on the factors influencing intervention use, and the balance between necessary interventions and positive birth experiences.

Overview of interventions

3.112 According to the NSW Nurses and Midwives' Association and Australian College of Midwives, there has been a notable rise in the rates of interventions during childbirth, with a particularly significant increase observed within the private sector.[331] Research from the Australian Institute of Health and Wellbeing reported that, among women in New South Wales who gave birth in 2021:

- 51 per cent had a non-instrumental vaginal birth
- 37.6 per cent had a caesarean section
- 7.1 per cent had a vaginal birth assisted by vacuum
- 4.3 per cent had a vaginal birth assisted by forceps.[332]

3.113 While interventions are often deemed necessary to protect maternal and neonatal health outcomes, Ms Sally Cusack from Maternity Choices Australia cautioned against the overuse, citing research from the World Health Organisation showing 87 per cent of women could give birth without intervention.[333]

3.114 Professor Hannah Dahlen from Western Sydney University attributed the escalating rate of birth trauma to the increased use of interventions.[334] This concern was supported by data from a recent survey by NSW Nurses and Midwives' Association, which showed that 72 per cent of respondents believe birth trauma can be attributed to the rising rates of interventions.[335]

3.115 Similarly, data from the BESt study indicated that the mode of birth was associated with reported birth trauma, as summarised below:

- Spontaneous vaginal birth – 15 per cent reported birth trauma
- Caesarean before labour (elective) – 28 per cent reported birth trauma
- Caesarean during labour (emergency) – 57 per cent reported birth trauma

331 Submission 854, Australian College of Midwives, p 13 quoting AIHW. (2023). Australian Core Maternity Indicators 2021. Retrieved from https://www.aihw.gov.au/reports/mothers-babies/national-core-maternity-indicators-1/contents/labour-and-birth-indicators/caesarean-section.

332 Submission 252, Australian Medical Association (NSW), p 4, quoting *Australia's mothers and babies: Method of Birth* (29 June 2023), Australian Institute of Health and Wellbeing, https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/labour-and-birth/method-of-birth.

333 Evidence, Ms Sally Cusack, Maternity Choices Australia, 4 September 2023, p 13.

334 Evidence, Professor Hannah Dahlen AM, Professor of Midwifery, School of Nursing and Midwifery, Western Sydney University, 4 September 2023, p 29.

335 Submission 242, NSW Nurses and Midwives' Association, p 15.

- Instrumental birth – 55 per cent reported birth trauma.[336]

3.116 The BESt study also found that inductions of labour were associated with birth trauma, with 38 per cent of induced women experiencing trauma compared to 23 per cent who went into labour spontaneously.[337]

3.117 Australian Medical Association (NSW) however asserted that not all births involving interventions result in birth trauma, and that instrumental births are essential tools in obstetrics.[338] Dr Kathryn Austin from the Australian Medical Association (NSW) stated there is no risk-free way to have a baby as challenging situations can arise, and doctors are trained to use intervention methods to minimise adverse outcomes. Dr Austin emphasised the importance of comprehensive postpartum care, including pelvic floor rehabilitation, to mitigate potential long-term consequences associated with certain interventions.[339]

3.118 The following sections discuss the impact of caesarean sections, inductions and instrumental births on mothers.

Caesarean sections

3.119 A caesarean section (also known as c-sections) is an operation whereby the baby is delivered by a doctor cutting into the uterus through the abdomen.[340] Caesarean sections have become increasingly common in childbirth, reflecting a broader trend of increased intervention rates. According to international data from Organisation for Economic Co-operation and Development (OECD) there has been a notable global increase in caesarean section rates, with Australia's rate surpassing the OECD average.[341] Human Rights in Childbirth shared data from AIHW which confirmed that caesarean section rates in New South Wales have risen from 31.3 per cent in 2011 to 37.8 per cent in 2021.[342]

3.120 While the World Health Organisation acknowledges the effectiveness and life-saving potential of caesarean sections, it cautions that rates exceeding 10 per cent may not lead to reductions in maternal and newborn mortality rates.[343] However, Ms Amy Dawes from the Australasian Birth Trauma Association addressed the challenges of setting targets for caesarean section rates, citing

336 Submission 232, Western Sydney University, p 9.

337 Submission 232, Western Sydney University, p 8.

338 Submission 252, Australian Medical Association (NSW), p 4.

339 Evidence, Dr Kathryn Austin, Vice President, Australian Medical Association (NSW), 9 October 2023, p 67.

340 *Mothers & Babies: Glossary* (15 August 2023), Australian Institute of Health and Welfare, Australian Government, https://www.aihw.gov.au/reports-data/population-groups/mothers-babies/glossary.

341 Tabled document, Leeton Midwifery Group Practice, *Continuity of Care Models – A Midwifery Toolkit*, NSW Ministry of Health, June 2023, p 7, quoting OECD 'Health at a glance 2021: OECD indicators.' (2021) *Paris: Organisation for Co-operation and Development Publishing.*

342 Submission 409, Human Rights in Childbirth, p 39, quoting *Australia's Mothers and Babies*, (29 June 2023), Australian Institute of Health and Welfare, https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/labourand-birth/method-of-birth.

343 Tabled document, Leeton Midwifery Group Practice, *Continuity of Care Models – A Midwifery Toolkit*, NSW Ministry of Health, June 2023, p 7, quoting OECD 'Health at a glance 2021: OECD indicators.' (2021) *Paris: Organisation for Co-operation and Development Publishing.*

a United Kingdom inquiry that revealed adverse outcomes associated with overly restrictive caesarean section policy. She stressed the need for genuine choice in maternity care and cautioned against overly simplistic comparisons between vaginal births and caesarean births.[344]

3.121 GP Obstetrician, Dr Trudi Beck, shared this viewpoint and discussed the challenge doctors face when trying to align with the World Health Organisation's 10 per cent recommendation. She highlighted the need for clinicians to balance hospital policies, patient wishes, while ensuring safety to achieve optimal outcomes.[345]

3.122 In New South Wales, the incidence of Lower Section Caesarean Sections (commonly used planned caesareans), increased from 27 per cent in 2002 to 36 per cent in 2020.[346] Dr Jared Watts from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) attributed this rise partly to factors such as improved fertility, older maternal age, and the increasing prevalence of medical conditions among pregnant women.[347] He also noted that private hospitals often have higher rates of caesarean sections driven in-part by patient requests.[348]

3.123 Dr Kathryn Austin from Australian Medical Association (NSW) added that caesarean sections also allow for a timely delivery, reducing the risks associated with prolonged labour, such as oxygen deprivation for the baby.[349] She recognised that there are some risks involved, noting that obstetrics involves split second decision-making to ensure the safety of both the mother and baby.[350]

3.124 The committee heard from a number of women who shared their experiences and desires to have a VBAC (Vaginal Birth after Caesarean) for subsequent pregnancies after a caesarean.[351]

3.125 Despite being a valid choice, women stated that health providers often discouraged it due to safety concerns and medico-legal risks. One example was from Mrs Jessica Hipsley who shared her personal experience, highlighting the reluctance of maternity clinicians to perform a VBAC. Mrs Hipsley had a caesarean section with her first child and told her maternity team that she did

344 Evidence, Ms Amy Dawes OAM, Cofounder and CEO, Australasian Birth Trauma Association, 4 September 2023, p 26.

345 Evidence, Dr Trudi Beck, GP Obstetrician, Nova Health and Murrumbidgee Region GP Antenatal Shared Care Program, 12 December 2023, p 31.

346 Tabled document, Leeton Midwifery Group Practice, *Continuity of Care Models – A Midwifery Toolkit*, NSW Ministry of Health, June 2023, p 7, quoting *NSW Mothers and Babies 2021*, HealthStats NSW, 14 June 2023.

347 Evidence, Dr Jared Watt, Board Director, Royal Australian College of Obstetricians and Gynaecologists, 4 September 2023, p 6.

348 Evidence, Dr Jared Watt, Board Director, Royal Australian College of Obstetricians and Gynaecologists, 4 September 2023, p 7.

349 Evidence, Dr Kathryn Austin, Vice President, Australian Medical Association (NSW), 9 October 2023, p 68.

350 Evidence, Dr Kathryn Austin, Vice President, Australian Medical Association (NSW), 9 October 2023, p 67.

351 Tabled document, Leeton Midwifery Group Practice, *Exploring women's experiences in midwifery continuity of care model following a traumatic birth*, 10 February 2023, p 5, citing Hazel Keedle, Virgina Schmie, Elaine Burns, and Hannah Dahlen, 'Women's reasons for, and experiences of, choosing a homebirth following a caesarean section' (2015) *BMC Pregnancy & Childbirth*, p 1.

not want another caesarean section and desired a physiological birth. Despite stating her preference, she said she felt pressured into another caesarean by an obstetrician who employed fear-inducing tactics and cherrypicked statistics to sway her from her decision. Mrs Hipsley told the committee that she was continuously warned of all the risks associated with VBAC, but she claims she was not adequately briefed on the risks of undergoing a second caesarean.

3.126 Mrs Hipsley criticised the maternity care systems bias against VBAC and noted the lack of consideration for the emotional trauma and prolonged recovery following a surgical intervention.[352] She told the committee:

> I'm sure you have all heard, "All we want is a healthy baby", which I heard so many times when I was pushing for trying to do the VBAC, and just the insinuation that I, as the mother, would not like a healthy baby out of this is outrageous, and so inappropriate. But also, "I'm just doing what I think is best", or, "We're doing this because". It just completely invalidates your entire experience, where you're expressing a particular want for a particular reason, and to have that comment or that sort of situation completely undermined is terrible. I guess this goes towards the imbalance in the room, but I mean that in terms of the health professionals as well.[353]

3.127 The committee heard that the limited availability of VBAC played a role for some women choosing to birth 'outside of the system', particularly since many hospitals do not offer this option. Dr Melanie Jackson stated that for women who did not want a repeat caesarean section had limited alternatives, resorting to travelling long distances, hiring a private midwife to attend a homebirth, or opting to freebirth without medical assistance.[354]

3.128 With regard to emergency caesarean sections, Human Rights in Childbirth shared evidence that women often feel coerced or misled into having an emergency caesarean, only to later discover the procedures were not genuine emergencies. The organisation stated that women were given false information which impaired their ability to provide informed consent.[355]

3.129 Human Rights in Childbirth explained that all caesareans performed after the onset of labour are considered an 'emergency caesarean', with different categories of urgency:

- Category 1: Urgent threat to the life or health of a woman or fetus
- Category 2: Maternal or fetal compromise but not immediately life threatening
- Category 3: Needing earlier than planned delivery
- Category 4: At a time acceptable to both woman and the clinical team.[356]

3.130 According to Human Rights in Childbirth, categories 3 and 4 do not align with common definitions of emergencies, and this classification system allows providers to declare emergencies based on subjective criteria. The organisation argued that this practice, incentivised by Medicare and private insurers, can result in 'overtreatment', leaving women to bear the physical and emotional burden.[357] A number of stakeholders raised concern about the current

352 Evidence, Mrs Jessica Hipsley, Individual, 11 March 2023, p 10.

353 Evidence, Mrs Jessica Hipsley, Individual, 11 March 2024, p 14.

354 Submission 1096, Dr Melanie Jackson, p 8.

355 Submission 409, Human Rights in Childbirth, p 21.

356 Submission 409, Human Rights in Childbirth, pp 21-22.

357 Submission 409, Human Rights in Childbirth, p 22.

'activity based' funding model of maternity care, including Transforming Maternity Care Collaborative and Australian Midwifery and Maternity Alliance, who gave evidence that:

> Most maternity care funding is activity based meaning the more episodes of care provided the more funding the health services receives. Complex care such as caesarean section and longer than average postnatal inpatient stay costs more, and therefore attract greater funding, than normal birth with a shorter postnatal inpatient stay. This system provides financial incentive to prioritise service volume over consumer outcomes and disincentivises approaches to care that are cost-effective, such as midwifery continuity of care.[358]

3.131 The Australian College of Midwives similarly raised concerns about this funding model, arguing it does not 'preference continuity of care':

> The current funding supports models based on fee for service and acute episodes of care. This perversely incentivises activity rather than outcome. Activity in maternity care tends to be linked with actions, potentially interventions.[359]

3.132 Instead, these stakeholders argued for consideration of 'bundled' maternity funding used in other countries, such as New Zealand:

> In these models, services are provided a single payment which covers all the care provided to a woman throughout pregnancy, intrapartum, and postnatally. In this way, bundled funding provides costs savings for services who provide care most efficiently, rather than rewarding those who deliver the most episodes and highest-cost procedures. Evidence suggest that bundled payments lead to increased coordination of care, enhanced quality of care and less fragmentation across the health system.[360]

3.133 According to Maternity Choices Australia, the physical, psychological and emotional risks that caesareans present for mother and baby are well-documented, and the impact of an emergency caesarean can be devastating for the mother who had wanted a vaginal birth.[361] According to data from Centre for Women's Health Research, women who experienced an emergency caesarean were 2.5 to 3.1 times more likely to experience emotional distress during labour than those who had not.[362]

3.134 Ms Carly Griffin shared her personal experience of having an emergency caesarean. She told the committee that despite repeated warnings that her baby was in distress, her baby was born healthy. Ms Griffin believed there was no medical reason to have a caesarean, and she speculated that the reason a caesarean was performed was because her labour had continued for too long and the hospital wanted her birthing room for other women.[363] Mrs Tamara Leetham shared a similar story. Mrs Leetham had originally planned a homebirth but was transferred to hospital

358 Submission 248, Transforming Maternity Care Collaborative and Australian Midwifery and Maternity Alliance, p 6.

359 Submission 854, Australian College of Midwives, p 23.

360 Submission 248, Transforming Maternity Care Collaborative and Australian Midwifery and Maternity Alliance, p 6.

361 Submission 253, Maternity Choices Australia, p 8.

362 Submission 239, Centre for Women's Health Research Australian Longitudinal Study on Women's Health, p 3.

363 Evidence, Ms Carly Griffin, Individual, 7 September 2023, p 16.

following a prolonged second stage of labour. She told the committee that she was pressured into an emergency caesarean section, including the use of a general anaesthesia without consent.[364] Based on their experiences, both Ms Griffin and Mrs Leetham advocated for stricter criteria to ensure emergency caesarean sections are reserved for genuine emergencies.[365]

3.135 Other stakeholders spoke to the importance of caesarean sections in certain cases. For example, Dr Kathryn Austin, Vice President of the Australian Medical Association (NSW), reminded the committee that emergency caesarean sections are performed for various reasons, including where the health of the mother or baby is at risk, such as when there is a sudden drop in the baby's heart rate.[366]

3.136 This was echoed by Dr Elizabeth Skinner who acknowledged that vaginal deliveries with the assistance of instruments may be attempted but can sometimes lead to complications or not progress as hoped.[367] In these cases, Dr Skinner explained that caesarean sections may be necessary to avoid potential risks, such as tearing or pelvic organ prolapse.[368]

3.137 Better Births Illawarra raised concerns that some women were being 'routinely separated from their healthy baby after a caesarean', despite significant evidence showing the importance of uninterrupted skin to skin contact after birth:

> We know from research how vital immediate and uninterrupted skin to skin contact is. For the mother, it promotes the release of oxytocin which encourages bonding and helps uterine contractions to deliver the placenta. It also encourages prolactin production which facilitates milk production. For babies uninterrupted skin to skin stabilizes their temperature, heart rate and breathing. Immediate and continuous skin to skin is in line with current best practices for maternity health care. RANZCOG policy recommends that healthy term infants be placed on their mothers' bare skin and covered with a warm blanket and that this practice facilitates breastfeeding and bonding.[369]

3.138 Dr Susan Tawia, Breastfeeding Researcher and Health Professional Educator, gave further evidence about the importance of skin-to-skin contact:

> Mothers and babies should be skin to skin straightaway. That encourages a whole lot of physiological things. It encourages breastfeeding and all the hormones that are required to get that all going; then mothers and babies staying together; the health professionals working with them understanding how important that is. [370]

364 Submission 1181, Mrs Tamara Leetham, pp 3-4.

365 See, Evidence, Ms Carly Griffin, Individual, 7 September 2023, p 16; Submission 1181, Mrs Tamara Leetham, pp 3-4.

366 Evidence, Dr Kathryn Austin, Vice President, Australian Medical Association (NSW), 9 October 2023, p 68.

367 Evidence, Dr Elizabeth Skinner, Academic and lecturer, Faculty of Nursing and Midwifery, University of Technology Sydney, 8 April 2024, p 51.

368 Evidence, Dr Elizabeth Skinner, Academic and lecturer, Faculty of Nursing and Midwifery, University of Technology Sydney, 8 April 2024, p 51.

369 Submission 880, Better Births Illawarra, p 7.

370 Evidence, Dr Susan Tawia, Breastfeeding Researcher and Health Professional Educator, Australian Breastfeeding Association, 8 April 2024, p 39.

3.139 Better Births Illawarra told the committee that the practice of separating mothers from their babies was causing 'incredible trauma' to women, sharing the following testimony from a woman who was unable to do skin-to-skin following her birth:

> I begged and cried and yelled to have my baby brought to me after my c section and was both ignored and refused. It was horrible and terrifying laying in recovery being ignored when all I wanted was my baby. After 3hrs they let me see her as they took me back to the ward. I'm still angry. I had issues bonding with her and breastfeeding was difficult.[371]

Inductions

3.140 An induction is a procedure used to initiate or speed up labour.[372] However, use of inductions raised concerns among stakeholders. A number of women shared their personal accounts of feeling pressured into an induction which they believe caused or contributed to their birth trauma.[373]

3.141 The Centre for Women's Health Research and Australian Longitudinal Study on Women's Health shared data that women who experienced an induction were 1.5 times more likely to experience emotional distress during labour than those who had not undergone an induction.[374]

3.142 Additionally, statistics provided by Human Rights in Childbirth demonstrate a trend of increasing induction rates in New South Wales, rising from 26.5 per cent in 2011 to 35.5 per cent in 2021, prompting concerns about the necessity and risks associated with these procedures.[375]

3.143 Maternity Choices Australia and Better Births Illawarra raised concerns about the increasing rates of induction, linking them to higher incidents of birth trauma and questioning their medical necessity. Maternity Choices Australia cited research which stated that 'unnecessary inductions' make up at least 15 per cent of cases, which they describe as a 'great concern'.[376] Furthermore, Better Births Illawarra suggested potential factors contributing to the increase rates of 'unnecessary' inductions including convenience-driven scheduling due to staff shortages.[377]

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371 Submission 880, Better Births Illawarra, p 8.

372 Submission 854, Australian College of Midwives, p 13.

373 See for example, Submission 19, Montana Marsden, p 1; Submission 22, Mrs Claire Kilgallon, p 1; Submission 129, Mrs Melinda McLennan, p 1.

374 Submission 239, Centre for Women's Health Research and Australian Longitudinal Study on Women's Health, p 2.

375 Submission 409, Human Rights in Childbirth, p 39, quoting *Australia's mothers and babies, Labour and birth: onset of labour* (29 June 2023) Australian Institute of Health and Wellbeing, https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/labour-and-birth/onset-of-labour.

376 Submission 253, Maternity Choices Australia, p 7, quoting Catherine Bell, 'The maternity crisis in Australia is worsening.' (2023), *The Birth Map blog,* https://birthmap.life/the-maternity-crisis-in-australia-is-worsening/.

377 Submission 880, Better Births Illawarra, p 5.

3.144 A number of submissions referred to the 'cascade of interventions' that can occur during birth, starting with an induction, as described by the Australian College of Midwives:

> Instrumental birth often results from what is referred to as 'the cascade of intervention' and often commences following the use of exogenous oxytocics to initiate (induce) or augment (speed up) labour. This can lead to less tolerable contractions and results in other interventions such as epidural anaesthesia, contributing to a three-fold increase in the rate of instrumental birth in primiparous women (first births). The use of instruments and devices for assisted birth is often reflected by women to be highly traumatic. The procedures involve women in vulnerable positions (in stirrups) and are usually conducted due to a perceived problem with the progress of labour or distress of the unborn baby. The use of continuous electronic fetal monitoring severely restricts the mobility of the women, if telemetry is not available. All of these factors alone may contribute to the experience of birth trauma.[378]

3.145 Dr Hazel Keedle and Professor Hannah Dahlen AM from the School of Nursing and Midwifery at Western Sydney University emphasised the impact of inductions on women's birth experiences, with many expressing regret and feeling inadequately informed or prepared for the process.[379] In addition, the Nurses and Midwives' Association highlighted instances of 'fearmongering' language used by some doctors to coerce women to agree to an induction.[380] One story shared by the NSW Nurses and Midwives' Association suggested doctors tell women that inductions are the 'only safe option for their baby to have its greatest chance of surviving'. The association stated that such language means that informed consent is not often gained as there is only one side of the information being portrayed.[381]

Instrumental birth involving forceps and vacuum

3.146 Instrumental delivery, involving forceps or vacuum assistance, is a common practice in maternity care, accounting for 11.4 per cent of births in New South Wales in 2021.[382] However, these rates have raised concerns about the increased likelihood of birth trauma associated with instrument-assisted deliveries.[383]

3.147 Evidence from the Centre for Women's Health Research indicated that women who undergo forceps or vacuum deliveries are 1.6 to 2.4 times more likely to experience emotional distress during labour than those who had not experienced an instrumental birth.[384]

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378 Submission 854, Australian College of Midwives, p 13.

379 See, Evidence, Dr Hazel Keedle, School of Nursing and Midwifery, Western Sydney University, 4 September 2023, p 40; Evidence, Professor Hannah Dahlen AM, School of Nursing and Midwifery, Western Sydney University, 4 September 2023, p 40.

380 Submission 242, NSW Nurses and Midwives' Association, p 6.

381 Submission 242, NSW Nurses and Midwives' Association, p 6.

382 Submission 862, NSW Health, p 37, quoting Centre for Epidemiology and Evidence, *NSW Mothers and Babies 2021*, HealthStats NSW, 14 June 2023, p 19.

383 Submission 234, Australian Lawyers Alliance, p 28.

384 Submission 239, Centre for Women's Health Research and Australian Longitudinal Study on Women's Health, p 3.

3.148 The Australian Institute of Health and Welfare noted the increased risk of physical injuries caused by forceps and vacuums, include urinary and faecal incontinence, increased risk of injury to the tissues of the vagina, perineum and anus, which may lead to long-term pain and sexual difficulties.[385]

3.149 Personal accounts shared with the committee shed light on the risks involved with an instrumental delivery. For example, Mrs Lyn Leger recounted her birth experience, revealing that her first child was delivered vaginally using vacuum, forceps and an episiotomy, resulting in injuries including bruising and incontinence. Despite seeking medical care, she was not informed of the full extent of her injuries. After giving birth to her second child, she discovered that she had a prolapse. Subsequent medical evaluations revealed a bilateral avulsion of the levator ani muscle, which she says has impacted her life profoundly.[386] Mrs Leger stated that she was not informed of the high rates of levator avulsion among people who had forceps deliveries.[387]

3.150 Notwithstanding the risk of injuries, forceps and vacuum deliveries are routinely used throughout New South Wales. The NSW Nurses and Midwives' Association highlighted issues with antenatal education, communication, and consent processes related to instrumental deliveries. The association argued that inadequate education can contribute to a lack of awareness about the risks, leading to birth trauma.[388]

3.151 Australian Medical Association (NSW), however, advised the committee that not all births involving instruments result in birth trauma, and that instruments are essential tools in obstetrics.[389] Vice President, Dr Katherine Austin, stated that forceps and vacuum assistance can expedite birth in certain situations, reducing the risk of complications associated with prolonged labour. [390]

Birthing environment

3.152 This section delves into the impact of birthing environments including hospitals, birth centres, and homes on the birth experience.

Impact of the birthing environment

3.153 The committee heard that the birthing environment can play a crucial role in shaping a woman's experience of childbirth. Stakeholders including Ms Sally Cusack and Ms Azure Rigney from

385 Submission 234, Australian Lawyers Alliance, p 28, quoting *National Core Maternity Indicators* (13 July 2023), Australian Institute of Health and Welfare, https://www.aihw.gov.au/reports/mothers-babies/ncmi-data-visualisations/contents/labour-and-birthindicators/instrumental-vaginal-birth.

386 Submission 944, Mrs Lyn Leger, p 1.

387 Submission 944, Mrs Lyn Leger, p 2 quoting, HU Memon, JL Blomquist, HP Dietz, CB Pierce, MM Weinstein, VL Handa, 'Comparison of levator ani muscle avulsion injury after forceps-assisted and vacuum-assisted vaginal childbirth' (2015) *Obstet Gynecol.*

388 Submission 242, NSW Nurses and Midwives' Association, p 7.

389 Submission 252, Australian Medical Association (NSW), p 4.

390 Evidence, Dr Kathryn Austin, Vice President, Australian Medical Association (NSW), 9 October 2023, p 67.

Maternity Choices Australia emphasised the significance of thoughtful design in hospital wards. They advocated for separate spaces and amenities tailored to the specific needs of women giving birth.[391] Ms Rigney stressed the importance of privacy, safety, and comfort, recommending features like dark-painted walls, standalone birth centres, and separate lifts away from other hospital units, as well as access to water immersion for comfort and pain relief.[392]

3.154 Maternity Choices Australia referred to research conducted by Dr Sarah Buckley on the hormonal physiology of childbirth, highlighting the need for women to feel safe and 'unobserved' during labour.[393] Ms Sally Cusack from Maternity Choices Australia told the committee that bright lights, constant surveillance and unfamiliar surrounding can disrupt the natural birthing process, leading to increased stress and discomfort for women. According to Ms Cusack, a sterile and bright hospital environment can 'turn off the birthing hormones' (oxytocin) which she says is 'highly counterproductive' and can slow down the progress of birth.[394]

3.155 A similar view was shared by refugee support service STARTTS (NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors) which stated that hospitals should provide a safe and supportive environment that promotes a sense of control and empowerment for women. The support service stated that factors including the biomedical nature of hospitals can hinder women's ability to cope with pain and contribute to feelings of distress.[395] Zamzam Mums and Bubs and The Still Nest echoed this view stating that the 'act of birthing should not be perceived as a medical condition that needs to be treated and medicalised'.[396]

3.156 In order to make the birthing environment more conducive for labour, Ms Sharon Settecasse from Better Births Illawarra, spoke about the benefits of water immersion and props, which she described as non-invasive methods to shorten labour and help women manage pain without the need for epidurals or inductions.[397]

3.157 Maternity Choices Australia advocated for maternity care that respects women's physiology and recommended redesigning maternity wards and birthing centres to align with consumer engagement standards and international best practices. They shared:

> The very fact that the vast majority of births occur in hospitals and are overseen by obstetricians assumes birth is a pathological process that requires medical intervention, rather than regarding it as the normal physiological process it is. The maternity care provided in hospitals largely focuses on the medical aspects of pregnancy and birth and

391 Evidence, Ms Azure Rigney, National Advocacy Manager, Maternity Choices Australia, 4 September 2023, p 14.

392 Evidence, Ms Azure Rigney, National Advocacy Manager, Maternity Choices Australia, 4 September 2023, p 15.

393 Evidence, Ms Sally Cusack, National Secretary, Maternity Choices Australia, 4 September 2023, p 15.

394 Evidence, Ms Sally Cusack, National Secretary, Maternity Choices Australia, 4 September 2023, pp 15-16.

395 Submission 877, NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS), pp 4-5, quoting L.Y Whitburn, L.E Jones, M Davey, & S McDonald, 'The nature of labour pain: An updated review of the literature' (2019) 32(1) *Women and Birth*, pp 28-38.

396 Submission 929, Zamzam Mums and Bubs and The Still Nest, p 2.

397 Evidence, Ms Sharon Settecasse, Vice President, Better Births Illawarra, 7 September 2023, p 23.

> ignores the emotional, psychological, cultural and spiritual facets of this important rite of passage in a woman's life, contributing to the experience of birth trauma. In addition to the way that maternity care is provided, the hospital environment itself is not supportive of physiological birth. Tiling, stainless steel, bright lights, strangers in positions of authority, and being in an unknown environment are all contraindications of normal physiological birth.[398]

3.158 Dr Namira Williams from disAbility Maternity Care also highlighted the significance of tailoring birthing environments to meet individual's needs. She recounted an instance where a clinical midwife sought her guidance on assisting an expectant mother with autism. Together, they established an environment with reduced sensory stimulus to create a safe and calming birthing environment that suited the mothers' unique needs.[399]

Homebirths and Privately Practicing Midwives

3.159 Some stakeholders shared that there is an increasing preference for women in New South Wales to give birth away from a hospital environment, to avoid birth trauma. A number of stakeholders shared research indicating that women birthing at home with a known midwife experienced higher levels of childbirth satisfaction and fewer complications compared to those birthing in hospital, in large part to the continuity of care this model provides to birthing women.[400]

3.160 Homebirth NSW presented data from the NSW Mothers and Babies report revealing a notable 100 per cent increase in homebirths in 2021 compared to the previous year.[401] They attributed this surge in demand to women's previous traumatic experiences within hospital settings, where they felt unheard or lacked control during birth.[402] Similarly, Homebirth Australia noted an increase in homebirth enquires, driven in part because of restrictive hospital policies.[403]

3.161 Homebirths in New South Wales are generally arranged either through a publicly funded homebirth program or through a privately practicing midwife. New South Wales has six public homebirth programs, however, it was noted that these programs had long waiting lists and were not meeting currently demand.[404] Some stakeholders also expressed that too many women were being 'risked out' of these programs due to restrictive eligibility criteria.[405]

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398 Submission 253, Maternity Choices Australia, p 7, quoting M Foureur, D Davis, J Fenwick, N Leap, R Iedema, I Forbes, CS Homer, 'The relationship between birth unit design and safe, satisfying birth: developing a hypothetical model' (2010) *Midwifery*.

399 Evidence, Dr Namira Williams, Chief Executive Officer and Educator, disAbility Maternity Care, 8 April 2024, p 22.

400 See for example, Submission 235, Homebirth New South Wales, p 2; Submission 248, Transforming Maternity Care Collaborative and Australian Midwifery and Maternity Alliance, p 3; Submission 251, MAMA Midwives, p 2.

401 Submission 235, Homebirth New South Wales, p 1, quoting Centre for Epidemiology and Evidence, *NSW Mothers and Babies 2021*, HealthStats NSW, 14 June 2023.

402 Submission 235, Homebirth New South Wales, p 2.

403 Submission 889, Homebirth Australia, p1.

404 See, Submission 248, Transforming Maternity Care Collaborative and Australia Midwifery and Maternity Alliance, p 2; Evidence, Ms Katelyn Commerford, President, Homebirth NSW, p 43.

405 Submission 235, Homebirth New South Wales, p 3.

3.162 Several advocacy groups including Homebirth Australia, Maternity Choices Australia, Zamzam Mums and Bubs and The Still Nest, called for the expansion of publicly funded homebirths in New South Wales. They cautioned that without adequate homebirth services some women resort to unassisted births, also known as freebirths.[406]

3.163 Mrs Katelyn Commerford, President of Homebirth NSW, argued that public funded homebirths could also be a more affordable option for the healthcare system, citing evidence that estimated that homebirth has a lower average cost per place of birth compared to birth in a birthing centre or a planned hospital birth.[407]

3.164 If women are not able to access a publicly funded homebirth program, they may choose to pay out of pocket to access a privately practicing midwife. This model of care was praised by a number of stakeholders, including Homebirth NSW:

> Many women come to homebirth for the model of care as much as the place of birth. Private midwifery continuity of care is truly a gold standard - women have prenatal appointments usually around an hour long, and usually in their own homes, they have the direct contact for their midwife and instructions on how and when to contact them, their midwife is the one to attend to them in labour, and they receive in home postpartum care usually every day or second day in the first week postpartum, and then once a week for the next couple of weeks, and then fortnightly until 6-8 weeks depending on the health and wellbeing of the mother and baby.[408]

3.165 However, Homebirth NSW also pointed out the limited accessibility due to systemic barriers, including the lack of Medicare rebates for privately practicing midwifery care and medical bias within the healthcare system:

> The safety of homebirth with a privately practising midwife—a PPM—has been well established in the literature, as has the cost saving to the health system. Unfortunately, homebirth is not an option that all women can access, due to location, PPM availability or finances. Intrapartum PPM care is not Medicare rebatable for homebirth so, even with antenatal and postnatal care rebates, families are left thousands out of pocket. This results in homebirth being a privilege afforded primarily to white middle class women and those who are low risk, and it excludes those who are at greatest risk of trauma…To access Medicare rebates for antenatal and postnatal privately practising midwifery care, women must obtain a referral from a GP. Yet GPs frequently refuse, either under instruction from their insurers or due to their own medical bias.[409]

3.166 According to Homebirths Australia, safety and effectiveness of homebirth relies on collaboration between midwives and hospitals, particularly in cases where transfers become necessary. [410] Ms Virginia Maddock from Homebirths Australia emphasised the need for

406 See for example, Evidence, Ms Kristyn Begnell, Coordinator, Homebirth Australia, 11 March 2024, p 46; Evidence, Mrs Katelyn Commerford, President, Homebirth NSW, 11 March 2024, p 46; Submission 253, Maternity Choices Australia, pp 8-9; Submission 929, Zamzam Mums and Bubs and The Still Nest, p 11.

407 Evidence, Ms Katelyn Commerford, President, Homebirth NSW, 11 March 2024, pp 47-48.

408 Submission 235, Homebirth New South Wales, p 2.

409 Evidence, Ms Katelyn Commerford, President, Homebirth NSW, 11 March 2024, p 46; Evidence, Dr Aimee Sing, Vice-President, Homebirth NSW, 11 March 2024, p 43.

410 Evidence, Ms Virginia Maddock, Assistant Coordinator, Homebirth Australia, 11 March 2024, pp 44-45.

collaboration and respect between homebirth midwives and hospital staff to ensure seamless transitions from home to hospitals and prevent further trauma for the birthing women:[411]

> Women who choose homebirth deserve access to safe and respectful hospital care in the event that it is wanted or needed. Some women who plan to homebirth might transfer to hospital during pregnancy due to unexpected medical conditions, transfer during labour—which is most often due to non-emergency reasons such as lack of progress or need for pain relief—or after birth due to additional medical assistance. Unfortunately, women's experiences of homebirth transfer are often traumatic because of the way they and their midwives are treated by hospital staff when they arrive. Estimates show that up to 50 per cent of privately practising midwives in New South Wales—and, indeed, probably around Australia—have been reported to AHPRA, many of them vexatious reports from hospital staff. Hospital staff have been known to use their power to threaten, coerce, bully and report privately practising midwives and women for being "difficult". If women and midwives feel they can't stand up for themselves, it compounds their trauma.[412]

3.167 It was noted that Westmead Hospital is the only hospital in New South Wales that provides formal admitting rights to privately practising midwives.[413] This allows privately practicing midwives to transfer into the hospital from a planned homebirth.[414] This model was praised by stakeholders such as Ms Katelyn Commerford from Homebirth NSW, who stated:

> Genuine transfer pathways that are created with genuine collaboration, like we see in Westmead Hospital, which is the one that has admitting rights—that's an excellent example of how things can work really well, where there's a relationship with the obstetrician. It's more about relationships and respect for the work that these private midwives are doing with women.[415]

3.168 Homebirth NSW clarified the importance of 'genuine collaboration' over mandated arrangements, highlighting instances where delays occur due to distrust or lack of communication between midwives and hospital staff during transfers.[416] Mrs Commerford said that establishing genuine transfer pathways, such as those observed at Westmead Hospital, where there is a mutual respect and understanding between midwives and obstetricians, can lead to more favourable outcomes for women seeking homebirth.[417]

3.169 In addition to allowing midwives to transfer into hospital from a homebirth, Westmead Hospital is also the only hospital in New South Wales which allows privately practicing midwives to book

411 Evidence, Ms Virginia Maddock, Assistant Coordinator, Homebirth Australia, 11 March 2024, pp 44-45.

412 Evidence, Ms Virginia Maddock, Assistant Coordinator, Homebirth Australia, 11 March 2024, pp 44-45.

413 Evidence, Ms Katelyn Commerford, President, Homebirth NSW, 11 March 2024, p 48.

414 *Private Practice Midwives,* (2024), Women's & Newborn Health Westmead Hospital, https://www.wslhd.health.nsw.gov.au/WNH/Health-Professionals/privately-practicing-midwives.

415 Evidence, Ms Katelyn Commerford, President, Homebirth NSW, 11 March 2024, p 48.

416 Evidence, Ms Katelyn Commerford, President, Homebirth NSW, 11 March 2024, p 48.

417 Evidence, Ms Katelyn Commerford, President, Homebirth NSW, 11 March 2024, p 48.

women in and provide private midwifery care for those women who choose to give birth at the hospital.[418]

3.170 The Australian College of Midwives expressed concern that this 'minimises the opportunities for full use of this midwifery workforce', noting that 'the low level of birth trauma associated with privately practising midwifery, demonstrates that not only should midwifery continuity of care be maximised, but additionally that private practice models using endorsed midwives should also be optimised'.[419] They recommended that integration of privately practising midwives into New South Wales maternity services be made a priority, including ensuring midwives have authority to practise within hospital settings as well as hospital admitting rights across New South Wales.[420]

3.171 Professor Hannah Dahlen gave evidence of the challenge midwives face in trying to operate in New South Wales hospitals, in part due to the fact that midwives are required to obtain 'collaborative arrangements' with specific obstetricians, rather than the hospitals:

> Queensland very smartly got the arrangements in with the hospital and not the individual provider, and they enabled private practising midwives to set their businesses up and bring those women directly into hospital and provide their care postnatally and antenatally in the community. We are way behind Queensland when it comes to that… That's not to say we shouldn't collaborate; collaboration is absolutely key to safety. Women want us to collaborate; we want to collaborate. But to force a signature and make doctors feel vulnerable that they're responsible for decisions midwives make was always going to be a problem.[421]

Workforce challenges

3.172 The inquiry heard that the maternity healthcare system in New South Wales is facing workforce culture and staffing issues, impacting both healthcare professionals and the quality of care provided. This section considers:

- workload demands, with a particular focus on the ability to offer continuity of care
- vicarious trauma, reflective practices and staff wellbeing
- recruitment, retention and staff development
- the proposal to appoint a Chief Midwifery Officer.

3.173 Maternity care in New South Wales is provided by a diverse array of healthcare professionals, including midwives, obstetricians, gynaecologists, and general practitioners, among others. The committee notes that while obstetricians and gynaecologists are integral to the maternity healthcare system, the evidence to this inquiry largely focused on the role of midwives and issues within the midwifery workforce.

418 *Private Practice Midwives,* (2024), Women's & Newborn Health Westmead Hospital, https://www.wslhd.health.nsw.gov.au/WNH/Health-Professionals/privately-practicing-midwives.

419 Submission 854, Australian College of Midwives, pp 18 and 26.

420 Submission 854, Australian College of Midwives, p 25.

421 Evidence, Professor Hannah Dahlen AM, School of Nursing and Midwifery, Western Sydney University, 4 September 2023, p 35.

Workload demands

3.174 This section discusses the workforce demands within the New South Wales maternity system, including the psychological impacts on clinicians, the strain on resources, and staff burnout.

3.175 Quantitative data provided by the NSW Nurses and Midwives' Association illustrated a decline in midwife numbers and experience. According to data from the Nursing and Midwifery Board of Australia, the midwifery workforce in New South Wales declined from 9,533 in 2021 to 8,669 in 2023.[422] Additional data provided showed a 9.7 per cent decrease in the number of midwives with seven years or more experience between 2018 and 2022.[423] The association stated that fewer experienced midwives means that junior midwives are struggling to find mentorship, highlighting a growing need to better support new graduates.[424]

3.176 The Australian College of Midwives added that the domino effect of decreasing numbers as well as experienced midwives reducing their hours has placed burden on junior staff, leading to potential burnout, compromised patient care, and birth trauma with women feeling unheard or rushed during childbirth.[425]

3.177 Dr Rakime Elmir from the School of Nursing and Midwifery stressed the need for urgent changes to support and increase the number of midwives, emphasising that optimal care is unattainable with skeleton staff.[426] Additionally, the NSW Nurses and Midwives' Association raised concerns about hospitals implementing workforce replacement strategies, such as nurses filling in for midwives on postnatal wards. The Association highlighted that this practice is deemed inappropriate by the Nursing and Midwifery Board of Australia which states that the 'substitution of health workers for nurses or midwives must not occur when the knowledge and skills of nurses or midwives are needed'.[427]

3.178 Several women shared their experiences highlighting workforce challenges in the New South Wales maternity system. Mrs Larissa Palamara recounted inadequate support from healthcare providers following her traumatic childbirth and the loss of her daughter.[428] Ms Kristyn Begnell, a consumer representative, emphasised the importance of adequate staffing in reducing birth trauma.[429] She stated that birth trauma can be exacerbated by staffing demands and maternity care models that were not trauma-informed. To improve outcomes, Ms Begnell advocated for the expansion of continuity of care models across the state.[430]

422 Submission 242, NSW Nurses and Midwives' Association, p 8, quoting, *Nurse and Midwife Registration Data Table* (March 2021) and (March 2023), Nursing and Midwifery Board of Australia.

423 Submission 242, NSW Nurses and Midwives' Association, p 8.

424 Submission 242, NSW Nurses and Midwives' Association, p 8.

425 Submission 854, Australian College of Midwives, p 2.

426 Evidence, Dr Rakime Elmir, Senior Lecturer, Deputy Director Clinical Education Midwifery, School of Nursing and Midwifery, Western Sydney University, 9 October 2023, p 25.

427 Submission 242, NSW Nurses and Midwives' Association, p 8, quoting *Decision-making framework for nursing and midwifery 2020,* Nursing and Midwifery Board of Australia.

428 Evidence, Mrs Larissa Palamara, Individual, 8 April 2024, p 8.

429 Evidence, Ms Kristyn Begnell, Individual, 11 March 2024, p 9.

430 Evidence, Ms Kristyn Begnell, Individual, 11 March 2024, p 9.

3.179 The NSW Nurses and Midwives' Association highlighted research indicating that continuity of care models can lead to cost savings by reduced intervention rates, shortening hospital stays and decreased reliance on postnatal follow-up care.[431] However, the Association also recognised staffing challenges within continuity of care models, specifically Midwifery Group Practice, stating:

> Midwives in these models usually have unpredictable on-call hours which can be impossible to balance with carers responsibilities. This is especially the case for single mothers or those with young children who rely on childcare services that are inflexible or unavailable.[432]

3.180 Ms Rebecca Quiring and Ms Leselle Herman referred to the *Continuity of Care Models: A Midwifery Toolkit* which outlines how the staffing of continuity of care models work. In models such as MGP, midwives operate under flexible arrangements, providing care as needed to women rather than adhering to fixed rostered shifts. Should a MGP patient birth while her primary midwife is on leave, the on-call midwife will attend the birth. To minimise these instances, midwives are required to book annual leave with the maternity services manager at least six months in advance.[433]

3.181 Regarding on-call duties, MGP midwives are on 24-hour call during their schedule 'days on'. Outside of on-call hours, the midwife forwards her mobile phone to the next on-call midwife within the group practice. During 'days on', midwives attend antenatal, intrapartum, and postnatal care as necessary for their caseload. In adhering to their salary agreement, MGP midwives work a maximum 12 hours. If it becomes evident that intrapartum care will surpass this limit, the midwife arranges handover to the on-call colleague.[434]

3.182 Mrs Gemma Deng, Professional Officer Midwifery, NSW Nurses and Midwives' Association elaborated on practical barriers continuity of care models can have. She said that she herself stopped working in the continuity of care model because she had small children and the model did not allow for flexibility and or part-time work.[435]

3.183 Representatives from NSW Health, Ms Julie Swain from Western Sydney Local Health District and Ms Jacinta Selby from Sydney Local Health District and Concord MGP, acknowledged concerns regarding staffing in continuity of care models. They mentioned that many midwives, who are in their child-rearing years, prefer part-time or flexible work. They highlighted that models like MAPS offer better work-life balance for midwives with small children.[436]

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431 Submission 242, NSW Nurses and Midwives' Association, p 16.

432 Submission 242, NSW Nurses and Midwives' Association, p 16.

433 Tabled document, Leeton Midwifery Group Practice, *Continuity of Care Models – A Midwifery Toolkit*, NSW Ministry of Health, June 2023, p 86.

434 Tabled document, Leeton Midwifery Group Practice, *Continuity of Care Models – A Midwifery Toolkit*, NSW Ministry of Health, June 2023, p 86.

435 Evidence, Mrs Gemma Deng, Professional Officer, Midwifery, NSW Nurses and Midwives' Association, 4 September 2023, p 55.

436 See, Evidence, Ms Julie Swain, Deputy Director of Nursing & Midwifery, Women's and Newborn Health, Western Sydney Local Health District, 8 April 2024, pp 67-68; Evidence, Ms Jacinta Selby, Principal Midwifery Manager, Sydney Local Health District, and Midwifery Manager, Concord MGP, 8 April 2024, p 68.

Vicarious trauma, reflective practices and staff wellbeing

3.184 Organisations such as the Australasian Birth Trauma Association, Australian College of Midwives, and the NSW Nurses and Midwives' Association provided data and insight into the prevalence of traumatic stress, vicarious trauma, and the need for psychological support among healthcare professionals.[437]

3.185 The NSW Nurses and Midwives' Association wrote that witnessing traumatic births can take an emotional toll on health practitioners leading to vicarious trauma and feelings of helplessness or stress. According to their survey:

- 58 per cent of members said their psychological health had been negatively impacted after caring for a woman experiencing birth trauma
- 80 per cent of members reported feeling unable to successfully advocate to prevent birth trauma[438]

3.186 Clinical midwife consultant Ms Fiona Reid described clinicians as the 'second victims of birth trauma'. She explained that repeated exposure to trauma, unequal power structures, and 'being complicit' in trauma-causing care increases the likelihood of midwives and obstetricians experiencing trauma, reducing a clinician's ability to 'think, listen, ask questions, feel, express compassion, be authentic or advocate to be and remain woman-centred'.[439]

3.187 This view was shared by Gidget Foundation Australia who noted that traumatic birth can impact healthcare workers who witness or participate in distressing events. Gidget gave evidence that midwives and other healthcare providers report feeling 'shock, fear, guilt, shame, and failure' following exposure to traumatic births as well as a loss of confidence in professional practice and an increased desire to leave the profession.[440]

3.188 Evidence cited by the Australian College of Midwives, revealed significant burnout among midwives, with systematic issues contributing to the desire to leave the profession. According to the report:

- 20 per cent of midwives were unsure of their future in midwifery
- nearly 40 per cent regularly thought about leaving the profession
- 73 per cent were 'worn out'
- 64 per cent experiencing work-related stress.[441]

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437 See, Submission 242, NSW Nurses and Midwives' Association, p 10; Submission 854, Australian College of Midwives, p 15; Submission 254, The Australasian Birth Trauma Association, p 18.

438 Submission 242, NSW Nurses and Midwives' Association, p 10.

439 Evidence, Ms Fiona Reid, Clinical midwife consultant, 7 September 2023, pp 29-30.

440 Submission 249, Gidget Foundation Australia, p 7, quoting R Aydin, S Aktas, 'Midwives' experiences of traumatic births: A systematic review and meta-synthesis' (2021) 5 *European Journal of Midwifery*.

441 Submission 854, Australian College of Midwives, p 15, citing Robyn Mathews, Della Forster, Rebecca Hyde, Helen McLachlan, Michelle Newton, Sharon Mumford, et al., 'FUCHSIA Future proofing the midwifery workforce in Victoria: A state-wide cross sectional study exploring health, well-being and sustainability.' (2023) *La Trobe*.

3.189 The report stated that midwives felt overworked with insufficient time for individualised care and education due to administrative burdens and short postnatal care durations. Additionally, the absence of flexible working options further compounded the problem, limiting opportunities for midwives to manage their workload effectively.[442] According to a 2017 survey of Australian midwives, post-traumatic stress can have implications for midwifery practice, including 'a lack of empathy and emotionally distant care, an over estimation of clinical risk and defensive practices by health professionals and a tendency to leave the profession'.[443]

3.190 NSW Health expressed their commitment to staff wellbeing through various initiatives, including reflective practice, debriefing, and investment in education programs. According to NSW Health, incorporating reflective practices into maternity care promotes 'wellbeing, stronger teamwork, and communication, and increased professional satisfaction among maternity clinicians' which they note leads to better outcomes for women and their babies.[444]

3.191 Despite the initiatives outlined by NSW Health, witnesses like Ms Fiona Reid pointed out ongoing deficits, including in critical incident debriefing and psychological support for clinicians. In Ms Reid's experience, most hospitals providing maternity care do not have adequate clinical debriefing after critical incidents. She explained that clinicians need to process critical incidents to protect psychological harm, highlighting the need for support without judgement or guilt.[445]

3.192 Ms Fiona Reid further explained that if clinicians provide patient care with an 'unrelieved sympathetic nervous system', they may develop emotional fatigue. She elaborated that other side effects include 'over eating, heavy use of alcohol, high levels of relational conflict, episodes of rage, insomnia, excessive exercise, poly drug use, excessive spending and relationship breakdown'.[446] Ms Reid stressed the necessity of supports like clinical supervision, Employee Assistance Programs (EAP), and psychological help as integral part of clinicians' regular work life to effectively manage the emotional and psychological consequences of birth trauma.[447]

3.193 Professor Hannah Dahlen of the School of Nursing and Midwifery, Western Sydney University, also acknowledged that that there are 'lots of traumatised midwives and obstetricians out there who are traumatised by what they work in, what they see and what they are part of'. According to Professor Dahlen, this is driving the workforce away. She argued that improving birth trauma rates will assist in recruiting and retaining midwives and obstetricians.[448] Ms Azure Rigney,

442 Submission 854, Australian College of Midwives, p 16, citing Robyn Mathews, Della Forster, Rebecca Hyde, Helen McLachlan, Michelle Newton, Sharon Mumford, et al., 'FUCHSIA Future proofing the midwifery workforce in Victoria: A state-wide cross sectional study exploring health, well-being and sustainability.' (2023) *La Trobe.*

443 Submission 254, The Australasian Birth Trauma Association, p 18, quoting J Leinweber, et al., 'Responses to birth trauma and prevalence of posttraumatic stress among Australian midwives.' (2017) 30(1) *Women and birth: journal of the Australian College of Midwives,* pp 40-45.

444 Submission 862, NSW Health, p 47.

445 Submission 24a, Ms Fiona Reid, p 1.

446 Submission 24a, Ms Fiona Reid, p 1.

447 Submission 24a, Ms Fiona Reid, p 1.

448 Evidence, Professor Hannah Dahlen AM, School of Nursing and Midwifery, Western Sydney University, 4 September 2023, p 36.

National Advocacy Manager at Maternity Choices Australia, shared similar beliefs, stating that by addressing workforce burnout issues there will be reduced attrition rates at universities.[449]

Recruitment, retention and staff development

3.194 Addressing the challenges in maternity care, stakeholders highlighted the critical need for comprehensive strategies to improve recruitment, retention of staff, and as well as diversity.

3.195 Dr Kathryn Austin, Vice President at Australian Medical Association (NSW), emphasised the importance of recruitment and retention strategies for creating a happy, healthy and safe workforce. She highlighted the need for appropriate resourcing, funding, and salary models for both midwives and obstetricians in both public and private sectors to ensure the provision of excellent and empathetic care to patients.[450]

3.196 The imperative for workforce diversification was highlighted by Ms Sharon Coulton Stoliar, PhD candidate and registered midwife, emphasising the need for a culturally responsive maternity care system. She stated that New South Wales maternity care system 'systematically fails to take into account the cultural needs of almost half of the population it serves'.[451] Ms Coulton Stoliar advocated for a workforce that reflects the diversity of the population it services, recognising the importance of cultural connection in facilitating effective communication and care.[452]

3.197 A number of stakeholders addressed concerns about workforce shortages in regional, rural and remote New South Wales. For example, Dr Trudi Beck spoke of the pressure on rural midwives and general practitioner obstetricians due to high on-call ratios and resource challenges.[453] The Australian College of Midwives shared this perspective stating 'there is definitely a maldistribution of the workforce across Australia' with most of the workforce located in metropolitan areas.[454] This workforce shortage, according to the NSW Nurses and Midwives' Association, leads to reduced access to regular antenatal care and limited birthing options, increasing the risk of birth trauma.[455] This is discussed further in Chapter 4.

3.198 Ms Deb Willcox, Deputy Secretary, NSW Health discussed the challenges of recruiting healthcare professionals, especially in rural and regional communities. Despite efforts such as rural incentive schemes, workforce shortages persist, impacting access to antenatal care and birthing options. She acknowledged that 'the challenges for recruitment across the health system

449 Evidence, Ms Azure Rigney, National Advocacy Manager, Maternity Choices Australia, 4 September 2023, p 17.

450 Evidence, Dr Kathryn Austin, Vice President, Australian Medical Association (NSW), 9 October 2023, p 70.

451 Evidence, Ms Sharon Coulton Stoliar, PhD Candidate, Registered Midwife & Author, 9 October 2023, p 26.

452 Evidence, Ms Sharon Coulton Stoliar, PhD Candidate, Registered Midwife & Author, 9 October 2023, p 26.

453 Evidence, Dr Trudi Beck, GP Obstetrician, Nova Health and Murrumbidgee Region GP Antenatal Shared Care Program, 12 December 2023, p 37.

454 Evidence, Ms Alison Weatherstone, Chief Midwife, Australian College of Midwives, 4 September 2023, p 53.

455 Submission 242, NSW Nurses and Midwives' Association, p 11.

are pretty difficult at the moment and it's getting a lot of attention with the Commonwealth and the States'. She added:

> there is a health workforce task force that the Secretary of Health is chairing, and there's a whole lot of work going on with the Commonwealth Minister and with immigration, border affairs and all manner to see what we can do to accelerate recruitment into the system.[456]

3.199 NSW Health spoke of initiatives to grow the midwifery workforce such as GradStart and MidStart, as well as the Mentoring in Midwifery program and Midwifery Pathways in Practices which aim to support midwifery practice, culture, recruitment and retention. According to NSW Health, these programs focus on developing leadership, enhancing skills, and providing access to learning opportunities for midwives.[457]

3.200 Better Births Illawarra gave evidence that midwifery staff shortages need to be addressed 'by increasing university access and through paid student midwife placements'. They further argued that 'core retention issues must be addressed by increasing pay, altering ratios, improving professional safety and wellbeing. This includes debriefing and psychological care to address vicarious trauma and facilitating pathways for working in preferred models of evidence-based care'.[458]

3.201 NSW Nurses and Midwives' Association also made a number of recommendations around addressing the midwifery workforce shortage and retention, including the following:

- Implementation of a new staffing model in all maternity units must be undertaken to ensure there are sufficient midwifery staff of an appropriate skill-mix to provide high quality midwifery care to all women and their families
- Urgent workforce planning, in consultation with academics, regulatory bodies, professional and industrial representatives, and employers, must occur. Particular attention is needed to increase the number of Aboriginal and Torres Strait Islander midwives being trained, registered and employed
- Introduction of protocols to ensure that midwives are offered the opportunity to have a 'hot debrief' either following an adverse event or when identified as needed by the midwife
- Clinical supervision must be available for all midwives and accessible in protected time
- Competitive remuneration for NSW midwives working in caseload models must be addressed in order to recruit and retain suitable numbers of midwives into this model of care.[459]

Chief Midwifery Officer

3.202 Throughout the inquiry, stakeholders consistently advocated for the appointment of a Chief Midwifery Officer in New South Wales. Dr Bashi Kumar-Hazard cited the recent appointment

456 Evidence, Ms Deb Willcox, Deputy Secretary, Health System Strategy and Planning, NSW Health, 4 September 2023, p 63.

457 Submission 862, NSW Health, pp 4 and 47.

458 Correspondence from Ms Sharon Settecasse, Director of Community Engagement, Better Births Illawarra to the committee, 3 May 2024.

459 Submission 242, NSW Nurses and Midwives' Association, p 3.

of Queensland's first Chief Midwife as a significant step in addressing the shortage of maternity health services in Queensland.[460]

3.203 Maternity Choices Australia raised concerns regarding the dual Chief Nurse and Midwife, highlighting the power imbalance between nurses and midwives within NSW Health. The organisation argued that the appointment of a Chief Midwifery Officer would ensure effective governance and representation for midwives within the healthcare system.[461]

3.204 Professor Hannah Dahlen from the School of Nursing and Midwifery at Western Sydney University drew attention to other jurisdictions, such as the United Kingdom, which also have a Chief Midwifery Officer, emphasising the role they play in providing advice to the government:[462]

> We have a chief nurse midwife in this State that isn't a midwife but functions in both roles … They do a wonderful job and they have a very hard job. This is no criticism of them. But, often as a result of lack of knowledge and also dealing with a massive portfolio of nursing, midwifery gets left off the agenda and is not often prioritised or properly advocated for. So the role of a chief midwife would be to give advice to government, would be to be looking at what's happening on the ground, would be around putting into place support programs that are around sustaining the midwifery workforce, that are about growing that midwifery workforce, that are about putting evidence into practice and advocating for that profession.[463]

Committee comment

3.205 Throughout the inquiry, the committee learned about a number of key factors in the healthcare system that contribute to birth trauma. These include lack of continuity of carer and trauma-informed care, inadequate antenatal education, poor consent practices, cascading medical interventions, concerns with traditional birthing environments and workforce challenges in the maternity care system.

3.206 It was clear to the committee that continuity of carer is crucial in preventing birth trauma. The committee heard evidence about the critical importance of fostering safe and trusting relationships between women and their maternity care provider, as well as the significant benefits associated with continuity of carer, including reduced rates of intervention. Despite the widespread support for this model, many women in New South Wales are still not able to access continuity of carer models. Therefore, the committee believes a focus should be on increasing accessibility of all continuity of carer models across the state.

460 Additional information, Dr Bashi Kumar-Hazard, Chair, Human Rights in Childbirth, 7 April 2024, p 1.

461 Submission 253, Maternity Choices Australia, p 13.

462 Evidence, Professor Hannah Dahlen, School of Nursing and Midwifery, Western Sydney University, 4 September 2023, p 35.

463 Evidence, Professor Hannah Dahlen, School of Nursing and Midwifery, Western Sydney University, 4 September 2023, p 35.

Recommendation 9

That the NSW Government ensure that all women have access to continuity of carer models with a known provider.

3.207 Stakeholders to this inquiry overwhelmingly favoured midwifery-led continuity of care models, which were hailed as the 'gold standard'. In addition to the use of privately practicing midwives (discussed further below), Midwifery Group Practice was praised as an example of a publicly funded model of midwifery-led continuity of care. However, the committee also became aware of workforce shortage challenges, particularly in regional, rural and remote communities, and the unsuitability of this model for some midwives that presents challenges to operate this model across the state. The committee believes though, that given the significant support for this model, and the evidence that its adoption has the potential to significantly reduce birth trauma, that action should be taken to urgently address these workforce shortages (see further discussion below) so that midwifery-led continuity of care can be expanded across New South Wales.

3.208 The committee recognises that NSW Health has sought to address the staffing challenges of continuity of care models by developing the Maternity Antenatal and Postnatal Service which provides more work flexibility and achieves more work-life balance for midwives. However, on balance, the committee is of the view that the absence of a known carer during labour risks undermining continuity of care, which can lead to increased stress and inadequate support for mothers. The committee therefore recommends that the NSW Government specifically invest in and expand midwifery continuity of care models, including Midwifery Group Practice.

Recommendation 10

That the NSW Government invest in and expand midwifery continuity of care models, including Midwifery Group Practice and all risk models, by increasing the number of services providing midwifery continuity of care, especially in regional, rural and remote New South Wales, and expanding places in existing services.

3.209 The committee heard that in many rural communities GP Obstetricians can provide continuity of care through the antenatal, intrapartum and postpartum periods. Evidence to the inquiry suggested that this is often a preferred model of care for many people in these communities, however, the insufficient number GP Obstetricians impacts on this model's ability to provide genuine continuity of care. The committee therefore recommends that the NSW Government invest in the GP Obstetric workforce to improve continuity of care in regional, rural and remote communities, and advocate to the Australia Government for Medicare rebates for antenatal and postnatal care delivered by GPs.

Recommendation 11

That the NSW Government invest in the GP Obstetric workforce to improve continuity of care in rural areas.

Recommendation 12

That the NSW Government advocate to the Australian Government for Medicare rebates for antenatal and postnatal care delivered by GPs to reflect the cost of providing quality care.

3.210 Various stakeholders emphasised the importance of trauma-informed care in the delivery of maternity care services, highlighting that it plays a role in creating a safe space for women who are impacted by past traumas. The committee appreciates the commitment to trauma-informed care by NSW Health as evidenced by its policy on the matter and its use of the SAFE START screening tool. However, the committee heard that healthcare professionals are not adequately trained in delivering trauma-informed care and that there are concerns with SAFE START's ability to identify risks associated with previous birth trauma. The committee also heard there are limitations to the use of these screening tools, and that continuity of care with a known provider is critical to ensuring women are able to comfortably disclose past trauma and avoid being re-traumatised by having to tell their story repeatedly to new providers.

Recommendation 13

That the NSW Government commit to trauma-informed care by:

- funding and providing education and training to all maternity health practitioners on trauma-informed practice, including support to identify and plan care for women who have previously experienced trauma
- reviewing and improving the SAFE START screening tool to better identify risks associated with previous birth trauma.

3.211 In regard to education and communication, the committee recognises that antenatal education is a critical component in preventing birth trauma, with stakeholders highlighting that it is important for parents to receive accurate, unbiased information to help facilitate informed decisions during childbirth. However, stakeholders also expressed concerns about the accessibility of formal antenatal education programs, despite efforts by NSW Health to tailor programs to various demographics. As a result, many parents are often unprepared for potential emergency situations during childbirth, including the need for interventions. Therefore, the committee recommends that the NSW Government develop minimum standards for and ensure access to comprehensive evidence-based antenatal education for birthing and non-birthing parents covering models of care, potential interventions and their rights during childbirth.

Recommendation 14

That the NSW Government develop minimum standards for and ensure access to comprehensive evidence-based antenatal education for birthing and non-birthing parents covering all aspects of birth, including different models of maternity care, potential interventions and their rights during the birthing process. This education should be made available in a variety of modalities and in a form that is accessible to culturally and linguistically diverse communities.

3.212 It was also apparent that there are serious problems regarding a lack of informed consent during childbirth. It is imperative for healthcare providers to foreshadow any potential interventions as soon as possible, and ideally well before the birthing parent is in the birthing process, to maximise the opportunity for genuine informed consent. The committee was particularly concerned about stories of women who felt forced into procedures without adequate information or time to consider their options. The committee calls on the NSW Government to consider this issue as a matter of urgency.

Finding 4

That prospective parents need to be provided with clear and comprehensive education about all aspects of pregnancy and childbirth so that consent given to any obstetric intervention is fully informed.

3.213 The committee heard positive feedback to the changes to the Queensland *Human Rights Act*, which now mandates true and proper informed consent for medical treatment. Stakeholders highlighted that this shift has promoted cultural changes in Queensland maternity care facilities, offering women avenues to seek justice if proper informed consent is not obtained. The committee therefore recommends that the NSW Government review laws and considers any necessary legislative changes regarding informed consent taking into account practices in other comparable jurisdictions. The committee also recommends that the NSW Government provide support through adequate funding to ensure all practising maternity health practitioners undertake informed consent training.

Recommendation 15

That NSW Health urgently support maternity staff with appropriate local protocols and training to ensure that the *Consent to Medical and Healthcare Treatment Manual* is implemented.

Recommendation 16

That the NSW Government review laws and consider any necessary legislative changes regarding informed consent taking into account practice in other comparable jurisdictions

Recommendation 17

That the NSW Government provide support through adequate funding to ensure all practising maternity health practitioners in New South Wales undertake informed consent training.

3.214 Stakeholders generally viewed birth plans as a helpful tool to ensure informed consent with many stating that birth plans empower mothers to make informed decisions about their healthcare and express their preferences. Nonetheless, the committee acknowledges the potential for conflicts to arise when healthcare providers' medical advice clash with women's birth plans. The committee acknowledges that there are occasions when medical professionals may sometimes need to deviate from birth plans in emergencies. Nonetheless, the committee urges medical professionals to adhere to birth plans and obtain consent prior to emergencies occurring, wherever possible.

3.215 The committee received reports of instances where birth plans were disregarded during labour due to hospital guidelines and policies, resulting in traumatic birth experiences. To mitigate these instances, the committee calls on the NSW Government to offer evidence-based birth plans as a guide which include all potential interventions and outcomes. This should ensure that women are well-informed about their options in the event there are changes or emergencies during labour.

Recommendation 18

That the NSW Government make evidence-based birth plans freely available, as a guide.

3.216 Stakeholders presented evidence to the committee suggesting the overuse of interventions was contributing to birth trauma. While recognising the medical necessity of some interventions, the committee notes the importance of balancing hospital policy with patients' preferences in the birthing process. The committee was concerned to hear of instances where women felt coerced or misled into procedures including inductions, emergency caesarean sections, or instrumental deliveries. We were particularly alarmed to hear of instances where women felt that medical interventions were conducted to suit the hospital or health practitioner's schedule. Therefore, the committee recommends that the NSW Government review NSW Health, hospital and health facilities' maternity policies and guidelines around birthing interventions, ensuring that the processes for seeking genuine and informed consent are reviewed and that interventions are evidence-based. The committee also recommends that the NSW Government ensure that NSW Health, hospital and health facilities' policies and guidelines regarding birthing interventions are made publicly available.

Recommendation 19

That the NSW Government review NSW Health, hospital and health facilities' maternity policies and guidelines around birthing interventions, ensuring that the processes for seeking genuine and informed consent are reviewed and that interventions are evidence-based.

Recommendation 20

That the NSW Government ensure that NSW Health, hospital and health facilities' policies and guidelines regarding birthing interventions are made publicly available.

3.217 The committee notes the evidence that women want to be listened to by their health practitioners and have their birth preferences and choices respected – but unfortunately, this was not always happening, particularly in relation to provision of pain relief. We also heard evidence about the need for New South Wales to implement procedures to support women who decline recommended care during birth, with significant support for the Queensland model. The committee therefore recommends that the NSW Government, in consultation with relevant professional bodies and maternity consumer groups, implement policies, guidelines and training that assist health practitioners to support a woman's birthing preferences and respect women's birth choices, including around pain relief.

Recommendation 21

That the NSW Government implement policies, guidelines and training that assist health practitioners to support a woman's birthing preferences and respect women's birth choices, including around pain relief. This should include the introduction of guidelines for women who decline recommended maternity care, similar to Queensland. These policies and guidelines should be developed in consultation with relevant professional bodies and maternity consumer groups.

3.218 The committee was shocked by the volume of cases where women were refused pain relief, or their pain was downplayed or ignored. The committee affirms that women need to be listened to, believed, and heard. The committee is cognisant of a gender-bias in the provision of pain relief generally. The committee therefore recommends that the NSW Government invest in research into evidence-based interventions and training of healthcare professionals to overcome gender bias relating to the access and efficacy of pain management.

Recommendation 22

The NSW Government invest in research into evidence-based interventions and training of maternity healthcare professionals to overcome gender bias in the provision of pain relief to women to ensure timely access to effective pain management.

Recommendation 23

That the NSW Government review guidelines and consumer information for options for pain relief, both pharmacological and non-pharmacological, during and following labour and birth.

3.219 The committee also recognises the benefits of immediate skin to skin contact for both the birthing parent and the baby and the need to ensure that this can occur after caesarean section births where safe to do so.

Recommendation 24

That the NSW Government review hospital practices to ensure that, wherever possible, parents and baby are able to remain together after birth and have skin to skin contact.

3.220 The committee heard that the birthing environment can significantly influence the childbirth experience. Stakeholders to this inquiry stressed that hospital settings, including bright lights and constant surveillance, may impede the birthing process. The committee therefore recognises the importance of thoughtful design in hospital wards, including privacy, safety and comfort to support women's needs. Furthermore, some stakeholders noted the benefits of water immersion during labour as a non-invasive method of pain management. To this end, the committee recommends that the NSW Government collaborate with consumers to co-design maternity wards, and ensure future maternity wards are designed with these considerations in mind.

Recommendation 25

That the NSW Government collaborate with consumers to co-design maternity wards to customise the birthing environment to meet the needs of individuals and their support people and ensure water immersion options are available, and ensure future maternity wards are designed with these considerations in mind.

3.221 The committee recognises that hospital settings are not a preferred birthing environment for all women. We acknowledge homebirths are a preferred alternative for some women, enabling midwives to provide continuity of care and assist mothers to give birth in the comfort of their own homes. Supporting homebirths could reduce the number of free births which carry additional risks. The committee therefore recommends that the NSW Government investigate expanding publicly funded homebirth services to all NSW Local Health Districts.

Recommendation 26

That the NSW Government investigate expanding publicly funded homebirth services to all NSW Local Health Districts.

3.222 The committee was also concerned about the evidence we received that some women who planned to have a homebirth, but ultimately transferred to a hospital, did not feel they were treated with respect by hospital staff. We also heard experiences from privately practicing midwives, who raised concern about the regulatory regime and lack of access rights for privately practicing midwives in New South Wales hospitals generally. The committee therefore recommends that the NSW Government review the regulatory framework and funding arrangements for privately practicing midwives, including ensuring these midwives have authority to practise within hospital settings as well as hospital admitting rights for homebirth

transfers, and take steps to ensure all midwives and women who are involved in a homebirth-hospital transfer are treated with dignity and respect.

Recommendation 27

That the NSW Government review the regulatory framework and funding arrangements for privately practicing midwives, including ensuring these midwives have authority to practise within hospital settings as well as hospital admitting rights across New South Wales.

Recommendation 28

That the NSW Government take steps, including training for healthcare professionals, to ensure all midwives and women who are involved in a homebirth-hospital transfer are treated with respect and dignity.

3.223 The committee acknowledges that there are workforce challenges that must be addressed. The committee was concerned by the declining numbers of midwives working across the New South Wales maternity care system. It is evident that these staff shortages are leading to increased workloads and burnout, which is compromising patient care and contributing to birth trauma. We recommend that the NSW Government urgently investigate ways, and take action to address, the midwifery shortage.

Recommendation 29

That the NSW Government investigate ways, and take action to address, the midwifery shortage, including:

- reviewing pathways to increase entry into the midwifery profession, including incentives
- implementation of a staffing model which ensures there are sufficient midwifery staff of an appropriate skill-mix to provide high quality midwifery care to all women and their families.
- ensuring competitive pay and working conditions for New South Wales midwives
- prioritising the recruitment of midwives into continuity of care models

3.224 The committee also recognises the prevalence of traumatic stress and vicarious trauma among maternity care professionals, highlighting the need for more psychological support. We heard that repeated exposure to trauma can cause stress and burnout among clinicians, which has significant impacts on workforce retention. It is critical to ensure policies and procedures are in place to provide debriefing and psychological support for clinicians, including comprehensive clinical supervision.

Recommendation 30

That the NSW Government establish protocols for debriefing and psychological support for maternity clinicians following exposure to a traumatic birth experience, including mentoring and regular clinical supervision.

3.225 The recent appointment of a Chief Midwifery Officer by the Queensland Government led many to advocate for the appointment of a standalone Chief Midwifery Officer in New South Wales. Several inquiry participants were concerned about the current dual role of Chief Nurse and Midwife and suggested that a standalone Chief Midwifery Officer would be better able to represent the unique needs of midwives. While NSW Health shared that there are other lead positions in midwifery, it is clear that the broader consensus among stakeholders remains in favour of creating a distinct Chief Midwifery Officer role in New South Wales. The committee appreciates that a Chief Midwifery Officer will better represent the interests of midwives in the healthcare system, helping to address some of the key challenges faced by midwives in the state.

Recommendation 31

That the NSW Government appoint a standalone Chief Midwifery Officer in New South Wales.

3.226 Finally, the committee notes a number of stakeholders raised concerns about the current 'activity-based' funding model for funding maternity care - noting concerns that it may inadvertently incentivise interventions – and expressed a preference for a 'bundled' maternity care funding model. Other stakeholders raised concerns about the adequacy of current Medicare Benefits Scheme item numbers around the provision of antenatal care. Given these concerns, the committee recommends that the NSW Government undertake a comprehensive review of the funding of maternity care and make appropriate representations to the Australian Government following the outcome of that review.

Recommendation 32

That the NSW Government undertake a comprehensive review of the funding of maternity care and make appropriate representations to the Australian Government following the outcome of that review.

Chapter 4 Other factors contributing to birth trauma

This chapter examines the ways in which an individuals' unique life circumstances influence their response to traumatic births. Additionally, it explores the emotional complexities surrounding pregnancy loss, as well as the challenges faced by families dealing with prenatal diagnosis of genetic conditions, such as Down syndrome.

Lack of inclusivity in maternity care

4.1 This section examines the experiences and challenges faced by various groups in maternity care, including First Nations people, culturally and linguistically diverse communities, refugees, LGBTQIA+ individuals and families, young parents, regional, rural, and remote communities, people with pre-existing conditions and disabilities, as well as fathers and non-birthing parents. The committee heard that by better understanding the unique needs of these groups, maternity healthcare providers can deliver more inclusive, effective and respectful care, which will lead to better maternal and infant health outcomes.

First Nations people

4.2 Throughout the inquiry the committee heard that there were significant disparities faced by First Nations people in maternity care, including higher rates of premature birth, birth trauma, maternal deaths, and perinatal deaths.

4.3 The Australia Institute of Health and Welfare (AIHW) reported that in 2023 First Nations women represented five per cent of birthing mothers in Australia, with the Australian Birth Experience Study (BESt) reporting 37 per cent of those women experienced birth trauma.[464]

4.4 The AIHW data also revealed that in First Nations communities:

- women have higher rates of premature birth
- the maternal mortality rate is nearly triple that of non-Indigenous Australians, with 16.9 deaths per 100,000 compared to 5.5 deaths per 100,000
- the perinatal mortality of babies born to First Nations parents was 17 deaths per 1,000 births compared with 10.1 deaths per 1,000 babies born to non-Indigenous parents.[465]

4.5 According to inquiry participants, these disparities are due to a number of interrelated factors including fragmented healthcare in regional and remote communities, intergenerational trauma, as well as a lack of culturally appropriate models of maternity care.

4.6 The Aboriginal Health and Medical Research Council (AH&MRC) advised that First Nations women are less likely than their non-Indigenous counterparts to access antenatal care,

464 Submission 232, Western Sydney University, p 11, quoting *Australia's mothers and babies*, Australian Institute of Health and Welfare, December 2023.

465 Submission 947, Aboriginal Health and Medical Research Council (AH&MRC) p 3, quoting *Aboriginal and Torres Strait Islander mothers and babies, Maternal and perinatal mortality*, Australian Institute of Health and Welfare, October 2023.

particularly those who live in regional, rural or remote areas where care is often fragmented and requires mothers to travel far to give birth away from country and community.[466]

4.7 In addition, the committee heard that First Nations women also face intergenerational trauma stemming from historical child removal policies enacted by former Australian governments,[467] with ongoing policies contributing to this trauma. Data from AIHW show that First Nations children are taken into statutory out-of-home care at disproportionate rates, with First Nations infants ten times more likely to be placed into out-of-home-care compared to non-Indigenous children.[468] The Australasian Birth Trauma Association highlighted the harm and distress that high rates of out-of-home care placements cause, explaining that it contributes to the 'fear and anxiety that some First Nations mothers will experience in going into hospital … and where they must give birth separated from their country and culture'.[469]

4.8 The AH&MRC informed the committee that many First Nations women find birthing in hospitals 'traumatic and frightening' due to the lack of culturally safe care.[470] The research council stated that the experiences of racism, disrespect, and dismissal of cultural protocols can exacerbate birth trauma.[471] This concern was corroborated by the NSW Nurses and Midwives' Association who stated that 60 per cent of their surveyed members felt they had insufficient training in delivering culturally safe care to First Nations women.[472]

4.9 In response, a number of stakeholders emphasised the need for Aboriginal-led models of care, notably Birthing on Country, which has demonstrated improved maternal health outcomes for participants.[473]

4.10 Birthing on Country is a model of maternity care rooted in First Nations leadership and governance. It encompasses traditional practices, connection with the land and country, incorporates holistic definition of health, values indigenous ways of knowing and learning, and is developed by and for First Nations people.[474] According to Waminda, this model provides continuity of care and culturally safe practices for First Nations women and their families.[475]

4.11 A number of stakeholders, including AH&MRC and the Australian College of Midwives, highlighted that First Nations women who engaged in Birthing on Country programs demonstrated improved maternal health outcomes.[476] Outcomes included reduction in preterm

466 Submission 947, Aboriginal Health and Medical Research Council (AH&MRC), p 4.

467 Evidence, Ms Cleone Wellington, Executive Manager, Waminda, 9 October 2023, p 50.

468 Submission 254, The Australasian Birth Trauma Association, p 37, quoting *Child protection Australia 2019–20*, Australian Institute of Health and Welfare, May 2021.

469 Submission 254, The Australasian Birth Trauma Association, p 37.

470 Submission 947, Aboriginal Health and Medical Research Council (AH&MRC), p 2.

471 Submission 947, Aboriginal Health and Medical Research Council (AH&MRC), pp 2-3.

472 Submission 242, NSW Nurses and Midwives' Association, p 12.

473 See for example, Submission 253, Maternity Choices Australia, p 7; Submission 854, Australian College of Midwives, p 18; Submission 947, Aboriginal Health and Medical Research Council (AH&MRC), p 5.

474 Submission 862, NSW Health, p 16.

475 Evidence, Ms Melanie Briggs, Birthing on Country Manager, Waminda, 9 October 2023, p 43.

476 See; Submission 947, Aboriginal Health and Medical Research Council (AH&MRC), p 5; Submission 854, Australian College of Midwives, p 18.

birth by 50 per cent, reduction in low birth weight, reduction in interventions including caesarean section and increases in breastfeeding rates.[477]

4.12 Despite these outcomes, the Western Sydney University Birth Experience Study (BESt) suggested there are not enough Birthing on Country options currently available in New South Wales.[478]

4.13 Recognising the need for more culturally safe maternity care options, NSW Health advised that it developed maternity services tailored to First Nations people, including:

- Aboriginal Maternal and Infant Health Service (AMIHS) which aims to address disparities across the state by offering prenatal and postnatal care and culturally sensitive support and education throughout pregnancy and up to eight weeks after childbirth.[479]
- Building Strong Foundations program which supports Aboriginal families, children, and communities, to ensure Aboriginal children have an optimal start in life. The program offers a range of services delivered by Aboriginal health workers and family health nurse teams, and allied health professionals. NSW Health explained that the services are 'integral to providing cultural linkages within local Aboriginal community groups and events to ensure Aboriginal children can maintain their cultural identity and networks'.[480]

Culturally and linguistically diverse communities

4.14 A number of stakeholders identified the unique challenges faced by culturally and linguistically diverse (CALD) women within the maternity healthcare system in New South Wales. These challenges include language barriers and a lack of culturally safe care, leading to increased incidences of birth trauma.

4.15 In New South Wales, 37 per cent of women who had a baby in 2021 were born overseas, with the top four regions being 'Southern Asia, South-East Asia, Chinese Asia, and the Middle East'.[481] The BESt study indicated that 30 per cent of CALD women in New South Wales reported experiencing birth trauma, which is slightly higher than those from English speaking backgrounds.[482]

4.16 The NSW Nurses and Midwives' Association shared survey responses from their members that revealed that 67 per cent of the nursing and midwifery workforce feel that they have received inadequate training on culturally safe care for CALD women.[483]

4.17 NSW Health recognised the importance of culturally safe maternity care, informed by feedback from CALD women, including ensuring respect for cultural contexts and providing access to

477 Submission 854, Australian College of Midwives, p 18.

478 Submission 232, Western Sydney University, p 11.

479 Submission 862, NSW Health, p 15.

480 Submission 862, NSW Health, p 34.

481 Submission 232, Western Sydney University, p 12, quoting *Australia's mothers and babies*, Australian Institute of Health and Welfare, December 2023.

482 Submission 232, Western Sydney University, p 12.

483 Submission 242, NSW Nurses and Midwives' Association, p 13.

interpreters for effective communication. The department also acknowledged the need for tailored antenatal care and education to address the diverse needs of CALD women, promoting inclusivity and accessibility in maternal healthcare.[484]

4.18 Stakeholders including the Australasian Birth Trauma Association and NSW Service for the Treatment of Rehabilitation of Torture and Trauma Survivors (STARTTS), highlighted the additional complexities, notably language and cultural barriers, faced by CALD women when navigating the New South Wales maternity care system. STARTTS shared that low English proficiency can impact the ability of CALD women to make informed choices and maintain control over the birthing experience.[485] This barrier can also limit health care professionals' ability to provide important information, potentially leading to misinformed consent for childbirth interventions.[486] STARTTS advocated for providing qualified interpreters throughout their perinatal journey - including continuity of interpreter wherever possible - to improve outcomes by establishing 'trust and rapport' between the woman and the interpreter.[487]

4.19 Ms Elahe Yazdani suggested that these interpreters should be 'medically qualified' to ensure they are able to appropriately assist women, following her experience in hospital:

> They asked me to sign the papers. Even when English is your first language, when you are stressed, when you are under pain, it is hard to understand medical things. They asked me to sign the paper. I even didn't know what I'm signing. I asked them for an interpreter and the interpreter over the phone was explaining for me—she was telling me the wrong thing. I was an ICU nurse in my home country. I could understand that she is telling me the wrong thing. I had a little bit of medical experience and I could understand. Imagine people in that hospital without any English background.[488]

4.20 The committee also heard that cultural practices and preferences play a crucial role in ensuring a positive birthing experience. For example, Zamzam Mums and Bubs and the Still Nest shared with the committee the importance of modesty for Muslim women. The committee heard that these preferences include the desire for female healthcare providers and recognition of religious practices including wearing modest clothing (noting that for some women, rules around modesty are relaxed in medical settings).[489] Zamzam Mums and Bubs and the Still Nest stressed that what is more important is ensuring a woman's preferences are established from the first interaction and these choices are respected.[490] STARTTS recommended that cultural safety training programs be implemented for all health care professionals, which also 'increases the understanding of and capacity to respond to interconnected and/or compounding experiences of trauma, including birth trauma.[491]

484 Submission 862, NSW Health, p 31.

485 Submission 877, NSW Service for the Treatment of Rehabilitation of Torture and Trauma Survivors (STARTTS), p 6.

486 Submission 877, NSW Service for the Treatment of Rehabilitation of Torture and Trauma Survivors (STARTTS), p 6.

487 Submission 877, NSW Service for the Treatment of Rehabilitation of Torture and Trauma Survivors (STARTTS), p 7.

488 Evidence, Ms Elahe Yazdani, Individual, 9 October 2023, p 11.

489 Submission 929, Zamzam Mums and Bubs and The Still Nest, p 8.

490 Submission 929, Zamzam Mums and Bubs and The Still Nest, p 8.

491 Submission 877, NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS), p 10.

4.21 Stories shared by Zamzam Mums and Bubs and the Still Nest illustrated the negative experiences some Muslim women encounter in the maternity healthcare setting due to a lack of cultural sensitivity:

> One particular incident began a whole series of appointments where I was treated extremely disrespectfully as I had hurt a doctor's feelings by requesting a female to do an ultrasound and physical check. I was told by them it was okay because there would be a woman nearby or in the room if I wanted and was disregarded when I explained I felt uncomfortable with this being done by a man regardless and then was subjected to a lecture by him about how I was intentionally harming my baby by rejecting his assistance and that it would be my fault when I went home and my baby died meaning I'd have a stillbirth.[492]

4.22 A number of submissions raised concerns about experiences of racism and discrimination within the maternity care system, and the way this contributed to trauma. Ms Victoria Smith, a mother of two First Nations babies, shared her experiences of implicit and explicit moments of racism. One incident involved midwives misdiagnosing her child as having jaundice after commenting 'on his colour':

> During my time in the hospital and over the first few weeks of my baby's life, the nurses were constantly concerned about my baby having jaundice. Over and over again they would comment on his colour and make disappointing noises about how my milk had not come through yet. We asked his Dr, the Obstetrician from the Aboriginal Medical Service for advice and she laughed and said he doesn't have jaundice, it's just his colour as his father is a black man and I am a white woman.[493]

4.23 On the back of this advice, Ms Smith declined to have a prick test from the hospital but after attempting to leave the hospital, she and her husband returned to the hospital and complied as she was 'anxious about the possibility of them reporting us to family services'. A medical test came back negative. 'All of that stress was for nothing. I don't understand why they didn't listen to our Doctor'.[494]

4.24 Ms Elahe Yazdania recounted her experience after giving birth where she felt her pain and concerns were ignored due to her skin colour and refugee status:

> After around four hours, I buzzed the button to ask for help and nobody came. Finally, I start screaming and crying and asking for help. When the midwife came, I told them, "Why do you ignore me? Why do you think I'm nobody here? Because my hair is black? Because English is not my first language? Because I am a refugee? Because my skin is brown? Why don't you care about me? I'm here like any other patient. Everyone comes to this room looking after the other lady and, when I ask about help, no-one cares about me… I believe I was racially discriminated against because I was brown and I was refugee.[495]

492 Submission 929, Zamzam Mums and Bubs and The Still Nest, p 8.

493 Submission 1077, Ms Veronica Smith, p 3.

494 Submission 1077, Ms Veronica Smith, p 4.

495 Evidence, Ms Elahe Yazdani, Individual, 9 October 2023, p 11.

4.25 Mrs Dulce Munoz also gave evidence about her birthing experience, which resulted in an emergency caesarean section. Mrs Munoz felt that the fact that she was a 'person of colour with a very deep accent' led to her pain and discomfort being dismissed and ignored by hospital staff:

> One of the hardest things is, although I have a thick accent, I am highly educated and I come from a comfortable background, and for the first time in my life, ever—and I have lived in many places—I felt racism. I don't know if it was racism because I was a pregnant migrant. I wasn't asked my level of education or where I lived, so it wasn't economic racism; it was racism. It was very strange.[496]

4.26 Mrs Munoz said she chose to give evidence to this inquiry so 'no other expectant mothers—no matter where they come from, their accent, their age or their medical history—experience the same distress that I did'.[497]

Refugees

4.27 In addition to the challenges faced by mothers from culturally and linguistically diverse communities, evidence to this inquiry illustrated that refugees face additional challenges as a result of past traumatic experiences and resettlement stressors.

4.28 According to NSW Service for the Treatment of Rehabilitation of Torture and Trauma Survivors (STARTTS), challenges for refugees stem from experiences of war, organised violence, harassment, intimidation, imprisonment, sexual abuse, rape, and forced displacement, leading to profound psychological trauma, with women and girls particularly vulnerable due to additional discrimination, and sexual and gender-based violence.[498] Exposure to these stressors and trauma can contribute to adverse health outcomes for pregnant women such as preterm birth and low birth weight.[499]

4.29 Additionally, resettling in a new country also presents hurdles for refugees, including language barriers and cultural dissonance, which can further compound existing trauma. STARTTS argued that despite residing in a high-income host country like Australia, refugee women often experience poorer perinatal outcomes, underscoring the need for targeted interventions.[500]

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496 Evidence, Mrs Dulce Munoz, Individual, 9 October 2023, p 7.

497 Evidence, Mrs Dulce Munoz, Individual, 9 October 2023, p 2.

498 Submission 877, NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS), p 3.

499 Submission 877, NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS), p 3, quoting E Riggs, J Yelland, FK Mensah, et al., 'Group Pregnancy Care for refugee background women: a codesigned, multimethod evaluation protocol applying a community engagement framework and an interrupted time series design' (2021) *BMJ Open*.

500 Submission 877, NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS), p 3, quoting Jan Yelland, Elisha Riggs, Fatema Fouladi, et al., 'Having a baby in a new country the views and experiences of Afghan Families and Stakeholders' (2013) *Murdoch Childrens Research Institute*.

4.30 Evidence provided by STARTTS indicated that refugee women have higher rates of pregnancy complications, including postpartum haemorrhage, gestational diabetes, and preeclampsia.[501] According to STARTTS, medical birth spaces commonly used in Australia may not provide the sense of safety and support needed, leading refugee women to become 'passive, hypervigilant and distressed'.[502]

4.31 During her evidence, Ms Elahe Yazdani, a refugee, recounted the difficult experience of giving birth without adequate support or language assistance, and spoke of being coerced into an induction which led to psychological distress:

> I wasn't offered any support or any information in my own language… it was so hard to understand everything… I had no-one. I had no friends and no family here… My birth experience was one of the worst experiences... I try to forget my birth but I can't. It has been three years. I still have to see a psychologist every week. I have a happy, healthy son but I am not okay. I am not happy sometimes, and it is so hard… I still sometimes got panic attacks. I got anxiety, crying, nightmares and all of these things with me. I never thought how a birth could traumatise me. I was forced to have an induction when I was 41 weeks, and I didn't want to have it... They didn't give me a good reason… With force and with pressure, I agreed to do induction.[503]

4.32 STARTTS recommended that specialised services be introduced for refugee women and shared examples from other jurisdictions that could be implemented:

- The Group Pregnancy Care (GPC) is a model co-designed with a refugee community and other key stakeholders in Melbourne. It offers a holistic approach to maternity care, fostering empowerment, social support, and improved health literacy among refugee women.[504] The aim of the GPC is to increase the engagement of women from refugee backgrounds with antenatal care, increase their health literacy, overcome language barriers, and provide cultural safety within a safe and supportive environment. The model is delivered by health care professionals and a bicultural worker, that is woman-directed, culturally appropriate and in the women's language.[505]
- The Integrated Refugee Health Service and Refugee Maternity Service at Mater Hospital Brisbane provides health care, resources, and psycho-social support for women from refugee backgrounds. The specialised clinic offers a continuity of care model that

501 Submission 877, NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS), pp 3-4, quoting Mpho Dube, Yu Gao, Michelle Steel, Angela Bromley, Sarah Ireland, Sue Kildea, 'Effect of an Australian community-based caseload midwifery group practice service on maternal and neonatal outcomes for women from a refugee background' (2023) 36(3) *Women and Birth*.

502 Submission 877, NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS), p 4.

503 Evidence, Ms Elahe Yazdani, Individual, 9 October 2023, p 11.

504 Submission 877, NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS), pp 8-9.

505 Submission 877, NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors STARTTS), pp 8-9.

acknowledges the impact of refugee trauma, and presentation of a range or pre-existing medical conditions that can impact on childbirth.[506]

- The Refugee Midwifery Group Practice (RMGP) in Brisbane offers tailored antenatal care to refugee women, emphasising continuity of care and cultural safety. STARTTS informed the committee that by providing access to language-specific care, peer support, and comprehensive postnatal services, RMGP can address the unique needs of refugee women before, during, and after birth.[507] STARTTS outlined that women involved in the RMGP have promising outcomes, including spontaneous vaginal birth and improved maternal well-being, highlighting the potential for culturally responsive maternity care in enhancing perinatal outcomes for refugee women.[508]

LGBTQIA+ individuals and families

4.33 The committee heard from a number of LGBTQIA+ advocates who stated that there is ongoing prejudice and discrimination within New South Wales healthcare settings, particularly within traditional maternity spaces, leading to adverse health outcomes and birth trauma for LGBTQIA+ individuals. To address these concerns, a number of stakeholders called for trauma-informed, inclusive and gender-affirming care to be incorporated into maternity spaces.

4.34 In March 2022, NSW Health published the *NSW LGBTIQ+ Health Strategy*, aiming to ensure LBGTQIA+ people in New South Wales have access to 'high quality, safe, inclusive and responsive healthcare that delivers outcomes that matter to them'.[509] This strategy outlines four key priorities:

5. deliver high quality, safe, inclusive and responsive care
6. respond to the health needs of transgender and gender diverse people in New South Wales
7. respond to the health needs of intersex people in New South Wales
8. capture data on sexuality, gender and intersex variations at the point-of-care and population levels.[510]

4.35 Despite the release of the strategy, the NSW Nurses and Midwives' Association presented findings from a survey conducted in 2023, indicating that 78 per cent of nurses and midwives stated that their employers had not provided sufficient training on culturally safe care for LGBTIQA+ individuals.[511]

506 Submission 877, NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS), pp 9-10.

507 Submission 877, NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS), p 10.

508 Submission 877, NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS), p 10, quoting Mpho Dube, Yu Gao, Michelle Steel, Angela Bromley, Sarah Ireland, Sue Kildea, 'Effect of an Australian community-based caseload midwifery group practice service on maternal and neonatal outcomes for women from a refugee background' (2023) 36(3) *Women and Birth*.

509 Submission 862, NSW Health, p 32.

510 Submission 862, NSW Health, p 32.

511 Submission 242, NSW Nurses and Midwives' Association, p 8.

4.36 Stakeholders including ACON and the Australasian Birth Trauma Association suggested that LGBTQIA+ individuals continue to face prejudice and discrimination within healthcare settings and are more likely to encounter negative experiences than others.[512] According to these stakeholders, prejudice and discrimination can adversely impact the health, exacerbate birth trauma, contribute to poor mental health outcomes and increase the risk of suicide.[513]

4.37 ACON characterised traditional maternity healthcare settings as 'cisgender and heterosexual spaces',[514] suggesting that healthcare professionals can have implicit biases, rooted in heteronormative assumptions.[515] According to ACON, these implicit biases become evident through a lack of sensitivity and knowledge towards pregnant LGBTQIA+ individuals.[516]

4.38 Because of the gaps in knowledge among people working in maternity care, LGBTQIA+ individuals told the committee they find themselves having to educate healthcare practitioners on sexuality, gender, and the use of appropriate language.[517] This was illustrated when Ms Mary Van Reyk told the committee:

> My dad is a gay sperm donor and, for me, every time—we would have to go through the family history again and again … they would have questions. But then that is putting us in the realm of educator. That is making us have to educate people…I felt the need to advocate, because we always feel like we're advocating for queer families.[518]

4.39 The committee also heard from other individuals within the LGBTQIA+ community who raised concerns that they were treated differently. For example, Ms Alexandra Crichton raised concerns that she was subjected to discrimination when being discharged after giving birth because she was a single, gay woman:

> A nurse came into the room and told me 'given your circumstances and lack of support at home' she would report me to FACS if I discharged my newborn and I [went] against medical advice. I feel strongly that this decision was made due to me being a single, gay woman without a second parent for my child. I work in a respected position; I had family and friends to support me at home and have previously worked in childcare. I have no doubt that if I had a male partner, they would not have threatened this which I feel is discriminatory. I felt forced to stay, this discussion and the threat made me very distressed.[519]

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512 See, Submission 254, The Australasian Birth Trauma Association, p 37; Submission 223, ACON, pp 4-6.

513 See, Submission 254, The Australasian Birth Trauma Association, p 37; Submission 223, ACON, p 6.

514 According to Submission 223, ACON, p 4, heteronormative is the perspective that sees heterosexuality as the only, preferred or 'normal' sexuality, and spaces that are cisgendered create a form of prejudice that denies, denigrates and/or pathologises non-cisgender identities and expressions, where cisgender refers to individuals whose gender is the same as the sex that was presumed for them at birth.

515 Submission 223, ACON, p 4.

516 Submission 223, ACON, p 5.

517 See, Submission 223, ACON, p 7; Evidence, Ms Mary van Reyk, Individual, 11 March 2024, p 6.

518 Evidence, Ms Mary Van Reyk, Individual, 11 March 2024, p 6.

519 Submission 932, Miss Alexandra Crichton, p 2.

4.40 Mrs Tamara Leetham raised similar concerns about the way she and her partner were treated during their birth experience:

> I was taken to ICU, my perfectly healthy baby was taken to special care and my spouse, my baby's legal parent, was refused to stay with our baby and sent home. Again, is this because we are not heterosexual? This instance of a perfectly healthy baby being removed from their parents is outrageous and deeply affected our child who was highly distressed for the start of their life.[520]

4.41 Inquiry participants suggested ways in which the maternity care system could be more inclusive. For example, the Australasian Birth Trauma Association argued that the use of gender-specific language in maternity care, such as 'women' and 'mother', can be particularly isolating for those who do not identify within these categories, underscoring the need for a more inclusive approach to healthcare terminology and practices.[521]

4.42 Similarly, ACON highlighted that transgender individuals, especially transgender men, face considerable challenges in accessing maternity care that respects their gender identity.[522] These barriers include judgement, misgendering, incorrect assumptions about bodies, and limited access to gender-affirming care.[523] In order to fulfill the objectives of the *NSW LGBTIQ+ Health Strategy*, ACON advocated for trauma-informed, gender-affirming care to be incorporated into learning principles and tertiary education, and applied in all medical settings, to ensure a supportive and inclusive environment for all.[524]

Young parents

4.43 The inquiry heard that young parents often have negative experience within the New South Wales maternity healthcare system, including reports of neglect, dismissive treatment, and pervasive stereotypes.

4.44 Statistics shared with the committee revealed that:

- women aged 24 years and under have higher rates of birth trauma compared to the general population
- despite only representing 11 per cent of birthing women in New South Wales, 41 per cent of young mothers experience birth trauma
- babies of young women have higher rates of perinatal deaths with 15.8 per 1,000 compared with 8.8 per 1,000 of the general population.[525]

4.45 The Australian Lawyers Alliance noted that young parents often feel their concerns are dismissed by medical professionals due to perceptions about their age and inexperience.

520 Submission 1181, Mrs Tamara Leetham, pp 2-3.

521 Submission 254, The Australasian Birth Trauma Association, p 37.

522 Submission 223, ACON, p 5.

523 Submission 223, ACON, p 5.

524 Submission 223, ACON, pp 4-6.

525 Submission 232, Western Sydney University, p 13, quoting *Australia's mothers and babies*, Australian Institute of Health and Welfare, December 2023.

According to the alliance this puts young parents at risk of experiencing birth trauma, especially if they are not listened to during birth, or are not afforded the opportunity to provide informed consent.[526]

4.46 The committee heard evidence from young mothers detailing instances of healthcare providers disregarding their concerns due to their age. One mother, Mrs Larissa Palamara, recounted feeling belittled and stereotyped by her midwife, who consistently discussed their age difference and subjected her to critical comments about her appearance and intelligence.[527] Despite expressing concerns about her pregnancy and the welfare of her baby, Mrs Palamara said she felt that her worries were ignored, which she believes led to a stillbirth. Furthermore, she described enduring ongoing mistreatment from her primary midwife, who publicly humiliated her and perpetuated negative stereotypes about teenage pregnancy.[528]

4.47 Similarly, Ms Cassidi-Rae Amosa told the committee she encountered dismissive attitudes from healthcare providers who deemed her too young to understand her pregnancy and birthing needs. Despite voicing concerns about her health, Ms Amosa said her worries were disregarded, resulting in an oversight of symptoms that led to a stroke.[529]

4.48 Both women highlighted the importance of improving support for young mothers and recognising their unique needs such as financial limitations and the need for additional resources.[530] They also called on professionals to treat young mothers with respect and attentiveness, regardless of their age.

Regional, rural, and remote communities

4.49 During the inquiry the committee heard evidence from key stakeholders highlighting the distinct maternity care challenges faced by individuals in rural, regional, and remote areas of New South Wales.

4.50 In 2021, 26 per cent of babies in New South Wales were born outside of metropolitan Local Health Districts.[531] The committee heard that giving birth outside of metropolitan centres presents additional obstacles including remoteness, limited options for models of care, staff shortages, financial costs associated with travel and accommodation, and cultural attitudes specific to these communities.

4.51 Turning first to the issue of remoteness, Gidget Foundation Australia explained that people in rural and regional New South Wales are expected to travel significant distances to access specialist care and are required to leave family for extended periods of time to be close to maternity services.[532] Gidget also noted that lengthy separation from other children and social

526 Submission 234, Australian Lawyers Alliance, p 32.

527 Submission 36, Mrs Larissa Palamara, Individual, p 2.

528 Evidence, Mrs Larissa Palamara, Individual, 8 April 2024, pp 2 and 5.

529 Evidence, Ms Cassidi-Rae Amosa, Individual, 8 April 2024, p 7.

530 Evidence, Mrs Larissa Palamara, Individual, 8 April 2024, p 3.

531 Submission 862, NSW Health, p 37, quoting Centre for Epidemiology and Evidence, *NSW Mothers and Babies 2021*, HealthStats NSW, 14 June 2023, p 13.

532 Submission 249, Gidget Foundation Australia, p 7.

supports can also happen after childbirth if there are physical complications for the mother or baby.[533] Furthermore the requirement to travel means that these women are less likely to have continuity of care with a trusted health professional adding to potentially negative outcomes. Stakeholders commented that where services do exist, there are limited options for models of care.[534]

4.52 In addition to limited services, Miracle Babies Foundation highlighted the social and financial difficulties for parents from regional, rural and remote communities. The foundation shared that without community support 'parenting can be a very isolating, lonely, stressful and traumatic experience' and that the 'financial burden' of accommodation, transport and parking costs at hospitals adds 'another layer of trauma' for parents.[535]

4.53 Recognising the need for some women to travel, NSW Health advised that it offers financial support through the Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS). This program assists with the expense of accessing antenatal, birthing, or postnatal care for women living in regional, rural and remote areas of New South Wales who need to travel more than 100 km.[536]

4.54 In addition to the issue of remoteness, a number of stakeholders observed that regional and rural areas of New South Wales face shortages in maternity facilities and workforce impacting the level of care and education available to mothers and their babies.[537] According to these stakeholders:

- a shortage of maternity care facilities, including hospitals with obstetric units means delays in getting important care during pregnancy and birth, increasing the risk of complications and trauma[538]
- workforce shortages can have a flow on effect to the care available to women and their babies as there is reduced access to regular antenatal care and limited availability of birthing options, which increases the risk of birth trauma[539]
- a lack of healthcare workers reduces accessibility to antenatal education, which can lead to decreased awareness about birth options, resources, and coping strategies, contributing to feelings of anxiety and loss of control.[540]

4.55 Finally, the NSW Nurses and Midwives' Association explained that rural and remote communities may have social and cultural attitudes that influence perceptions of childbirth and

533 Submission 249, Gidget Foundation Australia, p 7.

534 See for example, Submission 854, Australian College of Midwives, p 18; Submission 250, Miracle Babies Foundation, p 11.

535 Submission 250, Miracle Babies Foundation, p 11.

536 Submission 862, NSW Health, p 32.

537 See for example, Submission 234, Australian Lawyers Alliance, p 29.

538 See for example, Submission 854, Australian College of Midwives, p 18; Submission 250, Miracle Babies Foundation, p 11; Submission 242, NSW Nurses and Midwives' Association, p 11.

539 Submission 242, NSW Nurses and Midwives' Association, p 11. See also, Submission 38, Dr Maria del Pilar Luna Ramirez, p 1.

540 Submission 242, NSW Nurses and Midwives' Association, p 11.

medical interventions.[541] These attitudes can impact the decision-making process during childbirth and may contribute to a reluctance to seek medical care, even in critical situations.[542] Adding to this, access to mental health resources, including counselling and support for trauma survivors, may be limited in rural and remote areas, which can impede the availability of specialised care for parents who have experienced birth trauma.[543]

4.56 NSW Health recognised the unique challenges faced by people living in regional, rural and remote New South Wales, advising that the *NSW Regional Health Strategic Plan 2022-2032* outlines a vision for a sustainable, equitable and integrated health system catering for the needs of patients and communities across regional and rural areas of New South Wales.[544] Central to this vision is the delivery of maternity care aligned with three strategic priorities:

1. strengthening the regional health workforce
2. enabling better access to safe, high quality and timely health services
3. keeping people healthy and well through prevention, early intervention and education.[545]

Individuals with pre-existing conditions and disabilities

4.57 The committee heard that individuals with pre-existing conditions, such as neurodivergence, mental health conditions and physical disabilities face barriers when accessing maternity care, in part due to inadequate services.

4.58 Recent research provided by the Australasian Birth Trauma Association indicated that women with disabilities often have poorer perinatal outcomes, with many hospitals lacking specialised services and staff training in disability identification and support.[546] Interviews conducted by the Australasian Birth Trauma Association with healthcare professionals highlighted the negative impacts on the birthing experiences of individuals with disabilities.[547]

4.59 Dr Namira Williams, CEO of disAbility Maternity Care, described women with a disability as 'invisible' within the maternity care system. Despite the challenges in identifying these individuals, disAbility Maternity Care stated that mothers with a disability encompass 9-10 per cent of the birthing population.[548]

4.60 Dr Williams presented research from the United Kingdom which outlined types of maternal disability, including:

541 Submission 242, NSW Nurses and Midwives' Association, p 11.

542 Submission 242, NSW Nurses and Midwives' Association, p 11.

543 Submission 242, NSW Nurses and Midwives' Association, p 11.

544 Submission 862, NSW Health, p 7.

545 Submission 862, NSW Health, p 7.

546 Submission 254, The Australasian Birth Trauma Association, p 36.

547 Submission 254, The Australasian Birth Trauma Association, p 36.

548 See, Evidence, Dr Namira Williams, CEO, disAbility Maternity Care, 8 April 2024, p 19; Tabled document, Dr Namira Williams, disAbility Maternity Care, *Working with women who have a disability*, 2021, quoting R Malouf, J Henderson, M Redshaw, 'Access and quality of maternity care for disabled women during pregnancy, birth and the postnatal period in England: data from a national survey' (2017) 7 *BMJ Open.*

- physical disability (45 per cent)
- mental illness (34 per cent)
- sensory disability (8.7 per cent)
- intellectual disability (6.5 per cent)
- multiple disabilities (6 per cent).[549]

4.61 Dr Williams presented evidence indicating that women with disabilities face challenges before, during and after childbirth:

- before pregnancy, women with a disability are more likely to have been sexually assaulted or be socially or economically disadvantaged
- during pregnancy, women with a disability can experience a range of health risks, including gestational diabetes, pre-eclampsia, or other pregnancy complications
- during labour, women with a disability are more likely to deliver preterm, have a caesarean section, or have a stillbirth
- after giving birth, women with an intellectual disability are more likely to have their child removed from their care.[550]

4.62 Furthermore, Gidget Foundation Australia noted that women with intellectual disabilities are at higher risk of pregnancy and birth complications, requiring tailored support that addresses both their physical and psychological needs.[551] Gidget also shared that individuals with physical disabilities require improved access to person-centred maternity care, including expert support for birthing options, anaesthesia, and postnatal care, as well as access to facilities designed to enhance autonomy and self-reliance.[552]

4.63 Dr Namira Williams illustrated the unintended negative consequences of childbirth for people with a disability. She shared one example of a woman with a physical disability who underwent a planned caesarean birth. Despite having had multiple surgeries as a child, none of her maternity care clinicians discussed with her the potential triggering emotional impact undergoing a caesarean could have. During the procedure, she felt retraumatised and anxious as a result of her past surgeries. Dr Williams explained that this highlights the importance of communication and trauma-informed care to help mitigate negative birth experiences.[553]

549 Tabled document, Dr Namira Williams, disAbility Maternity Care, *Working with women who have a disability*, 2021.

550 See; Evidence, Dr Namira Williams, CEO, disAbility Maternity Care, 8 April 2024, p 19; Tabled document, Dr Namira Williams, disAbility Maternity Care, *Working with women who have a disability*, 2021.

551 Submission 249, Gidget Foundation Australia, p 9.

552 Submission 249, Gidget Foundation Australia, p 9.

553 Evidence, Dr Namira Williams, CEO, disAbility Maternity Care, 8 April 2024, p 23.

Fathers and non-birthing parents

4.64 Finally, a number of stakeholders identified that the experiences of fathers and non-birthing parents are often overlooked in relation to birth related trauma.[554] While there is little data currently available on the prevalence of birth-related trauma among fathers and non-birthing parents, the Australasian Birth Trauma Association argued that fathers have needs just as birthing individuals do during pregnancy and childbirth.[555]

4.65 Evidence from Prepare Foundation shed light on the impact of birth trauma on fathers, revealing that witnessing birth complications and emergencies can lead to significant emotional distress.[556] According to Prepare Foundation, fathers may experience feelings of guilt, anxiety, depression, intrusive thoughts, sleep disturbances, difficulty bonding with the baby, and relationship challenges.[557] Both Prepare Foundation and the Australasian Birth Trauma Association noted evidence that suggested that even uncomplicated births can trigger depression or post-traumatic stress disorder (PTSD) in non-birthing parents.[558]

4.66 Studies quoted by the Australasian Birth Trauma Association indicated that:

- fathers are more likely to experience depression, anxiety and stress compared to men in the general population[559]
- up to one in ten fathers may experience paternal depression from the first trimester to one year postpartum[560]
- about one in six fathers may experience anxiety during pregnancy, and up to one in five may experience it postnatally[561]
- partners who witness adverse outcomes during pregnancy or birth, including termination for medical reasons, may also experience higher rates of depression and post-traumatic

554 See; Submission 249, Gidget Foundation Australia, p 4; Submission 1051, Prepare Foundation, p 4; Submission 254, The Australasian Birth Trauma Association, p 17.

555 Submission 254, The Australasian Birth Trauma Association, p 17.

556 Evidence, Mr Steven Kennedy, Founder and Executive Director, Prepare Foundation, p 53.

557 Submission 1051, Prepare Foundation, p 4.

558 See, Submission 254, The Australasian Birth Trauma Association, p 17; Submission 1051, Prepare Foundation, p 4, quoting Rakime Elmir, Virginia Schmied, 'A meta-ethnographic synthesis of fathers' experiences of complicated births that are potentially traumatic' (2016) 32 *Midwifery*, pp 66-74.

559 Submission 254, The Australasian Birth Trauma Association, p 17, quoting E Cameron, I Sedov, L Tomfohr-Madsen, 'Prevalence of paternal depression in pregnancy and the postpartum: An updated meta-analysis' (2016) *Journal of affective disorders*.

560 Submission 254, The Australasian Birth Trauma Association, p 17 quoting James Paulson and Sharnail Bazemore, 'Prenatal and postpartum depression in fathers and its association with maternal depression: a meta-analysis' (2010) *JAMA*.

561 Submission 254, The Australasian Birth Trauma Association, p 17, quoting Liana Leach, Carmel Poyser, Amanda Cooklin, and Rebecca Giallo, 'Prevalence and course of anxiety disorders (and symptom levels) in men across the perinatal period: A systematic review' (2016) 190 *Journal of Affective Disorders,* pp 675-686.

stress (for instance, 83 per cent of male non-birthing partners who receive a prenatal diagnosis of fetal anomaly found it a traumatic event).[562]

4.67 The Prepare Foundation highlighted that men who experience birth trauma often 'suffer in silence' as support is provided and focused primarily on the birthing mother. As a result, limited opportunities exist for fathers to openly share their experiences, further compounding their distress.[563] Similarly, registered psychologist Ms Alysha-Leigh Fameli noted the need to address the trauma experienced by non-birthing parents stating that their trauma can impact on the entire family. She told the committee, 'when you have a woman who is traumatised by her birth, she is often turning to her partner or her co-parent for support. If that person is equally traumatised, then we have a whole system of trauma'.[564]

4.68 Prepare Foundation informed the committee that a contributing factor to birth trauma is the presence of unprepared fathers in the delivery room, particularly first-time fathers, whose unfamiliarity with childbirth can pose psychological challenges and hinder their ability to provide calm support.[565] Prepare Foundation wrote that 'this has the potential to make the progress of labour slow or cease and increase the likelihood of medical intervention', which may also increase the risk of birth trauma.[566]

4.69 Stakeholders gave evidence that fathers and non-birthing parents are often not kept properly informed on what is happening during birth. For example, Ms Carly Griffin stated that, when she was told she needed an emergency caesarean section, 'there was no explanation to me or to my son's dad, who was at my birth'.[567] Mrs Tamara Leetham similarly gave evidence that while she was in the ICU having a blood transfusion after birth, her spouse was left alone with their newborn baby for hours with no idea where she was or what was happening, leaving her spouse feeling 'helpless'.[568]

4.70 Dr Rakime Elmir, Senior Lecturer, Deputy Director Clinical Education Midwifery, School of Nursing and Midwifery, Western Sydney University, confirmed these individual experiences were also borne out in her research:

> Existing research I have published highlighted that men are not prepared, particularly first-time fathers, for the events that may unfold at the birth, yet they are expected to be present and support their partners. They are excluded from decision-making processes and often feel out of their depth. They feel helpless, emasculated and merely like a bystander, yet they so desperately want to be involved as parenting partners.[569]

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562 Submission 254, The Australasian Birth Trauma Association, p 17, quoting L Aite, A Zacccara, N Mirante, A Nahom, A Trucchi, L Capolupo, and P Bagolan, 'Antenatal diagnosis of congenital anomaly: a really traumatic experience?' (2011) *Journal of perinatology: official journal of the California Perinatal Association*.

563 Submission 1051, Prepare Foundation, p 4.

564 Evidence, Ms Alysha-Leigh Fameli, Registered Psychologist, PhD candidate at University of Sydney, 8 April 2024, p 33.

565 Submission 1051, Prepare Foundation, p 5.

566 Submission 1051, Prepare Foundation, p 5.

567 Evidence, Ms Carly Griffin, Individual, 7 September 2023, p 15.

568 Submission 1181, Mrs Tamara Leetham, p 2.

569 Evidence, Dr Rakime Elmir, Senior Lecturer, Deputy Director Clinical Education Midwifery, School of Nursing and Midwifery, Western Sydney University, p 24.

4.71 According to Prepare Foundation, fathers play a critical role in supporting birthing mothers, yet they receive minimal training on how to effectively fulfill this role, leaving them ill-prepared to navigate the complexities of childbirth.[570] The foundation added that current support and resources for fathers is lacking, leaving many to grapple with increased distress and uncertainty, which may cause increased or longer-term distress for the patient.[571]

4.72 This concern was echoed by registered psychologist Ms Alysha-leigh Fameli who told the committee:

> In terms of education around childbirth, I think it's really important that we talk to partners about the things that they might see and what it might feel like to be a bystander. Vicarious trauma can be as visceral as experiencing it yourself. Often one of the things I see is that birth partners come into treatment to support their wives or their partners and their responses are so visceral and so intense that they're actually part of the system that's retraumatising their wife, particularly if they go to have another baby.[572]

4.73 Evidence indicated that providing targeted support strategies and resources can empower fathers and non-birthing parents to better understand and address both the physical and psychological impacts of birth trauma on maternal wellbeing. According to the Prepare Foundation, encouraging open communication, creating a supportive environment, and actively participating in medical appointments and therapy sessions can help fathers alleviate their partners' distress and navigate their own emotional challenges. The foundation also suggested that targeted antenatal education for first time fathers could equip them with essential information and strategies to reduce the incidence of birth trauma.[573]

4.74 Stakeholders suggested that with improved understanding and access to professional support, fathers and non-birthing parents can play a pivotal role in facilitating their partners' recovery from birth trauma and promote family wellbeing.[574]

Challenges associated with pregnancy loss and genetic diagnosis

4.75 This section discusses the prevalence and challenges associated with miscarriage and stillbirth in New South Wales, highlighting the psychological impacts of grief and loss. It also explores the difficulties encountered when fetal conditions and disabilities, such as Down syndrome, are diagnosed, and the challenges families face when navigating support systems.

570 Submission 1051, Prepare Foundation, pp 2 and 5.

571 Submission 1051, Prepare Foundation, pp 2 and 5.

572 Evidence, Ms Alysha-Leigh Fameli, Registered Psychologist, PhD candidate, University of Sydney, 8 April 2024, p 33.

573 Submission 1051, Prepare Foundation, p 3.

574 See, Submission 1051, Prepare Foundation, p 4; Evidence, Ms Alysha-Leigh Fameli, Registered Psychologist, PhD candidate, University of Sydney, 8 April 2024, p 33; Evidence, Ms Sahra Behardien O'Doherty, President, Australian Association of Psychologists Inc, 8 April 2024, p 34.

Miscarriage and stillbirth

4.76 Evidence provided by some stakeholders revealed the common experience of miscarriage, stillbirth and infant death in New South Wales and the impact these experiences can have on expecting parents.

4.77 The Early Pregnancy Grief and Loss Coalition stated that early pregnancy loss is estimated to affect between one-in-three and one-in-four known pregnancies.[575] The aftermath of such loss often includes heightened levels of depression, anxiety and post-traumatic stress disorder, impacting subsequent pregnancies as well. The Early Pregnancy Grief and Loss Coalition highlighted that the lack of support and acknowledgement of these losses in healthcare and social settings can exacerbate feelings of isolation and grief among affected individuals and families.[576]

4.78 The Early Pregnancy Grief and Loss Coalition indicated that despite the common occurrence of early pregnancy loss, many individuals are not provided with information about available support or counselling services, with nearly two-thirds of their survey participants reporting that they were not offered any information about miscarriage or pregnancy loss or referral to counselling services.[577]

4.79 The Early Pregnancy Grief and Loss Coalition informed the committee that the challenges are particularly difficult for those who experience pregnancy loss in healthcare and maternity care settings. For example:

- those who experience miscarriage in emergency departments are often classified as non-urgent cases, leading to delays in care and clinical, rather than empathetic treatment
- individuals seeking care in Early Pregnancy Assessment Service units for pregnancy loss often endure ongoing trauma by sharing waiting areas with pregnant individuals not experiencing complications, which is contrary to policy guidelines that calls for discrete waiting areas
- women experiencing miscarriage or stillbirth in maternity units may encounter birth trauma when inadvertently exposed to the sights and sounds of healthy babies which compounds their grief.[578]

4.80 One witness to the inquiry, Ms Mary van Reyk, spoke about the miscarriages she experienced throughout her pregnancy journey. Her first miscarriage occurred in a hospital waiting room designated for pregnant women. She described sitting for hours surrounded by expectant mothers, feeling increasingly distressed. She said it was not until her partner demanded that she be taken to a private space that the hospital staff finally took her to a consultation room and informed her of her miscarriage. Ms van Reyk called for a dedicated space separate from maternity care where she could process and ask questions about her experience.[579]

575 Submission 243, Early Pregnancy Loss Coalition, p 12.

576 Submission 243, Early Pregnancy Loss Coalition, p 12.

577 Submission 243, Early Pregnancy Loss Coalition, p 13.

578 Submission 243, Early Pregnancy Loss Coalition, pp 14-15.

579 Evidence, Ms Mary van Reyk, Individual, 11 March 2024, p 2.

4.81 Ms Naomi Bowden shared a similar account of stillbirth illustrating the profound trauma experienced by individuals and families in such circumstances. Ms Bowden recounted the events surrounding the loss of her daughter Bella in 2009. Ms Bowden told the committee of her experience of being kept in the maternity ward overnight and hearing the sounds of new mothers and healthy babies crying while grieving her loss. Being in a maternity ward was an overwhelming experience for Ms Bowden and did not provide her with the necessary support she required in that situation.[580]

4.82 Ms Bowden also recounted having to identify her daughter's body to authorities, and the distress she experienced when she went to her six-week check-up appointment with hospital staff and was asked, "Where's your baby?", because staff had 'not informed them or even read my files before seeing me'. Ms Bowden reflected that:

> The death of my baby was heartbreaking enough, but it was the disrespectful, inappropriate and appalling treating by numerous staff at this hospital, and the complete lack of care in the hours and weeks and months after losing my daughter Bella that exacerbated and compounded and left me profoundly traumatised.[581]

4.83 Ms Bowden advocated for improved training and policies around miscarriage and pregnancy loss, emphasising the critical need for ongoing support.[582]

4.84 In addition to the impact on the mother, many stakeholders, including Zamzam Mums and Bubs and The Still Nest, identified the severe psychosocial impact that pregnancy loss can have on the families, which can be exacerbated by barriers such as financial, language, geography, and access to resources.[583]

4.85 NSW Health acknowledged the increased risk of birth trauma among individuals experiencing miscarriage and stillbirths.[584] The department advised of the implementation of the *The Safer Baby Bundle* across NSW Health maternity services focused on evidence-based elements of maternity care to reduce preventable stillbirths. Moreover, it highlights the importance of providing high-quality and culturally safe bereavement care to parents and families following the death of a baby, recognising the significant impact of respectful bereavement care on coping with grief.[585]

Genetic conditions and congenital anomalies

4.86 The committee heard evidence regarding the challenges faced by families who receive a prenatal diagnosis of fetal anomalies or genetic conditions, with concerns raised about the lack of psychological support available for affected families.

4.87 Stakeholders such as Through the Unexpected, told the committee that the current rate of parents who received a prenatal diagnosis of fetal anomaly is unknown, as state and territory

580 Evidence, Ms Naomi Bowden, Individual, 7 September 2023, p 2.

581 Evidence, Ms Naomi Bowden, Individual, 7 September 2023, p 2.

582 Evidence, Ms Naomi Bowden, Individual, 7 September 2023, p 2.

583 Submission 929, Zamzam Mums and Bubs and The Still Nest, p 14.

584 Submission 862, NSW Health, p 22.

585 Submission 862, NSW Health, p 22.

registers do not keep records. However, a recent available report suggests a congenital condition affects in one in every 32 births.[586]

4.88 According to Through the Unexpected, parents receiving these diagnoses do not receive sufficient psychosocial support due to a lack of specialised training for clinicians.[587] Furthermore, Through the Unexpected noted that clinicians feel 'ill-equipped' to care for these families due to gaps in their knowledge.[588]

4.89 Ms Pieta Shakes from Through the Unexpected spoke about the stresses some parents feel after receiving a diagnosis. She told the committee that parents are often asked to make life-changing decisions in a short timeframe with limited support. For example, parents described receiving a diagnosis and then feeling 'pressure' to decide if they wish to terminate within a single appointment.[589] Ms Shakes spoke about the importance of 'slowing down' this process and meeting people 'where they are at', sitting with them as they process this news, and providing compassionate and individualised care.[590]

4.90 A common genetic condition the committee heard about was Down syndrome. Down syndrome is characterised by individuals having an extra chromosome 21. In Australia, approximately 13,000 people have Down syndrome, with a birth rate of about one in every 1,100 births.[591] Statistics provided by Down Syndrome NSW indicated that 9 out of 10 pregnancies diagnosed with Down syndrome are terminated.[592] According to Down Syndrome NSW, these choices are often based on 'outdated information' and 'discussions about limitations not possibilities'.[593]

4.91 Down Syndrome NSW highlighted that Down syndrome is not an illness or disease, but simply a variation resulting in unique strengths, physical characteristics, intellectual disability to varying degrees, increased health risks, and developmental delays.[594]

4.92 Ms Emily Caska and Ms Melissa Cotterill from Down Syndrome NSW spoke about the pervasive negative stereotypes and assumptions many people within the healthcare profession have about Down syndrome. They described how many families feel pressure to terminate their pregnancies or conceal the truth about the diagnosis which can lead to birth trauma.[595]

4.93 Approximately 95 to 98 per cent of families report poor perinatal experiences, marked by outdated information and discussions focussed on limitations rather than possibilities. Ms Caska stated that health professionals often contribute to the trauma, perpetuating misconceptions about life expectancy and capabilities.[596] Ms Cotterill added that the Down Syndrome NSW

586 Submission 246, Through the Unexpected, p 2.
587 Submission 246, Through the Unexpected, p 5.
588 Submission 246, Through the Unexpected, p 5.
589 Evidence, Ms Pieta Shakes, Executive Director, Through the Unexpected, 8 April 2024, p 28.
590 Evidence, Ms Pieta Shakes, Executive Director, Through the Unexpected, 8 April 2024, p 28
591 Submission 945, Down Syndrome NSW, p 30.
592 Submission 945, Down Syndrome NSW, p 30.
593 Submission 945, Down Syndrome NSW, p 6.
594 Submission 945, Down Syndrome NSW, p 30.
595 Evidence, Ms Emily Caska, Chief Executive Officer, Down Syndrome NSW, 11 March 2024, p 52.
596 Evidence, Ms Emily Caska, Chief Executive Officer, Down Syndrome NSW, 11 March 2024, p 52.

Congratulations Initiative strives to counteract these negative assumptions and provide up to date data and education about Down syndrome to ensure families receive support upon diagnosis.[597]

4.94 Stakeholders further highlighted the current shortcomings in the maternity care system's ability to assist families facing a pre-natal diagnosis. Through the Unexpected noted the high rates of post-traumatic stress disorder and suicidal ideation among mothers in this situation. To address these challenges, Through the Unexpected advocated for improved policies and processes for managing diagnosis, increased psychological support for families, and allowing individuals sufficient time to consider their options, while respecting their individual circumstances.[598]

Committee comment

4.95 In addition to factors in the healthcare system contributing to birth trauma, the committee acknowledges that the way individuals respond to a traumatic birth is heavily influenced by their unique circumstances and life experiences. Consequently, a 'one size fits all' approach is inadequate for the New South Wales maternity care system. Rather, tailoring care to meet the needs of individuals is essential for improving outcomes.

Finding 5

That a 'one size fits all' approach is inadequate for the New South Wales maternity care system and that tailoring care to meet the needs of individuals is essential for improving outcomes.

4.96 As discussed in Chapter 3, trauma-informed care is an important component in preventing or minimising birth trauma. We also heard that it can play a vital role in creating a supportive, inclusive and compassionate environment for all. The committee therefore reiterates its recommendation that the NSW Government reaffirm its commitment to trauma-informed care by funding and providing education to all maternity health practitioners on trauma-informed practice.

4.97 The committee learned that the maternity care system in New South Wales is not always inclusive, including for First Nations people, culturally and linguistically diverse communities, refugees, LGBTQIA+ individuals and families, young parents, regional, rural and remote communities, people with pre-existing conditions and disabilities, and fathers and non-birthing parents. The committee believes that maternity care must be an inclusive and safe place for all families and was distressed to hear experiences where this was not occurring.

4.98 The committee also acknowledges the added challenges faced by those who experience pregnancy loss or receive genetic diagnoses and recognises system failures that has caused further trauma for these parents.

4.99 First, the committee recognises the significant disparities in maternity care faced by First Nations women and babies, including higher rates of birth trauma, premature birth, maternal deaths, and perinatal deaths. These disparities can be attributed to a myriad of factors such as

597 Evidence, Ms Melissa Cotterill, Prenatal and New Baby Manager, Congratulations Initiative, Down Syndrome NSW, 11 March 2024, p 53.

598 Evidence, Ms Pieta Shakes, Executive Director, Through the Unexpected, 8 April 2024, p 28.

the fragmented healthcare system in regional, rural and remote areas, intergenerational trauma, and a lack of culturally appropriate care models. The committee recommends expanding initiatives like Birthing on Country, which has demonstrated significant improvements in maternal health outcomes for First Nations women.

Recommendation 33

That the NSW Government ensure culturally safe maternity care is accessible for all First Nations mothers and babies by:

- investing in and expanding Birthing on Country models of maternity care
- increasing the First Nations maternity workforce
- implementing training for healthcare practitioners to deliver culturally safe care to First Nations women.

4.100 Evidence to this inquiry highlighted a range of challenges faced by other diverse groups and demographics within the New South Wales maternity healthcare system. We heard that culturally and linguistically diverse women encounter language barriers and lack of culturally safe care, while refugees experience added challenges stemming from past traumatic experiences and resettlement stressors.

4.101 The committee was particularly shocked to hear about incidences of racism and discrimination within the maternity care system in New South Wales, and the lack of culturally safe and responsive maternity care. The committee recognises that safety and respect for all birthing women is paramount.

4.102 We also heard that LGBTQIA+ individuals can encounter prejudice and discrimination within traditional maternity healthcare settings, and that many young parents experience negative stereotyping and dismissive treatment. Similarly, individuals with pre-existing conditions and disabilities encounter barriers accessing maternity care and negative assumptions about their capacity to parent. The committee recognises these experiences are unacceptable.

4.103 Those living in regional, rural and remote areas face limited options of care, staff shortages, and financial burdens associated with travel. The committee recognises the work done in this space in 2022 in the Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales, and the solutions put forward in that report.

4.104 Additionally, we heard that fathers' and non-birthing parents' needs are often overlooked and require recognition within maternity care spaces.

4.105 The committee acknowledges the additional challenges faced by various groups can contribute to and/or exacerbate birth trauma. It is therefore important for the government to acknowledge and address the diverse needs of various demographics in the maternity care system.

Recommendation 34

That the NSW Government acknowledge and address the diverse needs of various demographics in the maternity care system by:

- ensuring education and training for healthcare practitioners on the unique health and support needs of First Nations people, culturally and linguistically diverse communities, refugees, LGBTQIA+ individuals, young parents, individuals from rural and regional communities, individuals with pre-existing conditions and disability, and fathers and non-birthing parents
- designing specialised services and programs tailored to diverse demographics
- providing additional financial support for parents traveling from regional, rural and remote areas
- implementing the recommendations of the 2022 inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales.
- upgrading equipment and increasing accessibility for people with disabilities in maternity care spaces
- increasing access to antenatal education and postpartum support services for fathers and non-birthing parents, including online support groups
- ensuring fathers, non-birthing parents and nominated birth partners are keep informed throughout birth, to enable them to advocate
- ensuring access to professional interpreters with medical training and, where possible, continuity of interpreter
- investigating any allegations of racism and discrimination within maternity care in New South Wales
- providing appropriate education and training for maternity healthcare practitioners to address concerns around racism and discrimination.

4.106 Stakeholders presented compelling evidence highlighting the traumatic effects of miscarriage and stillbirth, which the committee understands can be unnecessarily exacerbated by shortcomings in maternity care. This includes insufficient counselling and psychological support, and inadequate privacy and space for grieving.

Recommendation 35

That the NSW Government ensure dedicated spaces are available for parents experiencing miscarriage or stillbirth in all healthcare settings, including private waiting rooms separate from pregnant women, new mothers and babies, and that all maternity healthcare practitioners are provided training on bereavement support.

Recommendation 36

That the NSW Government improve psychological support for parents managing grief following pregnancy loss.

4.107 Finally, the committee was also shocked to hear about the lack of support for families receiving prenatal diagnosis of fetal anomalies or genetic conditions. It is evident that there is an urgent need to enhance policies and guidelines to help clinicians better manage these diagnoses sensitively.

Recommendation 37

That the NSW Government review and revise guidelines for informing parents of fetal anomalies and genetic conditions ensuring that clinicians:

- present unbiased options
- offer ample time and support for decision-making
- provide trauma-informed assistance and psychological support to aid parents in coping with the emotional impact of such diagnoses.

Recommendation 38

That NSW Health liaise with peak and parent bodies representing parents, children and families with members who have fetal abnormalities or genetic conditions and arrange with them to provide information on a website about support and education for expectant parents with a child diagnosed with these issues. This website should be circulated widely among expectant parents.

Chapter 5 The medico-legal environment and complaints handling mechanisms

This chapter examines the legal responsibilities of maternity healthcare providers and how these obligations can affect the provision of patient-centred care. It also explores the pathways available to address concerns and seek accountability for individuals who have experienced birth trauma.

Legal liability, fear of litigation and birth preferences

5.1 As discussed in Chapter 3, numerous stakeholders in this inquiry highlighted the importance of women being supported to achieve their birth plans and preferences, wherever possible.

5.2 Stakeholders also raised concerns about the way hospital guidelines, policies and protocols are frequently written in ways that 'mandate' routine interventions that women may not want, such as repeat vaginal examinations, fetal monitoring, and pitocin induction of labour – and the distress many women felt at having these routine interventions forced upon them, without their genuine informed consent.

5.3 However, the committee also heard that legal liability and fear of litigation can heavily influence maternity healthcare practices. Ultimately, stakeholders argued that despite efforts to prioritise patient well-being, the prevailing medico-legal climate fosters a risk-averse healthcare system, where adherence to guidelines is strongly encouraged to mitigate legal risks.[599] Some stakeholders therefore advocated for legislative support to balance patient rights with legal protection for maternity care clinicians.[600]

5.4 For example, according to the NSW Nurses and Midwives' Association the fear of litigation can lead to restrictive hospital policies and practices, with unintended consequences for patient care.[601]

5.5 Dr Carl Henman, GP Obstetrician and O&G Sonologist at Nova Health, highlighted the tension between rigid adherence to guidelines and the need for individualised care. He stated that while guidelines are necessary to ensure safety, they should not hinder tailored approaches that may fall outside standard protocols. Dr Henman stressed the importance of considering the unique circumstances of each patient, advocating for a balance between adherence to guidelines and personalised care.[602]

599 See for example, Evidence, Dr Carl Henman, GP Obstetrician, O&G Sonologist, Nova Health, 12 December 2023, p 31.

600 See for example, Dr Jared Watts, Board Director, Royal Australian College of Obstetricians and Gynaecologists, 4 September 2023, p 5; Evidence, Dr Carl Henman, GP Obstetrician, O&G Sonologist, Nova Health, 12 December 2023, p 30; Evidence, Dr Trudi Beck, GP Obstetrician, Nova Health and Murrumbidgee Region GP Antenatal Shared Care Program, 12 December 2023, p 24.

601 Evidence, Mr Michael Whaites, Assistant General Secretary, NSW Nurses and Midwives' Association, 4 September 2023, p 50.

602 Evidence, Dr Carl Henman, GP Obstetrician, O&G Sonologist, Nova Health, 12 December 2023, p 30.

5.6 Stakeholders including Leeton Midwifery Group Practice and Royal Australian College of Obstetricians and Gynaecologists (RANZCOG), spoke about how medico-legal implications and fear of litigation drives healthcare providers to be risk adverse and less likely to accommodate non-standard birth plans.[603] Dr Jared Watts, Board Director, at RANZCOG, noted the pressure on obstetricians to avoid adverse outcomes due to potential legal repercussions resulting in obstetricians taking a more cautious approach.[604] Dr Watts stressed the need for legislative support to shield healthcare providers and hospitals when patients opt for non-standard birth plans:

> If we are going to support women to have a non-standard management plan, if things do go wrong, we must have the legislative support to say, "We counselled you correctly. This is the decision you made. If you change your mind, we are there to support you at any time," but there is protection for the obstetricians and the midwives to be able to provide that care for the patients.[605]

5.7 Other stakeholders shared similar tensions that exist in other environments.

- Dr Aimee Sing, Vice President at Homebirth NSW, noted barriers faced by privately practicing midwives due to liability and insurance concerns, limiting access to homebirth options.[606]
- GP Obstetrician, Dr Trudi Beck highlighted the impact of the medico-legal environment on collaborative care, including the challenge of balancing well-intentioned hospital safety protocols with individualised care.[607]

Accountability and complaints handling mechanisms

5.8 A number of mothers shared with the committee their firsthand accounts of seeking justice and accountability following traumatic births. This section considers the adequacy of the following accountability mechanisms:

- complaints to the Health Care Complaints Commission
- legal action
- reports or complaints directly to the hospital or other healthcare organisation where care was provided.

603 Evidence, Ms Leselle Herman, Midwife, Leeton Midwifery Group Practice, 12 December 2023, pp 33-34.

604 Evidence, Dr Jared Watts, Board Director, Royal Australian College of Obstetricians and Gynaecologists, 4 September 2023, p 5.

605 Evidence, Dr Jared Watts, Board Director, Royal Australian College of Obstetricians and Gynaecologists, 4 September 2023, p 9.

606 Evidence, Dr Aimee Sing, Vice President, Homebirth NSW, 11 March 2024, p 49.

607 Evidence, Dr Trudi Beck, GP Obstetrician, Nova Health and Murrumbidgee Region GP Antenatal Shared Care Program, 12 December 2023, p 24.

Health Care Complaints Commission

5.9 The Health Care Complaints Commission (HCCC) in New South Wales provides an avenue to safeguard public health and safety by addressing complaints about healthcare services.[608] Established under the *Health Care Complaints Act 1993*, it is an independent body responsible for resolving, investigating, and prosecuting complaints concerning all health services and providers in New South Wales.[609] Any individual or their representative can lodge a complaint with the HCCC, or the HCCC can initiate complaints on its own if significant risks to the public are identified.[610]

5.10 A number of concerns were raised by stakeholders including Western Sydney University, Maternity Consumer Network, and Human Rights in Childbirth, about the effectiveness of the HCCC in responding to complaints, particularly in the maternity healthcare system. Maternity Consumer Network criticised the system's lack of accountability, noting that complaints often result in minimal consequences for healthcare providers, hindering improvements in service delivery.[611] Ms Emilia Bhat, President of Maternity Consumer Network, characterised the current system as 'demoralising'.[612] Dr Bashi Kumar-Hazard from Human Rights in Childbirth argued that lodging a complaint is 'largely a waste of time' due to the 'remit of the HCCC'. [613]

5.11 Other stakeholders also commented on the remit of the HCCC. Human Rights in Childbirth argued the issue lies within the scope of the HCCC. Dr Bashi Kumar-Hazard, Chair of Human Rights in Childbirth, stated that complaints regarding mistreatment that does not result in physical harm are often dismissed, even if there are multiple breaches or complaints to investigate allegations, with the justification that the provider was well intentioned and 'meant no harm'. Dr Kumar-Hazard stated that this apparent dismissal echoes past narratives used to excuse domestic violence.[614] She said that for women, 'being told that the violence they experienced at the hands of a provider was not sufficiently important having regard to the outcome is a devastating experience and compounds the injuries they experience'.[615]

5.12 Although the HCCC states that they may confer with the parties during their investigation, Maternity Consumer Network gave evidence that, in their experience, the HCCC does not take the time to speak with patients about their complaint and believes this to be a significant process gap when assessment or investigation of the matter is underway.[616]

5.13 Furthermore, Dr Hazel Keedle from Western Sydney University School of Nursing and Midwifery, highlighted challenges faced by women in navigating the complaints process, often

608 Submission 862, NSW Health, p 45.

609 Submission 862, NSW Health, p 45.

610 Submission 862, NSW Health, p 45.

611 Evidence, Ms Emilia Bhat, President, Maternity Consumer Network, 9 October 2023, p 18.

612 Evidence, Ms Emilia Bhat, President, Maternity Consumer Network, 9 October 2023, p 18.

613 Answers to questions on notice, Dr Bashi Kumar-Hazard, Chair, Human Rights in Childbirth, 7 October 2023, p 3.

614 Answers to questions on notice, Dr Bashi Kumar-Hazard, Chair, Human Rights in Childbirth, 7 October 2023, pp 3-4.

615 Answers to questions on notice, Dr Bashi Kumar-Hazard, Chair, Human Rights in Childbirth, 7 October 2023, pp 3-4.

616 Evidence, Ms Emilia Bhat, President, Maternity Consumer Network, 9 October 2023, p 15.

due to a lack of awareness about available options or inadequate responses from healthcare facilities.[617]

5.14 Dr Kumar-Hazard recommended a number of reforms to the HCCC framework, including powers to:

- require all maternity care providers to provide consumers with information about their rights
- enforce a Code of Rights/human rights legislation either through a complaint or of its own initiative
- provide consumers with direct access to a specialised division within the HCCC, independent of the professional boards, for complaints concerning violations of their rights
- accept and use consumer video and/or audio recordings of health care treatment without breaching the Surveillance Devices Act 2007 (NSW)
- implement a range of accountability measures such as strict liability pecuniary penalties for minor (as defined) violations, disciplinary proceedings for repeat offenders, legal proceedings for rights violations against facilities and/or providers
- depending on the nature of the complaint, refer incidences of obstetric violence to the police, the Anti-Discrimination Board or any other facility that can more appropriately deal with the subject matter of that complaint
- monitor and report on rights violations to NSW Health and to Parliament on an annual basis.[618]

Legal action

5.15 Beyond the HCCC, consumers have few other avenues for seeking justice when they have experienced mistreatment or trauma during childbirth. The committee heard that these alternatives, like the HCCC, have limited capacity to hold practitioners accountable. As a result, stakeholders such as the NSW Nurses and Midwives' Association called for more effective mechanisms to deter misconduct and ensure accountability.[619]

5.16 One option the committee heard is to pursue civil legal action, such as filing a medical negligence lawsuit. However, according to stakeholders, this can be emotionally and financially burdensome. Ms Emilia Bhat, President of Maternity Consumer Network, highlighted the challenges, noting that often serious physical injuries are required for civil cases, leaving many victims without recourse. The mental toll of legal proceedings can also be a deterrent for some seeking justice through this route. Ms Bhat reiterated there is currently no specific legislation in New South Wales to address obstetric violence, leaving a gap in legal protections for birthing women.[620] See Chapter 2 for more detail about the debate around the term 'obstetric violence'.

617 Evidence, Dr Hazel Keedle, School of Nursing and Midwifery, Western Sydney University, 4 September, p 40.

618 Answers to questions on notice, Dr Bashi Kumar-Hazard, Chair, Human Rights in Childbirth, 7 October 2023, p 4.

619 Submission 242, NSW Nurses and Midwives' Association, p 18.

620 Evidence, Ms Emilia Bhat, President, Maternity Consumer Network, 9 October, p 21.

5.17 Dr Bashi Kumar-Hazard highlighted that it is very difficult for women to commence civil legal action in New South Wales in relation to birth trauma due to significant restrictions in the *Civil Liability Act* 2002 (NSW) and argued that 'women aren't really getting access to justice' through this system.[621]

5.18 Even where options for civil action are technically possible for some, the emotional and financial cost can be prohibitive for many. For example, Mrs Rachelle Edwards outlined the challenges of trying to seek justice through legal action:

> [T]he mental trauma that going through legal action and the dragging out of the worst moments of your life, not just at that point in time but prior to that—they'll drag you out through everything because they want to avoid paying. Really, you're in a no-win situation… I can't go through the legal system; I don't have it in me.[622]

5.19 Human Rights in Childbirth argued that Australia is obliged (under the Convention on the Elimination of All Forms of Discrimination Against Women) to establish a 'Patients' Bill of Rights', and that NSW should take to steps to develop this legislation, ensuring it includes the following:

- provision for the protection from obstetric violence and recognises the right to informed consent and the right to choose or refuse treatment;
- authorises consumer video and/or audio recordings in birthing suites;
- provides consumers with an avenue to complain against providers and/or facilities for breaches to HCCC for investigation; and
- gives consumers standing to commence proceedings against facilities and individual providers for rights violations, including obstetric violence.[623]

5.20 Some stakeholders advocated for the establishment of a government-funded legal clinic dedicated to supporting victims to assist with alleviating some of the challenges of undertaking this course of action for serious cases.[624]

Healthcare system internal feedback and accountability mechanisms

5.21 A number of stakeholders identified that women often pursue complaints about mistreatment directly with the healthcare provider with the goal of preventing others from facing similar experiences.[625] Zamzam Mums and Bubs and The Still Nest advocated for improved support and guidance for birthing women in navigating the complaints process. They emphasised the importance of comprehensive advice and proactive assistance from hospitals to facilitate complaint handling and improve patient safety processes. Currently, the burden often falls on the birthing women to engage with the system, highlighting the need for more proactive measures to gather feedback and address concerns within the maternity healthcare system.[626]

621 Evidence, Dr Bashi Kumar-Hazard, Chair, Human Rights in Childbirth, 4 September 2023, p 45.

622 Evidence, Mrs Rachelle Edwards, Individual, 9 October 2023, pp 15-16.

623 Submission 409, Human Rights in Childbirth, pp 56-57.

624 See for example, Submission 253, Maternity Choices Australia, p 12; Answers to questions on notice, Dr Bashi Kumar-Hazard, Chair, Human Rights in Childbirth, 7 October 2023; Evidence, Ms Emilia Bhat, President, Maternity Consumer Network, 9 October 2023, p 18.

625 See for example, Submission 409, Human Rights in Childbirth, p 38.

626 Submission 929, Zamzam Mums and Bubs and The Still Nest, p 21.

5.22 However, some stakeholders considered it problematic for complaints to be managed directly with the healthcare provider. For example, Maternity Consumer Network argued that it is inappropriate to expect women to complain about abuse and mistreatment directly, including to maternity services.[627]

5.23 Human Rights in Childbirth highlighted a systematic issue where service providers tend to self-assess complaints, often to mitigate liability concerns or to follow insurer recommendations. This perpetuates a culture that prioritises medico-legal outcomes over human rights, hindering efforts to address mistreatment effectively within the healthcare system.[628] They also highlighted that 'women who speak up about mistreatment will be told that they are very lucky to be giving birth in one of the safest countries in the world and that they should be grateful for a healthy baby'.[629]

5.24 Some consumers expressed their challenges with making complaints.

- 'Despite being a lawyer and assisting others to lodge a complaint about their issues, it felt too overwhelming to take the steps to do this for myself. It has taken me 4.5 years to write down and reflect on the issues I experienced during my birth'.[630]
- 'The hospital offered a "debrief" when I asked how to make a report. All debriefs are gaslighting patients in to believing what was done to them was necessary so I declined. I could not afford a lawyer and the free ones kindly told me to not bother as it's not often people win against public hospitals as you can't necessarily prove your claims really happened. Nurses don't go against doctors and doctors don't go against each other and so I accepted I could do nothing'.[631]

5.25 The Australian Lawyers Alliance recommended that 'where processes fail and women (or their support networks) experience birth trauma, there must be adequate, independent and responsive complaints processes in place'.[632]

5.26 Other stakeholders identified accountability mechanisms that they considered to be more effective for consumers such as:

- establishing formal debriefing clinics
- providing ways for consumers to give feedback directly to the hospital in their own time.

5.27 According to Obstetrician and Gynaecologist Dr Maria del Pilar Luna Ramirez, debriefing aims to provide 'women and families the opportunity to clarify or explain the events related [to] the

627 Evidence, Ms Azure Rigney, National Advocacy Manager, Maternity Choices Australia, 4 September 2023, pp 14-15.

628 Submission 409, Human Rights in Childbirth, p 38.

629 Submission 409, Human Rights in Childbirth, p 29.

630 Submission 929, Zamzam Mums and Bubs and The Still Nest, p 3.

631 Submission 792, Name suppressed, p 4.

632 Submission 234, Australian Lawyers Association, p 36.

birth'.[633] GP Obstetrician Dr Carl Henman, highlighted that appropriate debriefing can help to reduce the long-term impacts of birth trauma.[634]

5.28 As a clinical midwifery consultant, Ms Fiona Reid established a formal debriefing clinic after seeing how ineffective the debriefing process was within the hospital she consulted. Aware of the research demonstrating a strong connection between ineffective or non-existent debriefing and poor postpartum mental health,[635] Ms Reid developed a formal debriefing program for clients based on neurophysiological research of trauma.

5.29 In terms of time period that debriefs should be conducted, Ms Reid advised the committee that the research is unclear regarding when the most effective time for debriefing is after the birth due to varying factors such as how the trauma has affected the brain's ability to process the events.[636] However, in order to support self-determined healthcare, Ms Reid emphasised the importance for the woman to have the option to visit a formal debriefing clinic, have awareness that the service exists, and be supported to access its services should she wish.[637] Though the clinics could be established as part of the hospital system, Ms Reid strongly recommended that the clinics should not be physically held within the hospital as this could trigger a trauma response upon re-entry.

5.30 The committee also heard that receiving direct consumer feedback can help to improve maternity services and assist with accountability. Recognising the importance of allowing consumers to provide feedback when ready to do so, Dr Maria Del Pilar Luna Ramirez shared a proactive initiative in northern New South Wales currently being trialled, where women receive a QR code after childbirth, giving them an avenue to provide feedback or complaints online at any time. Dr Ramirez suggested that this pathway, managed by the midwifery unit manager, facilitates continuous improvements in maternity care.[638]

5.31 NSW Health stated that they were 'committed to listening and connecting' with women and responding to their consumer concerns and using feedback to enhance maternity care.[639] They outlined their approach to handling complaints against health practitioners under various policy directives, including *Incident Management*, which aims to foster a culture of learning following adverse events to prevent future occurrences.[640]

633 Submission 38, Dr Maria del Pilar Luna Ramirez, p 1.

634 Evidence, Dr Carl Henman, GP Obstetrician, O&G Sonologist, Nova Health, 12 December 2023, p 31.

635 Evidence, Ms Fiona Reid, Clinical midwife consultant, 7 September 2023, pp 29-36; Submission 24, Ms Fiona Reid, p 1.

636 For example, Ms Fiona Reid offered formal debriefings at 12 weeks following the birthing event for clients.

637 Evidence, Ms Fiona Reid, Clinical midwife consultant, 7 September 2023, p 31.

638 Evidence, Dr Maria Del Pilar Luna Ramirez, Obstetrician and Gynaecologist staff specialist, Acting Head of Department, Women's care unit, Northern NSW Local Health District, 11 March 2024, p 64.

639 Submission 862, NSW Health, p 42.

640 Submission 862, NSW Health, p 39.

Case study – Complaints regarding Wagga Wagga Base Hospital

5.32 In 2022, the Maternity Consumer Network lodged a complaint with the Health Care Complaints Commission on behalf of 30 women who endured traumatic birth experiences at Wagga Wagga Base Hospital. These reports included allegations of disrespectful and abusive treatments, leading to investigations both within the local health district and statewide.[641]

5.33 At the committee's hearing in Wagga Wagga, Ms Jill Ludford, Chief Executive of the Murrumbidgee Local Health District, publicly apologised to these women, acknowledging their suffering and the profound impact of birth trauma on their lives:

> On behalf of the Murrumbidgee Local Health District, I sincerely apologise to the women who have accessed our maternity services and found that their needs or expectations were not met. I'm sorry we let you down, and I acknowledge the legacy birth trauma can have on a woman's mental, physical, social and emotional wellbeing and the impacts on their family.[642]

5.34 Following the apology, senior representatives from the local health district and the hospital provided updates on reforms implemented since the complaints surfaced. Measures included appointing a clinical director in obstetrics and gynaecology, forming a consumer group for care co-design, and the introduction of a post-natal follow up service.[643] This work is ongoing, and at the time of publishing this report, the outcomes of the changes made by Wagga Wagga Base Hospital remain to be seen.

Committee comment

5.35 The committee commends those health practitioners who take an individualised care approach for the women they work with. However, we also acknowledge the tensions that exist for many healthcare professionals between providing individualised care and legal liability. Stakeholders shared with us that this can create a risk averse environment. It is unacceptable to enforce standardised policies when informed consent has not been properly obtained, or when the interventions are not in the best interests of the birthing woman. We implore the NSW Government to work with stakeholders to legislate protections for healthcare practitioners to ensure they can deliver individualised, responsive maternity care and ensure consumers' birthing decisions and preferences can be supported and respected. We therefore recommend that the NSW Government undertake consultation for this legislative change.

Recommendation 39

That the NSW Government undertake consultation to consider legislative change to protect health practitioners when delivering individualised, responsive maternity care, and ensure that consumers' birthing decisions and preferences can be supported and respected.

641 Kathleen Calderwood, *Investigation underway after 30 women complain about maternity experience at NSW hospital*, (7 June 2023), ABC News.

642 Evidence, Ms Jill Ludford, Chief Executive, Murrumbidgee Local Health District, 12 December 2023, pp 40-49.

643 Evidence, Ms Jill Ludford, Chief Executive, Murrumbidgee Local Health District, 12 December 2023, pp 40-49.

5.36 The committee recognises the serious concerns raised by some stakeholders about the mistreatment some women have experienced within the New South Wales maternity care system, and the difficulties they have faced in obtaining justice through the HCCC or legal system more generally. It is concerning that complaints processes were described as intimidating or 'too hard' by individuals so re-traumatised by the complaints process that they discontinued their complaints. The committee therefore recommends that the Health Care Complaints Commission and its associated disciplinary forums be adequately resourced so as to resolve complaints more quickly, which would reduce distress experienced by both complainants and health practitioners subject to complaints, and to provide more accessible and trauma-informed support to complainants throughout the complaints process.

Recommendation 40

That the NSW Government support the Health Care Complaints Commission and its associated disciplinary forums to be able to resolve complaints more quickly and provide more accessible and trauma-informed support to complainants throughout the complaints process.

5.37 The committee commends proactive initiatives for feedback and complaints such as that with the QR code trialled in Northern New South Wales for consumers to provide feedback in their own time. The committee notes that research indicates that some women may not be able to report their experience while at the hospital or maternity facility due unprocessed or unnoticed trauma. We also acknowledge that consumers may feel pressured to give positive feedback when in the facility for fear of punitive action. Therefore, providing avenues that enable consumers to share when they are ready is a useful approach.

5.38 Based on the evidence received, the committee considers there to be significant value in debriefing clinics to provide an avenue for feedback. In particular, we recognise the benefits of effective and appropriate debriefing to reduce the longstanding effects of trauma. We therefore recommend that the NSW Government establish debriefing clinics. However, it is important that there is some independence from the hospital facility so that those who feel they were mistreated can feel safe to share these experiences with a trauma-informed debriefing counsellor without repercussion or punitive action from the hospital. The committee also acknowledges that re-entering a place where the trauma-inducing event occurred could be triggering. Therefore, there should be an option to debrief with a health practitioner who is independent from the service who provided the care if requested.

Recommendation 41

That the NSW Government establish formal debriefing clinics attached to all public hospitals with maternity services to provide:

- an evidence-based framework for effective debriefing
- the ability for clinics to establish a feedback loop to the hospital for improvements to services, including options to provide feedback online
- an option to debrief with a health practitioner who is independent from the service who provided the care if requested.

5.39 The committee heard that women are often unaware of the avenues available to raise claims of mistreatment in maternity matters or make complaints. Furthermore, the committee is concerned that the remit of the Health Care Complaints Commissions (HCCC) is not suitably sensitive to reviewing, assessing and investigating claims. The committee therefore recommends that the NSW Government review local maternity complaints processes and ensures all pregnant women are provided with information that outlines pathways to ask questions, raise concerns and make complaints. In addition, the Chair of the Select Committee on Birth Trauma should write to the Chair of the Committee on the Health Care Complaints Commission to consider the public reporting of complaints data relating to maternity care and birth trauma.

Recommendation 42

That the NSW Government review local maternity complaint processes and ensure that all pregnant women are provided with information that outlines pathways to ask questions, raise concerns and make complaints.

Recommendation 43

That the Chair of the Select Committee on Birth Trauma write to the Chair of the Committee on the Health Care Complaints Commission to consider the public reporting of complaints data relating to maternity care and birth trauma and its referral processes, including complaints that may have allegations of assault.

Appendix 1 Submissions

No.	Author
1	Name suppressed
2	Name suppressed
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6	Name suppressed
7	Mrs Steffanie Hoschke
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17	Name suppressed
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19	Miss Montana Marsden
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21	Name suppressed
22	Mrs Claire Kilgallon
23	Name suppressed
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24a	Ms Fiona Reid
25	Name suppressed
26	Name suppressed
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28	Name suppressed
29	Name suppressed
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39	Ms Claire Handleman
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43	Name suppressed
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45	Name suppressed
46	Miss Tearnna Mitchell
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49	Ms Hayley Gibbons
50	Name suppressed
51	Mrs Kate Walton
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74	Name suppressed
75	Miss Cassidi-Rae Amosa
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224	Hygieia Health Ltd
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229	Sofya-Mia Marso
230	Confidential
231	Australian Physiotherapy Association
232	Western Sydney University
233	Breastfeeding Advocacy Australia
234	Australian Lawyers Alliance
235	Homebirth New South Wales
236	Parents Work Collective
237	Law Society of New South Wales
238	Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
239	Centre for Women's Health Research and Australian Longitudinal Study on Women's Health
240	Fantastic Futures
241	Perinatal Anxiety & Depression Australia (PANDA)
242	NSW Nurses and Midwives' Association
243	Early Pregnancy Loss Coalition
244	Maternal Health Matters Inc
245	Australian Association of Psychologists Inc
246	Through the Unexpected
247	Confidential
248	Transforming Maternity Care Collaborative and Australian Midwifery and Maternity Alliance
249	Gidget Foundation Australia
250	Miracle Babies Foundation
251	MAMA Midwives
252	Australian Medical Association (NSW)
252a	Australian Medical Association (NSW)
253	Maternity Choices Australia
254	The Australasian Birth Trauma Association
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1348	Dr Rhiannon Dowla
1349	Name suppressed
1350	Name suppressed
1351	Name suppressed
1352	Name suppressed
1353	Name suppressed
1354	Ms Erin Jamieson
1355	Name suppressed
1356	Name suppressed
1357	Name suppressed
1358	Name suppressed
1359	Name suppressed

No.	Author
1360	Confidential
1361	Name suppressed
1362	Name suppressed
1363	Name suppressed
1364	Name suppressed
1366	Name suppressed
1367	Name suppressed
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1370	Name suppressed
1371	Name suppressed
1372	Name suppressed
1373	Emily Mitchell
1374	Name suppressed
1375	Kelly Pearsall
1376	Name suppressed
1377	Name suppressed
1378	Name suppressed
1379	Name suppressed
1380	Name suppressed
1381	Name suppressed
1382	Mrs Kate Holmdahl
1383	Name suppressed
1384	Name suppressed
1385	Name suppressed
1386	Name suppressed
1387	Name suppressed
1388	Name suppressed
1389	Name suppressed
1390	Name suppressed
1391	Name suppressed
1392	Name suppressed
1393	Mrs Jenny Vandewinkel
1394	Ms Stephanie Carroll
1395	Alanah BarringhAm

No.	Author
1396	Name suppressed
1397	Name suppressed
1398	Miss Lauren Baird
1399	Mrs Jane Hardwicke Collings
1399a	Mrs Jane Hardwicke Collings
1399b	Mrs Jane Hardwicke Collings
1402	Mrs Catherine Zahrai
1404	Name suppressed
1407	Name suppressed
1409	Name suppressed
1410	Name suppressed
1412	Name suppressed
1413	Name suppressed
1414	Mrs Alyss Phillips
1415	Name suppressed
1415a	Name suppressed
1417	Name suppressed
1418	Mrs Magenta-Rose KUMAR
1419	Name suppressed
1420	Name suppressed
1421	Miss Jasmine Thom
1422	Name suppressed
1423	Name suppressed
1424	Name suppressed
1425	Name suppressed
1426	Name suppressed
1428	Name suppressed
1429	Name suppressed
1430	Name suppressed
1432	Name suppressed
1433	Name suppressed
1434	Name suppressed
1436	Sandie Pulver
1437	Name suppressed
1438	Allee Wright

No.	Author
1439	Name suppressed
1441	Name suppressed
1442	Name suppressed
1443	Mrs Stacey Walker
1444	Name suppressed
1445	Name suppressed
1446	Confidential
1447	Name suppressed
1448	Name suppressed
1449	Mrs Olga Heath
1450	Name suppressed
1453	Name suppressed
1456	Name suppressed
1463	Miss Madison Neal
1463a	Miss Madison Neal
1464	Name suppressed
1465	Name suppressed
1466	Mrs Kyomi Kobayashi
1466a	Mrs Kyomi Kobayashi
1468	Name suppressed
1470	Name suppressed
1470a	Name suppressed
1471	Name suppressed
1472	Name suppressed
1473	Name suppressed
1480	Name suppressed
	Name suppressed bulk processed short submissions
	Confidential bulk processed short submissions
	Confidential submissions from individuals residing outside NSW
	Confidential submissions received after the deadline

Appendix 2 Witnesses at hearings

Date	Name	Position and Organisation
Monday, 4 September 2023 **Macquarie Room** **Parliament House, Sydney**	Dr Jared Watts	Board Director, Royal Australian College of Obstetricians and Gynaecologists
	Ms Sally Cusack	National Secretary, Maternity Choices Australia
	Ms Azure Rigney	National Advocacy Manager, Maternity Choices Australia
	Ms Amy Dawes OAM	Cofounder and CEO, Australasian Birth Trauma Association
	Ms Amanda Turnill	Chair, Australasian Birth Trauma Association
	Dr Hazel Keedle	School of Nursing and Midwifery, Western Sydney University
	Professor Hannah Dahlen AM	School of Nursing and Midwifery, Western Sydney University
	Dr Bashi Kumar-Hazard	Chair, Human Rights in Childbirth
	Mr Michael Whaites	Assistant General Secretary, NSW Nurses and Midwives Association
	Mrs Gemma Deng	Professional Officer, Midwifery, NSW Nurses and Midwives Association
	Dr Vanessa Scarf	Midwife and NSW Branch Chair, Australian College of Midwives
	Ms Alison Weatherstone	Chief Midwife, Australian College of Midwives
	Ms Deb Willcox AM	Deputy Secretary, Health System Strategy and Planning, NSW Health
	Adjunct Professor Michael Nicholl	Chief Executive, Clinical Excellence Commission, NSW Health
Thursday, 7 September 2023 **Sage Hotel** **Wollongong**	Jessica Holiday	Individual
	Naomi Bowden	Individual
	Amanda Macaulay	Individual

Date	Name	Position and Organisation
	Carly Griffin	Individual
	Olivia Prain	Individual
	Aimee Keating	Individual
	Ms Sharon Settecasse	Vice President, Better Births Illawarra
	Ms Alyssa Booth	Secretary, Better Births Illawarra
	Ms Fiona Reid	Clinical midwife consultant
	Ms Margot Mains	Chief Executive, Illawarra Shoalhaven Local Health District
	Ms Maria Flynn	Executive Director Nursing Midwifery and Clinical Governance, Illawarra Shoalhaven Local Health District
	Dr Andrew Woods	Senior Clinical Advisor Obstetrics, Health and Social Policy Branch, Ministry of Health
Monday, 9 October 2023 **Preston Stanley Room** **Parliament House, Sydney**	Mrs Dulce Munoz	Individual
	Mrs Amy Mageropoulos	Individual
	Mrs Rachelle Edwards	Individual
	Mrs Lyn Leger	Individual
	Ms Elahe Yazdani	Individual
	Ms Emilia Bhat	President, Maternity Consumer Network
	Ms Sharon Coulton Stoliar	PhD Candidate, Registered Midwife & Author
	Dr Rakime Elmir	Senior Lecturer, Deputy Director Clinical Education Midwifery, School of Nursing and Midwifery, Western Sydney University
	Ms Jasmina Bajraktarevic-Hayward	Community Services Coordinator, NSW STARTTS
	Ms Deborah Gould	Senior Consultant, NSW STARTTS

Date	Name	Position and Organisation
	Ms Yusra Metwally	Advocacy Liaison, Zamzam Mums and Bubs
	Ms Saltanat Bora	Co-founder, Zamzam Mums and Bubs
	Dr Fatima El-Assaad *(via videoconference)*	The Still Nest; Senior Research Associate, UNSW
	Ms Melanie Briggs	Birthing on Country, Manager, Waminda
	Ms Cleone Wellington	Cultural Manager/Executive Manager, Waminda
	Ms Shana Quayle	Acting CEO, Aboriginal Health & Medical Research Council of NSW
	Mr Steven Kennedy	Founder and Executive Director, Prepare Foundation
	Dr Alka Kothari	Associate Professor Obstetrics and Gynaecology, University of Queensland, and Prepare Foundation Board Member
	Dr Kathryn Austin	Vice President, AMA (NSW), and Obstetrician, Gynaecologist and Maternal Fetal Medicine subspecialist
	Ms Fiona Davis	CEO, Australian Medical Association (NSW)
Tuesday, 12 December 2023	Ms Laura Johnston	Individual
RSL Club	Mrs Carmel Biddle	Individual
Wagga Wagga	Mrs Francesca Male	Individual
	Mrs Belinda Alexander	Individual
	Miss Stephanie Poll	Individual
	Mrs Hannah Eising	Individual
	Mrs Eilis Sheahan	Individual
	Mrs Courtney Signor	Individual
	Dr Trudi Beck	General Practitioner, Nova Health

Date	Name	Position and Organisation
	Dr Carl Henman	GP Obstetrician, O&G Sonologist, Nova Health
	Ms Leselle Herman	Midwife, Leeton Midwifery Group Practice
	Ms Rebecca Quiring	Clinical Midwifery Educator, Leeton Midwifery Group Practice
	Mr Andrew Heap	Senior Manager Primary Care Engagement, Murrumbidgee Region GP Antenatal Shared Care Program
	Dr Trudi Beck	GP Obstetrician, Murrumbidgee Region GP Antenatal Shared Care Program
	Ms Jill Ludford	Chief Executive, Murrumbidgee Local Health District
	Professor Lenert Bruce	General Manager Wagga Wagga Base Hospital
	Ms Carla Bailey	Executive Director Operations, Murrumbidgee Local Health District
	Ms Sandra Forde	Midwifery Manager, Murrumbidgee Local Health District
Monday, 11 March 2024	Ms Mary van Reyk	Individual
Preston Stanley Room	Ms Tamara Leetham	Individual
Parliament House, Sydney	Ms Alexandra Crichton	Individual
	Mrs Jessica Nash	Individual
	Mrs Jessica Hipsley	Individual
	Mrs Kristyn Begnell	Individual
	Professor Deborah Loxton	Director of the Australian Longitudinal Study on Women's Health and Centre for Women's Health Research, The University of Newcastle

Date	Name	Position and Organisation
	Associate Professor Nicole Reilly	Associate Professor, Perinatal & Women's Mental Health, Discipline of Psychiatry and Mental Health, School of Clinical Medicine, UNSW Sydney and SJOG Burwood Hospital; Mental Senior Research Fellow, Rural Health, Graduate School of Medicine, Faculty of Science, Medicine and Health, University of Wollongong
	Ms Natalie Townsend	Research Executive Manager of the Australian Longitudinal Study on Women's Health and Centre for Women's Health Research, The University of Newcastle
	Ms Catherine Willis	Pelvic Health Physiotherapist, Member Director, Australian Physiotherapy Association
	Ms Sheree DiBase *(via videoconference)*	Lake City Physical Therapy representing Association for Pelvic Organ Prolapse Support
	Dr Jenny King OAM	Head of Department Urogynaecology Westmead Hospital
	Ms Julie Borninkhof	CEO, PANDA
	Ms Karen Edwards	Clinical Director, Gidget Foundation Australia
	Mrs Katelyn Commerford	President, Homebirth NSW
	Dr Aimee Sing	Vice President, Homebirth NSW
	Ms Kristyn Begnell	Coordinator, Homebirth Australia
	Ms Virginia Maddock	Assistant Coordinator, Homebirth Australia
	Ms Emily Caska	CEO, Down Syndrome NSW
	Ms Melissa Cotterill	Congratulations Initiative Manager, Down Syndrome NSW
	Ms Kylie Pussell	CEO and CoFounder, Miracle Babies Foundation
	Ms Fiona O'Shaughnessy	Project Manager, Hygieia Health

Date	Name	Position and Organisation
	Dr Maria Del Pilar Luna Ramirez	Obstetrician and Gynaecologist staff specialist, Acting Head of Department, Women's care unit, Northern NSW Local Health District
Monday, 8 April 2024 **Preston Stanley Room** **Parliament House, Sydney**	Mrs Larissa Palamara *(via videoconference)*	Individual
	Miss Cassidi-Rae Amosa *(via videoconference)*	Individual
	Ms Karen Logan	National President, Childbirth & Parenting Educators of Australia (CAPEA)
	Ms Alison Summerville	Engagement Officer, Childbirth & Parenting Educators of Australia (CAPEA)
	Dr Namira Williams *(via videoconference)*	Chief Executive Officer and Educator, disAbility Maternity Care
	Ms Alysha-leigh Fameli	Registered Psychologist and PhD candidate, University of Sydney
	Ms Sahra Behardien O'Doherty *(via videoconference)*	President, Australian Association of Psychologists Inc
	Ms Pieta Shakes	Executive Director, Through the Unexpected
	Ms Amy Tyson	Doula, Breastfeeding Advocacy Australia
	Dr Susan Tawia *(via videoconference)*	Breastfeeding Researcher and Health Professional Educator, Australian Breastfeeding Association
	Dr Rebekah Hoffman	NSW&ACT Faculty Chair, The Royal Australian College of General Practitioners
	Dr Isabella Sukka	General Practitioner
	Dr Elizabeth Skinner	Academic and lecturer Faculty of Nursing and Midwifery, University of Technology Sydney, Published author and reviewer on birth trauma, Co-founder of Australasian Birth Trauma Association, and Expert/trustee UK Birth Trauma Association

Date	Name	Position and Organisation
	Dr Eveline Staub	Councillor, AMA (NSW) and Neonatal Intensive Care Physician, Royal North Shore Hospital
	Ms Deb Matha	Director, Maternity, Policy and Strategy, Health and Social Policy Branch, Ministry of Health
	Ms Jacinta Selby	Principal Midwifery Manager, Sydney Local Health District, and Midwifery Manager, Concord MGP
	Ms Julie Swain	Deputy Director of Nursing & Midwifery – Women's and Newborn Health, Western Sydney Local Health District
	Dr Andrew Pesce	Clinical Network Director – Women's Health, Western Sydney Local Health District
	Ms Deb Willcox AM	Deputy Secretary, Health System Strategy and Patient Experience, NSW Health

Appendix 3 Minutes

Minutes no. 1
Friday 30 June 2023
Select Committee on Birth Trauma
Room 1043, Parliament House Sydney, 4.31 pm

1. Members present
Ms Hurst, *Chair*
Mr Banasiak *(via videoconference)*
Dr Cohn *(via videoconference)*
Mr D'Adam *(via videoconference)*
Mr Donnelly
Mrs Maclaren-Jones *(via videoconference)*
Mrs Mitchell *(via videoconference)*
Ms Suvaal *(via videoconference)*

2. Apologies
Mrs Carter, *Deputy Chair*

3. Tabling of resolution establishing the committee
The committee noted the following resolution of the House establishing the committee, which reads as follows:

1. That a select committee be established to inquire into and report on birth trauma, and in particular:
    a. the experience and prevalence of birth trauma (including, but not limited to, as a result of inappropriate, disrespectful or abusive treatment before, during and after birth, also referred to as "obstetric violence"),
    b. causes and factors contributing to birth trauma including:
        i. evaluation of current practices in obstetric care,
        ii. use of instruments and devices for assisted birth, for example, forceps and ventouse,
        iii. the availability of, and systemic barriers to, trauma-informed care being provided during pregnancy, during birth and following birth,
    c. the physical, emotional, psychological, and economic impacts of birth trauma, including both short and long term impacts on patients and their families and health workers,
    d. exacerbating factors in delivering and accessing maternity care that impact on birth trauma generally, but also in particular:
        i. people in regional, rural and remote New South Wales,
        ii. First Nations people,
        iii. people from culturally and linguistically diverse (CALD) backgrounds,
        iv. LGBTQIA+ people,
        v. young parents,
    e. the role and importance of "informed choice" in maternity care,
    f. barriers to the provision of "continuity of care" in maternity care,
    g. the information available to patients regarding maternity care options prior to and during their care,

h. whether current legal and regulatory settings are sufficient to protect women from experiencing birth trauma,

i. any legislative, policy or other reforms likely to prevent birth trauma, and

j. any other related matter.

2. That, notwithstanding anything to the contrary in the standing orders, the committee consist of nine members comprising:

   a. three government members,

   b. three opposition members, and

   c. three crossbench members, being Ms Hurst, Mr Banasiak and Dr Cohn.

3. That the Chair of the committee be Ms Hurst, and the Leader of the Opposition is to nominate the Deputy Chair in writing to the Clerk of the Parliaments.

4. That, unless the committee decides otherwise:

   a. all inquiries are to be advertised via social media, stakeholder emails and a media release distributed to all media outlets in New South Wales,

   b. submissions to the inquiry are to be published, subject to the Committee Clerk checking for confidentiality and adverse mention and, where those issues arise, bringing them to the attention of the committee for consideration,

   c. attachments to submissions are to remain confidential,

   d. the Chair's proposed witness list is to be circulated to provide members with an opportunity to amend the list, with the witness list agreed to by email, unless a member requests the Chair to convene a meeting to resolve any disagreement,

   e. the sequence of questions to be asked at hearings is to alternate between government, opposition and crossbench members, in that order, with equal time allocated to each,

   f. transcripts of evidence taken at public hearings are to be published,

   g. supplementary questions are to be lodged with the Committee Clerk within two business days, following the receipt of the hearing transcript, with witnesses requested to return answers to questions on notice and supplementary questions within 21 calendar days of the date on which questions are forwarded to the witness,

   h. answers to questions on notice and supplementary questions are to be published, subject to the Committee Clerk checking for confidentiality and adverse mention and, where those issues arise, bringing them to the attention of the committee for consideration, and

   i. media statements on behalf of the committee are to be made only by the Chair.

5. That the committee report by 1 February 2024.

4. Correspondence

Committee noted the following items of correspondence:

- 27 June 2023 – Letter from the Hon Penny Sharpe MLC, Leader of the Government in the Legislative Council, to Mr David Blunt, Clerk of the Legislative Council, regarding Government nominations for the animal welfare and birth trauma committees
- 28 June 2023 – From the Hon Damien Tudehope MLC, Leader of the Opposition in the Legislative Council, to Mr David Blunt, Clerk of the Legislative Council, regarding Opposition nominations for the animal welfare and birth trauma committees.

5. Conduct of the Inquiry into birth trauma

5.1 Proposed timeline

Resolved, on the motion of Mr Donnelly: That the committee adopt the following timeline for the administration of the inquiry:

- Prior to submissions closing: Briefing with birth trauma expert, trauma-informed response expert, and First Nations health expert. Secretariat to circulate names of experts to committee for consideration.
- Friday 11 August 2023: Submissions close
- August-October 2023: Three or four hearings, roundtables and site visits (Sydney and regional New South Wales)
- December 2024: Report deliberative meeting
- Thursday 1 February 2024: Report tabling.

5.2 Stakeholder list

The committee considered the Chair's proposed stakeholder list.

Resolved, on the motion of Mr Donnelly: That:

- the committee agree to the proposed stakeholder list
- members be provided with the opportunity to nominate additional stakeholders by 12.00 pm Wednesday 5 July 2023, and that the committee agree to additional stakeholders by email, unless a meeting of the committee is required to resolve any disagreement.

5.3 Approach to submissions

Resolved, on the motion of Mrs Maclaren-Jones: That, to enable significant efficiencies for members and the secretariat while maintaining the integrity of how submissions are treated, in the event that 200 or more individual submissions are received, the committee may adopt the following approach to processing short submissions:

- All submissions from individuals 250 words or less in length will:

- have an individual submission number, and be published with the author's name or as name suppressed, or kept confidential, according to the author's request
- be reviewed by the secretariat for adverse mention and sensitive/identifying information, in accordance with practice
- be channelled into one single document to be published on the inquiry website

- All other submissions will be processed and published as normal.

5.4 Approach to sensitive content and themes in evidence

Resolved, on the motion of Mr Donnelly: That, for the duration of the inquiry into birth trauma:

(a) evidence containing sensitive content and themes be published, subject to identifying material of particular concern and bringing it to the attention of the committee for consideration

(b) the Chair include in her opening statement at each hearing a warning to people observing proceedings that owing to the nature of this inquiry, evidence may contain sensitive content or themes

(c) a guide to making a submission be published on the webpage

(d) a statement regarding sensitive content and themes, and a list of mental health and support services be published on the inquiry webpage, subject to the Chair's approval.

6. Adjournment
The committee adjourned at 4.59 pm, *sine die*.

Jessie Halligan
Committee Clerk

Minutes no. 2

Tuesday 8 August 2023
Select Committee on Birth Trauma
McKell Room, Parliament House Sydney, 9.48 am

1. Members present
Ms Hurst, *Chair*
Mrs Carter, *Deputy Chair*
Mr Banasiak
Dr Cohn
Mr D'Adam
Mr Donnelly (until 11.11 am)
Mrs Maclaren-Jones (from 10.24 am)

2. Apologies
Mrs Mitchell
Ms Suvaal

3. Draft minutes
Resolved, on the motion of Dr Cohn: That draft minutes no. 1 be confirmed.

4. Correspondence
The committee noted the following items of correspondence:

Received:

- 10 July 2023 – Email from Dr Joanne Katsoris, Executive Officer, Australian Health Practitioner Agency (AHPRA), to the Chair, declining the provide a submission to the inquiry
- 13 July 2023 – Email from Ms Jenny Addy, National Manager, PANDA, to the secretariat, advising that PANDA do not provide face to face support and advising to engage with other parties
- 19 July 2023 – Email from Dr Trish Bradd, Director Patient Safety, Clinical Excellence Commission, to the secretariat, advising that Professor Nicholl will be available to present at the expert briefing on 8 August
- 19 July 2023 – Email from Professor Hannah Dahlen AM, Professor of Midwifery, Associate Dean Research and HDR, Midwifery Discipline Lead School of Nursing and Midwifery, Western Sydney University, to the secretariat, advising that she is unavailable attend the expert briefing on 8 August and asking whether the briefing could be held on an alternative date
- 20 July 2023 – Email from Dr Hazel Keedle, Academic Program Advisor Bachelor of Midwifery, Deputy Director, NSW Centre for Evidence Based Health Care- JBI Affiliated Group, Western Sydney University, to the secretariat, advising that she can attend the expert briefing on 8 August
- 20 July 2023 – Email from Adjunct Professor Michael Nicholl, Chief Executive, Clinical Excellence Commission, to the secretariat, confirming his availability for the expert briefing on 8 August

- 24 July 2023 – Email from Ms Mirna Tarabay, Registered Clinical Counsellor and Accredited Supervisor (PACFA), Griefline Accredited Counsellor, to the secretariat, advising that she is unavailable to attend the expert briefing on 8 August
- 24 July 2023 – Email from Ms Jaclyn Rae, BSW Specialist Grief Therapist, Accredited Mental Health Social Worker, to the secretariat, advising that she is unavailable to attend the expert briefing on 8 August
- 25 July 2023 – Email from Ms Alexandra Nixey to the secretariat outlining a possible issue, and proposed solution, regarding timeframes within the inquiry's terms of reference
- 27 July 2023 – Email from Mr Peter List, Senior Business Partner, Executive and Ministerial Services, NSW Health, to the secretariat, seeking an extension to provide a submission to the inquiry
- 27 July 2023 – Email from Ms Parissa Bozorg, Policy Assistant, STARTTS, NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors, to the secretariat, seeking an extension to provide a submission to the inquiry
- 28 July 2023 – Email from Ms Karen Edwards, Clinical Director, Gidget Foundation Australia, to the secretariat, advising that Gidget Australia can provide support for individuals participating in the roundtables and hearings and outlining proposed costs
- 31 July 2023 – Email from Mr Peter List, Senior Business Partner, Executive and Ministerial Services, NSW Health, to the secretariat, requesting further extension to provide a submission to the inquiry.

Sent:

- 13 July 2023 – Email from the secretariat to Ms Jenny Addy, PANDA, asking whether PANDA organisation would be interested in providing mental health support to roundtable and hearing participants
- 19 July 2023 – Email from the secretariat to Professor Hannah Dahlen and Dr Hazel Keedle, Western Sydney University, inviting them to present at the expert briefing on 8 August
- 19 July 2023 – Email from the secretariat to Professor Michael Nicholl, Chief Executive, Clinical Excellence Commission, inviting him to present the expert briefing on 8 August
- 21 July 2023 – Email from the secretariat to Ms Jaclyn Rae asking whether she would be interested in attending the private briefing as an expert in trauma informed care
- 24 July 2023 – Email from the secretariat to Ms Mirna Tarabay, asking whether she would be interested in attending the private briefing as an expert in trauma informed care
- 25 July 2023 – Email from the secretariat to Dr Athena Hammond, inviting her to present at the expert briefing on 8 August.

5. Submissions

5.1 Public submissions

The committee noted that the following submissions were published by the committee clerk under the authorisation of the resolution appointing the committee: submission nos. 9, 22, 24, 30, 31, 33, 36, 38, 39, 46, 49, 51, 57, 63, 65, 66, 67, 70, 72, 73, 78, 92, 96, 97, 101.

5.2 Partially confidential submissions

Resolved, on the motion of Mr Banasiak: That the committee keep the following information confidential, as per the request of the author names and/or identifying and sensitive information in submissions nos. 1-6, 8, 10, 11, 12-14, 15, 16, 17, 20, 21, 23, 25, 26, 28, 29, 32, 34, 35, 37, 40, 41-45, 48, 50, 52-55, 56, 59-62, 64, 68, 69, 71, 74, 77, 79, 80, 82-89, 91, 93, 95, 98, 100.

Resolved, on the motion of Mrs Carter: That the committee keep the following information confidential, as per the recommendation of the secretariat: potential identifying and/or sensitive information, and adverse mention in submissions nos 7, 18, 19, 27, 75, 94.

5.3 Confidential submissions

Resolved, on the motion of Dr Cohn: That the committee keep submission nos 47, 76 and 81 confidential, as per the request of the author, as they contain identifying and/or sensitive information.

6. Upcoming inquiry activity

The committee noted the updated dates for future inquiry activity:

- Monday 4 September 2023 – hearing/roundtable at NSW Parliament
- Thursday 7 September 2023 – regional hearing/roundtable in Wollongong
- Friday 8 September 2023 – regional hearing/roundtable in Wagga Wagga
- Monday 9 October 2023 – public hearing at NSW Parliament.

7. Mental health support for witnesses with lived experience

Resolved, on the motion of Dr Cohn: That the committee invite and compensate Gidget Foundation Australia ($2,500) to provide mental health support during public hearings and roundtables involving individuals who have experienced birth trauma.

8. Extension of the submission deadline

The committee noted the submission deadline has been extended until Tuesday 15 August.

9. Birth trauma private briefing

9.1 Recording briefing for note taking purposes

Resolved, on the motion of Mr Banasiak: That the secretariat records the private briefing for the purposes of assisting the secretariat's note taking, and that the recording be destroyed once the notes have been circulated to the committee.

9.2 Presentations provided at private briefing

The committee requested that the secretariat liaise with the briefing participants to ensure that public versions of the presentations were made available to the committee at a later date.

9.3 Private briefing

Committee conducted a private expert briefing with the following individuals:

- Adjunct Professor Michael Nicholl, Obstetric Advisor to NSW Health and Chief Executive, Clinical Excellence Commission
- Dr Hazel Keedle, Senior Lecturer of Midwifery, Western Sydney University
- Dr Athena Hammond, Counsellor and Psychotherapist
- Mr Steven Collins, Senior Aboriginal Liaison Officer, NSW Parliament.

10. Adjournment

The committee adjourned at 12.07 pm, until Monday 4 September 2023 (roundtable/hearing).

Jessie Halligan
Committee Clerk

Minutes no. 3

Tuesday 22 August 2023
Select Committee on Birth Trauma
Room 1043, Parliament House Sydney, 7.05 pm

1. Members present

Ms Hurst, *Chair*
Mrs Carter, *Deputy Chair*
Dr Cohn
Mr D'Adam
Mr Donnelly
Mrs Maclaren-Jones

Mrs Mitchell
Ms Suvaal (via videoconference)

2. Apologies
Mr Banasiak

3. Draft minutes
Resolved, on the motion of Mrs Carter: That draft minutes no. 2 be confirmed.

4. Correspondence
The committee noted the following items of correspondence:

Received:

- 4 August 2023 – Email from Virginia Stulz, Associate Professor of Midwifery, School of Nursing and Midwifery, Centre for Nursing and Midwifery Research to the secretariat, providing a copy of workforce paper on behalf of the Midwifery Advisory Group
- 8 August 2023 - Email from Amy Dawes, CEO and co-founder, Australasian Birth Trauma Association to the Chair, providing feedback and requests on behalf of their community
- 9 August 2023 - Email from Karen Edwards, Clinical Director, Gidget Foundation Australia to the secretariat, providing list of clinicians who will be supporting witnesses appearing during inquiry hearings
- 9 August 2023 - Email from Karen Edwards, Clinical Director, Gidget Foundation Australia to the secretariat, providing an overview of their support for committee hearings
- 11 August 2023 - Email from Michael Nicholl to the secretariat, declining the committee's request to publish the presentation from the expert briefing due to the verbal narrative required to provide context
- 16 August 2023 - Letter from Susan Pearce AM, Secretary, NSW Health to the Chair, requesting that the committee avoid the publication of personalised information of health practitioners that may cause harm.

Sent:

- 8 August 2023 - Email from the secretariat to Amy Dawes OAM, Cofounder & CEO, Australasian Birth Trauma Association (ABTA), informing about extended submission deadline and accepted submissions formats
- 11 August 2023 - Correspondence from the Chair to Dr Athena Hammond, thanking them for meeting with the committee
- 11 August 2023 - Correspondence from the Chair to Adjunct Professor Michael Nicholl, thanking them for meeting with the committee
- 11 August 2023 - Correspondence from the Chair to Dr Hazel Keedle, thanking them for meeting with the committee.

Resolved, on the motion of Mrs Carter: That the committee write to Ms Susan Pearce AM, Secretary NSW Health, detailing the committee's submission process, including redaction of names and identifying information prior to publication.

Resolved, on the motion of Mrs Maclaren-Jones: That the committee:

- seek advice from the Clerk about managing submissions involving allegations currently before the courts, Health Care Complains Commission, or other tribunals
- keep confidential the names of all hospitals, workplaces and locations in all submissions, including those already published on the committee's website, to avoid identifying any individuals adversely mentioned
- authorise the secretariat to place a note on the committee's website and in submission acknowledgement emails that the committee does not investigate individual complaints and that any complaints should be referred to the Health Care Complaints Commission.

5. Submissions

5.1 Public submissions

The committee noted that the following submissions were published by the committee clerk under the authorisation of the resolution appointing the committee: submission nos. 90, 106, 107, 129, 146, 154, 155, 158, 160, 161, 170, 175, 182, 185, 189, 198.

5.2 Partially confidential submissions

Resolved, on the motion of Mrs Mitchell: That the committee keep the following information confidential, as per the request of the author names and/or identifying and sensitive information in submissions nos. 54, 99, 102-105, 108-113, 114-128, 130, 132-144, 147, 148, 150, 151-153, 157, 159, 162, 163, 165-169, 171, 174, 177, 180, 181, 183, 186-188, 190, 192, 193, 196, 197, 199.

Resolved, on the motion of Mrs Carter: That the committee keep the following information confidential, as per the recommendation of the secretariat: potential identifying and/or sensitive information, and adverse mention in submissions nos. 58, 109, 123, 156, 172, 176, 178, 179, 184, 194, 200.

5.3 Confidential submissions

Resolved, on the motion of Mrs Carter: That the committee keep submissions nos. 149, 164, 173, 191, 195 confidential, as per the request of the authors, as they contain identifying and/or sensitive information.

5.4 Approach to processing and reviewing submissions

The committee has received over 4000 submissions. The committee considered an approach to the management of these submissions.

Resolved, on the motion of Mrs Maclaren-Jones: That the committee adopt the following approach to managing submissions:

- all organisation submissions be processed first, regardless of where the organisations are located
- all individual submissions from NSW of 501 words or more be processed next
- all individual submissions received after the submission closing date be kept confidential, with the exception of those who have already been granted an extension
- all individual submissions from NSW of 500 words or less, and individual submissions from outside NSW be considered at another meeting.

Resolved, on the motion of Mrs Carter: That the committee authorise the following communication to stakeholders in relation to submissions:

- the following words on the committee's website:

The committee has received over 4000 submissions. Thank you to all individuals who have contributed to the inquiry. Sharing your story will help inform the committee's understanding of the issues.

Please note, the committee will be prioritising the processing and reviewing of submissions from individuals residing in NSW. While all other submissions will be distributed and considered by members, they will likely be kept confidential

- a media release on behalf of the Chair be circulated to the media and published on the committee's website acknowledging the large volume of submissions, thanking stakeholders for their contributions, explaining the committee's approach to managing, noting that the approach is consistent with practice in previous inquiries, and highlighting that the committee will be moving onto the hearing phase of the inquiry
- the Chair write to the authors residing outside of NSW thanking them for their submission, noting that their submission has been received and considered by the committee, and will be treated as confidential due to the large number of submissions received and the constraints on the secretariat to process and review them all
- the Chair read a statement at the first hearing thanking stakeholders for their contribution and explaining the approach taken by the committee given the volume of submissions.

5.5 Extension requests

The committee noted the following submission extension requests:

Stakeholder	Extension
NSW Health	28 August 2023
STARTTS	25 August 2023
Aboriginal Health and Medical Research Council	23 August 2023
Australian College of Midwives	16 August 2023
NSW Maternity Services	25 August 2023
Zam Zam Mums	22 August 2023
Australian Association of Social Workers (AASW)	29 August 2023
National Association of Specialist Obstetricians	16 August 2023
Better Births Illawarra	18 August 2023
Individual	15 August 2023
Individual	18 August 2023
Individual	23 August 2023
Individual	29 August 2023
Individual	29 August 2023
Individual	29 August 2023

6. Upcoming inquiry activity

Resolved, on the motion of Mr D'Adam: That the committee:

- reschedule the Wagga Wagga public hearing date to November 2023 and seek advice from the Clerk about the conduct of the hearing in the event there are legal proceedings occurring at the same time about individuals in the region
- hold an additional public hearing/forum at NSW Parliament or regionally in early February 2024
- seek agreement from the House to extend the report tabling date to 3 June 2024.

7. Proposed witness list for Monday 4 September and Thursday 7 September 2023

The committee discussed witness lists for the hearings on 4 September and 7 September 2023.

Resolved, on the motion of Mr Donnelly: That the secretariat recirculate the draft witness lists via email for the committee's approval.

8. Adjournment

The committee adjourned at 8.20 pm, until Monday 4 September 2023 (public hearing).

Jessie Halligan
Committee Clerk

Minutes no. 4

Monday 4 September 2023
Select Committee on Birth Trauma
Macquarie Room, Parliament House, Sydney at 9.01 am

1. Members present

Ms Hurst, *Chair*
Mrs Carter, *Deputy Chair*
Mr Banasiak
Dr Cohn
Mr D'Adam (until 2.45pm)
Mr Donnelly
Mrs Maclaren-Jones (from 9.04 am until 2.45 pm)
Mrs Mitchell (from 9.07 am until 5.14 pm)
Ms Suvaal

2. Previous minutes

Resolved, on the motion of Ms Suvaal: That draft minutes no. 3 be confirmed.

3. Correspondence

The committee noted the following items of correspondence:

Received:

- 27 August 2023 – Email from Annalee Atia, Maternity health consumer representative to the committee, outlining relevant experience for the inquiry and interest to speak as a witness.
- 31 August 2023 – Email from Annalee Atia, Maternity Consumer Representative to the Committee requesting to have consumers represented at the hearing on Monday 4 September.
- 9 September 2023 – Email from Amanda Turnill, Board Chair Australasian Birth Trauma Association to secretariat requesting that the panel with Maternity Choices Australia be split in two.

Sent:

- 25 August 2023 - Letter from the Chair to Ms Susan Pearce AM, Secretary NSW Health, providing information about committee's management of evidence.

4. Submissions

4.1 Public submissions

The committee noted the following submissions were published by the committee clerk under the authorisation of the resolution appointing the committee: submission nos. 220, 223, 224, 231, 232, 233, 235, 236, 237, 238, 239, 242, 245, 246, 248, 249, 251, 253, 255, 854, 857, 862, 877 and 878.

4.2 Partially confidential submissions

Resolved, on the motion of Ms Suvaal: That the committee keep the following information confidential, as per the request of the author: names and/or identifying and sensitive information in submission no. 886.

Resolved, on the motion of Ms Suvaal: That the committee keep the following information confidential, as per the recommendation of the secretariat: potential identifying and/or sensitive information, and adverse mention in submissions nos. 24, 234, 243, 244, 250, 254, 409, 670, 880, 881, 882, 883, 884, 885.

4.3 Confidential submissions

Resolved, on the motion of Dr Cohn: That the committee keep submission nos. 230 and 247 confidential, as per the request of the author, as they contain identifying and/or sensitive information.

4.4 Approach to submissions

The committee considered an approach to managing short submissions from authors residing within NSW and submissions from border communities outside NSW, which was deferred from the meeting on 22 August 2023.

Resolved, on the motion of Ms Suvaal: That short public submissions (500 words or less) from within NSW be processed individually, and that name suppressed and confidential submissions be bulk processed.

Resolved, on the motion of Dr Cohn: That the secretariat prioritise processing the 135 submissions from towns on the border of NSW, before other interstate submissions, and that these submissions are circulated to the committee members and kept confidential.

5. Birth trauma private briefing notes

Resolved, on the motion of Ms Suvaal: That the committee keep the notes from the expert briefing confidential.

6. Request from Australasian Birth Trauma Association regarding panel with Maternity Choices Australia

Resolved, on the motion of Mr Banasiak: That the panel involving Australasian Birth Trauma Association and Maternity Choices Australia on Monday 4 September 2023 be divided into two 45-minute sessions.

7. Clerk's advice regarding evidence concerning matters before the courts, the Health Care Complaints Commission and other tribunals

The committee considered advice from the Clerk of the Parliaments.

Resolved, on the motion of Mr Donnelly: That the Chair read a statement before the appearance of each witness/panel at public hearings reminding all witnesses to avoid naming specific individuals or hospitals, or other identifying information, which may prejudice proceedings before the courts, Health Care Complaints Commission or other tribunals.

8. Sequence of questions

Resolved, on the motion of Mrs Maclaren-Jones: That the allocation of questions be left in the hands of the Chair.

9. Public hearing

Witnesses, the public and the media were admitted.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witness was sworn and examined:

- Dr Jared Watts, Board Director, Royal Australian College of Obstetricians and Gynaecologists

The evidence concluded and the witness withdrew.

The following witnesses were sworn and examined:

- Ms Sally Cusack, National Secretary, Maternity Choices Australia
- Ms Azure Rigney, National Advocacy Manager, Maternity Choices Australia

Ms Cusack and Ms Rigney tendered the following documents:

- Maternity Choices Australia, Best Birth Finder Bookmark, A free service for sharing your birth experience
- Queensland Health, webpage graphic, Clinical Excellence Queensland 'Continuity of carer: Benefits from continuity of midwifery models', February 2019
- Maternity Choices Australia, NSW Election Birth Plan, dated March 2023

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Amy Dawes OAM, Cofounder and CEO, Australasian Birth Trauma Association
- Ms Amanda Turnill, Chair, Australasian Birth Trauma Association

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Dr Hazel Keedle, School of Nursing and Midwifery, Western Sydney University
- Professor Hannah Dahlen AM, School of Nursing and Midwifery, Western Sydney University

Dr Keedle and Professor Dahlen tendered the following documents:

- Best: The Birth Experience Study 'What Women Want' Overview of Study
- Research Article, 'Dehumanized, Violated, and Powerless: An Australian Survey of Women's Experience of Obstetric Violence in the Past 5 Years' by Hazel Keedle, Warren Keedle, and Hannah Dahlen, dated 2022.

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined:

- Dr Bashi Kumar-Hazard, Chair, Human Rights in Childbirth

The evidence concluded and the witness withdrew.

The following witnesses were sworn and examined:

- Mr Michael Whaites, Assistant General Secretary, NSW Nurses and Midwives Association
- Mrs Gemma Deng, Professional Officer, Midwifery, NSW Nurses and Midwives Association
- Dr Vanessa Scarf, Midwife and NSW Branch Chair, Australian College of Midwives
- Ms Alison Weatherstone, Chief Midwife, Australian College of Midwives

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Deb Willcox AM, Deputy Secretary, Health System Strategy and Planning, NSW Health
- Adjunct Professor Michael Nicholl, Chief Executive, Clinical Excellence Commission, NSW Health

Ms Willcox and Adjunct Professor Nicholl tendered the following documents:

- NSW Health, 'Connecting, listening, and responding: A Blueprint for Action – Maternity Care in NSW', dated March 2023.

The evidence concluded and the witnesses withdrew.

10. Tendered documents

Resolved, on the motion of Ms Mitchell: That the committee accept and publish the following documents tendered during the public hearing:

- Maternity Choices Australia, Best Birth Finder Bookmark, A free service for sharing your birth experience, tendered by Ms Cusack and Ms Rigney
- Queensland Health, webpage graphic, Clinical Excellence Queensland 'Continuity of carer: Benefits from continuity of midwifery models', February 2019, tendered by Ms Cusack and Ms Rigney
- Maternity Choices Australia, NSW Election Birth Plan, dated March 2023, tendered by Ms Cusack and Ms Rigney
- Best: The Birth Experience Study 'What Women Want' Overview of Study, tendered by Dr Keedle and Professor Dahlen
- Research Article, 'Dehumanized, Violated, and Powerless: An Australian Survey of Women's Experience of Obstetric Violence in the Past 5 Years' by Hazel Keedle, Warren Keedle, and Hannah Dahlen, dated 2022, tendered by Dr Keedle and Professor Dahlen
- NSW Health, 'Connecting, listening, and responding: A Blueprint for Action – Maternity Care in NSW', dated March 2023, tendered by Ms Willcox and Adjunct Professor Nicholl.

11. Submissions

11.1 Approach to submissions from organisations

Resolved, on the motion of Mrs Carter: That, in reviewing submissions received from organisations, the committee:

- publish the names of hospitals, workplaces or locations where the submission is positive or neutral and does not contain adverse mention or sensitive/identifying information
- authorise the secretariat to publish the names of hospitals, workplaces or locations redacted in previously published submissions where the submission is positive or neutral and does not contain adverse mention or sensitive/identifying information
- keep confidential the names of hospitals, workplaces and locations where they have been adversely mentioned or could identify a healthcare practitioner, in accordance with the committee's practice in reviewing individual submissions.

11.2 Partially confidential submission

Resolved, on the motion of Mr Donnelly: That the committee keep the following information confidential, as per the request of the author: names and/or identifying and sensitive information in submission no. 887.

12. Upcoming inquiry activity

Resolved, on the motion of Mr Donnelly: That the committee:

- invite submission authors 200, 670, 881, 882, 885 and 887 to give evidence at the hearing on Thursday 7 September in Wollongong
- invite submission authors 883, 884, 886, in the event one or more of the above submission authors cannot attend.

Resolved, on the motion of Ms Suvaal: That the committee hold a public hearing/roundtable in Wagga Wagga on Tuesday 12 December 2023.

13. Adjournment

The committee adjourned at 5.18 pm, until 7.50 am, Thursday 7 September 2023, Hospital Rd, NSW Parliament (public hearing – Wollongong)).

Jessie Halligan
Committee Clerk

Minutes no. 5

Thursday 7 September 2023
Select Committee on Birth Trauma
Hospital Road, NSW Parliament at 7.50 am

1. Members present

Ms Hurst, *Chair*
Mrs Carter, *Deputy Chair*
Mr Banasiak (from 10.10 am, until 3.00 pm)
Mr Buttigieg (substituting for Mr D'Adam, until 3.00 pm) (via teleconference)
Dr Cohn
Mr Donnelly (from 10.00 am until 4.15 pm)
Mrs Maclaren-Jones (from 10.00 am until 4.15 pm)
Mrs Mitchell (until 1.59 pm)
Ms Suvaal

2. Previous minutes

Resolved, on the motion of Mr Banasiak: That draft minutes no. 4 be confirmed.

3. Correspondence

The committee noted the following items of correspondence:

Received

- 30 August 2023 – Email from Parissa Bozorg, Policy Assistant | STARTTS, NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors to the secretariat providing links to the STARTTS Masterclass referred in their submissions.
- 5 September 2023 – Email from Louise Hill to committee regarding the definition of 'Birth Trauma'.
- 5 September 2023 – Email from Melanie Briggs, Manager of Birthing on Country at Waminda to committee, declining invitation to give evidence on 7 September, but offering to attend hearing on 9 October.
- 6 September 2023 – Email from Dr Maria Hannemann to committee declining invitation to appear at the hearing on 7 September 2023.

Sent

- 6 September 2023 – Letter to Mr Paul Scully MP, advising that the committee will be visiting Wollongong.

4. Submissions

4.1 Public submissions

The committee noted the following submissions were published by the committee clerk under the authorisation of the resolution appointing the committee: submission nos. 220, 223, 224, 231, 232, 233, 235, 236, 237, 238, 239, 242, 245, 246, 248, 249, 251, 253, 255, 854, 857, 862, 877 and 878.

5. Upcoming inquiry activity

The committee noted the updated future inquiry activity:

- Monday 9 October 2023 – public hearing at NSW Parliament
- Tuesday 12 December 2023 – regional hearing/roundtable in Wagga Wagga (flying in on Monday 11 December)

6. Sequence of questions

Resolved, on the motion of Mr Banasiak: That the allocation of questions be left in the hands of the Chair.

7. Public hearing

Witnesses, the public and the media were admitted.

The Chair made an opening statement regarding the broadcasting proceedings and other matters.

The following witnesses were sworn and examined:

- Jessica Holiday, individual
- Naomi Bowden, individual
- Amanda Macaulay, individual.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Carly Griffin, individual
- Olivia Prain, individual
- Aimee Keating, individual.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Sharon Settecasse, Vice President, Better Births Illawarra
- Ms Alyssa Booth, Secretary, Better Births Illawarra.

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined:

- Ms Fiona Reid, Clinical midwife consultant.

The evidence concluded and the witness withdrew.

The following witnesses were sworn and examined:

- Ms Margot Mains, Chief Executive, Illawarra Shoalhaven Local Health District
- Ms Maria Flynn, Executive Director Nursing Midwifery and Clinical Governance, Illawarra Shoalhaven Local Health District
- Dr Andrew Woods, Senior Clinical Advisor Obstetrics, Health and Social Policy Branch, Ministry of Health.

The evidence concluded and the witnesses withdrew.

The public hearing concluded at 4.15 pm.

8. Adjournment
The committee adjourned at 6.20 pm, until Monday 9 October 2023, Preston-Stanley Room, Parliament House, Sydney.

Jessie Halligan & Kara McKee
Committee Clerk

Minutes no. 6
Wednesday 20 September 2023
Select Committee on Birth Trauma
Room 1136, Parliament House, Sydney at 6.37 pm

1. Members present
Ms Hurst, *Chair*
Mrs Carter, *Deputy Chair*
Mr Banasiak
Dr Cohn
Mr Donnelly
Mrs Maclaren-Jones
Mrs Mitchell
Ms Suvaal

2. Apologies
Mr D'Adam

3. Previous minutes
Resolved, on the motion of Ms Suvaal: That draft minutes no. 5 be confirmed.

4. Correspondence
The committee noted the following items of correspondence:

Received

- 4 September 2023 – Email from Dr Deepak Chohan, Emergency Physician to the secretariat providing submission and relevant correspondence to the birth trauma inquiry.
- 6 September 2023 – Email from Hannah Dahlen AM, Professor of Midwifery, Associate Dean Research and HDR to the secretariat providing correspondence on behalf of a women with birth trauma experience.
- 7 September 2023 – Email from Jessica Miller to the secretariat providing her feedback on the recent committee hearings.
- 11 September 2023 – Email from Alecia, Volunteer, Maternity Consumer Network Management Committee to the secretariat providing feedback after off-site hearing in Wollongong.
- 12 September 2023 – Email from Sharon Settecasse, Vice President, Better Births Illawarra to the secretariat providing feedback on the recent Committee hearings.
- 15 September 2023 – Email from Kristyn Begnell, maternity consumer representative to the secretariat providing an overview of experience and willingness to appear as a witness at committee hearing.
- 18 September 2023 – Email from Izzy Angeli, Policy Officer, Australian Medical Association (NSW) to the secretariat expressing willingness for AMA to be called to give evidence at committee hearing.

5. Submissions

5.1 Public submissions

The committee noted the following submissions were published by the committee clerk under the authorisation of the resolution appointing the committee: submission nos. 145, 667, 672, 673, 675, 677, 680, 681, 683, 684, 687, 692, 694, 888, 889, 943.

5.2 Partially confidential submissions

Resolved, on the motion of Dr Cohn: That the committee keep the following information confidential, as per the recommendation of the secretariat: potential identifying and/or sensitive information, and adverse mention in submissions nos. 205, 206, 208, 212, 219, 225, 256, 661-666, 668, 669, 671, 674, 676, 678, 679, 682, 685, 686, 688-691, 693, 929, 944.

Resolved, on the motion of Mrs Mitchell: That the committee keep the following information confidential, as per the request of the author: names and/or identifying and sensitive information in submissions nos. 131, 201, 202, 203, 204, 207, 209, 210, 211, 213, 214, 215, 216, 217, 218, 405.

5.3 Confidential submissions

Resolved, on the motion of Mr Banasiak: That the committee keep submission nos. 547, 828-842 confidential, as per the request of the author, as they contain identifying and/or sensitive information.

6. Answers to questions on notice and supplementary questions

Resolved, on the motion of Mrs Maclaren-Jones: That the committee authorise the publication of answers to questions on notice from Ms Fiona Reid, Clinical midwife consultant, received on 7 September and 8 September 2023.

7. Maternity Consumer Network attachments

Resolved, on the motion of Dr Cohn: That the committee write to Maternity Consumer Network to request an analysis and summary of the findings and insights from the birth stories they provided as attachments to their submission.

8. Proposed witness list for Monday 9 October 2023

Resolved, on the motion of Mr Donnelly: The committee to:

- invite the following witnesses to appear at the upcoming hearings on Monday 9 October 2023:
    - Individuals:
        - Ellahe Yazhdani (individual)
        - Dulce Munoz (individual)

        - Amy Mageropoulos (individual)
        - Lyn Leger (individual)
        - Louise Upshall (individual)
        - Rachelle Edwards (individual)
    - Maternity Consumer Network
    - NSW STARTTS
    - ZamZam Mums and Bubs
    - Birthing on Country, Waminda
    - Aboriginal Health and Medical Research Council of NSW
    - Birthing Dads
    - AMA NSW
    - CALD Panellists:
        - Sharon Coulton Stoliar
        - Wimbayi Musodza
        - Madeleine Hartcher (Simpson)
        - Dr Rakime Elmire
- write to the CALD panellists (listed above) and invite them to provide a written submission or an overview of evidence,
- write to Royal Australian College of General Practitioners and invite them to provide a written submission.

9. Adjournment

The committee adjourned at 7.10 pm, until Monday 9 October 2023, Preston-Stanley Room, Parliament House, Sydney.

Jessie Halligan
Committee Clerk

Minutes no. 7

Monday 9 October 2023
Select Committee on Birth Trauma
Preston-Stanley Room, Parliament House, Sydney at 8.50 am

1. Members present

Ms Hurst, *Chair*
Ms Suvaal, *Acting Deputy Chair*
Mr Banasiak (until 1.30 pm)
Dr Cohn
Mr D'Adam (until 4.15 pm and from 4.43 pm)
Mr Donnelly (until 9.00 am)
Mrs Maclaren-Jones (until 1.30 pm and from 4.32 pm)
Mrs Mitchell (from 8.55 am until 4.51 pm)

2. Apologies

Mrs Carter

3. Previous minutes

Resolved, on the motion of Ms Suvaal: That draft minutes no. 6 be confirmed.

4. Correspondence

The committee noted the following items of correspondence:

Received

- 22 September 2023 - Email from Wimbayi Musodza to the secretariat, declining invitation to appear at the hearing on 9 October
- 22 September 2023 - Email from Sharon Settecasse, Vice President, Better Births Illawarra to the committee, providing feedback and suggestions for future hearings
- 23 September 2023 - Email from Louise Upshall to the secretariat, declining invitation to appear at the hearing on 9 October
- 26 September 2023 - Email from Deb Bowman to the secretariat, declining invitation to appear at the hearing on 9 October
- 27 September 2023 - Email from Madeleine Hartcher to the secretariat, declining invitation to appear at the hearing on 9 October
- 27 September 2023 - Letter from Anja Nikolic, CEO Australian Physiotherapy Association CEO to the Chair, asking to provide evidence at an upcoming hearing
- 3 October 2023 - Email from Stanislas Leger to the committee, expressing his willingness to appear as a witness at a committee hearing
- 4 October 2023 - Email from Emilia Bhat, MCN President, to committee, stating that due to time constraints and resources limitations MCN is unable to provide deep analysis of their stories/data before the hearing on 9 October.

Sent

- 3 October – Letter from Chair to MCN, inviting MCN to provide an analysis and summary of findings from the attachments to their submission
- 3 October – Letter from Chair to RACGP, inviting RACGP to make a submission to the inquiry into birth trauma.

5. Submissions

5.1 Public submissions

The committee noted the following submissions were published by the committee clerk under the authorisation of the resolution appointing the committee: submission nos. 221, 947, 1051.

5.2 Partially confidential submissions

Resolved, on the motion of Ms Suvaal: That the committee keep the following information confidential, as per the request of the author: names and/or identifying and sensitive information in submission no 226, 257, 261, 265, 274, 279, 281, 282, 285, 288, 289, 297, 298, 301, 302, 309, 315, 316, 322, 326, 327, 334, 336, 338, 339, 343, 344.

Resolved, on the motion of Mrs Mitchell: That the committee keep the following information confidential, as per the recommendation of the secretariat: potential identifying and/or sensitive information, and adverse mention in submissions nos. 222, 227, 228, 229 258, 259, 260, 262, 263, 264, 266-273, 275-278, 280, 283, 284, 286, 287, 290-296, 299, 300, 303-308, 310-314, 317-321, 323-325, 328-333, 335, 337, 340-342, 345-350.

5.3 Confidential submissions

Resolved, on the motion of Mr D'Adam: That the committee keep submission no. 946 confidential, as per the request of the author.

6. Requests from lived experience panel members

The secretariat briefed the committee about requests from lived experience panel members regarding their evidence.

7. Answers to questions on notice and supplementary questions

Resolved, on the motion of Mrs Mitchell: That the committee authorise the publication of the following answers to questions on notice and supplementary questions:

- Answers to questions on notice and supplementary questions and attachments, Professor Hannah Dahlen and Dr Hazel Keedle, School of Nursing and Midwifery, Western Sydney University, received 3 October 2023
- Answers to questions on notice and supplementary questions, Ms Deb Willcox, NSW Health, and Adjunct Professor Michael Nicoll, Clinical Excellence Commission, received 3 October 2023
- Answers to supplementary questions, Alison Weatherstone, Australian College of Midwives, received 3 October 2023
- Answers to supplementary questions, Carly Griffin, received 4 October 2023
- Answers to questions on notice and supplementary questions, NSW Nurses and Midwives Association, received 5 October 2023.

Resolved, on the motion of Ms Suvaal: That the committee authorise the answers to questions and notice and supplementary questions from Sally Cusack, Maternity Choices Australia, received 3 October 2023, with the exception of the names and photographs of third party individuals.

8. Declaration of interest

Dr Cohn made a declaration that she is a member of AMA (NSW) and did not contribute to the AMA's submission to the inquiry.

9. Election of Acting Deputy Chair

In the absence of the Deputy Chair, the Chair called for nominations for Acting Deputy Chair.

Mr Donnelly moved: That Ms Suvaal be elected Acting Deputy Chair of the committee for the purpose of the meeting.

There being no further nominations, the Chair declared Ms Suvaal elected Acting Deputy Chair for the purpose of the meeting.

10. Public hearing

Witnesses, the public and the media were admitted.

The Chair made an opening statement regarding the broadcasting proceedings and other matters.

The following witnesses were sworn and examined:

- Mrs Dulce Munoz, individual
- Mrs Amy Mageropoulos, individual.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Mrs Rachelle Edwards, individual
- Mrs Lyn Leger, individual
- Ms Elahe Yazdani, individual.

Mrs Lyn Leger tendered the following documents:

- Mind map, 'A birth injury that cannot be seen impacts every aspect of my life' by Lyn Leger

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined:

- Ms Emilia Bhat, President, Maternity Consumer Network.

The evidence concluded and the witness withdrew.

The following witnesses were sworn and examined:

- Ms Sharon Coulton Stoliar, PhD Candidate, Registered Midwife & Author
- Dr Rakime Elmir, Senior Lecturer, Deputy Director Clinical Education Midwifery, School of Nursing and Midwifery, Western Sydney University.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Jasmina Bajraktarevic-Hayward, Community Services Coordinator, NSW STARTTS
- Ms Deborah Gould, Senior Consultant, NSW STARTTS
- Ms Yusra Metwally, Advocacy Liaison, Zamzam Mums and Bubs
- Ms Saltanat Bora, Co-founder, Zamzam Mums and Bubs
- Dr Fatima El-Assaad, Director, The Still Nest; Senior Research Associate, UNSW (via videoconference).

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Melanie Briggs, Birthing on Country, Manager, Waminda
- Ms Cleone Wellington, Cultural Manager/Executive Manager, Waminda
- Ms Shana Quayle, Acting CEO, Aboriginal Health & Medical Research Council of NSW.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Mr Steven Kennedy, Founder and Executive Director, Prepare Foundation
- Dr Alka Kothari, Associate Professor Obstetrics and Gynaecology, University of Queensland, and Prepare Foundation Board Member.

Mr Steven Kennedy and Dr Alka Kothari tendered the following documents:

- Graph, 'Men's Health After an Adverse Pregnancy Event'
- Research BMC Pregnancy and Childbirth, '"It's a lot of pain you've got to hide": a qualitative study of the journey of fathers facing traumatic pregnancy and childbirth' by A. Kothari, G. Bruxner, L. Callaway, and J. M. Dulhunty, dated 2022
- Research BMC Pregnancy and Childbirth, 'Dads in Distress: symptoms of depression and traumatic stress in fathers following poor fetal, neonatal, and maternal outcomes' by A. Kothari, G. Bruxner, J. M. Dulhunty, E. Ballard, and L. Callaway, dated 2022.
- Research ANZJOG, 'The forgotten fathers in obstetric care' by Alka Kothari, Joel Dulhunty, and Leonie Callaway, dated 2023
- List of Prepare Foundation resources for expectant fathers
- Prepare Foundation resource, 'So, you're going to be a dad?' in English, Nepali, Mongolian, Arabic, Chinese Simplified, and Bangla.
- Prepare Foundation resource, 'Wheel of continuous support'
- Healthy Male Andrology Australia, 'Plus Paternal: A focus on fathers. Case for Change'.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Dr Kathryn Austin, Vice President, AMA (NSW), and Obstetrician, Gynaecologist and Maternal Fetal Medicine subspecialist
- Ms Fiona Davis, CEO, AMA (NSW).

Dr Kathryn Austin and Ms Fiona Davis tendered the following documents:

- Ockenden Report 'Findings, conclusions and essential actions from the independent review of maternity services at The Shrewsbury and Telford Hospital NHS Trust', dated 30 March 2022.

The evidence concluded and the witnesses withdrew.

The public hearing concluded at 5.27 pm.

11. Tendered documents

Resolved, on the motion of Ms Suvaal: That the committee accept and publish the following documents tendered during the public hearing:

- Mind map, 'A birth injury that cannot be seen impacts every aspect of my life' by Lyn Leger, tendered by Mrs Lyn Leger
- Graph, 'Men's Health After an Adverse Pregnancy Event', tendered by Mr Steven Kennedy and Dr Alka Kothari
- Research BMC Pregnancy and Childbirth, '"It's a lot of pain you've got to hide": a qualitative study of the journey of fathers facing traumatic pregnancy and childbirth' by A. Kothari, G. Bruxner, L. Callaway, and J. M. Dulhunty, dated 2022, tendered by Mr Steven Kennedy and Dr Alka Kothari
- Research BMC Pregnancy and Childbirth, 'Dads in Distress: symptoms of depression and traumatic stress in fathers following poor fetal, neonatal, and maternal outcomes' by A. Kothari, G. Bruxner, J. M. Dulhunty, E. Ballard, and L. Callaway, dated 2022, tendered by Mr Steven Kennedy and Dr Alka Kothari
- Research ANZJOG, 'The forgotten fathers in obstetric care' by Alka Kothari, Joel Dulhunty, and Leonie Callaway, dated 2023, tendered by Mr Steven Kennedy and Dr Alka Kothari
- List of Prepare Foundation resources for expectant fathers, tendered by Mr Steven Kennedy and Dr Alka Kothari
- Prepare Foundation resource, 'So, you're going to be a dad?', in English, Nepali, Mongolian, Arabic, Chinese Simplified, and Bangla, tendered by Mr Steven Kennedy and Dr Alka Kothari
- Prepare Foundation resource, 'Wheel of continuous support', tendered by Mr Steven Kennedy and Dr Alka Kothari
- Healthy Male Andrology Australia, 'Plus Paternal: A focus on fathers. Case for Change', tendered by Mr Steven Kennedy and Dr Alka Kothari
- Ockenden Report 'Findings, conclusions and essential actions from the independent review of maternity services at The Shrewsbury and Telford Hospital NHS Trust', dated 30 March 2022, tendered by Dr Kathryn Austin and Ms Fiona Davis.

12. Public submission

Resolved, on the motion of Ms Suvaal: That the committee authorise the publication of submission 946.

13. Adjournment

The committee adjourned at 5.28 pm, until Tuesday 12 December 2023, Wagga Wagga regional hearing.

Jessie Halligan
Committee Clerk

Minutes no. 8

Tuesday 12 December 2023
Select Committee on Birth Trauma
Wagga RSL Club, Wagga Wagga at 8.45 am

1. Members present

Ms Hurst, *Chair*
Mrs Carter, *Deputy Chair*
Mr Banasiak
Dr Cohn
Mr D'Adam (videoconference)

Mrs Maclaren-Jones
Mrs Mitchell
Ms Suvaal

2. Apologies
Mr Donnelly

3. Previous minutes
Resolved, on the motion of Dr Cohn: That draft minutes no. 7 be confirmed.

4. Correspondence
The committee noted the following items of correspondence:

Received

- 10 October 2023 – Email from Nicki Bergin, Hospital Program Manager, Gidget Foundation Australia to the secretariat providing two documents on behalf of Gidget Foundation Australia
- 10 October 2023 – Email from Dr Rakime Elmir, Deputy Director Clinical Education Midwifery, School of Nursing and Midwifery to the secretariat thanking the inquiry staff and the Committee for their support in preparation for the hearing
- 11 October 2023 – Email from Ms Sophia Johnson, PhD, Research Associate, The University of Sydney Business School to the Committee noting her interest in the inquiry and informing about her research relevant to the inquiry
- 18 October 2023 – Email from Sharon Settecasse, Vice President, Better Births Illawarra to the Committee highlighting a statement made by Australian Medical Association (AMA) during Committee hearing and asking to provide evidence
- 11 October 2023 – Email from Mr Steven Kennedy, Founder, PREPARE Foundation to the secretariat regarding possible witness
- 9 November 2023 – Email from Amy Mageropoulos, providing additional information to her evidence from hearing on 9 October 2023
- 11 November 2023 – Email from Hannah Dahlen AM, Professor of Midwifery, School of Nursing and Midwifery to the secretariat seeking to clarify her and Dr Keedle's evidence given during the public hearing on 4 September 2023
- 22 November 2023 – Email from Ms Vanessa Strong, declining invitation to appear at hearing on 12 December 2023
- 24 November 2023 – Letter from Margot Mains, Chief Executive, Illawarra Shoalhaven Local Health District, with formal request to change evidence given during the public hearing on 7 September 2023
- 28 November 2023 – Email from Ms Sasha Lyons, declining invitation to appear at hearing on 12 December 2023, and providing her opening statement
- 1 December 2023 – Email from Ms Jenna Mooney, Nova Health, apologising for not being able to attend the hearing on 12 December.

Sent:

- 6 December 2023 – Letter from Chair to Dr Joe McGirr MP, advising that the committee will be visiting the Wagga Wagga on 12 December 2023.

Resolved, on the motion of Dr Cohn: That the committee authorise:

- the publication of the email from Ms Amy Mageropoulos, received on 9 November 2023, providing additional information from the public hearing on 9 October 2023
- the publication of the email from Ms Sasha Lyons, received on 28 November 2023, declining invitation to appear at hearing on 12 December 2023, and providing her opening statement.

Resolved, on the motion of Ms Suvaal: That the committee authorise:

- the publication of the email from Hannah Dahlen AM, Professor of Midwifery, School of Nursing and Midwifery, received on 11 November 2023, providing clarifications to evidence given at the public hearing on 4 September 2023
- the insertion of footnotes at the relevant points in the transcript of 4 September 2023 noting that correspondence clarifying the evidence had been received and providing a hyperlink to the published correspondence.

Resolved, on the motion of Mrs Carter: That the committee authorise:

- the publication of the letter from Margot Mains, Chief Executive, Illawarra Shoalhaven Local Health District, received on 24 November 2023, providing clarifications to evidence given at the public hearing on 7 September 2023
- the insertion of footnotes at the relevant points in the transcript of 7 September 2023 noting that correspondence clarifying the evidence had been received and providing a hyperlink to the published correspondence.

5. Submissions

5.1 Public submissions

The committee noted the following submissions were published by the committee clerk under the authorisation of the resolution appointing the committee: submission nos. 718 and 944a.

5.2 Partially confidential submissions

Resolved, on the motion of Mr Banasiak: That the committee keep the following information confidential, as per the request of the author: names in submissions nos. 351, 352, 354, 355, 358, 359, 361, 362, 366, 368, 369, 375, 379, 384, 386, 387, 392, 393, 395, 397, 398, 402, 403, 405 – 408, 410, 413, 418 – 420, 423, 424, 430, 432, 435, 439, 440, 442, 444, 446, 449, 462 – 464, 467, 469, 470, 473, 478, 483, 486, 489, 496, 500, 503, 504, 506 – 511, 514, 518, 527, 532, 534, 535, 544, 545, 548, 551, 552, 555, 558, 561 – 563, 568, 569, 574, 580, 583, 586, 588, 589, 592, 595, 598, 600, 603, 604, 613, 614, 616, 618 – 620, 622, 629, 632, 634, 637, 643, 646, 649, 652, 654, 656, 658, 698, 873, 900, 923, 950.

Resolved, on the motion of Ms Suvaal: That the committee keep the following information confidential, as per the recommendation of the secretariat: potential identifying and/or sensitive information, and adverse mention in submissions nos. 353, 356, 357, 363 – 365, 367, 370 – 374, 376, 377, 378, 380 – 383, 385, 388 – 390, 394, 396, 399 – 401, 404, 411, 412, 414 – 417, 421, 422, 425 – 429, 431, 433, 434, 436 – 438, 441, 443, 445, 447, 448, 450 – 461, 465, 466, 468, 472, 474 – 477, 479 – 482, 484, 485, 487, 488, 490, 491, 493 – 495, 497 – 499, 501, 505, 512, 513, 515, 519 – 526, 528 – 531, 533, 536 – 543, 546, 549, 550, 554, 556, 557, 559, 560, 564 – 567, 570 – 573, 575 – 579, 581, 582, 584, 585, 587, 590, 591, 593, 594, 596, 597, 599, 601, 602, 605 – 612, 615, 617, 621, 623 – 628, 630, 631, 633, 635, 636, 638 – 642, 644, 645, 647, 648, 650, 651, 653, 655, 657, 659, 660, 695 – 697, 699, 700, 777, 796, 851, 860, 948, 949, 951.

5.3 Confidential submissions

Resolved, on the motion of Mrs Maclaren-Jones: That the committee keep submission no. 492 confidential, as per the request of the author.

5.4 Approach to submissions

The secretariat briefed members on the progress to date in managing the high volume of submissions.

Resolved, on the motion of Dr Cohn: That the committee:

- seek advice from the Clerk of the Parliaments regarding options for reviewing and publishing submissions after the reporting date
- seek advice from Gidget Foundation regarding the impact of keeping submissions confidential and
- an appropriate protocol for contacting submission authors in the event the committee keeps confidential submissions from authors residing in NSW of 500 words or less.

6. Answers to questions on notice and supplementary questions

The committee noted that the following answers to questions on notice and supplementary questions, and attachments were published by the committee clerk under the authorisation of the resolution appointing the committee:

- Answers to supplementary questions, Ms Amy Dawes OAM and Ms Amanda Turnill, Australasian Birth Trauma Association, received 6 October 2023
- Answers to supplementary questions, Dr Bashi Kumar-Hazard, Human Rights in Childbirth, received 7 October 2023
- Answers to questions on notice and supplementary questions, Naomi Bowden, received 5 October 2023
- Answers to questions on notice and attachments, NSW Health, Ms Margot Mains, Illawarra Shoalhaven Local Health District, Ms Maria Flynn, Illawarra Shoalhaven Local Health District, and Dr Andrew Woods, Ministry of Health, received 5 October 2023
- Answers to supplementary questions, Aimee Keating, received 5 October 2023
- Answers to questions on notice and supplementary questions, Ms Sharon Settecasse and Ms Alyssa Booth, Better Births Illawarra, received 10 October 2023
- Answers to questions on notice, Ms Jasmina Bajraktarevic-Hayward and Ms Deborah Gould, NSW STARTTS, received 18 October 2023
- Answers to questions on notice, Ms Saltanat Bora and Ms Yusra Metwally, Zamzam Mums, received 10 November 2023
- Answers to questions on notice, Dr Alka Kothari, Prepare Foundation, received 19 November 2023
- Answers to questions on notice, Dr Kathryn Austin and Ms Fiona Davies, AMA NSW, received 14 November 2023.

Resolved, on the motion of Mrs Maclaren-Jones: That the committee keep the following information confidential, as per the recommendation of the secretariat: potential identifying and/or sensitive information in the following answers to questions on notice and supplementary questions:

- Answers to questions on notice and attachment, Ms Emilia Bhat, Maternity Consumer Network, received 10 November 2023

7. Upcoming inquiry activity

Resolved, on the motion of Dr Cohn: That the secretariat canvass members' availability for a reserve hearing date in March/April 2024.

8. Public hearing

Witnesses, the public and the media were admitted.

The Chair made an opening statement regarding the broadcasting proceedings and other matters.

The following witnesses were sworn and examined:

- Ms Laura Johnston, individual
- Mrs Carmel Biddle, individual.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Mrs Francesca Male, individual
- Mrs Belinda Alexander, individual
- Miss Stephanie Poll, individual.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Mrs Hannah Eising, individual
- Mrs Eilis Sheahan, individual

- Mrs Courtney Signor, individual.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Dr Trudi Beck, General Practitioner, Nova Health
- Dr Carl Henman, GP Obstetrician, O&G Sonologist, Nova Health.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Leselle Herman, Midwife, Leeton Midwifery Group Practice
- Ms Rebecca Quiring, Clinical Midwifery Educator, Leeton Midwifery Group Practice
- Mr Andrew Heap, Senior Manager Primary Care Engagement, Murrumbidgee Region GP Antenatal Shared Care Program.

The following witness was examined on their former oath:

- Dr Trudi Beck, GP Obstetrician, Murrumbidgee Region GP Antenatal Shared Care Program.

Ms Leselle Herman and Ms Rebecca Quiring tendered the following documents:

- Article, 'Midwife-led continuity models versus other models of care for childbearing woman (Review)' by Sandall J, Soltani H, Gates S, Shennan A, Devane D, dated 2016
- Article, 'Caseload midwifery care versus standard maternity care for women of any risk: M@NGO, a randomised controlled trial' by Sally K Tracy, Donna L Hartz, Mark B Tracy, Jyai Allen, Amanda Forti, Bev Hall, Jan White, Anne Lainchbury, Helen Stapleton, Michael Beckmann, Andrew Bisits, Caroline Homer, Maralyn Foureur, Alec Welsh, Sue Kildea, dated 17 September 2013
- Article, 'Continuity of care by a primary midwife (caseload midwifery) increases women's satisfaction with antenatal, intrapartum and postpartum care: results from the COSMOS randomised controlled trial' by Della A. Forster, Helen L. McLachlan, Mary-Ann Davey, Mary Anne Biro, Tanya Farrell, Lisa Gold, Maggie Flood, Touran Shafiei, and Ulla Waldenström, dated 2016
- Article, 'Exploring women's experiences in a midwifery continuity of care model following a traumatic birth' by Annabel Tafe, Allison Cummins, and Christine Catling, dated 10 February 2023
- Handbook, 'Delivering midwifery continuity of care to Australian women: A handbook for hospitals and health services (3rd Edition)', by Australian College of Midwives, dated 2017
- Toolkit, 'Continuity of Care Models: A Midwifery Toolkit' by NSW Health, dated June 2023.

Mr Andrew Heap tendered the following document:

- Checklist, '2023 Checklist for Pregnancy: GP Shared Care in the Murrumbidgee Region", by phn, firstHealth, and NSW Health, 15 October 2023
- Brochure, 'Murrumbidgee GP Antenatal Shared Care Program: Options for Antenatal (Pregnancy) Shared Care', by phn, firstHealth, and NSW Health, dated July 2023

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Jill Ludford, Chief Executive, Murrumbidgee Local Health District
- Professor Lenert Bruce, General Manager Wagga Wagga Base Hospital
- Ms Carla Bailey, Executive Director Operations, Murrumbidgee Local Health District
- Ms Sandra Forde, Midwifery Manager, Murrumbidgee Local Health District.

The evidence concluded and the witnesses withdrew.

The public hearing concluded at 3.02 pm.

9. Tendered documents

Resolved, on the motion of Dr Cohn: That the committee accept and publish the following documents tendered during the public hearing:

- Article, 'Midwife-led continuity models versus other models of care for childbearing woman (Review)' by Sandall J, Soltani H, Gates S, Shennan A, Devane D, dated 2016, tabled by Ms Leselle Herman and Ms Rebecca Quiring
- Article, 'Caseload midwifery care versus standard maternity care for women of any risk: M@NGO, a randomised controlled trial' by Sally K Tracy, Donna L Hartz, Mark B Tracy, Jyai Allen, Amanda Forti, Bev Hall, Jan White, Anne Lainchbury, Helen Stapleton, Michael Beckmann, Andrew Bisits, Caroline Homer, Maralyn Foureur, Alec Welsh, Sue Kildea, dated 17 September 2013, tabled by Ms Leselle Herman and Ms Rebecca Quiring
- Article, 'Continuity of care by a primary midwife (caseload midwifery) increases women's satisfaction with antenatal, intrapartum and postpartum care: results from the COSMOS randomised controlled trial' by Della A. Forster, Helen L. McLachlan, Mary-Ann Davey, Mary Anne Biro, Tanya Farrell, Lisa Gold, Maggie Flood, Touran Shafiei, and Ulla Waldenström, dated 2016, tabled by Ms Leselle Herman and Ms Rebecca Quiring
- Article, 'Exploring women's experiences in a midwifery continuity of care model following a traumatic birth' by Annabel Tafe, Allison Cummins, and Christine Catling, dated 10 February 2023, tabled by Ms Leselle Herman and Ms Rebecca Quiring
- Handbook, 'Delivering midwifery continuity of care to Australian women: A handbook for hospitals and health services (3rd Edition)', by Australian College of Midwives, dated 2017
- Toolkit, 'Continuity of Care Models: A Midwifery Toolkit' by NSW Health, dated June 2023, tabled by Ms Leselle Herman and Ms Rebecca Quiring
- Checklist, '2023 Checklist for Pregnancy: GP Shared Care in the Murrumbidgee Region", by phn, firstHealth, and NSW Health, 15 October 2023, tabled by Mr Andrew Heap
- Brochure, 'Murrumbidgee GP Antenatal Shared Care Program: Options for Antenatal (Pregnancy) Shared Care', by phn, firstHealth, and NSW Health, dated July 2023, tabled by Mr Andrew Heap.

10. Adjournment

The committee adjourned at 3.14 pm, until Monday 11 March 2024, NSW Parliament, public hearing.

Jessie Halligan
Committee Clerk

Minutes no. 9

Monday 11 March 2024
Select Committee on Birth Trauma
Preston Stanley Room, Parliament House at 8.50 am

1. Members present

Ms Hurst, *Chair*
Mrs Carter, *Deputy Chair*
Dr Cohn (from 8.50 am)
Mr D'Adam (from 1.17 pm until 4.05 pm)
Mr Donnelly (until 10.30 am, from 1.15 pm
Mrs Mitchell (from 8.52 am)
Ms Suvaal (until 12.00 pm, from 3.15 pm until 3.25 pm)

2. Apologies

Mr Banasiak
Mrs Maclaren-Jones

3. Previous minutes

Resolved, on the motion of Ms Suvaal: That the draft minutes no. 8 be confirmed.

4. Correspondence

The committee noted the following items of correspondence:

Received

- 14 December 2023 – Email from Ms Kristyn Begnell, maternity consumer representative to the secretariat, expressing her willingness to speak at the committee's next hearing
- 10 January 2024 – Email from Ms Kristyn Begnell, maternity consumer representative to the secretariat, following up the request to provide evidence at the next hearing
- 6 February 2024 – Email from Ms Kristyn Begnell, maternity consumer representative to the secretariat asking to speak at the next hearing on the issue of consumer engagement within NSW Health and providing media articles, Clinical Services Plan and NSLHD response
- 19 February 2024 – Email from Ms Catherine Beck, Manager, RACGP to the secretariat, advising RACGP were not able to source a representative to attend the hearing on 11 March 2024
- 20 February 2024 – Letter from Ms Fiona Davies, Chief Executive Officer, AMA NSW to the Committee Chair, providing further advice from HWL Ebsworth Lawyers as an addition to the evidence provided during the hearing on 4 September 2023
- 20 February 2024 – Letter from Ms Fiona Davies, Chief Executive Officer, AMA NSW to the Chair, seeking to make a further supplementary submission, and requesting Dr Eveline Staub, Councillor and neonatal intensive care physician to provide evidence at the next hearing
- 1 March 2024 – Email from Ms Sherrie Palm, Founder and CEO of Association for Pelvic Organ Prolapse Support to the secretariat, providing her opening statement, supplementary submission, and link to study Forceps Delivery, by Stephanie M Evanson and John Riggs dated 10 July 2023
- 2 March 2024 – Email from Kristyn Begnell, Coordinator Homebirth Australia to the committee, providing an amended Homebirth Australia submission
- 8 March 2024 – Email from Dr Elizabeth Skinner, Founder: Birth Trauma Consultancy, Founder: Australasian Birth Trauma Association, Trustee/expert: UK Birth Trauma Association, Trustee/expert: UK Birth Trauma Association, University of Technology Sydney, requesting to be consulted on the inquiry
- 9 March 2024 – Email from Richmond Heath, physiotherapist specialising in trauma prevention, providing evidence to the committee on the topic of the role and purpose of neurogenic tremors in preventing birth trauma.

Resolved, on the motion of Mrs Carter: That the committee keep the following correspondence confidential, as per the request of the author, as it contains confidential legal advice:

- Letter from Ms Fiona Davies, Chief Executive Officer, AMA NSW providing further advice from HWL Ebsworth Lawyers as an addition to the evidence provided during the hearing on 4 September 2023.

Resolved, on the motion of Ms Suvaal: That the committee authorise the publication of the email from Ms Sherrie Palm, received on 1 March 2024, providing opening statement, supplementary submission, and link to study 'Forceps Delivery', by Stephanie M Evanson and John Riggs.

5. Submissions

5.1 Redaction of hospitals and locations in the first 200 submissions

The committee noted that the secretariat has redacted names of hospitals and locations from the following submissions, as per the committee's resolution: submission nos. 2, 5, 6, 9, 10, 11, 15, 16, 18, 22, 25-30, 33-39, 41-44, 46, 51-53, 55, 57, 58, 60, 63, 64, 66, 69, 71, 73, 75, 77, 79, 82-90, 92-95, 98, 100, 101, 103-105, 107, 109, 110, 111, 113-118, 122-124, 126, 128-130, 132, 140, 143, 144, 148, 152, 156, 159, 160, 166, 167, 170, 171, 175, 176, 178, 179, 184, 186, 187, 189, 192, 194, 199, 200.

5.2 Public submissions

The committee noted that the following submissions were published by the committee clerk under the authorisation of the resolution appointing the committee: submission nos. 703-705, 707, 710, 712, 728, 730, 736, 747, 748, 759, 761, 766, 769, 772, 774, 780, 783, 799, 803, 804, 807, 812, 814, 818, 823, 866, 892, 918, 935, 964, 971, 973, 975, 1010, 1012, 1021, 1023, 1038, 1059, 1072, 1074, 1078, 1084, 1095, 1096, 1102, 1108, 1111, 1116-1120, 1128-1131, 1134, 1139, 1142, 1148, 1151, 1154, 1162, 1186, 1190-1205, 1209-1212, 1214, 1215, 1217, 1218, 1221, 1228-1230, 1232, 1234-1236, 1240-1243, 1246, 1247, 1249, 1254-1257, 1260, 1262-1264, 1266, 1267, 1270, 1271, 1274, 1275, 1277, 1285-1287, 1291, 1294, 1296-1302, 1309, 1320, 1322, 1336, 1337.

Resolved on the motion of Ms Suvaal: That the committee authorise the publication of submission nos. 220a and 252a.

5.3 Partially confidential submissions

Resolved on the motion of Ms Suvaal: That the committee keep the following information confidential, as per the request of the author: names in submissions nos. 553, 934, 940, 966, 979, 991, 997, 999, 1002a, 1006, 1009, 1018, 1025, 1029, 1032, 1033, 1042, 1043, 1045, 1057, 1058, 1060-1063, 1065, 1067, 1079, 1080, 1082, 1083, 1086-1088, 1090, 1110, 1115, 1121, 1122, 1132, 1133, 1137, 1160, 1169, 1179.

Resolved on the motion of Dr Cohn: That the committee keep the following information confidential, as per the recommendation of the secretariat: potential identifying and/or sensitive information, and adverse mention in submissions nos. 210a, 360, 391, 471, 502, 516, 517, 701, 702, 706, 708, 709, 711, 713-717, 719-727, 729, 731-735, 737-746, 749-758, 760, 762-765, 767, 768, 770, 771, 773, 775, 776, 778, 779, 781, 782, 784-795, 797, 798, 800-802, 805, 806, 808-811, 813, 815-817, 819-822, 824-827, 855, 859, 863-865, 867-872, 874, 875, 876, 887, 891, 893-899, 901-917, 919-922, 924-928, 931, 933, 936, 937-939, 941, 942, 945, 952-958, 959, 960-963, 967-970, 972, 974, 976-978, 980, 982-990, 992-994, 996, 998, 1000, 1001, 1002b, 1002c, 1002d, 1004, 1005, 1007, 1008, 1011, 1013, 1014, 1016, 1017, 1019, 1020, 1022, 1026-1028, 1030, 1031, 1034 - 1037, 1039, 1041, 1044, 1046, 1047, 1049, 1050, 1054-1056, 1066, 1068, 1068a, 1070, 1071, 1073, 1075-1077, 1081, 1085, 1089, 1091, 1092, 1093, 1094, 1097-1101, 1103, 1104, 1105, 1106, 1107, 1109, 1112-1114, 1123, 1125, 1126, 1127, 1135, 1136, 1138, 1140, 1141, 1143, 1144-1147, 1149, 1150, 1152, 1153, 1155 - 1159, 1161, 1163-1168, 1170, 1173, 1178, 1180, 1181, 1183, 1184, 1187-1189, 1207, 1208, 1213, 1219, 1223-1227, 1231, 1233, 1237, 1239, 1244, 1245, 1250, 1253, 1258, 1259, 1261, 1265, 1272, 1273.

5.4 Confidential submissions

Resolved, on the motion of Ms Suvaal: That the committee keep submissions 843-850, 852, 853, 856, 861, 879, 890, 930, 965, 981, 995, 1003, 1015, 1024, 1040, 1040a, 1048, 1052, 1053, 1064, 1069, 1124 confidential, as per the request of the authors, as they contain identifying and/or sensitive information.

5.5 Homebirth Australia amended submission

Resolved, on the motion of Mrs Mitchell: That the committee agree to Homebirth Australia's request to replace their submission 889.

6. Approach to submissions

The committee noted the following:

At the meeting on 12 December 2023, the committee resolved to seek advice from the Clerk about publishing submissions after the reporting date and seeking advice from Gidget Foundation Australia on communicating to stakeholders in the event the committee keeps submissions confidential.

Taking into account members' views on the importance of publishing submissions, the secretariat will aim to finalise submissions before the reporting date and advised the committee of this approach via email. The committee deferred consideration of the Clerk's advice and advice from Gidget Foundation Australia only if there are further workload concerns by the secretariat.

7. Answers to questions on notice

The committee noted that the following answers to questions on notice and supplementary questions, and additional information were published by the committee clerk under the authorisation of the resolution appointing the committee:

- Answers to questions on notice and additional information, Ms Leselle Herman and Ms Rebecca Quiring, Leeton Midwifery Group Practice, received 8 January 2024
- Additional information, Ms Jill Ludford, Professor Lenert Bruce, Ms Carly Bailey, and Ms Sandra Forde, Murrumbidgee Local Health District, received 8 January 2024
- Answers to questions on notice, Ms Jill Ludford, Professor Lenert Bruce, Ms Carly Bailey, and Ms Sandra Forde, Murrumbidgee Local Health District, received 12 January 2024.

8. Upcoming inquiry activity

Resolved, on the motion Mrs Carter: That:

- the committee hold a public hearing on Monday 8 April 2024
- the committee meet during the week commencing Monday 18 March 2024 to discuss the witness list for the hearing
- the secretariat circulate the Chair's proposed witness list via email to the committee at least 48 hours prior to the deliberative.

9. Sequence of questions

The committee noted that it previously resolved that the allocation of questions be left in the hands of the Chair.

10. Public hearing

Witnesses, the public and the media were admitted.

The Chair made an opening statement regarding the broadcasting proceedings and other matters.

The following witnesses were sworn and examined:

- Ms Mary van Reyk individual
- Ms Tamara Leetham, individual
- Ms Alexandra Crichton, individual.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Mrs Jessica Nash individual (via videoconference)
- Mrs Jessica Hipsley, individual
- Mrs Kristyn Begnell, individual.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Professor Deborah Loxton, Director of the Australian Longitudinal Study on Women's Health and Centre for Women's Health Research, The University of Newcastle
- Associate Professor Nicole Reilly, Associate Professor, Perinatal & Women's Mental Health, Discipline of Psychiatry and Mental Health, School of Clinical Medicine, UNSW Sydney and SJOG Burwood Hospital; Senior Research Fellow, Rural Mental Health, Graduate School of Medicine, Faculty of Science, Medicine and Health, University of Wollongong
- Ms Natalie Townsend, Research Executive Manager of the Australian Longitudinal Study on Women's Health and Centre for Women's Health Research, The University of Newcastle.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Catherine Willis, Pelvic Health Physiotherapist, Member Director, Australian Physiotherapy Association
- Ms Sheree DiBiase, Lake City Physical Therapy representing Association for Pelvic Organ Prolapse Support

Ms Willis tendered the following document:

- Australian Physiotherapy Association, Birth Trauma Position Statement.

The following witness was sworn and examined:

- Dr Jenny King OAM, Head of Department Urogynaecology Westmead Hospital.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Julie Borninkhof, CEO, PANDA
- Ms Karen Edwards, Clinical Director, Gidget Foundation Australia.

The following witnesses were sworn and examined:

- Mrs Katelyn Commerford President, Homebirth NSW
- Dr Aimee Sing Vice President, Homebirth NSW
- Ms Kristyn Begnell Coordinator, Homebirth Australia
- Ms Virginia Maddock Assistant Coordinator, Homebirth Australia.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Emily Caska CEO, Down Syndrome NSW
- Ms Melissa Cotterill, Congratulations Initiative Manager, Down Syndrome NSW
- Ms Kylie Pussell, CEO and CoFounder, Miracle Babies Foundation.

Ms Pussell tendered the following document:

- Miracle Babies Foundation, Submission of Ms Kylie Purcell and supporting documents.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Fiona O'Shaughnessy Project Manager, Hygieia Health
- Dr Maria Del Pilar Luna Ramirez Obstetrician and Gynaecologist staff specialist, Acting Head of Department, Women's care unit, Northern NSW Local Health District.

The witnesses, the public, and the media withdrew.

The public hearing concluded at 5.01 pm.

11. Tendered documents

Resolved, on the motion of Mrs Mitchell: That the committee accept and publish the following documents tendered during the public hearing:

- Australian Physiotherapy Association, Birth Trauma Position Statement, tendered by Ms Willis
- Miracle Babies Foundation, Submission of Ms Kylie Purcell and supporting documents, tendered by Ms Pussell.

12. Adjournment

The committee adjourned at 5.04 pm, *sine die*.

Shaza Barbar
Committee Clerk

Minutes no. 10

Thursday 21 March 2024
Select Committee on Birth Trauma
Room 814, Parliament House at 12.36 pm

1. Members present

Ms Hurst, *Chair*
Mrs Carter, *Deputy Chair*
Dr Cohn (from 12.38 pm)
Mr D'Adam (from 12.37 pm)
Mr Donnelly
Mrs Maclaren-Jones (from 12.38 pm)
Mrs Mitchell
Ms Suvaal

2. Previous minutes

Resolved, on the motion of Mrs Carter: That the draft minutes no. 9 be confirmed.

3. Correspondence

The committee noted the following items of correspondence:

Received

- 13 March 2024 – Email from Dr Hazel Keedle, School of Nursing and Midwifery, Western Sydney University, to Chair to advise that Western Sydney University are analysing submissions to the inquiry for a paper
- 15 March 2024 – Email from Ms Catherine Bell, Birth Cartographer, to Committee responding to evidence provided by Dr Jenny King and Dr Jared Watts and providing three attachments.

Resolved, on the motion of Ms Suvaal: That the committee:

- keep confidential the email from Ms Catherine Bell, along with two attachments – 'Finding a Way Forward' and Second Victims in Maternity Care – The Hidden Fallout of Parental Birth Plans', as per the request of the author
- publish the attachment 'Birth plans: A systemic, integrative review into their purpose, process, and impact' by Ms Catherine Bell, Sally Muggleton, and Deborah Davis, as per the request of the author.

4. Submissions

4.1 Partially confidential submissions

Resolved on the motion of Mrs Carter: That the committee keep the following information confidential, as per the recommendation of the secretariat: potential identifying and/or sensitive information, and adverse mention in submissions nos. 1280-1282, 1288-1290, 1292, 1304-1306, 1308, 1310, 1312-1318, 1321, 1323, 1324, 1327-1330, 1332-1334, 1338.

5. Proposed witness list

Resolved, on the motion of Mrs Carter: That:

- the following witnesses be invited to appear at the upcoming hearing on Monday 8 April:

- Rachael Rose, individual
- Individual Young People panel:
  - Mrs Larissa Palamara (Submission 36)
  - Anna MacIntyre (Submission 37)
  - Miss Cassidi-Rae Amosa (Submission 75)
  - Ms Dorothy Deas (Submission 87)
- Brave Foundation
- Childbirth and Parenting Educators of Australia (CAPEA)
- disAbility Maternity Care
- Psychologist panel:
  - Ms Alysha-leigh Fameli, psychologist (Submission 675)
  - Australian Association of Psychologists Inc (Submission 245)
  - Through the Unexpected (Submission 246)
- ACON (Submission 223) and Rainbow Families
- Breastfeeding Advocacy Australia (Submission 233) and Australian Breastfeeding Association
- The Royal Australian College of General Practitioners
- Dr Elizabeth Skinner (Submission 221), Dr Andrew Bisits, Royal Women's in Randwick, Dr Eveline Staub (Councillor & neonatal intensive care physician), and AMA (NSW) (Submission 252 and Submission 252a)
- NSW Health (Submission 862), and Concord, Westmead and Blacktown MGP programs

- the secretariat circulate a draft hearing schedule for Monday 8 April 2024 based on the witness list for the committee's approval.

6. Adjournment

The committee adjourned at 12.57 pm, until Monday 8 April 2024, NSW Parliament (public hearing)

Jessie Halligan
Committee Clerk

Minutes no. 11

Monday 8 April 2024
Select Committee on Birth Trauma
Preston Stanley Room, Parliament House at 8.49 am

1. Members present

Ms Hurst, *Chair*
Mrs Mitchell, *Acting Deputy Chair*
Mr Banasiak (until 12.45 pm, and from 1.55 pm)
Dr Cohn (from 9.01 am)
Mr D'Adam (via videoconference)
Mr Donnelly (from 5.20 pm)
Mrs Maclaren-Jones (from 8.53 am until 2.42 pm, and from 5.20 pm)
Ms Suvaal

2. Apologies

Mrs Carter, *Deputy Chair*

3. Previous minutes

Resolved, on the motion of Ms Suvaal: That the draft minutes no. 10 be confirmed.

4. Correspondence

The committee noted the following items of correspondence:

Received

- 25 March 2024 - Email from Lucy Watson, A/Director, Policy, Strategy and Research, ACON, declining the invitation for ACON to appear at 8 April hearing
- 26 March 2024 - Email from Rose O'Leary, Government Relations and Partnerships Advisor, Brave Foundation, declining the invitation for Brave Foundation to appear at 8 April hearing
- 27 March 2024 - Email from Ms Dorothy Deas, individual, declining the invitation to appear at 8 April hearing
- 2 April 2024 - Email from Ashley Scott, CEO Rainbow Families, declining the invitation for Rainbow Families to appear at 8 April hearing
- 3 April 2024 - Email from Isabella Angeli, policy officer, AMA NSW, notifying the secretariat of the CEO AMA NSW, Fiona Davies' apologies for not being able to attend the public hearing 8 April
- 5 April 2024 - Email from Dr Andrew Bisits, notifying the secretariat that he will not being able to attend the public hearing 8 April
- 7 April 2024 – Email from Dr Bashi Kumar-Hazard, providing supplementary information.

Sent:

- 2 April 2024 - Email from the secretariat to Rachael Lord (aka Rachael Rose), individual, providing written confirmation that Rachael declined the invitation to appear at the public hearing 8 April over the phone.

Resolved, on the motion of Mrs Mitchell: That the committee authorise the publication of supplementary information provided by Dr Bashi Kumar-Hazard, received on 7 April 2024.

5. Submissions

5.1 Partially confidential submissions

Resolved on the motion of Mrs Mitchell: That the committee keep the following information confidential, as per the recommendation of the secretariat: potential identifying and/or sensitive information, and adverse mention in submissions nos. 932 and 1002.

6. Election of Acting Deputy Chair

In the absence of the Deputy Chair, the Chair called for nominations for Acting Deputy Chair.

Ms Suvaal moved: That Mrs Mitchell be elected Acting Deputy Chair of the committee for the purpose of the meeting.

There being no further nominations, the Chair declared Mrs Mitchell elected Acting Deputy Chair for the purpose of the meeting.

7. Sequence of questions

The committee noted that it previously resolved that the allocation of questions be left in the hands of the Chair.

8. Public hearing

Witnesses, the public and the media were admitted.

The Chair made an opening statement regarding the broadcasting proceedings and other matters.

The following witnesses were sworn and examined:

- Mrs Larissa Palamara, individual (via videoconference)
- Miss Cassidi-Rae Amosa, individual (via videoconference).

Miss Cassidi-Rae Amosa tendered the following document:

- Miss Amosa – Full opening statement from hearing Monday 8 April 2024.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Karen Logan, National President, Childbirth & Parenting Educators of Australia (CAPEA)
- Ms Alison Summerville, Engagement Officer, Childbirth & Parenting Educators of Australia (CAPEA).

Ms Logan tendered the following document:

- CAPEA, National Competency Standards for Childbirth and Early Parenting Educators Second Edition, dated 2018.

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined:

- Dr Namira Williams, Chief Executive Officer and Educator, disAbility Maternity Care (via videoconference)

Dr Williams tendered the following document:

- Article from publication of Australian College of Midwives, 'Working with women who have a disability' by Dr Namira Williams, CEO, Disability Maternity Care.

The evidence concluded and the witness withdrew.

The following witnesses were sworn and examined:

- Ms Alysha-leigh Fameli, Registered Psychologist and PhD candidate, University of Sydney
- Ms Sahra Behardien O'Doherty, President, Australian Association of Psychologists Inc (via videoconference)
- Ms Pieta Shakes, Executive Director, Through the Unexpected.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Amy Tyson, Doula, Breastfeeding Advocacy Australia
- Dr Susan Tawia, Breastfeeding Researcher and Health Professional Educator, Australian Breastfeeding Association (via videoconference).

Ms Tyson tendered the following document:

- Breastfeeding Advocacy Australia (BAA) Birth Trauma Impact Survey.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Dr Rebekah Hoffman, NSW&ACT Faculty Chair, The Royal Australian College of General Practitioners
- Dr Isabella Sukka, General Practitioner.

Dr Cohn made a declaration that she is a member of the Royal Australian College of General Practitioners.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Dr Elizabeth Skinner, Academic and lecturer Faculty of Nursing and Midwifery, University of Technology Sydney, Published author and reviewer on birth trauma, Co-founder of Australasian Birth Trauma Association, and Expert/trustee UK Birth Trauma Association
- Dr Eveline Staub, Councillor, AMA (NSW) and Neonatal Intensive Care Physician, Royal North Shore Hospital.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Deb Matha, Director, Maternity, Policy and Strategy, Health and Social Policy Branch, Ministry of Health
- Ms Jacinta Selby, Principal Midwifery Manager, Sydney Local Health District, and Midwifery Manager, Concord MGP
- Ms Julie Swain, Deputy Director of Nursing & Midwifery – Women's and Newborn Health, Western Sydney Local Health District
- Dr Andrew Pesce, Clinical Network Director – Women's Health, Western Sydney Local Health District.

The following witness was examined on their former oath:

- Ms Deb Willcox AM, Deputy Secretary, Health System Strategy and Patient Experience, NSW Health.

The witnesses, the public, and the media withdrew.

The public hearing concluded at 5.16 pm.

9. Tendered documents

Resolved, on the motion of Dr Cohn: That the committee accept and publish the following documents tendered during the public hearing:

- Miss Cassidi-Rae Amosa – Full opening statement from hearing Monday 8 April 2024, tendered by Miss Amosa
- CAPEA, National Competency Standards for Childbirth and Early Parenting Educators Second Edition, dated 2018, tendered by Ms Logan
- Article from publication of Australian College of Midwives, 'Working with women who have a disability' by Dr Namira Williams, CEO, Disability Maternity Care, tendered by Dr Williams.

Resolved on the motion of Dr Cohn: That:

- the committee accept and publish the Breastfeeding Advocacy Australia (BAA) Birth Trauma Impact Survey
- authorise the secretariat to redact place names, hospital names and adverse/identifying information if the document is not a public document.

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10. Timeframe for return of answers to questions on notice and supplementary questions

Resolved, on the motion of Mr Banasiak: That witnesses be requested to return answers to questions on notice and / or supplementary questions from members within 14 days of the date on which questions are forwarded to the witnesses by the committee clerk.

11. Distribution of the Chair's draft report

Mrs Mitchell moved: That the committee receive the Chair's draft report 9 calendar days (13 May 2024) before the report deliberative to be held on 22 May 2024.

Mr Donnelly moved: That Mrs Mitchell's motion be amended by omitting 9 calendar days (13 May 2024) and inserting instead 12 calendar days (10 May 2024).

Amendment of Mr Donnelly put.

The committee divided:

Ayes: Ms Suvaal, Mr Donnelly, Mr D'Adam

Noes: Dr Cohn, Mr Banasiak, Ms Hurst, Mrs Maclaren-Jones, Mrs Mitchell.

Question resolved in the negative.

Original question of Mrs Mitchell put and passed.

12. Adjournment

The committee adjourned at 5.32 pm, until Wednesday 22 May 2024, Room 1043, NSW Parliament (report deliberative).

Jessie Halligan
Committee Clerk

Draft minutes no. 12

Wednesday 22 May 2024
Select Committee on Birth Trauma
Room 1043, Parliament House, 10.05 am

1. Members present

Ms Hurst, *Chair*
Mrs Carter, *Deputy Chair* (from 10.05 am to 12.25 pm, and via teleconference from 12.39 pm until 1.15 pm)
Dr Cohn
Mr D'Adam (until 1.15 pm)
Mr Lawrence (via videoconference)
Mrs Maclaren-Jones
Mrs Mitchell (until 2.07 pm)
Ms Suvaal

2. Apologies

Mr Banasiak

3. Previous minutes

Resolved, on the motion of Mrs Carter: That the draft minutes no. 11 be confirmed.

4. Correspondence

The committee noted the following items of correspondence:

Received

- 17 April 2024 – Email from Katelyn Commerford, President, Homebirth NSW, requesting a transcript clarification for the birth trauma public hearing on 11 March 2024
- 30 April 2024 – Email from Dr Elizabeth Skinner, requesting transcript clarifications for the birth trauma public hearing on 8 April 2024
- 29 April 2024 – Email from the Office of the Hon Dr Brad Pettitt MLC, Member for the South Metropolitan Region, Legislative Council, Parliament of Western Australia, requesting information on how many submission authors have been identified as WA residents
- 3 May 2024 – Email from Sharon Settecasse, Better Births Illawarra, providing a set of key recommendations for consideration in relation to the inquiry's report
- 7 May 2024 – Email from Sharon Settecasse, Better Births Illawarra, providing an additional recommendation for consideration in relation to the inquiry's report.

Resolved, on the motion of Mrs Maclaren-Jones: That the committee authorise:

- the publication of the correspondence from Mrs Katelyn Commerford, received 17 April 2024, providing clarifications to evidence at the public hearing on 11 March 2024
- the insertion of a footnote on page 50 of the transcript of evidence from 11 March 2024 noting that correspondence clarifying the evidence has been received and providing a hyperlink to the published correspondence.

Resolved, on the motion of Mrs Maclaren-Jones: That the committee authorise:

- the publication of the correspondence from Dr Elizabeth Skinner, received 30 April 2024, providing clarifications to evidence at the public hearing on 8 April 2024
- the insertion of footnotes on pages 51 and 52 of the transcript of evidence from 8 April 2024 noting that correspondence clarifying the evidence has been received and providing a hyperlink to the published correspondence.

Resolved, on the motion of Mrs Maclaren-Jones: That the committee authorise the secretariat to respond to the correspondence from the office of the Hon Dr Brad Pettit MLC with the total number of submission authors from Western Australia who provided a submission to the inquiry into birth trauma.

Resolved, on the motion of Ms Suvaal: That the committee authorise the publication of correspondence from Ms Sharon Settecasse, Better Births Illawarra, received on 3 May 2024 and 7 May 2024, regarding suggested key recommendations for the final report on birth trauma.

5. Submissions

5. 1 Public submissions

The committee noted that the following submissions were published by the committee clerk under the authorisation of the resolutions appointing the committee: submission nos. 1171, 1174, 1206a, 1222, 1238, 1248, 1283, 1311, 1325, 1354, 1373, 1382, 1394, 1398, 1418, 1421, 1438, 1443, 1463a, 1466, 1466a.

5.2 Partially confidential submissions

Resolved, on the motion of Mrs Mitchell: That the committee keep the following information confidential, as per the request of the author: names in submissions nos. 652a, 1172, 1176a, 1176b, 1177, 1185, 1220, 1251, 1268, 1279, 1279a, 1293, 1293a, 1293b, 1326, 1335, 1341, 1341a, 1344a, 1345, 1345a, 1349, 1353, 1355, 1356, 1359, 1361, 1364, 1366, 1367, 1370, 1371, 1376, 1379, 1384, 1385, 1387, 1388, 1389, 1391, 1413, 1422, 1424, 1425, 1426, 1428, 1432, 1433, 1434, 1441, 1447, 1448, 1456, 1465, 1468, 1470a, 1471, 1472, 1480.

Resolved, on the motion of Mrs Mitchell: That the committee keep the following information confidential, as per the recommendation of the secretariat: potential identifying and/or sensitive information, and adverse mention in submissions nos. 194a, 224a, 224b, 224c, 224d, 224e, 224f, 224g, 224h, 224i, 224j, 549a, 826a, 1175, 1176, 1182, 1206, 1252, 1264a, 1276, 1278, 1284, 1295, 1303, 1307, 1319, 1319a, 1331, 1340, 1342, 1343, 1344, 1346, 1347, 1348, 1350, 1351, 1352, 1357, 1358, 1362, 1363, 1368, 1369, 1372, 1374, 1375, 1377, 1378, 1380, 1381, 1383, 1386, 1390, 1392, 1393, 1395, 1396, 1397, 1399, 1399a, 1399b, 1402, 1404, 1407, 1409, 1410, 1412, 1414, 1415, 1415a, 1417, 1419, 1420, 1423, 1429, 1430, 1436, 1437, 1439, 1442, 1444, 1445, 1449, 1450, 1453, 1463, 1464, 1470, 1473.

5.3 Confidential submissions

Resolved, on the motion of Ms Suvaal: That the committee keep submissions 1339, 1360, 1446 confidential, as per the request of the authors, as they contain identifying and/or sensitive information.

5.4 Bulk processed submissions

Resolved, on the motion of Mrs Carter: That the committee keep the following information confidential, as per the recommendation of the secretariat: potential identifying and/or sensitive information, and adverse mention in submissions: '965 pages - name suppressed bulk processed submissions circulated 2 May 2024'.

Resolved, on the motion of Mrs Maclaren-Jones: That the committee keep the following submissions confidential: '97 pages - confidential bulk processed submissions circulated 2 May 2024'.

5.5 Submissions from authors residing outside New South Wales

The committee noted that it previously resolved to keep submissions from authors residing outside New South Wales confidential.

5.6 Submissions received after submissions closing date

The committee noted that it previously resolved to keep submissions received after submission closing date confidential.

6. Answers to questions on notice and supplementary questions

The committee noted that the following answers to questions on notice and supplementary questions, and attachments were published by the committee clerk under the authorisation of the resolution appointing the committee:

- Answers to questions on notice, Homebirth NSW, (with the exception of Appendix A), received 16 April 2024
- Answers to questions on notice and additional information, Ms Natalie Townsend, Prof Deborah Loxton, A/Prof Nicole Reilly, received 17 April 2024
- Answers to questions on notice, Dr Maria del Pilar Luna Ramirez, received 17 April 2024
- Answers to questions on notice, Kristyn Begnell, individual, received 18 April 2024
- Answers to questions on notice, Dr Susan Tawia, Australian Breastfeeding Association, received 18 April 2024
- Answers to questions on notice and supplementary questions, Amanda Curran, Chief Services Officer, Australian Association of Psychologists Inc, received 23 April 2024
- Answers to questions on notice, CAPEA, received 29 April 2024
- Answers to questions on notice, Ms Amy Tyson, Breastfeeding Advocacy Australia, received 29 April 2024
- Answers to questions on notice, Ms Pieta Shakes, Through the Unexpected, received 29 April 2024
- Answers to supplementary questions, Ms Alysha-leigh Fameli, registered psychologist, received 29 April 2024
- Answers to questions on notice, Dr Eveline Staub, Australian Medical Association (NSW), received 29 April 2024
- Answers to questions on notice and supplementary questions, NSW Health, received 30 April 2024.

Resolved, on the motion of Mrs Carter: That the committee keep the following information confidential, as per the recommendation of the secretariat: potential identifying and/or sensitive information in the following answers to questions on notice and supplementary questions:

- Answers to questions on notice, Kylie Pussell, CEO, Miracle Babies Foundation, received 18 April 2024
- Answers to questions on notice, Homebirth Australia, received 18 April 2024
- Answers to questions on notice, Homebirth NSW, Appendix A, received 16 April 2024.

Resolved, on the motion of Ms Suvaal: That the committee publish the following for the purposes of tabling only:

- Homebirth Australia a video file titled 'Webinar recording: Collaborative Care panel' in response to a question taken on notice, received 18 April 2024.

7. Consideration of the Chair's draft report

The Chair submitted her draft report entitled *Birth trauma*, which, having been previously circulated, was taken as being read:

Chapter 1

Resolved, on the motion of Mrs Mitchell: That Finding 1 be amended by:

a) omitting 'significant' before 'number of individuals have suffered'

b) inserting 'distressing and' before 'unacceptable' at the end.

Ms Suvaal moved: That Finding 3 be omitted: 'That some cases of birth trauma can be considered a form of gendered violence', and the following new finding be inserted instead:

'That in some cases of birth trauma, women have recounted that they experienced this as a form of violence'.

Question put.

The committee divided.

Ayes: Mrs Carter, Mr D'Adam, Mr Lawrence, Mrs Maclaren-Jones, Mrs Mitchell, Ms Suvaal.

Noes: Dr Cohn, Ms Hurst.

Question resolved in the affirmative.

Chapter 2

Resolved, on the motion of Ms Suvaal: That:

a) paragraph 2.94 and Recommendation 1 be amended by inserting *'Connecting, listening and responding:*' before *'A Blueprint for Action'*

b) all references in the report to 'A Blueprint for Action' be amended by inserting 'Connecting, listening and responding:' before 'A Blueprint for Action'.

Resolved, on the motion of Mrs Mitchell: That paragraph 2.95 be amended by:

a) inserting 'if possible' after 'consumer reference groups be made public',

b) inserting 'if permitted' at the end.

Resolved, on the motion of Mrs Mitchell: That Recommendation 2 be amended by:

a) omitting 'ensure that' and inserting instead 'investigate if'

b) omitting 'is' and inserting instead 'can be' before 'made public'

c) inserting 'if permitted' at the end.

Resolved, on the motion of Ms Suvaal: That Recommendation 2 be amended by inserting a new dot point at the end:

'That the NSW Government publish information about the Terms of Reference of NSW Health Maternity Expert Advisory Group and the NSW Health Maternity Consumer Reference Group, and provide updates on the implementation of *Connecting, listening and responding: A Blueprint for Action – Maternity Care in NSW*.'

Resolved, on the motion of Mrs Mitchell: That paragraph 2.96 be amended by:

a) inserting 'some evidence' before 'that since the implementation of the Queensland Birth Strategy'

b) inserting 'The committee also heard evidence from NSW Health acknowledging the need to learn from other jurisdictions.' before 'We therefore recommend that the NSW Government review'.

Resolved, on the motion of Mrs Mitchell: That Recommendation 3 be amended by inserting 'clinical practices in other jurisdictions, including' after 'That the NSW Government review and evaluate'.

Dr Cohn moved: That paragraph 2.98 be amended by omitting 'implications' and inserting instead 'the impact on health professionals of such a punitive approach'.

Question put.

The committee divided.

Ayes: Mrs Carter, Dr Cohn, Mr D'Adam, Mr Lawrence, Mrs Maclaren-Jones, Mrs Mitchell, Ms Suvaal.

Noes: Ms Hurst.

Question resolved in the affirmative.

Mrs Carter moved: That paragraph 2.98 be amended by omitting 'On balance, the committee considers that it would be worthwhile to investigate this further. We therefore recommend that the NSW Government investigate the possibility of legislative changes to recognise obstetric violence in New South Wales', and inserting instead 'On balance, the committee considers that more work needs to be done in this area'.

Question put.

The committee divided.

Ayes: Mrs Carter, Dr Cohn, Mr D'Adam, Mr Lawrence, Mrs Maclaren-Jones, Mrs Mitchell and Ms Suvaal.

Noes: Ms Hurst.

Question resolved in the affirmative.

Mrs Carter moved: That Recommendation 4 be omitted: 'That the NSW Government investigate the possibility of legislative changes to recognise obstetric violence in New South Wales', and the following new recommendation be inserted instead:

'That the NSW Government consider further research into the benefit and difficulties of legislating with respect to the birthing experience, including operating with the existing law of medical negligence'.

Question put.

The committee divided.

Ayes: Mrs Carter, Dr Cohn, Mr D'Adam, Mr Lawrence, Mrs Maclaren-Jones, Mrs Mitchell, Ms Suvaal.

Noes: Ms Hurst.

Question resolved in the affirmative.

Resolved, on the motion of Mrs Maclaren-Jones: That the following new committee comment be inserted after paragraph 2.100:

'Committee comment

Some evidence suggested the Australian government should increase the number of Medicare-rebatable psychological sessions available to new parents to 40 sessions and to reduce gap fees. The committee recognises there is a broad range of clinical needs where some people may only need a few sessions while others may need more than 40.'

Resolved, on the motion of Dr Cohn: That Recommendation 5 be omitted:

'That the NSW Government improve mental health support for women and families affected by birth trauma by:

- the NSW Minister for Health writing to the Federal Minister for Health and advocating to the Australian government to increase the number Medicare-rebate psychology sessions available for new mothers to 40 rebated sessions
- ensuring that birthing parents have access to psychological support beyond 12 months
- reviewing the funding needs of services currently offering specialised helplines for birth trauma counselling and committing to providing the level of funding and support required.'

and the following new recommendation be inserted instead:

'That the NSW Government improve mental health support for women and families affected by birth trauma by:

- including psychological support in public postnatal care
- ensuring that birthing and non-birthing parents have access to psychological support beyond the immediate post-partum period
- reviewing the funding needs of services currently offering specialised helplines for birth trauma counselling and committing to providing the level of funding and support required
- advocating to the Australian Government to increase Medicare-rebatable psychological support for new parents to reduce gap fees and enable access to the number of sessions clinically required.'

Resolved, on the motion of Mrs Mitchell: That Recommendation 5 be amended by omitting 'birthing and non-birthing'.

Ms Suvaal moved: That Recommendation 5 be amended by:

a) inserting 'on behalf of NSW Health' after 'counselling'

b) omitting 'and committing to providing the level of funding and support required.'

Question put.

The committee divided.

Ayes: Mr D'Adam, Mr Lawrence, Ms Suvaal

Noes: Mrs Carter, Dr Cohn, Ms Hurst, Mrs Maclaren-Jones and Mrs Mitchell

Question resolved in the negative.

Resolved, on the motion of Dr Cohn: That Recommendation 6 be amended by omitting 'pilates' and inserting instead 'supported exercise programs'.

Ms Suvaal moved: That Recommendation 6 be amended by omitting: 'That the NSW Government fund postpartum services, including physiotherapy and pilates, to support those who acquire a pelvic floor injury as a result of birth', and the following new recommended be inserted instead:

'That the NSW Government review the NSW Health service provision and access to postpartum physiotherapy services and if required provide recommendations for future funding considerations.'

Question put.

The committee divided.

Ayes: Mr D'Adam, Mr Lawrence and Ms Suvaal.

Noes: Mrs Carter, Dr Cohn, Ms Hurst, Mrs Maclaren-Jones, Mrs Mitchell.

Question resolved in the negative.

Ms Suvaal moved: That paragraph 2.101 and Recommendation 7 be amended by omitting 'comprehensive' before 'education'.
Question put.

The committee divided.

Ayes: Mrs Carter, Mr D'Adam, Mr Lawrence, Mrs Maclaren-Jones**,** Mrs Mitchell, Ms Suvaal.

Noes: Dr Cohn, Ms Hurst.

Question resolved in the affirmative.

Resolved, on the motion of Ms Suvaal: That paragraph 2.101 and Recommendation 7 be amended by:

a) omitting 'expectant mothers' and inserting instead 'parents'

b) inserting 'maternity' before 'health practitioners'.

Chapter 3

Resolved, on the motion of Dr Cohn: That the following new paragraphs be inserted after paragraph 3.36:

'In many rural communities in New South Wales, GP Obstetricians provide antenatal, intrapartum and postpartum care as well as longitudinal and holistic care for patients and often whole families. This is a preferred model of care for many people in these communities and may not meet demand as insufficient medical practitioners are trained and retained as GP Obstetricians.

'Dr Rebekah Hoffman representing the Royal Australian College of General Practitioners explained that Medicare rebates for antenatal care by GPs are insufficient to cover the cost of care to the standard that both practitioners and patients reasonably expect, and that the Medicare Rebates Schedule incentivises shorter appointments.'

Resolved, on the motion of Dr Cohn: That paragraph 3.89 be amended by omitting "medical item numbers' on the Medicare Care Benefits schedule' and inserting instead 'the Medicare Benefits Schedule'.

Resolved, on the motion of Dr Cohn: That:

a) paragraph 3.113 be amended by omitting 'the type of birth a woman experiences will also impact their likelihood of birth trauma' and inserting instead 'mode of birth was associated with report birth trauma'

b) paragraph 3.114 be amended by omitting 'found to increase the risk of' and inserting instead 'associated with'.

Dr Cohn moved: That paragraph 3.122 be amended by omitting 'While risks are associated with repeat operative deliveries including increased trauma and surgical complications, VBAC offers benefits such as a quicker recovery, reduced trauma, and shorter hospital stays.' after 'The committee heard from a number of women who shared their experiences and desires to have a VBAC (Vaginal Birth After Caesarean)'.

Question put.

The committee divided.

Ayes: Mrs Carter, Mr D'Adam, Mr Lawrence, Mrs Maclaren-Jones, Mrs Mitchell, Ms Suvaal.

Noes: Ms Hurst.

Question resolved in the affirmative.

Ms Suvaal moved: That Recommendation 9 be amended by omitting 'all' before 'women have access to'.

Question put.

The committee divided.

Ayes: Mr D'Adam, Mr Lawrence, Ms Suvaal.

Noes: Mrs Carter, Dr Cohn, Ms Hurst, Mrs Maclaren-Jones, Mrs Mitchell.

Question resolved in the negative.

Ms Suvaal moved: That Recommendation 9 be amended by omitting 'of their choice' after 'continuity of care models with a known provider'.

The committee divided.

Ayes: Mrs Carter, Dr Cohn, Mr D'Adam, Mr Lawrence, Mrs Maclaren-Jones, Mrs Mitchell, Ms Suvaal.

Noes: Ms Hurst.

Question resolved in the affirmative.

Ms Suvaal moved that Recommendation 10 be omitted: 'That the NSW Government invest in and expand Midwifery Group Practice by:

- increasing the number of services providing Midwifery Group Practice, especially in regional, rural and remote New South Wales, and expanding places in existing Midwifery Group Practice services
- ensuring Midwifery Group Practice is available to women in New South Wales who want to access this model of care, including those deemed 'high risk'.',

and the following new recommendation be inserted instead:

'That the NSW Government invest in and expand midwifery continuity of care models, including all risk models, by increasing the number of services providing midwifery continuity of care, especially in regional, rural and remote New South Wales, and expanding places in existing services.'

Dr Cohn moved: That the motion of Ms Suvaal be amended by inserting 'Midwifery Group Practice and' before 'all risk models'.

Amendment of Dr Cohn put and passed.

Original question of Ms Suvaal, as amended, put.

The committee divided.

Ayes: Mrs Carter, Dr Cohn, Mr D'Adam, Mr Lawrence, Mrs Maclaren-Jones, Mrs Mitchell, Ms Suvaal.

Noes: Ms Hurst.

Original question of Ms Suvaal, as amended, resolved in the affirmative.

Dr Cohn moved: That the following new recommendation be inserted after Recommendation 10:

'Recommendation X

That the NSW Government invest in the GP Obstetric workforce to improve continuity of care in rural areas.'

Question put.

The committee divided.

Ayes: Mrs Carter, Dr Cohn, Mr D'Adam, Mr Lawrence, Mrs Maclaren-Jones, Mrs Mitchell, Ms Suvaal.

Noes: Ms Hurst.

Question resolved in the affirmative.

Resolved, on the motion of Dr Cohn: That the following new recommendation be inserted after Recommendation 10:

'**Recommendation X**

That the NSW Government advocate to the Australian Government for Medicare rebates for antenatal and postnatal care delivered by GPs to reflect the cost of providing quality care.'

Mrs Carter moved: That:

a) paragraph 3.208 be amended by inserting 'This allows them to take responsibility and understand the birthing process.' after 'unbiased information to help facilitate information decisions during childbirth.'

b) Recommendation 12 be amended by omitting 'birthing and non-birthing' after "parents'

c) Recommendation 12 be amended by inserting 'and responsibility' after 'potential interventions and their rights'.

Question put.

Committee divided.

Ayes: Mrs Carter, Mrs Maclaren-Jones, Mrs Mitchell.

Noes: Dr Cohn, Mr D'Adam, Ms Hurst, Mr Lawrence, Ms Suvaal.

Question resolved in the negative.

Ms Suvaal moved: That Recommendation 12 be amended by omitting 'provide' and inserting instead 'develop minimum standards for'.

Dr Cohn moved: That the motion of Ms Suvaal be amended by inserting 'and ensure access to' after 'develop minimum standards for'.

Amendment of Dr Cohn put and passed.

Original question of Ms Suvaal, as amended, put and passed.

Resolved, on the motion of Mrs Carter: That the following new finding be inserted after paragraph 3.209:

'Finding X

That prospective parents need to be provided with clear and comprehensive education about all aspects of pregnancy and childbirth so that consent given to any obstetric intervention is fully informed.'

Resolved, on the motion of Dr Cohn: That Recommendation 13: 'That the NSW Government urgently review laws regarding informed consent in other jurisdictions, including Queensland, and consider legislative changes to adopt similar laws in New South Wales' and Recommendation 14: 'That the NSW Government require all health practitioners in New South Wales to undergo informed consent training as a matter of urgency' be omitted, and the following new recommendations be inserted instead:

'Recommendation X

That NSW Health urgently support maternity staff with appropriate local protocols and training to ensure that the *Consent to Medical and Healthcare Treatment Manual* is implemented.

Recommendation X

That the NSW Government review laws and consider any necessary legislative changes regarding informed consent taking into account practise in other comparable jurisdictions.

Recommendation X

That the NSW Government provide support through adequate funding to ensure all practising maternity health practitioners in New South Wales undertake informed consent training.'

Resolved, on the motion of Mrs Mitchell: That paragraph 3.213 be amended by:

a) omitting 'only performed with' after 'guidelines to ensure interventions are evidence-based and'

b) inserting 'is sought' after 'a woman's genuine informed consent'.

Resolved, on the motion of Mrs Mitchell: That Recommendation 16 be omitted: 'That the NSW Government review hospital policies and guidelines to ensure interventions are evidence-based and are only performed after seeking informed consent', and the following new recommendation be inserted instead:

'That the NSW Government review NSW Health, hospital and health facilities' maternity policies and guidelines around birthing interventions, ensuring that the processes for seeking genuine and informed consent are reviewed and that interventions are evidence-based'.

Resolved, on the motion of Ms Suvaal: That Recommendation 17 be amended by:

a) omitting 'hospital' and inserting instead 'NSW Health, hospital and health facilities'

b) inserting 'birthing' before 'interventions'.

Ms Suvaal moved: That Recommendation 17 be amended by omitting 'so that women are able to make an informed decision when choosing where they want to give birth' after 'are made publicly available'.

Question put.

The committee divided.

Ayes: Mrs Carter, Dr Cohn, Mr D'Adam, Mr Lawrence, Mrs Maclaren-Jones, Mrs Mitchell, Ms Suvaal.

Noes: Ms Hurst.

Question resolved in the affirmative.

Dr Cohn moved: That Recommendation 18 be amended by omitting: 'That the NSW Government implement policies, guidelines and training that assist health practitioners to support a woman's birthing preferences and respect women's birth choices, including around pain relief. This should include the introduction of guidelines for women who decline recommended maternity care, similar to Queensland.' and inserting instead:

'That the NSW Government implement policies, guidelines and training that assist practitioners to support informed birthing preferences, including around pain relief. This should include the introduction of guidelines for women who decline recommended maternity care.'

Question put.

Ayes: Mrs Carter, Dr Cohn, Mrs Maclaren-Jones, Mrs Mitchell.

Noes: Ms Hurst, Mr D'Adam, Mr Lawrence, Ms Suvaal.

There being an equality of votes, question resolved in the negative on the casting vote of the Chair.

Resolved, on the motion of Mrs Mitchell: That Recommendation 18 be amended by inserting at the end: 'These policies and guidelines should be developed in consultation with relevant professional bodies and maternity consumer groups.'

Resolved, on the motion of Mrs Mitchell: That Recommendation 19 be amended by omitting: 'The NSW Government invest in research into evidence-based interventions and training of healthcare professionals to overcome gender variations relating to the access and efficacy of pain management', and inserting instead:

'That the NSW Government invest in research into evidence-based interventions and training of maternity healthcare professionals to overcome gender bias in the provision of pain relief to women to ensure timely access to effective pain management.'

Resolved, on the motion of Ms Suvaal: That a new recommendation be inserted following Recommendation 19:

'**Recommendation X**

That the NSW Government review guidelines and consumer information for options for pain relief, both pharmacological and non-pharmacological, during and following labour and birth.'

Resolved, on the motion of Mrs Mitchell:

a) That paragraph 3.218 be amended by omitting 'cost effective, and' following 'We acknowledge homebirths are'

b) That paragraph 3.218 be amended by omitting 'expand' before 'publicly funded homebirth services' and inserting instead 'investigate expanding'

c) That Recommendation 22 be amended by omitting 'expand' and inserting instead 'investigate expanding'.

Mrs Carter left the meeting.

Mr D'Adam left the meeting.

Ms Suvaal moved: That Recommendation 23 be amended by:

a) omitting 'and funding arrangements'

b) inserting 'who meet the access agreement' after 'ensuring these midwives'.

Question put.

The committee divided.

Ayes: Mr Lawrence, Ms Suvaal.

Noes: Dr Cohn, Ms Hurst, Mrs Maclaren-Jones, Mrs Mitchell.

Question resolved in the negative.

Ms Suvaal moved: That Recommendation 25 be amended by:

a) omitting 'implementation of a staffing model' and inserting instead 'review staffing models and develop an implementation strategy'

b) omitting 'ensuring competitive pay and working conditions' and insert instead 'review pay and working conditions'

Question put.

The committee divided.

Ayes: Mr Lawrence, Ms Suvaal.

Noes: Dr Cohn, Ms Hurst, Mrs Maclaren-Jones, Mrs Mitchell.

Question resolved in the negative.

Ms Suvaal moved: That Recommendation 27 be omitted and the following new recommendation be inserted instead:

'That the NSW Government strengthen senior midwifery representation in the NSW Ministry of Health and consider implementation of a standalone Chief Midwifery Officer' after.

Question put.

The committee divided.

Ayes: Mr Lawrence, Ms Suvaal.

Noes: Ms Hurst, Dr Cohn, Mrs Maclaren-Jones, Mrs Mitchell.

Question resolved in the negative.

Resolved, on the motion of Mrs Mitchell: That paragraph 3.223 and Recommendation 28 be amended by omitting 'pending' before 'the outcome of that review' and inserting instead 'following'.

Chapter 4

Resolved, on the motion of Ms Suvaal: That Recommendation 29 be amended by:

a) inserting 'and babies' after 'First Nations mothers'

b) omitting 'the Birthing on Country model' and inserting instead 'Birthing on Country models'.

Resolved, on the motion of Mrs Mitchell: That Recommendation 30 be amended by omitting 'investigating and addressing issues of racism and discrimination within maternity care in New South Wales, including education and training for healthcare practitioners', and inserting instead:

- 'investigating any allegations of racism and discrimination within maternity care in New South Wales
- providing appropriate education and training for maternity healthcare practitioners to address concerns around racism and discrimination'.

Ms Suvaal moved: That Recommendation 31 be amended by omitting 'dedicated' and inserting instead 'private'.

Question put.

The committee divided.

Ayes: Mr Lawrence, Ms Suvaal

Noes: Dr Cohn, Ms Hurst, Mrs Maclaren-Jones, Mrs Mitchell.

Question resolved in the negative.

Resolved, on the motion of Ms Suvaal: That Recommendation 31 be amended by inserting 'maternity' before 'healthcare practitioners'.

Resolved, on the motion of Mrs Maclaren-Jones: That paragraph 4.107 be amended by omitting 'the committee also heard concerns regarding' and inserting instead 'the committee was also shocked to hear about the'.

Mrs Maclaren-Jones moved: That paragraph 4.107 be amended by inserting at the end: 'We were particularly concerned to hear about the pressure which some women faced to terminate their pregnancy after receiving a diagnosis of fetal abnormality. We restate that consent at all stages of the pregnancy and birth process is important, and women's decisions should be respected'.

The committee divided.

Ayes: Mrs Maclaren-Jones, Mrs Mitchell

Noes: Dr Cohn, Ms Hurst, Mr Lawrence, Ms Suvaal.

Question resolved in the negative.

Resolved, on the motion of Mrs Maclaren-Jones: That the following new recommendation be inserted after Recommendation 33:

'**Recommendation X**
That NSW Health liaise with peak and parent bodies representing parents, children and families with members who have fetal abnormalities or genetic conditions and arrange with them to provide information on a website about support and education for expectant parents with a child diagnosed with these issues, this website to be circulated widely among expectant parents.'

Chapter 5

Resolved on the motion of Ms Suvaal: That Recommendation 34 be amended by omitting 'for' and inserting instead 'to consider'.

Ms Suvaal moved: That Recommendation 35 be omitted:

'That the NSW Government develop a NSW Patients Bill of Rights, in consultation with women and legal experts on human rights, which includes:

- provision for the protection from obstetric violence and recognises the right to informed consent and the right to choose or refuse treatment
- authorises consumer video and/or audio recordings in birthing suites
- provides consumers with an avenue to complain against providers and/or facilities for breaches to HCCC for investigation
- gives consumers standing to commence proceedings against facilities and individual providers for rights violations, including obstetric violence.'

Question put.

The committee divided.

Ayes: Mr Lawrence, Mrs Maclaren-Jones, Mrs Mitchell, Ms Suvaal.

Noes: Dr Cohn, Ms Hurst.

Question resolved in the affirmative.

Resolved, on the motion of Dr Cohn: That:

a) paragraph 5.36 be omitted: 'Given these concerns, the committee recommends that the NSW Government establish a "Patients Bill of Rights" which enshrines some key legal protections and avenues for recourse for victims of obstetric violence and birth trauma.' and the following new paragraph be inserted instead:

> 'It is concerning that complaints processes were described as intimidating or 'too hard' by individuals sore-traumatised by the complaints process that they discontinued their complaints. The committee therefore recommends that the Health Care Complaints Commission and its associated disciplinary forums be adequately resourced so as to resolve complaints more quickly, which would reduce distress experienced by both complainants and health practitioners subject to complaints, and to provide more accessible and trauma-informed support to complainants throughout the complaints process.'

the following new recommendation be inserted after paragraph 5.36:

'**Recommendation X**

That the NSW Government support the Health Care Complaints Commission and its associated disciplinary forums to be able to resolve complaints more quickly and provide more accessible and trauma-informed support to complainants throughout the complaints process.'

Resolved, on the motion of Ms Suvaal: That Recommendation 36 be amended by:

a) omitting 'but operating independently from all public hospitals' and inserting 'all public hospitals with maternity services to provide'

b) inserting a dot point at the end: 'an option to debrief with a health practitioner who is independent from the service who provided the care if requested.'

Ms Suvaal moved: That Recommendation 37 be omitted: 'That the NSW Government review the remit of the Health Care Complaints Commission, including:

- the scope of its assessments and investigations of consumer complaints to include consultation with the complainant, their witnesses, and their supporting evidence beyond clinical notes
- ensuring the HCCC is able to accept consumer video and/or audio recordings of health care treatment
- proactive referral of alleged assault to the NSW Police Force
- requiring the HCCC to report on complaints relating to maternity care and birth trauma to NSW Health and NSW Parliament on an annual basis.'

Question put.

The committee divided.

Ayes: Dr Cohn, Mr Lawrence, Mrs Maclaren-Jones, Mrs Mitchell, Ms Suvaal.

Noes: Ms Hurst.

Question resolved in the affirmative.

Resolved, on the motion of Ms Suvaal: That the following new Recommendation be inserted after paragraph 5.40:

'**Recommendation X**

That the NSW Government review local maternity complaint processes and ensures that all pregnant women are provided with information that outlines pathways to ask questions, raise concerns and make complaints.'

Mrs Mitchell left the meeting.

Resolved, on the motion of Dr Cohn: That the following new recommendation be inserted after paragraph 5.40:

'Recommendation X

That the Chair of the Select Committee on Birth Trauma write to the Chair of the Committee on the Health Care Complaints Commission to consider the public reporting of complaints data relating to maternity care and birth trauma and its referral processes, including complaints that may have allegations of assault.'

Resolved on the motion of Mrs Maclaren-Jones: That:

The draft report as amended be the report of the committee and that the committee present the report to the House;

The transcripts of evidence, submissions, tabled documents, answers to questions on notice and supplementary questions, and correspondence relating to the inquiry be tabled in the House with the report;

Upon tabling, all unpublished attachments to submissions be kept confidential by the committee;

Upon tabling, all unpublished transcripts of evidence, submissions, tabled documents, answers to questions on notice and supplementary questions, and correspondence relating to the inquiry, be published by the committee, except for those documents kept confidential by resolution of the committee;

The committee secretariat correct any typographical, grammatical and formatting errors prior to tabling;

The committee secretariat be authorised to update any committee comments where necessary to reflect changes to recommendations or new recommendations resolved by the committee;

Dissenting statements be provided to the secretariat within 24 hours after receipt of the draft minutes of the meeting;

The secretariat is tabling the report on Wednesday 29 May 2024;

The Chair to advise the secretariat and members if they intend to hold a press conference, and if so, the date and time.

8. Other business

Resolved, on the motion of Ms Suvaal: That the Chair write to the Gidget Foundation thanking them for support during public hearings and providing counselling and debriefing with witnesses who shared their personal experiences of birth trauma.

Resolved, on the motion of Dr Cohn: That the Chair of the Select Committee on Birth Trauma write to the Chair of the Committee on the Health Care Complaints Commission to consider the public reporting of complaints data relating to maternity care and birth trauma and its referrals processes, including where there are allegations of assault.

9. Adjournment

The committee adjourned at 2.15 pm, *sine die*.

Jessie Halligan
Committee Clerk

Appendix 4 Dissenting statements

Hon Susan Carter MLC, Liberal Party

This is an important report, considering issues of concern to all parents. It is my sincere hope that it will be carefully considered and will serve as a first step to drive cultural change to assist mothers and improve the experience of childbirth. It gathers together significant evidence and has made carefully considered recommendations.

However, I am concerned that the report does not sufficiently address the experience of mothers whose unborn children receive a diagnosis of foetal abnormality. To feel the excitement of pregnancy, and then to learn that there is a medical issue with the child you are carrying can be overwhelming. And it is clear that the way in which this news is delivered, and the follow up care can be very traumatic for a number of expectant mothers.

In the course of the Hearings, and in written submissions, the Committee heard reports from organisations such as Down Syndrome NSW of the immediate pressure placed on many mothers as soon as a diagnosis of Down Syndrome, or other foetal abnormality, was detected. A pressure to terminate the pregnancy. We heard of women whose healthcare professionals arranged an appointment for them before even consulting with the mother. We heard of women who declined to terminate being pressed at each subsequent appointment to reconsider this decision.

The CEO of Down Syndrome NSW in testimony said:

> *"The NDIS talks about the importance of early intervention.*
> *We have a whole cohort—a whole population— who en-masse are being told, "There's no place for you here", before they're even born. Coming from that and the trauma that ensues from that… we are seeing families not accessing early intervention as early as they should".*

It is paradoxical for a society to extend care and a welcome to all people living with a disability, but only after birth and not during pregnancy. And we can see that the trauma of being made to feel that the child you are carrying is not welcome, reverberates into the early life of that child, and that family's experience.

Research conducted by Down Syndrome NSW found 49% of families who received a Down syndrome diagnosis for their child felt pressure to terminate the pregnancy from healthcare professionals, and 42% of families were given information which they later found to be false. This misinformation includes the claim that there are only three outcomes for a baby with Down syndrome: stillbirth, neonatal death or lifelong dialysis. We know that the reality is very different.

The Report highlights the link between the birth trauma experienced by women and the pressure they have felt from detached or paternalistic clinicians who have pushed or coerced them to undergo a procedure without first asking for consent, or in some cases disregarding their informed consent. It is clear that these same coercive and paternalistic attitudes are too often present in the way our health system treats parents who have received a diagnosis of abnormality in their unborn child. If we are truly to address all birth trauma, this too must be addressed.

This experience of pressure and lack of respect for mother's role in the care of her child extends to the majority of foetal abnormalities detected during pregnancy, with Down Syndrome merely being an

example case. Health care professionals are frequently placing pressure on mothers to undergo procedures without proper regard for the mother's role as a decision-maker. As such, it is a source of ongoing trauma for these families, both when the pregnancy is terminated and when the mother chooses to give birth to the child.

This Report highlights the importance of informed consent for mothers at all stages of their pregnancy and during birth. Informed consent requires that a mother needs to be properly informed about a situation before she can make a decision about the correct mode of care, both for herself and her unborn child.

Furthermore, the importance of informed consent is that it recognises that a woman is a decision-maker in her own right and that she is responsible for her own body and that of her child. It is disappointing that this link between the right to make decisions and being respected as responsible for making those choices was not recognised in Recommendation 12. I am troubled that the responsibility of mothers as rights-bearers, to exercise their rights responsibly, on behalf of themselves and their unborn child has not been recognised.

This report is an important first step. The fact that it is not perfect should not detract from its strengths. I believe it does not sufficiently highlight the role of a mother as a decision-maker capable and responsible for making her own decisions. But it does highlight the paradox at the heart of our response to foetal abnormality and our belief in diversity and inclusion as a society. I was saddened to hear of these experiences both for the mothers and for their children.

Hon Emily Suvaal MLC on behalf of Government Committee Members

We acknowledge the distressing nature of the experiences that were recounted during the Inquiry and thank the witnesses who have volunteered their time to participate and shown great courage in doing so.

We also acknowledge the NSW Health workforce who assist in birthing over 70,000 babies each year and acknowledge that these maternity clinicians demonstrate tireless commitment to proving safe and holistic maternity care and assisting families to navigate these milestone events with overwhelmingly positive outcomes.

In terms of the Committee Report, we do not agree with the limited scope of Recommendation 27 to appoint a Chief Midwifery Officer without seeking to undertake a review of the evidence available to support this investment. We do not believe the Inquiry sufficiently established a case to support appointing an additional high paid executive in NSW as the best use of resources, and equally we believe a fiscally responsible approach would include a review of the progress already achieved to strengthen senior midwifery representation in the NSW Government.

We otherwise do not take issue with the recommendations in the report and were glad to contribute additions and amendments to strengthen the report, which have been adopted by the Committee.

Hon Emma Hurst MLC, Animal Justice Party

Thousands of women vulnerably shared their stories with this committee in hope of achieving systemic change in the (mis)treatment of women by our healthcare system.

While I believe this report goes a long way to achieving this, I felt compelled to put on the record that there were several recommendations I wanted to include in the report, but was not able to, as these recommendations were watered or voted down by the majority of committee members.

I want every parent reading this report to know that your voices were heard by me. Below is a list of the recommendations that should have been in the report, but were removed. I want every survivor of birth trauma to know that these are the recommendations, along with those formally in the report, that I will continue to fight for. I heard you loud and clear.

Recommendations omitted from Report

1. A finding that **'Some cases of birth trauma can be considered a form of gendered violence'**.

The UN has recognised obstetric violence as a form of gendered violence, and the stories we heard reflected this. The rewording of this finding implies that violence was a perception rather than a fact, and fails to recognise the very clear evidence that this is a gendered issue.

2. A recommendation that **'The NSW Government investigate the possibility of legislative changes to recognise obstetric violence in New South Wales'.** Instead, the majority of members chose to include a committee comment focussing on 'the impact on health professionals of such a punitive approach'.

This fails to recognise the power imbalance between birthing parents and health practitioners and the systemic issues that were clearly presented to the committee regarding the presence of obstetric violence in maternity care systems globally. Failure to even consider legislative changes to protect birthing parents from obstetric violence is unacceptable.

3. A recommendation that **'The NSW Government develop a NSW Patients Bill of Rights, in consultation with women and legal experts on human rights**, which includes:
    - provision for the protection from obstetric violence and recognises the right to informed consent and the right to choose or refuse treatment
    - authorises consumer video and/or audio recordings in birthing suites
    - provides consumers with an avenue to complain against providers and/or facilities for breaches to HCCC for investigation
    - gives consumers standing to commence proceedings against facilities and individual providers for rights violations, including obstetric violence.'

This would have gone a long way to protect birthing parents from birth trauma. It is beyond me why patients having recognised rights is considered controversial.

4. A recommendation that **'The NSW Government review the remit of the Health Care Complaints Commission**, including:

- the scope of its assessments and investigations of consumer complaints to include consultation with the complainant, their witnesses, and their supporting evidence beyond clinical notes
- ensuring the HCCC is able to accept consumer video and/or audio recordings of health care treatment
- proactive referral of alleged assault to the NSW Police Force
- requiring the HCCC to report on complaints relating to maternity care and birth trauma to NSW Health and NSW Parliament on an annual basis.'

The Committee received significant evidence about the challenges and limitations of the HCCC – this recommendation would have assisted in addressing these issues.

5. While the Committee made a critical recommendation about ensuring that all women have access to continuity of carer models with a known provider, **the majority of the committee voted against ensuring that women have access to a known provider 'of their choice'**.

We heard this repeatedly – both in the submissions and evidence at the hearings. Why my fellow committee members believe women should not be able to make their own birthing choices is beyond me.

6. While the committee has made an important recommendation about investing in and expanding midwifery continuity of care models, the majority of the committee failed to support my specific recommendation, which was that '**the NSW Government invest in and expand Midwifery Group Practice** by:
    - increasing the number of services providing Midwifery Group Practice, especially in regional, rural and remote New South Wales, and expanding places in existing Midwifery Group Practice services
    - ensuring Midwifery Group Practice is available to women in New South Wales who want to access this model of care, including those deemed 'high risk'.

I will continue to fight for this. Investing in and expanding MGP was clearly one of the most significant ways we can reduce birth trauma rates. The committee as a whole failed women by failing to listen to their calls for this strong recommendation.

7. The Committee declined to support my recommendation to ensure that hospital policies and guidelines regarding interventions are made publicly available **'so that women are able to make an informed decision when choosing where they want to give birth'**

Again, we need to support women's right to informed choices, and I have no words to explain why the rest of the committee does not support women to do this.

8. The majority of the committee voted to **remove the following evidence about VBACs:** *"While risks are associated with repeat operative deliveries including increased trauma and surgical complications, VBAC offers benefits such as a quicker recovery, reduced trauma, and shorter hospital stays."*

It is highly unusual to remove evidence from an Inquiry report. It is not up the committee to remove evidence they personally disagree with. A balanced report was written including many views that I don't personally agree with - to remove one piece of evidence was unjustified.

9. Committee members voted to include a recommendation '**That the NSW Government invest in the GP Obstetric workforce to improve continuity of care in rural areas.**'

While I support expanding access to maternity care in rural areas, we also received evidence that GP obstetrics and GP shared care have higher rates of intervention, which is linked to birth trauma, and is often not a true continuity of care model.