2026 (No. 5)

PARLIAMENT OF TASMANIA

House of Assembly Select Committee on

REPRODUCTIVE, MATERNAL AND PAEDIATRIC HEALTH SERVICES IN TASMANIA

MEMBERS OF THE COMMITTEE

Ms *Dow*
Mr *Fairs*
Ms *Haddad* (Chair)
Ms *Johnston*
Ms *Rosol* (Deputy Chair)

Contents

SENSISITVE CONTENT DISCLAIMER AND SUPPORT SERVICES **9**

FINDINGS **11**

RECOMMENDATIONS **19**

1 BACKGROUND, APPOINTMENT, TERMS OF REFERENCE AND CONDUCT OF INQUIRY **23**

Background 23

Appointment and Terms of Reference 24

Conduct of the Inquiry 27

Structure of this Report 29

2. CONTEXT OF THE INQUIRY IN TASMANIA **31**

3. ADEQUACY, ACCESSIBILITY AND SAFETY OF REPRODUCTIVE HEALTH SERVICES **33**

Contraception 33

Fertility 36

Termination 42

Findings 55

Recommendations 56

4. ADEQUACY, ACCESSIBILITY AND SAFETY OF MATERNAL HEALTH SERVICES **59**

Maternal health services context 60

Access to maternal health services in Tasmania 69

Structure of care 82

Neonatal Intensive Care Unit (NICU) services 107

Freebirth 113

Bereavement care 115

Findings 149

Recommendations 150

5. HOMEBIRTH AND PROFESSIONAL INDEMNITY INSURANCE **153**

Professional Indemnity Insurance (PII) 169

Provision of care by midwives 176

Findings 178

Recommendations 179

6. EXPERIENCES WITH BIRTH TRAUMA **181**

Defining birth trauma in the Tasmanian context 181

Occurrences of birth trauma 188

Impact of birth trauma on life experiences 196

Factors and causes contributing to birth trauma 200

Complaints processes and legal pathways 218

Resources for change 227
Findings 230
Recommendations 231
7. ADEQUACY, ACCESSIBILITY AND SAFETY OF PERINATAL MENTAL HEALTH SERVICES 233
Lived experience 234
Current access to perinatal mental health support 237
Proposals and recommendations for perinatal mental health 259
Findings 275
Recommendations 276
8 ADEQUACY, ACCESSIBILTITY AND SAFETY OF THE CHILD HEALTH AND PARENTING SERVICE (CHAPS) AND PAEDIATRIC HEALTH SERVICES 277
Child Health and Parenting Services (CHaPS) 277
Available services 281
Access to CHaPS 292
Paediatric Health Services 293
Findings 310
Recommendations 311
9. EDUCATION AND WORKFORCE 313
Midwifery 315
General Practitioners (GPs) 329
Physiotherapists 330
Findings 331
Recommendations 332
APPENDIX A: LIST OF SUBMISSIONS 333
APPENDIX B: LIST OF HEARING WITNESSES 337
APPENDIX C: GLOSSARY OF TERMS 343
APPENDIX D: MINUTES 347
APPENDIX E: TRANSCRIPTS OF EVIDENCE 395

CHAIR'S FOREWORD

On behalf of the Committee I pay sincere thanks to the many people who generously shared their experiences with us. Often these were deeply personal stories of traumatic and life changing experiences, while others were touching stories of positive experiences.

Sharing these powerful personal stories has enabled us to make practical, necessary and implementable recommendations which, if implemented, would significantly improve the provision and experience of reproductive, maternal and paediatric health care in Tasmania.

Due to the particularly personal nature of many of the stories shared, the Committee decided to redact the names and birth dates of children and babies referred to in submissions and by people who provided evidence at our public hearings. Additionally, some submitters requested their contributions be published anonymously.

Many distinct themes emerged in the evidence received by the Committee. These include the vital importance of early intervention services, continuity of care and multidisciplinary care teams that develop comprehensive understandings of the individual needs of their patients.

While public access to termination of pregnancy has been restored in Tasmania there is still work to do to maintain and increase this access and other reproductive health services.

Staffing shortages prevent the delivery of a truly woman-centred multidisciplinary model of maternal healthcare. Currently, patients in the Tasmanian Health Service are not experiencing continuity of care throughout pregnancy and following birth, including into parenthood.

Difficulty accessing all these types of care is more pronounced for women in rural and regional parts of the state where service provision is severely lacking.

Staffing challenges affect all areas of the health system relevant to this Committee's Terms of Reference. There are shortages of midwives, paediatricians, General Practitioners and Child and Family Health Nurses, as well as allied health professionals across the board.

While each profession involved in providing reproductive, maternal and paediatric healthcare is struggling to meet current and growing demand, there is an incredibly dedicated workforce committed to holistic care and patient centred outcomes.

The Committee is grateful to these dedicated health professionals, and to the organisations, peak bodies and unions who represent them for sharing invaluable information with us. The information they shared explained many of the challenges facing each workforce but also highlighted the professionalism and dedication of so many people in the system.

Each of the recommendations made in this report is important and should be prioritised. Some can be acted on more quickly than others which require systemic reform.

Since the establishment of this Inquiry in its original form in 2023, the landscape of maternal healthcare in Tasmania has changed significantly. Some of the key changes that have already occurred include:

- The transition of private maternity services in the North West to the public North West Regional Hospital;
- The closure of the maternity ward of the Hobart Private Hospital;
- The proposed sale of the Hobart Private Hospital to Calvary Health Care;
- The establishment of a postgraduate midwifery qualification at the University of Tasmania (UTAS);
- Improvements to the proposed insurance for Privately Practicing Midwives (PPMs); and
- Low and bulk billed access to long-acting reversable contraception (LARCs) being made available through the Commonwealth funded Pelvic Pain Clinics.

I acknowledge the work of former Minister for Health, the Hon. Jacquie *Petrusma* MP, who was initially a member of the Committee, for progressing the negotiations with UTAS to establish a postgraduate midwifery course relatively swiftly, as well as initiating research in the Department of Health for a return to publicly funded homebirth services in Tasmania.

Stretching over almost three years, the Committee membership has changed over time, and I wish to sincerely thank all former Members of the Committee: Simon *Behrakis* MP, Michelle *O'Byrne* MP, Jacquie *Petrusma* MP, Nic *Street* MP, Simon *Wood* MP and Rosalie *Woodruff* MP. Thank you to the Committee's final membership: Anita *Dow* MP, Rob *Fairs* MP, Kristie *Johnston* MP and Cecily *Rosol* MP for your commitment to this important piece of work.

In particular I thank my colleague Anita *Dow* MP for initiating this Inquiry following harrowing experiences of women in the North West, the closure of the St Helen's Hospital and its Mother Baby Unit and significant staffing issues at the Royal Hobart Hospital.

Thank you to Gidget Foundation Australia for providing on site in-person support to the lived experience witnesses who presented evidence to the Committee.

Thank you to staff from the Parliamentary Broadcasting Service and Parliamentary Reporting Service (Hansard) for supporting the Committee's public hearings, including Hansard's assistance with our regional hearings in Burnie and Launceston.

Thank you to the Parliamentary Officers who assisted the Committee, in particular Committee Secretary Mary de Groot, for their dedicated work on the Committee and this Report.

This Inquiry has been a profoundly impactful piece of work for this Committee and we sincerely hope the recommendations will be prioritised and implemented by Government.

While there are many positive patient experiences, those that are traumatic can have lasting negative impacts on patients, as well as healthcare professionals involved in their care.

We are hopeful for a patient-centred best practice model of care in the provision of reproductive, maternal and paediatric healthcare in Tasmania.

Ella Haddad MP
Member for Clark

Chair

24 February 2026

SENSISITVE CONTENT DISCLAIMER AND SUPPORT SERVICES

The Committee recognises that this Report discussed highly sensitive matters that have deeply impacted the lives of Tasmanians. This may be a trigger for individuals who have participated in the Inquiry or who choose to read this Report.

If you are impacted by the content of the Report, the Committee encourages you to seek support from available services including:

Lifeline's helpline on 13 11 14 or via text at 0477 13 11 14 for 24/7 mental health support.

Tresillian Tasmania's Parents helpline on 1300 827 282.

PANDA National helpline on 1300 726 306. PANDA's Helpline provides support Monday – Friday from 9am – 7:30pm and from 9am – 4pm on Saturdays and public holidays

FINDINGS

The Committee finds:

1. Financial, geographic and social factors negatively impact access to contraception in Tasmania.

2. Tasmania has a lack of qualified physicians who can insert long–acting reversible contraception (LARCs).

3. The expanded scope of practice of pharmacists in Tasmania to prescribe oral contraception will increase access to contraception.

4. There is limited availability of reproductive and fertility services in Tasmania.

5. Tasmanians access reproductive and fertility services for a broad range of health reasons, not limited to infertility or embryo implantation.

6. There are no publicly funded In Vitro Fertilisation (IVF) services in Tasmania.

7. Two private clinics provide In Vitro Fertilisation (IVF) services in southern Tasmania, but none in the North or North West of the state.

8. The process of obtaining a parentage order after a surrogacy can be administratively burdensome for Tasmanian families.

9. While terminations are available in Tasmania under the *Reproductive Health (Access to Terminations) Act 2013*, significant barriers to access exist. Barriers include a lack of awareness of available services, lack of regional services, complex referral pathways, financial barriers and legislated gestational limits.

10. Barriers to accessing terminations can impact a woman's right to choose termination options. This can increase the risk of adverse health and mental health outcomes for women and increase pressure on and cost to the Tasmanian health system.

11. The financial barriers to accessing medical terminations of pregnancy (MToP) limits choice and can result in women accessing surgical terminations of pregnancy (SToP) in the public system. This more invasive procedure leads to increased health risks to the women and greater financial burden on the health system.

12. Women seeking terminations experience stigma and resistance, including from medical professionals and loved ones.

13. Insufficient data is collected on the number of terminations accessed in Tasmania, which results in an inability to properly evaluate the effectiveness of service provision.

14. The process for seeking late-stage terminations in Tasmania is administratively complex and lacks transparency and appeal mechanisms. This delays time critical access;

15. Accessing the Youth Health Fund is complex, especially when compared to the process for accessing the Women's Health Fund. This exacerbates disadvantage in an already vulnerable cohort of young women.

16. Community education and information about accessing termination services in Tasmanian is limited.

17. Education for Tasmanian health professionals regarding termination care is ad hoc and insufficient.

18. Post-termination support is limited in Tasmania.

19. Women and family centred maternal healthcare leads to optimal outcomes for parents, babies and families.

20. Women's experience of maternal healthcare in Tasmania is variable and is influenced by factors including location, cost and the knowledge and attitude of the health professionals involved in their care.

21. There are significant regional inequities in access to maternal healthcare in Tasmania.

22. Private obstetric services are not available in the North West. This limits patient choices and has broad workforce implications.

23. There has been significant instability and uncertainty in accessing maternal healthcare in both public and private hospitals in Tasmania which has influenced the standard and level of care available.

24. There is no clear public strategy in Tasmania for the future provision of women's health, including reproductive and maternal health.

25. There is some support for a dedicated women's and children's hospital in Tasmania.

26. There are insufficient women's health specialists in Tasmania, including midwives, anaesthetists, maternal-foetal medicine specialists, sonographers and urogynaecologists.

27. Continuity of care in maternal healthcare is considered best practise and is widely supported by health consumers and professionals.

28. Continuity of care in maternal healthcare is not consistently available in Tasmania.

29. Tasmania has both midwifery-led and obstetric-led models of maternal healthcare.

30. The availability of midwifery-led models in Tasmania does not meet demand.

31. Many Tasmanian women do not receive their preferred model of maternal healthcare.

32. Some Tasmanian women are supported by private doulas.

33. Difficulties in accessing preferred models of maternal healthcare contribute to individuals choosing freebirth.

34. Birth plans inform and educate parents and contribute to continuity of care, increasing the occurrence of optimal outcomes for mothers, babies and families.

35. Birth plans are not always prepared, recognised or followed.

36. Aboriginal and Torres Strait Islander, Culturally and Linguistically Diverse (CALD) and LGBTIQA+ Tasmanians experience greater barriers to accessing appropriate and essential maternal healthcare.

37. Aboriginal and Torres Strait Islander, Culturally and Linguistically Diverse (CALD) and LGBTIQA+ Tasmanians do not always receive culturally sensitive care which can lead to feelings of isolation or alienation.

38. The standard of care for pregnancy loss and bereavement in Tasmania is inadequate and inconsistent.

39. Families experiencing pregnancy loss and bereavement are not provided adequate physical or psychological support during their admission and discharge.

40. Dedicated spaces for care following pregnancy loss are not available in all Tasmanian hospitals.

41. Antenatal classes are not available to all Tasmanians. For those who do have access, current services are not meeting their needs.

42. Postnatal support is inadequate, including for families in the Neonatal Intensive Care Unit (NICU) or Special Support Unit (SSU), and after second or subsequent pregnancies.

43. Peer support is valuable for helping people adjust to parenthood.

44. There is a lack of understanding of reproductive and maternal healthcare in reproductive and sexual health education for Tasmanian students.

45. Despite a high number of women wanting to breastfeed many struggle to either take up or continue breastfeeding due to a lack of timely support.

46. Publicly available data is not collected on breastfeeding in Tasmania.

47. The high demand for breastfeeding education and lactation consultants in Tasmania is currently unmet.

48. Currently available services do not meet the demand for homebirth in Tasmania.

49. There is strong evidence that, in the majority of cases, homebirths are a safe option and provide a positive birth experience.

50. Tasmania is the only state or territory in Australia that does not fund homebirth in the public system.

51. Some other states and territories in Australia provide co-located homebirthing centres.

52. The Department of Health is investigating publicly funded homebirth in the Tasmanian Health Service.

53. There is limited availability in Tasmania of private homebirth through the care of Privately Practising Midwives (PPMs). Access is limited due to their small number, locations and the cost of services.

54. The Launceston Birth Centre is the only privately operating birth centre in Tasmania and often has long waitlists.

55. Long term advocacy for a Hobart birth centre continues, including discussions with the Government.

56. Publicly funded homebirth increases accessibility for anyone unable to afford the cost of private homebirth.

57. Few Tasmanian Aboriginal women currently access homebirth.

58. Privately Practising Midwives (PPMs) in Tasmania do not have permanent admitting rights in hospital.

59. Tasmanian Midwives operate under a limited medication formulary, provided in the *Poisons Act 1971*. Tasmania is the only state to continue use of a legislated formulary for midwives. Previous consultation and planning undertaken to change this has stalled.

60. Negotiations for Professional Indemnity Insurance for Privately Practising Midwives (PPMs) resulted in uncertainty for midwives and patients.

61. The Federal Government's proposal for Professional Indemnity Insurance (PII) for Privately Practising Midwives (PPMs) at the time the Committee received evidence was not fit for purpose. It would have limited the scope of practice of, and access to, Privately Practising Midwives (PPMs).

62. Some Tasmanians experience physical and psychological birth trauma.

63. There is no singular cause of birth trauma, with each birth experience affected by individual circumstances.

64. Birth trauma can be experienced by individuals giving birth, their support network and medical and health professionals.

65. An individual may not immediately understand or acknowledge that they have experienced birth trauma.

66. Birth trauma can have impacts beyond physical and psychological health, including financial costs and social impacts.

67. There are limited services available for family members who are impacted by birth trauma.

68. There is currently no dedicated public urogynaecology service provided in Tasmania.

69. There are instances in which Tasmanian women are not asked or able to give consent or informed consent during their labour.

70. Some women report a lack of opportunity during pregnancy to discuss birth options and potential interventions that could occur during labour. This can limit their ability to provide informed consent during labour.

71. Birth plans provide an opportunity for people to identify and discuss complications that may occur, and prepare for potential decisions they may need to make during labour.

72. Obstetric violence is not legally defined in Tasmania.

73. Actions which may be defined as obstetric violence can contribute to birth trauma.

74. Current complaint handling processes are not sufficiently person-centered and can lead to further trauma.

75. Other jurisdictions, including Victoria and New Zealand, have legislation that provides additional avenues for legal recourse and support services for those who have experienced birth trauma.

76. Trauma–informed training for medical and health professionals regarding consent, informed consent and birth trauma may assist in the provision of patient-centered care.

77. Perinatal mental health services do not meet the needs of Tasmanian families.

78. Tasmania has less perinatal mental health services than some other Australian jurisdictions, including inpatient and outpatient services, online support, navigation services and community education.

79. There is inequity of access to perinatal mental health services in regional and rural areas of Tasmania.

80. The Department of Health and stakeholder organisations recognise the lack of perinatal mental health services and have indicated a willingness to work together to increase services.

81. Birthing parents do not routinely undergo perinatal mental health screening and non-birthing parents and support networks are almost never screened.

82. The closure of the St Helen's Private Hospital Mother Baby Unit has had a profoundly negative impact on access to perinatal mental health care in Tasmania.

83. The Department of Health acknowledges that the interim Mother Baby Unit at the Royal Hobart Hospital does not provide best practice in mother baby units. A more appropriate model of care is planned for the new St John's Park facility.

84. At the time the Committee heard evidence, the Tresillian TAS BUB Parent's Help Line had not received a significant number of calls and was not operating to its full capacity.

85. The underutilisation of the Tresillian TAS BUB Parent's Help Line is likely linked to a lack of community awareness of this new service and potential perceived duplication between it and other existing services including the Child Health and Parenting Service (CHaPS) Parent Line.

86. Increased education for health professionals would improve access to perinatal mental health support.

87. The Child Health and Parenting Service (CHaPS) is a key healthcare service for Tasmanians which is highly valued and trusted by the community and healthcare practitioners.

88. There are some limitations on service provision by the Child Health and Parenting Service (CHaPS) including:

    a. Geographical access, particularly in rural and regional Tasmania;

    b. Timeliness of access; and

    c. Consistency and flexibility in service provision.

89. The ability of the Child Health and Parenting Service (CHaPS) to provide four-year-old health checks in Tasmania is inadequate due to under resourcing. This results in many children missing this check, preventing the early identification of developmental delays and the opportunity for early intervention prior to the commencement of school.

90. Outside of the Child Health and Parenting Service (CHaPS), there is further inequitable access to four-year-old health checks as some, but not all, schools have access to a school nurse who can provide these checks and only some families can afford to pay for these checks with a private practitioner.

91. The number of Child Health Family Nurses (CHFNs) employed by the Child Health and Parenting Service (CHaPS) is inadequate to meet the needs of Tasmanian families.

92. Parenting groups provided by the Child Health and Parenting Service (CHaPS) are highly valued by the Tasmanian community, however accessing the groups, or information about them, can at times be difficult.

93. There is a significant shortage of paediatricians in Tasmania. There is also a shortage of General Practitioners and other medical and allied health specialists.

This places a burden on the healthcare system more broadly and leads to Tasmanian children missing out on timely healthcare.

94. Tasmanian families experience significant wait times in accessing specialised support for the assessment, diagnosis, intervention and treatment of Attention – Deficit and Hyperactivity Disorder (ADHD) and Autism Spectrum Disorder (ASD).

95. Accessing the Tasmanian Autism Diagnostic Service (TADS) is complicated and difficult to navigate. There are limited referral pathways and the capacity of the service is inadequate, delaying diagnosis and intervention.

96. The capacity of the Early Childhood Inclusion Service (ECIS) has been reduced, making it harder to access services. A lack of early intervention can have lifelong impacts on children and their families.

97. Early intervention services such as Early Childhood Inclusion Service (ECIS) can reduce the need for the National Disability Insurance Scheme (NDIS) services.

98. The estimated wait time for paediatric physiotherapy through the Tasmanian Health Service is four to six months.

99. There is potential to expand the range of allied health services provided through Child and Family Learning Centres (CFLCs).

100. The Committee note the current Government Administration Committee B, *Inquiry into the Assessment and Treatment of attention deficit hyperactivity disorder (ADHD) and Support Services*, and expect its recommendations will be relevant to matters raised in this Committee regarding paediatric attention deficit hyperactivity disorder (ADHD) diagnosis and treatment.

101. There is a local, national and international shortage of midwives.

102. Workforce shortages, including of midwives, is a major factor in the cessation of maternal services at the Hobart Private Hospital.

103. Workforce shortages negatively impact patient experience of maternal healthcare and limit choice.

104. Conditions for healthcare professionals, including staff shortages and workplace culture, impact recruitment, job satisfaction and staff retention.

105. Implementing the 'Count the Babies' policy to include both mothers and babies in midwifery workloads would ensure appropriate and safe staffing levels and better outcomes on obstetric wards in the Tasmanian Health Service.

106. When Tasmanians have to study midwifery qualifications interstate, it results in many choosing to work interstate. This contributes to midwife shortages in Tasmania.

107. The Government and University of Tasmania have announced the establishment of a graduate Diploma of Midwifery by 2026 and a direct-entry undergraduate course potentially by 2027.

108. General Practitioner shortages in Tasmania lead to additional pressure on the public health system.

109. Tertiary education and continuing professional development for health professionals require a greater focus on the needs of Aboriginal and Torres Strait Islanders, culturally and linguistically diverse people and members of the LGBTIQA+ community.

110. There are not enough women's and paediatric physiotherapy FTE positions in the Tasmanian Health Service.

RECOMMENDATIONS

The Committee recommends:

1. **The Government prioritise access to no-cost or low-cost access to contraception and sexual healthcare.**
2. **The Government fund training opportunities for medical practitioners in the provision of long-acting reversible contraception (LARCs).**
3. **The Government provide In Vitro Fertilisation (IVF) services in the Tasmanian Health Service.**
4. **The Government review relevant legislation relating to parentage orders for surrogacy, with a view to simplifying and improving the process.**
5. **The Government increase collection of de-identified termination of pregnancy data to inform better service provision.**
6. **The Tasmanian Health Service develop and provide clear information and education resources about termination pathways in Tasmania for community and healthcare professionals.**
7. **The Government provide public access to Medical Terminations of Pregnancy (MToP) at no out-of-pocket cost.**
8. **The Government removes barriers and improves access to Medical Termination of Pregnancy (MToP) and Surgical Termination of Pregnancy (SToP).**
9. **The Government make the Youth Health Fund easier to access.**
10. **The Government prioritise the development and implementation of best practice standards for post-termination care in the Tasmanian Health Service, including education and training for health professionals.**
11. **The Government develop a women's health strategy, including reproductive and maternal healthcare, to inform service provision and guide infrastructure development.**
12. **The Government conduct an audit of available maternal and reproductive healthcare infrastructure in Tasmania.**
13. **The Government work with private obstetricians to recommence service provision in the North West.**
14. **The Government investigate the feasibility of the establishment of a dedicated Tasmanian women's and children's hospital.**
15. **The Government ensure a continuity of care model is available to all pregnant people in the Tasmanian Health Service, including a focus on midwifery-led care.**
16. **Every pregnant person is offered the opportunity to develop a birth plan in consultation with health professionals and that these birth plans are recognised, respected and followed.**

17. **The Tasmanian Health Service ensure postnatal home support is available to families after discharge from the Neonatal Intensive Care Unit (NICU) or Special Support Units (SSU).**

18. **The Government develop a standard model of care for pregnancy loss and bereavement care in Tasmania.**

19. **The Tasmanian Health Service provide separate, dedicated space for pregnancy loss and bereavement care in Tasmanian hospitals.**

20. **The Tasmanian Health Service review antenatal classes, including updating content and improving accessibility and availability of classes.**

21. **The Government increase funding and support for peer led parenting and family groups.**

22. **The Government include reproductive and maternal healthcare in the curriculum for Tasmanian schools.**

23. **The Government improve breastfeeding education and support services in the Tasmanian Health Service and ensure access to ongoing assistance when required.**

24. **The Government collect and make publicly available breastfeeding data in Tasmania.**

25. **The Government fund and facilitate professional development in women and family centred maternal healthcare and breastfeeding for health practitioners within the Tasmanian Health Service.**

26. **The Government embed culturally sensitive knowledge and practices in the provision of maternal and reproductive healthcare in consultation with stakeholder groups.**

27. **The Government fully fund and support public homebirth in Tasmania.**

28. **The Government investigate the establishment of public birth centres co-located with public hospitals in Tasmania and continue conversations with proponents of The Birth House in Hobart.**

29. **The Government investigate the need for and provide travel assistance to facilitate public homebirth.**

30. **The Government develop policies and procedures for admitting rights for Privately Practising Midwives (PPMs) in all public hospitals.**

31. **The Government reestablish consultation on the medication formulary for midwives with a view to removing the formulary from the *Poisons Act 1971* in line with other states.**

32. **The Government advocate to the Federal Government to ensure the Professional Indemnity Insurance (PII) scheme is fit for purpose and does not restrict private midwifery practise.**

33. **All pregnant people have the opportunity during pregnancy to develop a birth plan during pregnancy in consultation with health professionals. Birth plans**

should include consideration of unexpected birth events and potential interventions.

34. **The Tasmanian Health Service provide a dedicated urogynaecology service in the state.**

35. **The Tasmanian Health Service develop and provide consent and informed consent education resources for use with patients during antenatal care.**

36. **The Tasmanian Health Service adopt the internationally recognised definition of obstetric violence and educate staff and patients about birth trauma and obstetric violence.**

37. **The Tasmanian Health Service provide the Better Birth with Consent Workshop, or a similar program, to all maternal health professionals.**

38. **A review of the Tasmanian Health Service complaints handling processes, with a view to providing a more trauma-informed process.**

39. **The Department of Health implement an open disclosure scheme similar to that operating under the *Victorian Charter of Human Rights and Responsibilities Act 2006*.[1]**

40. **The Government ensure the adequate funding and provision of perinatal mental health support services in Tasmania.**

41. **The Government establish an expert working group, including not-for-profit organisations and peak bodies, to investigate and recommend a holistic model for the provision of perinatal mental health services.**

42. **The Tasmanian Health Service develop and implement clear perinatal mental health service navigation pathways.**

43. **The Tasmanian Health Service introduce universal perinatal mental health screening of both birthing parents and non-birthing parents, and where needed, support networks and families in both the antenatal and postnatal period.**

44. **The Government establish state run permanent inpatient mother baby units in each region of Tasmania.**

45. **The Government evaluate the public awareness and effectiveness of the Tresillian TAS BUB Parent's Help Line.**

46. **As a matter of urgency the Government recruit additional Child and Family Health Nurses (CFHNs), paediatricians and General Practitioners with Special Interests (GPwSIs) to meet the level of need.**

[1] Victorian Legislation, Charter of Human Rights and Responsibilities Act 2006, https://www.legislation.vic.gov.au/in-force/acts/charter-human-rights-and-responsibilities-act-2006/015.

47. **The Government fund and deliver as a priority, four-year-old health checks to all Tasmanian children.**

48. **The Tasmanian Health Service provide additional Child and Parenting Health Service (CHaPS) parenting groups for all parents or caregivers.**

49. **The Government increase funding to the Early Childhood Inclusion Service (ECIS) to enable a return to the delivery of more community place-based services.**

50. **The Government review referral processes for Autism Spectrum Disorder (ASD) assessment, including exploring the expansion of Tasmanian Autism Diagnostic Service (TADS) referral pathways to include General Practitioners, Child and Family Health Nurse (CFHNs) and psychologists.**

51. **The Government expand the provision of allied health services in Child and Family Learning Centres (CFLCs).**

52. **The Government continue to provide workforce incentives to increase the midwife, nurse and General Practitioner workforce in Tasmania.**

53. **The Government prioritise as a matter of urgency the ongoing development of graduate and undergraduate midwifery degrees with the University of Tasmania.**

54. **The Tasmanian Health Service implement the 'Count the Babies' policy.**

55. **The Government work with providers of tertiary and continuing professional development education in Tasmania to ensure cultural awareness training is implemented into all degrees and programs for health professionals.**

56. **The Government create more FTE positions in women's and paediatric physiotherapy in the Tasmanian Health Service.**

1 BACKGROUND, APPOINTMENT, TERMS OF REFERENCE AND CONDUCT OF INQUIRY

Background

1.1. The experiences of Tasmanians accessing health services during perinatal and paediatric periods has a significant impact on the experience of parents, children and their families and wider support networks. These experiences are impacted by issues of accessibility and adequacy of these services. The experiences of people accessing reproductive, maternal and paediatric healthcare in Tasmania as well as the provision of services by medical professionals, can differ.

1.2. The Committee's Terms of Reference were relatively broad, but predominantly focused on the provision of reproductive, perinatal and paediatric services in the Tasmanian public health system. This introductory Chapter will provide a brief insight into the Committee's Terms of Reference, as well as some of the main areas the Committee received evidence about. These included reproductive health services, maternal health services, birth trauma, workforce shortages, midwifery Professional Indemnity Insurance, perinatal mental health services, paediatric services and the Child Health and Parenting Service (CHaPS). The Chapter will then detail the structure of the Committee's work. Chapter 2 will provide an overview of the broader context of the establishment of the Committee.

1.3. In 2021, Tasmania saw the birth of 6,081 babies.[2] 3,221 occurred in the South of the state, 1,588 in the North and 1,237 in the North West. Seven Tasmanians were born interstate.[3] 28 of the total births were not live births.[4]

1.4. 98.5% of 2021 births occurred in hospital, 0.4% in birth centres and 0.9% were in neither a hospital nor birth centre. These included homebirths, "freebirths" and undefined others.[5]

1.5. Reproductive health services include fertility care, contraception and pregnancy terminations. Access to these services varies across Tasmania and will be explored in more detail in Chapter 3.

1.6. Maternal health services include the continuum of care to mothers and babies during pregnancy, labour, birth and the postnatal period.[6] These services include care provided by midwives, gynaecologists, obstetricians, doctors, nurses, paediatricans and other specialist health providers.[7] Access to maternal health services will be discussed in Chapter 4.

1.7. Birth trauma, also referred to as birth-related trauma, is defined by Birth Trauma Australia as 'including any injury or trauma, whether physical or psychological, sustained at any time in connection with all stages of the birth journey and can

[2] Submission No. 129, Department of Health, p. 19.
[3] Submission No. 129, Department of Health, p. 19.
[4] Submission No. 129, Department of Health, p. 19.
[5] Submission No. 90, Homebirth Australia, p. 1.
[6] Submission No. 129, Department of Health, p. 18.
[7] Submission No. 129, Department of Health, p. 18.

affect the mother, birthing parent, fathers or non-birthing parents,'[8] as well as healthcare workers. Chapter 6 will discuss birth trauma further.

1.8. The employment conditions, education, training opportunities and insurance for healthcare workers across the Inquiry's areas of investigation are varied and impact the experiences of workers and patients. The full context of these workforce matters will be discussed in both Chapters 5 and 9.

1.9. Perinatal mental health conditions include 'all adult mental health conditions in addition to perinatal period-specific disorders such as postpartum psychosis'[9] which occur in the perinatal period. While definitions of the perinatal period vary, leading experts, the Centre of Perinatal Excellence (COPE) define it as the period from pregnancy to 12 months post birth.[10] Chapter 7 examines perinatal mental health services in Tasmania.

1.10. In March 2023, 5.13 per cent of the Tasmanian population were aged between 0 – 4 years, equating to 29, 327 children[11].

1.11. Public hospital admissions for children aged 0 – 5 years from 2022 – 2023 were 5,651, including 196 admissions for paediatric surgery.[12]

1.12. From May 2023, the State Government began implementation of the Tasmanian Paediatric Model of Care. The Model aims to address issues including the navigation of paediatric services for Tasmanian families.[13]

1.13. In Tasmania, the CHaPS provides health and wellbeing services to Tasmanian families with children aged 0 – 5. The Department of Health (DoH or the Department) notes that in a year, CHaPS conducts approximately 52,000 consultations, 30,000 Child Health Assessments, including seeing 5, 500 babies.[14]

1.14. The CHaPS service operates in 70 locations statewide and provides care from a range of professionals including child health nurses, allied health workers and clinical specialists. CHaPS further facilitates programs and groups including New Parent Groups, Circle of Security Groups, Mother Matters Groups, sleep support groups, Sustained Home Visiting program and the cu@home program.[15] An assessment of paediatric health services and CHaPS is undertaken in Chapter 8.

Appointment and Terms of Reference

1.15. The House of Assembly Select Committee on Reproductive, Maternal and Paediatric Health Services in Tasmania was established on 18 October 2023 with the following Terms of Reference:

[8] Submission No. 24, Birth Trauma Australia, p. 9.
[9] Submission No. 13 Attachment B, Centre of Perinatal Excellence, p. 22.
[10] Submission No. 13 Attachment B, Centre of Perinatal Excellence, p. 7.
[11] Submission No. 129, Department of Health, p. 35.
[12] Submission No. 129, Department of Health, p. 35.
[13] Submission No. 129, Department of Health, p. 36.
[14] Submission No. 129, Department of Health, p. 43.
[15] Submission No. 129, Department of Health, p. 44.

(1) *A select committee be appointed with the power to send for persons, papers and records to inquire into, consider and report on reproductive, maternal and paediatric health and perinatal mental health services in Tasmania, with the following terms of reference:—*

(a) to assess the adequacy, accessibility and safety of the following services for Tasmanian parents and their children in relation to:—

(i) reproductive health services;

(ii) maternal health services;

(iii) birth trauma;

(iv) workforce shortages;

(v) midwife professional Indemnity Insurance;

(vi) perinatal mental health services;

(vii) paediatric services for children aged 0-5 years;

(viii) the Child Health and Parenting Service (CHaPS).

(b) to examine disparities in the availability of services, staffing and outcomes between:—

(i) Tasmania and other Australian states and territories;

(ii) Tasmanians living in rural, regional and metropolitan areas;

(iii) Tasmanians experiencing socio-economic disadvantage; and

(c) to make recommendations on actions that can be taken by the State Government to ensure reproductive, maternal and paediatric health and perinatal mental health services meet the needs of Tasmanian parents, families and children.

(2) The number of Members appointed by the House to serve on the committee be six: two nominated by the Leader of Government Business; two nominated by the Leader of Opposition Business; one nominated by the Leader of Tasmanian Greens Business and an Independent Member nominated by the Mover.

(3) The committee shall report by 9 April 2024.

1.16. The Committee first met on 9 November 2023, with the following membership: Mr Simon *Behrakis* MP, Ms Anita *Dow* MP (Chair), Ms Kristie *Johnston* MP, Ms Michelle *O'Byrne* MP (Deputy Chair), Mr Simon *Wood* MP and Dr Rosalie *Woodruff* MP.

1.17. The Committee had not yet reported when the House of Assembly was dissolved and the Parliament of Tasmania prorogued on 14 February 2024.

1.18. On 13 June 2024 a new (second) Select Committee was formed by the Fifty-First Parliament. The new Committee was authorised to receive all evidence and papers of the former Committee.

1.19. The new Committee's Terms of Reference provided that the Committee report by 28 November 2024. On 10 September 2024 the Committee Chair sought an extension of the new reporting date until 25 March 2025. A further extension was sought on 27 November 2024, with the report to be tabled on 19 August 2025.

1.20. The second Committee first met on 23 August 2024 with the following Members: Ms Anita *Dow* MP, Mr Rob *Fairs* MP, Ms Ella *Haddad* MP (Chair), Ms Kristie *Johnston* MP, Mrs Jacquie *Petrusma* MP (Deputy Chair), and Ms Cecily *Rosol* MP.

1.21. On 26 November 2024, Mrs *Petrusma* MP resigned from the Committee, with Mr Nic *Street* MP appointed as her replacement. Prior to her resignation from the Committee, Mrs *Petrsuma* MP participated as a member in one public hearing on 21 October 2024. Extracts from the associated Hansard transcript are used in this Report. Mrs *Petrsuma* MP then attended a hearing on 26 February 2025 in her then role as Minister for Health, with extracts again used from this Hansard transcript. Attention should be given to the appropriate context in which Mrs *Petrusma* MP appeared before the Committee.

1.22. On 18 February 2025, Ms *Dow* MP was nominated as the Deputy Chair, replacing Mrs *Petrusma* MP.

1.23. During the Committee's conduct throughout the Fifty-First Parliament, the role of Minister for Health was held by two Members of Parliament. For clarity it is noted that the Hon. Guy *Barnett* MP held the position from the commencement of the Parliament in May 2024 to 23 October 2024. During this time, the submission from the DoH was received and signed by then Minister *Barnett*. This was the only interaction Minister *Barnett* had with the Committee in this role. From 23 October 2024 until the appointment of the Cabinet after the General Election, on 11 August 2025, the Hon. Jacquie *Petrusma* MP held the position of Minister for Health.

1.24. The portfolio of Mental Health and Wellbeing was also held by two Members of Parliament throughout the Fifty-First Parliament. The Honourable Guy *Barnett* MP, filled the role from 11 April 2024 until 23 October 2024. Minister Roger *Jaensch* MP then held the role from 23 October 2024 until the appointment of the Cabinet after the General Election, on 11 August 2025.

1.25. The Committee had not yet reported when the House of Assembly was dissolved, and Parliament of Tasmania was again prorogued on 11 June 2025.

1.26. On 9 September 2025 a new Select Committee, being the third, on Reproductive, Maternal and Paediatric Health Services in Tasmania was established by the Fifty-Second Parliament. The new Committee was authorised to receive all evidence and papers of the former Committees.

1.27. The new (third) Committee's Terms of Reference established that the Committee report by 19 March 2026.

1.28. The third iteration of the Committee held its first meeting on 16 September 2025 with the following Members: Ms Anita *Dow* MP, Mr Rob *Fairs* MP, Ms Ella *Haddad*

MP, Ms Kristie *Johnston* MP, and Ms Cecily *Rosol* MP. Ms *Haddad* was re-elected Chair and Ms *Rosol* was elected Deputy Chair.

1.29. At the time of the establishment of the third Committee, the Honourable Bridget Archer MP held the position of Minister for Health, Mental Health and Wellbeing. This position was maintained until the conclusion of the Inquiry.

Conduct of the Inquiry

1.30. The Committee of the Fiftieth Parliament resolved to invite interested persons and organisations to make a submission in relation to the Terms of Reference. This was advertised on the Parliament of Tasmania website and in the three major Tasmanian newspapers.

1.31. The first iteration of the Committee received 26 submissions. No public hearings were held.

1.32. The Fifty-First Parliament established the second Committee and access was provided to the previous Committee's evidence.

1.33. The new Committee also resolved to re-open submissions to allow for further evidence to be collected. This was advertised on the Parliament of Tasmania website and in the three major Tasmanian newspapers. Individuals and organisations who had contributed to the former Committee were invited to provide an updated submission if they wished.

1.34. The Committee received an additional 109 submissions. The total number of submissions received across the three versions of the Committee, noting only two versions opened for submissions, is 135. Nine submitters from the first Committee provided updates to their submissions.

1.35. The Committee held seven public hearings, five in Hobart, one in Burnie and one in Launceston. 71 witnesses attended public hearings. The Committee participated in three site visits, attending the North West Regional Hospital, Launceston Birth Centre and the Launceston General Hospital.

1.36. In recognising the sensitive nature of the Committee's work, several adjustments to standard Committee practice were made, with the lived experience of witnesses and observers given significant care and held at the forefront of decision making. The Committee made several procedural resolutions to allow these adjustments.

1.37. First, a content disclaimer and support services contact numbers were included on the Committee's webpage, on media releases and in the Chair's opening statement for public hearings. This disclaimer was read at the commencement of each session of a public hearing to ensure that any potential new observers of the hearing or readers of the transcript were aware of the contacts.

1.38. Second, the Committee resolved to provide clinical support services to lived experience witnesses participating in public hearings. The Committee engaged Gidget Foundation Australia (Gidget Foundation) to provide this support, with two mental health clinicians engaged for the three lived experience public hearings held

in Burnie, Launceston and Hobart. The clinicians provided onsite support to witnesses prior, during and immediately after their appearance. For these three hearings a separate breakout space was also provided for Gidget Foundation and witnesses to utilise for privacy before or after their hearing.

1.39. Third, prior to the formal commencement of each session with a lived experience witness, an informal introduction was held. This provided an opportunity for witnesses and their support persons to be introduced to Members of the Committee and parliamentary staff before the formal proceedings and broadcast commenced. This also provided another opportunity for witnesses to ask any administrative or procedural questions before their contribution. Once all parties were prepared, the Chair commenced the formal proceedings, starting with an introduction, including the content disclaimer.

1.40. Fourth, the Committee also resolved that some reactions would be applied to submissions when published. When included, the names, dates of birth or other identifying dates regarding the personal information of children or minors was redacted.

The Committee also resolved to redact the names of medical professionals, recognising the Committee does not have the remit to investigate individual complaints.

1.41. The Committee of the Fifty-Second Parliament sought updated information from key stakeholders to the Inquiry. Updates were invited from the Minister for Health, Mental Health and Wellbeing, the DoH, Calvary Healthcare and Calvary Lenah Valley Hospital (Calvary), Healthscope and the Hobart Private Hospital (the Hobart Private), the Australian Medical Association (AMA) Tasmania Branch, the Australian Nursing and Midwifery Federation (ANMF) Tasmania and Tresillian. Updates were received from a number of these organisations and are available on the Committee's webpage.[16]

1.42. This Report should be read in conjunction with the attached documents.

1.43. A list of submissions can be found in Appendix A.

1.44. A list of hearing witnesses can be found in Appendix B.

1.45. A Glossary of repeated terms can be found in Appendix C.

1.46. The minutes of the Committee are attached as Appendix D.

1.47. The transcript of evidence from the Committee's hearings are available in Appendix E.

[16] Updated information available on the Committee webpage: https://www.parliament.tas.gov.au/committees/house-of-assembly/select-committees/select-committee-on-reproductive,-maternal-and-paediatric-health-services-in-tasmania2

Structure of this Report

1.48. This report consists of the following Chapters:

- Chapter 1 provides a brief overview and administrative details of the Inquiry.
- Chapter 2 examines the local context of the Inquiry in Tasmania.
- Chapter 3 examines the provision and access to reproductive care in Tasmania.
- Chapter 4 addresses access to maternal healthcare services in Tasmania.
- Chapter 5 explores homebirth and Professional Indemnity Insurance (PII) for midwives.
- Chapter 6 discusses birth trauma in the Tasmanian context.
- Chapter 7 explores perinatal mental health and related supports in Tasmania.
- Chapter 8 assesses the provision of paediatric healthcare in Tasmania and the services of CHaPS.
- Chapter 9 provides an assessment of workforce matters, including education and training.

2. CONTEXT OF THE INQUIRY IN TASMANIA

2.1. This chapter explores the context of the Inquiry in the Tasmanian community.

2.2. From the evidence received, the Committee understands that the experiences of Tasmanians with healthcare related to the Terms of Reference are individual, varied and dependent on a number of intersecting factors relevant on the individual level. Given the breadth of the Committee's work, much evidence has been heard which details the stories of individuals and families in the Tasmanian healthcare system and how this interplays with the institutional settings in the state.

2.3. The original establishment motion for the Select Committee of the Fiftieth Parliament was moved by Ms *Dow* MP on 18 October 2023.[17] The debate on this motion provided a number of contextual reasons for the establishment of the Committee.

2.4. One key contextual matter raised as an influence on the establishment of the Committee was the closure in mid-2023 of St Helen's Private Hospital (St Helen's) in Hobart.[18] The services previously provided at St Helen's included an eight bed Mother Baby Unit, Tasmania's only inpatient maternal and perinatal health unit as well as a wide range of private mental health services. St Helen's was the only service provider in Tasmania for some of the services they offered.

2.5. In response to the closure of the Mother Baby Unit, the Tasmanian Health Service (THS) and DoH established a three bed inpatient unit at the Royal Hobart Hospital (RHH) to provide access to perinatal mental health support.[19]

2.6. Ongoing concerns for access to adequate reproductive and maternal health services for residents in the North West of Tasmania was another driving contextual factor for the establishment of the Committee.[20] This included advocacy from patients who received care in the North West, who shared their stories with each other, the media and with the Government including the Premier, the Hon. Jeremy *Rockliff* MP.[21]

2.7. The experiences of patients and medical professionals on the North West Private Hospital's maternity ward was also raised by representative bodies. In February 2023, the Australian Medical Association (AMA) Tasmania raised their concern regarding the standard of available services. This matter was raised in reporting by the ABC, who quoted Annette Baratt, Vice – President of the AMA Tasmania as follows:

[17] Parliament of Tasmania, House of Assembly Hansard, 18 October 2023, pp. 66 – 86.
[18] Submission No. 31, Women's Health Tasmania, p. 25
[19] Submission No. 129, Department of Health, p. 8.
[20] Submission No. 25, Australian Medical Association Tasmania, pp. 1-2.
[21] Champ, Manika, ABC News, 'North-west Tasmanian birthing services 'inefficient, ineffective and dangerous', AMA warns', dated 10 February 2023, https://www.abc.net.au/news/2023-02-10/ama-warning-over-burnie-birthing-services/101951836.

We believe the current maternity services which are based at the private are inefficient, ineffective and dangerous to mothers and children, and need to be changed so that the patients are now seen back in the public sector[22]

2.8. Due to the length in duration of the Committee's activity, a number of matters arose, changed or were updated across 2023 – 2025. These matters will be raised throughout the Report in the Chapters relevant to their content matter. These matters include:

- Reviews of maternity services ordered by the Department of Health;
- The transition of the maternity services in the North West; and
- The closure of maternity services at the Hobart Private Hospital (the Hobart Private) and the resulting transition of services to Calvary and the RHH.

[22] Champ, Manika, 10 February 2023, 'North-west Tasmanian birthing services 'inefficient, ineffective and dangerous', ABC News, https://www.abc.net.au/news/2023-02-10/ama-warning-over-burnie-birthing-services/101951836.

3. ADEQUACY, ACCESSIBILITY AND SAFETY OF REPRODUCTIVE HEALTH SERVICES

3.1. The adequacy, accessibility and safety of reproductive health services in Tasmania was a key consideration of the Inquiry. Throughout its work, the Committee received evidence regarding three main areas of reproductive healthcare, being contraception, termination and fertility services, with the latter focused on In Vitro Fertilization (IVF).

3.2. In its submission, the DoH provided an assessment of the scope of reproductive health services available in, or supported by, the Tasmanian Health Service (THS):

> *DoH provides a range of sexual and reproductive health services across the State, including dedicated sexual health services; youth health services; access to public sector surgical terminations; and women's and maternity services, including antenatal and postnatal care….*
>
> *DoH also works with non-government organisations to support access to information and services. This includes providing funding to support access to information on pregnancy options, services such as medical and surgical terminations, and long-acting reversible contraceptives outside of the public system. Together, these services and supports are designed to help ensure all Tasmanians are supported to access timely and high quality sexual and reproductive health services and information.*[23]

Contraception

3.3. Access to contraceptive options, the provision of education and resources regarding contraception and cost impacts were raised as areas of concern in reproductive healthcare in Tasmania.

3.4. Jo Flanagan, CEO of Women's Health Tasmania (WHT), described what the organisation observes as a significant issue with access to contraception in Tasmania:

> ***Ms FLANAGAN - ...*** *There are also structural problems impacting on people's experiences of contraception and abortion. Access to contraception is impacted by high costs and geographical issues, especially in rural regions, poor access to primary healthcare providers, health literacy issues, this trend away from hormonal contraceptives at the moment because of online misinformation. Community health promotion services need resources to improve community health literacy about contraceptives. Going into communities, co-designing appropriate information and producing resources that aren't text-based is resource intensive.*[24]

3.5. In their submission to the Inquiry, WHT also raised the matter of access to contraceptive prescriptions, noting the Governments new initiative to allow pharmacists prescribing rights, which was enabled from 1 July 2024:

> *We welcomed keenly the Tasmanian Government announcement of its new pharmacist prescribing initiative, therefore, allowing approved community pharmacists to provide*

[23] Submission No. 129, Department of Health, p. 13.
[24] Transcript of Evidence, 26 March 2025, Women's Health Tasmania, p. 43.

a resupply of the contraceptive pill for up to 12 months from 1 July 2024.[25] *This scheme brings Tasmania into line with other Australian states and territories that are trialling over-the-counter prescribing and dispensing initiatives, and saves consumers the cost, wait time and transport hurdles associated with accessing a GP.*[26]

3.6. The Chair asked Ms Flanagan further questions regarding the availability of prescribing at pharmacies:

> ***CHAIR*** *- I wanted to go to one other part of your written submission, which is pharmacy prescribing. I understand that's still in its pilot stage in Tasmania - UTI medication and now the contraceptive pill in limited circumstances. I know it's still pilot, and no doubt the government will do some kind of review around extension of that. Other states have added to the medications that pharmacists can provide. I wondered if you'd like to put anything on the record around that change in Tasmania: how you think it's been received and how it might benefit from continuation or otherwise.*
>
> ***Ms FLANAGAN*** *- It's a good initiative in that it increases access for people to be able to collect scripts, particularly in an environment in which they can't get appointments with their GPs. It's important to note that it doesn't lower the cost for them. The way it is organised, they don't get access to the PBS [Pharmaceutical Benefits Scheme] benefit, and they have to pay for an appointment with the pharmacist in order to begin the process.*
>
> *We haven't been able to do a comparison of costs, but it's probably pretty similar in terms of whether they go to the GP or the pharmacist. That's a really important point, because the cost of contraception is a massive barrier to the use of contraception. There's a lot of discussion going on nationally and internationally about the provision of free contraception and the value of that. In countries where they've done it they're seeing a decline in the need for termination services, of course. It just makes sense that would be something that we looked at.*
>
> ***CHAIR*** *- It must be part of the picture.*
>
> ***Ms FLANAGAN*** *- What has been done here around the provision of long-acting reversible contraceptives is a great first step, but we do need to be able to talk to the community about them. Australia's take-up of long-acting reversible contraceptives is lower than European countries, because the public doesn't understand them.*[27]

3.7. Dr Nisha Khot, representing the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) similarly raised concern with access to contraception in Tasmania:

> ***CHAIR*** *- I'd like to go to that issue as well and it's where you opened in your opening statement, which is access to termination, abortion services, and to contraception. What is the experience of your members here in Tasmania? You described it as an inequity of access and a lack of access. Can you just expand on that for the committee a little?*

[25] Footnote 9, Resupply of the oral contraceptive pill. Tasmanian Government Department of Health: https://www.health.tas.gov.au/health-topics/sexual-and-reproductive-health/reproductivehealth/contraception-fertility-control/resupply-oral-contraceptive-pill, from Submission No. 31, Women's Health Tasmania, p. 8.
[26] Submission No. 31, Women's Health Tasmania, p.8.
[27] Transcript of Evidence, 26 March 2025, Women's Health Tasmania, p. 26.

***Dr KHOT** - It's tied up with the lack of having appropriate clinicians there to provide both medical and surgical abortions as well as to provide long-acting reversible contraception because all three procedures require specific qualifications. If you don't have the appropriately qualified people to be able to provide this service, then that creates a desert, if you like, of those services.*

GPs are very crucial to the provision of all these services because they are qualified to provide medical abortion as well as contraceptive services. Utilising our GP colleagues to provide those services is something that we would definitely support and encourage. That's why the college runs specific programs to make sure GPs can have the extra knowledge and skills to be able to provide those services. That's where we come in, in trying to make sure that there is equitable access to abortion care.[28]

3.8. Family Planning Tasmania (FPT), a supplier of reproductive healthcare in Tasmania, detailed significant positive impacts of the provision of contraception to individuals:

In addition, contraception can avert significant economic, social and psychological costs, especially those arising from a mistimed or unwanted pregnancy. Such non-medical costs can limit life options for women and undermine the well-being of families. They can also hold back social and economic development, and hinder efforts toward gender equality and poverty reduction.[29]

3.9. The Committee also received evidence from Dr Natasha Vavrek, a GP and owner of The Bubble Tasmania, two multidisciplinary women's health clinics in Launceston and Hobart. In her submission, Dr Vavrek discussed the capacity for her business to provide services including prescribing contraception, as well as training for health professionals:

As state trainers for doctors seeking to specialise in intrauterine device (IUD) insertions, we operate a thriving IUD clinic, contributing to the broader medical community's knowledge and expertise in this field and cater to the increasing number of women accessing preferred long acting reversible contraceptives.[30]

3.10. Before a hearing of the Committee, Dr Vavrek also detailed the importance she considers of increasing the provision of long–acting reversable contraceptives (LARCs) in Australia:

***Dr VAVREK - ...** I don't like to dwell on the negative so much, so a positive is that, yes, we've had an increase in the rebate for IUD [intrauterine contraceptive device] insertions and so IUDs, also known as long-acting reversible contraceptives, or LARCs, are the number one recommended form of contraception or control of heavy menstrual bleeding in the world. Every country recommends them. Yet in Australia we do have one of the lowest rates of insertion. I think a lot of that did come down to costs, so having that rebate rise, so the patient gets more back is fantastic. That means I don't have to increase my gap for IUD insertions for at least the next five years which, as it*

[28] Transcript of Evidence, 23 October 2024, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, p. 55.
[29] Submission No. 28, Family Planning Tasmania, p. 4.
[30] Submission No. 14, Dr Natasha Vavrek, pp. 2 - 3.

has been every 12 months we do have to increase that to keep up with the rising costs. So now that can be passed onto the patient and we'll be able to freeze any kinds of increases on pricing for that. It would be really great to see that in other aspects.[31]

3.11. The Australian Medical Association (AMA) Tasmania provided a recommendation regarding access to contraception, as an element of their recommendation to increase the general understanding Tasmanians have of wellbeing:

> *Universal access to no-cost contraceptive and sexual health care for all young people to promote planned pregnancies.* [32]

Fertility

3.12. The Committee also heard evidence about access to fertility healthcare including access to IVF and the possibility that there is currently discrimination against some trying to access fertility services.

3.13. In their submission, the Royal Australian College of General Practitioners (RACGP) Tasmania provided the following overview of access to fertility care in Tasmania:

> *There are scarce resources available to families for the pregnancy planning phase of reproductive health, particularly in the public health system domain. Genetic screening is available, however in practice patient access to this is dependent on GP awareness and knowledge level which is currently limited and impacting coverage of this service. Patients accessing prenatal service privately have greater access to support and resource for pregnancy planning.*
>
> *Patients facing decreased fertility and infertility have no publicly funded access to reproductive assistance technologies including in vitro fertilisation (IVF). Privately funding this is prohibitively expensive for patients without health insurance, and still difficult for those who do. There is limited governance over setting of fees for reproductive assistance.*[33]

3.14. The AMA Tasmania also provided a contextual analysis of existing limitations to fertility services, suggesting a lack of access to IVF in Tasmania:

> *Reproductive services are essential services, in particular for individuals and families with infertility (both primary and secondary, including those with congenital anomalies, previous cancer treatment, surgical complications, same sex couples, and couples seeking surrogacy). Withholding public services discriminates against these Tasmanian individuals and families, many of whom have not chosen infertility. Members, some of whom have their own experiences of requiring IVF, find the lack of public services in Tasmania deeply distressing and disappointing.*
>
> *Two private clinics in Hobart offer reproductive healthcare in the form of IVF (and associated) services in Tasmania, however this is at a significant out of pocket cost to consumers (limiting accessibility for many Tasmanians). Neither private service publishes its outcome or safety data (available in some other states in Australia), limiting the capacity for Tasmanians to compare outcomes and safety with mainland services.*

[31] Transcript of Evidence, 26 March 2025, Dr Natahsa Vavrek, pp. 67 – 68.
[32] Submission No. 25, Australian Medical Association Tasmania, p. 15.
[33] Submission No. 104, The Royal Australian College of General Practitioners Tasmania, p.2.

Tasmania does not have any publicly funded nor bulk-billing IVF reproductive services. This is an incredible disadvantage to all those living in Tasmanians [sic], but particularly in the North West where there are also no private services to give people a choice. While there are no services in the North West, services in the North are not much better. Essentially all services are now run out of Hobart with patients having to travel to Hobart at short notice for all procedures - this is very arduous for those in the North let alone the North West. A person in the North is sometimes required to travel to Hobart for a 5-minute ultrasound due to unavailability of services at short notice when needed.

Added to these issues, there is no Patient Transport Access Scheme (PTAS) for people undergoing IVF treatment, further disadvantaging women in the North West who cannot afford to travel to access any treatment at all. And, the lack of services outside of Hobart also creates issues for urgent fertility preservation options in young patients with new diagnosis of aggressive malignancies requiring urgent chemotherapy in the North.

More services in the North (including procedural and IVF lab) and far better patient holistic care/support is needed.[34]

3.15. Dr Michael Lumsden-Steel, President of the AMA Tasmania, further discussed access to fertility care, including IVF at a hearing of the Committee:

***Dr LUMSDEN-STEEL**- … the provision of fertility services, effectively in Tasmania, is limited to those with either private health insurance or those that choose to self-fund. Critically - and this is feeding back from our most recent discussion, which actually was last night with our specialists - it's probably just as important, but there's so many things we think are probably a higher priority.*

Having said that, fertility services are provided by fertility experts. These are obstetricians and gynaecologists with a fertility subspecialty interest. At the moment, the two services are private - and this is based in Hobart - and what that means is that patients around Tasmania have to have the funds to be able to self-fund or be covered by insurance, and/or the means to travel to Hobart for their care. Now, there's obviously a telehealth component, but then there's the travelling to Hobart, and it's complex.

The other thing too is, the critical part of fertility services is having the appropriate accredited labs and scientists, which process the collected ovums and store them before you then undergo the fertilisation process, which will either be basically the eggs being inserted by a specialist, and/or the sperm being deposited in egg and then implanted. That's the real scientific part of actually then implanting that back in the female patient to carry the embryo.

It's complex. I don't think there's particularly a strong push at the moment that these services should necessarily be replicated by a separate public service, but there needs to be a strategic discussion and decision made by the government as to how they're going to support that process that also, gives a fair and transparent access to both providers, or an open tendered process…

[34] Submission No. 25, Australian Medical Association Tasmania, p. 2.

...

I would say, though, that there is enough capacity with the fertility experts that work in Tasmania to provide that service. The question is: could it be provided face-to-face around the state? Probably not. You do need to have a centralised expertise process that does it well. The question is: how we remove barriers to patients travelling and accessing that? Even if you can do a lot of the components by telehealth, one of the other challenges facing this is that you have to have sonographers who can do the accurate and appropriate ultrasounding, which will help determine how patients undergoing IVF treatment are suitable for, for example, egg collection or ovum pickups. That's been one of the other critical challenges that's meant that, unfortunately, sometimes patients having ultrasounds at the north of the state, when they're subsequently rescanned in Hobart are found to have less favourable conditions than have been reported because it's a subspecialist's scan.

What I'm saying is, it's not just the doctors, it's the ultrasonographers. It's then having the scientific process to safely manage that very careful process and then the implementation phase, which can be done either with or without anaesthesia involved.[35]

3.16. Dr Marita Jones and Dr Tim Jones, representing RACGP Tasmania, discussed the highly specialised nature of IVF care, matched with the significant percentage of the population requiring access to such services:

Ms DOW *- ... The other point was access to assisted reproductive therapies and was something you mentioned regarding the access to IVF in your submission...*

Dr M. JONES *- Assisted fertility and IVF therapies are very specialised therapies and we can't necessarily speak to the medical side of how specialised that is. From an access point of view of, those therapies are only accessible privately. Therefore, patients who are struggling to conceive, we can refer them to a private fertility specialist and they can embark on a very well supported, but extremely expensive journey, to hopefully end up starting a family of their own. If you don't have financial means, that's not an option for you.*

As far as we understand it, those fees can be set by the private practitioners or their companies. Recently, one of Tasmania's independent IVF companies has been bought out by a mainland company and so they can set the fees. They're not specific to our Tasmanian community or the practitioners aren't independent in the fees. So it's just highlighting that again, it's an inequity.

Dr T. JONES *- Could I also highlight that, across Australia, 30 per cent of pregnancies experience some issue with sub-fertility. This is a very large percentage of our population that we're talking about may need some degree of support. That inequity is only going to be more important into the future as we talk about our ageing population.*

CHAIR *- Are there states that offer publicly available IVF services?*

Dr T. JONES *- I'm afraid I don't know the answer to that question.*

[35] Transcript of Evidence, 30 October 2024, Australian Medical Association Tasmania, pp. 15-16.

> ***Dr M. JONES*** *- I don't know about IVF services, but there are some more clear pathways in terms of other sub-fertility assessments. Some people can receive help with injections to boost their fertility, that type of thing, which I think potentially could be done in our hospital if that person was there. But we don't have a pathway or a clinic set up to assess sub-fertility even to diagnose what the problem is.*[36]

3.17. Working It Out (WIO) also provided the Committee with an assessment of inequality in access to fertility services for LGBTIQA+ Tasmanians both in terms of accessing fertility care and accessing health practitioners generally:

- *Difficulty accessing fertility services for LGBTIQA+ people planning to have children.*
    - *This includes high costs barriers – compounded by LGBTIQA+ Tasmanians more likely to experience a greater income gap compared to general popular [sic] (Grant & Pisanu 2021).*
    - *Lack of easily accessible information (social, legal, medical) tailored for LGBTIQA+ couples seeking to access Assisted Reproductive Technology (ART) and surrogacy pathways.*
    - *WIO hears from trans and gender diverse (TGH [sic]) Tasmanians about receiving inadequate responses from services around their reproductive options and choices for fertility – feeling clinical responses lacked cultural safety and best practice for TGD topics.*[37]

3.18. Equality Tasmania also found access to fertility options for LGBTIQA+ Tasmanians was limited, including recognition of same sex couples:

> *Discrimination by health service providers including failure to recognise same-sex partners, same-sex co-parents, and/or non-medical infertility, and failure to respect gender identity through the use of incorrect pronouns.*
>
> *Unfortunately, this still occurs despite the law prohibiting it. Equality Tasmania receives several complaints a year involving this kind of discrimination.*
>
> *Structural and legal barriers including inability to access to Medicare for reproductive services including surrogacy.*[38]

Surrogacy

3.19. Chelsea Wingrove was a surrogate for Tristain Streefland and Corbin Halliday for the birth of their twin girls. They shared their experience engaging with the legal system throughout the surrogacy process, including after the birth of the twins. Even with their strong self-advocacy, professional and personal contacts, the legal requirements and processes for surrogacy remained complex and burdensome. This was discussed specifically in relation to Mr Streefland and Mr Halliday's application for a parentage order after the birth of their children:

> ***Ms WINGROVE*** *- … [to] go back to the legislative process, in Tasmania it's very difficult to access surrogacy, even more than in other states. As you know, probably, the Surrogacy Act is 2012 and it states that if you require a surrogate, you have to utilise*

[36] Transcript of Evidence, 23 October 2024, Royal Australian College of General Practitioners Tasmania, p. 66.
[37] Submission No. 34, Working It Out, pp. 2-3.
[38] Submission No. 27, Equality Tasmania, p. 2.

somebody who resides in Tasmania, so that's a very limiting barrier, particularly for same-sex couples who would like to start their family. Going overseas and spending hundreds of thousands of dollars is one thing, but not even being able to access a friend or family member on the mainland to help is completely different. Then, obviously, post-birth, there's a huge period of time, potentially, before the parentage order goes through. That makes it very difficult to access services like Medicare.[39]

3.20. The administrative process for the parentage order was discussed in further detail:

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

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

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

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

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

***Mr STREEFLAND** - But she still required it.*

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

***Mr STREEFLAND** - Yes.*

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

***Mr STREEFLAND** - You can lodge after 30 days for the parentage order and it has to be before six months. However, getting a court date was difficult. And then you're looking after twins post-birth. It was a complex process to get all the paperwork together, to then lodge it and then we turned up on the day and then the Magistrate asked for additional information, which was about - we had to do the counselling and she wanted*

[39] Transcript of Evidence, 20 February 2025, Chelsea Wingrove, Tristian Streefland and Corbin Halliday, p.41.

the report. It's a bit insulting to turn up for a Magistrate to read a report to see if you're fit parents when anyone can go and become a parent and how can we -

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

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

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

…

***Mr HALLIDAY** - … They lost paperwork. There's so many different things that happened in the process.*[40]

3.21. The three provided a direct example of limitations in accessing ongoing healthcare for the twins, as Medicare is not accessible until the parentage order is finalised:

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

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

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

***Mr STREEFLAND** - Correct.*

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

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

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

***CHAIR** - Others would struggle to get that assistance.*

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

[40] Transcript of Evidence, 20 February 2025, Chelsea Wingrove, Tristian Streefland and Corbin Halliday, pp. 43 – 44.

Mr HALLIDAY *- Or medical background, like Tristan.*[41]

Termination

3.22. Termination of pregnancy, also known as abortion, is part of reproductive healthcare. The DoH discussed access to terminations in Tasmania:

> *The Reproductive Health Act provides the framework through which pregnant Tasmanians can access terminations. The Act removed barriers that previously existed and established certain protections for people accessing these services.*
>
> *To ensure equitable access to surgical terminations, DoH has established a referral pathway for GPs and Prescribed Health Services to refer women seeking surgical terminations to a public hospital in Tasmania's three major regions. Surgical terminations up to at least 12 weeks are accessible free of charge at all Tasmania's major public hospitals. Funding assistance can be accessed to support women to travel to access surgical termination services (including accommodation costs) through the DoH Patient Travel Assistance Scheme, including women who choose to have their procedure out of their residential region.*
>
> *For women who are ineligible for Medicare, fees associated with this service are supported by the Women's Health Fund and Youth Health Fund. Either way, there are typically no out-of-pocket costs for the patient. As mentioned above, the Women's Health Fund and the Youth Health Fund also provide funding to assist women in accessing termination care outside of the public system, including access to medical and surgical terminations.*
>
> *Medication terminations are available in Tasmania up to nine weeks of pregnancy. Medication terminations are provided through primary care via services such as some GPs, Aboriginal Community Controlled Health Organisations, and Family Planning Tasmania.*[42]

3.23. FPT explained:

> *At least 1 in 4 people who have been pregnant will undergo an abortion in their lifetime, making it one of the most common gynaecological procedures in Australia.*[43]

3.24. WHT also discussed the collection of data on terminations in Tasmania, noting that it is not currently collected, but should be. They said that collection of robust data would allow for a clearer understanding of the use of existing services and how they can be better utilised, supported and communicated to the public:

> **Ms FLANAGAN** *- There are structural issues impacting on abortion access and quality of care. Unlike other states, Tasmania doesn't collect data on how many abortions are happening. The lack of centralised data on abortion referrals hampers effective service planning. Many clients still face high costs, especially those not eligible for the Women's Health Fund.*[44]

[41] Transcript of Evidence, 20 February 2025, Chelsea Wingrove, Tristian Streefland and Corbin Halliday, pp. 43 – 44.
[42] Submission No. 129, Department of Health, pp. 14 – 15.
[43] Submission No. 28, Family Planning Tasmania, p. 6.
[44] Transcript of Evidence, 26 March 2025, Women's Health Tasmania, p. 43.

3.25. WHT discussed access to terminations in Tasmania during their appearance:

> ***Ms SHANNON*** *- In Tasmania there are three ways of having an abortion. A medication abortion, as Jo referred to, which is available up to nine weeks. It's sometimes called early medical abortion. There's surgical abortion that is delivered in hospital settings. There's also medical induction of labour, which is also done in hospital settings. What's available to an abortion seeker depends on the gestation of the pregnancy and where they live. In Tasmania, three public hospitals provide surgical terminations and they provide them to different gestations. The Mersey Community Hospital in Latrobe provides terminations up to 12 weeks, the Launceston General Hospital provides up to 13 weeks, and the Royal Hobart Hospital provides up to 14 weeks. There is also a private provider who takes referrals for surgical terminations up to 16 weeks. This provider is based in Hobart. Currently, patients who are referred to this provider access the Women's Health Fund to cover the costs of the procedure.*
>
> ***Mr STREET*** *- .... The difference between the three hospitals, who makes that decision? Is there an administrator within each hospital that makes that decision?*
>
> ***Ms SHANNON*** *- That's a really good question. I'll come to that. It's essentially based on what we understand, gynaecology departments to be equipped in terms of the skill level and also what I call cultural readiness to provide a termination up to.*
>
> ***CHAIR*** *- Did you say the private provider is up to 19 weeks?*
>
> ***Ms SHANNON*** *- Sixteen.*
>
> *The gestational limits are applied strictly. What we mean when we say up to 16 weeks is that on the day the termination is done, the pregnant person's gestation is no more than 16 weeks and 0 days. Let me give you an example of what this means. For someone who's based in the north west to be eligible for a surgical procedure at Mersey Community Hospital, which would be their closest hospital, the GP they see needs to send the referral when the person is less than 11 weeks pregnant, so that there is time for the gynaecology clinic to do intake and then the following week book the patient for the procedure. On the day of the procedure, the person must be no more than 12 weeks and 0 days of gestation.*
>
> *Our understanding is that these gestational limits are based on the clinical skills of gynaecologists and the cultural readiness of gynaecology departments at the hospitals to perform these procedures at these limits. It's also no doubt informed as well by Tasmanian legislation, which states that women have the right to choose abortion up to 16 weeks, but after 16 weeks the decision is passed over to doctors to determine whether or not the abortion is necessary.*[45]

3.26. Lucinda Shannon, Deputy CEO of WHT, further explained the access for Tasmanians to late term abortions:

> ***Ms SHANNON*** *- Something that I would like you to take away from all of that is that abortions that happen after 16 weeks are not exceptional and they are not anomalies. There are reasons, always complex ones, that mean people are presenting close to 16 weeks or beyond 16 weeks. It is often because people are experiencing disadvantages*

[45] Transcript of Evidence, 26 March 2025, Women's Health Tasmania, pp. 46 – 47.

that then interact with those narrow, time-limited options that are available in the Tasmanian health system. The people who present late for abortions need more support, not less. Creating equitable, accessible, patient-centred abortion access in this state means we need to look at the gestational limits as set by the hospitals and how we can extend them. It also means providing more choice and access for abortions after 16 weeks. I'm going to talk about that now because our current system for late abortion, after 16 weeks, in Tasmania is narrow, one-size-fits-all, and lacks clarity.

What does abortion after 16 weeks look like in Tasmania today? Under the Reproductive Health (Access to Terminations) Act 2013, abortions over 16 weeks must be approved by two doctors, one of whom is a specialist in obstetrics or gynaecology. After 16 weeks, pregnant people who are approved for a termination can access a termination by induction of labour. From our conversations with pregnant people, induction of labour is not always an appropriate way to terminate a pregnancy. For example, we've had women seek other options outside the state because they had previously experienced stillbirth and told us that labouring to terminate a pregnancy would be highly distressing and they were concerned about the mental health impacts. In other states, surgical terminations of pregnancy are available at higher gestations and they don't require going into labour to terminate the pregnancy.

For those in Tassie who are amenable to an induction of labour or who determine that they cannot travel interstate, the situation is also dependent on gestation. Between 16 and 18 weeks the two doctors' sign-off is considered sufficient to provide a lawful grounding for the health professionals involved to proceed. Beyond 18 weeks, the hospital convenes a panel, what's referred to in the literature as a 'hospital termination review committee', to decide whether the abortion should be undertaken. To be very clear, the decision is no longer the pregnant person's decision. Whether or not the abortion will go ahead is now in the hands of medical professionals. I can't speak directly to local panels in Tasmania, but the Australian research on hospital termination review committees conducted by Professor Barbara Baird provides insights into how they can negatively impact the person seeking the abortion.[46]

3.27. Detail was also provided by Ms Shannon:

***Ms SHANNON** - The first thing is that review committees can increase delay. The panel needs to be convened, case reports written, sometimes psychiatric assessments done, and all of this takes time. There's a lack of transparency and accountability. In most jurisdictions, it appears to be the case that a patient has no right of appeal following a committee's determination. Details on who and how are scant, and they're not visible to health consumers. The last point to raise is that termination review committees are also vulnerable to inconsistency and domination by individual practitioners. For example, in medical hierarchies, a nurse's psychosocial assessment will be outweighed by that of a psychiatrist's psychosocial assessment.*

Let me give you an example of how we see those ideas from the research showing up in local people's experiences. We know of at least one service denial involving a young person who is being supported by [a] youth health service. The service explained to us that the young person was over 18 weeks pregnant, that they had parental support for the abortion, and that they also appeared to be competent to make their own decisions. Yet, they had been denied an abortion at the Royal [Hobart Hospital]. The

[46] Transcript of Evidence, 26 March 2025, Women's Health Tasmania, p. 49.

health service worker and the young person couldn't ascertain the reason for the service denial or how to appeal it. From our third-party point of view, we advised about options in Melbourne because it seemed like a more straightforward pathway for this young person to take.

I want to be very clear that we're not critiquing the intentions or clinical practice of the professionals who are on these committees. We know that these professionals are champions of reproductive rights and that actually without them our access system doesn't exist. However, they're working to do their best within a legal framework and a system that has inherent flaws. It's also clear that other jurisdictions aren't hampered by review committee processes and this is partly because their laws don't treat abortion after 16 weeks as exceptional, or problematic, or more ethically challenging, and partly because they've been through the cultural change and planning processes to embed choice of procedure after 16 weeks. We also cannot underestimate the role that leadership at all levels of government plays in normalising access to abortion.[47]

3.28. The closure of the Hobart Private's maternity services was announced in early 2025. The Hobart Private was invited to appear before the Committee. During this hearing, the Committee asked about the provision of gynaecological services at the hospital, including late-stage abortions, undertaken post 16 weeks of gestation. Georgia Banks, General Manager of the Hobart Private confirmed that these services would be continuing:

***Ms DOW** - … I wanted to seek confirmation from you today that there won't be any other changes, particularly around gynaecological services provided by the Hobart Private. Could you provide any further information on that?*

***Ms BANKS** - Yes, I'm more than happy to. That is something - we have a very large gynaecology service at Hobart Private, serviced by over 13 different providers. In my early conversations with all of those gynaecologists and obstetricians, the obstetric component will transition, but the gynaecology services at this stage, they have all requested to maintain their current lists. We don't see any change to that service provision with the exception of some later term terminations that occur at Hobart Private in that obstetric model. Beyond 16 weeks we would not be able to - that's more of an obstetric termination which would need to then be managed, we imagine, at the Royal Hobart.*

…

***CHAIR** - … [In relation to the transition of private services to Calvary] I suppose there will be some changes in terms of women's expectations around reproductive health services in particular and possibly around things like tubal ligation and contraceptive choices. I think some of those things might be handled slightly differently. We can ask Calvary that too. I don't expect to answer on behalf of Calvary. In terms of those termination services that are available currently, will Healthscope still be able to manage through the gynaecological services part terminations up to 16 weeks?*

***Ms BANKS** - Absolutely.*

[47] Transcript of Evidence, 26 March 2025, Women's Health Tasmania, p. 49.

CHAIR *- Then beyond 16, they will go to the Royal.*

Ms BANKS *- They will need to go to the Royal and be managed in that model. Yes, we would absolutely plan to continue all of those services as we currently do.*

Mr La SPINA *- Do you want to talk about how many?*

Ms BANKS *- In terms of late term terminations, we've run our data set over the last two years and it's about one per quarter.*

CHAIR *- Quite low.*

Ms BANKS *- Yes, very, very low numbers.*[48]

3.29. Since Healthscope and the Hobart Private appeared before the Committee on 26 March 2025, Healthscope has entered receivership, but their 37 hospitals nationwide remained operating. In early June 2025, the then Minister for Health, Hon. Jacquie *Petrusma* MP, said the federal and state governments were working with Healthscope to ensure operations continue and that a possible transition to new ownership is conducted.[49]

As at the time of writing, details of any potential transition of ownership, including any impact on existing services including gynaecological services, are unknown. It is therefore not possible to comment on future impacts of this.

3.30. WHT discussed the lived experience of accessing termination services in Tasmania:

> *While on paper these provisions have placed Tasmania ahead of other Australian jurisdictions, in practical terms they have not always translated to the provision of safe and accessible reproductive health services for all. Women continue to report a range of barriers to reproductive healthcare in their communities, including encountering stigma and judgemental attitudes in healthcare settings, a lack of specialist reproductive health knowledge, and the requirement to travel long distances for services.*[50]

Barriers to accessing terminations

3.31. The Committee received evidence from FPT regarding financial barriers to accessing terminations in Tasmania:

> *Sadly, there are cost barriers to Tasmanian women accessing Medication Termination of Pregnancy (MTOP). Perversely, it is now more affordable for many Tasmanian women to access Surgical Termination of Pregnancy (STOP), than MTOP. Access to STOP in Tasmania has improved greatly since the service was introduced in Tasmania's public hospitals in October 2021. STOP is now free for all women, including non-Medicare card holders. This approach is strongly supported by FPT.*

[48] Transcript of Evidence, 26 March 2025, Hobart Private Hospital by Healthscope, p. 85.
[49] Media Release, 'Statement on Healthscope,' Honourable Jacquie Petrusma MP, Minister for Health, 26 May 2025, https://www.premier.tas.gov.au/latest-news/2025/may/statement-on-healthscope.
[50] Submission No. 31, Women's Health Tasmania, p. 6.

Nonetheless, non-invasive MTOP is the preferred abortion alternative for many Tasmanian women. FPT provides approximately 400 MTOPs per year in a primary care setting. MTOP is also provided by some GPs. Perversely, MTOP is currently less affordable for many Tasmanian women than STOP. This is despite MTOP being a far less expensive service to deliver. Out of pocket costs for health consumers of MTOP are high because the service is time consuming, requiring significant patient preparation, monitoring and follow up. Further, because FPT is not specifically funded to provide MTOP, meeting current demand for MTOP must be balanced with provision of FPT's other essential sexual and reproductive health services. As a result, while FPT sets aside as many urgent appointments for MTOP as possible, on occasion it is unable to provide the service in time to for some women to meet the MTOP 9-week limit. Unfortunately, these women then only have the option of accessing STOP, when it is not their preferred option.[51]

3.32. The FPT submissions also discussed the impact of limited access to Medical Termination of Pregnancy (MTOP) procedures on the public health system:

The compounding impacts of the problem on the Tasmanian health system Women who would prefer to choose MTOP, but cannot due to out of pocket costs, can instead access free STOP in public hospitals at an approximate cost to the health system of $3,000 per procedure.

Conversely, every woman who chooses to access MTOP in a primary health setting, instead of STOP in a public hospital, reduces pressure on the public health system. MTOP also provides options for tele-health delivery that are not possible with STOP, which can be particularly beneficial for women in regional and remote Tasmanian communities. Some women who do not access MTOP due to affordability issues, may also be unwilling to undergo the more invasive STOP procedure, and instead proceed with an unplanned and potentially unwanted pregnancy. This can have profound, ongoing impacts on the woman and their child, and increase the need for broader provision of government services to them over many years.[52]

3.33. The RACGP Tasmania also discussed the potential financial burdens of accessing terminations, including through available funds:

Termination services in Tasmania face ongoing accessibility issues. For vulnerable populations over the age of 25 the Tasmanian Women's Health Fund can be accessed at the discretion of the GP, however this is not currently possible for people under the age of 25. Instead, this demographic must personally contact "The Link Youth Health Service", undergo an assessment, and obtain approval before scheduling an appointment with their GP. This additional step becomes a significant hurdle for many young people facing an unplanned pregnancy.[53]

[51] Submission No. 28, Family Planning Tasmania, p. 6.
[52] Submission No. 28, Family Planning Tasmania, pp. 6 - 7.
[53] Submission No. 104, Royal Australian College of General Practitioners Tasmania, p. 2.

3.34. Dr Vavrek from The Bubble also shared with the Committee her support for reconsideration of the administration of the Youth Health Fund, which assists young Tasmanians in accessing reproductive healthcare:

> ***CHAIR*** *- … You've mentioned towards the end [of your submission] the difference, administratively, in accessing the Women's Health Fund versus the Youth Health Fund. I wondered if you would like to expand on that at all?*
>
> ***Dr VAVREK -*** *I feel like this is something that could very easily be fixed, but for some reason it hasn't. Years ago when we opened the clinic, I tried to address it. Essentially, for a woman needing to access termination services and then insertion of a LARC, a long-acting reversible contraceptive, whether that is an IUD or an Implanon there, if you're over 25 there is a pool of money, the Women's Health Fund, that is very easily accessible if you have financial hardship. All that a woman has to do in order to access this is they make their appointment, just say, 'I have had an unexpected pregnancy, I want to terminate'. They come in and see me, we have a chat, I kind of gauge their financial situation and that may be that I notice they're on a healthcare card or, I had one patient who had to catch three buses to get to see me and so I explored that a little further. Then I just say, 'There is this funding that is available and I can access that for you'. I fill out a one-page form, very easy to fill out, and we submit that. The fee is paid to us out of the Women's Health Fund and the patient does not have to pay anything. She can also take that paperwork to the pharmacy and the Women's Health Fund will pay for the medication. Then she can come back and I can put an IUD in her and that is all fully funded. It is a very easy way of doing it.*
>
> *The Youth Health, the Link, way of doing it - if you're under 25, you have to organise a meeting with someone that is trained to do this paperwork, that might be a counsellor or a social worker who works through that service. Say you are a 16-year-old, you've just found out you're pregnant, you're freaking out, the first thing you think about is not 'I need to find out what services are available to fund this for me because I have little money' - but they have to do that first. They might call us, and if they book in with us and they come and actually see me in the room, then that kind of voids everything. I cannot fill any paperwork out for them. They have to get that paperwork and that discussion done before any appointment with the doctor. Sometimes, particularly for medical terminations, they're very time sensitive. They have to get the ultrasound and get the medication in before nine weeks. For some women, we've got them coming into the clinic at eight weeks and six days, so there's not much time for them to organise those appointments.*
>
> *Then the other thing is, if you're a 16 year old, 17 year old, maybe even younger - you really don't want to be discussing this with too many people. To go to talk to someone else before you've even seen the doctor to discuss why you need financial help in this situation is embarrassing; it's demoralising. It's just another step in this process that doesn't need to happen. If we've got enough trust in our GPs who are providing this service to make that decision, we should be able to make that decision for under 25s.*
>
> *In my opinion, I say it should be a very easy thing to do. Yes, there's that argument that when they book in, your staff should tell them to contact this person to organise funding, and yes, we can do that, but we also have to remember that some of them, they're young, they may not know what that means. Once again, they're embarrassed,*

they want to limit it to who knows what's going on. It's just a barrier, another step to make.

***Mr STREET** - Twenty-five is such an arbitrary number as well.*

***Dr VAVREK** - I know right? I have met with the Link youth group, and they can't really help in that situation. I've spoken to Michelle O'Byrne about this, I've spoken to Bridget Archer about this, but it doesn't really go anywhere. I feel like it's something that could easily-*

***CHAIR** - That first form that you described, the one that you fill in to access the Women's Health Fund, does that go directly to Women's Health Tasmania administering the fund or does it go to the state health department?*

***Dr VAVREK** - I think it goes to Women's Health Tasmania. They have access to that funding. I don't know what they do from their point.*[54]

3.35. General access to terminations was raised repeatedly as a problem for Tasmanians. One element of this general access is the experience of seeking care which WHT defines as 'fragmented' after consulting with a cohort of their patients:

> *Most people said the process of having an abortion was fragmented, particularly in terms of finding out how to access the procedure and receiving aftercare. GPs without specialist training added to the issue, with several participants commenting, "it was chaos until we went into the private system."*
>
> *Contributing to fragmentation was the need to visit multiple healthcare settings and practitioners for different stages of the process from the initial appointment, ultrasounds, blood tests, the actual procedure, and then follow up tests and appointments. This was particularly challenging for people in regional areas where there were often long geographical distances between all these appointments.*[55]

3.36. Ms Shannon from WHT recommended potential adaptions to termination care in Tasmania in the community and legislative spaces:

> ***Ms SHANNON – ...** What I really want you to take away is that, if we plan for and support our three public hospitals to extend their gestational limits, we will make a very real tangible difference to the experience of Tasmanians. We can increase the provision of surgical terminations at higher gestations, but to do this, we will need to increase the skills, support and cultural readiness of gynaecology department workforces. We can also create a pathway for surgical terminations in Tasmania available to the public at least up to 18 weeks. This then means people can choose between an induction of labour or a surgical termination, depending on their individual circumstances.*
>
> *The value of a transparent pathway means that we can ensure it is fair, accessible and available. We think that committing to and embedding these pathways is important groundwork before looking at legislative change. In 2013, abortion in Tasmania was decriminalised, but the follow-up work to build the capacity of the health system to*

[54] Transcript of Evidence, 26 March 2025, Dr Natahsa Vavrek, p. 65.
[55] Submission No. 31, Women's Health Tasmania, pp. 10 – 11.

support people's rights under the legislation was not done. Despite decriminalisation, Tasmanians had some of the worst access in the country.

Legislation on its own is not enough to guarantee that people can take up their reproductive rights, so we think that planning for, committing to and investing in transparent and equitable pathways are the steps that underpin and bolster any further legislative changes. We think we have an opportunity to build on the incredible work that has already happened in our public hospitals and ensure that Tasmanians have the same choices that people across the Bass Strait are offered...[56]

3.37. FPT recommended that fully funded, no out-of-pocket medical terminations be made available to all Tasmanian women:

Proposal 1: Fully funded (no 'out-of-pocket payment') Medication Termination of Pregnancy (MTOP) procedures for all Tasmanian women

FPT proposes to provide equitable access to MTOP for all Tasmanian women by fully funding MTOP through FPT clinics in Glenorchy, Launceston and Burnie, and via FPT outreach to remote and regional parts of Tasmania. FPT is a proven, high-quality provider of MTOP in Tasmania. FPT has systems, processes, facilities and equipment in place – including nursing support and specialised GP training – to expand on its current provision of 400 MTOP services per year. FPT now provides in-house ultrasound (required prior to some MTOP procedures) and has a focus on providing reliable contraception and support to all MTOP patients to prevent future unplanned pregnancy. Research with women who have undertaken MTOP in Tasmania demonstrates that satisfaction levels of patients who have accessed MTOP through FPT are much higher than those who have utilised other GP practices [original emphasis].[57]

Objectors and coercion

3.38. The Committee also received evidence from WHT regarding societal and cultural factors which may influence an individual's ability or opportunity to access a termination or other reproductive healthcare. They described 'reproductive coercion' as being 'any behaviour that interferes with a person's reproductive choice and autonomy.'[58] Examples of 'reproductive coercion' given were:

...hiding or disposing of a person's contraception, pressuring a person to become pregnant or to terminate a pregnancy, monitoring a person's menstrual cycle, and preventing a person from accessing sexual or reproductive healthcare.[59]

3.39. In her appearance before the Committee, WHT CEO Ms Flanagan explained the focus of the organisation on providing support for patients who are identified as potentially at risk or already under the influence of 'reproductive coercion':

Ms FLANAGAN - *We offer specialist counselling and case management around pregnancy options and reproductive coercion. This is a service not provided by any other Tasmanian organisation.*[60]

[56] Transcript of Evidence, 26 March 2025, Women's Health Tasmania, p. 50.
[57] Submission No. 28, Family Planning Tasmania, pp. 7 – 8.
[58] Submission No. 31, Women's Health Tasmania, p. 14.
[59] Submission No. 31, Women's Health Tasmania, p. 14.
[60] Transcript of Evidence, 26 March 2025, Women's Health Tasmania, p. 44.

3.40. MSI Australia, a specialised, non–profit advocacy group and provider of terminations and contraception services in Australia, provided an analysis of 'reproductive coercion' in relation to particular community groups:

> *Reproductive coercion can be particularly complex for First Nations women, migrant and refugee women, women with disability, sex workers and people who are incarcerated. The violence they endure may be more severe and prolonged and they often experience structural and interpersonal barriers to accessing support services.*[61]
>
> *Recent research using pregnancy choices counselling data demonstrates that in Australia, 15% of people experience reproductive coercion and abuse when considering their pregnancy options.*[62] [63]

3.41. WHT also defined healthcare providers who are conscientious objectors, working in ways that could be considered coercive. The WHT submission discussed how this interacts with the *Reproductive Health (Access to Terminations) Act 2013* (the Act):

> *There are also instances of reproductive coercion coming directly from healthcare practitioners, with several women who took part in our abortion research reporting encountering practitioners who tried to influence their decision – making.*
>
> *Notably, Tasmania's legislation does not require GPs to disclose their position as conscientious objectors, meaning a person seeking a GP referral for an abortion has no way of knowing whether their GP supports reproductive choice or not.*[64]

3.42. Conscientious objectors were discussed further at WHT's appearance at a hearing where Ms Flanagan discussed the complexity in identifying objectors:

> ***CHAIR** - …*
>
> *My other question is about some of what you both shared and in your written submission. I remember that debate very well when abortion was decriminalised in Tasmania and the requirement for health practitioners, if they are conscientious objectors, to refer a patient elsewhere...*
>
> *…*
>
> *Could you elaborate about how we might improve the system in terms of there being a way for GPs in particular to advertise, I suppose, they are a conscientious objector so nobody's time is taken up in an appointment that's not going to be what that person needs going into that appointment. Whether that's a legislative fix or something in regulation or elsewhere around how we can make sure with the shortage of*

[61] Footnote 8, https://www.anrows.org.au/publication/promoting-community-led-responses-to-violence-against-immigrant-and-refugee-women-in-metropolitan-and-regional-australia-the-aspire-project-state-of-knowledge-paper/ ., from Submission No. 26, MSI Australia, p. 7.
[62] Footnote 9, Sheeran, N., et al (2022). Reproductive coercion and abuse among pregnancy counselling clients in Australia: trends and directions. *Reproductive health*, *19*(1), 1-10.., from Submission No. 26, MSI Australia, p. 7.
[63] Submission No. 26, MSI Australia, p. 7.
[64] Submission No. 31, Women's Health Tasmania, p. 15.

appointments that we're making sure people are seeing GPs who will actually give them the service and referrals they need.

…

***Ms FLANAGAN** - The issue is some GPs might be very clear they are conscientious objectors for faith reasons or whatever and possibly wouldn't have any problem telling people and would be upfront. But not everybody does recognise that's what they are. What they are doing is making judgments about the person coming in the door about whether she should be given access to an abortion or not.*

***CHAIR** - On an individual basis.*

***Ms FLANAGAN** - On an individual basis and we see that at GP level and also in the hospital system where you might hear a clinician say, 'I'm willing to provide abortions if there's a medical reason, but for social reasons I only go to this gestation limit.' They're making decisions for the woman about her reasons, the gestation limit -*

***CHAIR** - But they might not identify that as a conscientious objection.*

***Ms FLANAGAN** - No, they wouldn't object necessarily. I guess the point is, it's only relatively recently we've been having community conversations about these things and there's a massive role for health promotion here on educating the community and the health workforce on this.*[65]

3.43. WHT also noted that the general attitudes and perceptions of healthcare providers can impact experiences of patients seeking access to abortion or information:

Our research suggests that people still encounter judgemental attitudes from clinicians across the care pathway.[66]

Community understanding of terminations

3.44. The Committee received evidence from multiple participants that there is a lack of community understanding in relation to accessing terminations. The submission from the DoH detailed their consideration of ensuring health literacy, most prominently through access to information, for Tasmanians:

DoH recognises the importance of providing patients with timely access to information on the full range of pregnancy options, and to services that meet their needs. This is necessary to help inform women of their available choices and to enable them to make decisions best suited to their individual circumstances. To support Tasmanian women to make informed choices regarding their reproductive health, DoH has progressed a range of initiatives to improve access to information regarding pregnancy and reproductive health options.

These initiatives include funding Women's Health Tasmania to establish a dedicated website providing upto- date and accurate information about services and personal

[65] Transcript of Evidence, 26 March 2025, Women's Health Tasmania, pp. 55 - 56.
[66] Submission No. 31, Women's Health Tasmania, p. 11.

supports (including counselling). The Pregnancy Choices Tasmania website[67] provides Tasmanian women with easily accessible information on pregnancy options. It also includes a service directory providing detailed information about available services, with filters for provider type, termination services, contraception services, travel distance and inclusiveness measures (such as LGBTIQA+ inclusive, female doctor availability or languages other than English).

Prescribed Health Services offer Tasmanians free information, advice and counselling about the full range of pregnancy options. Tasmania's Prescribed Health Services are mandated under the Reproductive Health (Access to Terminations) Act 2013 (the Reproductive Health Act) and currently include Family Planning Tasmania, Women's Health Tasmania, the Link Youth Health Services, and Pulse Youth Health South.[68]

3.45. Dr Tim Jones discussed what he sees as a lack of health literacy regarding termination services available in Tasmania, which impacts individuals seeking access to the services:

***Ms DOW** - … One of the issues that's been raised with us through the evidence presented has been the limited knowledge that Tasmanians have about accessing terminations across their community. Is there any further information that you'd like to leave with the committee about that issue?*

***Dr T. JONES** - Certainly what we've put in our submission about health literacy being key to accessing termination of pregnancy services as it currently stands, is important. There are some small-scale services providing advocacy support for people who need that sort of care to navigate our system, but there isn't a lot of community education about what services are available. Termination of pregnancy services can generally be accessed either through the public system or at reduced cost through primary care, but it requires awareness of how to navigate the system to get that.[69]*

3.46. Dr Khot also confirmed RANZCOG considers there to be an ongoing lack of public awareness in how to access termination services:

***CHAIR** - …Would you say that overall there is a lack of knowledge around abortion service access in Tasmania? I know there was a period where there was very little availability - I think that's been remedied now - but there may still be a lack of public awareness of what's available.*

***Dr KHOT** - Yes, there may be a lack of public awareness. There may be places where the doctors and healthcare providers are conscientious objectors and hence don't provide the service themselves, which means that women then have to travel and see someone else somewhere else for the service.*

Pharmacies may not be providing the medication that's needed for abortion care and again, that's something to also address. So, even though you might have a local doctor who provides the service, the pharmacy actually that is local to you doesn't provide you

[67] Footnote 3, For more information, refer to http://www.pregnancychoicestas.org.au/., from Submission No. 129, Department of Health, p. 14.
[68] Submission No. 129, Department of Health, p. 14.
[69] Transcript of Evidence, 23 October 2024, Royal Australian College of General Practitioners Tasmania, pp. 66-67.

with the drugs, so you have to go somewhere else, to another pharmacy somewhere else to get the medication.[70]

3.47. WHT shared with the Committee the work they are doing to increase understanding and awareness of termination services in the community and amongst healthcare providers. This includes the launch of the Pregnancy Choices Tasmania website, a resource with details of reproductive health services available in the state:

> **Ms FLANAGAN** - *Some recent work and key achievements that are relevant to this Inquiry are that we've developed the Pregnancy Choices Tasmania website. It's a searchable resource for Tasmanians who need reproductive health services and it's utilised by both patients and clinicians. It's the only place you can find out where are the GPs who provide long-acting reversible contraceptives.*
>
> *We coordinate statewide networks and support including the Sexual and Reproductive Health Collaborative Group, the Tasmanian Women's Mental Health Professionals Network, the Tasmanian Perinatal and Infant Mental Health Professionals Network, and we participate in around 20 policy networks. We support perinatal mental health initiatives such as mother-baby play groups for women with post-natal depression and services like the Migrant Mother and Baby Playgroup.*[71]

3.48. WHT's submission provided further detail regarding the Pregnancy Choices Tasmania website:

> *Women reported difficulty accessing abortion services both in regional areas of Tasmania and at certain times of the year. Pregnancy Choices Tasmania lists 27 practices that have practitioners providing medical terminations of pregnancy, a figure that we estimate to represent around 60% of the providers in Tasmania. The online service directory's map of services demonstrates the large areas of Tasmania where there is no service provision: the entirety of the North East, the East Coast and the Central Highlands, and the North West beyond Wynyard.*[72]

Post – termination support

3.49. Dr Marita Jones, a representative of the RACGP Tasmania described a lack of post pregnancy loss support:

> ***Dr M. JONES*** - *The other thing is that structured support post-termination is very ad hoc. So whether that is a person who is actually requiring contraceptive support and it's go and see your GP or sometimes after surgical terminations that will be organised in the hospital but that would, again, be an ad hoc service. Mental health support following a termination of pregnancy can be very limited because there is a lot of stigma associated with it. The same actually goes for pregnancy loss at any point…* [73]

3.50. WHT also provided information on this including a stakeholder's experience with a lack of adequate support:

---

[70] Transcript of Evidence, 23 October 2024, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, p. 55.
[71] Transcript of Evidence, 26 March 2025, Women's Health Tasmania, p. 45.
[72] Submission No. 31, Women's Health Tasmania, p. 10.
[73] Transcript of Evidence, 23 October 2025, Royal Australian College of General Practitioners Tasmania, p. 67.

Participants said the fragmented process of accessing an abortion in Tasmania contributed to a poor standard of aftercare. Some people reported having no follow up at all after a medical abortion, leading to anxiety about whether the procedure had worked. Most participants felt clinical aftercare alone (the test to ensure the pregnancy is terminated) was insufficient, representing only part of the support they needed.

There were also examples of mistreatment resulting from substandard aftercare. For example, one woman went through four rounds of abortion medication including ultrasounds at each stage because the GP "just didn't seem sure" what was normal and what wasn't. She was later told by a different practitioner that this had been "totally unnecessary overtreatment."[74]

Findings

The Committee finds:

1. Financial, geographic and social factors negatively impact access to contraception in Tasmania.
2. Tasmania has a lack of qualified physicians who can insert long–acting reversible contraception (LARCs).
3. The expanded scope of practice of pharmacists in Tasmania to prescribe oral contraception will increase access to contraception.
4. There is limited availability of reproductive and fertility services in Tasmania.
5. Tasmanians access reproductive and fertility services for a broad range of health reasons, not limited to infertility or embryo implantation.
6. There are no publicly funded In Vitro Fertilisation (IVF) services in Tasmania.
7. Two private clinics provide In Vitro Fertilisation (IVF) services in southern Tasmania, but none in the North or North West of the state.
8. The process of obtaining a parentage order after a surrogacy can be administratively burdensome for Tasmanian families.
9. While terminations are available in Tasmania under the *Reproductive Health (Access to Terminations) Act 2013*, significant barriers to access exist. Barriers include a lack of awareness of available services, lack of regional services, complex referral pathways, financial barriers and legislated gestational limits.
10. Barriers to accessing terminations can impact a woman's right to choose termination options. This can increase the risk of adverse health and mental health outcomes for women and increase pressure on and cost to the Tasmanian health system.

[74] Submission No. 31, Women's Health Tasmania, p. 11.

11. The financial barriers to accessing medical terminations of pregnancy (MToP) limits choice and can result in women accessing surgical terminations of pregnancy (SToP) in the public system. This more invasive procedure leads to increased health risks to the women and greater financial burden on the health system.

12. Women seeking terminations experience stigma and resistance, including from medical professionals and loved ones.

13. Insufficient data is collected on the number of terminations accessed in Tasmania, which results in an inability to properly evaluate the effectiveness of service provision.

14. The process for seeking late-stage terminations in Tasmania is administratively complex and lacks transparency and appeal mechanisms. This delays time critical access.

15. Accessing the Youth Health Fund is complex, especially when compared to the process for accessing the Women's Health Fund. This exacerbates disadvantage in an already vulnerable cohort of young women.

16. Community education and information about accessing termination services in Tasmanian is limited.

17. Education for Tasmanian health professionals regarding termination care is ad hoc and insufficient.

18. Post-termination support is limited in Tasmania.

Recommendations

The Committee recommends that:

1. **The Government prioritise access to no-cost or low-cost access to contraception and sexual healthcare.**

2. **The Government fund training opportunities for medical practitioners in the provision of long-acting reversible contraception (LARCs).**

3. **The Government provide In Vitro Fertilisation (IVF) services in the Tasmanian Health Service.**

4. **The Government review relevant legislation relating to parentage orders for surrogacy, with a view to simplifying and improving the process.**

5. **The Government increase collection of de-identified termination of pregnancy data to inform better service provision.**

6. **The Tasmanian Health Service develop and provide clear information and education resources about termination pathways in Tasmania for community and healthcare professionals.**

7. **The Government provide public access to Medical Terminations of Pregnancy (MToP) at no out-of-pocket cost.**

8. **The Government removes barriers and improves access to Medical Termination of Pregnancy (MToP) and Surgical Termination of Pregnancy (SToP).**

9. **The Government make the Youth Health Fund easier to access.**

10. **The Government prioritise the development and implementation of best practice standards for post-termination care in the Tasmanian Health Service, including education and training for health professionals.**

4. ADEQUACY, ACCESSIBILITY AND SAFETY OF MATERNAL HEALTH SERVICES

4.1. Maternal health services include a range of care options for women, their children, families and support people during pregnancy, birth and postnatally.

4.2. Maternal Health Matters define maternity health services as:

> *Maternity – pregnancy, birth and postnatal recovery - is a normal physiological life event not an illness to be treated. Therefore, maternity care must be safe both psychologically, socially and physically for women. We need to remember that birth is:*
>
> - *uncertain but not dangerous for the majority of women.*
> - *safest in a health system where the woman is central to that system;*
> - *safest when evidenced based care is provided with respect, in a partnership model.*
>
> *Maternity care above all, must do no harm – non-maleficence and above all, do good – beneficence. Outcomes of maternity care are enhanced when care:*
>
> - *focuses on the social determinants of health;*
> - *is provided within a wellness & primary health model of care; and*
> - *is culturally sensitive, valued by the woman and her community.*[75]

4.3. The DoH explained the scope of maternal health services available in the public health system:

> *DoH provides high quality, free and accessible public maternity health services in all three regions of Tasmania, including antenatal and postnatal care. As noted in the Introduction to this submission, the private health system also plays an important role in providing maternal health services in Tasmania, and there are a range of these services available to women through the private health system.*
>
> *The THS offers women multiple options for maternity and post-partum care, including medical clinics for women with specific health needs, midwifery models of care, and a Young Mums' Clinic for mothers under 20 to support and prepare them for birth and parenting. Across all regions of Tasmania, THS Maternity Services provide care for mothers and babies along the continuum of care, during pregnancy, labour and birth, and the postnatal period.*
>
> *Tasmanian women can access or be referred to the public maternity service of their choice (generally the nearest service to their place of residence and one that offers the patient's preferred model of care). There are a range of midwifery-led models of care utilised within the THS that vary across the three regions of Tasmania. These include the Midwifery Group Practice (MGP) model, where a patient is cared for by a primary and back-up midwife for their pregnancy, labour, birth and postnatal needs; and the Know Your Midwife (KYM) or Team of Midwives (TOM) model, where a patient is cared for by a team of midwives, in consultation with doctors, during their pregnancy.*

[75] Submission No. 132, Maternal Health Matters, p. 4.

Across all three regions, Midwife Satellite Clinics are utilised to make these maternity services available to women within their local community.[76]

4.4. This Chapter provides a timeline of events affecting maternal health services in Tasmania during the years of this Inquiry, including those leading to its initiation and the experiences of Tasmanians who participated in the Inquiry. The Chapter will then discuss specific areas of access that the Committee heard require further support including the structure of systems of care, Neonatal Intensive Care Units, bereavement care and resources for patients.

Maternal health services context

4.5. As discussed in Chapter 1 of this Report, the Inquiry was partly instigated in response to a number of issues in accessing maternal health services across Tasmania. Two prominent contextual drivers for the establishment of the Committee were the closure of the St Helen's Private Hospital (St Helen's) in 2023 and experiences of patients on the maternity ward of the then North West Private Hospital. In both instances, changes have occurred since the establishment of the Committee. Chapter 7 will discuss in more detail the THS and DoH response to the closure of the St Helen's mother baby unit. Plans have also been announced for the provision of services in the public system, including from external providers, to further expand access to perinatal mental health support.

Further, from 4 December 2023 private maternity services in Burnie were operationally transitioned to the North West Regional Hospital and have been running through the public system since. This transition came as a response to recommendations in the *Independent Review of Quality, Safety and Management in the North West Maternity Services.*[77]

4.6. Throughout the Inquiry, further events have occurred which the Committee wishes to note. On 30 August 2024 the DoH announced the commissioning of the *Independent Investigation into Maternity Services at the Royal Hobart Hospital (RHH)*, to be led by Amanda Singleton. On 9 January 2025 Ms Singleton's final report was released, with 38 recommendations.[78] The DoH has accepted all 38 recommendations. The recommendations cover a number of areas including adequate staffing and staff culture, audit requests including in the areas of Pregnancy Assessment Centres and the provision of lactation consultants, and medication safety.

4.7. At their appearance before the Committee, the Hon. Jacquie *Petrusma* MP, then Minister for Health, and DoH representatives shared an implementation plan for the recommendations with the Committee.[79] They discussed this plan as follows:

> ***Mr WEBSTER*** *- … We've recently done a review of the maternity service at the Royal [Hobart Hospital] [RHH], following some statements made by the ANMF [Australian*

[76] Submission No. 129, Department of Health, p. 18.
[77] The Final Report can be accessed at: https://www.health.tas.gov.au/news/news/release-north-west-maternity-services-review-report.
[78] The Final Report can be accessed at: https://www.health.tas.gov.au/sites/default/files/2025-01/independent_investigation_of_rhh_maternity_services_-_final_report_31_december_2024.pdf
[79] https://www.parliament.tas.gov.au/__data/assets/pdf_file/0027/92358/Tabled-Paper-26-March-2025-Minister-for-Health-Review-Implementation-plan.pdf

Nursing and Midwifery Federation]. I wanted to assure the Committee that, having looked at that in great detail independently with a nurse, a lawyer, a midwife, a consumer representative, and a doctor, that we found no evidence of that allegation. That is an important thing to say because that went to our reporting processes and did they work? Having looked behind the reporting processes, we could not find any evidence that occurred.

… with the maternity review at the RHH, there are 38 recommendations. We have an implementation plan for those being led by our chief nurse, but, importantly, being led from within the RHH to make sure that the RHH learns from that report. The chief nurse role is to make sure the system learns from that report…

…

***Mrs PETRUSMA** - … I welcome the release of the final report of the independent investigation of the Royal Hobart Hospital Maternity Services. I want to acknowledge the members of the Department of Health who are alongside me today because they were - when the allegations were first raised - it was taken with the utmost of all seriousness. We were determined to do a thorough investigation. The independent panel's findings have provided a strong opportunity for learning and for positive change, to make sure we are doing everything possible to provide safe and high-quality care to women during pregnancy and birth, and to families following the birth of their child. We did release the report publicly, only a couple of days after I first received it. The Department of Health has accepted all 38 recommendations made by the independent panel and is working to implement them in full.*

The recommendations cover a range of important matters to improve service delivery, including: to enhance staffing models, recruitment processes, leadership and culture; breastfeeding support, processes relating to the induction of labour as well as consumer engagement. The implementation committee comprises staff from all regions of Tasmania to share best practice and, importantly, it is to implement solutions statewide, where possible. The committee is reporting to the Department of Health Secretary and its membership includes a consumer representative, which we felt was very important to make sure the consumer's voice was on the committee, as well as a direct care midwife. I wish to express my sincere thanks again to all the health consumers and staff who contributed to this investigation.

… I can table for the Committee the timeline for all the recommendations. I can indicate that most of the major recommendations - you'll see that they are to be completed by quarter two 2025.

…

***Mr WEBSTER -** The way we did the review was, in fact, to set up a panel under the Tasmanian Health Services Act 2018, which gives the panel the ability to effectively do exactly what the Secretary can do. So, look at all of the records, call staff in to talk to them, meet with staff to look at what's happening. It overcomes any privacy provisions, et cetera, because they're acting on my behalf under the Act. We felt it was important that we give them that full power to look at our records, et cetera, and bring that independent eye in because these were fairly significant allegations.*

Having worked their way through, as I said, under the hood, behind our systems, they couldn't find any lack of report; so, any records that indicate that someone didn't report something. That was important because, obviously, the first place we went to was our Safety Learning and Reporting System (SLRS) to see whether there was anything in there that was reported that was missed as being a SAC1 [Severity Assessment Code 1]. Sorry, that's a category of level, if it's a SAC1, it's the highest level of safety concern. Importantly, I should also say that that level of safety concern, the moment it's entered into SLRS is actually flagged with myself and other senior executives. We get a text message as well as an email telling us that there's a SAC1 so that we can go in immediately and have a look. None of us had any memory of it. We then went to the system to see whether we'd missed it, and then we asked Amanda's [Singleton] panel to go beyond that and look at records from the relevant period. The person that made the allegation has not passed on any further detail, so we're unable to actually tie it to a particular record or thing, but I can assure you that the panel were determined if it was there, they would find it.

Under the implementation process and, as you'll see from the report that the Minister has tabled, there is activity underway. The first major milestone is a report to me in April of this year. So we're not quite there to get that report, but we thought it was important to table the timelines of what we're doing.[80]

4.8. In information provided on 27 October 2025, the Minister for Health, Mental Health and Wellbeing, the Hon. Bridget *Archer* MP provided an update to the Committee on work undertaken by the DoH up to 30 September 2025 to implement the recommendations:

- *23 recommendations have been completed*
- *Nine are on track for completion against original timeframes*
- *Six are delayed but are on track for completion by 31 December 2025, when full completion is due.*
    - *Four of the delayed recommendations relate to Birthrate Plus assessments (a midwifery-specific tool using planning and real-time staffing tool), which are delayed as date collection, assessment and analysis continue.*[81]

The Minister also provided an updated table noting the implementation progress, which is available in full on the Committee webpage.[82]

4.9. Throughout the length of the Inquiry, changes also occurred in the provision of private maternity services in the South of the state. On 20 February 2025 the Hobart Private, owned and run by Healthscope, publicly announced they would be closing

[80] Transcript of Evidence, 26 March 2025, Department of Health and Hon. Jacquie Petrusma MP, pp. 5 – 6.
[81] Updated information, Attachment 2, Minister for Health, Mental Health and Wellbeing, dated 27 October 2025, p. 1.
[82] Updated information, Attachment 2, Minister for Health, Mental Health and Wellbeing, dated 27 October 2025, p. 1

their maternity ward on 20 August 2025.[83] The decision was announced as the result of staff shortages on the ward.

4.10. On 26 May 2025 it was further announced that Healthscope had entered receivership.[84] At the time of this Report, the future operations of Healthscope in Tasmania is not clear.

4.11. After the announcement of the closure of the Hobart Private's maternity services, the Committee invited Healthscope to appear before the Committee. Healthscope CEO, Tino La Spina, General Manager of the Hobart Private, Ms Banks and State Manager of Healthscope Victoria and Tasmania, Chris Hewison appeared and discussed the closure of the ward, explaining workforce shortages were the most prescient factor in their decision. This is discussed further in Chapter 9.

4.12. Mr La Spina said the financial viability of the maternity ward was not a deciding factor in the closure. He did however reference difficulties in the broader structure of insurance and funding for private health providers in Australia:

> ***Mr La SPINA*** *- I do think that one of the other things we have, and it's not to ignore the financials - it's been well publicised that Healthscope, along with other private hospital operators, has been working hard to get fair funding from private health insurers. We've seen the payout of private health insurers go from pre-COVID levels of around 90 per cent of their premium income would be paid out, to well below 80 per cent. Effectively, that's just a redistribution. The system has the capacity to pay, but it's not funding hospitals well enough.*
>
> *…*
>
> ***Mr STREET*** *- … what levers are there to ensure that private health funds are distributing?*
>
> ***Mr La SPINA*** *- Helpfully, at the federal level we had the Federal Health Minister seek to intervene, and basically sent a message to the health insurers to come together with the private hospital operators to seek fair funding. If they can't work it out, then the Federal Minister is taking advice on what regulatory action he can take as well. I think that that's going to be good.*
>
> ***CHAIR*** *- That's good to hear. It's something that we've heard as well from private obstetricians that the rate of people choosing private births is declining, not just in Tasmania but nationwide, due to those insurance costs jumping. They went up five-fold, I think, for obstetricians, the personal insurance cost to them in terms of liability insurance.*
>
> ***Mr La SPINA*** *- It's not something that's limited to maternity itself. It goes beyond that into all private services, to be honest. I think it's a real challenge for the industry moving forward in fact, and what sort of model of care that we're going to be going down.*

[83] Healthscope, 'Healthscope announced intention to close maternity services at Hobart Private Hospital', dated 20 February 2025, https://healthscope.com.au/news-media/Healthscope-announces-intention-to-close-maternity-services-at-Hobart-Private-Hospital#:~:text=Hobart%20Private%20Hospital%20will%20be,close%20on%2020%20August%202025..

[84] Healthscope, 'Receivers appointed to Healthscope parent companies', dated 26 May 2025, https://healthscope.com.au/application/files/6917/4822/4218/Healthscope_receivership_announcement_Final.pdf.

CHAIR *- Are you happy to share a bit more about those insurance challenges with those private insurers? Obviously, a lot of this is in the Federal Government's scope, not the state Parliament's capacity to influence. We can nonetheless make comment about federal issues in our report and make recommendations about that…*

Mr La SPINA *- I think just reiterating that there was a period of time pre-COVID where the hospitals and the insurers were both able to make a fair return. There weren't super returns, that's not what we're talking about here. It was enough to be able to reinvest back into the system. What you have when you have a redistribution, the way it's happened now, I'd say over a billion dollars is gone from the hospitals to the insurers. That's a billion dollars, that kind of translates into a very difficult reinvestment environment back into the system.*

I accept that you have insurers out there with particularly different views on models of care and whatever. I think that that tension there with the hospital system is not a bad thing because I think we should all be thinking about different models of care moving forward. Ultimately, I guess I'm used to having a dyad-type model of care where management and clinical decisions - clinical decisions and clinical pathways need to be made by clinical experts, not by insurers…

CHAIR *- … We would hate to see Australia go down an American model where it's insurers making decisions about whether surgeries are even allowable or not under insurance, with no clinical relationship with the patient or maybe even training.*

Mr La SPINA - *That's an insightful comment. It's not difficult to see how we get from where we are now to that sort of model. It's a very slippery slope and once it starts, it is pretty hard to stop, so I would agree with that.*[85]

4.13. Mr Hewison described the timeline of engagement with the Government prior to the announcement of the ward's closure:

Ms DOW *- … at the point in time where you made the decision that it was untenable really to continue on due to your short staffing levels, did you make any request to the state Government for assistance, whether that be financial or whether that be about acquiring staff or was there any sort of representation made to the state Government about that?*

Mr HEWISON *- … In about August last year [2024], we entered dialogue with the Government, the Department of Health, and, in fact, a couple of meetings with the former, one meeting with the former Health Minister and certainly one meeting with the current. We commenced those discussions saying that it was becoming a difficult challenge for us to continue to staff maternity services, as Tino and Georgia have highlighted, and essentially as the months from August, September or thereabouts went into November, December [2024], it was becoming our view that there was really room in Hobart for probably one private provider and also the Royal. We came to that view at that time on the basis of the estimated birth numbers that we're seeing. We've seen a decline obviously at Hobart over the last few years and we were forecasting this year to be yet again approximately another 40 to 50 lower than 2024.*

[85] Transcript of Evidence, 26 March 2025, Hobart Private Hospital by Healthscope, pp. 82 - 84.

It was becoming quite clear that those workforce challenges weren't going away, as Tino highlighted in his opening statement, and we were not being successful in attracting those midwives, then coupled with lower patient demand through the birth rate seen across Tasmania, led us to that decision. The Government and the Department of Health were involved and engaged in those conversations since about August, September [2024] along the way.

***Ms DOW** - You said that it's about 500 birth deliveries a year currently, what numbers were you looking at say five years ago or how has that declined? Are you able to provide some examples of that?*

***Mr HEWISON** -Just pre-COVID, approximately 600 last year [2024] down to about 520, and this year [2025] forecast to be around that 470 mark, approximately…* [86]

4.14. Healthscope and Hobart Private representatives were also asked about the transition of their services to other providers. At the point of their appearance, the transition process was still in the initial planning stages, with a roundtable to be held between Healthscope, the Hobart Private, Calvary, the THS and the DoH. The first meeting of the roundtable was scheduled for 27 March 2025. It should be noted that this meeting also occurred prior to the Healthscope receivership announcement in May 2025, with further meetings and planning likely to have occurred between these time periods. At the hearing, Mr La Spina raised the importance of crafting an appropriate pathway, including the ongoing operations of all wards involved until the full transition in mid-August 2025:

***Mr La SPINA -** We understand the importance of a smooth transition for families and we're working closely with the Tasmanian Government, Calvary Health, and the Royal Hobart Hospital to ensure that expectant mothers have clear options for their care. We're committed to making this process as orderly and transparent as possible, ensuring minimal disruption to those affected. We want to assure families that any expectant mothers due to give birth prior to 21 August will receive the same high-quality care they expect from Hobart Private [Hospital]. For those with later due dates, we're working closely with their treating obstetricians to ensure a safe and supported transfer of care to alternative providers.*[87]

4.15. In additional information received from Calvary in October 2025, details regarding the format of the plan for transition was provided to the Committee. In this information, it was confirmed that a Working Party was established to provide oversight and outlined specific actions it had assisted Calvary in undertaking to ensure their campus could support potential increases in service demand:

Calvary Health Care, through Calvary Lenah Valley Hospital, has worked in close partnership with the Southern Maternity Services Working Party (including representatives from Calvary, the Royal Hobart Hospital, Hobart Private Hospital, and the Department of Health) to ensure a safe transition of maternity services following the closure of services at Hobart Private Hospital in August 2025. The Southern

[86] Transcript of Evidence, 26 March 2025, Hobart Private Hospital by Healthscope, pp. 87 - 88.
[87] Transcript of Evidence, 26 March 2025, Hobart Private Hospital by Healthscope, p. 80.

Maternity Services Working Party supported a series of forums for doctors, staff, and the community, which helped provide transparency and reassurance to all stakeholders during the transition period.[88]

4.16. Ms Banks also expanded on the transition plans:

> ***Ms DOW*** *- Of those staff, some obviously may retire I suppose, but are most of them transitioning across to other employment opportunities? Are you able to provide the Committee with an update on that please?*
>
> ***Ms BANKS -*** *... We are looking forward to our first working group led by Sally Badcock. That has just dropped into our diaries for tomorrow. We welcome that opportunity to work with the Government and also Calvary [Lenah Valley Hospital] and the Royal [Hobart Hospital]. Stakeholders have come together to really look at that transition plan.*
>
> *Our date being 27 August for the final service, it is a long transition period of time. We've had very early engagement with Calvary, which has been fantastic and very welcomed. We look forward to being together around the table to really transition the service. Our doctors are very engaged and keen to understand exactly what that looks like, because obviously the women in the community that we are servicing right now, as they transition, they will need those midwives to be able to transition that service successfully across to Calvary. Not all will go to Calvary, there will be a smaller proportion that will need to be managed and cared for at the Royal. Doing that really well is going to be a great starting point. We look forward to that tomorrow.* [89]

4.17. Representatives from Calvary discussed the (then) possible transition of maternity patients from the Hobart Private to Calvary Lenah Valley. Kris Salisbury, National Director of Clinical Governance and Chief Nurse, Leah Magliano, Director of Clinical Services for Calvary Hobart and Melissa Evans, Regional CEO for Calvary Tasmania and Victoria, discussed initial preparations being undertaken to develop the resources available on Calvary's maternity ward:

> ***Ms SALISBURY -*** *Currently, the women's health unit at Lenah Valley supports about 350 births a year, and that includes five delivery suites, nine licenced special care nursery beds, 24 post- and antenatal beds, and that includes a deluxe suite. In addition to Tasmania, Calvary also provides private maternity services in Canberra, New South Wales and South Australia.*[90]
>
> *...*
>
> ***Ms MAGLIANO*** *- We absolutely have the infrastructure to do it and we have plans to improve what is on site at the moment.*
>
> ***CHAIR*** *- Minister Petrusma announced that the Federal Health Minister, Mark Butler, committed $6 million infrastructure funding that would be shared between increasing capacity at Calvary, at the Royal, and building a mother-baby unit at St John's. I'm no engineer or builder, but $6 million that's a very welcome commitment from the Federal*

[88] Updated Information, Calvary Health Care, 3 October 2025, p. 1
[89] Transcript of Evidence, 26 March 2025, Hobart Private Hospital by Healthscope, p.84.
[90] Transcript of Evidence, 26 March 2025, Calvary Hospital Lenah Valley, p. 90.

Government, but are you confident that whatever portion of that comes to Calvary will be sufficient to expand your physical capacity?

***Ms EVANS** - We're hoping it is. We're working with our architects and builders at the moment to understand the costs. At the moment we don't have an actual final dollar value of the building works, plus there is some capital equipment to purchase as well.*

***CHAIR** - It's early days.*

***Ms EVANS** - Yes, it is early days. If you think about it, it has been six weeks since the announcement that Healthscope were deciding to make that decision to cease the services [at the Hobart Private Hospital]. We've worked really quickly with our local builders and architects, plumbers and electricians because once you start making change, you have to make a switchboard upgrade. I'm learning all these new things and we're just to the point where we've got some final drawings we think that we'll be able to price up and understand what that cost will be for us.*

***CHAIR** - Is that moving into another part of the hospital or existing?*

***Ms EVANS** - We have five birth suites. We use four, and the fifth one is from the 1970s, so there's some work to do in there to make it a modern birth suite with a bath, et cetera. That would be our first priority to do. Then there's stuff to do in our special care nursery, the step down stage. And then we're aiming to make two more deluxe suites.*

***CHAIR** - Will you need more birthing suites, or is five enough?*

***Ms MAGLIANO** - Five is enough.*

***CHAIR** - It's not as much of a blunt tool as your physical capacity to double the number of births? It does not work that way?*

***Ms MAGLIANO** - Remember, births are also by caesarean section, so you won't need it; they won't all use the birth suite.*

***Ms DOW** - … In the redevelopments that you have proposed, I think you said you had 24 beds on the ward for postpartum care. Are you looking to increase the number of beds as part of that work that you're doing or you'll maintain that?*

***Ms MAGLIANO** - We won't actually even maintain it. Some of the rooms were used for gynaecological surgery, so there're single bedrooms and they're just not what post-natal women want anymore. They want double rooms with double beds and with their husbands or partners who can stay. Two of those rooms we will earmark to become deluxe birth suites so that 24 may reduce to 20 odd.*[91]

4.18. In an update provided to the Committee by Ms Evans, the Regional CEO for Calvary Tasmania and Victoria, provided an update on the work undertaken by Calvary to prepare for the anticipated 60% increase in demand for services by December 2025 in the demand for maternity services at the campus[92]**:**

[91] Transcript of Evidence, 26 March 2025, Calvary Hospital Lenah Valley, p. 92.
[92] Updated Information, Calvary Health Care, 3 October 2025, p. 1.

Since March 2025, Calvary has undertaken detailed planning to establish the requirements for a clinically safe transition and the growth of its maternity service offerings. This has included completing asset audits, purchasing additional medical equipment, identifying workforce needs, recruiting midwives, updating policies and procedures, and establishing clear communication strategies with existing and new Obstetric Visiting Medical Officers, staff, and key strategic partners such as Ambulance TAS.[93]

4.19. The Australian Medical Association (AMA) Tasmania updated the Committee in October 2025 and noted the smooth transition of services, however they highlighted that a broader consideration of the structure of maternal health services in Tasmania was required:

Healthscope's closure of its maternity unit has resulted in private obstetric services being consolidated at Calvary. While the transition has proceeded smoothly, there remains a need for extended strategic discussions regarding the development of a statewide Women's and Children's tertiary hospital, potentially utilising K block infrastructure. This includes consideration of both public and private maternity units being co-located, as well as the possibility of establishing a new, purpose-built birthing centre on site.[94]

4.20. Before the public hearing in March 2025, Calvary representatives also discussed staffing considerations for the transition:

***Ms DOW** - You said that you have had difficulty around staffing as well, but it's obviously something that you don't think is insurmountable. Do you think the increase in patient numbers will be a challenge with the current staffing levels that you have…*

***Ms MAGLIANO** - It will be a challenge with the current staffing, absolutely. We need the Hobart Private midwives to come across. What I do know is that when you have close to full complement of midwives and lots of birth that attracts other midwives. I'm confident that even if we don't get a full complement of 28 FTE and have to utilise some agency in the interim, in the initial stages, we will attract and recruit other midwives because we will be the private provider in Hobart and the Centre of Excellence for private birthing.*

***Ms EVANS** - We've actually already engaged with the Hobart Private midwives and had a welcome evening so that we could actually show them our suite, introduce them to our nurse unit manager, introduce them to Leah who some of them may or may not have known from Leah's days at Healthscope. We're working really hard to engage people to transition to us and we've been really open with Georgia [Banks] from Healthscope as well around that and now it's working with Healthscope and the Royal and working together about transition plan because we need the midwives to be able to increase the activity.*

Whatever we do, it needs to be safe and that's the paramount thing that's in the back of our minds to make sure that we provide a safe service and that transition of nurses

[93] Updated Information, Calvary Health Care, 3 October 2025, p. 1.
[94] Updated Information, Australian Medical Association Tasmania, 10 October 2025, p. 3.

and midwives is the really important part, and obviously the obstetricians and the paediatricians, and making sure that we've got everything humming along so it's a really smooth welcome to Calvary as well. We've also met with all the obstetricians and all the paediatricians and the anaesthetists to keep them up to date with what we're doing. It seems like we've been doing this for months.[95]

Calvary confirmed with the Committee in October 2025 that to accommodate the growth in maternal services, an additional 12 FTE midwifery staff have been recruited.[96]

Further discussions of the Tasmanian healthcare workforce, including shortages, is discussed in Chapter 9.

4.21. The Hon. Bridget *Archer* MP, Minister for Health, Mental Health and Wellbeing also provided an update to the Committee about the transition process:

> *The Department proactively responded to the impact of this closure by increasing maternity service capacity at the RHH and Calvary Lenah Valley. This work has been supported by the Australian Government's commitment of $6 million in funding to expand maternity services in Southern Tasmania.*
>
> *This funding is being used for:*
> - *the expansion of inpatient maternity unit beds at RHH from 29 to 34 beds;*
> - *establishment of a "Transition to Home" model at RHH with three ensuite rooms;*
> - *renovation of birthing suites at Calvary Lenah Valley;*
> - *expansion of birthing capacity at Calvary Lenah Valley; and*
> - *relocation of the existing RHH Mother and Baby Unit to the new IRPU at St John's Park in New Town.*[97]

4.22. The update to the Committee also noted that while there has been an increase in maternity services at the RHH, it was too soon to provide data regarding this increase and any associated impacts.[98]

Access to maternal health services in Tasmania

4.23. This subsection of the Chapter will discuss access to maternal health services, including firsthand accounts from lived experience witnesses who participated in the Inquiry.

4.24. The Australian College of Midwives (ACM) provided a general discussion of maternal health service options in Tasmania:

> *Birthplace choices in Tasmania are limited to one of three public hospitals, three private hospitals, a single private birth centre, or home. There are no publicly funded birth centres in Tasmania, and Tasmania is now the only state in Australia that does not offer publicly funded homebirth. Women who wish to birth at home (or birth centre/house) have the option of employing a privately practicing endorsed midwife to support them,*

[95] Transcript of Evidence, 26 March 2025, Calvary Hospital Lenah Valley, pp. 93 - 94.
[96] Updated Information, Calvary Health Care, 3 October 2025, p. 1.

[97] Updated Information, Attachment 1, Minister for Health, Mental Health and Wellbeing, 27 October 2025, p. 3.
[98] Updated Information, Attachment 1, Minister for Health, Mental Health and Wellbeing, 27 October 2025, p. 3.

however the out-of-pocket costs of this and relatively small Medicare rebate means that this is not a viable option for many families. Freebirth, whereby women birth with either unregulated birth workers or alone, is reportedly on the rise. While data for Tasmania is not available, anecdotally, freebirth rates within the state are rising due to the limited number of private practice midwives offering this service, the high costs of homebirth, lack of access to caseload care and concerns about risk of unnecessary intervention within an over-medicalised hospital-based maternity system. These anecdotal reports are similar to women's concerns as reported to Jackson et al. (2020) and Sassine et al. (2021).[99]

4.25. Private Witness 77 to the Inquiry shared her consideration of a lack of support available in the North and North East of Tasmania:

> *There is a great lack of services to people living in the North and North East of Tasmania. We have no 'Private Hospital' for birth and therefore even the Private Healthcare providers are confused as to what they are offering us.*[100]

4.26. Private Witness 52 also shared her personal experience of receiving maternal and birthing care in Burnie:

> *My only issue is with the lack of funding for the maternity and birthing units at Burnie. There is not enough beds to accommodate the growing community and as a result, many women are being booked in for inductions (such as myself)or c-sections, and having these cancelled due to lack of beds and room. I was scheduled for an induction due to my age and previous medical history and had this postponed once , almost twice (the doctor refused to postpone it twice) due to this lack of bedding and room availability. The doctor's frustration about this was evident and his hands were clearly tied. They need more funding and more staff and more resources. The community needs this to happen.*[101]

4.27. A number of lived experience witnesses discussed the impact of staff and bed shortages on the care they received, including delays to the provision of care. Kate Marsden shared in her submission how her planned elective caesarean did not proceed, leading to an unplanned natural birth that she had not had the chance to prepare for:

> *Less than 24 hours prior to my scheduled c-section, I presented to hospital with my waters leaking, 2-3cm dilated (this initial dilation occurred when I was hospitalised for an antepartum haemorrhage & threatened preterm labour three weeks prior) and increasing pain - but my care was so poorly managed that I ended up having a vaginal birth without pain relief.!*
>
> *As a direct result from the vaginal birth that I did not want - I suffered a 3B tear, dislocated tailbone, pelvic organ prolapse, pudendal nerve damage, chronic anal fissures and other ongoing health issues including ongoing pain and increased risk for future pregnancies and birth.!*

[99] Submission No. 32, Australian College of Midwives, pp. 6 - 7.
[100] Submission No. 77, Private Witness, p. 4.
[101] Submission No. 52, Private Witness, p. 1.

Due to how uncontrolled and rapid the actual birth was, my son also had to be taken away from me shortly after birth to stay in the special care nursery on oxygen (I was told that if a baby comes 'too quickly' out of the birth canal, they don't get the chance to expel all of the fluid), as well as suffering from torticollis which significantly contributed to the shape his of head, after months of physiotherapy, he is about to be fitted for a helmet.[102]

4.28. Private Witness 49 shared in her submission that after not being admitted to hospital in the early stages of labour, because of a misdiagnosis of gastroenteritis, her birth progressed rapidly and it was only by chance that she had returned to the hospital in time:

I went in to hospital in early stages of labour (3 1/2 weeks before my due date) only to be told that I wasn't in labour my baby was weeks away and had a gastro bug and to go home take some pain relief, I was made feel stupid and convinced myself it wasn't labour.

The early hours of the next morning my pain and 'gastro' was so bad my husband insisted I call the hospital again.

I spoke to a nurse who said she saw me last night and that there was nothing she could do and I just needed to ride the 'gastro bug' out, it would be pointless me coming in as they would have to set up the isolation room for me and were to under staffed to do so.

If my husband hadn't of insisted we go to the hospital I would have had my daughter at home.

We left for the hospital immediately and from when we got the parking ticket to when she was born it was under 30 minutes.

We arrived at the hospital, buzzed in and an upset nurse wasn't happy as we had no masks on and the isolation room wasn't prepared for me.

She walked back leaving us outside the doors to get masks while I was bent over in pain in the last throws of labour.

As we walked up the corridor she goes.. oh maybe you don't have gastro.. no I don't we insisted once again.

Upon checking me out they realised she was actually on her way out and two nurses rushed around to get prepared. As it was coming to the end of their shift and they had worked overtime they complained the whole time setting up and once she was born they both left me there as soon as she came out for the next nurses to take over.. 2 hours later I'm still laying in the bed in my own blood while my husband went searching for someone to help me.

[redacted] *a midwife came and helped me clean up and explained that they didn't know I was there she then sent a midwife to come and do all my baby checks etc.*[103]

[102] Submission No. 85, Kate Marsden, pp. 1 - 2.
[103] Submission No. 49, Private Witness, p. 1.

4.29. The Committee also heard the views of medical professionals about risks experienced by Tasmanians accessing maternal health services. Dr Lumsden-Steel raised the AMA's concerns:

> ***Dr LUMSDEN-STEEL*** *- … Let's be frank, we have a midwife crisis in Australia. Tasmania no longer trains midwives for our own program. Our midwives are trained through university joint placements. I'm sure you're aware of this. What that means is that we are struggling to actually maintain enough midwives to provide services.*
>
> *We have a higher reliance for locums in the north-west, that's obstetricians and midwives. We have a model in Launceston, which actually - it's one location where it's performed seamlessly and that's at the Launceston General Hospital. At the North West, we heard reports last night that bringing the services back to one location isn't functioning effectively. We have unsafe paperwork, bureaucratic processes, which is delaying urgent access to maternity services because they're trying to run a dual paperwork process in one hospital, which is unsafe. This has been escalated and discussed by the AMA at the North West and it has not been addressed.*
>
> *If you're looking at having birthing suites and centres, at the moment we'd also have to acknowledge the challenges if it's not immediately co-located with an appropriate medical facility. If there is an emergency during that process, how do we get those patients transferred safely to a public hospital that can immediately deal with a birthing situation that is no longer progressing normally, needs to be rapidly assessed, and needs rapid access to specialist medical care that can mean going to theatre or vaginal assisted delivery. To be frank, we don't have the services to provide that at the moment.*[104]

4.30. Dr Lumsden-Steel continued to discuss the acute condition of access to adequate obstetric services in Tasmania:

> ***Dr LUMSDEN-STEEL*** *- We are struggling to provide safe obstetric care at the Royal Hobart Hospital. We've seen in the media recently that we have had extreme concerns raised by midwives around potential delays to labour through inadequate midwife resources. It literally is a case of trying to pick who is the most urgent delivery to start from induction time. That means we are starting inductions on patients at unsafe hours because that is when the next shift of midwives comes on. So a higher risk delivery, which would normally be started first thing in the morning, the induction process is started when the next midwife shift starts, which might be in the afternoon, which means that when it all goes to, unfortunately, needing a caesarean section or an urgent surgical intervention, that is happening after hours.*
>
> *Now, the corollary is that Tasmania has not set up a proper obstetric service that has dedicated caesarean section theatres available 24/7. That means that even in hours, and I can speak from frank experience, when we have an emergency caesarean section called from the labour ward for someone who needs to have a baby right now because the baby or the mother is going to die, we do not have a theatre that we can push a patient straight into. We have to find one, we have to scramble to move resources to that theatre, and that can mean there are delays. We had that as recently as this week at the Royal Hobart Hospital where, literally, a lady in labour was booked as an E1 caesarean section, it was upgraded 10 minutes later to 'this must come out now'*

[104] Transcript of Evidence, 30 October 2024, Australian Medical Association Tasmania, pp. 16 - 17.

because the lady's uterus had ruptured and the baby was free in the abdominal cavity. We then had to madly rush to move that patient to another theatre. That is a reflection of the fact that we have not told the Hobart - we are not funded to provide a service of having a dedicated theatre that we can take a mother to immediately.

Because we have not built enough capacity in our hospitals, we have to find a theatre, or wait till a patient has finished. I have even been in a situation where I have had to stop a patient who has been asleep from starting surgery, to get that patient out, to get a patient into that theatre. That is a reflection of what we have accepted as risk in our hospitals for not having immediate access to care.[105]

4.31. This discussion of obstetric care culminated in an acknowledgement of considerations which need to be given if existing services are expanded or additional services are offered:

Dr LUMSDEN-STEEL - *We get back to how we are designing our services. We can talk about having these birthing centres, which can provide another option. The critical thing is that those services must still have obstetric oversight. There must be a clear communication pathway. If there is a requirement to transfer, we need to do so. If we go back and look at all the previous papers published in the NHS, around the world, that looked at maternal deaths, they have highlighted all the issues. History has shown us why mothers and babies were dying and we have tried to make this the safest process as possible. Unfortunately, that does mean that things have become a bit more medicalised in our public hospitals, but that is because that is a safe way of delivering it.*

If we want to provide women with more choices for how they are going to deliver, that must be matched with a safe pathway that will facilitate rapid escalation of care. If you are at a birthing centre and you require transfer to a public hospital, that is going to require multiple other contingencies to get you there, notwithstanding an ambulance and some way of transferring you.

It is great to have these discussions, if those birthing centres are going to be within the public hospital in a great purpose-designed space, which leads me to the next thing I am going to say; for God's sake, why do we not have a women's and children's hospital in Hobart? We had one at the Queen Alex. It was a dedicated centre that did all the tertiary and complex stuff. That women's and children's hospital was closed. It is now a private hospital. We have now tried to make it work within the public system. We have seen the challenges we have for that. We have seen in Launceston that the private services were shut down and brought into the public. We have seen some of the challenges faced with that. We have seen up at the North West, running two locations in a facility that was in a town that was too small to provide sustainable services how we co-located.[106]

[105] Transcript of Evidence, 30 October 2024, Australian Medical Association Tasmania, p. 17.
[106] Transcript of Evidence, 30 October 2024, Australian Medical Association Tasmania, pp. 17 - 18.

4.32. In a written update to the Committee in October 2025, the AMA Tasmania provided further information regarding the impact of lack of infrastructure and resources on birthing options, with a specific focus on impacts on inductions:

> *AMA Tasmania understands that ongoing shortages of midwives and limited availability of birth suites continue to result in delays to labour inductions for expectant mothers admitted or awaiting induction for clinical reasons. These delays create significant triage and risk management challenges across all levels of care, particularly for those affected patients whose inductions do not proceed as planned. OBGYN trainees, in particular, are required to prioritise and allocate resources rather than proceeding directly with scheduled inductions, thereby increasing the complexity of managing clinical risk.*[107]

4.33. The specific North West context was also discussed by Dr Lumsden-Steel, who proposed that existing transition processes need to continue to ensure the safe operation of obstetric and maternal healthcare services for the region:

> ***Ms DOW*** *- … What needs to change in the North West to ensure that we have a good model of maternity service care that caters well for our dispersed population?*
>
> ***Dr LUMSDEN-STEEL*** *- Having spoken to the obstetricians again last night, maternity services have to be provided at one location, the public hospital, without any duplication or processes mixing up who is a public and private patient. One location, one provider, one clear pathway. This has to happen. The corollary is that if you wish to be treated as a private patient, you still can be treated as a private patient in that public hospital but there is one system looking after you.*
>
> *The other problem we have up the North West is the locum reliance. Now we've heard recently that we're going to make a commitment to support how our GP obstetricians might be able to help provide that obstetric cover in the North West. We heard last night that they've lost their accreditation for training registrars. That means that that site should not be providing medium- to high-risk deliveries because they do not have an obstetric registrar on there 24/7.*
>
> *We need to go back to look at how we can safely start that model, which is special supervision, the potential use of GP obstetricians, and how we can focus on getting that site back up to being accredited for registrars. If you can do those things at one location, let's cut this nonsense out which is having to have and run separate paper and separate stickers and call on separate teams to operate on private patients.*
>
> *…*
>
> *Likewise, we hear time and time again that, because we're offering limited obstetric services in the North West and we'll probably also lose private services in the North West, that means that all patients at the North West will be through the public system. That does actually remove the choice for those options at the North West. What we're saying is, the obstetric services in the North West should all be in the public hospital and the theatre should be in the public hospital.*

[107] Updated Information, Australian Medical Association Tasmania, 10 October 2025, p. 2.

I'm afraid that when there were specialist people brought in on how to design it up the North West, the obstetricians were largely ignored. Their concerns were largely overridden by the other services put in place up there.

The final element as everyone in the room would be aware of is, it's not just the obstetricians, it's the anaesthetic cover. We know when there was private obstetrics that ladies could not access epidurals and they had to change that classification to being public. If you make it all one hospital very clearly, you're one patient, you'll get access to 24/7 pain relief, which is at least giving them an epidural. But also, it's very clear if there's a paediatric attendance required to support midwives at delivery, who is going to be providing that cover.

Particularly regional centres, it's impossible to try to run a private-public roster. You're all one team, you're all working together for safe outcomes.[108]

4.34. Dr Khot, representing the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), was asked to comment on her consideration of how to manage a hospital, such as the North West Regional Hospital, which had lost accreditation:

***Ms DOW** – … As Ella said, I am based in the north-west, I live in Burnie where the North West Regional Hospital is, and you've spoken about the lack of accreditation at our local hospital. I want to understand what would need to happen for that - for the hospital to become accredited again to train doctors here locally? Could you explain that to me please?*

***Dr KHOT -** It's a bit of a chicken and egg situation, literally, you know, with pregnancy. In order to train a new generation of specialists, we need to have the specialists with the skills already working in those hospitals who can then provide the training. When you don't have the specialists, the appropriately qualified and experienced specialists, working in the hospital they can't then provide training, which means that there are no trainees. Then it becomes this kind of cycle in which it's really difficult to break that connection. You know, if you don't have trainees, because you don't have trainees, you then don't get senior doctors and you don't have senior doctors, hence, you don't get trainees. I think investing in having the right number of senior doctors with the ability to provide training is really important because that is what will get the site accreditation for training.*[109]

4.35. The intersection between the provision of maternal health services and adequate staffing was discussed by both the AMA Tasmania and RANZCOG as priorities to address access issues. Dr Lumsden-Steel from the AMA Tasmania discussed access, staffing levels and recruitment of maternal health professionals:

***Ms DOW** - … Obviously, there are lots of issues around recruitment and retention, what are your recommendations to this committee about how we can attract more obstetricians to regional Tasmania, or even to Tasmania full stop?...*

[108] Transcript of Evidence, 30 October 2024, Australian Medical Association Tasmania, pp. 18 - 19.
[109] Transcript of Evidence, 23 October 2025, Australian and New Zealand College of Obstetricians and Gynaecologists, p. 49.

Dr LUMSDEN-STEEL - *For workforce, we have identified issues with there being a disconnect between GPs who used to help provide co-managed obstetric care, that's one issue. The second issue is obviously again, and this is really lobbying with the private health insurance and the Federal Government, is that women are excluded from access to private obstetric cover unless they've had that for 12 months at the time of delivery. That's actually a barrier. We know that not all pregnancies are planned, some are unplanned but you're very happy when you fall pregnant when you're trying but that then obviously forces you to take the public hospital pathway or self-fund. That's the discussion we need to have with the health insurers. The Medicare rebates certainly are putting pressures on patients so that can sometimes make a private pathway a challenge because we know that Medicare hasn't been indexed, again it is a Federal Government issue.*

If we look locally at our public hospitals, we've got the capacity to train obstetric registrars in Tasmania, end-to-end training. They might go to the mainland for subspecialty training and we encourage that. We've now got competitive employment conditions for those doctors, but again, within Tasmania we don't tend to support the training rotation very well. At the moment you can't rotate to the North West because we've lost accreditation for training.

We need to again focus on supporting and rebuilding our sites to provide 24/7 cover. How can we get registrars back to North West? Part of that issue is going to be focusing on attracting retained specialists up in the north-west. We know is that if you work in an environment with a high locum turnover, that puts a lot of pressure and stress on you because you're having to supervise locums that are coming in. You actually don't know what the quality of the locums is going to be like: some are fantastic, some aren't fantastic. You're always carrying an additional mental load.

In the public hospital, looking at obstetrics, we need to look to make sure that we're providing an adequate interface for our private specialists to also work in the public hospital.

Vice versa, to be frank - and this is an issue that's Hobart-based because we're running three obstetric locations - it's the opinion of the specialist in Tasmania that running three obstetric locations in Hobart is not sustainable and probably not safe. The impact of losing a senior obstetrician in Calvary has halved their deliveries. Calvary Hospital now has gone from delivering between 30 and 40 deliveries a month and potentially being viable to now 15 deliveries a month. Specialists are not necessarily choosing not to work at Calvary because it's unsafe, but they're choosing to want to work at one location because it's more convenient and safe to know you've only got one person labouring at one hospital.

That's why we're seeing Hobart Private Hospital perform approximately 50 deliveries a month. Now if private obstetrics fell over in Hobart and Tasmania, that would be a disaster. Imagine if the public had to pick up an additional 1300 deliveries; it does not have the capacity to do so. I think it's really important that we understand the care and ensure we provide patients an option.

Unless we get together and talk about improving access to care and providing a better service, we're going to have this same conversation in 10, 15, 20 years' time. We need to get on with actually saying we can provide a better service, we've seen what they've

done on the mainland. They've certainly provided a clear and very well working functioning model whereby you've got a dedicated women's hospital, and within that women's hospital you actually have a dedicated functioning private ward and theatres. Unlike this hybrid model, which has failed completely in the north-west, you literally have a private model that's running separately to the public model, but physically in the same building. If you suddenly need to surge and you need to push patients into the public ward or private to public or into other theatres, you can deliver that safe and immediate care and it's more cost effective.

You also find you get much better collaboration between public and private if you're working in one building and you know that if you've got a high-risk private delivery, you can have that patient stay out of the public system. They can be treated in that ward, which is the private ward, but the baby can be treated safely because you've got the Neonatal Intensive Care Unit (NICU) in the same building. It is literally one floor down. What that does is unload the public system too because you've got these high-risk pregnancies staying in private but using the NICU, which they have to use anyway. That allows you to have new resources to treat your public patients, because at the moment you're competing in a public space for both private and public patients at the same time.

That collaboration is better for the public system. If it's done well, it does help you attract and retain specialists because they can see you can offer both a good mix of public and private practice. We know that, generally, procedural specialists do often enjoy that mixture of public and private practice. That allows you to help attract and retain more specialists and it also allows you to attract and retain more registrars because it offers more training program options if you can be exposed to training in the public and private sector. Many training programs allow that but at the moment, to be frank, we're not that sophisticated in doing that at all because we haven't set it up well to do so.[110]

4.36. Dr Khot from RANCOZG raised concerns regarding access to appropriate specialised maternal health services:

> ***Dr KHOT** - The second is maternal health services. Of course, ultrasound services come in to maternal health services as well. Because access to good quality ultrasound is very important for pregnancy care and again, inequity of access and access to a good quality ultrasound is something that concerns members. The other thing to highlight is the fact that the entire state of Tasmania has only one maternal foetal medicine specialist. We know that pregnant women are entering pregnancy with more medical disorders with more issues, things like being older mums, being heavier in pregnancy - all have implications for pregnancy outcomes. Having only one maternal foetal medicine specialist who would be the specialist to see those more complex pregnancies has implications for the health of the mother and of course for her pregnancy outcomes. Inequity of access to pregnancy care across the state is something that also needs to be highlighted.*[111]

Dr Khot further discussed specialist maternal health services, expanding upon maternal-foetal medicine specialists and urogynaecology:

[110] Transcript of Evidence, 30 October 2024, Australian Medical Association Tasmania, pp. 21 - 22.
[111] Transcript of Evidence, 23 October 2025, Australian and New Zealand College of Obstetricians and Gynaecologists, p. 48.

***Dr KHOT** - Starting with maternal-foetal medicine specialist, so these are subspecialists. They've done their basic training in obstetrics and gynaecology and then done specific training in maternal-foetal medicine (MFM). They deal with complicated pregnancies, especially in pregnancies where there is either an anomaly with the baby or there is a baby that's not growing well or a mother who has complex medical conditions like diabetes, blood pressure issues, things like that. As I said, there are more and more women coming into pregnancy at an older age with more chronic health conditions and so they would need a specialist maternal-foetal medicine person to be able to look after them.*

Currently, in Tasmania, there's only one MFM specialist and this person is based in Hobart and provides a referral service for the entire state, which would be around 6000 women. Normally in any other situation you would have more than one MFM subspecialist providing this service.

The second one is urogynaecology. Urogynaecology is gynaecologists who have done their basic obstetrics and gynaecology training and then had subspecialist training in managing urinary issues, usually urinary incontinence, things like that. Currently, Tasmania doesn't have a urogynaecology service as such. People from the mainland come and provide some service but there isn't anyone located in Tasmania. Women who have significant trauma after birth - third or fourth degree tears - may need further surgery and this surgery is usually performed by urogynaecologists. They certainly should be seeing someone with that kind of expertise to be able to manage any symptoms they have. As the population ages, women are more likely to have issues with urinary incontinence and so they would also need to see a urogynaecologist to get that treated.[112]

4.37. The structure of access to maternal health services in institutions across the state was a recurring theme raised with the Committee. Variations in access within private and public hospitals around the state were noted, including access to both general and specialised maternal care. There are no dedicated women's and/or children's hospitals in Tasmania. The states two former Maternity hospitals, the Queen Victoria Maternity Hospital in Launceston and the Queen Alexandra Maternity Hospital in Hobart, ceased operating by 1999. Hospital operated in Hobart until its closure in 1999. Dr Lumsden-Steel discussed the AMA Tasmania's recommendation for a return to this structure:

***Ms DOW** - You've made mention of the need for a women and children's hospital in Tasmania. Given the inequities that you've highlighted in your submission to this committee and that we know exist across the state - you said that should be in Hobart, but what are your thoughts on that being based in the north of the state, so that it's more equitable for women and children right across Tasmania?*

***Dr LUMSDEN-STEEL** - That's an excellent point. The reason I mentioned Hobart - the other reason for that is it's the tertiary subspecialty area where complex women's gynaecology surgery has to happen as well as complex deliveries do come to Hobart.*

I fully support the fact that you need to have dedicated women's and children spaces in all the zones. In fact, we know that there's significant concerns about how some of the

[112] Transcript of Evidence, 23 October 2025, Australian and New Zealand College of Obstetricians and Gynaecologists, p. 56.

service delivery up in the north of the state. I guess they're having an overarching statewide framework. Particularly, we highlighted our concerns there that perinatal support for those mums having depression, trouble breastfeeding, trouble with newborn babies and those that need that sort of combined midwife breastfeeding support and dealing with mental health issues after a birthing experience, which you know can be quite traumatic, and the access to those services is even harder in the north and north-west.

At the moment, the service delivery, having lost the mother and baby unit, is not fit for purpose, to be frank. I agree, we're not saying that the north should be excluded from these services. I guess the reason why we talk about that being a particular hospital in Hobart I have made the point because that's where the subspecialist complex deliveries have to happen. Patients do travel to Hobart for that, where we've got the paediatric and NICU intensive care unit.

It would also allow us to actually set up proper accommodation of the support, because if you're aware, we've got the Ronald McDonald House, which can support families with children and there's some elements of support coming to Hobart. But I look at what's offered to women in Melbourne with the Royal Women's Hospital and the Royal Children's Hospital, the fundraising that we can actually build to support that process, the accommodation support that can be offered and we've got nothing like that in Tasmania. If we refocused in the state, under a statewide umbrella, but if you do have to travel from Burnie and Launceston through a complex, complicated or high-risk delivery in Hobart, we can support that better. We can support you and your family better too if we've got a dedicated facility.

We find that delivering at the Royal Hobart Hospital, we have a capacity limit because there's only one obstetric theatre and that's only for normally the morning session, Monday to Friday. If there are extra deliveries, it's very hard to organise additional deliveries because they're competing with all the other elective surgery. Women's and children's surgery is often not the priority. It's not seen to be the priority because they're competing with all the other urgent surgery that has to happen in a public hospital that's got the tertiary emergency surgery for neurosurgery, for vascular as well too. They're always competing. They don't have their dedicated control of their theatre and access.

The other example is we don't run an obstetric list over a long weekend. So if you have a four or five day long weekend period - for example, recently you've got Good Friday, Saturday, Sunday, Monday, Tuesday, public holidays. At the moment, we haven't resourced and staff to plan to have an elective caesarean sections over that period. We often find that it's very hard for those mums trying to have deliveries during that period, they become emergency caesarean sections rather than elective caesarean sections. The focus needs to get back on 24/7 women's and children's health.[113]

4.38. Dr Khot was also asked to comment on RANZCOG's position on the structure of women's and children's hospitals as tertiary providers for care:

***Ms DOW** - The final question that I have for you is, in years gone by, we have had standalone maternity hospitals in Tasmania. We don't have any now. Other major capital cities and other centres around the country have women's and children's*

[113] Transcript of Evidence, 30 October 2024, Australian Medical Association Tasmania, pp. 20 - 21.

dedicated hospitals. I wondered if your organisation had an opinion on that, or could provide some further information to the committee about whether or not there is a need for a dedicated women's and children's hospital in Tasmania?

***Dr KHOT** - We don't have a firm position because different things work in different places. Certainly, a standalone women's and children's hospital will have the problems that are associated with women being not just either pregnant or not pregnant, or men with breasts or however we seem to kind of consider them. Women will also have other complex health issues and for that they need a range of different specialists and having a hospital that provides all those specialists within one location is a good thing.*

However, the advantage of having a standalone women's and children's hospital means that there is dedicated funding and dedicated space which is allocated to women's and children's health. Both have their advantages and disadvantages. We don't have a view one way or another. I think it has to be what works best for that place, that situation, that population of women. [114]

4.39. Dr Varek, a GP and founder of The Bubble Tasmania, discussed maternal healthcare in Tasmania from the perspective of a GP and business owner:

***CHAIR** - …In the interactions that you've had with the public health system, what do you think the public system could learn from your experience of providing a multidisciplinary practice? Could you identify any barriers to the public system from providing a multidisciplinary offering to Tasmanian women in particular?*

***Dr VAVREK -** I mean, discussing the public health system - it's a loaded question really that you've given me because there are so many issues with the public system. I think it does come down to lack of primary care services in our community. If we had adequate primary care services, adequate access to GPs who are the primary physicians when it comes to the family unit, we would have less pressure on the hospital system.*

When we talk about pregnancy care, particularly at the moment - maternity care services have been in the news a lot - I am primarily based here in the north of the state and, although we haven't had a maternity private hospital since 2016 - we only have two private obstetricians - now, when I have to tell patients who pay private obstetric cover that they can't access a private obstetrician, even though they can pay that and they have been paying those fees, their other option is to then go down the public health system. That puts a strain on the public health system for people who have been paying and expected to go down the private health system and that's a further stress on the public health system.

We also, for - antenatal care of low-risk women used to be bread and butter medicine for the GP, and it's something that GPs have done for a very long time. Over the years, the hospital systems were able to provide really great Midwifery Group Practice and midwifery services and the low-risk care in the GP setting slowly shifted into the hospital setting. There are still some GPs like myself who dabble in shared care, but now, with the public system being so inundated and very few midwives - and we've had a huge exodus of midwives leaving and they rely on a lot of locum - we need to bring that focus back into primary care, but we can't because GPs are inundated.

[114] Transcript of Evidence, 23 October 2025, Australian and New Zealand College of Obstetricians and Gynaecologists, pp. 56 - 57.

What we provide is a shared care service, we take on a lot of low-risk pregnancies in the GP setting and we look after patients, which means that they're not needing to go to the hospital for those appointments. They can be seen with their GP and this is something that all GPs should be able to do, but over time it's kind of been this push and shove between the hospital. I do think there's a lot more scope for more training of GPs, which wouldn't take much at all.

I know that our public hospitals, particularly up here in the north, are very supportive of the GP shared care model because it means when we look after a patient in pregnancy, they go to the hospital they have an appointment at 16 weeks, 20 weeks, 24, 28, 32, then they go 34, 36, 37, 38, 39, and then term 40, 41. That is a lot of appointments we can keep people out of the hospital system. I think a little more collaboration with our GPs and primary health sector could certainly help in that respect, but then, in saying that, we know that our GPs are so overloaded, how do they possibly fit those patients in?

It's a difficult one, but what we have proven is that a private business like The Bubble Tasmania has been able to help take the load off the public health system and work collaboratively with them to provide services for people who are able to pay that extra gap with the GP. Then that leaves it so those patients in our community who are unable to pay those gaps, it gives them the space to access those services through the public health system.[115]

4.40. Dr Vavrek discussed how insurance and Medicare rebates impact the potential provision of care by healthcare providers:

***Mr STREET** - … how much would the GP Medicare rebate need to rise to make your businesses financially sustainable without having to charge a gap?*

***Dr VAVREK** - It's a great question. I think to begin with, it would need to at least raise to be equal with what the AMA [Australian Medical Association] suggested rates are. At the moment, and obviously this has been in the news a lot - about 9 out of 10 GP visits being bulk billed in the next decade or so. If I was to go to a fully bulk-billing model at my clinic, all of my doctors, including myself, would be taking between a 30 and 40 per cent pay cut. It would need to be risen by at least 30 to 40 per cent in order for GPs to be taking home what we're essentially worth and to be able to pay the bills of running a clinic.*

***Mr STREET** - Just in your opinion, is the low rate of rebate one of the reasons we have a GP shortage at the minute as well because medical students are making the decision to - there was a figure quoted to me about the percentage of medical students coming out of university choosing to become a GP -… It's going down every year, but the drop being significant. Is the rebate and the financial sustainability of being a GP and running your own clinic one of the biggest problems we have?*

***Dr VAVREK** - Absolutely, 100 per cent. It all comes down to the rebate. I can't in good conscience tell a medical student now in 2025 that it is a good pathway to take to be a GP. It is really hard. You cannot be a GP and not get involved in the political landscape that being a GP has become at the moment. The feeling of being devalued, the feeling*

[115] Transcript of Evidence, 26 March 2025, Dr Natasha Vavrek, pp. 63 - 64.

that a lot of us feel like we are being pushed out of the space. There seems to be more attention on nurse practitioners and pharmacists taking on more of a role and doing jobs that we're meant to be doing, yet not needing to do the level of study and have that commitment that we do. It's not a great space to be working in and the conversation between many GPs does have that depressing note to it. I have a lot of colleagues who have dropped out of general practice and moved on to different areas or, in fact, are retraining in other specialties. [116]

4.41. The Committee asked Dr Vavrek how expanded or increased GP care could assist in access to maternity services, including continuity of care in particular, and if this could assist the public health system in the provision of care with additional spaces for triaging and treating patients in the private sector:

> ***Dr VAVREK*** *- … We do a lot of pregnancy care, as I mentioned, and when we see a patient for pregnancy care and antenatal care, we charge a certain item number - that's a 16,500. Now, 16,500 has a $20 less rebate compared to an equivalent time-based number. As a clinic that does mostly shared care, and a lot of pregnancy care, from a business perspective, it's better to charge that 36 so the patient gets more back, but if we get audited, we could be in trouble because of that. So, we have to charge that 16,500 and pass on that extra $20 to the patient just because they're pregnant. I mean, this is a great example of Medicare misogyny, right? And another way that women and access to these services are quite often limited because of these costings.*
>
> ***CHAIR*** *- Natasha, even though that's obviously in the Federal Government's domain, it's not outside our scope to make some recommendations about that kind of thing. I think it is medical misogyny. I heard from obstetricians recently, not at the Committee but elsewhere, that the surgical band, in terms of the payment of MBS [Medicare Benefits Schedule] for caesarean is two bands lower than any joint replacement performed by an orthopaedic surgeon. It's arguably just as complex and there's always going to be at least two patients, possibly more if it's multiple births at the end of it, which adds to the complexity. It's beyond our scope as a state Parliament to affect those things, but it's not beyond our ability to mention them in our report.*
>
> ***Dr VAVREK*** *- Absolutely. Particularly if we're looking at maternity services in Tasmania where - how can we help with that and how can we maybe bring a little more of that maternity service model into primary care? Or, if we could make it more affordable for women and increase that rebate for women that would help us as a state. So, I would really welcome some recommendations on that space.*
>
> *… taking pressure off the public health system can be done if we support our primary care physicians who are our GPs in the community. Not just GPs, but allied health because if we have more access to allied health, i.e., physiotherapists, psychologists - we'd have less of that severity and chronicity of conditions.*[117]

Structure of care

4.42. In addition to the provision of general maternal health services in Tasmania, the Committee heard significant evidence that two key elements of service provision should be prioritised continuity of care and midwifery-led care. The Committee

[116] Transcript of Evidence, 26 March 2025, Dr Natasha Vavrek, p. 64.
[117] Transcript of Evidence, 26 March 2025, Dr Natasha Vavrek, pp. 65 - 66.

heard that these two issues are inherently linked to provide a focus on women centred and personalised care.

4.43. In their submission, Maternal Health Matters discussed the historical changes to the form maternity care takes, including a shift from humanisation to medicalisation. Regarding this matter, it was raised that:

> *Obstetric training does not focus on developing skills to support the natural progression of an uncomplicated labour and birth therefore it is to be expected that this view will influence the care provided. Obstetric training is based upon treating pregnancy and birth as a medical procedure. Obstetricians are surgeons, and surgeons excel at performing surgery. In developed countries, obstetrician involvement and interventions have become routine in normal childbirth, without evidence of effectiveness.*[118]

Ellen O'Keefee, President of Maternal Health Matters, expanded upon this at a hearing of the Committee:

> ***Ms O'KEEFFE -*** *I'll actually go back 60 years and go back to 1964. In 1964, it was the first time maternal mortality fell below seven in Australia. It has stayed below seven since then, the majority of times. There have been times when it has picked up. In 1964, we also had the high-risk Aboriginal and Torres Strait Islander people in that, who had really poor outcomes. They're getting better outcomes now. What we've had since 1964 is an increasing amount of technology with actually no improvement in outcomes for morbidity. But for mortality, our outcomes are terrible.*
>
> *Our caesarean section rates are anything up to 80 per cent, but when they average out, we say it's about 32 per cent. We have country rural doctors saying they'll only perform caesarean sections in their town because they think they're safer and they lack back-up. We also see postnatal depression rates going up. Part of that could be the climate in which women have children today. Women had more nuclear families and all those things. But when postnatal depression goes up and it's related to birth trauma, one in three women who have postnatal depression also report birth trauma. That's not helpful at all. Ten per cent of women go on to get post-traumatic stress disorder.*
>
> *We've got to look at the humanisation of birth. We've evolved a way of birthing that means women no longer birth by themselves. Traditionally, they birth[ed] with family and what were called wise women. Wise women in some literature gets translated as witches, but actually they were wise women; they were very skilled at observing and understanding. Now we've got it all dominated by what we call technology and surgery, and we're not allowing women to follow normal physiological pathways.*
>
> *As a consequence of that, we also have women now birthing in hospitals. That's an illness model; it's not a wellness model. We expect to intervene when people are ill, whereas when people are well, we expect normal processes to take a path… but I think what's happening is that we've medicalised birth. We've made it a medical event when it's not a medical event. It's not an illness to have a baby. It's a normal physiological process. There should only be interventions in that process when it's valid.*
>
> *The medicalisation of pregnancy these days, especially of a normal healthy woman, ignores reliable evidence that pregnancy and childbirth are normal processes. I point*

[118] Submission No. 132, Maternal Health Matters, pp. 6-7.

you to the homebirth data. We ignore it. We ignore it at our peril. Homebirth can achieve a 97 per cent normal birth rate and a 95 per cent breastfeeding rate. Hospitals don't achieve a 95 per cent normal birth rate. We're lucky if we get a 50 per cent normal birth rate, and we certainly have appalling breastfeeding rates in Australia. That shows medicalisation is not necessarily working.

Having said that, technological advantages and surgical skills used appropriately can save life, but when used without valid indications, routine interventions transfer childbirth from a normal biological process into a potentially harmful medical procedure. When the medical model is applied to women and their infants who need intervention, it is medicine at its best. It is beautiful medicine. It transforms lives; it saves lives. When applied to all women, however, it has the potential to cause harm and violates the underpinning principle of medicine of above all, do no harm.

I think the changes that we've seen happen is because our society has changed. There's much more fear in our society. There's fear of litigation, fear of loss of reputation, and there's also a health system now that's hospitalised so it's like a factory. Birth isn't like a factory; it doesn't follow one path. When the hospitals are trying to be super efficient, and when health professionals want to work regular hours and don't want to be called out at 2 o'clock in the morning, then the system lets women down.[119]

Continuity of care

4.44. The Committee heard that the 'gold standard' of maternal healthcare is the consistent provision of care by a dedicated, known multi-disciplinary team of professionals, also know as continuity of care.[120] This can include the provision of specific systems of care, such as Midwifery Group Practice (MGP) and Know Your Midwife (KYM), but can also be facilitated through general, ongoing care with known healthcare providers including GPs, obstetricians, midwives and nurses. Specific midwifery-led programs of care will be discussed in more detail later in this Chapter.

4.45. In their submission, Maternal Health Matters provided the Committee with the National Maternity Service Plan's definition of continuity of care and explored aspects of providing continuity of care during pregnancy:

> *The National Maternity Service Plan defines 'Continuity of Care' as: "the practice of ensuring that a woman knows her maternity care provider(s) and receives care from the same provider, or small group of providers, throughout pregnancy, labour, birth and the postpartum period" (Commonwealth of Australia, 2011, p. 121).*
>
> *The philosophy behind continuity models includes: an emphasis on the natural ability of women to experience birth with minimum intervention by monitoring the physical, psychological, spiritual and social wellbeing of the woman and family throughout the childbearing cycle. Continuity of midwifery care works on the assumption that women will labour more effectively, have a shorter stay in hospital and feel a stronger sense of satisfaction and personal control if they have the opportunity to get to know their midwife at the beginning of pregnancy.*

[119] Transcript of Evidence, Maternal Health Matters, pp. 60 - 62.
[120] Transcript of Evidence, 20 February 2025, Dr Jennifer Ayton, p. 59, Transcript of Evidence, 23 October 2024, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, p. 52.

What are the elements of continuity of care and carer? All the care required to achieve a healthy pregnancy is provided by one person or a small team. This includes:

- *Monitoring the progress of the pregnancy.*
- *Providing education on pregnancy, labour, birth, post-natal recovery, breastfeeding and parenting.*
- *In labour, monitoring and care is provided by the health professional who provided your ante-natal care or another known to you.*
- *Providing the post-delivery care and postnatal care.*
- *Supports the commencement of infant feeding – breastfeeding or other.*
- *Supports transitioning to parenting.*
- *Furthermore midwifery continuity models of care are associated with longer prenatal visits, more education on pregnancy and breastfeeding; prenatal counselling, fewer hospital admissions & a more positive birthing experiences [sic] for women, easing a woman's transitioning [sic] to parenting and in meeting the demands of a new baby,(Leslie & Storton, 2007).*[121]

4.46. The Committee heard evidence from a number of lived experience witnesses who shared both positive and negative experiences. Across the board, very strong support was given to the continuity of care practices and associated programs but it was also noted that access to these systems of care was limited or varied geographically.

Private Witness 59 defined her experience in the Tasmanian maternal health system as:

> *… that of the Swiss Cheese model of a healthcare system.*
>
> *Our health system has a responsibility to support Tasmanians and, in many circumstances, through limited fault of most staff, the systems they have, the workforce shortages they face, and the lack of patient centred care they are able to offer, are leading to poor outcomes for women and their babies.*[122]

Private Witness 108 shared that she was unable to access continuity of care programs, which was her preferred model of maternal care:

> *In my pregnancy, I did not [sic] continuity of care. I attempted several times to give the practice my birth preferences and at no time was it 'convenient' for the midwife at hand to receive it. I found this odd and upsetting.*[123]

Private Witness 113 shared that while she appreciated the care offered by the medical practitioners who assisted her throughout pregnancy, the process was hindered by a lack of continual and connected care and that this impacted her entire pregnancy experience:

> *Most members of the RHH who looked after me were wonderful but I believe the system to be a broken one. No continuity of care, obstetrician led rather than midwife*

[121] Submission No. 132, Maternal Health Matters, p. 11.
[122] Submission No. 59, Private Witness, p. 1.
[123] Submission No. 108, Private Witness, p. 1.

led care, no option but to birth in a hospital (not in a birth centre or at home). I definitely feel as though I did not have an advocate who truly knew me and my wishes/needs for my body and my baby. As a healthcare worker myself I understand the need to work to policy and protocol but the hospital based care of a healthy birthing woman is not conducive to a natural or low intervention birth, which is what so many birthing people are asking for and which the majority of birthing people are not receiving.[124]

4.47. Representing the Australian Lawyers Alliance (ALA), Bernadette Davies discussed the interconnection of continuity of care and informed consent in maternal health services. Consent and informed consent will be further discussed in detail in Chapter 6 of this Report:

> ***CHAIR*** *- … Continuity of care and fragmentation of service provision has come through very strongly in the evidence that this Committee has heard so far of people seeing multiple different professionals each visit and not being able to actually feel like they're having a holistic approach to their care because they're seeing somebody different at each different appointment. How important is continuity of care from the experience you've had with the women you've represented and how important is it to your recommendation around a birth plan, that if a birth plan is written with the same clinicians each time, how much more impactful could it be in terms of the experience of that woman through her pregnancy and birth and postnatally?*
>
> ***Ms DAVIES*** *- One of the things that we noted was, in particular again for Aboriginal and Torres Strait Islander women, their continuity of care. They often don't even get in to see someone until they're a fair way along, but that can be in rural and regional areas as well. I think what you lose with a lack of continuity of care is that relationship development between the clinicians and the woman, and again, it comes down to that informed consent. They're not going to be in a position to properly provide informed consent if the midwife last week told them one thing and the obstetrician this week told them another, and this week it's a registrar and they've all been doing the same thing over and over, but things can so easily be missed.*
>
> *If it's the same person, I think that relationship and the meeting of the minds between the woman and her clinician, of course there would be a team and clear, clear detailed documentation of what was discussed, what worries she's got at that particular time, what was explained to her about where she's at and possible future interventions. All of that provides continuity of care and that birth plan provides a written record of that. It's absolutely important because, again, we've noted that informed consent - and it's a legal requirement, but it's a woman's right and it's basic, and it's not happening. Women are finding themselves making major life decisions for themself and their child in an emergency situation, having not been advised when they weren't in an emergency and in pain.*[125]

[124] Submission No. 113, Private Witness, p. 1.
[125] Transcript of Evidence, 23 October 2024, Australian Lawyers Alliance, p. 21.

4.48. Dr Khot of RANZCOG discussed the need for continuity of care models, including the need for ongoing improvements to be made by medical professionals to ensure that this model can operate safely and successfully:

> ***Ms JOHNSTON*** *- That leads on to my next question. We've also had a lot of evidence about the importance of continuity of care and building that relationship of trust with the clinicians in particular. It's been raised with us about concerns that often a woman will have an appointment with a midwife, with an obstetrician, with a registrar. Sometimes they are slightly different nuanced pieces of information that they receive. Is there any kind of guidelines in terms of what ought to be delivered at key points in time throughout a pregnancy? How would that information be provided to the pregnant woman, despite who is giving that particular advice?*
>
> ***Dr KHOT*** *- There are certainly guidelines around what information should be given at key appointments, but every individual will have their own way of delivering that information and sometimes that is the key to providing the information. We are saying the same thing, but if we are not saying it in the same way and we are not making sure that the person in front of us actually understands what we're saying, then we are missing out on giving that information, and absolutely, continuity of care is the gold standard that we should be aiming for.*
>
> *In my opinion, it doesn't really matter if that continuity of care is with a particular kind of provider, whether it's a doctor continuity of care, a midwife continuity care or GP continuity of care or a specialist continuity of care. The key is to make sure that there is some continuity of care provided there. We know that there are challenges in providing continuity of care across the full spectrum from pregnancy care, birth and care postpartum. Even if we can aim to provide continuity of care during pregnancy, then that will also achieve a degree of satisfaction for women.*
>
> ***Ms JOHNSTON*** *- Leading from that, in your opinion, is there good information sharing between different kinds of clinicians and healthcare providers in terms of information provided to a woman, so that if they are seeing various specialists or doctors or midwives, that all those people have a full picture of what's been happening for that particular woman on that journey?*
>
> ***Dr KHOT -*** *I think we do try to share the information, but we can do better.*
>
> ***Ms JOHNSTON*** *- Is there anything that would be better done that you can think of, off the top of your head, that you would think would be helpful?*
>
> ***Dr KHOT*** *- Having a common health record which can be accessed by everyone, the doctors, midwives, allied health, anyone else who needs to access it, in which we can document what the discussions we've had would help. Then there is a record that somebody else who's seeing the woman can go back to and look at and say, this is what was discussed, let's follow on from there. Having that sort of technology to help us would be good. We do have the technology, so we should use it to help us.*[126]

[126] Transcript of Evidence, 23 October 2024, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, pp. 52 - 53.

4.49. Kelly Langford, founder of Mothers & Midwives Australia (MAMA), a private practice midwifery clinic in Melbourne, discussed how continuity of care can be prioritised in all forms of maternal healthcare, across varied institutional forms:

> ***CHAIR*** *- … We are keen to hear about jurisdictions that provide that continuity of care in a more successful way, that ultimately, probably, reduces things like birth trauma and uninformed consent procedures. If there is continuity of care from health professionals through the prenatal period, it is more likely, I think, that women's wishes are going to be known and understood by their healthcare professionals.*
>
> ***Ms LANGFORD*** *- I think starting the conversations right at the start of pregnancy is really crucial; it is really important for people to have informed decision-making. Having GPs understanding what the different models are and what is available to people, having people understand what the likely outcomes are of walking into different settings, is really important. A lot of what we hear is they are finding this information out at the end of pregnancy or after birth that they did not know beforehand and felt that they were not informed or empowered to make decisions, because they just assumed that they would get all of the information and choices.*
>
> *I think, just having everybody understand what all of that is, it helps having the key health professionals who are providing the care understand that. Also, we are not aiming for enough in our maternity care system. That having a live mother and baby at the end of it is just not enough. We really have to support families and birthing people to come out of the experience feeling empowered, or at the very least, like they made choices. Because going into parenting after that huge transition, and arguably, one of the most important transitions in life feeling disempowered, really, just affects everything, all parenting and everything in life.*[127]

4.50. In a written submission, University of Tasmania (UTAS) researcher Dr Jennifer Ayton detailed the findings of her study titled the 'Giving Voice to Women Project.' Dr Ayton worked with a sample of over 170 Tasmanian women, her research demonstrating that women feel supported when they are able to build a relationship with their care providers. At a hearing, Dr Ayton discussed systems that prioritise continual and personalised support during pregnancy:

> ***CHAIR*** *- … In your written submission you spoke about describing women's experiences of maternity care with that broad spectrum, from an amazing experience with exceptional care through to traumatic experiences. You've described it as saying the good experiences were often described by women who received care from Midwifery Group Practice, MGP, or had engaged a doula, a private independent midwife, or a private obstetrician.*
>
> *I wondered if the positive stories were limited to those particular methods of care, or if there were positive stories across the board, or if you had anything you'd like to expand on in terms of the different models of delivering health care to women in pregnancy and labour?*
>
> ***Dr AYTON*** *- I think for our data, it's important that the context is that this encompasses the journey, so the positive and negative experiences can happen at any time.*

[127] Transcript of Evidence, 23 October 2024, Mothers & Midwives Australia, pp. 45 - 46.

***CHAIR** - Everywhere.*

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

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

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

***CHAIR** - One experience shapes that whole journey.*

***Dr AYTON** - That's correct. It's that one experience that can actually shape how she walks away, from or goes forward. That's a really important leverage point for frameworks to make sure that it's not just targeted at obstetricians or doctors or midwives, that it's actually a whole system that we need to actually support to do this.*[128]

4.51. Dr Ayton's discussed her findings that participants had seen numerous different care providers throughout their pregnancy. The Committee invited Dr Ayton to expand upon this finding and how this data is important in the creation of a draft respectful maternity care framework:

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

...

... we're actually being able to [use this to] map the system then. This is the system that's looking after women in this through their perinatal period. If we're going to do any interventions or do the framework or anything like that, we need to make sure that they all are players [providers] in that framework. As alarming as those numbers sound, it does offer up an opportunity to map out where the system is and who's doing what.

[128] Transcript of Evidence, 20 February 2025, Dr Jennifer Ayton, pp. 57 – 58.

They are also opportunities to make a difference. Back to the data that showed us that one person, one interaction can make a difference. That's reassuring again.

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

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

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

This is where the partnership needs to come in, so respect of both. Respectful frameworks are about respect for each other's profession as they are about respecting the health consumer.[129]

4.52. The Tasmanian Aboriginal Centre (TAC) shared insights from consumers who participate in a number of their programs for families and children. They explained that these groups provide a social opportunity for individuals to discuss their experiences and receive peer support, in addition to the formal services provided. They said this informal education often included discussions of maternal healthcare, such as breastfeeding or experiences with different types of births, which some of the women had not had explained to them during their pregnancy, due to inconsistent care. It was explained that increased continuity of care in formal healthcare services can enable and capitalise on a positive relationship between formal and informal education:

***Ms THOMPSON** - I wonder if it links in with another really big point that we were talking about before we came in around continuity of care. If it's not relationship based, which is everything you're talking about, Chloe, then somebody doesn't actually have the story of that mum. They don't know what their story's been. They don't know what their hopes are for the next birth or for feeding, that sort of thing. Whereas, if you do have continuity of care and you have a midwife that has been travelling through that journey of antenatal care with a woman, they're going to have a far bigger context of*

[129] Transcript of Evidence, 20 February 2025, Dr Jennifer Ayton, pp. 59 - 60.

that woman, their home, their family, what they'd love for their birth, all that sort of thing.

I just feel like that continuity of care piece is a massive part of getting better outcomes. We all know that, but it's how you actually get that practically hitting the ground where it is, what most women have the opportunity to be going into a birth with people they know in there with them, and are aware of what their needs are and what their hopes are for that time. As soon as it's someone you're just meeting because they're on shift, how would they know what you want?

Mrs PETRUSMA[130] *-Would you suggest that the Know Your Midwife program and the Midwifery Group Practice model needs to be increased?*

Ms THOMPSON *- Yes. One of the other things is to make that even more place-based, which we're just such a huge fan of. Whereas, instead of people having to leave community to come in here to Royal Hobart for their appointments, they can have those place-based in their community, that the midwives are running those clinics within community so that that's happening close to home. Other family can come along to those appointments and include more people within that antenatal and postnatal time. An extension of Know Your Midwife and MGP would be a great start in having more women experiencing that continuity of care.*

Ms FOSTER *- It worked really well when we had a relationship with the Department of Health and we had midwives coming into our service provision to provide services from the Aboriginal Health Service. That was Commonwealth funded. The Commonwealth was funding the state, the state was allowing the midwives to come into our centres and do that delivery. Not delivery of babies - delivery of service provision. When you had a complex care client then they were still able to do that within our health service rather than having, 'Sorry, you've got the complex care tick, we have to see you at the hospital'.*

CHAIR *- Is that no longer a funded service from the Commonwealth?*

Ms FOSTER *- I do not know what the state does with the money anymore but it actually hasn't been happening for a number of years now.*

Mrs PETRUSMA *- You're saying that the state is still taking the money but they're not delivering that service, or you don't know?*

Ms FOSTER *- I'm not sure how it works now but to me it doesn't matter. Often you don't need more money to do better work. If that model worked, then let's look at how that worked and say, 'Let's see if we can actually elevate that to support more families in our service provision'. You've got the cultural competence because they are learning that within our organisation. They are being able to use the multidisciplinary teams that we have in our health services to identify if there are some social things or there's some counselling or there's some other things; that there are these avenues to access that rather than go to a place. Then, all of a sudden, all you're getting attention for is your maternal needs at that point. We all know that there are many other things going on in people's lives and part of our work is doing that comprehensive primary care that encompasses the whole family and what that means to grow.*

[130] At the time of this hearing in October 2024, the Hon. Jacquie Petrusma MP was a Member of the Committee.

> ***Ms HARRIS*** *- It works so well because it's brought to them in their safe place and it breaks down that power imbalance. When community have to go to the hospital for their appointments, instantly there's that power imbalance of being in that uncomfortable environment. Whereas if we can make things more place based and bring services to places they're comfortable with and familiar with, then there's just going to be much better health outcomes. They're going to attend appointments because they feel comfortable to do so.*[131]

Midwifery-led maternal healthcare

4.53. Models of midwifery-led care were raised by a number of people and organisations presenting to the Committee, as an important aspect of providing positive, woman focussed maternal healthcare. There are three models of midwifery-led care available in Tasmania's public hospitals. These are Midwifery Group Practice (MGP), where care is provided by a lead and back–up midwife and the Know Your Midwife (KYM) and Team of Midwives (TOM) programs which operate a team of midwives supporting individuals through pregnancy, in consultation with doctors and obstetricians.[132] In these programs, women get to know a small group of healthcare professionals, who they are more likely to see for regular visits and checkups during pregnancy. Women described being reassured, knowing that it was likely that someone they had met during pregnancy would attend their labour. The two current private providers of maternity wards in Tasmania, Calvary and the Hobart Private (until August 20 2025) operate under obstetrician–led models of maternal care.

4.54. MGP models were defined by Better Births in Illawarra in their submission:

> *Midwifery Group Practice (MGP), is when a woman or birthing parent is cared for by a known primary midwife and a back-up midwife throughout pregnancy, birth and up to six weeks postpartum. It is a caseload or continuity of midwifery care model in the public health system. Midwifery-led continuity-of-care is proven to reduce birth trauma, improve outcomes for mothers and babies, save money, increase midwives' job satisfaction and improve culturally responsive care for Aboriginal and Torres Strait Island women. International studies have linked midwifery continuity-of-care with a 16 per cent reduction in pregnancy loss and neonatal death; 24 percent less chance of preterm birth; mothers are 16% less likely to be given an episiotomy and breastfeeding rates are higher at both 6 weeks and 6 months.*[133][134]

4.55. Evidence received from lived experienced witnesses emphasised strong support for midwifery-led models of care, while highlighting some access issues and shortcomings of the available care. The majority of this evidence was received in relation to the MGP program.

Brigid Cowen discussed with the Committee how she was able to participate in the MGP program, even though she was pregnant with twins. There are a number of risk factors which can preclude an individual from participating in the MGP

[131] Transcript of Evidence, 21 October 2024, Tasmanian Aboriginal Centre, pp. 9 - 10.
[132] Submission No. 129, Department of Health, p. 18.
[133] Footnote 4, *Benefits from continuity of midwifery models*, Queensland Health, Version 3.0 February 2019., from Submission No. 120, Better Births Illawarra, p. 3.
[134] Submission No. 120, Better Births Illawarra, p. 3.

program, with twin pregnancies typically included as such a risk. Ms Cowen discussed how, given her personal experience with the premature birth of her twins, the MGP model was not well adapted to suit the unique needs of her family:

> *...*
>
> ***Ms COWEN** - ... I loved the MGP. I thought it would be amazing if more mums could access it. It was amazing, amazing. Loved it. My midwives were just beautiful. I had two midwives who job-shared. Because I had the boys in prem[ature], they came to visit me in special care. So, when I got home, even though the boys were still pre-term, when we went home I didn't get any home visits.*
>
> ***CHAIR** - Those home visits had kind of been used up, for want of a better term.*
>
> ***Ms COWEN** - Used up, because they'd come to me in the special care. Yes.*
>
> ***CHAIR** - Okay, that's problematic.*
>
> ***Ms COWEN** - Yes. That would have been amazing if they had been able to continue that when I actually got home, when you need that practical help. When they're in special care, they're being looked after by amazing nurses.*[135]

Private Witness 115 shared her positive experience in the MGP in the public system:

> *My husband and I elected to receive pregnancy care through the Royal Hobart Hospital and were fortunate to [sic] accepted into the Midwifery Group Practice (MGP) model of care. We made this decision, despite having adequate private health cover, after speaking with several friends who are midwives, in both the public and private sector. We were advised that the best care we could receive in Tasmania was through the RHH, citing lack of OBGYNs on staff at any time in the Hobart Private or Calvary, neonatal intensive care facilities availability and several concerns around the scheduling of caesareans to suit private schedules.*
>
> *We had a wonderful experience with the MGP model of care - we were looked after by incredibly dedicated, skilled and kind midwives and I cannot praise them highly enough. I had a healthy pregnancy and a beautiful, uncomplicated birth at the RHH. I am very grateful for the care I was able to access and receive.*[136]

Private Witness 102 said that her access to the MGP program diffused some of the trepidation she felt regarding the potential medicalisation of her pregnancy and labour:

> *5. I received care under the Midwifery Group Practice (MGP) program while pregnant with both of my children. The MGP program was well suited to my circumstances as I experienced low-risk pregnancies and was well supported by family. I was allocated the same primary midwife during both pregnancies and her care was exemplary.*

[135] Transcript of Evidence, 20 February 2025, Brigid Cowen, p. 30.
[136] Submission No. 115, Private Witness, p. 1.

6. The option to have continuity of care in a setting outside of the hospital significantly shifted my perspective of pregnancy, from something medicalised and happening to me, to something normal, natural, and empowering. I cannot fault the MGP program and hope it receives the funding it requires to grow so that it can be available to more families.[137]

4.56. Kimberley Harding expressed support for the MGP program, saying she wished all of her friends who had had babies were able to participate in the program:

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

***Ms HARDING** - I think it was really just having that constant person to talk to. They were all different people until I was in MGP and then you had the same midwife every time. She knew what I wanted. The biggest thing with me, because I did have gestational diabetes, was that I did not want to be induced. I was very adamant on that. She wrote in all the notes for the doctors that, 'She does not want to be induced. Don't do it'. It was really great to be able to go in and know that she was accepting of my choices and I didn't have to explain myself or defend myself, but she knew exactly what I wanted. Made it so much easier. I think that continuity of care was the main difference before and after.*[138]

4.57. Ms Harding said experiencing the MGP program positively aided her in her transition into motherhood:

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

Much of our system, it seems wants to go against these instincts by following what doctors tell us, even if it goes against our instincts. As a part of MGP [Midwifery Group Practice], I was allowed to make decisions for my own care without judgment. My midwife empowered me and allowed me to put confidence in my own body. I'll be forever thankful for that.[139]

4.58. Criticisms of the models of midwifery–led care available in Tasmania focused on limited access, strict eligibility criteria, a lack of available places for patients, and disruptions and changes once care had commenced:

Private Witness 125 shared her disappointment in not being able to access MGP as there were no places available:

I was unable to access the MGP continuity of care program as it was full. I received differing opinions each appointment during my pregnancy, as each appointment was with a different Midwife or Doctor. Inconsistent notes taken and varying interpretations of these by different staff at each appointment, during the birth and after the birth. There were incredibly long wait time at the RHH Wellington Clinics for each appointment – at times I was waiting at least 2 hours.[140]

[137] Submission No. 102, Private Witness, p. 1.
[138] Transcript of Evidence, 18 February 2025, Kimberely Harding, p. 12.
[139] Transcript of Evidence, 18 February 2025, Kimberely Harding, p. 11.
[140] Submission No. 125, Private Witness, p. 1.

This experience mirrored several other contributions to the Committee.

Private Witness 116 shared that due to an administrative error, she was unable to access MGP:

> *I submitted my referral for RHH when I was 5 weeks pregnant. They lost my referral, so I missed out on MGP and ended up in the satellite stream seeing whoever was there in the Glenorchy clinic. This meant I had to constantly retell my story and make sure things were [sic] missed.*[141]

Private Witness 107 told the Committee that while MGP was her preferred model of care, her continuity of care was interrupted by changes to the supporting midwives throughout her pregnancy:

> *I went through the MGP program, and during my pregnancy, some of the MGP midwives swapped around and moved locations. I was reassigned to a new midwife, and when I asked I was told that I wasn't able to follow my midwife to her new location. This disrupted the continuity of care which had attracted me to the MGP program, and meant that I had to spend precious energy explaining my health needs again and establishing a rapport with a new midwife.*[142]

4.59. Representatives of the ACM discussed MGP and their experiences with the model in Tasmania:

> ***Ms SHAKES** - Midwifery Group Practice is a continuity of care model. You meet your midwife early on. Your primary midwife ideally provides the majority of your antenatal appointments, be on-call for your birth and postnatal care down here, up to two weeks. In our proposal we have suggested a six-week postnatal care period but I guess a lot of MGPs around the country, to my knowledge, have started out as being low risk and over time, as they have developed - this is my experience in Tasmania and one that I've been part of is that there's an expansion of the complexities that women may experience in their pregnancies that are supported within it, but there are still criteria where women are not eligible for it. We have suggested that women from minority backgrounds or who are experiencing a lot of complexities, would be some of the best to receive continuity of care throughout their pregnancies. So, we would definitely advocate for changes to the model to enhance that.*
>
> ***Ms WILKINSON** - The Hobart model, and I can't speak to the north or north-west, was set up with a goal to be more inclusive. Also bearing in mind that there's more socio-economic disadvantage in Tasmania. It's not solely a self-referral model, in that it's not only women that hear about it through their friends and ring up. Sometimes people are referred, through triage, through their GP or by recommendation from a care provider, which is a positive. It also tries to be more flexible and more open, in terms of medical risk for Aboriginal and Torres Strait Islander clients.*
>
> *I would say that probably some of the barriers come in, in terms of complexity, not so much in willingness, but more in just how to have those really robust systems of consultation with the obstetric team and with the other teams. That's probably where it's been a bit more restricted, would you say? Historically, I think sometimes some of those Aboriginal clients have been bouncing back between, you know - they've needed*

[141] Submission No. 116, Private Witness, p. 1.
[142] Submission No. 107, Private Witness, pp. 1 - 2.

to see an obstetrician or see a social worker, and then it just gets a bit much going to the MGP appointments as well. The more complex care and complex medical care as well as social care, needs to be a bit better integrated with MGP.

***Ms SHAKES** - Or, there be different models for it within the system.*

***Ms WILKINSON** - There could be like a combined model for those with higher medical risk or higher social risk.*

***Ms SHAKES** - Or one for young people having babies would be a fantastic idea.*[143]

4.60. Chief Midwife for the ACM, Alison Weatherstone, discussed the organisation's position on the necessity of continuity of care models in maternal health services:

***Ms WEATHERSTONE** -... It's definitely the position of the college that all women have access to Midwifery Group Practice or continuity of midwifery care, regardless of risk.*

There's a lot of evidence, research and data to demonstrate the improved outcomes for women and babies, such as reduced intervention, and less likely to have birth trauma. Our caesarean section rate nationally is rising and our induction of labour rates are rising. These sorts of models have protective factors for mums and babies. I think what we need to see is looking even at continuity of medical care, in alignment with midwifery and continuity that they received. Also it is strengthening the midwifery leadership, because where the Midwifery Group Practice becomes challenging, in terms of accessing, is because of workforce usually, and that's because annual leave isn't backfilled, and there is not combined leadership in governance over that model of care, and so it's less attractive to midwives to want to work in.[144]

4.61. Anne Folkerts, a midwife who spent the final years of her career as a Privately Practising Midwife (PPM), discussed the development of MGP in Hobart, which included her own advocacy:

***Ms FOLKERTS** - … I was the person to write the letter that resulted in the establishment of the MGP, the Midwifery Group Practice at the Royal in July 2012. That's when it began…*

This MGP was the first publicly funded continuity of care model in Southern Tasmania.[145]

4.62. Rowena Shakes, an endorsed midwife and Secretary of the ACM Tasmanian Branch and Maya Wilkinson, a midwife and ACM member, provided further context on access to the MGP in Tasmania:

***Ms SHAKES** - In the local context around the distances that you said there, workforce is probably the most significant contributing factor to that, because it's around, okay, do we have the midwife to be able to drive one hour to that person's house for the post-natal care? That's where the geographical aspects of it come into it. It's not about where the woman lives. Do we have a satellite clinic that the woman can attend for her appointments -*

[143] Transcript of Evidence, 23 October 2024, Australian College of Midwives, pp. 77 - 78.
[144] Transcript of Evidence, 23 October 2024, Australian College of Midwives, pp. 78.
[145] Transcript of Evidence, 21 October 2024, Homebirth Australia, p. 34.

Ms WILKINSON - *Because the MGP model utilises more post-natal care in the home and less in the hospital, compared to other models of care.*

Ms SHAKES *- And that's why it's cost saving, significant cost saving with midwifery group practice, partly through reduced intervention rates and then also through reduced hospital stays, which are very expensive. That means we can put that money towards longer postnatal care, which hopefully supports better breastfeeding, a better start to life. Some of the things the GPs were just talking about then wove in very well with what our position is or why it is our preferred model of care.*

Ms WILKINSON - *The Hobart MGP has recently offered a more part-time model because they have found a lot of the workforce, due to family demands and things, are not able to commit to being on-call and working 0.8 or full-time, and from what I have heard that is going very positively. That might be an option. I am not sure about Launceston.*[146]

4.63. The Committee heard evidence about how the risk categories during pregnancy are factored into eligibility for access to the MGP and similar programs. Cate Grant, representing Birth in Tasmania, Tasmania's newly formed and first local maternity consumer health group, discussed the consumer feedback the group had received around risk categories being used as eligibility criteria:

CHAIR *- From a clinical perspective, is there a reason why risk factors would, for want of a better phrase, class someone out of getting into an MGP versus added risk factors meaning they are more suitable to be receiving continuity of care through a Midwifery Group Practice?*

Ms GRANT - *I can't speak from a medical viewpoint because that's not my remit, but things that women have told me is that they feel safer in an MGP model because they know their care providers. They know that there are other obstetric services available to them. They are often are frustrated at being funnelled into a higher risk model of care which involves more obstetric appointments with different registrars. They don't get to see the one obstetrician throughout their care. Having a midwifery-led care model would often help with women not falling through the cracks, because they see the one provider the whole way through, and they are more likely to pick up on any anomalies in their presentation.*

CHAIR *- … - if you're going through an oncology treatment pathway, you're probably going to see the same people over and over again. If you're going through other medical treatments, you're probably going to see the same providers, but when it comes to prenatal care and labour, it's not the case. We have heard stories from women who say, if there is a risk factor that's identified, they are told at each different appointment, 'We'll check that out next time'. Then they see someone different next time and they say, 'Yes, we will look at that next time', and that goes on and on and throughout their pregnancy…*

Ms GRANT - *Or one provider says something is a risk factor and another one, in their opinion, says it's not an issue. There was a study done last year on MGP or continuity of care in Queensland and it showed that if continuity of care models were increased, the*

[146] Transcript of Evidence, 23 October 2024, Australian College of Midwives, pp. 79.

capacity was increased, the cost of obstetric care would go down because people who don't need that service are not being funnelled into that service. Therefore, you have lower risks for the people who do need the service because they're getting seen in a timely manner.[147]

4.64. Ms Magliano, Director of Clinical Services at Calvary Health Care explained that Calvary provides an obstetric-led model of care*:*

> ***Ms DOW*** *- ... Do you have Midwifery Group Practice model of care at Calvary?*
>
> ***Ms MAGLIANO*** *- No, we don't…*
>
> *That's not to say though, … that we can't look at a model of care that might promote continuity of care for women and their families. I'm quite passionate about that. Obviously, it needs to be something that women and their families will use and that obstetricians will support. I guess it's a space we can watch.* [148]

4.65. The Committee received recommendations for improvements to current midwifery–led models of care. Human Rights in Childbirth provided the following recommendations based on increasing access:

- *Aim to implement midwifery continuity of care as the minimum standard of care throughout Tasmania by 2028;*
- *Reduce or remove restrictions on consumer intake into birth centers and midwifery group practice;*
- *Double the number of birth centres and Midwifery Group Practices until midwifery continuity of care is fully implemented.*[149]

Minority group access to maternal health services

4.66. The Committee received evidence from many people regarding inequality in access to adequate maternal health services for members of particular minority groups, including Aboriginal and LGBTIQA+ Tasmanians.

Access for Aboriginal Tasmanians

4.67. The experiences of Aboriginal women and families in the maternal healthcare system were raised with the Committee. The ALA said:

> *37. The ALA submits that this is particularly concerning given the pre-existing conditions experienced by Aboriginal and Torres Strait Islander peoples at higher rates than non-Indigenous members of the public means that many Aboriginal and Torres Strait Islander women will have high-risk pregnancies. Examples of those conditions are diabetes, cardiovascular disease, hypertension, and respiratory illnesses.*
>
> *The following factors are currently compromising the experience of Aboriginal and Torres Strait Islander peoples in receiving proper and culturally safe care during their pregnancies and while giving birth, which exposes them to birth trauma as a result:*

[147] Transcript of Evidence, 26 March 2025, Birth in Tasmania, p. 73.
[148] Transcript of Evidence, 26 March 2025, Calvary Lenah Valley Hospital, p. 96.
[149] Submission No. 135, Human Rights in Childbirth, p. 70.

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

b. Antenatal care for Aboriginal and Torres Strait Islander women "occurs later and less frequently than for non-Indigenous women",[150] which increases the likelihood of those women having pre-term or low birthweight babies;[151]

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

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

e. An inherent distrust in government and government services (extending to hospital settings) felt by many Aboriginal and Torres Strait Islander peoples – especially those who have experienced racism directly in healthcare settings;[152] and

f. A lack of Aboriginal and Torres Strait Islander healthcare workers available to better communicate with and support Aboriginal and Torres Strait Islander patients, which is a symptom itself of the high rates of bullying, harassment and discrimination in healthcare settings.[153] [154]

4.68. The DoH detailed the provision of specialised care for Aboriginal Tasmanians:

DoH is committed to delivering better outcomes for Tasmanian Aboriginal people and their families through the National Agreement on Closing the Gap, which includes a target to increase the proportion of Aboriginal and Torres Strait Islander babies with a healthy birthweight to 91 per cent by 2031. In 2021, 90.7 per cent of Aboriginal and Torres Strait Islander babies born were of a healthy birthweight in Tasmania, compared to 89.6 per cent nationally.[155]

As part of responding to this Closing the Gap target, THS Maternity Services are authentically seeking ongoing ways to improve access and quality of care, and to ensure the lived experiences of Aboriginal and Torres Strait Islander women and their families whilst being cared for is as positive and culturally appropriate as possible. The MGP model has priority access for women that identify as Aboriginal or Torres Strait

[150] Footnote 12, Australian Health Ministers' Advisory Council, Aboriginal and Torres Strait Islander Health Performance Framework (Report, 2017) 7., from Submission No. 21, Australian Lawyers Alliance, p. 18.
[151] Footnote 13, Ibid 8. (Australian Health Ministers' Advisory Council, Aboriginal and Torres Strait Islander Health Performance Framework (Report, 2017) 7.), from Submission No. 21, Australian Lawyers Alliance, p. 18.
[152] Footnote 14, See: National Justice Project, Aboriginal Health Justice (Web Page. 2023) ., from Submission No. 21, Australian Lawyers Alliance, p. 18.
[153] Footnote 15, Housnia Shams, 'Indigenous doctors call for cultural reform in health sector to address workplace discrimination', ABC News ., from Submission No. 21, Australian Lawyers Alliance, p. 18.
[154] Submission No. 21, Australian Lawyers Alliance, pp. 17 – 18.
[155] Footnote 24, Australian Government Productivity Commission, Closing the Gap Information Repository, https://www.pc.gov.au/closing-the-gapdata/dashboard/socioeconomic/outcome-area2., from Submission No. 129, Department of Health, p. 24.

Islander, if appropriate. Referrals from the Tasmanian Aboriginal Centre (TAC) and South East Tasmanian Aboriginal Corporation are sent to the MGP clinical coordinator at the same time as the Women's Health Clinic referral pathway, to provide advanced notice to potentially earmark a spot as part of a midwife's caseload. The MGP also provides in-reach services at the TAC for low-to-medium-risk pregnancies.[156]

4.69. The Tasmanian context of Aboriginal experiences in accessing maternal healthcare was discussed in detail by the TAC. In their submission, they discussed the need for an understanding of these experiences:

> *The link between antenatal and postnatal outcomes and later life socio-economic outcomes is well documented, as is the higher levels of risk factors negatively impacting these outcomes for Aboriginal people nationally as well as jurisdictionally in lutruwita/Tasmania.*[157]

Raylene Foster, CEO of TAC, expanded upon this during the TAC's appearance before a hearing, noting the context and key considerations to hold in discussions regarding Aboriginal healthcare:

> **Ms FOSTER -** *As we are here today, it's a unique opportunity to consider co-designing a healthier future for our Aboriginal children and families. It's imperative that we confront the significant health disparities faced by Aboriginal people in lutruwita. Our collective goal must be to ensure that every Aboriginal child is born healthy and strong, that every family has the support they need, and that our cultural practices are honoured within a health system that ensures that our new babies are growing elders.*
>
> *I want to make a statement that when we talk about Aboriginal maternal child health, we talk about non-Aboriginal women carrying our Aboriginal babies and they are as important as the Aboriginal woman itself. I want to make sure that when we talk about that, that's in the context of whoever is birthing our babies on country.*[158]

4.70. The TAC submission shared a number of responses to the Committee's Terms of Reference which had been developed from consumer feedback:

- Concerns regarding swift discharge from hospital and a lack of ongoing post discharge support;
- Limited access to lactation consultants in the THS and community;
- Limited access to education and support programs throughout pregnancy or perinatally;
- Limited support for non-birthing parents or parents having a second or subsequent baby;
- A lack of cultural awareness and inconsistent approaches to Aboriginal individuals and families;
- Limited access to Know Your Midwife or Midwifery Group Practice, meaning lesser choice in care;

[156] Submission No. 129, Department of Health, pp. 24 - 25.
[157] Submission No. 91, Tasmanian Aboriginal Centre, p. 1.
[158] Transcript of Evidence, 21 October 2024, Tasmanian Aboriginal Centre, p. 2.

- Lack of place-based care; and
- Impacts of workforce shortages.[159]

4.71. The people who participated in WHT's 2023 'Talking about having a baby in Tasmania' research included Aboriginal people.[160] The project found these participants experienced a lack of cultural awareness in their healthcare:

> *Aboriginal research participants said there was no recognition of their Aboriginality at any point during their pregnancy care journey. One participant noted that her attempt to bolster her social supports while in hospital through family visits was met with resistance.* [161]

4.72. While focusing on the experiences of Aboriginal individuals who had early births, the Miracle Babies Foundation explained how cultural awareness should be increased to facilitate better experiences for members of the community:

> *The word 'separation' can be very emotionally triggering for our First Nations people and being discharged or not provided the opportunity to be the primary caregiver of their baby can be extremely traumatizing. … our First Nations people are removed from Country and their Community to give birth or baby is transferred for care, away from Country and Community. This trauma can be significant and long term. Facilities and Unit Design and working toward Zero Separation can assist in reducing this level of trauma and keeping family together. According to the Australian Institute of Health and Welfare, Australian Mothers and Babies Report Aboriginal and Torres Strait Islanders are 75% more likely to have a preterm baby.*[162] [163]

4.73. At a hearing, the TAC discussed the need for appropriate and informed cultural awareness in the health system:

> ***Ms FOSTER*** *- … One of the things that comes to my mind is around when you're asked if your Aboriginal or Torres Strait Islander and you tick the box, you're actually being disadvantaged because you have a lens looking upon you as though you are a stereotype of some notion of not being able to capably look after your children. It is so systemic. I've heard of families and some people quite close to me who have identified in hospital just having had their baby and they're told to watch a couple of videos that you'll need to watch.*
>
> *We can do bricks and mortar changes, we can put pretty pictures on the walls but unless we're actually really internally changing the systems, the value and the beautiful connection of families having babies. One of the things that also happens is this allowance of time to be with the birthing family where we are community. If I want to come along as aunts or uncles to share that beauty of the baby being born - because that's how we do business - then we should be allowed to do that. But we are excluded: you can come in between 2 p.m. and 4 p.m. and if you're outside those hours then you can't come in, you're not considered family.*

[159] Submission No. 91, Tasmanian Aboriginal Centre, p. 3.
[160] Heard, Elinor, Women's Health Tasmania, 'Talking about having a baby in Tasmania', 2024, https://www.womenshealthtas.org.au/sites/default/files/resources/talking-about-having-baby-tasmania-2024/2426-wht-talking-about-having-baby-tasmania-report-draft-5.pdf.
[161] Submission No. 31, Women's Health Tasmania, p. 18.
[162] Footnote 11, Hilder L, Zhichao Z, Parker M, Jahan S, Chambers GM (2014). Australian Institute of Health and Welfare (2012) Australian Mother's and Babies Report, from Submission No. 103, Miracle Babies Foundation, p. 11.
[163] Submission No. 103, Miracle Babies Foundation, p. 11.

It is really difficult in those institutionalised ways of having our babies in institutions, which brings me to the fact that there's some other ways in these worlds where we don't have to be in an institution to have a baby.[164]

4.74. The TAC provided a specific recommendations regarding the implementation of strategies to improve cultural awareness:

> • *Develop and implement a strategy to improve cultural appropriateness of reproductive, maternal and paediatric health services to Aboriginal people across lutruwita/Tasmania to ensure equity in access, uptake and usage of services; including the following:*
>
> - *Involve the Aboriginal community-controlled health organisation (ACCHO) sector and the lutruwita/Tasmania Community in genuine co-design of reproductive, maternal and paediatric health services.*
> - *Where possible, transfer funds for design, management and delivery of these services to the ACCHO sector.*
> - *Undertake on-going monitoring and reviewing of Tasmanian Government reproductive, maternal and paediatric health system and services for cultural appropriateness and responsiveness and implement timely and sound consequential changes identified.*[165]

4.75. Access to support in hospital during labour and post-birth period, was discussed by the TAC. The organisation strongly advocated for increased support, including length of stay for all parents. This includes ensuring that parents having their second or subsequent child, are able to access both immediate and ongoing support:

> ***Ms JOHNSTON*** *- ... What could you suggest in terms of trying to encourage, particularly in those first 24 to 48 hours, how that could be enhanced to provide extra support to the person birthing and the family involvement in that as well?*
>
> ***Ms FOSTER*** *- I think it's having that availability for families to support the birthing parents. It's also about not watching the time - okay, this family's next, this one is now, 12 hours in and they can go home. They've had two children before so they're ready to go out the door. Actually, having three children is a big hit…*
>
> ***...***
>
> ***Ms HARRIS*** *- Every baby is so different when they're born as well. Your first experience is going to be so different from your future ones. It's important for them to realise that just because you've had children in the past doesn't mean that you're not going to need that further help.*
>
> ***Ms JOHNSTON*** *- Do you think there's room for acknowledging informal support the family and community provide in that setting? In terms of others who've been through the process and involving them, rather than necessarily healthcare experts, involving family and community members in providing that support to new mothers.*
>
> ***Ms FOSTER*** *- Absolutely, and especially with breastfeeding. You might not have had the opportunity to try breastfeeding, or something was not working for you in your first or second, whatever, but this might be the time that you want to try again, and often that*

[164] Transcript of Evidence, 21 October 2024, Tasmanian Aboriginal Centre, p. 3.
[165] Submission No. 91, Tasmanian Aboriginal Centre, p. 3.

ability of lactation consultants in the public system is not there. Everybody is very, very busy and having the ability to bring in peer support for breastfeeding is not just a one-off, come in and help and do this. It is consecutive feeds and all of that.

***Ms JOHNSTON** - Over months, because their babies change.*

***Ms FOSTER** - Absolutely, it is really building that. What is it that would make that birthing experience the best for that individual family or that individual parent, whichever it is? How do we actually support that well, rather than having to have a bed available? Or, what are the other options? Is it that you go home with Dannielle as your nurse and she is contactable 24/7? Those things could be the difference about your experience going home with bub. That is beautiful and just the best it can possibly be to waking up at 12 o'clock, baby hasn't fed, you are looking for the next best thing, where is the formula, someone go down to Coles 24-hours and get me that formula or whatever. All of those things that actually -… Need support so that trauma is controlled because it can be very, very traumatic. If you had set destined to breastfeed and that was all that you wanted to do and that is not something that is working for you right now, that is absolutely devastating.*[166]

4.76. The need for supports, including in the community, was discussed at length by the TAC. This discussion encompasses the intersectional nature of provision of care across the pregnancy, birth and post-natal period. The explanation of community access explored below considers the work of the TAC across a number of the Committee's Terms of Reference, including maternal health services, perinatal mental health services and services adjacent to CHaPS and paediatric healthcare. These areas were explored in relation to the work of the TAC in their provision of community support programs:

***Ms WOOLNOUGH** - We have the three collectives: Palawa collective; Kanamaluka, which is Ravenswood up through to Georgetown; and Kutalayna, Old Beach through to Brighton. They're the areas in which we work and support community, but also looking at the services in those areas that are there to support families. So, when we had the two new collectives start, we acknowledge that there were things that we were hearing that were synergies. However, there were things that were place-based that the community had the power to work on and control within their space.*

So, we brought together a statewide group which has representatives from Health, Education, Housing - it's starting to see the relevance of everyone working collaboratively…

What we've been hearing, with health, for instance, is that people are hearing that all these services are in their community, yet they can't tell you who they are. So, we're starting to see our community want to hold services accountable. If you're in this area, I want to know who you are. I don't want to have the expectation that I come through the door constantly to you and that's where community - when we talk about co-design - they've come up with models that work for them. We hold events called Kipli & Kani. They've been designed by community for community. They invite services to come along to a local park which is out of their building, out of their office, and just engage with them, have the conversations, and from there, when we come together as a statewide group, now we're hearing people say, 'Oh yeah, one of our staff members

[166] Transcript of Evidence, 21 October 2024, Tasmanian Aboriginal Centre, pp. 5 - 6.

went along and they were saying that they met such and such' and then they came along and they were comfortable to come into the service.

But, it's also that connection piece for community to come together and have the conversations. As Anissa said, it's bringing community together, and then if someone has an issue, there's always somebody there that can support and we saw that last week in Kanamaluka.

4.77. Chloe Woolnough, the Manager of the TAC Connected Beginnings program, provided an example of support given to this mother in the lead up to the birth of her third child:

***Ms WOOLNOUGH** - We were chatting to one of the mums that has been with our program now for three years and she's just had another baby, and she spoke around the impact of knowing services but also having someone there consistently to support her through that journey, to break down what the jargon is that was being used in the paediatric appointments, but also advocating that she has a voice. She's just had a new baby and she spoke to her and she didn't know what a VBAC [Vaginal Birth After Caesarean] was. She'd always wanted to experience childbirth yet she was told 'Third child, you're having a caesarean, it's too dangerous, questions asked, go.'*

Then she was able to go along with the support of one of our amazing staff who brought up the question and she was able to express why she wanted to try it and that she was more than willing to have the caesarean, but she wanted to also have the opportunity. They spoke around that and she went into labour and they went up to visit her - she had other young children - to see how she was going. They'd been talking around this for a few months, and her partner actually said, and I remembered, 'I'm going to tell them that we don't go straight for the caesarean. She wants to have one of those VBAC things'. One of those VBAC things, but he had the language there. So, even if she became overwhelmed, he was like 'I know what she wants, and I know that I can advocate for her because that's what she's wanted'.

Then we moved into the journey around breastfeeding, and she said, 'Oh, you know, I was pretty much sent home, you've had two children, you know what to do'. She'd never successfully breastfed for those first two children. I said to her 'Did you share that?' She goes, 'No, no I didn't share because it was like, d-d-d home. There you go. Here's a magnet. Now, if you need anything in between, just call these numbers'. And she's like, 'I was never going to call those numbers, but I was going to call the person I knew from Connected Beginnings who'd helped me through this whole process'. She shared with us, just having her come and sit and have a coffee and then being able to say, 'You know what? I really want to breastfeed, but I'm just so confused. Someone's told me this, someone's told me that. What do I actually do?' We ended up having a little bit of a laugh because in the end the person who was working with her said 'Well, I'm happy to help you and can show you what to do, but I'll connect you with the lactation consultant. Let's try today. Let's make the phone call', but she stepped her through.

So, in the end, she actually breastfed for six weeks, and to see the pride that once she advocated for herself, for the first time during her third birth, she had a go at breastfeeding and her voice was heard. It was just amazing to see, she was empowered. She was like 'I actually had a say in what I wanted and what suited me and my family'.

She said 'Now, I don't feel like I've missed out on anything. For the first two births I really felt like I missed out. I wanted to have a natural birth, planned, had to go, ready, set, off. This time I really got to enjoy the experience and know what it was like to be a mum going through the birthing experience. To be able to not have that power imbalance and to say that it's my body and this is what I want and this is how I want to do it'.

The impact of that, but having the support, was the key thing we constantly heard. Her child's now four months old and we were sitting there and it was like hearing friends talk.

***CHAIR** - It would be transformative.*

***Ms WOOLNOUGH** - It really was.*

***Mrs PETRUSMA**[167] - With the first two births, do you think it was a lack of health professionals actually asking the right questions or offering information?*

***Ms WOOLNOUGH** - She shared that she very much had seen herself as not holding the knowledge. They were the experts. They told her this is what had to happen and that's how she had to have her babies. However, when she learnt that she can push back and advocate on what she also needs as a mother, then she was able to negotiate that with them. Obviously, didn't want it to be unsafe but this is something that as a mum she wanted to experience and to understand. Even though the first two hadn't gone to plan, there's also this opportunity. The fact that she's a third time mum who never even had mentioned to her the opportunity of a VBAC that then was agreed upon by medical professionals that it was doable. Why wasn't that option given in the first place?*[168]

4.78. TAC representatives expanded on how direct services through the THS and DoH could be increased to ensure adequate access for families to opportunities for ongoing support:

***Ms JOHNSTON** - I'm really interested in exploring a bit more about the second and third time experiences. From what you said, Chloe, that's a really good example to us of the disparities and the assumptions that are made about mums at second and third time round. I want to know a bit more about how they can be better supported.*

...

***Ms THOMPSON** - I think, straight up, that parenting groups, or whatever you want to call those groups postnatally, are essential for everybody, not just a first time mum. You're put through that system and offered that first baby and never offered that again. That is something that every woman giving birth is welcome to come along to those groups.*[169]

4.79. The Committee heard about the value of particular TAC group services:

[167] At the time of this hearing in October 2024, the Hon. Jacquie Petrusma MP was a Member of the Committee.
[168] Transcript of Evidence, 21 October 2024, Tasmanian Aboriginal Centre, pp. 7 - 9.
[169] Transcript of Evidence, 21 October 2024, Tasmanian Aboriginal Centre, pp. 11 - 12.

Ms THOMPSON *- Usually, if it's still the same as when I was a CHaPS nurse, you run the group for three to four weeks facilitated by a child health nurse. Then the group is welcome to continue that on themselves and meet ongoingly. I know that obviously the north-west is incredibly understaffed CHaPS-wise, so I don't know if things like groups have kicked back in depending on staffing.*

That extension to all mums is just - and Ningi Pakata are the mums and babies group that we have on Mondays, and in the other locations too, is a great example of that. The way in which some women - they're having their fourth or even their fifth - what they bring to the group and offer is extraordinary, and the things they're sharing.

Also what you notice around birth debriefing, which a woman's never had, and you see that being an important space where women can actually be debriefing birth one and they're having their fourth baby, but they've still got a lot to - because perhaps someone else has had a very similar experience and they then say, 'Wow, that was exactly the same for my first birth and I never talked about it, but it had a big impact'. The way in which that support can be there and that sharing of knowledge like we saw with the breastfeeding, and the numbers of bags of clothes that have been swapped and given is just extraordinary. Again, it's building up and allowing community to have places to come and meet and to provide that support.

Ms HARRIS *- The practicality of it also needs to be thought about. So, if they're second or third time mums, they need to think about if they're coming to these groups, they're going to have other children with them, and often that's the barrier, because they need to bring their other children and there's nowhere for those children to play or be supervised properly.*

Ms FOSTER *- We run those in the child and family learning centres and those respective places, so that becomes a support mechanism for them to know that there's another place where they can bring their children to accommodate all of those needs.*

Ms JOHNSTON *- Is that something that you'd like to see as a recommendation of this committee in the future around having that mothers' group, or whatever they call them? Mine was essential for me the first time round and I've got lifelong friends from that, but the second time there wasn't the ability to join and connect. As I say, they were very different experiences. Is that something you'd like to see - that ongoing support provided no matter what number baby you're birthing?*

Ms THOMPSON *- That postnatally you're offered a group to attend?*

Ms JOHNSTON *- Yes, because that was more powerful for me - the other mothers - than anything any health professional could provide me.*

Ms WOOLNOUGH *- It's also about the space where it's hosted, because it's great to say we'll run it for three or four weeks, but then it falls onto a new mother to try and hold it where we've seen - we 've got one mum who has four children and she comes along every week just for her cappuccino that's made and on the table ready for her. She's like, 'It's the one thing each week that's done for me, and I just get to come and enjoy it.'*

It's those little things that we're seeing, like having a morning tea, being able to create - and they've turned it into a bit of a craft group now where they're making something, because we acknowledge that it's awkward to walk into a room where you don't know anyone and then you're expected to talk.[170]

Access for the Tasmanian LGBTIQA+ community

4.80. Working It Out (WIO) supplied the Committee with insights into access to maternal health services for LGBTIQA+ Tasmanians, describing a lack of support and inclusivity within existing services:

> *Maternal health refers to the health of women during pregnancy, childbirth and the postnatal period. Each stage should be a positive experience, ensuring women and their babies reach their full potential for health and wellbeing. Some people who give birth are not women (e.g non-binary, agender, gender-diverse, trans men). WIO receives feedback from parents' experiences that accessing these Tasmanian maternal health services (and these services' documents) feel gender-binary, endosexist, and heteronormative.*[171]

4.81. WIO provided further detail on the experience of specific cohorts of the LGBTIQA+ community who may experience higher levels of inadequate care:

- *Non-inclusive language of people's living experience in these services. The issue of inclusive language has unfortunately become politicised while the intent remains simple - to include all people. WIO supports the continued use of terms such as 'mother' and 'maternal' and the inclusive language of 'birthing person/people', which more truly reflects our society's reality.*

- *Trans-men and gender diverse parents report direct and indirect discrimination at public maternal health services, paediatric services, and hospitals. These parents are not visible or welcomed in service offerings, and regularly experience their parent title, gender, name, and pronouns erased or invalidated.*

- *Parents of intersex infants report inappropriate medical treatments and responses. This has included a situation leading to lifelong neurological damage. This specific issue can be avoided with newborn testing for Congenital Adrenal Hyperplasia (CAH) which already widely occurs in other Australian jurisdictions, and also further generalised inservice training/education for maternal service staff on intersex issues.*

- *Same-sex parents continue to experience exclusion and stigmatisation in accessing maternity services that directly or indirectly discriminate via heteronormative assumptions, materials, and practices.*[172]

Neonatal Intensive Care Unit (NICU) services

4.82. Tasmania's tertiary NICU services are provided by the THS at the RHH. The survival rates of very preterm infants in Tasmania is comparable to other jurisdictions across Australia and New Zealand:

> *The most recent report from the Council of Obstetric and Paediatric Mortality and Morbidity (2021) shows that the survival for very preterm infants admitted to the RHH*

[170] Transcript of Evidence, 21 October 2024, Tasmanian Aboriginal Centre, pp. 12 - 13.
[171] Submission No. 34, Working It Out, pp. 3 - 4.
[172] Submission No. 34, Working It Out, p. 4.

Neonatal and Paediatric Intensive Care Unit between 2017 and 2021 is comparable to that of the Australian and New Zealand Neonatal Network, with an adjusted standardised mortality ratio for infants born at 23 to 28 weeks gestation of just under one.[173]

4.83. Miracle Babies Foundation, an Australian charity supporting premature and sick babies, told the Committee in their written submission that more than 48,000 Australian newborns require neonatal care each year.[174] They emphasised the importance of the following matters in relation to NICU services and the experiences of families:

- Logistical arrangements to reduce separation between the birthing parent and child;
- Access to breastmilk;
- Mental health support;
- Rates of early maternal discharge;
- Parental leave provisions; and
- Post-discharge support.[175]

4.84. Private Witness 62 shared her experience in the NICU with her child. Living in the North of Tasmania, the family was transferred to the RHH to ensure appropriate immediate care was given to their child after the birth:

> *When [redacted] was airlifted to RHH, unfortunately I was not, and I remained in the LGH for the first 24 hours after [redacted] birth, the severe separation was extreme, like nothing I have experienced before. I was then airlifted to RHH the following morning. My husband drove down to RHH as well. We stayed in the Ronald MacDonald [sic] House for the 10 days that [redacted] was in NICU. Whilst the charity is amazing, the severe separation from our home and our family during this extremely traumatic time was incredibly emotionally difficult for us as a family.*
>
> *[redacted] remained on life support for the first 4 days of his life. As with most life support scenarios, this time was touch and go, he required multiple medical interventions as part of his life support, I cannot bare to think of the pain and fear he must have felt throughout this. Rarely does the medical profession acknowledge this aspect of medical trauma, but us parents we know it exists, we can see it in the eyes and on the faces of our children. We could see the pain in our darling [redacted] eyes. The neonatal intensivists at RHH were phenomenal, kind caring and so highly skilled. The NICU team were so impressed with how strong [redacted] was proving to be, they said they rarely see babies as strong as [redacted], they said it was a miracle he was full term and not premature, they felt this made all the difference during the fight for his life. We know it did too.*

[173] Submission No. 129, Department of Health, p. 35.
[174] Submission No. 103, Miracle Babies Foundation, p. 1.
[175] Submission No. 103, Miracle Babies Foundation, pp. 2 - 4.

Through all of this I was not able to hold my son until he came off life support at 4 days old. My husband, [redacted] father [redacted], was also not able to hold him. This extreme separation at birth resulted in major difficulties establishing breastfeeding.[176]

4.85. Miracle Babies Foundation submitted it is necessary to make sure there is zero or limited separation between NICU patients and their families:

We advocate and support the World Health Organisation's recommendation for Zero Separation; the keeping of mother and baby together from birth. Miracle Babies Foundation is a member of the Global Alliance for Newborn Care (GLANCE). A priority for the Alliance is to eliminate the systematic and often unnecessary separation of primary caregivers from their child.

Separation alone is traumatic. It also compounds any existing birth associated distress and the ensuing trauma.

The response from mothers when asked 'what was it like going home and leaving your baby in hospital?', even years later, often evokes a trauma response or; 'It was the hardest thing I have ever had to do!'

Across Australia, families have experienced the distress from being separated from their loved ones amid the COVID-19 pandemic. The pandemic exposed the inability of neonatal units to safely allow parents with airborne viral infections to visit their baby without the risk of infecting others.

Miracle Babies CEO and Co-Founder, Kylie Pussell, has many years' experience supporting families. She concludes; "Limiting the contact parents would otherwise have if the baby didn't need specialised care, causes unnecessary distress and trauma to the whole extended family. This results in other early challenges for the parents such as isolation and loneliness. Isolation and loneliness, results in the mother feeling unsupported. This situation is highly likely to evolve into postnatal depression. We support and encourage all hospitals to fully implement family-centred care and to support full and continuous access to their baby during the hospital stay. The experience of having a premature or sick baby is traumatic with a range of emotions including failure, guilt, fear, uncertainty and others. The family should be together wherever possible, for the long-term health and outcome of the baby, the parents and the whole family unit."[177]

4.86. Kirsten Chilcott shared her family's experience with the NICU services available on the North and North West coast and how the adequacy of the available support was varied:

Just hours after being admitted, I was advised that I would be sent to Launceston for delivery the following day due to me being less than 34 weeks gestation. The care I received there was exceptional. I require testing multiple times a day, and daily ultrasounds, before being told I needed to deliver via an emergency caesarean section on [redacted]. My son was in their NICU, and the staff there were highly trained and competent, and took the time to explain everything to us as well as

[176] Submission No. 62, Private Witness, p. 3.
[177] Submission No. 103, Miracle Babies Foundation, pp. 1 - 2.

teach us how to care for our son using the feeding tube and how to fix the monitors etc.

We were transferred back to Burnie after the first week, which we were so excited about as it meant we were closer to home. However we quickly realised that the level of training and care provided by the nursery staff were nothing less than appalling. I met multiple staff who openly admitted that they had not worked in the nursery before and were just covering shifts due to staffing issues, or that they had not worked there for a long time. I had one nurse admit she didn't have experience with NGTs but told me she would "have a go" replacing my son's, to which I refused and requested a trained staff member change my son's tube. On multiple occasions the staff were so busy that they held the feeding tube too high, so they could be done faster, causing my poor premature baby to continuously vomit back up his feeds, which caused concerns with the paediatricians who just saw the notes of constant vomiting. I eventually took over as many feeds as I could to ensure the tube was held at an appropriate height which improved things significantly.

We met new paediatricians every day, and every day things seemed to change in terms of what their advice was. The lack of consistent advice or one consistent approach to care was confusing, at an already stressful time. Each paediatrician had their own opinion, often re-calculating the amount of formula required. When we were finally allowed to go home, the inconsistency continued as we were required to attend regular paediatric outpatient appointment [sic]where we always saw a different doctor, having to re-explain our story every time. I raised concerns multiple times at these appointments that my son was having feeding issues, projectile vomiting after every feed.[178]

4.87. The Committee heard from Private Witnesses 122, a couple whose baby was in the NICU. They shared that while staff were mostly well qualified and services adequate, there were some discrepancies:

11. We acknowledge that the RHH NICU nurses were exemplary, highly professional, ethical, knowledgeable and compassionate, for the most part. They knew how to work with families in NICU under the often extremely stressful and traumatic circumstances for which those families required attendance at the NICU.

12. However, the bad nurses stood out, through their lack of the temperament and commitment to professionalism that you would expect for a staff member working within NICU where families are going through tragic and terrifying ordeals with their young ones who are born too early, or with severe medical complications. We know this, because during our week stay in NICU, one family suffered the loss of one twin that had been born with complications. [179]

[178] Submission No. 78, Kirsten Chilcott, p. 7.
[179] Submission No. 122, Private Witness, p. 3.

4.88. Ms Cowen, a mother of premature twins, discussed her experiences in the RHH special care unit and the difference between services available in this unit and those in the 'new' (at the time of her family's experience) NICU:

> ***Ms COWEN*** *- I've seen the old NICU and special care unit because my sister had a prem[ature] baby. The boys were born at a time where they actually went to the old NICU unit for NICU, and that was the same week that they were then opening the new NICU and special care unit. The boys were then transferred up to the new special care unit.*
>
> ***CHAIR*** *- Oh right, while they were there?*
>
> ***Ms COWEN*** *- Yes. Say they'd been born three days later, they would have been taken straight to the new NICU unit. Anyway, we went in the old NICU unit, which was dated. It was fine. We went up to the new special care and each kid is in their own little cubicle, which, I mean, is great for privacy, but when you have two kids in separate rooms separated by a hard wall with a window and a blind, it made it really difficult.*
>
> ***Mr STREET*** *- So there were no double rooms?*
>
> ***Ms COWEN*** *- No, not in special care. I was told in the NICU there was. If we'd gone into the new NICU unit, we would have had a twin room, but in special care there wasn't. It just seemed crazy that this brand new ward isn't fit for purpose for twin parents who - so many of us have prem[ature] babies. It was difficult, very difficult.*
>
> ***CHAIR*** *- How long were they in there?*
>
> ***Ms COWEN*** *- Five weeks. … I had a scenario one day where I was having skin-to-skin with one, and then the doctors and nurses were doing their rounds and they went and saw the other twin and they're talking about him. I'm the type of mum - I was there like all the time and I would be there for all the doctors rounds and taking in what they said. But, I was just in this other room and they were just talking about my kid…*[180]

4.89. Ms Cowen also discussed the benefit additional mental health supports could provide to parents with children in the NICU:

> ***Ms DOW*** *- I have one question, in relation to the remarks that you make in your submission around not having access to a social worker before or during your time at NICU and the special care nursery. Could you talk to the Committee about what difference you think that might have made to your mental health and wellbeing at the time or to going home with your twins, whether that would have made a difference for you or whether you understand why that wasn't offered?*
>
> ***Ms COWEN*** *- Yes. I think I wasn't offered it because I seemed very strong, you know, like mentally well. I wasn't breaking down all the time in front of the nurses or anything, and I wasn't even doing that at home. I think you just do what you do to get through and you put a really brave face on. I think maybe that's why I wasn't offered any help. It would have been lovely to have someone come and offer any help, because my husband continued working so he could have some leave when the boys came home.*

[180] Transcript of Evidence, 20 February 2025, Brigid Cowen, pp. 28 – 29.

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

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

Then post-discharge, again there was no offer of help or support. It was quite upsetting for a number of years afterwards. Now I don't get so upset about it, but in the probably two years post-birth it was tricky.[181]

4.90. A preferred model of care for NICU spaces was proposed by Miracle Babies Foundation in the form of Family Integrated Care or FiCare:

Family Integrated Care (FiCare) is widely researched and evidenced and should be at the forefront of all neonatal units design, implementation and staff training. Providing facilities, zero separation and FiCare all work together to improve optimal outcomes for premature and sick babies and their families, reducing trauma and risks of mental health concerns.

In the modern NICU, preterm babies are cared for by highly specialised staff. While parents are welcome in the NICU, they do not feel that they can care for their baby as much as they would like to. Separation of babies and parents in the NICU leads to feelings of disempowerment in the parents. As a result, parents may feel stressed and anxious, a loss of control and experience and they develop concerns around their ability to care for their baby after discharge.

Family Centred Care (FCC) or Family Integrated Care (FiCare) is an approach to planning and delivery of health care that encourages greater parent involvement in their baby's care. A Lancet article found that FiCare in the NICU, FiCare improved infant weight gain, decreased parent stress and anxiety, and increased high-frequency exclusive breastmilk feeding at discharge.[182]

4.91. Recommendations proposed by Miracle Babies Foundation also spoke more broadly to concerns and proposals made by lived experience witnesses, regarding the NICU:

- *Policy, Investment and guidelines to implement neonatal unit design, development and retrofitting of family facilities.*
- *Develop maternity and neonatal models of care that support zero separation.*

[181] Transcript of Evidence, 20 February 2025, Brigid Cowen, p. 31.
[182] Submission No. 103, Miracle Babies Foundation, p. 6.

- *Funding peer support services for families experiencing preterm birth or admission to a neonatal unit.*
- *Neonatal services provide both pre and post discharge transition to home support for preterm and unwell babies.*[183]

Freebirth

4.92. A reoccurring theme in the Committee's consideration of access to readily available and appropriate maternal health services, including birth options, was the worrying rise in freebirths. Freebirths refer to births occurring without medical assistance, typically within an individual's own home. Representatives of Birth in Tasmania described the context in which they are observing the rise of freebirths:

> ***CHAIR*** *- ... While the Committee has heard lots of positive evidence around homebirthing, we've also heard some concerning evidence around freebirthing. I note that you've gone to that in your written submission as well. It's difficult to gather numbers of freebirths in Tasmania, obviously, because it's not a medically recommended or recorded way of birthing. I wondered whether, through your organisation or through your work as doulas, whether you have any comments to make around why people might make that choice, as opposed to a homebirthing choice or a hospital-based birth? And what the risks are.*
>
> ***Ms GRANT*** *- Yes. Professor Hannah Dahlen, in her research a couple of years ago, looked at why women choose to birth outside the medical system. Predominantly, that's around feelings of safety. They feel safe at home; they don't feel safe within the medical system. Often, it's because they can't get a homebirth midwife due to a lack of availability. They're the two big drivers for it.*[184]

4.93. Homebirth Australia also discussed the impact of a lack of accessible homebirth options in Tasmania and the link to increased freebirth. The status of homebirth in Tasmania is discussed in more detail in Chapter 5.

> ***Ms ROSOL*** *- I'm just trying to get my head around freebirthing, because that seems to me where the greatest risk is. Do you have any examples or anecdotes around that? Is there any data collected on that? How do they then access care afterwards if they've freebirthed?...*
>
> ***Ms FOLKERTS*** *- I don't know who's collecting statistics, but usually those who freebirth will educate themselves extensively about how to manage possible complications that would arise without the help of a midwife. I've had women call me after a freebirth, if you like, to ask me to give them the documents for the birth certificate, but they can just as easily sign a stat dec and do it. They're probably connected within their communities and their family systems, where they have what they must consider adequate support.*
>
> *A birth, in hindsight, it's fine. It went very well. Yes, the baby didn't die and I'm well, but what might happen and what can happen? Our midwifery skills - I could give you many examples of where a mother or baby might not have survived had I not been there. That would be so for all the private midwives - that we are sometimes called upon to*

[183] Submission No. 103, Miracle Babies Foundation, p. 13.
[184] Transcript of Evidence, 26 March 2025, Birth in Tasmania, p. 76.

resuscitate a baby or manage a postpartum haemorrhage, or deal with a baby whose head comes out and the shoulders won't. Those things are very much at risk in a freebirth situation.

***Ms BEGNELL** - I can speak to the statistics a little. The Australia's mothers and babies report - it doesn't report specifically on freebirth, but it has a category called 'other', which includes those babies that are born before arrival to hospital or born at home but weren't a planned homebirth, or they were born at home without a midwife in attendance. Those would be considered freebirths. It's a woman's choice to birth wherever she likes. The risk comes into it when that choice is not her first choice.*

As Anna said, those who choose freebirth do a lot of research and train themselves in first aid and CPR and all those things, in preparation for that. In the instance where a woman is at 37-38 weeks and has been kicked out of the MGP program because of her risk factors - or sometimes that happens with publicly funded homebirth programs - then she has an impossible choice in front of her. Many women choose homebirth because of previous hospital trauma, so re-entering the hospital system is the last thing many of them want to do. In that instance, that woman might choose to freebirth, and because she hasn't had the preparation time for that, that is where it becomes a bit risky.[185]

4.94. Georgia Lilley shared her freebirth experience. She said she and her partner decided to freebirth after a traumatic birth experience with their first child:

***Ms JOHNSTON** - … Can you outline or elaborate a bit more on that decision to freebirth given your concern about going back to a hospital, either for a delivery or an emergency situation and how that played out in terms of the support you had around you at home for that freebirth decision?*

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

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

***Ms LILLEY** - I talked about it a lot with my partner and I came to the realisation that as long as I was in control of all the decision-making … as long as I was consenting to any stage of the plan, if I was in charge of all decision-making then that would be an empowered birth. That's what helped me work through the fear, that if I was in control of when I say I need help, then I will still feel empowered. That was the biggest difference with my first birth - I did not feel in control of certain decisions. As a result, I felt very disempowered.*[186]

4.95. Ms Lilley also shared her experiences of being transferred to the Launceston General Hospital (LGH) for medical care after her birth, as well as the work she undertook to prepare for the birth:

***Ms ROSOL** - … what was that experience like, going in from having had a freebirth to going in for that treatment?...*

[185] Transcript of Evidence, 21 October 2024, Homebirth Australia, pp. 41 - 42.
[186] Transcript of Evidence, 19 February 2025, Georgia Lilley, p. 27.

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

That's all I ever asked for, that you keep your opinions to yourself if you don't agree. Everyone was very respectful. Nobody said anything negative or judgmental…

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

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

Aside from that, the other preparations were pretty minimal. It was just ordering a pool to birth in and some tinctures that might have supported the labour, that kind of thing, some towels. It was really pretty simple.[187]

4.96. Ash Barwick described her decision to freebirth. She discussed the moments which had influenced her decision to freebirth and how her experience unfolded:

In my pregnancy, with baby number 3, I visited my GP in to confirm my pregnancy, I had already decided I wanted a home birth, My Dr placed me in the system and I was contacted twice by phone, when I said I was having my baby at home, i was told i was being irresponsible and could kill my baby. On the 2nd call i was told because I was unvaccinated, I would essentially be treated as I was infectious and would have to wear masks and my partner couldn't attend appointments or birth at a hospital. This confirmed my home birth even more so, not once was I offered support of any kind, 3 months later I received a letter for an appointment at LGH which I of course did not attend as I didn't want to be ridiculed again.

LABOUR

In my labour, I rang ambulance Tasmania non emergency and informed them I was birthing my baby unassisted at home and provided my address in the unlikely event of anything bad happening but just for some support. They called my partner back once during my labour to see how I was and told us to ring back once I had birthed baby and placenta, which we did.[188]

Bereavement care

4.97. This section of the Report will discuss pregnancy loss, including early pregnancy loss, miscarriage and stillbirth. The Committee acknowledges that individuals

[187] Transcript of Evidence, 19 February 2025, Georgia Lilley, p. 29.
[188] Submission No. 95, Ash Barwick, p. 1.

reading this Report may have personal experience with pregnancy loss. If you or a loved one require support, please seek out Miscarriage Australia.[189]

4.98. Karen Schalge, a Churchill Fellowship recipient who studied international best practice and ways to improve care for individuals and families experiencing pregnancy loss, provided a submission to the Inquiry. In her submission Ms Schalge discussed the prevalence of pregnancy loss in Australia:

> *Sadly, pregnancy loss (both early pregnancy loss and stillbirth) is very common in Australia. Miscarriage[190] is estimated to occur in at least one in every four known pregnancies, believed to be approximately 285 miscarriages every day[191], or one miscarriage every 5 minutes. Miscarriage numbers may be even higher, because miscarriage statistics are not specifically recorded in Australia. There are also 7.7 stillbirths[192] for every 1000 live births in Australia, or 6 stillbirths per day[193]. This equates to more than 106,000 pregnancy losses in Australia every year.[194]*

4.99. The impact of pregnancy loss on individuals and families was also discussed by Ms Schlage:

> *A 2019 survey of Australian women found that 75% felt unsupported by their hospital care givers during their pregnancy loss[195]. International research indicates that up to 50% of women experience some form of psychological morbidity following miscarriage[196]. Recent Australian research shows that 60% of Australian women who have experienced pregnancy loss are living with depression and 31% of Australian women who have experienced pregnancy loss are currently dealing with Post Traumatic Stress Disorder (PTSD).[197] One study shows that parents who experience a perinatal death have significantly worse quality of life than the general population[198]. Across the world, pregnancy loss has been linked to PTSD, depression, anxiety,[199] attempted suicide and completed suicide[200].*
>
> *Pregnancy loss can also impact women's mental health during subsequent pregnancies[201] [202]*

4.100. The Committee received evidence from witnesses who had lived experiences of pregnancy loss in Tasmania. This evidence demonstrated a number of key themes including a lack of appropriate care for both physical and psychological needs of birthing and non-birthing parents, conduct by medical professionals lacking a

---

[189] https://miscarriageaustralia.com.au/.
[190] Footnote 4, The loss of a pregnancy at less than 20 weeks' gestation, from Submission No. 66, Karen Schlage, p. 5.
[191] Footnote 5, https://miscarriageaustralia.com.au/wp-content/uploads/2022/12/Understanding-Miscarriage.pdf, from Submission No. 66, Karen Schlage, p. 5.
[192] Footnote 6, The loss of a pregnancy at or beyond 20 weeks' gestation, from Submission No. 66, Karen Schlage, p. 5.
[193] Footnote 7, https://www.aihw.gov.au/reports/mothers-babies/stillbirths-and-neonatal-deaths, from Submission No. 66, Karen Schlage, p. 5.
[194] Submission No. 66, Karen Schlage, p. 5.
[195] Footnote 8, Berry, J. (2019), from Submission No. 66, Karen Schlage, p. 5.
[196] Footnote 9, Lok & Neugebauer (2007), from Submission No. 66, Karen Schlage, p. 5.
[197] Footnote 10, https://www.liptemberfoundation.org.au/2023-womens-mental-health-research, from Submission No. 66, Karen Schlage, p. 5.
[198] Footnote 11, Camacho et al (2024)., from Submission No. 66, Karen Schlage, p. 5.
[199] Footnote 12, Farren et al (2016); Westby et al (2021)., from Submission No. 66, Karen Schlage, p. 5.
[200] Footnote 13, Weng etc al (2018); Quenby et al (2021)., from Submission No. 66, Karen Schlage, p. 5.
[201] Footnote 14, Camacho et al (2024)., from Submission No. 66, Karen Schlage, p. 5.
[202] Submission No. 66, Karen Schlage, p. 5.

trauma informed perspective on bereavement care and a lack of access to support resources including opportunities to make memories with their child.

4.101. Emma Deane shared her family's experience with pregnancy loss, including the impact of the lived environment of the hospital and the ongoing impacts on her family as a result of the loss:

> *Walking into the maternity ward, seeing baby pictures and hearing the cry of newborn babies, I wanted to be anywhere in the world than there in that ward. My surgery was scheduled late Friday night, being wheeled to the surgery room and leaving [redacted] our whole world came crashing down. I felt shame, guilt and tremendous pain. In the waiting bay for surgery, a midwife comforted me, whilst I said my final goodbyes to my son. Some may say we made the wrong choice, but we did the best for our son who would have only known pain.*
>
> *Following the birth of our dear son [redacted] we were situated in the maternity ward, we had no idea where to start making memories that we would treasure forever. Whilst many families have a lifetime to make memories with their child, we had only a few days. Our experience of making memories is significantly different and consideration needs to be given to families like ours following the birth of their children. In the midst of our grief, we did not know what we needed or what we should be doing. We were given the options of photos, foot and handprints and molds which I will forever hold dear. Reflecting upon our experience, I have many regrets and wishes that cannot be changed. Weeks after [redacted] birth, our daughter started asking why she did not meet her baby brother? It was something we had not considered as it has not been suggested to us. Trying to explain to our then 3-year-old that her baby brother was no longer with us, that he would not be coming home and, that she will never meet him was excruciating. In hospital we were not provided with any information or resources on how to navigate these questions and our life after [redacted]. We were alone in our grief with it consuming our every thought and decision. We strongly advocate that there are specialists available to sit with families in their times of grief to speak with that about options available to them and their extended families as to how to make memories with their child. Whilst many families make plans to introduce their child to their families following their birth, no one expects to be in the position we found ourselves and in light of this, we had no idea how to make memories or, how to introduce [redacted] to his sister.*
>
> *This was also made all the more difficult owing to the fact we were on the maternity ward. The maternity ward is not designed for families like ours who are grieving the loss of a child. Whilst we cannot fault the care of the midwives who provided our care, being located on the maternity ward, there were reminders everywhere that this space was not intended for families experiencing loss. I chose not to leave my room as I didn't want to have continual reminders that I would not be taking [redacted] home with us. Further to this, I didn't think it was appropriate for me to leave my room for fear of impacting upon other families during their special time. I can appreciate that this may not have been the case however, in my mind at that time, this is how I felt.*[203]

4.102. Another lived experience witness discussed their experiences with pregnancy loss in the public system and how they sought private care after this:

> *My miscarriage was in 2020 and required two D&C's- I felt very let down by the lack of support from the public sector in terms of post op follow up & recovery, and*

[203] Submission No. 6, Emma Deane, p. 2.

emotional support (there was none). I ended up seeking advice from a private obstetrician (I do not have private health insurance) in regards to ongoing issues after my miscarriage that were not followed up by the public system.[204]

4.103. Private Witness 96 described the ongoing mental health impacts on them and their partner as a result of their pregnancy loss:

- *Ongoing medical anxiety including extreme anxiety in relation to personal health requiring treatment of daily prescription medication and ongoing support from a psychologist. I also note that this experience had a considerable toll on my partner who supported me through these failings. He too suffered anxiety as a result of this experience.* [205]

4.104. Crystal-Leigh Eiszele also discussed her need for further psychological support during her experience:

> *…women who are in this situation need urgent attention in the form of both physical and psychological supports. Not once was I offered any psychological supports.*[206]

4.105. From a professional perspective in her role as a GP, Dr Marita Jones discussed with the Committee the issues she encountered when trying to find support for a patient who experienced a pregnancy loss and required psychological support:

> ***Dr M. Jones - …*** *I recently had a patient who had an unexpected ectopic pregnancy loss after trying to fall pregnant for some time and was devastated. She had her emergency surgery in the hospital and was given a bag that had various pamphlets, the PANDA pamphlet and other 'you can call this number if you need support'. She came to see me and said, 'I haven't even been brave enough to open the bag but I need help when I don't know where to go'. We phoned around private psychologists and weren't able to find anyone with less than an eight-week wait, plus you would have to pay, through the mental health care plan. We organised for her to have a referral to Gidget House which has opened recently. I saw her only a week or two ago at about the eight or nine week mark and she still hadn't been given an appointment. The support for pregnancy loss, whether it be a planned pregnancy termination, or whether it be an unexpected pregnancy loss, is very poor.*[207]

Access to services

4.106. In their submission to the Inquiry, the DoH discussed stillbirth in Tasmania, noting the state has a lower perinatal mortality rate than the national average.[208] The submission documented the provision of the following services at public hospitals in the state, which were also addressed during the Committee's site visits to the North West Regional Hospital and the LGH:

> *DoH recognises the profound grief and devastation experienced by women, parents and families whose babies have died due to stillbirth. THS maternity services offer quiet, private spaces where bereaved parents can receive physical and emotional care*

[204] Submission No. 113, Private Witness, p. 1.
[205] Submission No. 96, Private Witness, p. 3.
[206] Submission No. 70, Crystal – Leigh Eiszele, p. 2.
[207] Transcript of Evidence, 23 October 2025, Royal Australian College of General Practitioners Tasmania, p. 67.
[208] Submission No. 129, Department of Health, p. 25.

from health professionals. Parents are given the option of a single room for privacy, where support from midwifery and obstetrics staff can safely continue to be provided.[209]

4.107. The DoH submission also noted their policy partnership with the Centre of Perinatal Excellence (COPE), which includes workplans to implement national initiatives to reduce stillbirth and access for medical professionals to training modules and opportunities.[210]

4.108. Arrangements for the provision of stillbirth autopsies were also explained in the DoH submission:

> *In May 2023, the Australian Government and Tasmania [Government] entered an agreement through which the Australian Government provides Tasmania with $909 000 over three years (2022-23 to 2025-26) to increase the capacity of the perinatal loss workforce in specific areas that support families experiencing stillbirth and considering stillbirth autopsy; and to assist families where financial considerations are a barrier to accessing stillbirth autopsies.*
>
> *The funding addresses a current workforce shortage of Perinatal Pathology services in the North and North West of Tasmania, with babies requiring autopsy needing to be transported to Hobart. As part of this funding, DoH will undertake statewide analysis of the perinatal loss coordination and support required to guide workforce initiatives, and will leverage existing work occurring around the State.*
>
> *In addition, dedicated funding will be available for families who wish to travel with their baby to Hobart for autopsy, and for timely mortuary transfer services.*[211]

4.109. While these services are available in the public system, the evidence from lived experience witnesses and support organisations suggested that there is a need for considerably improved and more appropriate service provision for Tasmanians experiencing a pregnancy loss. In her submission Ms Schlage, a researcher in international best practice in maternal care, shared an overview of the impact of having to access required services after pregnancy loss, in an inappropriate service location within hospitals or other medical facilities:

> *Many birthing people describe the birth trauma caused when they were admitted to a maternity unit/birth suite for their pregnancy loss. Such trauma is caused when they see or hear other families on the unit, including the sights and sounds of foetal heartbeats, babies crying and the joy and happiness of families who have a living baby. A lot is done by health professionals to shield bereaved families from these sights and sounds, but they cannot be completely avoided when pregnancy loss care is provided in the same unit as live birth care.*
>
> *Birthing persons experiencing pregnancy complications or pregnancy loss should be cared for in dedicated pregnancy complication/pregnancy loss units. Pregnancy loss*

[209] Submission No. 129, Department of Health, p. 26.
[210] Submission No. 129, Department of Health, p. 26.
[211] Submission No. 129, Department of Health, p. 26.

care can then be diverted from EDs, EPAS and maternity units to the dedicated unit, ensuring a private and sacred space for families to worry or grieve.

The ACT recently opened such a unit[212], which has been very positively received across Australia and internationally, by both bereaved families and medical professionals. The unit is designed to be a therapeutic, healing space where pregnant and birthing people can receive the care they need from a multidisciplinary team. The unit supports overnight stays and incorporates three private-room beds with ensuites, a quiet room, a family room, an ultrasound room and consulting rooms. The unit is attached to the antenatal ward, but requires swipe access and ensures a private space for families.[213]

4.110. In her written submission, Ms Schlage detailed the mechanisms through which similar dedicated services could be provided across Tasmania:

Bereaved families and their supporters are very strongly calling for this sort of care facility across Australia, with 31,161 Australians supporting a 2023 petition presented to Federal Parliament, calling for a dedicated bereavement suite or room in every Australian hospital.[214]

The pregnant people, birthing people and families of Tasmania need to know that there will be somewhere they can go during pregnancy complications or pregnancy loss, where they will receive the care and support they require during a time that is emotionally, physically and mentally demanding. This care and support needs to be consistent in delivery, so that people can be assured of a dignified and comforting experience during pregnancy loss.

The Tasmanian Department of Health should open units dedicated to caring for people experiencing pregnancy complications and loss, which are co-designed and are physically separate to antenatal wards and clinics, birth suites and emergency departments, at the following hospitals:

- Royal Hobart Hospital

- Launceston [General] Hospital

- North West Regional Hospital

- Mersey Community Hospital

A unit dedicated to caring for pregnancy complications and pregnancy loss should be provided in each hospital offering maternity services, particularly whenever any construction, renovation or relocation of maternity service facilities occurs in Tasmania [original emphasis].[215]

[212] Footnote 17, https://www.abc.net.au/news/2023-03-24/canberra-early-pregnancy-loss-unit-opens/102134498; https://www.cmtedd.act.gov.au/open government/inform/act government media releases/rachel-stephen-smith-mla-mediareleases/2023/new-dedicated-unit-for-early-pregnancy-service, from Submission No. 66, Karen Schlage, p. 7.
[213] Submission No. 66, Karen Schlage, p. 7.
[214] Footnote 18, https://www.aph.gov.au/e-petitions/petition/EN4873, from Submission No. 66, Karen Schlage, p. 7.
[215] Submission No. 66, Karen Schlage, p. 8.

4.111. Ms Schlage also proposed a pilot program for in-hospital companions for families throughout pregnancy and birth, with speciality training in regard to bereavement support:

> *The Tasmanian Department of Health should introduce pilot programs for in-hospital companions to support pregnant and birthing people at Royal Hobart Hospital, with a particular focus on an in hospital bereavement companion program to provide support during pregnancy complications and loss.*
>
> *Subject to the outcomes of the pilot program, the Tasmanian Department of Health should introduce scaled, in-hospital companion programs for both perinatal bereavement and general maternity care, across Tasmania.*[216]

4.112. Early Pregnancy Loss Coalition (EPLC) discussed common instances in which pregnancy loss may be treated in inappropriate locations within hospitals including emergency departments, Early Pregnancy Assessment Services and general maternity wards:

> *Birthing people and their families also report significant levels of birth trauma due to the location of their care during pregnancy loss. This is particularly prevalent amongst people cared for in hospital Emergency Departments (EDs), Early Pregnancy Assessment Services (EPAS) and maternity units in both the private and public system, as opposed to those cared for in the community. Emergency Departments in particular are frequently cited as environments where people experiencing pregnancy loss have suboptimal experiences. Pregnancy loss presentations are typically treated as lower acuity emergency cases because the majority of birthing people remain clinically and physiologically stable during miscarriage, despite the birthing person usually experiencing significant grief, emotional distress and anxiety.*
>
> *While the non-urgent status is relative to the context of critical and immediately life-threatening emergencies managed in EDs, this can inadvertently cause further birth trauma for the birthing person and bereaved family. This may occur through delayed and sometimes substandard definitive care that is often very clinically focussed and may be perceived to lack social and emotional support.*
>
> *There are also reported instances of birthing people miscarrying in ED waiting room toilets and then needing to decide whether to flush or retrieve their baby, causing additional birth trauma.*
>
> *Emergency Departments remain ill-equipped to provide optimal holistic care to people and families experiencing pregnancy loss for a multitude of reasons, including preconceived clinician attitudes*[217] *or lack of knowledge pertaining to pregnancy loss as well as structural issues such as busy bed-blocked departments and long waits to be seen.*

[216] Submission No. 66, Karen Schlage, p. 4.

[217] Footnote No. 24, Bellhouse C, Temple-Smith M, Watson S, Bilardi J. "The loss was traumatic… some healthcare providers added to that": Women's experiences of miscarriage. Women Birth. 2019;32(2):137-146., Submission No. 131, Early Pregnancy Loss Coalition, pp. 8 – 9 .
doi:10.1016/j.wombi.2018.06.006 cited in Submission No. 131, Early Pregnancy Loss Coalition, pp. 8 - 9.

Pregnant people who are treated in EPAS units for pregnancy loss report birth trauma from sitting in waiting areas alongside pregnant people who are not experiencing complications or loss.[218]

4.113. Ms Deane, a lived experience witness who has experienced a pregnancy loss, strongly recommended the provision of dedicated space for bereavement care:

> *A separate safe place for families experiencing all baby loss away from the maternity ward or, rooms for bereavement only which are designed for families to be able to feel comfortable and not in a clinical setting as they make memories.*[219]

4.114. Isabelle Oderberg, Co-Founder and Chair of EPLC also discussed how traditional information sharing systems in the medical field, including in hospitals, are not typically accessible for trauma-informed practices:

> ***Ms ODERBERG** - … So, second question regarding files being updated. There are various best practice methods being used overseas, for instance, when someone is pregnant after loss. There are a few hospitals in the UK that are involved with Tommy's National Centre for Miscarriage Research. They put a little sticker, a rainbow, on the person's chart so that whoever is treating that patient is aware that it's a pregnancy after loss, and is careful, understands that that patient may be experiencing higher levels of anxiety or stress, or those sorts of things.*
>
> *One of the biggest problems we have in Australia is that, because the systems do not talk to each other, even if you have had a loss that is acknowledged by a file with one medical provider, another medical provider may not be aware of it. So, often what you have, especially in the public system, is someone will have a loss and then get a call two months later, 'Are you ready to come in for your next midwifery appointment' or whatever. There is just no consistency in communication across the different touchpoints, even when it is in the same hospital. I have had examples of case studies where people have miscarried, attended emergency, been diagnosed, had a D&C, everything, and the same hospital's maternity setting will contact them and say, 'Are you coming in for your appointment next week? We are just calling to confirm'. So, there is a real issue with communication as well.*[220]

4.115. Further concerns relating to a lack of accessible data regarding pregnancy loss were raised. It was particularly noted that patient records of clinical intervention may not reflect whether the intervention was for pregnancy loss or another reason. Data collection on pregnancy loss in general is inconsistent and does not provide an accurate picture of the occurrence of pregnancy loss in Tasmania:

> ***Ms ODERBERG** - … There is generally an issue with data collection in Australia for a number of reasons, but I'm going keep this specifically to the early pregnancy loss issue.*
>
> *There are a number of things going on here. The first issue is that people who experience early pregnancy loss have a number of different touch points. They may be under the care of a GP, they may be under the care of an obstetrician, they may attend an emergency room, and they may, especially if it's not a first loss, actually miscarry at*

[218] Submission No. 131, Early Pregnancy Loss Coalition, pp. 8 - 9.
[219] Submission No. 6, Emma Deane, p. 3.
[220] Transcript of Evidence, 30 October 2024, Early Pregnancy Loss Coalition, p. 5.

home and no one outside of their circle - as in no one in a medical setting - knows that they've miscarried especially in the case of earlier losses like chemical pregnancies and things like that. That's the first issue with the collection of data.

The second issue is that there's been an obfuscation of miscarriage data because of its intertwining with abortion statistics. This is in no one's interest. I know that the pro-choice lobby wants that to be unwound as well. We see this in the lack of transparency in Medicare coding. For someone who attends, for instance, a hospital for an early pregnancy loss and is given a D&C [dilation and curettage], that'll just be recorded as a D&C. It won't be recorded whether that is a situation where that person has made a choice to end that pregnancy because they don't want to proceed with the pregnancy, as opposed to a miscarriage where the person really is doing it for surgical management of that pregnancy.

What we also see is that sometimes, where a hospital is unable to offer care, that patient may go to, say, an abortion clinic or something like that in order to receive adequate care - or the care of their choice, I should say. Again, in that situation, it's not necessarily defined as to why they are seeking the abortion in question or the D&C. Therefore, that's where the obfuscation happens where there's confusion over which is which and what is what.

...

***Dr SIMONS** - ... whilst the introduction of processes like My Health Record have been significantly beneficial to try to track all these things, it won't ever capture outpatient ultrasound scans that may have been done publicly or privately. It won't access any of the psychology or psychiatric input that we know has a significant overlay with pregnancy loss. It doesn't often capture lots of these sporadic GP appointments and many of those will be within the public sphere, but also the private sphere.*

To have ... a touchpoint where you can collate all these contacts is really challenging and often the onus is then put back onto the person who presents to say, 'Hey, look, what can I do?'[221]

4.116. Concerns were also expressed regarding immediate access to required medical care for those experiencing a pregnancy loss. Both Ms Schlage and EPLC noted it is essential that once a decision is made regarding the management of a loss, the appropriate medical care is undertaken as soon as possible.

Psychological support

4.117. Pregnancy loss can have an ongoing psychological impact on those who experience it. The Committee received evidence suggesting there is a substantial lack of access to appropriate psychological support throughout the experience of pregnancy loss. EPLC discussed in their submission the interconnection of psychosocial experiences as a result of pregnancy loss that individuals may encounter:

[221] Transcript of Evidence, 30 October 2024, Early Pregnancy Loss Coalition, pp. 3 - 4.

Despite a global evidence base showing that positive support experiences at the time of healthcare contact with pregnancy loss leads to better psychosocial outcomes12, further data (including research undertaken by EPLC) has shown that people undergoing pregnancy loss continue to have significantly negative experiences relating to the level and quality of emotional support offered by healthcare professionals.

Issues commonly cited include:

- *Focus on physical but not emotional needs*
- *A lack of sensitivity, empathy, and acknowledgement of the loss*
- *Use of medicalised terminology*
- *Lack of and clarity pertaining to follow-up care, including referral to support services*
- *Lack of information provision around causes, physical symptoms, recovery, and subsequent pregnancy prospects*
- *An expectation that recovery from grief should occur quickly.*[222] [223]

4.118. Appearing before the Committee representing EPLC, Ms Oderberg, discussed how psychological supports are essential at the time of pregnancy loss, but also after a loss, including during any potential future pregnancies and labours:

> ***Ms ODERBERG** - In addition to supplying support or providing support or best practice clinical care for those who experience miscarriage, we can never forget pregnancy after loss is incredibly difficult. It comes with its own challenges. We know that supporting those patients clinically and with psychosocial support actually results in better outcomes and live births. That's very important as well.*[224]

4.119. In their submission, it was also shared with the Committee that non-birthing parents need to be offered appropriate psychological support after a loss, an area which is currently lacking:

> *Male partners and LGBTIQA+ people often feel their role and loss is devalued and their grief is unacknowledged in the same way, if at all, as women*[225]*.*[226]

[222] Footnote 13, -Bellhouse C, Temple-Smith M, Watson S, Bilardi J. "The loss was traumatic… some healthcare providers added to that": Women's experiences of miscarriage. Women and Birth. 2019;32(2):137-46. -Lee L, Ma W, Davies S, Kammers M. Toward optimal emotional care during the experience of miscarriage: an integrative review of the perspectives of women, partners, and health care providers. Journal of Midwifery & Women's Health. 2023;68(1):52-61., from Submission No. 131, Early Pregnancy Loss Coalition, pp. 10 – 11.
[223] Submission No. 131, Early Pregnancy Loss Coalition, pp. 10 – 11.
[224] Transcript of Evidence, 30 October 2024, Early Pregnancy Loss Coalition, p.2.
[225] Footnote 36, Khan RA, Drudy L, Sheehan J, Harrison RF, Geary M. Early pregnancy loss: how do men feel?. Irish Medical Journal. 2004 Jul 1;97(7):217-8., from Submission No. 131, Early Pregnancy Loss Coalition, p. 12.
[226] Submission No. 131, Early Pregnancy Loss Coalition, p. 12.

4.120. This provision of these additional services was also recommended by Ms Deane:

> *Mental health care is provided to not only the mother but also the partner immediately following the loss. If the care is declined a plan can still be in place if circumstance change.*[227]

4.121. Ms Deane also discussed the need for access to referrals to ongoing post loss care, as needed on a case-by-case basis for each patient:

> *Ensuring an adequate discharge plan is in place from the hospital including follow up care and handover care to GP and/or mental health care provider.*[228]

Bereavement care resources

4.122. The Committee heard the provision of appropriate resources and supports for individuals and families to manage pathways after a pregnancy loss is lacking. Resources and supports include, but are not limited to, memory–making processes, support with legal and administrative matters and funeral arrangements.

4.123. Ms Schlage discussed the provision of appropriate supports in bereavement care to allow families to transition through the difficult post-loss period:

> *Birth trauma has been caused when bereaved families have been provided with incomplete or even no information about their options regarding memory-making and/or funeral arrangements, which prevents families from fully experiencing memory-making, bonding with and paying tribute to their baby.*
>
> *Memory-making and funeral arrangements can be provided for any gestation of pregnancy loss, but the offering of such care is often for babies who die at a later gestation, leaving many families unaware of their options if they suffer early pregnancy loss.*
>
> *The lack of information regarding these options has the potential to create further birth trauma by preventing families from following traditions that are culturally important to them.*
>
> *Tasmanian resources and health professionals must ensure memory-making and funeral arrangement options are offered to families at the time of pregnancy loss within any Tasmanian health care setting.*[229]

4.124. The Committee was also made aware of providers who supply bereavement support for individuals and families, such as A Little Help from Jack. The provision of these types of services was recommended by Ms Deane:

> *Having all appropriate resources available in the hospital to be provided to families immediately, including both A Little Help from Jack and Beyond the Rainbow. Ensuring*

[227] Submission No. 6, Emma Deane, p. 3.
[228] Submission No. 6, Emma Deane, p. 3.
[229] Submission No. 66, Karen Schlage, p. 9.

all maternity staff are educated and trained to assist with providing these valuable resources.[230]

In March 2025, the then Minister for Health, the Hon. Jacquie *Petrusma* MP provided the Committee with a number of materials including brochures and pamphlets available in the THS. The Committee notes that pamphlets for A Little Help from Jack and A Little Help from Remy were both included as available resources for patients receiving care in the THS.

Knowledge of medical professionals

4.125. The Committee received evidence regarding current deficiencies in care provided by medical professionals in the areas of pregnancy loss, bereavement care and support. Two key areas of this concern were raised in relation to the language used and available training for professionals.

4.126. The language used to explain pregnancy loss was raised by Ms Schlage as a national concern:

> *Families report birth trauma generated through the use of terminology that is deemed to be medically correct, but is often incredibly upsetting, such as "products of conception" or "spontaneous abortion".*[231]

4.127. Ms Oderberg of EPLC discussed how appropriate language can be used by reflecting the linguistic choices of the patient:

> ***Ms JOHNSTON*** *- … Are there any examples of guidelines on material that you suggest we look at, or recommend that we adopt in Tasmania, that have the appropriate terminology and some training and awareness for health professionals around what that might be in best practice?*
>
> ***Ms ODERBERG*** *- I know that Pink Elephants provide some workplace-based training. I should declare that they are an organisational member of ours, as is Red Nose. I absolutely suggest that you look at Tommy Centre for Miscarriage Research, which is probably the world's leading provider of research in the early pregnancy loss space. The Early Pregnancy Loss Coalition has a lot of information on our website, and Miscarriage Australia also has information on its website around optimal terminology. We're also working with the Royal Australian College of Obstetricians and Gynaecologists, and the Nursing and Midwifery Federation and the College of Midwives.*
>
> *We're all on the same page. None of these things are controversial but, as you know, often changing culture isn't just flipping a switch. It's a lot of work … There are also significant cultural issues that need to be embedded and that's where the work needs to happen and a shift needs to take place.*
>
> *I'll give you an example. A patient that I was interviewing went to hospital, severe ectopic, needed emergency surgery. They were explaining to the patient what they were going to do and the male obstetrician was laughing and joking the whole time*

[230] Submission No. 6, Emma Deane, p. 3.
[231] Submission No. 66, Karen Schlage, p. 5.

with a nurse in the room. He then said, 'What we do is inflate your abdomen like your 40-weeks pregnant to do the procedure'. This is someone who was losing a very, very much wanted pregnancy and was completely traumatised both by the demeanour of the treating clinician, which was totally inappropriate for the circumstance, but also by what was a terrible metaphor in the circumstances.[232]

4.128. Trauma informed training for medical practitioners and support staff was also recommended to the Committee by Private Witness 59 to ensure that an understanding of bereavement care is present in all staff:

> *Compulsory training for all staff involved in maternity services (including administrative, allied health, nursing, medical etc.) on how to deal with pregnancy loss for patients and trauma informed care.*[233]

4.129. EPLC representative Dr Sarah Simons also discussed potential advancements to training and education in detail. They discussed how training should be provided to health care providers to address the physical and psychological experiences of pregnancy loss:

> ***Ms JOHNSTON*** *- Is undergraduate training for healthcare providers being delivered, in terms of being trauma informed and understanding the significance of early pregnancy loss? …*
>
> ***Dr SIMONS*** *- There is a movement towards - shared gold standard of care has historically always been ideas around shared communication and decision making. Often with patients who present with pregnancy complications, the level of health literacy surrounding the pregnancy and expectations can be a lot higher than perhaps somebody who comes in with a foot that's sore. That's like another consideration.*
>
> *So, often establishing someone's baseline understanding, but also their expectations, their understanding, their hopes, and the level of risk that they're willing to accept. Again, a lot of that does come down to what we were saying about the regional/rural/metropolitan split. If home is five minutes down the road and you're still near a tertiary centre, the risk that you might be willing to accept and talk through with your clinician is very different from if you were to live 200 km away on a farm.*
>
> *There is a movement, … with communication training. Lots of medical schools are now pushing towards placement-based experience. That was obviously impeded by COVID. We have a class and a cohort of medical students who unfortunately had to undertake a lot of their training time online and didn't sit in the same clinical spheres that we would have done however many years ago. We're working on that, but that's a recognised limitation of a lot of the care for junior trainees at the moment.*
>
> *Aside from that, different hospitals have different provisions. There are certain public hospitals that are religiously guided and therefore the access to pregnancy care is compounded by the restrictions of what the hospital can offer. There are different experiences that people will have in different hospitals and there isn't a standardised model of care. Every hospital has an EPAS; every hospital has an obstetrician or a gynaecologist. That does affect people's experiences of seeing these encounters earlier*

[232] Transcript of Evidence, 30 October 2024, Early Pregnancy Loss Coalition, pp. 6 - 7.
[233] Submission No. 59, Private Witness, p. 2.

in their career. That's something that would need to go back to the universities to ensure that that practice is standardised. That's a very difficult thing to take from a population-level public-health approach.

4.130. The culture and attitudes of medical professionals impacts on the care provided to, and the experience of patients:

> ***Ms ODERBERG** - I'd add - in addition to conscientious objectors when it comes to certain forms of treatment - the best practice for miscarriage, the best practice care, is that the patient is offered three options. Expectant management, where they, by whatever natural means, go home and pass the miscarriage naturally, or they do it in an ED, whatever. The second option is medical management, which is the administration of - we're trying to get this changed - mifepristone and misoprostol, or just misoprostol, which are your 486 or one component of, in order to bring the miscarriage on, in which case you pass it vaginally. The third is a D&C, which is the same procedure as an abortion in order to end that pregnancy. That is patient choice. There are different reasons different patients would choose different options.*
>
> *What happens is, in addition to the conscientious objectors, these are not seen as in any way - for instance, if a patient opts for a D&C, often it's not seen as a priority in the context of a hospital setting, which is usually really under pressure, resource light, not fit for purpose to come in and do the procedure for a variety of reasons and, therefore, they say they are not willing to pay for an anaesthetist or that it will take two weeks, in order to deter the patient from seeking surgical management of the miscarriage. There are numerous reasons that care is not offered or provided in the way that it should be balanced with best practice.* [234]

Navigating maternal health services

4.131. The Committee received evidence which considered resources for parents in the maternal healthcare space. A number of these are already available in Tasmania, with differing degrees of accessibility and effectiveness. This section discusses the details of these resources and additional support services, including if they are already available in the state, what changes could be made, or how access to them could be improved.

Birth plans

4.132. Birth plans were identified as important. Catherine Bell, a PhD candidate who submitted her thesis, 'The Birth Map: Improving Maternity experiences Through Effective Communication and Supported Maternal Decision Making,' in early 2025, explored birth plans as a concept:

> *introduced to provide a sense of agency to women in an increasingly medicalised maternity care system in which the cultural messaging and power imbalances dismiss women's experiences. Birth plans were intended to improve communication between women and their care providers.*[235]

4.133. The Committee heard both positive and negative experiences of the acceptance and implementation of birth plans.

[234] Transcript of Evidence, 30 October 2024, Early Pregnancy Loss Coalition, pp. 7 - 8.
[235] Submission No. 110, Catherine Bell, p. 2.

4.134. Ms Harding, a witness who appeared in Burnie, discussed her positive experience with her birth plan, including its development:

> ***Ms DOW*** *- … you've talked about the importance of a birth plan and you've talked about the contrasting experiences of your friends and the traumatic births that they experienced. Did they have birth plans or understand the importance of a birth plan? Is there anything else that you'd like to leave with the committee around the importance of birth plans?*
>
> ***Ms HARDING*** *-… For me, having a birth plan meant that I understood everything on the birth plan. It wasn't actually about having a birth plan, it was about knowing my choices and my options.*
>
> *When they came in and would say, 'You need an episiotomy,' and I'd go, 'What does that mean? What are the risks?' Because I already know the risks, because I know why I didn't want one and I've really seen a trend of people saying, 'I'll just go in and wing it, I'll see what the options are.' It's like - I think you mostly have children - you know those hormones are running like crazy. You do not want to make a decision when you're pushing a baby out. It is not the time.*
>
> ***Ms ROSOL*** *- … When you prepared the birth plan with the midwife, what was that interaction like? Who was making suggestions and how did you build it together?*
>
> ***Ms HARDING*** *- We had a few drafts. I did a lot of my own research. I went home and there's a really good podcast called The Great Birth Rebellion and it gave me so much information and I built my own plan from that. I also did the breastfeeding program by Dr Robyn Thompson and that had a few really good options, suggestions for birth plan, and how that would transition to breastfeeding.*
>
> *I've had a few drafts and a few things I'd go in and she'd say - I originally had three hours skin to skin before weighing and injections, and she kind of said, 'Look, it's a little bit long, but that's fine if you want that, but you might want to consider maybe changing to two hours', and I did do that in the end, which was fine.*
>
> ***CHAIR*** *- And then you had that time?*
>
> ***Ms HARDING*** *-Yes, we actually had two-and-a-half hours in the end and it was incredible. So, she kind of fine-tuned things and suggested things… She suggested warm compresses, which I hadn't heard about, for the perineum to prevent tearing. I hadn't heard about that and so, of course, then I went and researched it and put it on my birth plan. It was one of the best things that was on my birth plan. It was very much a communal thing, back and forth, me suggesting things, she suggested things.*[236]

4.135. Ms Harding also noted that the majority of medical professionals involved in her birth showed respect for her birth plan:

> ***CHAIR*** *- Do you know whether the medical professionals involved with* [redacted] *birth … had read the birth plan as well?*

[236] Transcript of Evidence, 18 February 2025, Kimberley Harding, p. 14.

Ms HARDING - *They were incredible. Everybody who entered that room, except the doctor, read that birth plan before. They introduced themselves and then the first midwife would say, 'Here's the birth plan, have a read'. I was so respected. I had on my birth plan to not have Syntocinon for delivery of the placenta and, at that time, when I was pushing out, the midwife said, 'You've got on your birth plan about the no Syntocinon, are you still happy for no Syntocinon?' I said, 'No, just give it to me'.*[237]

4.136. Ms Lilley shared her lived experience with the treatment of her birth plan in her first birth, detailing that while she had a physical plan and felt as prepared as she felt possible for birth, the plan was ignored:

CHAIR *- You mentioned earlier you went into the hospital that day feeling like you were as informed as you could be about all the likely outcomes and you've mentioned in your written submission you did have a birth plan. You've said that wasn't respected or adhered to or taken seriously. Can you tell us a bit more about that?*

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

Then the next day when I was - by that point I had an epidural and was resting, and my partner said that he overheard two staff members having a conversation on the other side of the curtain. He heard one of them say, 'No, there's no birth plan, just a verbal birth plan', which wasn't true.[238]

4.137. Private Witness 88 shared his family's experience with what he viewed as a lack of respect for their birth plan, which had a significant impact on their birth experience:

In preparation for our birth, we wrote our birth plan on instruction from our midwife. This was a plan we were happy with, as it aligned with our values, made us feel safe, thinking that the plan would guide any medical professionals we engaged with. It felt like a very valuable tool to give us power in an unfamiliar space (the hospital). We thought that we would have agency over my wife's body and the body of our child.

However, once in the hospital during labour, we did not feel protected or supported by our birth plan in our interactions with the Doctors. Whilst the nurses and midwives were personable, caring and attentive, the doctors were rigid, controlling and efficient, caring more about the hospital running to maximise the efficiency of their energy and resources. Our experience with the doctors was not consensual, and they didn't respect our birth plan, in fact we feel that they didn't even read the plan.

[237] Transcript of Evidence, 18 February 2025, Kimberley Harding, p. 15.
[238] Transcript of Evidence, 19 February 2025, Georgia Lilley, pp. 25 - 26.

During our time in the hospital, the doctors performed a couple of invasive internal examinations that made my wife feel pain, discomfort and later led to her experiencing PTSD around her birth, which impacted our life significantly.[239]

This experience led them to make the following recommendation to the Committee regarding the recognition and use of birth plans:

A birth plan should be treated as a contract that all medical professionals must respect and NOT breach, unless in emergency situations.[240]

4.138. Ms Marsden shared several aspects of her birth experience. During her pregnancy, Ms Marsden planned an elective caesarean section. While this was her preferred option, Ms Marsden also wanted to be prepared for other types of birth in case any changes occurred throughout her pregnancy or during labour. At a public hearing Ms Marsden discussed how her request for additional information and support, including an alternate birth plan accounting for her vaginal birth preferences if her caesarean could not go ahead, was not facilitated. When a caesarean section was not possible at the time of her labour, Ms Marsden consequently felt she had not been able to properly prepare for the vaginal birth she experienced, despite really wanting to prepare for all possibilities:

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

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

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

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

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

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

***Ms MARDSEN** - No, no.*[241]

[239] Submission No. 88, Private Witness, p. 1.
[240] Submission No. 88, Private Witness, p. 1.
[241] Transcript of Evidence, 19 February 2025, Kate Marsden and Timothy Mohr, p. 20.

4.139. Ms Wingrove, Mr Streefland and Mr Halliday discussed the positive experience they had creating a personalised surrogacy birth plan with the LGH complex care midwives:

> ***Ms WINGROVE*** *- In relation to the surrogacy process, we did receive incredible support from complex care midwives at the LGH [Launceston General Hospital]…*
>
> *…*
>
> *… they really were able to develop a surrogacy birth plan in hand with us that really was patient centred. In speaking with [her] afterwards, she said, 'Surrogacy is the ultimate in patient-centred care and what we should be doing with everyone'. Because, obviously, every surrogate team is different. This isn't a standard practice, it's an ad hoc process that [they] have developed because there are more cases like this coming through, and it would be amazing if something like that could be developed statewide and built in, particularly in terms of the resourcing. Even up until the day of the birth, we didn't know whether the boys would be able to stay in a room there with their girls.*
>
> ***…***
>
> *We were very adamant that I'm being treated as the patient. These guys are the parents. I'm not a parent. I really appreciated the way that the whole time we were admitted, even during labour and thereafter, no one ever referred to me as the mum. I was so glad that they treated me as a patient, used my name and no one ever came into my room and said, 'How come you're in here by yourself, where's your baby?' or anything like that, which was wonderful because, as far as I was concerned, it was -*
>
> ***CHAIR*** *- Creating a family.*
>
> ***Ms WINGROVE -*** *a direct handover. We were there to support each other, but it was your time to be parents and that was fantastic.*
>
> ***Mr HALLIDAY*** *- The level of care from the midwives in LGH was absolutely outstanding.*[242]

4.140. They also expressed the desire to see the development of personalised birth plans available for all families:

> ***Mr STREEFLAND*** *- … Going back to the complex care midwives again, we feel like that's not role-specific, the job that they did. That's individual-specific. It means if there was another individual in that role, were they going to provide us with the same level of care? Possibly not. It should be role-specific.*
>
> ***CHAIR*** *- It should be systematic, yes.*
>
> ***Ms WINGROVE*** *- And would someone get that if they were on the north-west coast, or if they were -*
>
> ***Mr STREEFLAND*** *- Down south?*

[242] Transcript of Evidence, 20 February 2025, Chelsea Wingrove, Tristian Streefland and Corbin Halliday, p. 40.

***Ms WINGROVE** - Yes. It was very much due to their care and attention, which we really appreciated.*[243]

4.141. Ms Bell shared her research on birth plans and reported that while birth plans were created to increase communication and clarity between patients and health practitioners, they have become ineffective in practice:

> ***Ms BELL** - Birth plans are intended to improve communication between women and their care providers. However, birth plans need a woman led structure and a process supported by the system to ensure that women are seen and heard. With collaborative and supportive birth preparation, women report greater satisfaction, a greater sense of control and more aligned expectations. In the absence of collaboration and support, women are less satisfied and at greater risk of trauma, and the validity of consent is drawn into question.*
>
> *In response to these issues, the Birth Map was developed from a consumer perspective to be a woman led, collaborative and structured approach to birth preparation. The Birth Map acknowledges the importance of communication and enables confident decision making for women. In the form of a book, the Birth Map provides an overview of the Australian maternity system with question prompts to assist women to engage with care providers and suggested resources to aid in knowledge building. The evaluation was framed around the question, does the Birth Map facilitate communication, enhance experience and aid decision making?*[244]

4.142. Ms Bell explained the concept of the Birth Map in her submission:

> *The tool I have been evaluating is a book called The Birth Map: boldly going where no birth plan has gone before. I wrote this book to fill a gap I saw as a Mother, and after training as a doula and breastfeeding counsellor. The book primarily consists of a series of question prompts to help engage with care providers. Women use these questions to build an understanding of their options and a relationship with the care providers. This then aids in confident decision making, which is important for informed consent.*[245]

4.143. The value of informed decision making was further affirmed by Ms Bell in person before the Committee:

> ***Ms BELL** - Women need to go through a process of sense making during pregnancy where they place the information they receive into their own context and come to understand what it means for them. This helps them to recognise gaps in knowledge that they can then seek to fill, build a support network, which ideally includes a relationship with the care provider, and then they can make confident decisions as their birth unfolds. This process is underpinned by effective communication, which is the cornerstone of informed consent.*
>
> *Embedding this approach into the maternity system involves two critical aspects which address the systematic barriers that were identified in particularly standard and obstetric models of care. The first is to provide women with a comprehensive overview*

[243] Transcript of Evidence, 20 February 2025, Chelsea Wingrove, Tristian Streefland and Corbin Halliday, p. 44.
[244] Transcript of Evidence, 20 February 2025, Catherine Bell, p. 80.
[245] Submission No. 110, Catherine Bell, p. 4.

and prompts for questions in early pregnancy and the second is resourcing the care providers towards relationship-based care, effective communication and supported maternal decision making. This may look like training and support for practising care providers and inclusion in curriculums for emerging practitioners.

Systemic change would shift us from a consent seeking process to a decision supporting one that recognises women as capable decision makers regarding their own experiences. So the Birth Map approach has the potential to lead to this effective communication, supported maternal decision making and enhanced experience for women accessing maternity services.[246]

4.144. Building confidence through enhanced understanding is a key element of of a birth plan. Ms Bell discussed how her proposed Birth Map system provides the environment for informed autonomy and agency for women and their families during labour:

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

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

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

That then, in turn, builds into that confidence. They feel confident that they're being heard and supported. They feel confident that they understand the skill base of the

[246] Transcript of Evidence, 20 February 2025, Catherine Bell, pp. 80 – 81.

clinician and what is available in their facility, so their expectations align with reality. That can help them to accept some of those difficult scenarios if they arise.[247]

4.145. Ms Bell also acknowledged that changing the social and cultural perceptions of birth, including through the Birth Map, is complex:

> ***CHAIR*** *- … for the success of the Birth Map to really flourish and be given its best chance, how vital is it that there's significant support and buy in from health professionals individually but also from health systems more generally, in terms of heads of hospitals, people who coordinate university courses for medical students, midwifery students and allied health professionals who might be involved in something holistic and broad like the Birth Map is? What are the barriers or the challenges to getting that buy in at the system level, from health system heads, individual practitioners and universities and training facilities?*
>
> ***Ms BELL*** *- When I started out the study, I really did hope that the book on its own would be the problem solver. Yay, you give women a copy of the book, problem solved; communication runs freely. It's all good. But the barriers that they came up against show that we do need to build a bridge from both sides. The resourcing of the women takes us halfway across the harbour and we need to bring the care providers across with the other half. That really does look like embedding it within curriculums, putting it into policy, making sure that it is part of every aspect of the care or the education and practice that they're going through. It doesn't necessarily have to look like a module in one class, but something that's embedded as a procedure, a protocol, a credo, if you like, throughout their education and practice.*
>
> *The biggest barrier is the logistics of getting the resources to women en masse. What I have found is that for a lot of very motivated women, they'll seek out the book and do the work and be quite happy. But there's a lot of women who are waiting for the care provider to give them permission. Even in the study, women who opted to be in the study were waiting for the care provider to engage. That often didn't happen until the 36-week appointment, and even then it was fairly limited. So, it needs to be written in as a protocol that we're going to walk together on this journey, ask some questions and build that map together. We really do need to resource the practitioners in some way.*
>
> *I would love to see buy in by the health system. That's the bit where I don't know how that bit works, whether it's at the top, in the middle or whether it has to happen in the sporadic one-conversation-at-a-time way.*
>
> *But the research is done, the product or the solution is there and it can be developed to meet the needs. Westmead has indicated that one of the biggest challenges is going to be translations. That's a very expensive process. They put the figure of about 150 - probably about every language on the planet is represented in western Sydney. In order to do it with cultural sensitivity, you translate it. But it also needs to be placed into the context of those different cultures that we're working with, which is a beautiful opportunity to enrich that multicultural background that Australia now has where care providers can then actually step into the context of those families they're working with and perhaps understand a bit better where they're coming from because the communication will hopefully be facilitated in a more welcoming way, which the framework is designed to do.*

[247] Transcript of Evidence, 20 February 2025, Catherine Bell, pp. 83 – 84.

If it's not embedded within the system, we do potentially run the risk that the Birth Map won't gain the power that it could potentially have, and it could be similar to birth plans: it's only as good as the care provider is willing or able to engage with the process.[248]

Doulas

4.146. Doulas do not have formal obstetric training but can offer support services to the individuals who employ them. Doulas may specialise in particular periods of maternal healthcare, ranging from ante-natal, birth and postnatal care. The Committee heard from Birth in Tasmania members, Ayla Judd, a postpartum doula and remedial massage therapist and Ms Grant, a birth and postpartum doula. Ms Judd and Ms Grant discussed the work of doulas in Tasmania:

> ***Ms DOW*** *- … How many doulas are there across Tasmania practising in the community? …*
>
> ***Ms GRANT*** *- How many hands have you got? You can count them on one hand probably. I am the only full-time birth doula, as far as I know, in southern Tasmania. There's a couple of other part-time doulas as birth doulas and there's a few in the north and north west. There's more postpartum doulas because that's an area of need and it suits a lot of people with younger children too, not being on call.*
>
> ***Ms JUDD*** *- To add, it's a very growing space. Having people for that emotional and practical support for postpartum is beautiful and just to support people. A lot of things are out of scope for a doula, but being able to direct people to the best professionals that are going to help them along the way. That's a big job of being a postpartum doula and knowing who's the IBCRC [International Board Certified Lactation Consultant], who's the GP that specialises in a particular topic and being able to connect families with the appropriate healthcare provider.*[249]

4.147. Heather Sharpe shared her personal experience of hiring a doula for her third birth to assist in ensuring her birth preferences were known. This decision was made as a result of not being able to proceed with her preferred option of a homebirth, which she had chosen in previous births:

> *I have had to be incredibly hard line about some of my birthing boundaries in the system. The focus has been entirely on the mechanics of birth, not the mental health or emotional stability of the parent. There is no recognition of how the discussions, the means of discussion and the focuses of discussions disempower the birthing person or stress them out.*
>
> *These experiences have made my stress levels higher, they make me feel more anxious about birthing in the hospital, I feel less confident that my wishes will be listened to. During birth I do not want to have to speak. It concerns me that the consequence of this could mean that my birth wishes will not be followed through on unless I constantly reaffirm them during birth, this would mean I would have to be constantly vigilant during birth, rather than relaxing and allowing my body to birth. For this reason I have chosen to take on the expense of a doula to maintain my birth*

[248] Transcript of Evidence, 20 February 2025, Catherine Bell, pp. 85 - 86.
[249] Transcript of Evidence, 26 March 2025, Birth in Tasmania, pp. 74 – 75.

boundaries. Not all birthing parents can financially afford to access a doula to ensure they are safe and respected during birth. The fact that in order to ensure I feel safe and my boundaries will be respected during birth is unjust and ensures that those without financial access are less likely to have their boundaries maintained. … I am not treated as an expert in my own birthing by doctors, even though I am the one who has given birth, with my body, twice already.[250]

Education and resources

4.148. Education and resources for Tasmanian women, families and their support networks were prominent themes, particularly antenatal and breastfeeding education.

4.149. Evidence received by the Committee suggested that while antenatal education is available in Tasmania, access is inequitable across the state. Playgroup Tasmania conducted a large survey to inform the submission they made to this Inquiry. Survey respondents who had access to education opportunities prior to labour, said they felt more equipped for the final stages of their pregnancy and labour. Access varied across survey respondents and many had experienced a complete lack of availability during COVID-19:

> *While all participants described adjusting to life with a new baby as challenging, it was clear that participants who felt well supported by maternal health services during pregnancy and birth also felt better equipped for the postnatal period. Correspondingly, participants who described feeling inadequately supported during pregnancy and birth experienced additional challenges postnatally, particularly with regard to their emotional wellbeing.*
>
> *Participants also said their sense of preparedness for pregnancy, birth and beyond was impacted by access to birth education and antenatal classes, with several participants noting that the advent of the Covid pandemic led to widespread cancellation of antenatal classes and maternity unit tours. Excluding one woman who chose to pay privately for hypnobirthing classes, these participants had no access to practical birth preparation and did not set foot inside the unit where they would give birth until they were in labour.*[251]

4.150. Jacinda Armstrong, CEO of Playgroup Tasmania, expanded upon the survey data, explaining geographic impacts on access:

> ***Ms ARMSTRONG** - There is feedback around the inconsistency in terms of availability for some maternal and antenatal services. Birthing classes and the like aren't always available on an equitable basis. I understand there is obviously workforce challenges within the sector, but this is what we're hearing. There is also some lack of engagement, I think, from families when some of those services are available, just through fear of judgment.*
>
> *Whether that's through previous experiences or what their community might say. Obviously, when there's been negative experiences they are quite often shared more broadly than what a positive experience will be, but yes, there is still some inequitable access to antenatal services.*

[250] Submission No. 56, Heather Sharpe, p. 2.
[251] Submission No. 31, Women's Health Tasmania, p. 17.

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

Ms ARMSTRONG *- What we're hearing is mainly regionally in terms of the geographic availability for some of those. I think some of the - this is a bit of a consistent theme actually, the availability of some of these services, when these services are placed in Child and Family Learning Centres mean that some of the community is locked out of that. What we're seeing is that services going into the Child and Family Learning Centres leave gaps in areas where families can access them in a more universal way, because of the fact that Child and Family Learning Centres do have a geographic boundary put around them, essentially.*[252]

4.151. In its submission Playgroup Tasmania recommended that access be made available to all pregnant Tasmanians:

> *… Ensure all pregnant people in Tasmania have access to birth education, including providing antenatal classes through online modalities should in-person classes be paused or cancelled.*[253]

4.152. The TAC also provided support for increased provision of prenatal birthing classes and other educational opportunities, and emphasised the need for transport options to allow participants to attend:

> *Provision of transport support to attend birthing classes, as well as mum's groups, and more classes and groups held in the community.* [254]

4.153. Women's Health Tasmania (WHT) shared consumer responses regarding a lack of access to many services related to the Committee's Terms of Reference, including birth education and other forms of antenatal classes:

> *Participants who relied on public health services had less access to birth education and antenatal classes, mental health support, pelvic floor physiotherapy, fewer ultrasounds in pregnancy, and less continuity of care than participants who were able to pay for services privately.* [255]

4.154. Holly Bennett shared her experiences of having difficulty accessing sufficient birthing classes:

> *I also feel like I was not properly prepared for my experience in the birth suite very well. During the group birthing class, I unfortunately was so sick that I was unable to stay in the class. During the class, I spent a majority of the first 30 minutes running to the bathrooms. Due to this, I asked to be excused and do a 1 on 1 class later on to get the information. Once I got the 1 on 1 class, I was presented the first half, or what I assume was roughly half, of the class PowerPoint by a midwife. After this, the midwife said she would just send me the rest to go over by myself at home. I wonder if I had had the option to complete the whole PowerPoint and go over any questions with a midwife in person, whether I would have been more aware and prepared for my options regarding pain medications, which became an issue when I was in labour.*[256]

[252] Transcript of Evidence, 18 February 2025, Playgroup Tasmania, pp. 34 – 35.
[253] Submission No. 31, Women's Health Tasmania, p. 18.
[254] Submission No. 91, Tasmanian Aboriginal Centre, p. 3.
[255] Submission No. 31, Women's Health Tasmania, p. 18.
[256] Submission No. 37, Holly Bennett, p. 3.

4.155. A Private Witness to the Inquiry shared recommendations for increased access to information and education including:

- *Develop an information sheet for pregnant individuals to understand what services they need to interact with week by week, including the purpose of the appointment and outcomes.*
- *Create digital systems for patients to book and manage outpatient interactions.*
- *Create waitlists with a prioritisation model applied for education and facility orientation classes. I.e. Breastfeeding classes, tour of birthing suites.*
- *Patient awareness and education of health issues and resolution pathways (e.g. breastfeeding, mastitis, signs and symptoms in pregnancy to watch out for).*[257]

4.156. Ms O'Keeffe, representing Maternal Health Matters, suggested that a comprehensive age appropriate understanding of sexual, reproductive and maternal health, is essential as early as possible for children and young people, as it provides a foundation for being better informed adults:

> ***Ms DOW*** *- … The only other question I have is around your recommendations around education in schools, around breastfeeding, childbirth and being more open and upfront about the experiences of women across our community and families. Can you provide examples of where that's done well, or do you have anything further that you'd like to leave with the committee about those educational programs?*
>
> ***Ms O'KEEFFE*** *- There's growing awareness in our society that we educate children, women, and girls and boys about sex and birth control because we don't want teenage pregnancies. Of course we don't want teenage pregnancies, but actually we really need to educate boys and girls about sexuality, and pregnancy is part of sexuality.*
>
> *Until recently, in Australia, we had a sexual health policy that didn't include maternity. Now there's push to get maternity into sexual health. What we're seeing is sexuality and preventing babies means that women no longer know about menstrual cycles. There is an increasing body of evidence that women don't even realise that ovulation is how they get pregnant. That sounds naive to us, but it is actually true. In the infertility literature, some of them, there are two obstetricians in particular who have said that all they've taught women is about ovulation and they get pregnant.*
>
> *Women need to know that it's not just about sex, it's not just about birth control. It is actually about the opportunity later in life to reproduce children and to put that into context and we need to educate young girls, in particular, that there's no need to be scared of being pregnant or birthing. Yes, it's not the most comfortable procedure we'll ever go through, but your body is designed to do it. So, they have confidence and are not undermined when they do become pregnant and end up in a medicalised system that treats birth and pregnancy as an illness.*
>
> *We know from the Calm Birth literature, the hypnobirth literature, and the relaxing into parenting literature, the research evidence around is that the better informed girls and women are about pregnancy and how to cope with pregnancy, the better the outcomes. At the moment we have antenatal education in hospitals, but it's about the hospital's procedures and policies. It's not about the woman's body and there are now*

[257] Submission No. 59, Private Witness, p. 2.

recommendations that any childbirth education should take place outside of the hospital setting and it should be more in a social context so that women and their partners form community groups that can provide support because they're going through a similar journey and they start their community - it's a community development approach - before the baby is born. Once the baby is born, it's really hard to reach out and get help and you usually end up in the medical model. Whereas, if you can get it up in a community development model, it's better.

Also, regarding education, if a young girl does happen to get pregnant, if you do it in schools, they know what's available to them so that they can work their way through it rather than keep it quiet until it's too late to get the care they need. It's about empowering women with knowledge about their bodies and having respect for their bodies. That's a really important message, and also helping them to seek help early in their pregnancy about their processes and their choices, place of birth, health professional who will provide care for them. I think that preparation works very well and again, we see communities where they do really good sex education in school and it includes maternity.[258]

4.157. Evidence was received about breastfeeding experiences in Tasmania, including education and professional support. This evidence highlighted considerable deficiencies in appropriate resources.

4.158. The DoH provided information about breastfeeding support provided by the THS:

Trends reported in Tasmania indicate that the percentage of women who gave birth and were breastfeeding at maternal discharge has increased gradually. In 2021, 87.4 per cent of women who gave birth were breastfeeding at the time of discharge.[259]

DoH is committed to creating a supportive and enabling environment for breastfeeding across its services via the policy framework outlined in the Australian National Breastfeeding Strategy: 2019 and beyond,[260]*including a priority for health services to achieve and maintain Baby Friendly Hospital Initiative (BFHI) accreditation. The BFHI is a joint UNICEF and the World Health Organisation project that aims to give every baby the best start in life, with BFHI accreditation in hospitals associated with higher rates of breastfeeding initiation.*[261]

All Tasmanian major hospitals are BFHI-accredited, which means that the whole hospital is supportive of breastfeeding and provides antenatal classes and one-on-one conversations if required. BFHI also encourages babies to be skin to skin with their mother straight after birth and for as long as possible, for mothers and babies [to] stay together while in hospital, and for mothers to have ongoing support to establish feeding and receive or know where to get help once they go home.[262] *DoH also offers mothers access to specialist lactation services, staffed by International Board Certified Lactation Consultants.*

[258] Transcript of Evidence, 21 October 2024, Maternal Health Matters, pp. 63 – 64.
[259] Footnote 17, COPMM Annual Report 2021., from Submission No. 129, Department of Health, p. 23.
[260] Footnote 18, The Strategy can be accessed at: https://www.health.gov.au/sites/default/files/documents/2022/03/australian-national-breastfeeding-strategy2019-and-beyond.pdf., from Submission No. 129, Department of Health, p. 23.
[261] Footnote 19, Sinha B, Chowdhury R, Sankar MJ, et al. Interventions to improve breastfeeding outcomes: a systematic review and-meta analysis, https://pubmed.ncbi.nlm.nih.gov/26183031/., from Submission No. 129, Department of Health, p. 23.
[262] Footnote 20, More information on the BFHI can be found at https://bfhi.org.au/about/., from Submission No. 129, Department of Health, p. 23.

For mothers who are unable to, or choose not to breastfeed, feeding support can be accessed through midwives and nurses on wards and clinics. Upon discharge from hospital, CHaPS will also provide mothers with bottle-feeding and breastfeeding support.[263]

4.159. Witnesses provided firsthand evidence about their experiences with breastfeeding. The Committee heard that education opportunities on breastfeeding were limited and insufficient:

I found the breastfeeding classes at RHH to be lacking. There was a captive audience of individuals who wanted to learn how to breastfeed, but the education was mostly on breastfeeding and baby bowel habits, and its benefits over bottle feeding. There was also a lot of language used that made participants feel guilty if they weren't able to breastfeed, or wanted to share responsibilities through expressing and bottle feeding. There also wasn't any education on breast care and what to do if you suffered from blocked milk ducts. I had multiple cases about 6 months into motherhood and had no idea what to do, other than go to my GP, which had a 12 day wait for appointments. It was only through explaining my plight to a physio friend, that I was informed ultrasound was an effective method for breaking down blockages. She got me in for an appointment and the issue was resolved rather quickly after that. I also found out there is significant research on it, and it is not being implemented or shared in the health system.[264]

4.160. A Private Witness shared the experiences of their family in seeking support for difficulties with initiating breastfeeding:

My wife had been very firm about wanting to breastfeed our child, but found that there was minimal assistance available with this process, nursing and midwifery staff were too quick to offer opinions, and some were physically aggressive with my wife, yanking at her breasts and the baby to try to get it to feed. Their insistence that our baby would just 'get it' eventually and insufficient investigation into the causes of why breastfeeding was not occurring successfully caused significant delay in identifying the cause of the issue. In fact, I rang a family member in Queensland, a qualified senior midwife, whose advice was that our son's case was consistent with cases she had observed in practice of cerebral palsy. In contrast the view of the Tasmanian nursing staff was that they had never seen this issue occur. Clearly there is a lack of experience in feeding and attachment issues, which needs to be remedied.

The investigation by nursing staff as to the cause, and appropriate support measures to help our son learn to feed, only occurred within the last 3 weeks of our son's stay in special care. He eventually required specialist assessment by an Occupational Therapist, and we had to teach him to latch (even with a bottle). Our son came home with an NGT [nasogastric tube] intact, due to his delay in being able to latch and properly suck and swallow milk. [265]

4.161. Private Witness 46 told the Committee about her self-advocacy with early feeding of her second child. She said her decision to move to formula feeding to ensure

[263] Submission No. 129, Department of Health, p. 23.
[264] Submission No. 59, Private Witness, p. 5.
[265] Submission No. 122, Private Witness, p. 4.

her baby received adequate nutrition was not supported by some healthcare practitioners involved in their care:

> *I worked hard with my ObGyn and a psychiatrist throughout my next pregnancy to better prepare myself and my mental health. Upon the birth of my second son I felt far more confident and in control of what happened to me, my baby and my body. When my milk supply was low again, I didn't hesitate to request to start formula feeding. This was positively supported by my ObGyn who suggested I take a medication to dry up my milk supply and avoid mastitis.*
>
> *The midwife who brought the medication into me arrived at my room and slammed the medication down on the tray table in front of me. I asked her what it was and she said words to the effect of "it's the medication that will stop you giving your son the best start in life". Feeling so much more confident this time around, I eagerly scooped up the medication and said a very over the top "oh why thank you so very much" before swallowing it with gusto. Had that happened to me with my first son though, it would have been devastating and potentially have sent me over the edge of my postnatal depression. There is no place for this overt judgment of women in their most vulnerable state.*[266]

4.162. Representatives from the TAC also discussed the importance of both formal and peer support for families wishing to breastfeed:

> ***Mrs PETRUSMA***[267] *- We are talking about lactation consultants and breastfeeding support in communities is lacking, and identified the need for more breastfeeding support from discharge and available close to home, place-based - are there certain locations that are the worst for that?*
>
> ***Ms FOSTER -*** *In all the footprints that I have, I do not think I can say there is one place that is wonderful. There was a lady, ... Sue Cox…. And she was amazing. We actually delivered a peer support breastfeeding team at a point in time and that knowledge transfer - and people are nodding in the room - but you have to get those champions in the system who are actually going to support that, wholeheartedly, for all families.*
>
> ***Ms THOMPSON*** *- We had that beautiful example at Ningi Pakata, the mum and baby group, that is on Mondays. It is on right now, out at Kutalayna today. There was a mum there who gave the most beautiful breastfeeding support to another new mum. She had come back in with a two-week-old baby. She was expressing and giving expressed breast milk and she was struggling with a pump. Anyway, this mum just stepped in, showed her how to use it. She was like, 'Oh, I think you are are using the wrong flange size'. All this high-level information and skills she was passing on. It was amazing for us to step back and watch and see that exchange of information. Here is this wealth of information right there in the community, happy to be contacted at any time of the day or night. It is just priceless.*[268]

[266] Submission No. 46, Private Witness, p. 2.

[267] At the time of this hearing in October 2024, the Hon. Jacquie Petrusma MP was a Member of the Committee.

[268] Transcript of Evidence, 21 October 2024, Tasmanian Aboriginal Centre, pp. 6-7.

4.163. The Australian Breastfeeding Association (ABA) Tasmania Branch discussed the access issues they have observed in Tasmania:

> *Most mothers of babies born in Tasmania initiate breastfeeding, but many stop earlier than planned.*[269] *Around 85% of Tasmanian mothers leave hospital intending to breastfeed, but in the following weeks and months there is a substantial decline, and low exclusive breastfeeding rates are seen. The best data we have, from 2010, revealed that only 15 per cent of Australian babies were being exclusively breastfed at about 6 months.*[270] *There is no current breastfeeding data publicly available in Tasmania.*
>
> *The reasons that mothers do not continue breastfeeding are highly complex, with a number of societal and cultural barriers known to contribute. However, the most common reasons given by Australian mothers for not continuing breastfeeding, as described in the ANBS,*[271] *relate to challenges that can typically be overcome with accurate information and skilled support: 1) perceived low breastmilk supply; 2) child not attaching properly; 3) unsettled baby; and 4) pain during breastfeeding.*[272]

4.164. Charlotte Fielding, Assistant Branch President of the ABA Tasmania Branch, provided context to relevant obligations and recommendations for breastfeeding:

> ***Ms FIELDING*** *- … The recommendation of the Tasmanian and Australian governments and the World Health Organization is that a baby is exclusively breastfed until about six months of age. This means no other food or drinks are given unless medically indicated. At the moment, mothers in Tasmania find it very difficult to access the right support to enable them to achieve this. ABA volunteers frequently hear this from mothers around the state.*[273]

4.165. While it was established that there are considerable limitations in accessing consistent breastfeeding support in Tasmania, the Committee did hear of existing services available outside of the THS, including support groups run by the ABA Tasmania Branch:

> ***CHAIR*** *- … I'd like to start with the groups that you run around the state. Whereabouts are they held and how do people find out about them?*
>
> ***Ms FIELDING*** *- … They happen at the moment in South Hobart, in Ulverstone, Penguin and in Burnie and Wynyard.*
>
> ***Mrs PETRUSMA***[274] *- So mainly in north west coast then?*
>
> ***Ms FIELDING*** *- At the moment, yes. We're limited by our volunteer capacity. Our local mothers groups are run by our trained volunteers.*

---

[269] Footnote 24, Ayton, J., Howes, F., Hansen, E., Nelson, M. (2015). Evaluating the prevention of premature cessation of exclusive breastfeeding in the general practice setting during the scheduled child immunisation consultation: A pilot study. Australian Journal of Primary Health, 21(3), 299–304. https://doi.org/10.1071/PY13152, from Submission No. 16, Australian Breastfeeding Association Tasmania Branch, p. 3.

[270] Footnote 25, Australian Institute of Health and Welfare. (2011). 2010 Australian National Infant Feeding Survey: Indicator results. https://www.aihw.gov.au/getmedia/af2fe025-637e-4c09-ba03-33e69f49aba7/13632.pdf.aspx?inline=true, from Submission No. 16, Australian Breastfeeding Association Tasmania Branch, p. 3.

271 Footnote 3, COAG Health Council. (2019). Australian National Breastfeeding Strategy: 2019 and beyond. https://www.health.gov.au/resources/publications/australian-national-breastfeeding-strategy-2019-and-beyond as cited in Submission No. 16, Australian Breastfeeding Association Tasmania Branch, p. 3.

[272] Submission No. 16, Australian Breastfeeding Association Tasmania Branch, p. 3.

[273] Transcript of Evidence, 21 October 2024, Australian Breastfeeding Association Tasmania Branch, p. 19.

[274] At the time of this hearing in October 2024, the Hon. Jacquie Petrusma MP was a Member of the Committee.

Mrs PETRUSMA *- How many volunteers in the state?*

Ms FIELDING *- We have about 29 volunteers, about 19 of them are trained breastfeeding counsellors and about five are breastfeeding educators. I think in our submission it says we have 16 breastfeeding counsellors but we've recently had three newly qualified. Now we've got 19 breastfeeding counsellors, which is great.*

CHAIR *- Do people register interest and then do their training through the ABA in terms of that Certificate IV qualification or how does that process work?*

Ms FIELDING *- Anybody can do the training. They can go online and have a look. The one criterion for being a breastfeeding counsellor is having breastfed a baby for at least six months. To be a breastfeeding educator, you do not have to have breastfed a baby. That includes a whole range of other people who can do the training. The training is delivered mainly online, but we are fortunate here in Tasmania to have two trainers who really enjoy doing the face-to-face training as well. It's very family friendly. The trainees can bring along their children to the training if they want to do that. It's kind of a traineeship format. It's focused on actually working in the workplace, which is your ABA local group.*[275]

4.166. Ms Fielding expanded on the logistics of how these services are made available to birthing parents and families:

CHAIR - .... *Do you have access, first of all, to people antenatally during pregnancy to start that conversation? Secondly, do you have access to mums in Tasmanian public hospitals or private hospitals after their babies are born to be able to start those breastfeeding conversations? Or are there ways to provide that access to ABA councillors and educators?*

Ms FIELDING *- It all comes down to resources. We don't really have a direct kind of pipeline. A lot depends on the actual hospital and that sort of thing, and the communications that we have with that hospital. With our paid worker who we've had due to this funding that we received in December last year, that allows us to improve those connections, but it's only a part-time worker so we need more money in order to extend her hours. That funding finishes at the end of June next year [2025].*

...

Yes. Also it's very much up to the mothers to contact us. We don't go running around asking who's breastfeeding their baby. That's none of our business. They have to reach out to us and they have to be able to receive the information.

CHAIR *- Do they, at the moment, receive that information through the hospital, through CHaPS or elsewhere?*

Ms FIELDING *- Antenatally, they would receive it through the hospitals. We have information on our online breastfeeding preparation sessions which run every Wednesday evening and Saturday afternoon, and they have access to that through most of the hospitals. It depends on how they go getting through their resources in*

[275] Transcript of Evidence, 21 October 2024, Australian Breastfeeding Association Tasmania Branch, p. 20.

terms of distribution and that kind of thing, and then the support from CHaPS would come postnatally.

Then there is also that gap that we talked about between leaving hospital and the first appointment with CHaPS potentially being two weeks, which, as Anissa [Thompson, Tasmanian Aboriginal Centre] said, its a very long time.

Mrs PETRUSMA[276] *- Do some people have Zoom calls for those meetings you said you have on Wednesdays and Saturdays. Can they Zoom into those if they can't actually get there?*

Ms FIELDING *- That's an online session. The Wednesday evening ones, yes. They're part of our suite of resources, which is part of the Newborn Virtual Village, and that's online every Wednesday evening and Saturday afternoons. The other good thing about that is that in Tasmania, that cost is $20, and in Tasmania, our generous local groups refund that cost. For a member of the virtual village, that is free once you're part of the virtual village, which is a fee-based service.*

Mrs PETRUSMA *- The mother can attend the sessions as many times as she wants to?*

Ms FIELDING - *The breastfeeding preparation session, that's the one-off antenatal, yes. The breastfeeding helpline, which is one of the core roles our breastfeeding counsellors do, that's a federally funded service. The Breastfeeding Helpline is available 24/7 and the number is 1800 686 268. That's available 24/7 for anybody to phone. They can phone that as often as they like. All the breastfeeding counsellors in Tasmania volunteer on the helpline and the calls come through to us at home. We do a monthly or a weekly shift, or whatever it is, to answer those calls.*

The other thing about the online breastfeeding antenatal sessions is that for a FIFO family, your partner can attend from a different location. If one partner is here in Tasmania they can register, and the other partner, wherever they are in Australia or even overseas, can attend the same class at the same time.[277]

4.167. The timing of the provision of breastfeeding support and advice was also discussed. Ms Fielding recommended that learning should ideally commence prior to labour:

Mrs PETRUSMA[278] *- I noticed on page 4, where you discuss the inconsistencies most prominent in regards to breastfeeding experiences on the hospital ward, suggesting that women struggle to comprehend the advice provided to them. Why do you think that is so? Is it lack of time with midwives, or not explaining in simple enough terms, or not spending enough time with the mother? Why do you think that is happening?*

Ms FIELDING - *I would say it's all of those, Jacquie. The best time to learn about breastfeeding is before you have your baby. Research shows the best time to absorb information about breastfeeding is in the middle trimester. In the first trimester, you are feeling really sick and not really good about anything, then in the last trimester, you are focused on the labour and the birth. The middle trimester is when, the evidence shows, is best for mothers, for parents, to take in that information.*

[276] At the time of this hearing in October 2024, the Hon. Jacquie Petrusma MP was a Member of the Committee.
[277] Transcript of Evidence, 21 October 2024, Australian Breastfeeding Association Tasmania Branch, pp. 21 - 22.
[278] At the time of this hearing in October 2024, the Hon. Jacquie Petrusma MP was a Member of the Committee.

In terms of being on the ward, just after you've had a baby is a really difficult time to learn about anything - and you have so much to learn about at that stage, not just breastfeeding. You have to learn how to look after this baby, you have to learn about everything. You have to learn how to cope with your other children, if you have other children, as well. Of course, in getting information across, different people accept information in different ways. That is another element of it too, possibly. Also, the mothers consistently tell us that, in hospital, they felt there was not enough time, and the midwives did not have enough time to spend with them.[279]

4.168. Ms Fielding also continued to share that intensive breastfeeding support should be available for at least six weeks after birth. She discussed how the National Breastfeeding Helpline plays an important role in providing some of this access, which is available at any time of the day. This is helpful in particular for people who cannot access in person support because of where they live, either in a timely manner, or in some cases, at all. The full extent of support provided by the Helpline was addressed in more detail in the ABA Tasmania Branch submission:

> *The free ABA-staffed National Breastfeeding Helpline sees the consequences of mothers not being supported to breastfeed. They call the Helpline in large numbers, tens of thousands every year, looking for basic information and support that should have been available from the health professionals working with them.*
>
> *Data from the Helpline evaluation shows that mothers are calling for the same reasons, repeatedly, year in and year out. They need reassurance and help with breastfeeding basics: sore breasts or nipples, positioning and attachment, concerns with low milk supply, and information on breastfeeding patterns.*
>
> *ABA volunteers on the Helpline were able to help them. After calling the Helpline, most callers felt: reassured, less stressed and less worried, more confident and knowledgeable about breastfeeding and more determined to continue breastfeeding. They also agreed that the support they received helped them to resolve their issues and encouraged them to continue breastfeeding.*[280] [281]

The Helpline has been funded by the Australian Government since 2008.

4.169. The Breastfeeding Coalition Tasmania also submitted that education and support need to remain available in the postnatal period, including in appropriately accessible locations and formats:

> *Families need access to the right care in the right place at the right time.* ***Postnatal education and care need*** *to be* ***easily accessible*** *to families after discharge from hospital. In the early days, weeks and months at home with their new baby families can face unexpected challenges with breastfeeding. Data show that breastfeeding rates drop during this early period. Often these challenges can be prevented or overcome with the right support, leading to continued breastfeeding and better outcomes. Easier access to breastfeeding support from Lactation Consultants and the Child Health and*

[279] Transcript of Evidence, 21 October 2024, Australian Breastfeeding Association Tasmania Branch, p. 23.
[280] Footnote 26, Tawia, S., & Haines, N. (2023). The impact of the National Breastfeeding Helpline in Australia: An evaluation of caller satisfaction, wellbeing and breastfeeding. Breastfeeding Review, 31(2), 6-13, cited in Submission No. 16, Australian Breastfeeding Association Tasmania Branch, p. 3.
[281] Submission No. 16, Australian Breastfeeding Association Tasmania Branch, p. 3.

Parenting Service (CHaPS) during the transition from hospital to home need to be supported to ensure safe and quality care. [282]

4.170. The ABA Tasmania Branch also provided a specific recommendation for the provision of such ongoing opportunities for support:

Enhance postnatal breastfeeding support:

a. increase the frequency of CHaPS visits and ensure that all mothers receive contact from a CHaPS nurse immediately after discharge from hospital
b. extend the radius from major centres for eligibility for skilled post-natal breastfeeding support at home
c. extend the timeframe for eligibility for skilled post-natal breastfeeding support at home so that every mother is supported to fully establish breastfeeding, no matter how long that takes. [283]

4.171. ABA Tasmania Branch also recommended the following:

Provide breastfeeding education for a mother's primary support network, including partners and grandmothers. ABA encourages a mother's support people to access information and support through our comprehensive website and network of local trained volunteers [284]

4.172. The Committee received detailed evidence that said that increased training opportunities are needed for health professionals, to facilitate increased access to breastfeeding education and support as well as higher levels of informed care. The Breastfeeding Coalition Tasmania summarised this recommendation:

*Effort is needed to increase the proportion of **health professionals** who receive **adequate, evidence-based breastfeeding education and training** that is free from commercial influence. This needs to be provided as part of undergraduate and graduate training for all health professionals who care for women and young children. Ongoing competency of the health professional workforce needs to be supported with regular breastfeeding professional development [original emphasis].* [285]

4.173. The ABA Tasmania also recommended that ongoing training be offered to medical professionals:

Providing access and support for staff to attend regular professional development on breastfeeding is an important way to ensure safe and adequate services, and to ensure mothers receive information that is accurate and up to date. Mothers often report confidentially to ABA breastfeeding counsellors in Tasmania that they have received out-of-date information. [286]

4.174. GP and owner of The Bubble Tasmania, Dr Vavrek explained that she had recently qualified as a lactation consultant, making her, at the time of giving evidence, the only GP in Tasmania with this qualification. She described the benefit of this:

***Dr VAVREK -** I just passed my exams late last year. We just don't have the services, but if we look at Victoria, there is a huge proportion of GP, doctor lactation consultants. We do have nurse lactation consultants in Tasmania, which is fantastic, but there is only a*

[282] Updated Submission No. 1, Breastfeeding Coalition Tasmania, p. 3.
[283] Submission No. 16, Australian Breastfeeding Association Tasmania Branch, p. 8.
[284] Submission No. 16, Australian Breastfeeding Association Tasmania Branch, p. 8.
[285] Updated Submission No. 1, Breastfeeding Coalition Tasmania, p. 3.
[286] Submission No. 16, Australian Breastfeeding Association Tasmania Branch, p. 5.

small handful, and being a GP lactation consultant is a whole other spectrum because we can do prescribing and we can diagnose. If we had more GP lactation consultants, more doctors, GPs who specialise in the perinatal space, we'd take pressure off the public health system, we'd take pressure off that small cohort that already do exist who are only getting burnt out.[287]

Dr Vavrek described the approach that should be taken to postnatal care:

> ***Dr VAVREK** - As I mentioned earlier, I'm a GP lactation consultant and I'm very passionate about breastfeeding. I think a lot of women experience issues with breastfeeding and end their journeys early because of the lack of services in that space that we have and the lack of education. I'd love to see more in this space, particularly the postpartum area. I know we've heard a lot about menopause in recent years and how there's been lack of education for GPs in menopause. I would say there's as equally the same amount or lack of education for GPs in postpartum care, which includes breastfeeding.*
>
> *I shudder to think of the advice that I used to give to women in my days fresh out as a newly minted GP - sleep-deprived mothers coming in and just those comments. You think you know it all and you don't. These days there has been extra training that has come out which myself and a number of my doctors at the clinic and midwives have done, which looks at infant care, breastfeeding, feeding in general, tongue ties, infant irritability, cry-fuss issues, and sleeping - all through an evidence-based lens.*
>
> *We know so much more in this space and are providing 60 to 90 minute appointments to address a lot of these concerns. The parents can help reduce that maternal mental health load that we see so much, which then can really take on a life of its own and really become quite severe mental health disorders. If there were more services or more training for GPs in this space, I think we'd see a huge reduction in maternal mental health problems.*[288]

The Breastfeeding Coalition Tasmania and the ABA Tasmania Branch both also strongly emphasised the need for an increase of lactation consultants in Tasmania.

4.175. The Committee received evidence about provisions that can be made in workplaces to ensure people who are breastfeeding can more easily return to work. The Breastfeeding Coalition Tasmania discussed this also addressing the socio-economic factors evident in ensuring that support mechanisms are available to increase return to work rates:

> ***Breastfeeding-friendly workplace policies and facilities** are important as more women return to work earlier than they had planned to address workforce shortages or meet their financial commitments. Supporting breastfeeding in the workplace helps families with the transition back to work after having a baby. It has implications for workforce participation, retention, advancement and productivity. A supportive workplace helps to allow parents to meet their family goals while participating in the workforce.*
>
> - *For example - Staff at the Royal Hobart Hospital are currently being impacted on return to work by the lack of a safe and dedicated staff space to express*

[287] Transcript of Evidence, 26 March 2025, Dr Natasha Vavrek, p. 62.
[288] Transcript of Evidence, 26 March 2025, Dr Natasha Vavrek, pp. 68 – 69.

breastmilk. This may impact decisions about infant feeding or their ability to continue breastfeeding when they return to work [original emphasis]. [289]

Findings

The Committee finds:

19. Women and family centred maternal healthcare leads to optimal outcomes for parents, babies and families.

20. Women's experience of maternal healthcare in Tasmania is variable and is influenced by factors including location, cost and the knowledge and attitude of the health professionals involved in their care.

21. There are significant regional inequities in access to maternal healthcare in Tasmania.

22. Private obstetric services are not available in the North West. This limits patient choices and has broad workforce implications.

23. There has been significant instability and uncertainty in accessing maternal healthcare in both public and private hospitals in Tasmania which has influenced the standard and level of care available.

24. There is no clear public strategy in Tasmania for the future provision of women's health, including reproductive and maternal health.

25. There is some support for a dedicated women's and children's hospital in Tasmania.

26. There are insufficient women's health specialists in Tasmania, including midwives, anaesthetists, maternal-foetal medicine specialists, sonographers and urogynaecologists.

27. Continuity of care in maternal healthcare is considered best practise and is widely supported by health consumers and professionals.

28. Continuity of care in maternal healthcare is not consistently available in Tasmania.

29. Tasmania has both midwifery-led and obstetric-led models of maternal healthcare.

30. The availability of midwifery-led models in Tasmania does not meet demand.

31. Many Tasmanian women do not receive their preferred model of maternal healthcare.

32. Some Tasmanian women are supported by private doulas.

33. Difficulties in accessing preferred models of maternal healthcare contribute to individuals choosing freebirth.

34. Birth plans inform and educate parents and contribute to continuity of care, increasing the occurrence of optimal outcomes for mothers, babies and families.

35. Birth plans are not always prepared, recognised or followed.

[289] Updated Submission No. 1, Breastfeeding Coalition Tasmania, p. 4.

36. Aboriginal and Torres Strait Islander, Culturally and Linguistically Diverse (CALD) and LGBTIQA+ Tasmanians experience greater barriers to accessing appropriate and essential maternal healthcare.

37. Aboriginal and Torres Strait Islander, Culturally and Linguistically Diverse (CALD) and LGBTIQA+ Tasmanians do not always receive culturally sensitive care which can lead to feelings of isolation or alienation.

38. The standard of care for pregnancy loss and bereavement in Tasmania is inadequate and inconsistent.

39. Families experiencing pregnancy loss and bereavement are not provided adequate physical or psychological support during their admission and discharge.

40. Dedicated spaces for care following pregnancy loss are not available in all Tasmanian hospitals.

41. Antenatal classes are not available to all Tasmanians. For those who do have access, current services are not meeting their needs.

42. Postnatal support is inadequate, including for families in the Neonatal Intensive Care Unit (NICU) or Special Support Unit (SSU), and after second or subsequent pregnancies.

43. Peer support is valuable for helping people adjust to parenthood.

44. There is a lack of understanding of reproductive and maternal healthcare in reproductive and sexual health education for Tasmanian students.

45. Despite a high number of women wanting to breastfeed many struggle to either take up or continue breastfeeding due to a lack of timely support.

46. Publicly available data is not collected on breastfeeding in Tasmania.

47. The high demand for breastfeeding education and lactation consultants in Tasmania is currently unmet.

Recommendations

The Committee recommends that:

11. The Government develop a women's health strategy, including reproductive and maternal healthcare, to inform service provision and guide infrastructure development.

12. The Government conduct an audit of available maternal and reproductive healthcare infrastructure in Tasmania.

13. The Government work with private obstetricians to recommence service provision in the North West.

14. The Government investigate the feasibility of the establishment of a dedicated Tasmanian women's and children's hospital.

15. The Government ensure a continuity of care model is available to all pregnant people in the Tasmanian Health Service, including a focus on midwifery-led care.

16. **Every pregnant person is offered the opportunity to develop a birth plan in consultation with health professionals and that these birth plans are recognised, respected and followed.**

17. **The Tasmanian Health Service ensure postnatal home support is available to families after discharge from the Neonatal Intensive Care Unit (NICU) or Special Support Units (SSU).**

18. **The Government develop a standard model of care for pregnancy loss and bereavement care in Tasmania.**

19. **The Tasmanian Health Service provide separate, dedicated space for pregnancy loss and bereavement care in Tasmanian hospitals.**

20. **The Tasmanian Health Service review antenatal classes, including updating content and improving accessibility and availability of classes.**

21. **The Government increase funding and support for peer led parenting and family groups.**

22. **The Government include reproductive and maternal healthcare in the curriculum for Tasmanian schools.**

23. **The Government improve breastfeeding education and support services in the Tasmanian Health Service and ensure access to ongoing assistance when required.**

24. **The Government collect and make publicly available breastfeeding data in Tasmania.**

25. **The Government fund and facilitate professional development in women and family centred maternal healthcare and breastfeeding for health practitioners within the Tasmanian Health Service.**

26. **The Government embed culturally sensitive knowledge and practices in the provision of maternal and reproductive healthcare in consultation with stakeholder groups.**

5. HOMEBIRTH AND PROFESSIONAL INDEMNITY INSURANCE

5.1. The Committee received considerable evidence in relation to homebirth options and Professional Indemnity Insurance (PII) for midwives in Australia.

5.2. The National Perinatal Data Collection, facilitated through the Australian Institute of Health and Welfare, defines a homebirth as 'one that is planned to take place at a home and is attended by a midwife or other medical professional.'[290]

5.3. Homebirths are medically monitored births, with qualified midwives in attendance. Some public commentary can conflate homebirths with freebirths, however there is a distinct difference in practice. The Australian College of Midwives (ACM) defined freebirth as births 'whereby women birth with either unregulated birth workers or alone.'[291]

5.4. Privately Practising Midwives (PPMs) provide qualified midwifery care and are registered under the Australian Health Practitioner Regulation Agency (AHPRA) Nursing and Midwifery Board. PPMs practise in private homes, birth centres and in some jurisdictions in public hospitals.

5.5. In Tasmania homebirth services are provided through PPMs who typically practice in private homes. The Launceston Birth Centre is the only formal private homebirth facility in Tasmania and is a PPM-led service.

5.6. Other states in Australia publicly fund homebirths, Tasmania is the only state which does not. Kristyn Begnell, representing Homebirth Australia discussed this:

> ***Ms BEGNELL*** *- Publicly funded homebirth programs have existed in Australia for over 20 years and are provided by every state and territory except Tasmania.*[292]

5.7. According to Homebirth Australia, 65 Tasmanian births in 2022 occurred as designated homebirths.[293]

5.8. Homebirth Australia provided additional information:

> *According to that latest data from the Australia's Mothers and Babies report from the Australian Institute of Health and Welfare, 6081 babies were born in Tasmania in 2021. 98.5% of those babies were born in hospital, 0.4% were born in birth centres and 0.9% were born at home.*[294]

5.9. Homebirth Australia stated that:

> *It is estimated that there are currently 4 Privately Practising Midwives (PPMs) providing homebirth services in Tasmania and there are no Publicly Funded Homebirth*

[290] Australian Institute of Health and Welfare, Australian Government, 31 July 2025, 'Australia's mothers and babies,' https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/labour-and-birth/place-of-birth.
[291] Submission No. 32, Australian College of Midwives, p.6.
[292] Transcript of Evidence, 21 October 2024, Homebirth Australia, pp. 22 – 23.
[293] Additional information, Homebirth Australia.
[294] Submission No. 90, Homebirth Australia, p.1.

(PFHB) programs. PPMs have reported to us that this year in particular, the number of enquiries they've received has increased significantly.[295]

5.10. The Committee heard a broad range of homebirth experiences from families, midwives and other health professionals. This included reasons why some Tasmanians wish to access homebirth and some of the support that is offered to facilitate homebirth.

5.11. Ms Begnell, representing Homebirth Australia, explained:

> ***Ms BEGNELL** - Birth is not an illness or an injury, but it's been pathologised and monetised by our health system. When a woman feels safe, supported and unobserved, she's perfectly capable of giving birth to her baby without medical intervention the majority of the time.*[296]

5.12. At a hearing, Ms Begnell explained:

> ***Ms BEGNELL** - Our health system does not fully trust midwives or women. Midwives are unable to practice to their full scope due to the restrictions placed on them by hospital policy and a medicalised approach to birth. According to the latest Australia's Mothers and Babies Report, 1.1 per cent of all births in Tasmania in 2022 were planned homebirths, one of the highest rates of homebirth in the country. This is a 0.2 per cent increase on homebirths in 2021 and it correlates with the information we received from PPMs in Tasmania. That demand for homebirth services has increased significantly and there is not enough supply to meet the demand. This is partly due to the many barriers that midwives face in entering private practice.*[297]

5.13. Similar issues regarding the evidence base behind homebirths was also raised by Jaimee Smith, a practising PPM who provides homebirth care at the Launceston Birth Centre:

> *Endorsed private midwives offer gold-standard continuity of care, and carer from conception, throughout pregnancy, labour and birth and for 6 weeks postpartum. This is a relationship-based model of care and it is extremely effective in leading to excellent outcomes for women and babies, as well as facilitating the highest standards of safety on all levels (physical, emotional, cultural and spiritual safety).*[298]

In 2024 Mrs Jaimee Smith was awarded Australian Midwife of the Year, by the ACM.

5.14. Ms Smith further provided a definition of midwifery at her appearance before a hearing of the Committee in Launceston:

> ***Ms SMITH –** We [midwives] are really experts in normal physiology, where nursing and medicine, the underlying philosophy of that would be looking after sick, unwell, injured people. Midwifery's underlying philosophy really is we're looking after well women.*

[295] Submission No. 90, Homebirth Australia, p.1.
[296] Transcript of Evidence, 21 October 2024, Homebirth Australia, p. 23.
[297] Transcript of Evidence, 21 October 2024, Homebirth Australia, p. 32 - 33.
[298] Submission No. 109, Jaimee Smith, p. 1.

Pregnancy, birth and postpartum is normal physiology. That's the perspective I come from.[299]

5.15. The Committee heard strong evidence that all birthing options, including homebirth, should be available to all families across the state regardless or geographic or socioeconomic circumstances. In its submission Homebirth Australia said:

> *In Tasmania, as in other states and territories around Australia, the demand for homebirth services far outweighs the supply. Women who live in rural and remote areas are particularly impacted by lack of services.*
>
> *Women in Tasmania deserve to have access to their preferred model of care, regardless of their financial situation or where they live.*[300]

5.16. Witness Kaylia Marshall shared her positive homebirth experience on the Nort West coast at a hearing in Burnie:

> ***Ms MARSHALL** - We're well connected. The difference for me in birthing at home; we just snuggled down. We stayed in our space. We didn't pick up diseases. People could come and visit us. We had the support we needed. I wish with all my heart that more women, more families had that experience. It set me up really well for breastfeeding. I've breastfed both of my babies, still now two and a half years with my son and then 17 months in now with my daughter. These are really great things that are supported by the experience that I have had.*
>
> *...*
>
> *it is about choice and we are not giving women the choice. If we hold ourselves up as being a developed nation and a developed state, we are not giving women who are half the population - and a critical half in terms of families being healthy and strong. We need to really think back to the beginning and this is where it begins.* [301]

5.17. Ms Marshall also expanded upon the services provided by her PPMs, their professional agreements and scope of practice in regard to her labour:

> ***Ms MARSHALL -** Our midwives are not hippie midwives who are doing everything outside standard protocols; there's scientific backing to a lot of these things. They wanted us to have scans and appropriate blood tests to help us monitor. I was fine with that. That gave us all confidence, my husband, myself and our midwives too, to birth at home because we understood more about what was going on in my body. That was really good.*
>
> *We were still engaging with the public system in Burnie, going to the obstetrician appointments as normal, again making sure we were ticking off that everything was looking okay, and getting that well-rounded support and feedback on how the pregnancy was progressing. I can't remember exactly where, but my 20 week scan with my first pregnancy - the size was suggesting a little bit larger. From memory I*

[299] Transcript of Evidence, 19 February 2025, Jaimee Smith, p. 2.
[300] Submission No. 90, Homebirth Australia, p. 1.
[301] Transcript of Evidence, 18 February 2025, Kaylia Marshall, pp. 6 -7.

don't know whether it was 70th or 90th percentile, but the scan was really a bit larger.

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

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

***CHAIR** - What week were you during that?*

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

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

We all had a bit of a laugh about that afterwards, the experienced midwives. After having a look into it more and during that time, but also afterwards, there's a lot of evidence that late-term scans actually don't give you very good, reliable reads on size. They give you a lot of other information that's valuable, but not on size. That's been my understanding.[302]

Publicly funded homebirth

5.18. Homebirth Australia stated in their submission:

> *Tasmania is the only state in Australia that does not provide publicly funded homebirth. Due to the costs of running a private midwifery practice, a homebirth with a PPM can cost between $6000 and $7500, with limited access to Medicare rebates. This leaves many women unable to access their preferred model of care due to financial constraints.*[303]

[302] Transcript of Evidence, 18 February 2025, Kaylia Marshall, pp. 3 - 4.
[303] Submission No. 90, Homebirth Australia, p. 4.

5.19. Representing Homebirth Australia at a public hearing, Ms Folkerts noted that plans to provide publicly funded homebirths in Tasmania have been considered over many years, but never actioned:

> ***Ms FOLKERTS*** *- ... at that time, 2012 to 2020, the MGP [Midwifery Group Practice] manager prepared a solid case for a publicly funded homebirths program to arise from within the MGP model, similar to what has been successful interstate. That is another body of work that has ended up remaining on a silicon chip in a THS computer.*[304]

5.20. At a hearing of the Committee, representatives from Homebirth Australia explained how publicly funded homebirth would increase services available to those of varied socio–cultural demographics:

> ***Mrs PETRUSMA***[305] *- Also, just on page 4 of the submission, under Public Funded HomeBirth, I was interested in the last line in the first paragraph which says:*
>
> > *Publicly funded homebirth is more accessible to migrant women, women from low socio-economic demographics, and those who are unable to secure a PPM due to the high demand of their services.*
>
> *Why is a publicly funded homebirth more accessible to migrant women and women from lower socio-economic demographics?*
>
> ***Ms BEGNELL*** *- Well, largely because of the cost.*
>
> ***Mrs PETRUSMA*** *- Isn't it about $6,000 for the cost?*
>
> ***Ms FOLKERTS*** *- Only with a private midwife; publicly funded it's free.*
>
> ***Mrs PETRUSMA*** *- A publicly funded homebirth - are you saying it's not in the home?*
>
> ***Ms FOLKERTS*** *- A publicly funded homebirth is like having the Midwifery Group Practice currently at the Royal offering women to birth in the hospital or to birth at home. The midwives would be covered by the hospital's insurance and the woman gets to choose the venue for her birth, providing she meets certain criteria. That would be free to the woman. Whereas, if you engage a private midwife like me, then you would be paying thousands of dollars, some of which you would get back on Medicare rebates.*
>
> ***Mrs PETRUSMA*** *- Have you asked to see if a publicly funded homebirth could happen at the Royal Hobart Hospital?*
>
> ***Ms FOLKERTS*** *- As I said previously, there was a project underway by the midwifery group practice manager years ago.*
>
> ***Mrs PETRUSMA*** *- And that didn't go any further.*

[304] Transcript of Evidence, 21 October 2024, Homebirth Australia, p. 35.

[305] At the time of this hearing in October 2024, the Hon. Jacquie Petrusma MP was a Member of the Committee.

Ms FOLKERTS *- No, it didn't.*[306]

5.21. Homebirth Australia further provided a formal recommendation to the Committee:

> *We recommend that the first location for PFHB [Publicly Funded Homebirth] in Tasmania should be Hobart Public Hospital. Hobart has an established Midwifery Group Practice program, which has great outcomes for mothers and babies.*[307]

5.22. Ms Sharpe, a witness of the Committee who has experienced both home and hospital based labours, provided insight into her experience:

> ***Ms SHARPE*** *- … It comes down to this for me: when we're measuring homebirth and hospital birth, so often homebirth is seen by the general public as a risky thing. The majority of society thinks homebirth is a risky thing… I remember having to have lots of difficult conversations with other people about why I was being selfish.*
>
> *…*
>
> *Those of us who do homebirths actually also know that this idea is not true. It's not actually true that homebirth is really, really risky or really, really dangerous…*
>
> *…*
>
> *Whenever I see homebirths measured or compared to hospital births, I see them measured by hospital standards, so in hospital priorities. Risk is measured in terms of what hospitals and insurers consider to be risky, and everything relates to mortality. Don't get me wrong, mortality is an important thing to consider. But the picture of giving birth is one of nuance. It involves humans, and humans are filled with nuance. Homebirth and hospital birth are not the same thing. Only someone who measured things in a superficial or medical way might suggest it. I would like to suggest that data and the language used around birth needs to have not such a heavy influence from a system that has such a poor track record of birth trauma. Why do we only measure homebirth in comparison to hospital birth on hospital-dictated risks? Where is the data on how likely birth trauma is in homebirth versus hospital? Where is the data on a sense of parental confidence following birth, on the nuance of parental experience, on the likelihood of postnatal depression, on the effects on siblings, on the likelihood of birth-related injury due to intervention?*
>
> *Homebirths and hospital births may be two ways of achieving the birth of the baby, but birth is not a mechanical process. Again and again, in the hospital system - not with the midwives, but when I was having to justify things, that's how it felt…*[308]

[306] Transcript of Evidence, 21 October 2024, Homebirth Australia, pp. 39 - 40.
[307] Submission No. 90, Homebirth Australia, p. 4.
[308] Transcript of Evidence, 20 February 2025, Heather Sharpe, pp. 52 – 53.

5.23. At her appearance before the Committee with representatives from the DoH on 26 March 2025, the then Minister for Health, the Hon. Jacquie *Petrusma* MP, provided updated information to the Committee on developments to provide publicly funded homebirth in Tasmania:

> ***Mrs PETRUSMA*** *- In regards to publicly funded homebirth in Tasmania, we believe it does have the potential to provide the community with greater choice in woman-centred models of care that align with their needs and preferences. I'm absolutely delighted that the Department of Health is currently developing an internal discussion paper to explore options to deliver high-quality, safe public homebirths in Tasmania. This paper will explore the local Tasmanian context and consider relevant research and guidelines across Australia and will be progressed to the Secretary for consideration very, very soon.*
>
> *...*
>
> *Subject to the Secretary's endorsement, consultation will occur with women, midwives, medical practitioners, administrators and, importantly, women seeking to choose this model of care. The consultation process will assist to determine agreed model-of-care requirements for planning and implementation.*
>
> *Our long-term health workforce strategy, Health Workforce 2040, emphasises the need for Tasmania's health system to expand with midwifery continuity of care models and to strengthen workforce recruitment. That will be at the heart of the strategy. We believe that developing a publicly funded homebirth program supports our strategy to strengthen midwifery continuity of care models and allows Tasmania to be more competitive in recruiting midwives, as well as supporting them to practise to their full scope.*[309]

5.24. In updated information from the Hon. Bridget *Archer* MP, Minister for Health, Mental Health and Wellbeing, received in October 2025, the Committee was informed the DoH had continued investigations into public homebirth in Tasmania. Stakeholders were invited to participate in consultation for the development of a model, with submissions to this consultation having closed on 19 October 2025.[310]

5.25. Ms Smith, a PPM based in Launceston, discussed some of the challenges regarding risk and eligibility criteria for existing publicly funded homebirth programs in Australia. Ms Smith noted that certain comorbidities, such as gestational diabetes, and previous birth history, such as prior caesarean section, excluded individuals from participating in public homebirth programs. She also explained that in some circumstances existing particpants of a publicly funded homebirth program can be required to leave the program if their pregnancy exceeds 42 weeks which, if they were using PPM services, would not be a risk criteria for exclusion. Ms Smith shared her view of existing programs in Australia and potential considerations for the Tasmanian context:

[309] Transcript of Evidence, 26 March 2025, Department of Health and Hon. Jacquie Petrusma MP, p. 13.
[310] Updated information, Attachment 1, Minister for Health, Mental Health and Wellbeing, p. 1.

> ***Ms SMITH -*** *I know that it's also recently been expanded in Western Australia. I actually think Queensland do it best of anywhere. They seem to have been doing it longest and best. They have visiting rights for midwives a lot more easily than any other state, but yes, I think that's the problem. You hear that come up over and over, especially my perspective and interaction with private midwives, that's what I'm hearing, that they're sort of getting last minute calls from women.*
>
> ***...***
>
> *The hospital has the right to then determine the policies that the midwives operate under because they're employed by that, but ideally they would use guidelines like we have instead… I know hospitals are actually businesses and they're looking at risk from a different perspective than women and midwives are...*[311]

Access to Privately Practising Midwives

5.26. Substantial evidence was received regarding the current lack of access to practising PPMs in Tasmania. PPMs provide women with their only opportunity to homebirth in Tasmania.

5.27. In her submission to the Inquiry, Private Witness 36 explained the difficulty in accessing homebirth:

> *Unfortunately, homebirth options in Tasmania are extremely scarce. There are only two midwives working in my area, and they book out extremely fast. This means that a lot of women that would like a homebirth miss out, and are forced through the hospital system.*[312]

5.28. Private Witness 92 explained her experience of seeking homebirth options in Tasmania. She chose to labour at the other end of the state from where she lives:

> *Due to the shortage of private midwives in Tasmania, in order to have a 'homebirth' we had to book an Airbnb in Hobart - 3 hours from our actual home! We had to travel to Hobart for our prenatal appointments or have them via telehealth, which is obviously not ideal for prenatal checks and care.*
>
> *Also due to the shortage of private midwives in Tasmania we weren't able to choose a provider that we actually felt comfortable with. We had to go with the only one available. This impacted our experience with our pre and post natal care, and care during the birth. We ended up being advised to transfer to hospital.*[313]

5.29. Rashelle Szoke, a PPM, discussed access to her services in her submission:

> *I'm a privately practising midwife in Southern Tasmania*
>
> *I have been providing community based continuity of care to families as an endorsed midwife since 2021…*
>
> *In 2024 the inquiries for PPM care have far outweighed previous years and the demand is bigger than our capacity to meet this change.*

[311] Transcript of Evidence, 19 February 2025, Jaimee Smith, pp. 8 - 10.
[312] Submission No. 36, Private Witness, p. 1.
[313] Submission No. 92, Private Witness, p. 1.

I am currently mentoring two other midwives into private practice.[314]

5.30. Birth in Tasmania shared stories from community members noting the complexity and inequity of accessing PPMs, including cost barriers:

> *We have had many reports of women struggling to access private midwifery care. Due to the shortage of private midwives, we hear that midwives have already been booked out, or that women need to drive for hours in labour, whilst attempting to attend a birth centre. Other women that we have spoken to have said that they would love to choose homebirth, but simply cannot afford it.*[315]

5.31. Individual witnesses shared the impact of covering the cost of accessing PPM services in the absence of publicly funded options. Private Witness 92 stated:

> *It's beyond ridiculous that if you choose, want or need to have a homebirth, the most psychologically normal and appropriate way to give birth for mother and baby, and family, you have to pay thousands and thousands of dollars. Or you can have a birth for free if you're willing to sign over to the medicalized interventionist system.*
>
> *The system is backwards, broken, unscientific and is harming mothers, babies and families.*[316]

5.32. In her submission Ms Sharpe shared her experience of birth including her limited access to homebirth services:

> *I was fortunate to be able to financially and logistically access a homebirth service for my 2nd child's birth.*
>
> *I would like to raise some of the issues that come out of the contrast between my maternity experience for my 2nd child, during which my consent, choices and mental health were prioritised by my homebirth provider ([redacted]) and the ways in which I have been treated during this 3rd pregnancy.*
>
> *Due to a lack of homebirth midwives in the current maternity climate, I have been forced to go through the hospital system for this 3rd birth.*
>
> *I would like to raise the issue that homebirth is regularly represented in the media and by hospitals as risky. However, hospitals have a very specific measure of risk. The risk of experiencing birth trauma is not even on the radar when "birth risks" are discussed. I would suggest that if one compared the data of people who homebirthed and people who birthed in the hospital system, the risk of experiencing birth trauma of any kind is far, far higher in the hospital system.*[317]

[314] Submission No. 106, Rashelle Szoke, p. 1.
[315] Submission No. 97, Birth in Tasmania, p. 3.
[316] Submission No. 92, Private Witness, p. 1.
[317] Submission No. 56, Heather Sharpe, p. 1.

5.33. Ms Sharpe expanded upon her experiences of her homebirth, compared to her labour in a public hospital:

> ***CHAIR*** *- … We have heard a lot through this Committee about the difference between the homebirth experience and the hospitalised experience and you've experienced both. Are you willing to just expand a little bit on the differences that you experienced?*
>
> ***Ms SHARPE*** *- …I experienced homebirth during COVID. That was a huge influence on why we chose to have a homebirth. Many factors were considered in relation to that, but really the biggest one was that I didn't want to be anywhere near a hospital during a COVID pandemic with a newborn.*
>
> *The process of having a homebirth, my midwife, [redacted], walking with someone who walked with you and who was so experienced in birth that she didn't need to focus on a risk to talk to you about what was happening with your body. She could find ways to talk about it without being like, 'Let's talk about all the risks right now'…*
>
> *…Those are the things that you know about. Talk to me about the things, the choices that I'm making and phrase them as choices. That was a big factor, whenever we would talk about something that was going to happen or needed to happen or could happen, she'd be like, 'This is a thing, this is the information it gives us. Do you want to do it?'*[318]

5.34. Ms Sharpe also noted the community context for access to homebirth:

> ***Ms SHARPE*** *- …There's an issue with availability of homebirth midwives at the moment. I know at least six children who've been born in a car on the way from the Huon Valley to the hospital. If those people had been at home, that would have been a safer environment than trying to race to a hospital and having a baby on the side of a highway. The Huon Valley is only 45 minutes to an hour away. Nubeena's ages away, so the access issue is big in that way.*
>
> *I couldn't get a homebirth midwife because there was one operating at that time and she was already booked. Basically, at that point, I had to make a decision about whether I didn't use the system at all or I went through the hospital system. I went through the hospital system for one reason: to be able to have access to the Syntocin injection at the end of labour if I required it, because I had required it for the last two.*[319]

5.35. Ms Marshall, who had homebirths on the North West coast, discussed the response she received when considering homebirths, and the limitations on accessing homebirth support in the North West:

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

[318] Transcript of Evidence, 20 February 2025, Heather Sharpe, p. 49.
[319] Transcript of Evidence, 20 February 2025, Heather Sharpe, p. 50.

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

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

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

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

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

Another thing that I can think that I would like to say is that on the mainland, there is a number of hospitals that have been trialling and having great success with publicly funded homebirth. It's not hard. There needs to be frameworks around it, but I think the year before last there was a study around the economics of it. It's actually cheaper for the health system.[320]

5.36. Community education on accessing PPMs would increase awareness of homebirth. Ms Folkerts, a retired PPM representing Homebirth Australia, discussed how information about accessing PPMs in Tasmania is currently shared:

***Ms JOHNSTON** - ... How do women find out about the choice to privately homebirth?...*

***Ms FOLKERTS** - ... I have quite a few GP friends but I don't know of any GP who will say to a pregnant woman, 'Would you like to see an obstetrician, would you like to go to*

[320] Transcript of Evidence, 18 February 2025, Kaylia Marshall, pp. 5 - 6.

the Royal, or would you like a private midwife?'. It doesn't happen and that's really quite sad that there's still that tension there, a sense of disapproval, despite the very good statistics on homebirth for low-risk women across the world.

It is by word of mouth. People don't usually advertise. The younger ones, not me, might have a web page that flags homebirth where women might look it up. The first-time mums don't know. It's only after they've had their first baby - they're amongst the big mother's club - then they find out their options.

***Ms JOHNSTON** - … is there some work that could be done with GPs in terms of when they could provide that referral - referrals to an obstetrician - but to give mums the opportunity to have that choice?*

***Ms FOLKERTS -** Information, yes, there is a lot of room for that. I had thought that I might offer to go around GP surgeries and talk to the GPs on some of their in-service things, suggesting that could be spoken of and women given a little bit of information about choice, but I haven't done it.*[321]

5.37. Currently the only dedicated facility for homebirths in Tasmania is the Launceston Birth Centre. Other homebirths conducted by PPMs occur in the homes of patients or other private locations. Labours in birth centres are still classed as homebirths, as they occur outside a clinical hospital setting. Representatives from the ACM discussed birth centres that provide care for families to labour outside hospital:

***Ms WILKINSON -** The Launceston Birth Centre is a great example and Jamie does have some really great stats on the outcomes there. Then there is a lot of new building research on the birthing on country, particularly in Waminda [New South Wales].*
….

***Ms SHAKES -** The difference for the Launceston Birth Centre, it's a privately funded space. We would very much advocate for publicly funded freestanding birth centres, as well as those privately funded birth houses or birth centres, because women want choice. We hear that overwhelmingly in the feedback they provide.*

***CHAIR** - The Hobart Birth House, do either of you have experience in that?*

***Ms SHAKES** - There has been a committee looking at that for a number of years. It's stalled and hasn't progressed at the moment, but it's not off the cards if there's some public funding for it.*

…

***Ms WILKINSON** - A lot of this is on the endorsed midwives also. The Launceston Centre is run by an endorsed midwife. Changes to the opportunities for midwives to seek endorsement and changes to the potential ways of working and improved scope for endorsed midwives could then lead to further opportunities in the private space as well as them working in the public system.*[322]

[321] Transcript of Evidence, 21 October 2024, Homebirth Australia, p. 40.
[322] Transcript of Evidence, 23 October 2024, Australian College of Midwives, pp. 80 – 81.

5.38. In her submission, PPM Ms Smith lent on her experience working in maternity care in Launceston for many years and shared her clinical perspective of accessing homebirth:

> *I've been the only PPM offering privately [sic] midwifery care to women in Launceston and surrounds for several years. I am constantly inundated with women wanting to engage in my services. I currently have over 50 women on a wait list hoping for private midwifery care.*[323]

5.39. Claire Holloway, a lived experience witness based in the North shared her positive experience of labour at the Launceston Birth Centre. She explained the factors leading to her decision to seek a homebirth and the stories she had heard in the community from those who had not been able to access homebirth or PPMs:

> *I lived in Trevallyn for 3.5 years (2018 - 2022) and was extremely privileged and fortunate to birth my second child at the Launceston Birth Centre with a Privately Practising Midwife.*
>
> *The reason I chose this birth option was due to PTSD experienced at the Launceston hospital from my husband having a severe acute illness treated there prior to my pregnancy.*
>
> *I knew many other women who were pregnant whilst I was who missed out on the opportunity to be able to access a private midwife due to this service being so unavailable in the Northwest of Tasmania and also due to the costs involved. Two of these women went on to have unassisted free births for this reason.*[324]

5.40. The Committee received evidence from multiple submissions and hearings about current work to establish a Hobart birth house. Ms Grant representing Birth in Tasmania, told the Committee:

> ***Ms GRANT** - … the birth house project that Rashelle's [Szoke] trying to get up and running in Hobart, which is similar to the Launceston birth house… It's a project that's been on the agenda for a couple of years and she's working towards that. That would be a great option too. That's an independent service where healthcare practitioners, whether it's midwives, obstetricians, other allied health service providers can use the space to provide care to women. Women can effectively hire a room within that space to birth their baby. It's a middle ground between having a homebirth - a private homebirth at home, or a hospital birth, but still have access to transferring to a hospital if a greater level of care is needed during that birth. There are lots of good options out there that we can look at funding and expanding.*[325]

[323] Submission No. 109, Jaimee Smith, p. 1.
[324] Submission No. 76, Claire Holloway, p. 1.
[325] Transcript of Evidence, 20 February 2025, Birth in Tasmania, p. 74.

5.41. The then Minister for Health, the Hon. Jacquie *Petrusma* MP, was also asked about this work regarding a Hobart birth house, noting that contact had been made between her office and the proponents in early 2025:

> ***Mrs PETRUSMA*** *- I want to provide an update to one of my answers. An email was received from the Hobart Birth House on the 24 February [2025]. My hardworking office met with them on 13 March 2025 and they had been busily seeking further advice from the department regarding the matters raised.*[326]

5.42. The Committee also heard from Victorian PPM and founder of Mothers & Midwives Australia (MAMA), Ms Langford. MAMA is a provider of homebirth services, as well as antenatal and postnatal care. Ms Langford discussed the cost and demand of their private service:

> ***Ms DOW*** *- … What is the cost to utilise a service like yours?...*
>
> ***Ms LANGFORD*** *- Yes, it varies based on practitioner and service but for our homebirth client, anywhere from $5000 to $12,000 out of pocket. There are some Medicare rebates available or we mentioned private healthcare rebates available. That's an area that is really limiting and makes it not accessible to everybody.*
>
> ***Ms DOW*** *- How many women and families would you have on your caseload at a given time?*
>
> ***Ms LANGFORD*** *- We've fairly consistently since 2014 had 200 births per year. So yes, that's where we've sat, and we have 10 midwives now that are providing that care. Some of our midwives have smaller caseloads than others, work part time and full time and that's a new model of care that we've instigated in the last two years because burnout in the private midwifery space is, as you can imagine, fairly hefty and midwives find working seven days a week on call not sustainable.*
>
> *We actually have an employed private midwifery practice model where the midwives work whatever EFT that they are able to.*[327]

5.43. Ms Anita *Dow* MP requested further information from Ms Langford regarding the services offered at MAMA:

> ***Ms DOW*** *- I have had a look at the service that you provide and obviously it extends postpartum as well. You provide breastfeeding support. I invite you to put any comments around the importance of that extended midwifery service and support after the birth of a child, as well as for the mother and baby…*
>
> ***Ms LANGFORD*** *- Thank you. Yes, I think that's part of the beauty of the private midwifery model in that we do get to see our true scope of practice from early pregnancy. We get people calling us up as soon as they wee on a stick and have two lines, and we can take them right through all of their maternity care. Then, through to that six or seven week postnatal period, we are very closely connected to our clients in that period because such big things are changing and we have breastfeeding support*

[326] Transcript of Evidence, 26 March 2025, Department of Health and Hon. Jacquie Petrusma, p. 22.
[327] Transcript of Evidence, 23 October 2024, Mothers & Midwives Australia, p. 44.

services integrated into our care as well. All the midwives provide breastfeeding support, but we have a lactation team as well that comes in and has free breastfeeding drop-ins a couple of times a week. Also, if the ability to support the client is out of the midwife's scope and we need lactation consultants, we've got them there as well.

Our breastfeeding rates are close to 100 per cent because in those first few days, particularly that first couple of weeks, we're seeing our clients most days. As things are changing with breastfeeding and postpartum healing, we're really seeing them a lot. Thank you for pointing that out, that is key in that transition for the parents.[328]

5.44. Ms Langford was asked about accessing publicly funded homebirth in comparison to private homebirth in Victoria:

***Ms LANGFORD** - … There is certain criteria that are inclusion and exclusion criteria at the start of pregnancy. But, officially, no one is accepted into the [public] homebirth program until they've had - well, they're accepted in, but they're not confirmed that they will be able to birth at home until they've had a 36-week obstetric visit. So it's quite a long journey for those people going through the publicly funded homebirth programs to have that confirmation at the 36-week visit. We quite often have clients coming to us at that point saying 'I thought I was in, but I'm out. What can I do now?'...*

So there's certain criteria that definitely risks people out of the public homebirth programs, but the criteria that don't allow much wiggle room for practitioners to look at the individual case and figure out if this individual is safe to have a homebirth rather than a criteria that just risks a population out.[329]

5.45. Ms Langford discussed the benefits of publicly funded homebirth, while noting that improvements can continue to be made:

***CHAIR** -... I wondered if you can share with us a little bit about how publicly funded homebirth works in Victoria, so that we can learn a little bit about what Tasmanian women are missing out on by not having those publicly funded services here.*

***Ms LANGFORD** - Yes, it's incredible having publicly funded homebirth programs because there's such a large portion of the population where having a homebirth is a safer place for them to birth. We know that from evidence. So having the hospital offering this just, you know, brings it into the public eye and people can actually view it as a safe option. If the hospital is offering it, it must be a safe option. So it's wonderful in terms of cost savings for the public healthcare system because it is a much better, more cost effective model of care, but also for the women going or women and birthing people going through those services. It's free, compared to* the *private midwifery model, it's accessible, but also it's a very trauma informed, wonderful continuity model that has to exist for that home birthing service to exist. We have five hospitals currently providing public homebirth services.*

There are quite strict criteria on the publicly funded homebirth models, which I understand why it exists and that differentiates the public models from the private midwifery models. There's still work that can be done.[330]

[328] Transcript of Evidence, 23 October 2024, Mothers & Midwives Australia, p. 46.
[329] Transcript of Evidence, 23 October 2024, Mothers & Midwives Australia, p. 43.
[330] Transcript of Evidence, 23 October 2024, Mothers & Midwives Australia, pp. 42 – 43.

Birth on country

5.46. The Tasmanian Aboriginal Centre (TAC) told the Committee about the importance of birthing on country programs. The Chair asked TAC CEO, Ms Foster about co – designing birthing on country programs in public and private settings:

> ***CHAIR*** *- … You talked about co-design in your opening statement and submission and also the need to consider a First Nations' birthing on country program. Are you able to share a bit more information about what both of those things would look like?...*
>
> ***Ms FOSTER*** *- When I say birthing on country, I don't mean going and birthing a baby under a tree, because that's what people immediately think. It's about having the opportunity to say, 'I would like to have my baby at home', or 'I would like to have my baby in this place'; 'I don't want to be in a hospital system because that's where sick people go. I'm not sick. I want to celebrate this birth and I want to celebrate it with the people who are around me'.*
>
> *I think in relation to that is co-designing, without the four walls of what that should look like in today's society, about what that co-designed approach could be and how we share the opportunities of having babies, where babies are celebrated and everything's as natural as it possibly can be without a whole lot of interventions that often mums don't have choices about: we're watching the clock, we've got to get this baby out. Those are some of the really hard things for our families and that continued trauma that brings around for that family every time they have to go into an institution, the hospital setting.*
>
> *There's that real ability with the co-design work. NACCHO, the National Aboriginal Community Control Health Organisation, national body, has an expert panel which I sit on designing what a maternal and child health program could look like for Aboriginal people...*[331]

5.47. The Committee continued to discuss access to homebirth for Tasmanian Aboriginal women with the TAC:

> ***CHAIR*** *- … Do you know whether many Tasmanian Aboriginal women are accessing homebirths at the moment?*
>
> ***Ms FOSTER*** *- No.*
>
> *…*
>
> *I would say zero to my knowledge. It's an expensive thing to do as well, but no, it's never been a real option for our community. It's hard enough to get accessible midwifery services for our community who don't have to leave their place of home, like if you live in Launceston/Kanamaluka or Kutalayna at Bridgewater, you have to go out of your suburbs to actually access…* [332]

[331] Transcript of Evidence, 21 October 2024, Tasmanian Aboriginal Centre, p. 4.
[332] Transcript of Evidence, 21 October 2024, Tasmanian Aboriginal Centre, pp. 4 - 5.

Professional Indemnity Insurance (PII)

5.48. The Committee's Terms of Reference included consideration of PII for PPMs. While the insurance model is in the remit of the Federal Government, the Tasmanian experience is relevant in a national context.

5.49. Current insurance available to PPMs covers antenatal and postnatal care, but not intrapartum (birth) care. The Federal Government is currently investigating a new insurance product that would also cover labour and birth for PPMs. Until this product is available, PPMs are able to provide intrapartum care under a Federal Government exemption.[333]

5.50. Ms Smith's submission details what role PII plays in the work of PPMs and the current state of insurance in Australia:

> *Midwives in Australia are able to practice in any context provided they have Professional Indemnity Insurance (PII). To date, there is no [intrapartum care] PII product available to PPMs in Australia so we have been given an exemption that allows us to offer homebirth without insurance provided we meet the exemption requirements.*
>
> *Earlier this year the [Federal] government announced that this exemption would not be extended beyond 30 June 2025 and that they would introduce a PII insurance product for PPMs. Whilst this may have been announced with good intentions, the proposed product is not fit for purpose and is unacceptable to PPMs and women alike. The proposed product is a risk-based product, and only allows PPMs to care for low-risk women.*[334]

5.51. Better Births in Illawarra discussed the debate around the model of PII being proposed at the time, noting potential impacts of the proposed risk criteria for care by PPMs:

> *The Federal Labor Government has made proposed changes to Professional Indemnity Insurance for PPMs. Whilst it is positive to see more investment by the Federal Government in maternity services and midwifery services, the commitment to cover 100% of claim costs for PPMs providing "low risk" homebirth and intrapartum care outside of the hospital (the proposed changes) is flawed.*
>
> *The proposed changes which will only provide cover for a PPM to support "low risk" women will result in many women in Australia (who do not fall neatly in the low-risk category) such as women over 40 years, IVF pregnancies, women with a 35 + BMI etc will being denied the option to birth safely at home with a PPM. It is highly concerning that the ACM's National Midwifery Guidelines for Consultation and Referral are being used entirely out of context to develop an insurance product and should not be used to determine a woman's ability to birth at home with the support of a PPM.*[335]

[333] Nursing and Midwifery Board, Australian Health Practitioner Regulation Agency, July 2025, 'Fact Sheet: Professional indemnity insurance arrangements,' https://www.nursingmidwiferyboard.gov.au/codes-guidelines-statements/faq/fact-sheet-pii.aspx.
[334] Submission No. 109, Jamiee Smith, p. 1.
[335] Submission No. 120, Better Births Illawarra, p. 120.

5.52. Representatives from Homebirth Australia discussed the risk criteria of the proposed PII scheme:

> ***Ms BEGNELL*** *- Our understanding is the Federal Government did a consultation process in August and is still going through all the submissions from that process. The insurer they are working with, we've been told there will be a product coming out and they'll be making an announcement in the next couple of weeks. This extension is to allow families who are - or women who are pregnant now to make appropriate plans for their birth because women who are pregnant now will be due in June/July next year, which is when the previous exemption was meant to expire.*
>
> *The way things work now that Anna alluded to in her introduction is that the Australian College of Midwives has guidelines for referral and consultation, which lists numerous risk factors a woman can develop in pregnancy, during birth or immediately after birth. They are labelled as category A, B or C depending on the severity of the condition. These guidelines are used by homebirth midwives currently as a guide to collaborate with other health professionals, as Anna mentioned as well. If a woman does have a complication, the midwife will offer a referral to the woman and she has the right to decline that consultation. Then they document that in a record of understanding which protects the midwife should anything happen to the woman as a result of this complication she chose not to seek third party referral for.*
>
> *What this new proposal for insurance by the Federal Government leaves out is that whole process. They have stated that women with category A conditions will be considered low risk. Some category B, but as I said before, that's really only 25 per cent of the women who currently seek a homebirth. Anna mentioned many of her previous clients have what are considered category B or C conditions. Most midwives we surveyed said that the majority of their client base were considered category B or C. They are already facilitating care for these women safely in the home and, if a transfer to hospital is required, they have pathways to do that.*
>
> *If third-party advice is required during the pregnancy, they have pathways but the woman has choice - always - to decline or accept these referrals. That is the one thing really left out in this Federal Government proposal, because they have explicitly said that category C women will be encouraged to birth in hospital and category B women will have to have a referral with a third-party, there is no choice in there anymore.*
>
> ***CHAIR*** *- … if the current proposal went ahead and a category B woman or a category A woman whose risk status might change during her pregnancy or labour did not take up that referral, what would that then mean for her rights to birth at home and what would it mean for the PPM and their insurance status or their safety as a worker?*
>
> ***Ms BEGNELL -*** *This is one of the questions we have put to the Federal Government and do not yet have an answer for. However, with the information we have currently, that midwife would not legally be allowed to provide [a] woman care in the home which, of course, makes all sorts of problems from that point on because complications can arise during labour. An example would be if a woman declines ultrasounds throughout her pregnancy - as some do - and then the midwife finds out during labour, this woman's baby is breech. That is a category C condition that she would not be covered for to buy insurance, to provide care to that woman in the home. What would happen in that scenario? This is one of the things we have asked the government. These things do come up more commonly during pregnancy. Again, we would hate to see a situation where*

midwives are put in a position where they need to drop a client at 38 weeks because their baby has turned breech when that could be safely managed at home as they do now and many other examples.

***CHAIR** - … For the states and territories that provide publicly available homebirth, are those health professionals covered through insurance provided by their regular work in the state health system?*

***Ms FOLKERTS -** It is the hospital insurance.*[336]

5.53. The Committee heard that any new PII product should cover the provision of a range of birthing options for parents and families. Lived experience witnesses to the inquiry told the Committee they felt PII is an essential insurance product, to allow midwives to provide their services. Private Witness 36 shared the following:

If private midwives were to have adequate professional indemnity insurance, we may have more midwives wishing to work privately in Tasmania. Not only would this be hugely beneficial for women and their reproductive choices, but it would also take pressure off the hospital system. It is important that any sort of insurance covers all women, and not just those deemed 'low risk'. I am currently pregnant with my third child, and if I cannot access private midwifery care, I will be forced to free birth.[337]

5.54. Ms Smith defined the risk criteria proposed in the Federal Government's draft PII model.

***CHAIR** - … one of the concerns that we've heard from other privately practicing midwives is that the insurance product that was recommended or suggested, … was a risk-based formula. It was explained to us that that's not fit for purpose because that risk category could change throughout a woman's pregnancy, even throughout labour.*

Can you just talk us through why that wouldn't work…

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

5.55. Ms Smith then provided the Committee with a case study from the Launceston Birth Centre to illustrate potential limitations of the proposed PII model:

They were saying the insurance product would only cover low risk category A women and therefore no one else would be eligible for private midwifery care. I know private midwives from all around Australia, I mentor a lot of midwives and I contacted them. A lot of them sent their statistics in to me, because I thought how many of our women

[336] Transcript of Evidence, 21 October 2024, Homebirth Australia, pp. 37 - 38.
[337] Submission No. 36, Private Witness, p. 1.

are only category A? It was less than 15 per cent. That would put us all out of business. We could not run our practices with only 15 per cent of our current load.

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

At 28 weeks she developed iron deficiency anaemia, which is a common thing to happen in pregnancy. Babies start to suck up all that iron from the mum and she was symptomatic with that. That's also a Category B/C. She also developed thrombocytopenia, which is an issue with her platelets that some women just have happen in pregnancy and her platelets were dropping. The way I manage those things to date, I sent her to see a haematologist to give her an iron infusion or excess and she ended up having an iron infusion and to monitor her thrombocytopenia.
I booked her in for a tertiary ultrasound at Women's Imaging in Hobart because we don't have tertiary scans in Launceston and often placentas move away from the cervix, so we did that. At 30 weeks, her baby was sideways so babies can't be born sideways except via caesarean and she had an irritable uterus where she looked like she was going into premature labour from 30 weeks.

At 32 weeks, she developed gestational diabetes –

…

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

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

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

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

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

***CHAIR** - From 20 weeks?*

***Ms SMITH -** Yes, from right back then.*

***CHAIR** - You would not have been able to continue to have her in your care…*

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

That is an example of the risk categories and how they should be utilised and why, as private midwives, we do not want to be limited to risk-based care, we want to be able to offer woman-centred care – when women do not get traumatised by having things imposed on them that they have not wanted or even necessarily needed.[338]

5.56. Ms Smith also discussed the impact the ongoing insurance debate was having on midwives considering private practice. She explained the issue of PPMs not having admitting rights at Tasmanian hospitals, and her relationship with the Launceston General Hospital:

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

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

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

[338] Transcript of Evidence, 19 February 2025, Jaimee Smith, pp. 4 - 6.

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

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

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

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

Usually that's well respected here in Launceston. I'm really grateful for that because I know it's actually unusual. I think this is the best place in all of Australia to work as a private midwife. We have a beautiful house across the road from the hospital that women can birth in if they want, rather than at home or if they're too far away, and a really receptive hospital if we need them.[339]

5.57. The ACM also raised concerns surrounding the complicated process of finding an appropriate PII solution, noting that communication with practitioners should ensure the product is a best practice model and fit for purpose:

> ***Ms WEATHERSTONE*** *- We understand that the exemption will be extended to the end of December 2026 while this insurance solution is finalised. We do understand that this is a final extension. Obviously, we do know that the removal of collaborative arrangements comes into effect from 1 November also. We are fairly confident as a college that the consultation is in train and that our number one thing would be communication for midwives because it's really important that all midwives, whether they're working in private practice or not, understand what's happening in terms of*

[339] Transcript of Evidence, 19 February 2025, Jaimee Smith, pp. 6 -7.

communications for this professional indemnity insurance because that also translates to communication for consumers as well.

…..

***Ms WILKINSON** - It is about not defining risk as solely related to medical or physical risk. Sometimes even women with higher risk in an obstetric sense, pregnancies, home can be the safest place for them and that we know that sometimes past trauma or birth trauma can lead people to that choice. We're not wanting to restrict those clients from that option or drive people into freebirth or unsafe situations.*

***Ms SHAKES -** That is one of the genuine risks of an unsuitable or not fit-for-purpose insurance product is that people will opt out and we will have to respect that's their right to make that choice, but it would be a shame to see freebirth rates on the rise for this reason.*

***Ms WEATHERSTONE** - In terms of advocacy from Tasmania, it would be really great to ensure there is ongoing communication because as you mentioned, unintended consequences are what we want to avoid. By having subject matter experts at the table, we are able to arrive at that decision appropriately from the outset.*[340]

5.58. Hygieia Health Ltd explained that the possible restrictions proposed in the current draft PII may cause unintentional harm to birthing practices, midwives and healthcare consumers:

Our concern is that these changes will ultimately undermine women's reproductive rights and lead to unintended, potentially harmful outcomes, increasing birth trauma as a result. The specific risks include:

• Restricting women's bodily autonomy and freedom of choice in how they birth;

• Limiting access to safe, supported homebirths, potentially forcing more women into clinical settings that increase the risk of unnecessary interventions and trauma;

• Driving more women towards freebirths without the presence of trained and registered midwives.

Additionally, the changes may inadvertently be discriminatory, particularly against women based on race, disability, sexual orientation, or age. [341]

5.59. In regard to the draft PII model, Hygeia Health Ltd proposed the Federal Government consider the following matters:

To ensure the safety, empowerment, and well-being of birthing women and to prevent birth trauma Hygieia Health calls on the government to:

- *Engage in a comprehensive public consultation process, centring the voices and needs of women who will be directly affected by these proposed changes, particularly those who have experience [sic] birth trauma.*

[340] Transcript of Evidence, 23 October 2024, Australian College of Midwives, pp. 83 – 84.
[341] Submission No. 73, Hygieia Health Ltd, p. 2.

- *Ensure any changes promote and protect:*
    a. *Women's reproductive rights, bodily autonomy, and the freedom to make informed decisions regarding their birth;*
    b. *Access to safe homebirth options with PPMs for all women, regardless of race, age, sexual orientation, or disability;*
    c. *Reduced risk of birth trauma by supporting women to make empowered, trauma – informed decisions about their birthing experiences.*[342]

Provision of care by midwives

5.60. In addition to PII, PPMs also face difficulties providing care in Tasmania due to other obstacles including prescribing rights and admitting rights to hospitals.

5.61. Ms Shakes, a representative of the ACM, noted:

> **Ms SHAKES** - *...*
>
> *Endorse midwives' work in both public and private settings. This endorsement qualifies midwives to prescribe medications, pathology, and diagnostics within their scope of practice. In Tasmania this is currently limited in both the public sector and by the Poisons (Midwifery Substances) Order 2011, which details a limited medications formulary. Tasmania is now the only state that retains a formulary for midwives. An example of a known barrier is the inability of midwives in Tasmania to be able to prescribe the MS-2 step for early termination of pregnancy.*
>
> *Endorsed private practice midwives do not have visiting rights access in any Tasmanian hospitals. This limitation means that women and families employing a privately practicing midwife do not benefit from continuity of care during labour, the cost savings associated with Medicare rebates when care is provided in the hospital, and women may be restricted in their choice of birthplace and care provider.*[343]

5.62. While PPMs currently provide care to their patients outside of the hospital system, if a homebirth requires a transfer to a hospital, the practising PPM is generally unable to lead the midwifery care of their patient in hospital.

5.63. Ms Folkerts explained the current situation and how if PPMs had admitting rights, they would be able to provide better support to their patients:

> ***Ms FOLKERTS*** *- Currently, with no admitting rights, the private midwife gives a handover to hospital staff and then is required to step back into the position of a support person, not being permitted to advocate for her client or give any midwifery care. In this situation, the birthing woman can feel abandoned. Women reflect later that they lost their agency in a system that seeks actively to manage all labours and births...*[344]

[342] Submission No. 73, Hygieia Health Ltd, p. 3.
[343] Transcript of Evidence, 23 October 2024, Australian College of Midwives, p. 74.
[344] Transcript of Evidence, 21 October 2024, Homebirth Australia, p. 36.

5.64. Ms Begnell representing Homebirth Australia discussed the connection between limited homebirth provision in Tasmania and the lack of admitting rights:

> ***Ms BEGNELL -*** *Tasmanian women and midwives are unfairly disadvantaged with the lack of publicly funded homebirth programs. Women who choose homebirth also deserve access to safe and respectful hospital care if it's wanted or needed. PPMs provide gold standard continuity of care to women and their babies. Admitting rights with public hospitals enable them to continue providing care within a hospital setting should the woman require a transfer during pregnancy, birth, or shortly after.*[345]

5.65. Ms Folkerts discussed the work which has previously been undertaken with the DoH to establish public admitting rights for PPMs in the THS:

> ***Ms FOLKERTS*** *- During my last six years in private practice, I spent countless hours as a volunteer on a committee at RHH to establish admitting rights for private midwives. That body of work was concluded in 2018 with a robust agreement from private midwives, the Royal Hobart Hospital's midwifery and obstetrics staff, the whole thing was agreed upon. It proceeded to Crown Law in December 2018 but has not yet come to pass.*[346]
>
> *…*
>
> ***Mrs PETRUSMA***[347] *- Have you ever been told why the admitting rights you submitted in 2018 is still with Crown Law?*
>
> ***Ms FOLKERTS -*** *It may have passed through Crown Law, it might be back in the Royal. One of our colleagues is communicating with somebody at the Royal about it. I spoke to her the other day and she just says she keeps being told it is close, but it was close six years ago.*
>
> ***Mrs PETRUSMA*** *- Yes, that is what I am trying to understand.*
>
> ***Ms FOLKERTS -*** *There was a woman who did the project. She put in an enormous amount of work on it and it was a really robust agreement. We all got together. We had obstetricians, midwives and private midwives around a table, agreeing. It was very special and it has been sitting there.*[348]

5.66. Becky French, Nursing Midwifery Director for Women's and Children's Services at the RHH, provided an update to the Committee regarding an operational arrangement the RHH has with PPMs:

> ***Ms FRENCH*** *- At the RHH, we have made a pathway around the admitting rights for the privately practising midwives. We've moved forward with that as a flow for them to be comfortable and actually bringing their women in to be cared for in the hospital. But as per, I guess, the birth house model, we're aware of it within the Hospital. There hasn't actually been any conversation with us around that shared moment.*[349]

[345] Transcript of Evidence, 21 October 2024, Homebirth Australia, p. 33.
[346] Transcript of Evidence, 21 October 2024, Homebirth Australia, p. 34.
[347] At the time of this hearing in October 2024, the Hon. Jacquie Petrusma MP was a Member of the Committee.
[348] Transcript of Evidence, 21 October 2024, Homebirth Australia, pp. 38 – 39.
[349] Transcript of Evidence, 26 March 2025, Department of Health and Hon. Jacquie Petrusma MP, pp. 15.

5.67. Ms Langford from MAMA in Victoria described negotiations for admitting rights in a Victorian hospital. She detailed several difficulties which prevented MAMA PPMs from practicing in some hospitals. It was noted that fees charged by hospitals differed, with higher fees making it less financially viable for PPMs to access admitting rights. Further, lack of permission for PPMs to visit their patients in the home during early labour and hospital policies and procedures also made hospital credentialing unviable.[350] Without admitting rights, PPMs who transfer a patient to a hospital can only fulfil a support role throughout the birth:

> *……. When we step into the hospital at the moment, we are there as, we become support people, so we're not officially recognised as midwives, which means that it's hard from a moral perspective as well that we walk in and then suddenly we're not health professionals any more...*[351]

5.68. Another limitation on the scope of practice of PPMs in Tasmania is the medication formulary. Tasmania is the only Australian jurisdiction which continues to have a formulary which limits medications PPMs can prescribe. Ms Smith, a Tasmanian PPM provided the Committee with evidence regarding this matter:

> *Private midwives offer Medicare rebates and can prescribe medications relevant to a woman's needs. Unfortunately in Tasmania, PPMs are limited by a Prescription formulary and can only prescribe from that short list. We are the last State / Territory to limit PPMs to a formulary. All other States / Territories have abolished the formulary and recognise the PPMs competence to prescribe whatever is within their scope to meet the woman's needs. I would urge you to bring Tasmanian PPMs in line with the rest of Australia and enable us to do the same by abolishing our formulary as well.*[352]

Findings

The Committee finds:

48. Currently available services do not meet the demand for homebirth in Tasmania.

49. There is strong evidence that, in the majority of cases, homebirths are a safe option and provide a positive birth experience.

50. Tasmania is the only state or territory in Australia that does not fund homebirth in the public system.

51. Some other states and territories in Australia provide co-located homebirthing centres.

52. The Department of Health is investigating publicly funded homebirth in the Tasmanian Health Service.

[350] Transcript of Evidence, 23 October 2024, Mothers & Midwives Australia, pp. 41 – 42.
[351] Transcript of Evidence, 23 October 2024, Mothers & Midwives Australia, pp. 41 – 42.
[352] Submission No. 109, Jaimee Smith, p. 1.

53. There is limited availability in Tasmania of private homebirth through the care of Privately Practising Midwives (PPMs). Access is limited due to their small number, locations and the cost of services.

54. The Launceston Birth Centre is the only privately operating birth centre in Tasmania and often has long waitlists.

55. Long term advocacy for a Hobart birth centre continues, including discussions with the Government.

56. Publicly funded homebirth increases accessibility for anyone unable to afford the cost of private homebirth.

57. Few Tasmanian Aboriginal women currently access homebirth.

58. Privately Practising Midwives (PPMs) in Tasmania do not have permanent admitting rights in hospitals.

59. Tasmanian Midwives operate under a limited medication formulary, provided in the *Poisons Act 1971*. Tasmania is the only state to continue use of a legislated formulary for midwives. Previous consultation and planning undertaken to change this has stalled.

60. Negotiations for Professional Indemnity Insurance for Privately Practising Midwives (PPMs) resulted in uncertainty for midwives and patients.

61. The Federal Government's proposal for Professional Indemnity Insurance (PII) for Privately Practising Midwives (PPMs) at the time the Committee received evidence was not fit for purpose. It would have limited the scope of practice of, and access to, Privately Practising Midwives (PPMs).

Recommendations

The Committee recommends the Government:

27. Fully fund and support public homebirth in Tasmania.

28. Investigate the establishment of public birth centres co-located with public hospitals in Tasmania and continue conversations with proponents of The Birth House in Hobart.

29. Investigate the need for and provide travel assistance to facilitate public homebirth.

30. Develop policies and procedures for admitting rights for Privately Practising Midwives (PPMs) in all public hospitals.

31. Reestablish consultation on the medication formulary for midwives with a view to removing the formulary from the *Poisons Act 1971* in line with other states.

32. **Advocate to the Federal Government to ensure the Professional Indemnity Insurance (PII) scheme is fit for purpose and does not restrict private midwifery practise.**

6. EXPERIENCES WITH BIRTH TRAUMA

6.1. A significant quantity of the evidence received by the Committee related to birth or post birth experiences, including many of a traumatic nature. This significant evidence was heard from personal lived experience witnesses, as well as from medical professionals, individuals and organisations. The Committee received a significant number of recommendations to address and reduce birth trauma and provide better support when it does occur.

6.2. The Committee again wishes to sincerely thank people who shared their deeply personal stories with us, including experiences of birth trauma. The submissions and participation at public hearings have been critical in informing the Committee's recommendations.

6.3. This Chapter will discuss this evidence. The Committee recognises this includes highly sensitive matters and themes that have deeply impacted the lives of Tasmanians and may be distressing for some people. Readers are encouraged to exercise self-care when reading the Report and any matters it may raise and seek any support if required. Details for available support services are available on page 9 of the Report and on the Committee webpage.

6.4. This Chapter will discuss the nature of birth trauma, detail lived experiences of Tasmanians and focus on factors contributing to birth trauma. This includes risk, intervention, legal considerations, healthcare provider education and informed consent. The matters raised in this Chapter should be read in conjunction with Chapter 4 on access to maternal healthcare in Tasmania, with the issues raised in both Chapters intersecting.

Defining birth trauma in the Tasmanian context

6.5. Witnesses described birth trauma in many different ways. While the understandings and experiences were broad and varied, there were common elements raised.

6.6. Birth trauma can include physical as well as psychological injuries that can occur at any point during pregnancy, labour and the perinatal period.

6.7. In their submission the DoH offered a defined physical birth trauma to have occurred only if there has been a third- or fourth-degree perineal tear.

> *For physical birth trauma, which is clinically defined as a third- or fourth-degree perineal tear, women are reviewed by an Obstetric and Gynaecology Team after birth and prior to discharge. A further review occurs between weeks one to six post-partum and thereafter as required. A management plan is also developed for subsequent births during review.*
>
> *Third- and fourth-degree perineal lacerations cause persistent and distressing physical and psychological symptoms, including perineal pain, sexual and urinary problems,*

faecal urgency and incontinence of both flatus and stool.[353] If these injuries are not recognised and repaired promptly, they can have serious longterm consequences for women's lives. DoH is working to reduce the impact and occurrence of these injuries, seen as Hospital Acquired Complications under national standards, to improve the adequacy and safety of patient care.[354]

6.8. The Australian Physiotherapy Association (APA) defines physical birth trauma as:

…, in many cases, preventable, although it often remains undiagnosed, untreated, or in too many cases, both.

Physical birth-related trauma can include:

- *Perineal tears and episiotomy (a surgical cut made to the perineum, which is the tissue between the vagina and the anus to expand the vaginal opening during birth).*
- *Urinary or faecal incontinence.*
- *Muscle damage to the pelvic floor. The muscles and ligaments in the pelvic floor help to keep the bladder, uterus, and the bowel in position. During birth trauma, the pelvic floor can sustain microtrauma, also called a 'levator avulsion'.*
- *Pelvic organ prolapse (if pelvic muscles are damaged or become weak, the organs inside the pelvis can drop down towards the vagina).*
- *Bone injuries to the pelvis including coccyx fractures, dislocations, or pubic bone (separation or fractures).*
- *Problems emptying the bowel.*
- *Nerve damage (caused if nerves in the perineal area are stretched during childbirth).*
- *Pain or problems engaging in vaginal sex.*
- *Persistent pain in the lower back.*
- *Problems with lifting and even standing caused by a 'dragging' feeling in pelvic region, sometimes described as feeling that 'something is 'falling out'.*
- *Headaches, dizziness and gastro-intestinal issues not diagnosed as another medical conditions [sic].*

These effects can severely limit a mother's ability to:

- *Bond and develop a strong relationship with her baby, increasing the risk of poor maternal and child mental health*

[353] Footnote 40, Australian Commission On Safety And Quality In Health Care, Hospital-Acquired Complications Fact Sheet, https://www.safetyandquality.gov.au/sites/default/files/migrated/Short-Hospital-Acquired-Complications-Factsheets-all-HACs.pdf. 41 Australian Commission On Safety And Quality In Health Care, Hospital Acquired Complications Fact Sheet., from Submission No. 129, Department of Health, p. 33.

[354] Footnote 41, Australian Commission On Safety And Quality In Health Care, Hospital Acquired Complications Fact Sheet., from Submission No. 129, Department of Health, p. 33.

- *Work – impacting on workforce participation and productivity.*
- *Exercise – reducing overall health and wellbeing.*
- *Undertake domestic chores, which places additional burden on families.*
- *Enjoy sexual relations, which places pressure on relationships.*
- *Socialise and participate in community activities, affecting mental health.*
- *Make basic choices, such as what clothing to wear.*
- *There are, however, health interventions that can decrease the risk of birth trauma. These treatments and supports must be funded so that all women in Tasmania have access to the best birthing care.*[355]

6.9. Emma Green, representing the APA, discussed the limitations of the DoH definition, including the time at which a patient may come to understand their experience of physical birth trauma:

> ***CHAIR*** *- … In the information that we've received so far from the Department of Health … They define physical birth trauma simply as, 'a third or fourth degree perineal tear'. I wondered, from your professional experience ... If you can just talk us through what you think the Committee would benefit from hearing around how we might arrive at a suitable definition of physical birth trauma.*
>
> ***Ms GREEN*** *- Certainly a third- or fourth-degree tear, or obstetric anal sphincter injury is it's other word, is a type of birth trauma. But people can have a third- or fourth-degree tear and have no symptoms and get on with their lives. People can have a first- or second-degree tear and be really disabled. So, I guess the things that we see are a lot of are urinary incontinence, when people are leaking from the bladder; faecal incontinence; pelvic organ prolapse, where people feel a sense of dragging or heaviness or bulging around the vagina.*
>
> *Pain is another big one that we see. Either perineal pain, people might find they can't wear skinny jeans or tight undies anymore because there's something rubbing against their perineum, or they might have pain around their coccyx. Some people can fracture their coccyx even, giving birth, which is certainly a type of physical birth trauma. Pubic symphysis dysfunction, so at the front of the pelvis where the bones join together, that can become separated or the ligaments can become damaged, either during pregnancy or during childbirth. Pain with sexual intercourse is another big one that we see as well.*
>
> *There's certainly more to it than just third- or fourth-degree tears. That's the easiest one to capture within the statistics because you know at the time of birth if somebody has had that.*
>
> ***CHAIR*** *- The others might take longer to present.*
>
> ***Ms GREEN*** *- Yes, exactly right. Even today in my work, I saw two women who were two years postpartum and had only just started having issues in the last couple of months. Sometimes these things take months, years, or even around the time of menopause or post-menopause to present. We know that there are certain risk factors associated with birth, like if women are pushing for a long time, that is associated with risk of prolapse or levator avulsion, where some of the pelvic floor muscles come away from the bone. Certain positions that people birth in can create risk as well.*

[355] Submission No. 133, Australian Physiotherapy Association, p. 5.

The thing for us as physiotherapists that we can offer is that we know that doing pelvic floor exercise that's supervised and intense during pregnancy can reduce the pushing phase of labour, so we can reduce the risk of the sequelae. The other thing is perineal massage, which is the technique that we can teach women in the later phase of their pregnancy. That reduces the risk of third- and fourth-degree tears and reduces the pushing phase of labour as well.[356]

6.10. The submission from the DoH provided data on the prevalence of third- and/or fourth degree tears, as a form of physical birth trauma, in Tasmania:

In 2022-23, the rate of third- and/or fourth-degree perineal lacerations per 10 000 delivery was 449.0 at the LGH, 383.3 at the RHH, and 303.5 at the NWRH. The AIHW reports that the prevalence of third- and fourth-degree tears in vaginal births for the period 2013-2021 was approximately 2.9 per cent on average in Tasmania, similar to the Australian average during the same period (at 3 per cent).[357]

6.11. The DoH submission discussed the provision of care for individuals managing psychological trauma:

It is important that the management of psychological birth trauma is specific to the individual needs of each woman. While one woman may find the clinically normal delivery of a healthy infant causes her trauma, another woman with a clinically difficult birth and poor outcome may not report experiencing psychological trauma.

For women accessing THS Maternity Services, maternity care plans used for women post-birth include a 'birth debrief' to ensure all women are given an opportunity to discuss their birth prior to discharge. This may be undertaken as an individual discussion with the mother, or a family consult with a support person included.

Women who indicate psychological trauma directly after birth are referred with consent to the Obstetrics and Gynaecology team and the THS Social Work team. A collaborative multidisciplinary approach is taken, and a plan is made for the individual women, including if indicated and with consent an additional referral to PIMHS. The maternity team ensures supports are in place prior to discharge, and the Extended Care Midwifery (ECM) teams provide care and assessments as required in the home.

For subsequent pregnancies, awareness of any past psychological birth trauma is discussed in a multidisciplinary High Risk Pregnancy meeting and an individualised plan developed. Continuity of care is a priority for women in this situation.[358]

6.12. The individuality of a birth experience, including potential trauma, was also noted by Tresillian in their discussion of psychological birth trauma, including its correlation to the physical experience:

Psychologically there are multiple potential points of distress for parents throughout their pregnancy and parenting journey that includes traumatic grief associated with stillbirths and perinatal deaths.

[356] Transcript of Evidence, 20 February 2025, Australian Physiotherapy Association, pp. 103 - 104.
[357] Submission No. 129, Department of Health, p. 33.
[358] Submission No. 129, Department of Health, p. 34.

The birthing experience can be confronting and overwhelming, with parents experiencing new physical sensations, which are often intense, a requirement to allow others to assist them, and feelings of being out of control or uncertain. Research shows that certain elements of women's subjective experiences of pregnancy and birth are central to the experience of birth trauma.[359]

6.13. The Centre of Perinatal Excellence (COPE) provided an analysis of experiences of psychological birth trauma in Australia:

> *The level of intervention during childbirth and the perception of inadequate intrapartum care are associated with the development of acute trauma symptoms, with one in three women in an Australian cohort study reporting the presence of at least three trauma symptoms at 4-6 weeks postpartum (Creedy et al 2000). Physical birth injury also affects mental health - among a self-selected sample of women who experienced birth injury, 85.5% reported that their mental health was affected (Dawes et al 2022). Of the women with a self-reported mental health diagnosis, 40% experienced depression or anxiety and 30% post-traumatic stress disorder, with some respondents experiencing more than one condition. Another study suggested that post-traumatic stress disorder (PTSD) can result from a traumatic birth experience (1.2% of women met PTSD criteria at 4-6 weeks, 3.1% at 12 weeks and 3.1% at 24 weeks postpartum), though this is not the normative experience (Alcorn et al 2010). Both birthing and non-birthing parents may experience significant levels of psychological trauma following birth (Heyne et al 2022).*[360]

6.14. Evidence was also received regarding the correlation between physical and psychological birth trauma. Tresillian, a provider of perinatal mental health support across Australia described this connection as follows:

> *Birth trauma includes both physical and psychological elements in that:*
>
> - *a birth may be physically traumatic which results in sequelae that negatively impact on the woman's individual quality of life, relationships, sexual function and physical health which can then also lead to significant psychological challenges.*
> - *a birth may be physically uncomplicated, but be experienced as psychologically confronting, frightening and/or dangerous, and thus would be considered traumatic. Such births can lead to significant psychosocial disturbance and require attention.*
> - *for many women a birthing experience can be both physically profoundly compromising, and psychologically disturbing, leading to a complex interplay between physical and emotional aspects.*
>
> *Definitions encompass both the physical facts of birth but imply that there needs to be a component of psychological distress to reach the threshold of 'traumatic'. Greenfield acknowledges that a 'traumatic birth' is a 'complex concept' that involves "events and/or care that have caused deep distress or disturbance to the mother, and*

[359] Submission No. 5, Tresillian, p. 6.
[360] Submission No. 13 – Attachment A, Centre of Perinatal Excellence, p. 24.

the distress has outlived the immediate experience." (Greenfield, Jomeen and Glover, 2016).[361]

6.15. The Birth Experience Study (BESt) undertaken by Western Sydney University in 2021, said the feelings of individuals are relevant in the definition of birth trauma:

> *Birth trauma is the experience of feeling the perinatal journey (or parts of it) were traumatic from the women's [sic] point of view. The feelings of trauma can include fearing for their life or their baby's life, a loss of control, perineal trauma/pelvic floor damage, disrespectful care and obstetric violence.*[362]

6.16. Birth Trauma Australia, defines birth trauma more broadly, explaining it can be experienced by the whole family or support unit, not just birthing parents:

> *The ABTA defines "birth-related trauma" as including any injury or trauma, whether physical or psychological, sustained at any time in connection with all stages of the birth journey and can affect the mother, birthing parent, fathers or non-birthing parents*[363]*. Birth-related trauma can also impact maternity healthcare workers who attend, witness or are involved in birth experiences.*
>
> *Birth-related trauma is not isolated to the event of birth alone. Trauma can occur when trying to conceive, during pregnancy, during labour and birth, and in the period after the birth. For many women and birthing people we support, it is often more than one event in the journey to parenthood which we call 'the cascade of trauma'. Therefore, the ABTA uses the term birth-related trauma rather than birth trauma to recognise the complex and often compounding nature of traumatic events and experiences in the perinatal period, extending from conception to early parenthood.*
>
> *Birth-related trauma can be both psychological and/or physical. Psychological birth-related trauma may relate to a traumatic experience during pregnancy and/or birth and can impact women and birthing people, fathers, non-birthing parents, support people and maternity care providers. Impacts of psychological birth-related trauma can include post-traumatic stress disorder (PTSD) or symptoms of PTSD, postnatal depression and anxiety (PNDA) and suicidal ideation and suicide.*
>
> *…*
>
> *Physical birth-related trauma refers to birth injuries that women and birthing people may sustain as a result of pregnancy and/or birth. Examples of physical birth-related trauma can include vaginal and labial tears, anal sphincter tears (i.e. obstetric anal sphincter injuries (OASIS), irreparable pelvic floor damage (e.g. levator avulsion), bladder damage, infected wounds, musculoskeletal injuries or fractures such as coccyx fracture or dislocation, pubic bone stress fracture or pubic diastasis, and hysterectomy.*[364]

The Committee notes Submission 24, received by the first iteration of the Committee in early 2024 from the then Australasian Birth Trauma Association. On 8 February 2025, the organisation announced its name change to Birth Trauma

[361] Submission No. 5, Tresillian, p. 6.
[362] Submission No. 35, Western Sydney University School of Nursing and Midwifery, p. 8.
[363] Footnote 1, https://birthtrauma.org.au/our-story/, from Submission No. 24, Birth Trauma Australia, p. 9.
[364] Submission No. 24, Birth Trauma Australia, p. 9.

Australia.[365] For consistency and accuracy at the time of publication, Birth Trauma Australia will be used throughout this Report when the organisation is referenced.

6.17. Gidget Foundation Australia (Gidget Foundation) also spoke to the specificity of birth trauma for each individual, as opposed to an universalised experience that can fit neatly into any one definition:

> *There is no single criterion which defines a traumatic birth.*
>
> *Birth trauma emerges from an interaction between the individual, their care journey, and the complexities of their birthing experience. This makes the provision of accessible, trauma-informed care critical for every birthing parent, given the role of negative care provider interaction in the development of PTSD (Simpson & Catling, 2016).*[366]

6.18. Human Rights in Childbirth define birth trauma as an outcome of obstetric violence:

> *Birth trauma refers to the consequences of mistreatment and abuse* [367] [368]

6.19. Amy Dawes, founder of Birth Trauma Australia, discussed the cultural understanding of birth trauma in Australia, and the potential consequences of a lack of understanding of its prevalence and options for care:

> **Ms DAWES** - **…** *Throughout the history of medicine, there has been a flawed paradigm adopted by certain members of the medical community that women should just accept their fate; that medical intervention, research and conditions that primarily affect women don't require as much study or research as those that affect men. Suicide remains the leading cause of death of women, of mothers up to the first year postpartum, and the most likely time for women to suicide is between the ages of 45 and 55.*
>
> *There seems to be a dysregulation [sic] between those who choose to promote the health of women through pregnancy, birth and the postnatal transition, and those who accept the status quo. Birth-related trauma is under reported, undervalued, and over represented in the community. This issue has wide-ranging ramifications across society, yet it is mainly women and families that must shoulder the burden of managing the impacts and seeking treatment.*
>
> *From feedback within our community we see the health system care pathways are fractured and access to care can be a lottery depending on your postcode and your social economic status. This shouldn't be the case.*[369]

6.20. Another consideration of defining birth trauma is the terminology of 'mistreatment.' The Mistreatment Index was developed by researchers at the

[365] Birth Trauma Australia, 'Media Release – Birth Trauma Australia – Same Dedications, New Names', dated February 8 2025, https://birthtrauma.org.au/media-release-birth-trauma-australia-same-dedication-new-name/
[366] Submission No. 22, Gidget Foundation Australia, p. 3.
[367] Footnote 2, Maria TR Borges, "A Violent Birth: Reframing Coerced Procedures During Childbirth as Obstetric Violence" (2018) 67(4) Duke Law Journal 827-862., from Submission No. 135, Human Rights in Childbirth, p. 5.
[368] Submission No. 135, Human Rights in Childbirth, p. 5.
[369] Transcript of Evidence, 23 October 2024, Birth Trauma Australia, pp. 2 – 3.

BirthPlace Lab in Canada in 2019 and is a survey which measures occurrences of the mistreatment of women in the maternal space. The Mistreatment Index provides the seven following items identifying disrespect and abuse as:

MiST Statements

1. *Your private or personal information was shared without your consent*
2. *Your physical privacy was violated, for example being uncovered or having people in the delivery room without your consent*
3. *A healthcare provider shouted at or scolded you*
4. *Healthcare providers withheld treatment or forced you to accept treatment that you did not want*
5. *Healthcare providers threatened you in any other way*
6. *Healthcare providers ignored you, refused your request for help or failed to respond to requests for help in a reasonable amount of time*
7. *You experienced physical abuse, such as aggressive physical contact, inappropriate sexual conduct, a refusal to provide anaesthesia for an episiotomy etc.*[370]

Occurrences of birth trauma

6.21. The Committee received evidence detailing experiences of both physical and psychological birth trauma. This subsection will discuss this and the experiences of birth trauma suffered by non-birthing support people.

6.22. The management of birth trauma within the THS was noted by the Hon. Bridget *Archer* MP, Minister for Health, Mental Health and Wellbeing, in an update to the Committee:

> *Physical birth trauma is managed by the Obstetrics and Gynaecology team in hospital after birth and prior to discharge, with further follow-up care and support organised as required.*
>
> *Management of psychological birth trauma is specific to the individual needs to each woman and, therefore, differs from case to case. THS maternity care plans include post-birth debriefs, during which women are given the opportunity to discuss their birth prior to discharge. Those who indicate psychological trauma are provided with a referral to Obstetrics and Gynaecology and THS Social Work teams.*[371]

6.23. The BESt study undertaken by Western Sydney University utilised the Mistreatment Index from the BirthPlace Lab in Canada. 202 Tasmanians participated in the BESt study, with the following findings:

> *36% of women in Tasmania experienced at least 1 type of mistreatment*
>
> *18% of women in Tasmania felt ignored by clinicians*
>
> *2% of women in Tasmania experienced physical abuse*[372]

[370] Submission No. 35, Western Sydney University School of Nursing and Midwifery, p. 8.
[371] Updated information, Attachment 1, Minister for Health, Mental Health and Wellbeing, 27 October 2025, p. 7.
[372] Submission No. 35, Western Sydney University School of Nursing and Midwifery, p. 8.

6.24. Data collection on the prevalence of birth trauma in Tasmania, and Australia more broadly, is very limited. Evidence on the national prevalence was provided by Birth Trauma Australia:

> *Birth-related trauma is still a relatively new area of research, with limited data on the prevalence across the population. Research suggests that in Australia, between 30% and 48% of women identify their birth as traumatic*[373]*.*[374]

6.25. The BESt study determined, that of its Tasmanian participants, 29% reported their most recent birth as traumatic.[375]

6.26. The BESt study provided further detail regarding specific cohorts of Tasmanian women who participated in the study, and their experiences with birth trauma. This includes culturally and linguistically diverse (CALD) Tasmanian women. To define this demographic, the Australian Institute of Health and Welfare (AIHW), in 2022, found that 20% of women birthing in Tasmania were born overseas, with the top four regions being Southern Asia, South-East Asia, China and Southern and East Africa.[376] [377] The BESt study found:

> *52% of CALD women reported birth trauma in TAS*[378]
>
> *1 in 4 CALD women reported obstetric violence in TAS*[379]

6.27. The Australian Lawyers Alliance (ALA) submission detailed negative birth trauma experiences that CALD clients of ALA members shared:

> *a. Language barriers and a lack of available interpreters (if one is even offered at any appointments or during/after labour) with adequate training in medical terminology;*
>
> *b. A lack of understanding among many medical professionals of patients' religious and cultural practices – for example, male medical professionals can be sent to undertake a physical, internal examination of a female patient from a CALD background, who would rather only be seen by female medical professionals; and*
>
> *c. Unconscious bias and/or complacency with people from CALD backgrounds by some medical professionals.* [380]

6.28. The BESt study provided data on young parents, including in Tasmania. The AIHW reported women aged 24 or under, represent 11% of birthing women in Tasmania. The AIHW further report a trend in data capturing higher rates of perinatal death

[373] Footnote 2, Creedy, D. K., Shochet, I. M., & Horsfall, J. (2000). Childbirth and the development of acute trauma symptoms: incidence and contributing factors. Birth, 27(2), 104–111., from Submission No. 24, Birth Trauma Australia, p. 9.
[374] Submission No. 24, Birth Trauma Australia, p. 9.
[375] Submission No. 35, Western Sydney University School of Nursing and Midwifery, p. 8.
[376] AIHW, 2024, referenced in Submission No. 35, Western Sydney University School of Nursing and Midwifery, p. 9.
[377] Submission No. 35, Western Sydney University School of Nursing and Midwifery, p. 9.
[378] Submission No. 35, Western Sydney University School of Nursing and Midwifery, p. 9.
[379] Submission No. 35, Western Sydney University School of Nursing and Midwifery, p. 9.
[380] Submission No. 21, Australian Lawyers Alliance, p. 19.

across Australia for babies of young women, at a rate of 27.3 per 1,000 vs 8.5 per 1,000.[381] The BESt study found:

> *55% of young women in TAS reported birth trauma*
>
> *1 in 3 young women reported obstetric violence in TAS*[382]

6.29. Maternity Consumers Network (MCN) conducted a birth survey in July 2024 which received approximately 80 responses. The survey collected data through the following questions with 'yes', 'no' or 'n/a' response options:

a) ***Inappropriate, disrespectful or abusive treatment before, during, and after birth also referred to as "obstetric violence"?*** *56% of respondents selected yes*

b) ***Causes and factors contributing to birth trauma including: use of instruments and devices for assisted birth eg. forceps and ventouse?*** *49% responded yes*

c) ***Informed choice in maternity care?*** *48% answered no and a further 20% were unsure*

d) ***Continuity of midwifery carer [sic] in maternity care?*** *54% responded no.*

Information regarding maternity care options prior to or during care?

44% responded no with a further 18% responding that they were unsure [original emphasis].[383]

6.30. The ALA told the Committee that many women from rural and regional areas are seeking legal assistance for medical negligence claims due to pregnancy and birth experiences:

> *ALA members report that there are increasing numbers of women presenting for legal assistance after experiencing significant problems giving birth in regional and rural areas. Many medical negligence claims arise as a result of maternal birth trauma experienced in hospitals or medical facilities in regional and rural areas.*
>
> *30. The ALA submits that the gap between medical services offered to those in urban centres versus medical services offered in rural and regional Tasmania must be closed. The current gap in medical services provision is not in any way an excuse – and nor should it ever be used as an excuse – for the evident failures in the standard of care experienced by those giving birth in rural and regional Tasmania. Patients in regional and rural areas of Tasmania are entitled to the exact same standard of care as persons in cities. That includes medical professionals in regional and rural areas of Tasmania having the same level of skill and knowledge as medical professionals in urban centres.*[384]

6.31. The Committee received a number of submissions from individuals with lived experience of birth trauma. Many of these submissions spoke to the trauma

[381] Submission No. 35, Western Sydney University School of Nursing and Midwifery, p. 9.
[382] Submission No. 35, Western Sydney University School of Nursing and Midwifery, p. 10.
[383] Submission No. 83, Maternity Consumer Network, p. 8.
[384] Submission No. 21, Australian Lawyers Alliance, p. 16.

itself, as well as the nature of care provided. Private Witness 50 noted her experience with physical birth trauma and post-birth care:

> *During my first birth, I ended up with a broken coccyx. I remember being in severe pain and feeling disregarded when a midwife tried to move me from the bed to the shower. I was unable to move on my own, and despite expressing my pain, it felt like my concerns were ignored. My partner had to step in and advocate for me. Unfortunately, the follow-up care was lacking. The focus seemed to be more on increasing my milk supply, which was challenging due to the strong medication I was on for my injury.*[385]

6.32. A reoccurring theme of submissions was the prolonged impacts of birth trauma on personal functioning, sense of self and association with the birth, with many people telling the Committee that birth trauma has a long-term psychological impact on their daily lives.

6.33. Amy Ramsey, a lived experience witness, detailed how her physically traumatic labour continues to impact her mental health:

> *If I'd had adequate pain relief I would have been rested before reaching the pushing stage. I would have actually been able to push instead of only being lucid to push every now and then. Maybe I would have even been able to deliver her without instruments and an episiotomy. I wouldn't have begged for a c-section, vacuum, forceps, general anaesthetic and death. I wouldn't have dissociated. I wouldn't have spent the first weeks of motherhood thinking I'd died and was existing in thought. I wouldn't have suspected my baby wasn't real. I might have even been capable of loving her or regarding her at all at the time of her birth. Instead, I wasn't allowed adequate pain relief. My daughter's birth was the worst day of my life. It haunts me even in my nightmares. Rare are days without tears, flashbacks and constant anxiety and few are the nights without violent and disturbing nightmares and sleep broken by hypervigilance. The ripple effects of my trauma of obstetric violence have touched every part of my life and relationships. I'm still struggling to know if I can live with what happened. The trauma of the forced torture of oxytocin without pain relief has plunged me into devastating depression, unshakable anxiety and ongoing PTSD symptoms. My fear of medical staff causes me heart palpitations and I shake in panic and sob after meeting pregnant women who tell me they are booked for Burnie. I'm so afraid for them.*[386]

6.34. Mrs Ramsey also discussed the difficulty she faced in accessing appropriate mental health support in the immediate post-labour period, as well as in the time since her daughter was born:

> *The Extended Care Midwifery Service commenced the next morning,* [redacted] *From the first visit, I said that I needed trauma counselling. This began the frustrating and damaging process of struggling to advocate for myself while still*

[385] Submission No. 50, Private Witness, p. 1.
[386] Updated Submission No. 9, Amy Ramsey, p. 34.

dissociated and grappling with fresh trauma, flashbacks and nightmares. I was also learning to be a new mother and recovering from an episiotomy.

Getting help on the coast was impossibly difficult. I asked for help from every practitioner who saw us. I'll abridge some of the story by saying that endless referrals were made to a series of services that I can't even remember. Everyone had lots of phone numbers for me to call but no one to answer those phones. Each department handballed to other departments insisting that the others had staff, but in reality those staff didn't exist.[387]

6.35. Private Witness 86 detailed her experiences with severe postpartum depression after the birth of her son:

Once I was home it took me a very long time to be able to speak of my sons birth without crying, I still can get quite overwhelmed thinking of how I felt in a moment that is supposed to be one of your most precious. I suffered extremely severe postpartum depression as a result of my birth trauma that took almost 2yrs to recover from. That deeply impacted my relationship with my son. My experience at the LGH left me with very little faith in midwives after I was made to feel uncomfortable & not safe around them.[388]

6.36. Psychological birth trauma played a considerable role in the difficultly Private Witness 62 experienced in developing an attachment to her child. After a traumatic birth, her son was taken from the LGH to the NICU at the RHH, remaining there for 10 days. During this time, the family stayed at the Ronald McDonald House:

During that first 6 month [sic] we both struggled deeply with our own maternal and paternal dettachement from our son. It is difficult to explain just how profoundly our birth trauma impacted the early formation of bonding. For myself, as [redacted] *mother, I struggled to understand how I had even become a mother, in some ways I could not comprehend it given the severe separation that we had experienced, yet here I was holding my often screaming highly distressed son trying to establish breastfeeding and heal his emotional wounds. I began to experience flashbacks from my birth, and nightmares that people were coming to take my son, or that we were separated again and I could not get to him. As if I needed any less sleep than I was already getting. I knew the risks of me developing PTSD, PND, or PNA were extremely elevated given our traumatic birth. Being the proactive woman that I am I sought out clinical psychology, counselling and a local supportive mother's group to help me through. I am grateful and proud of that fact that to this day I never spiraled into any post-partum mental illness.*[389]

6.37. She continued to detail how her experience has impacted her future family planning:

Afterall these traumatic experiences, I made the difficult decision to not have anymore children. Prior to my son's birth I had often wanted to have two children.

[387] Updated Submission No. 9, Amy Ramsey, pp. 27 - 28.
[388] Submission No. 86, Private Witness, p. 3.
[389] Submission No. 62, Private Witness, pp. 4 – 5.

However, after experiencing what I had, I knew that I could not face the possibility of a similar birth and that I could not risk my families stability again. To decide to not have another child was a confronting and difficult decision, and it was one born directly from the severe birth trauma that I experienced during the birth of my first, and only son [redacted].[390]

6.38. A lack of access to necessary mental health supports was explained to the Committee by Private Witness 41:

After everything, I developed post-traumatic anxiety. I was anxious all the time, constantly crying, and plagued by terrible nightmares. The experience consumed me, and I couldn't think about anything else. I felt anger toward myself and the hospital, as I believed the whole ordeal was unnecessary. I was disappointed and ashamed to have needed a caesarean. Coming from a long line of strong farming women with no birth complications so I thought, I couldn't stop thinking, "Why me?" I felt robbed of the choice of when and how to have more children. And I felt robbed of a beautiful welcoming of my baby girl, the first two days I couldn't look after my baby well myself because I was in bed unable to move much, in a lot of pain and I was given pain killers that made me sick so I only vaguely remember it.

After a few months, I realized I needed help. I went to a GP. I explained my situation and he offered me antidepressants straight away and then told me to go online to look for a psychologist. I thought that was absolutely bizarre.

I found an amazing GP who helped me find an amazing psychologist who specializes in birth trauma, and she helped me process everything. I even wrote letters to my obstetrician and the hospital.[391]

6.39. Private Witness 94 also shared the lack of support she and her partner were provided with after a physically traumatic birth:

The significant lack of empathy and emotional sensitivity, harsh and unfeeling communication style and lack of professionalism exhibited by the doctors.

There was a profound disregard for the distress and emotional turmoil experienced by my partner and I regarding the turn the birth had taken and the impact of this. I felt as though our emotional state was completely overlooked.[392]

6.40. Many submitters also discussed the correlation between physical and psychological birth trauma, such as Private Witness 117:

My experience through the RHH maternity system is one I think about every day. I am now left with irreparable damage, I wear a permanent pessary and may never have the opportunity to deliver vaginally again. Not to mention the on going psychological damage and affect on my mental health.[393]

[390] Submission No. 62, Private Witness, p. 6.
[391] Submission No. 41, Private Witness, p. 2.
[392] Submission No. 94, Private Witness, p. 1.
[393] Submission No. 117, Private Witness, p. 2.

6.41. In her submission, Ms Marsden shared changes she believes should be made which would have supported her after her physically traumatic birth experience:

> *'A woman with a third or fourth degree perineal tear is to receive individualised continuity of care and appropriate follow up and referral to optimise her ongoing physical, emotional, psychological and sexual health' - this is another quality statement from the Third and Fourth Degree Perineal Tears Clinical Care Standard from the Australian Commission on Safety and Quality in Health Care, I wish that the THS would deliver this level of care for women who sustained significant birth injuries. If this was implemented and adhered to, it would have made a significant difference to my physical recovery and perhaps would have meant my mental health wouldn't have suffered as much if I felt supported. Following my experience of having my appointment with the pelvic floor physiotherapist cancelled and never rebooked, as well as the delays in receiving follow up care I have serious concerns about how many women in Tasmania go months with undiagnosed pelvic floor prolapse or other health issues caused by child birth.*[394]

Non-birthing care providers

6.42. Birth trauma is usually considered in relation to the impact on the birthing parent. However non-birthing parents, as well as other family members, can also experience or be impacted by birth trauma. There is a lack of understanding of these impacts. Tresillian noted a lack of literature regarding the impact of witnessing traumatic birth experiences on non–birthing parents, but that interest in this area is increasing over time.[395]

6.43. Birth Trauma Australia discussed the prevalence of non-birthing parents experiencing or observing birth trauma:

> *Fathers and non-birthing parents can also experience birth-related trauma yet are too often forgotten. It is known that fathers have similar needs to those of women and birthing people during pregnancy and birth, yet, in Australia, these needs are not being met*[396]*. This is especially true for first-time fathers.*[397] [398]

6.44. Data shared by Gidget Foundation shows one in ten fathers are affected by perinatal depression and anxiety in Australia each year.[399]

6.45. Ms Dawes, representing Birth Trauma Australia discussed the impact of birth trauma on the family unit:

> ***Ms DAWES -*** *... let's not forget the father or non-birthing parent. We support dads within our service and they experience trauma too, and the ramifications of that on the family unit, and there's no access to care. It's hard enough for women to seek support, but the other parents just don't get to look in. I was speaking again to a clinician about*

[394] Submission No. 85, Kate Marsden, pp. 14 – 15.
[395] Submission No. 5, Tresillian, p. 6.
[396] Footnote 10, Healthy Male: Andrology Australia (2020). Plus Paternal, A focus on Fathers: A Case for Change, Melbourne., from Submission No. 24, Birth Trauma Australia, p. 10.
[397] Footnote 11, Ibid. (Healthy Male: Andrology Australia (2020). Plus Paternal, A focus on Fathers: A Case for Change, Melbourne)., from Submission No. 24, Birth Trauma Australia, p. 10.
[398] Submission No. 24, Birth Trauma Australia, p. 10.
[399] Submission No. 22, Gidget Foundation Australia, p. 1.

this recently, talking about the carer's trauma with fathers and he was like - it's not vicarious, it's direct trauma and understanding what those red flags for fathers may be.

I was delivering one of our in-person support groups about a year and a half ago. There were seven individuals there and six of the seven women had to have further surgery after their birth experience. A few of them were in surgery for a couple of hours, a couple of them were in surgery for four hours, and one mum was having an emergency hysterectomy, A young mum, 27, was having an emergency hysterectomy. I asked, 'How were your partners in this?'. Only one of the six said that their partner was communicated to on the wellbeing of mum or baby. They're just kind of left and you can understand you're thinking about your loved one or your child and no one's checking in on you …

… We need to think of the family unit if that's the case and provide resources and support for both parents.[400]

6.46. A Private Witness to the Inquiry discussed additional care needs for non-birthing parents who may have witnessed traumatic births and in many instances, may become a carer for their partner and child after a physically traumatic birth:

The addition of support for fathers would also be ideal. Most services in this space are geared towards mothers, but a traumatic experience for a mother and child also affects the father. Moreso when they are left to care for both mother and infant in the weeks following the birth. [401]

6.47. Karitane recommended that sufficient mental health screening be provided to non-birthing parents, as well as birthing parents, to assist in triaging potential mental health impacts in the transition to parenthood:

Provide routine mental health screening for partners (including fathers and non-birthing partners) during and after pregnancy, with the capacity for service provision for those at risk of perinatal mood and anxiety disorders.[402]

6.48. Dr Khot, the Vice-President of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) discussed the importance of adapting parental preparations to include birthing partners and caregivers:

Ms JOHNSTON *- … We've heard a lot from witnesses about community and the importance of community… Can you speak a bit more about how that can be enhanced in terms of providing information to birthing partners and other caregivers in that scenario?*

Dr KHOT*- I think including birthing partners and caregivers in all our discussions when we talk about whether it is antenatal education, whether it is talking to two people about intervention, including the family, the key people who are the support people is given. It should happen all the time.*

[400] Transcript of Evidence, 23 October 2025, Birth Trauma Australia, p. 11.
[401] Submission No. 122, Private Witness, p. 7.
[402] Updated Submission No. 17, Karitane, p. 17.

***Ms JOHNSTON** - In your experience, is that what's happening? In terms of that particular antenatal appointments, I suppose it's often difficult to ensure that everyone's there at those appointments.*

***Dr KHOT** - Correct. Some of the things that we could do in that space is actually flagging key appointments. For those key appointments, the support people are there because it's not like we have all these discussions at all the appointments. There are certain key appointments where we would have these discussions and then flagging them and saying, this is the appointment at which we will be having this discussion. Make sure you've got whoever you want to be there in the room with you for this particular appointment.*[403]

6.49. The DoH noted there is a current gap in non-birthing parent screening for mental health conditions in the pregnancy and perinatal period, but that it is an important consideration for developments of appropriate screening and care into the future:

> *It is also recognised that fathers and secondary carers are likely to experience perinatal depression and anxiety, with up to one in ten fathers experiencing depression between the first trimester and one year postpartum.*[404] *As Tasmanian fathers and secondary carers are very rarely screened or directly access PMH services, this places them at risk of not receiving the specialised PMH support they require, which can place extra stress on the family unit.*
>
> *Like other states and territories, Tasmania is working to standardise PMH screening and supports for the mother/primary carer and increase screening of fathers and secondary carers. To support this standardisation, DoH is working with the Australian Government on implementing a PMH pilot to support the facilitation of routine digital PMH screening and reporting in line with the COPE, which is expected to commence in late 2024. The Australian Government has provided $2.66 million, and the Tasmanian Government has provided an in-kind contribution through the Bilateral Schedule on Mental Health and Suicide Prevention*[405] *to support this work. This funding will be used to build on existing infrastructure and to digitalise PMH screening, data capture, and central extraction and reporting of this data from public antenatal and postnatal healthcare settings to the AIHW, which can then be used for research purposes.*[406]

Impact of birth trauma on life experiences

6.50. The Committee received evidence regarding the holistic impact of birth trauma on people's lives.

6.51. Birth Trauma Australia discussed the intersecting impact of birth trauma on an individual's engagement with their life as follows:

> *The impacts of birth-related trauma extend into challenges for family life, such as the ability for parents to bond with their baby, to parent other children, and difficulties in relationships with their partner.*[407]

[403] Transcript of Evidence, 23 October 2025, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, p. 52.
[404] Footnote 37, COPE 2023 Perinatal Mental Health Practice Guideline., from Submission No. 129, Department of Health, p. 32.
[405] Footnote 38, See https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2022-05/nmh sp bilateral agreement tas.PDF., Submission No. 129, Department of Health, p. 32.
[406] Submission No. 129, Department of Health, p. 32.
[407] Submission No. 24, Birth Trauma Australia, p. 15.

Birth-related trauma can commonly create fear of future pregnancies, increasing anxiety and the likelihood of trauma in subsequent birth experiences.[408]

The impact of physical injuries, particularly those related to incontinence and prolapse, can result in shame, stigma, and feelings of isolation. This can impact on ability to work, and in addition to the cost of medical bills, creates significant financial impacts.[409]

6.52. The impacts of birth trauma can also be misunderstood by individuals, with people taking on average seven years to recognise their birth experience was traumatic and seek support. Birth Trauma Australia explained this in their submission:

Research suggests that it takes an average of seven years for someone to seek support for their trauma.[410] [411]*It is extremely common for many women we support to contact us when they are thinking about another pregnancy or pregnant a second time. Some may not have recognised that they have experienced birth-related trauma until this point. For fathers and partners, they may never seek support.*[412]

6.53. Ms Davies, a member of the ALA, discussed how delay in recognising birth trauma can impact the time in which people may seek medical or legal support:

CHAIR *- … One of the things that we heard from the previous presenter … is when somebody recognises that they have experienced birth trauma, …that it could be months or even years down the track. Are you finding that in your client cohort of women that you're representing? How do they come to know necessarily that they might have a legal avenue to pursue to the point where they reach out to a medical negligence specialist lawyer and on their kind of trajectory of birth to litigation, when they might recognise that what they went through did represent birth trauma?*

Ms DAVIES *- Yes, I think for some women unfortunately it is the baby that has suffered a trauma. And so, often times the baby doesn't reveal or it doesn't show signs of a birth trauma until developmental milestones begin to be missed. At times that can be when they get to school and they're learning, that becomes obvious because it may not always be a physical injury.*

Often times, women may say, 'Look, there's a couple of times when I wondered …', but they might ask the doctor and the doctor might not come around that way. Sometimes school, for a child or a diagnosis at some point with a GP or a specialist and then yes, if it's a physical or psychological trauma, often it's through a diagnosis that they'll attend a psychologist and things will come up there or with a physical trauma, they'll begin to realise that this injury that they might have been told will get better or it will get better over time is not getting better.

There are instances where … incontinence and … severe injuries … can occur - nerve injuries. There are instances where women are told, 'This will get better and don't worry

[408] Submission No. 24, Birth Trauma Australia, p. 15.
[409] Submission No. 24, Birth Trauma Australia, p. 16.
[410] Footnote 32, Sayer, N. et al. (2007). Use of mental health treatment among veterans filing claims for posttraumatic stress disorder. J. Traum. Stress, 20:15-25., from Submission No. 24, Birth Trauma Australia, p. 23.
[411] Footnote 33, Wang, P. et al. (2005). Twelve-Month Use of Mental Health Services in the United States: Results From the National Comorbidity Survey Replication. Arch Gen Psychiatry. 62(6):629–640., from Submission No. 24, Birth Trauma Australia, p. 23.
[412] Submission No. 24, Birth Trauma Australia, p. 23.

about it', and it will not and it cannot. Then they'll find out one year, two years and that's when they'll often consult a lawyer.[413]

6.54. Ms Marsden, a lived experience witness, explained the profound impact her birth trauma had on intersecting aspects of her life due to a prolonged physical and psychological recovery. She discussed how her experience and that of other women who have shared their stories have shocked her:

> *For months I felt like I couldn't even begin to recover from the traumatic birth due to the ongoing delays in follow up care, it felt like I was constantly taking one step forward and two steps back. The thought of writing a complaint was keeping me awake at night and consuming my thoughts during the day, having to relive the birth trauma and the lack of care before and after birth took a lot of energy and mental space. It is extremely disappointing to not receive one ounce of acknowledgment from anyone working at the hospital in Maternity Care or Women's Health. It saddens me to say that I felt relieved when the Tasmanian Parliamentary Inquiry was reopened two weeks ago, it makes me sad that in Australia, in 2024 - this is needed. I feel relieved that there is hope something will change for women and their babies in Tasmania. I am hopeful that by publicly sharing what me and my son went through, it might play part in some catalyst for change.*[414]

> *I hate to think about how much time I have spent wondering what I could have done differently to have had an entirely different birth experience, because of the way I was spoken to by some hospital staff, it made me feel like all of this was somehow my fault. By being open and honest myself, I have found that an alarmingly high number of first time mothers that I speak to about their birth experiences in Launceston, also have stories to share of birth trauma or other negative experiences. While it has given me some relief that what happened to me was not my fault, it makes me sad that so many other women have had their birth experiences negatively affected, and that there are potentially more women after them, unless something changes.*[415]

Cost

6.55. The financial burden of birth trauma was also identified by Birth Trauma Australia as a potential ongoing impact on the lives of individuals who have experienced trauma:

> *A 2019 report estimated the broader economic and social costs of perinatal depression and anxiety as $877 million in one year, with lifetime impacts of $5.2 billion. A 2011 report estimated the overall cost of incontinence (one of the most common symptoms of physical injuries) at $66.7 billion in 2010 (over $95 billion in 2024 terms), or approximately $14,014 per person with incontinence (over $20,000 in 2024).*
>
> *With these considerations, the ABTA estimates the cost of birth-related trauma in Australia to be in the vicinity of hundreds of millions of dollars each year, with lifetime costs in the billions.*[416]

[413] Transcript of Evidence, 23 October 2024, Australian Lawyers Alliance, pp. 17 - 18
[414] Submission No. 85, Kate Marsden, pp. 10 – 11.
[415] Submission No. 85, Kate Marsden, p. 11.
[416] Submission No. 24, Birth Trauma Australia, p. 18.

6.56. The ALA discussed the economic impact of birth trauma on women and families and how such matters, when prolonged, also impact demand on Government systems:

> *Finally, the ALA also notes the economic impacts of birth trauma on women and their families. ALA members report that women injured while giving birth have great difficulty in returning to work and/or education, yet incur increased expenses related to those injuries – including medication and ongoing treatments. Partners, family members and friends also need to forgo work and education to provide much-needed care for women injured while giving birth, as well as their babies (who may also be injured and require additional care). There are broader economic impacts on government systems and services, including Medicare, Centrelink and the National Disability Insurance Scheme.*[417]

6.57. Ms Davies representing the ALA expanded upon the interconnected personal and economic impact of birth trauma:

> ***Ms DOW*** *- … The other thing that you mentioned in your submission is around the economic impact of birth trauma. I wonder if you might elaborate on your thoughts and experiences of that to the committee…*
>
> ***Ms DAVIES*** *- I think that there is an economic impact on Tasmania in general because if there's birth trauma that was avoidable and preventable by greater informed consent, greater staffing levels, funding and technology, et cetera, then we're not going to see the level of trauma requiring psychological and physical intervention for a long period following these birth traumas. As well on a personal level for women, you're looking at complete life changing situations where they cannot work. Their economic loss is huge on a state level, but also on a personal level and we're seeing many times that these injuries are avoidable or can be reduced.*[418]

6.58. Lived experience witness Ms Marsden discussed the ongoing impact of physical birth trauma on her life, including the costs incurred by having to access private pelvic physiotherapy, as this was not provided by the public system where she had her baby:

> ***Ms DOW*** *- In your submission, you talk about the fact that obviously you weren't able to access the services that were really promised to you after having your little boy through the THS so that you had to seek care. Did this come at a significant cost to your family. Would you like to talk a little bit more about that and the financial impact this has had?*
>
> ***Ms MARSDEN*** *- Yes, so obviously the private pelvic floor physios aren't cheap and that is covered a little bit under health insurance but not much. So there were those appointments and all of the additional - I feel like I was at the GP every week for a while because I also had a couple of the emergency admissions and this was all ongoing from the gynaecologist appointment where I basically was misdiagnosed and given the wrong medication and all the pain relief I was taking, all the ibuprofen that I could, so I gave myself gastritis as well.*

[417] Submission No. 21, Australian Lawyers Alliance, p. 7.
[418] Transcript of Evidence, 23 October 2024, Australian Lawyers Alliance, p. 20.

And all my GP appointments, like none of them is bulk billed so they were quite expensive and what else was there? Oh, and well in future now because of what happened, obviously, I'm absolutely terrified that this could happen again. Because of the cause of the tear that I had, the colorectal surgeon said that there is a very big risk of becoming faecally incontinent if I was to have another vaginal birth. So there's no way I'm going to risk that.

But going through what I went through. I know there's no guarantee that the LGH is actually going to honour that. So we've, yes, increased our health insurance to the highest that we can and I've been seeing a private obstetrician as well who's also a gynaecologist so she's been working through other stuff with me too. This is going to be an ongoing cost until we do have another baby because there's no way I'm leaving that risk again.[419]

Factors and causes contributing to birth trauma

6.59. Due to the very individual nature of giving birth, many factors and causes can contribute to an individual experience of birth trauma. This section of the Chapter will discuss these factors and causes contributing to birth trauma including intervention and risk, obstetric violence, the legal question of consent and informed consent. The impacts, experiences of and possible solutions to address this will also be discussed.

6.60. Birth Trauma Australia discussed the broad medical contexts which contribute to birth trauma:

Factors in the healthcare system that cause or contribute to birth-related trauma include:

- *Mistreatment, dismissal and neglect by health professionals*
- *Inappropriate, disrespectful and abusive treatment by health professionals*
- *Lack of informed consent in maternity care*
- *Misdiagnosis or delayed diagnosis*
- *Impacts of interventions*
- *Lack of postnatal social and care pathways*
- *Health system policies and structures*
- *Lack of professional collaboration*[420]

6.61. Dr Khot, representing RANZCOG raised improvements which could be implemented in Tasmania to decrease the prevalence of birth trauma:

***Dr KHOT - ...** Birth trauma is a really important issue emerging increasingly amongst pregnant women. We know that what works to improve the rates of birth trauma is*

[419] Transcript of Evidence, 19 February 2025, Kate Marsden and Timothy Mohr, pp. 20 – 21.
[420] Submission No. 21, Birth Trauma Australia, p. 20.

having informed consent before we get into the space where birth occurs. Trying to have care that is multidisciplinary, so it's not just one discipline but actually having midwives, doctors, allied health, all involved in the care at the same time; making sure that every healthcare provider that is providing pregnancy care actually has training in trauma-informed care so that they're able to provide the care that is right for the particular woman in front of them. Having evidence-based antenatal education classes available to all women so that they enter pregnancy and birth well informed about their choices and their rights; having some information for healthcare practitioners on how to manage situations where women decline recommended care. This is again something we are increasingly encountering and we should have a collective way of managing this situation, keeping the woman at the centre and making sure she has all the information she needs to make her decisions.

Also having access to training in informed consent. This is something that all providers of maternity care should have access to, to reduce the rates of birth trauma. When we talk about birth trauma, we are talking about a wide variety of things. One of those traumatic things is actually the physical trauma of birth and what women who encounter physical trauma - things like significant perennial tearing - third and fourth degree perennial tears - need is a urogynaecology service to look after them after they have had these injuries. Currently, Tasmania doesn't have a urogynaecology dedicated service. It is serviced either by people who visit or generalists who have a special interest in urogynaecology. I think investing in urogynaecology service is really important for Tasmanian women. [421]

6.62. The Australian Medical Association (AMA) Tasmania also provided comment on the increased prevalence of women declining or delaying recommended care and how this should be managed alongside medical responsibility and informed consent. They provided a case study of a rural patient who declined recommended medical care and then required air transport during labour due to complications:

> *Such scenarios underscore the substantial resources and additional challenges involved in supporting birthing mothers who decline or resist clinically indicated examinations and interventions when deviations from expected labour progress occur—such as obstructed labour, failure to progress, reduced fetal variability on CTG indicating fetal distress, shoulder dystocia, hemorrhage, retained placenta, perineal tear, and uterine atony. These circumstances highlight the system's need to safely manage such complexities to avoid maternal or neonatal morbidity and mortality, while also addressing the psychological impacts on healthcare providers. Additionally, this situation draws attention to the increased demands placed on the healthcare system when patients make these choices.*[422]

This is discussed further later in this Chapter.

[421] Transcript of Evidence, 23 October 2024, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, p. 48.
[422] Updated Information, Australian Medical Association Tasmania, 10 October 2025, p. 3.

Intervention and risk

6.63. The Committee received evidence from lived experience witnesses, academics and professionals suggesting that physical intervention and the consideration of risk are key factors in the occurrence of birth trauma.

6.64. There are many physical interventions that can occur during labour including, but not limited to:

- induction of labour;
- caesarean sections;
- augmentation;
- episiotomies; and
- instrumental deliveries.

Interventions can be required for medical reasons to ensure the safety of the women and/or baby.

6.65. A Private Witness to the Inquiry detailed her experience of not experiencing the VBAC birth she had hoped for, proceeding instead with a further caesarean section:

> *The VBAC failed because having previously had a cesarean, I once again had a big target on my back that said intervention. I once again had to meet with the doctors to explain why I didn't want an induction and I didn't want the drip (both of which increase risk of uterine rupture but for some reason they're still pushed on women wanting VBAC).*[423]

6.66. Another Private Witness highlighted how, in her experience, she was unable to consent to or refuse an intervention as she was not informed of its true nature:

> *I had no idea I could have chosen to refuse cervical examinations, and any hands compressing my belly.*
>
> *I felt scared when the doctor had her hand inside my cervix whilst I was contracting and then she wanted her colleague doctor to push down on my belly to release excess amniotic fluid. I wasn't informed of this process prior to her attempting to apply this technique, before my midwife asked to stop as she could see I was so distressed I couldn't verbally communicate in the moment, as I was physically trying to move away from the doctor.*
>
> *I felt pressured to accept this process of intervention as her hand was inside me and there was no information about the procedure prior nor to give my consent to the doctor before the technique was being applied.*

[423] Submission No. 116, Private Witness, p. 2.

I had this procedure done to me, without my informed consent. This made me feel violated, distressed and trapped.[424]

6.67. Ms Lilley told the Committee she was confident that due to her research, she would be able to advocate for herself during labour, but that was not her experience once in labour:

> ***Ms LILLEY** - I felt going into the hospital that night that I was as fully informed as a person could be. I knew that I had a right to say no to any procedure that I didn't want to participate in, but I was operating under the false assumption that that would be respected.*
>
> *By the time I got in, it was around midnight and I was immediately sat down by the doctor and midwife, which, it was just odd from the get-go - that it felt like we were having a negotiation instead of me being supported in labour. We sat down and they immediately started trying to pressure me into having a - is it a hep-lock? I think that's what it's called.*
>
> ***...***
>
> *They immediately wanted me to put that in just in case. When I said 'No, I didn't want that', they didn't drop it. They persisted with why they thought it would be a good idea. They wanted to do the continual monitoring with the band. I explained that I wanted to be free to move around. The times that I had done CTGs [cardiotocography], the band just moves around. They're not very plus-size friendly, so I didn't want it. There was just a lot of back and forth and this general feeling they thought I was making silly choices and they were going to try to convince me to make better ones. They kept looking over at my partner as if they were trying to get him on side. Like, you're listening to this, right? This is a bit crazy.*
>
> ***...***
>
> *... it really did feel patronising, like they were hoping that he would convince me since their coercions weren't working.*
>
> *Meanwhile, I was having contractions every two minutes and having to pause the conversation, so I had to fight really hard for two whole hours in labour just to have the care and support that I needed. I didn't get it in the end. I had to compromise just because they weren't letting it go. I wasn't able to just move on.*
>
> *Even to the point that I'd been advised by a private midwife that the hospital had no legal right to stop me from accessing one of the baths, and that I should say that if they tried to coerce me. I did say that. I told them that I've been informed, that you have no legal right to stop me. When I said that, they just sort of stared at me blankly, like well, we're still not budging. They weren't going to show me where they were, they weren't going to assist in any way for that to happen, even though they clearly knew they had no legal right to stop me as well because they didn't deny it.*[425]

[424] Submission No. 54, Private Witness, p. 2.
[425] Transcript of Evidence, 19 February 2025, Georgia Lilley, pp. 24 – 25.

6.68. Ms Harding discussed her wish for access to supported and educated maternal care in Tasmania which includes content regarding potential interventions:

> ***Ms HARDING -*** *I believe that women should understand the risks of their choices and that they are not, [only] given the consequences. It's so easy to say yes to all the easy things like an epidural, but people are not aware of the risks of dural puncture that increases risk of C-sections. If you don't want a C-section and the cascade of interventions, people don't understand what it is.*[426]

6.69. The ALA submitted that there is a correlation between the use of physical interventions during birth and birth trauma:

> *25. In the experience of ALA members' clients, the use of instruments during vaginal deliveries greatly increases the chance of the woman giving birth (and others involved) experiencing birth trauma. In 2021, 21.6 per cent of women surveyed had an instrument-assisted delivery in Tasmania when giving birth for the first time.*[427]
>
> *26. Forceps and vacuum extractors during vaginal deliveries are routinely used, notwithstanding the risk of injuries. Those injuries include urinary and faecal incontinence, as well as nerve injury that can occur during instrumental delivery. The Australian Institute of Health and Welfare has noted the following about instrumental delivery:*[428]
>
> > *Both vacuum and forceps assisted delivery are associated with an increased risk of injury to the tissues of the vagina, perineum and anus. This may lead to long-term perineal pain and sexual difficulties; additionally, a very small number may have urinary or faecal incontinence.*
>
> *27. The literature reports that forceps deliveries are a major cause of levator avulsion injuries leading to a significant risk of symptomatic pelvic organ prolapse and incontinence – specifically, a 40 to 60 per cent increased risk of obstetric anal sphincter injuries (OASIs) and other maternal pelvic floor injuries with forceps delivery.*[429]
>
> *28. The ALA submits that the rate of birth trauma cases arising from the use of instruments speaks to the increased risk of birth trauma posed by the use of these instruments.*[430]

6.70. Birth in Tasmania noted the interconnection between interventions, data collection and the choices of birthing parents in planning their labour:

> *Tasmanian hospitals currently do not have adequate or transparent methods of reporting data. As consumers, women should be able to access current information about the rates of intervention and birth trauma reported from the hospital that they*

[426] Transcript of Evidence, 18 February 2025, Kimberley Harding, p. 18.
[427] Footnote 7, Australian Institute of Health and Welfare, National Core Maternity Indicators (Web report, 13 July 2023), from Submission No. 21, Australian Lawyers Alliance, p. 15.
[428] Footnote 8, Ibid. (Footnote 7, Australian Institute of Health and Welfare, National Core Maternity Indicators (Web report, 13 July 2023)), from Submission No. 21, Australian Lawyers Alliance, p. 15.
[429] Footnote 9, See, egs, Talia Friedman, Instrumental Delivery and OASI (IUGA annual meeting, August 2016); Hans Peter Dietz, Peter D Wilson and Ian Milsom, 'Maternal birth trauma; why should it matter to Urogynaecologist?' (2016) 28(5) Current Opinion in Obstetrics and Gynaecology 441; Hans Peter Dietz, 'Pelvic floor trauma in childbirth' (2013) 53(3) Australian and New Zealand Journal of Obstetrics and Gynaecology 217., from Submission No. 21, Australian Lawyers Alliance, p. 16.
[430] Submission No. 21, Australian Lawyers Alliance, pp. 15 - 16.

wish to birth in. Statistics such as the caesarean section, episiotomy, instrumental birth, inductions and augmentation of labour rates should be collected and made available to consumers from each individual hospital, so that women can make an informed decision about which model of care they wish to access. Women often feel like their bodies failed them, when they don't achieve the birth they had hoped for, however, research shows that provider preferences can influence birth outcomes.[431] *Women need to have an understanding of what their providers preferences are, before birth so they are able to make an informed decision.*[432]

6.71. MCN discussed how a lack of data available regarding births in Tasmania, including rates of intervention, contributes to women not having an informed understanding of intervention rates:

> *Transparency is a fundamental driver in healthcare improvements; from women being able to make informed decisions about where to access maternity care, to increasing accountability of staff and health services, increases in quality of care, cost effectiveness and overall maternity system performance.*
>
> *Perinatal Data should be easily accessible to women, in a format that is easy to understand. Women want to know the intervention rates of hospitals, they want to know how women before them have been treated (or mistreated), they want to know about postnatal care and other services including counselling for birth trauma and physiotherapy access.*[433]

Consent and informed consent

6.72. Consent and informed consent were themes raised with the Committee both in relation to general maternal healthcare and as being profoundly connected to birth trauma. Evidence provided by lived experience witnesses suggested many people felt they had not given informed consent during their labour.

6.73. Representing the ALA, Ms Davies discussed the legal definition of consent, as the basis of the legal organisation's recommendations regarding consent and choice:

> ***CHAIR -*** *I wondered if through the experience that you've had representing women who have had interventions during labour, if you can explain to us some of those experiences of what information is shared with women prenatally or during labour before those interventions are delivered or imposed… and the experience of those women having the risks around different interventions during labour explained to them.*
>
> ***Ms DAVIES -*** *What I'd say from the outset is that our experience is that the explanation is completely inadequate, that women are providing some level of consent, but it's not an informed consent and it's not reaching the standard that's required by the law, which is a meeting of the minds, so that the medical professional and the patient are on the same page... We're seeing it's inadequate and then women, of course, are*

[431] Footnote 10, Ingela Lundgren et al, 'Cultural perspectives on vaginal birth after previous caesarean section in countries with high and low rates - A hermeneutic study' (2019) 33(4) Women Birth 339; Lily McCarthy et al, 'Examining provider practice-level disparities in delivery outcomes among patients with a history of Caesarean Delivery' (2024) 24(243) BMC Pregnancy Childbirth 1., from Submission No. 97, Birth in Tasmania, p. 3.
[432] Submission No. 97, Birth in Tasmania, p. 3.
[433] Submission No. 83, Maternity Consumer Network, p. 11.

suffering various levels of trauma, physical and psychological trauma related directly to that lack of consent.

… we make submissions that there should be greater education and regulated education for medical providers, doctors, midwives, nurses beginning in their university or other training on how to assist a patient to provide consent, and how that can be provided in an ongoing manner from the beginning of the pregnancy, throughout the pregnancy, the labour, the birth and postpartum.

Some of the recommendations we make there are education, as I've said, but also the creation of a birth plan beginning in pregnancy, which can also be recorded in a written manner and that provides not only an opportunity for the woman to provide her specific preferences, but it's a written record of each time she's received advice as to instrumental deliveries, the risk-benefit of each potential intervention that she may undergo. If there's an emergency situation or an intervention that's required later in the pregnancy, she's been able to consider and write out her preferences along with her support people and family. That's one of the big recommendations we make there; the education and that written birth plan.[434]

6.74. Medical necessity was raised by Human Rights in Childbirth as the only instance where it may be appropriate to not gain informed consent:

The doctrine of medical necessity is the only narrow circumstance where informed consent is not required. It strictly applies where there is a genuine emergency, and the woman is either unconscious or found to be incompetent following assessment by two psychiatrists and a declaration sought from a court of law. Even in that instance, care providers must first ascertain whether a family member or support person has been given the authority by the woman to relay her wishes.[435]

6.75. Human Rights in Childbirth discussed the international legal definition of informed consent, including instances in which medical practitioners may not have operated in a way which respected the right to informed care:

Informed consent is defined, in international law, as follows:

> *An intervention in the health field may only be carried out after the person concerned has given **free and informed consent** to it.*
>
> *This person shall **beforehand** be given appropriate information as to the **purpose** and **nature** of the intervention as well as on its **consequences and risks.***
>
> *The person concerned may freely **withdraw consent** at any time.*[436][437]

The fundamental right to informed consent is underpinned by the fundamental human rights to bodily autonomy and bodily integrity.

[434] Transcript of Evidence, 23 October 2024, Australian Lawyers Alliance, p. 26.
[435] Submission No. 135, Human Rights in Childbirth, p. 29.
[436] Footnote 17, European Convention on Human Rights and Biomedicine 1997, Article 5., from Submission No. 135, Human Rights in Childbirth, p. 25.
[437] Submission No. 135, Human Rights in Childbirth, p. 25.

In Tasmania, care providers in both public and private sectors appear to be operating on several mistaken assumptions that violate the legal and human rights of women i.e.:

1. *Providers believe, contrary to law, that they do not need to obtain informed consent for what they consider to be routine or minor procedures;*

   When women repeatedly complain that certain procedures are being performed without consent, there can be no justification for the provider belief that they are minor procedures for which consent can be implied. These procedures involve an invasion of a woman's intimate parts. To say that women are impliedly consenting to these procedures is no different to claiming that women who sit on a bed are impliedly consenting to sexual intercourse.

   …

2. *Providers assume, contrary to law, that the requirement for consent in relation to 'major' surgical procedures such as cesarean sections (CS) is satisfied when women sign a consent form either underduress, without adequate explanation or through the provision of false information;*
   …

3. *Providers assume, contrary to law, that pregnant women do not have the right to refuse treatment.*

   …

4. *Providers assume, contrary to law, that they can mislead and deceive women into compliance "for their own good" [original emphasis].*[438]

6.76. The ALA explained that informed consent is not given in a singular instance but rather is an ongoing discussion between a patient and medical practitioner as events change throughout labour:

> *16. The ALA submits that a lack of communication between medical professionals and women (during pregnancy, when in labour and after delivery) – and by extension her support networks – is a feature in many birth trauma cases.*
>
> *17. There appears to even be a reluctance generally to discussing birthing options and the likely risks and complications associated with giving birth, including in relation to the use of instruments or undertaking a caesarean section. This is putting women and their babies at increased risk before, during and after delivery, as well as robbing women of the opportunity to provide proper and informed consent.*
>
> *18. Since Rogers v Whitaker,*[439] *the law in Australia has recognised and protected the individual's autonomy to make informed decisions about what happens to them and their body. The ALA submits that this is particularly important in pregnancy since the baby is being born via a mode or modes of delivery – staying in is not an option. Therefore, proper and informed consent should include a discussion of all reasonable alternative modes of delivery, and the risks and benefits (to the woman giving birth*

[438] Submission No. 135, Human Rights in Childbirth, pp. 26 - 28.
[439] Footnote 6, [1992] HCA 58; (1992) 175 CLR 479., from Submission No. 21, Australian Lawyers Alliance, p. 14.

and the baby) associated with each. It is only when presented with the full suite of such options can the woman giving birth's right to make an informed choice be truly respected.

19. The ALA further submits that informed consent must not be considered as a 'one-time event' during labour and, moreover, it is not limited to signing a consent form that is often thrust upon women in a rushed and emergency situation. Pregnant women need to receive adequate information throughout their pregnancies and be involved in decision-making at all stages. That is true and informed consent. [440]

6.77. The BESt study by Western Sydney University asked about participants' sense of autonomy during labour. The study defined informed choice as 'based on relevant knowledge, consistent with the decision maker's values and behaviourally implemented.'[441] Tasmanian women participated in the BESt study, which found the following rates of autonomy during birth for Tasmanian participants:

- 53 per cent high autonomy;
- 24 per cent moderate autonomy;
- 16 per cent low autonomy; and
- 5 per cent very low autonomy.[442]

Education resources for patients

6.78. The Committee heard two distinct themes relating to ensuring informed consent in labour. The first is increasing prenatal education to ensure that during pregnancy, people have the opportunity to fully understand the different interventions that may be required during labour. The second is expanded training for medical practitioners about the importance of informed consent.

6.79. PhD candidate Ms Bell shared the findings from her research, focussing on informed consent as a decision making process for women:

***CHAIR** - Have you come across that a lot in your research as well, the difference between consent and informed consent during labour?*

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

When we talk about informed consent and the focus on informed consent, we have this consent-seeking process rather than a decision-supporting process. I think a big part of that is that care providers and policies that sit around care providers are not structured

[440] Submission No. 21, Australian Lawyers Alliance, p. 14.
[441] Marteau et al, 2001, referenced in Submission No. 35, Western Sydney University School of Nursing and Midwifery, p. 11.
[442] Submission No. 35, Western Sydney University School of Nursing and Midwifery, p. 11.

to support them in a decision. There is quite a lot of pressure on the midwives and probably the obstetricians as well, to gain consent and move forward in the framework of recommended care, rather than what a woman's decision might be.[443]

6.80. MCN provided a synopsis of experiences that women had accessing education during pregnancy to prepare for their labour:

> *Women reported that they do not receive enough information to make informed decisions during labour and birth, or receive information biased towards their care provider's preference, resulting in them agreeing to interventions that do not align with their preferences.*[444]

6.81. Dr Khot, representing RANZCOG, discussed the provision of education during pregnancy:

> ***CHAIR*** *- … Can you elaborate on your views on the difference between consent and informed consent for labouring women, how that training might look for health professionals, and when those conversations around possible interventions should happen in the pregnancy phase so that women go into labour very informed?*
>
> ***Dr KHOT*** *- … There's two bits to it. First of all, when should women get information? Women should not be hearing about an intervention for the first time when they are in labour. That is not the time to be discussing interventions in the detail that they should be discussed. So, all these discussions should happen before we get into the labour room.*
>
> *If they should happen during pregnancy, we are very fortunate that pregnancy lasts nine months and most women attend pregnancy appointments. They usually attend multiple pregnancy appointments, so we have many opportunities for the vast majority of women to have these discussions, and they should be happening during pregnancy. The best way to do that is during antenatal education. Again, most women, especially women having their first baby, will attend some form of antenatal education. If that antenatal education incorporates the possibility of intervention, what that intervention looks like, what the reason for that intervention might be, that would be the best time to have these discussions and allow women to then have questions. If we did it in the antenatal education bit of it, then it takes it out from the clinical role when you go to see a doctor or a midwife. That might then spark women to ask those questions of their healthcare provider when they go for their appointments. So, definitely the discussions need to happen prior to labour.*
>
> *Of course, they should be revisited in labour. I'm definitely not saying that it's all been said and that's it, we don't need to ever talk about it again. Absolutely, when we are going to intervene in any form during labour, we must revisit that discussion and make sure that that consent is still valid. But definitely have it during pregnancy.*[445]

[443] Transcript of Evidence, 20 February 2025, Catherine Bell, p. 83.
[444] Submission No. 83, Maternity Consumer Network, p. 3.
[445] Transcript of Evidence, 23 October 2024, Royal Australian College of Obstetricians and Gynaecologists, p. 51.

6.82. Ms Dawes, representing Birth Trauma Australia, expanded on this:

> ***Ms DAWES** - …*
>
> *In terms of connecting in with women, I have to acknowledge that there is work now being done with the development of the LEAPP [Living Evidence in Australia Pregnancy and Postnatal Care] guidelines, that is national guidelines on antenatal education and postnatal support. That will hopefully guide more talking points in what we speak to women about. It's not only timing but it is also what do we talk to women and parents about? Because, for me working in this space, I did my first presentation back in 2017 and even then I was saying we need to talk about things that happen during birth. Always the pushback is, 'Well, you can't possibly inform women of all the risks associated with birth'. But, we can have conversations and we can guide to information because there are always going to be people who don't necessarily want to know the risks. Then, on the other end of the spectrum I want to know that one in four women may well end up with an instrumental delivery and what can I do to mitigate that risk.*
>
> *In terms of checking in, if we look at obtaining consent and that process of consent and informed decision-making, it's not just one conversation. It's a constant flow of obtaining consent and providing information in a range of ways which could be written, or videos to watch. Very simple and obviously translated into multiple languages. But in terms of the time, I think it just depends on the individual. That's when it comes down to individualised care and having access to someone who can provide that information. But there needs to be a centralised source of reliable evidence-based information because we live in a world where people are potentially getting their birthing information on social media and, you know, is that evidence based? Is it up to date? … So, in terms of timeframe, it's not necessarily about that, but it's access to information and guiding them to the information so that they can kind of lead the way.*
>
> *Also, in terms of antenatal information, again, I think it would be amazing for it to be a blue sky thinking that it would be delivered by a range of clinicians so they'd have their known carer and ideally midwifery-led care. They would also connect in with an obstetrician, so they can talk about, 'We do instrumental deliveries, emergency caesareans or elective caesareans', whatever that looks like, so that at the time of birth, people aren't forced into making decisions where they don't understand what they're consenting to. Because, I think the fear is, if we talk about, say, risks associated with vaginal birth, everyone would choose a caesarean - absolutely they wouldn't, but you know what, when there's an adverse outcome, they would emerge from the other side not being blindsided by their experience because they've prepared for it and they've made an informed decision about that process.*[446]

6.83. The AMA Tasmania also endorsed the access to education and understanding for birthing families regarding birth choices, including all available options and any potential risks associated with these:

> *AMA Tasmania is also concerned about the judgement and commentary directed toward mothers who elect to have a LUSCS [Lower Uterine Segment Caesarean Section] rather than a vaginal delivery. The Association advocates for all mothers to be fully apprised of the available options and choices, and to receive sensitive and*

[446] Transcript of Evidence, 23 October 2024, Birth Trauma Australia, pp. 5 – 6.

comprehensive information about both common and rare but significant risks associated with each delivery method. Mothers should be encouraged to discuss these matters openly with their medical OBGYN team.[447]

6.84. Human Rights in Childbirth recommended that information regarding hospital policies, care options and practices also be made available to families in the initial stages of pregnancy to allow for sufficient preparations:

> *All care providers (public and private) to, at the time of booking, give the woman a form listing routine procedures used and relevant policies applied by the facility and/or by the care provider with check boxes so women can use that form as a birth plan and to initiate discussions during ante-natal visits;*[448]
>
> *Develop a phone app which enables women to choose the model of care that suits their choices and preferences, which includes information provided by LHDs on each facility's admission and intervention rates, and any unique services they offer such as breech birth, birth centres or midwifery group practice or homebirth;*[449]

6.85. Ms O'Keeffe, representing Maternal Health Matters, said it is essential for medical practitioners to have the needs of the person in labour at the forefront of their mind in ensuring informed consent:

> ***Ms O'KEEFFE -*** *I actually think we can make this change really easily if we identify that the women do best in continuity of care that is in relationship. It's not a physical process of just doing monthly checks. It's about developing a relationship so the woman and her carer understand each other. The evidence absolutely says that that is midwifery models of care. We need to stop the coercion that is happening for women by designing health services that provide what they need.*
>
> *…Informed consent is only valid when a woman makes an informed decision based on the facts, the unbiased facts. Where a woman makes a decision based on facts that are biased, it's not informed and so that's really important.*
>
> ***…***
>
> ***Ms O'KEEFFE -*** *… we need health services designed by consumer voice, and this is a really hard thing to achieve. I've been in lots of forums where I've raised things and I've been asked, 'But what about the baby? What about the father? What about the health service?'. They are all important, but the woman is the start of it and unless that voice is heard and the services are designed around her, we will not provide good services.*[450]

6.86. Ms Dawes, representing Birth Trauma Australia, discussed the intersection of education, informed consent and choice for individuals giving birth:

> ***Ms DAWES -*** *… Women, post-traumatic birth experience, will say, 'I didn't realise how hard I had to advocate for myself', or 'I didn't realise I had choice', and it's really important to respect choice...*

[447] Updated Information, Australian Medical Association Tasmania, 10 October 2025, p. 2.
[448] Submission No. 135, Human Rights in Childbirth, p. 72.
[449] Submission No. 135, Human Rights in Childbirth, p. 70.
[450] Transcript of Evidence, 21 October 2024, Maternal Health Matters, pp. 67 – 68.

But, if we to look at genuine, individualised choice, and that was a key recommendation that came out of the birth trauma inquiry, that one-size-fits-all approach to birth is not suitable, but yet that does still seem to be very much the approach... So let's just speak to individuals and give them true choice. Why is there a fear of providing choice in mode of birth, in model of care, when facilitating positive birth outcomes is about making sure the woman or person is at the front and centre of what she wants? Why is it so complicated? [451]

Education opportunities for medical practitioners

6.87. Dr Khot, representing RANZCOG, said there is an acute lack of training for healthcare providers regarding informed consent:

> ***Dr KHOT** - The second question is training for healthcare providers. We don't get trained as well as we should when we talk about informed consent. And we certainly don't usually get training in having those discussions very, very quickly. We learn it on the job and we learn it from our senior person who we follow around during the day. It is time for us to actually have a more robust way of teaching how to do consent, how to talk about informed consent and do it in a formal way.*
>
> *So, absolutely, midwives, doctors, all should have a formal training program where we learn how to talk about informed consent, how we can make sure that we give people information without scaring them. Because sometimes when we give information, it can come across as being, you know, 'the doctor's telling me all these scary things might happen' to you. But it's how we put it across and how we make sure that we let the women know that this is not about scaring them, not about coercing them. It's about giving them information so that they can make the decision that works best for them.*
>
> *More importantly, I think it is respecting those decisions. Once women make those decisions, actually respecting the decision a woman has made is another thing that we all need to be able to manage better.* [452]

6.88. MCN described what this education should include:

> *Commit to ensuring that all clinicians practicing in Australia have a working understanding of women's right to informed consent to procedures during childbirth (we address this in our Better Births with Consent training).*
>
> ➔ *Review all policies and procedures and ensure they enshrine structural support for women's informed consent*
>
> ➔ *Ensure that data collected on the percentage of caesarean sections, episiotomies, induction of labour, and other relevant procedures performed in*
>
> ➔ *a service or by individual private clinicians is published in a manner accessible to women*

[451] Transcript of Evidence, 23 October 2024, Birth Trauma Australia, p. 7.
[452] Transcript of Evidence, 23 October 2024, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, p. 51.

➔ *Review complaints procedures in all jurisdictions such that women receive fair investigations into allegations of mistreatment during childbirth*

➔ *Ensure that clinicians who are found to have mistreated women undertake adequate measures to avoid repeated incidents*

➔ *Ensure that women who are found to have been mistreated are provided with adequate restitution.*[453]

6.89. Specific training for GPs, who are often the first point of call for individuals and families in a pregnancy journey, was raised by Alecia Staines, founder of MCN. Ms Staines defined this training as an essential element of increasing the information available regarding pregnancy and birth, allowing individuals to feel more prepared:

> ***Ms JOHNSTON*** *- … Can you perhaps expand on the lack of awareness about the options, and how that's not communicated to women about the different kinds of birth experiences that they might want to choose?*
>
> ***Ms STAINES*** *- I guess we have to look at women's first point of contact, and that's often with a GP. You're also now relying on a GP to provide unbiased advice on various models, which they mightn't even know about. Lot[s] of women will also say in hindsight they wish they'd been able to access MGP [Maternity Group Practice], but they got in too late. You have a supply issue there as well.*
>
> *I think even before women get to the GP - or is it provide the GP clinics with flyers and things like that, because I think we've gotten to the stage of social media being almost information overload. Whereas something tangible with just some unbiased information – 'Here are all the different models of care', - might be quite useful…*
>
> *I think trying to capture that is really important. You probably have a website that can provide some information to women too...*[454]

6.90. Ms Bell, an academic whose work focuses on birth maps as an educative method of informed consent, shared with the Committee her work in creating a game for both birthing families and medical practitioners. This game is another resource for increasing awareness of pregnancy and birth options:

> ***CHAIR - …*** *you wrote that last November you were going to be meeting with Westmead Hospital around embedding the Birth Map into their practise. I wondered how that went and if there are any reflections you'd be happy to share with us.*
>
> ***Ms BELL*** *- Yes. Alongside the book, I've developed a game that helps to understand the statistics behind what happens in birth and it's based on the 2018 Mother Baby Report. So, you roll a 20-sided dice and it gives you a scenario that's statistically based and then the kind of decisions you might be able to make. So, what are your options in that scenario? Westmead has asked me to create a Twister-sized version of this game that they can use in antenatal classes, which encourages engagement. You can play the game in about 10 minutes and it helps participants, which will usually be the pregnant woman*

[453] Submission No. 83, Maternity Consumer Network, p. 7.
[454] Transcript of Evidence, 20 February 2025, Maternity Consumer Network, p. 71.

and her partner, to really understand that there are several decision points in this journey. What if your birth does actually end up going down a medical pathway where interventions are necessary, how do you recognise what's going on and understand how one intervention can lead to another.

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

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

So, having sat in that difficult scenario in a hypothetical, when it is happening, you can recognise it for what it is and feel a bit safer. The game helps you to sit in those trickier spaces as well...[455]

6.91. The ALA provided their views on best practice information provision during pregnancy and labour:

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

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

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

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

[455] Transcript of Evidence, 20 February 2025, Catherine Bell, pp. 82 – 83.

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

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

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

iv. what decisions the woman giving birth and her support network may need to make during labour, and what their preferences are (preferences which should be considered even in an emergency or urgent situation) [original emphasis]. [456]

6.92. Dr Khot, representing RANZCOG, shared a framework that she uses in her own practice to facilitate ongoing engagement with patients throughout their treatment:

> ***Dr KHOT*** *- I do hear these discussions happen and one of the things that sometimes it's useful to have a framework and to give people a framework of how to have these discussions. For my purposes, I use what's called the BRAIN framework. So that's the Benefits, Risks, Alternatives, Interventions and what happens if I say No. That sort of framework is really useful for both the provider, the clinician, and also for the woman to ask those questions. My firm belief is that, yes, of course we should train ourselves and our professions to do this well. But we should also make sure that we let women know that these are the questions that they can and should ask their healthcare providers. When presented with an intervention, or a test or an option, they should also feel comfortable asking, 'Doctor what are the benefits of this, what are the risks, what if I say no, what are the alternatives?'.*[457]

6.93. MCN recommended amendments be made to the DoH website to ensure information is easily accessible for patients, potential patients and the people who support them.[458]

6.94. Ms Sharpe, a witness to the Inquiry, also shared her belief that increased access to and understanding of homebirths in Tasmania could assist in reducing experiences of birth trauma but would require increased education for health professionals and the Tasmanian community:

> *Homebirth is a really important part of how we can reduce the risks of birth trauma. Access to homebirth should not be linked to financial privilege (a homebirth in Tasmania costs $6000+). Homebirth midwives need more support and more positive support from the mainstream system.*[459]

[456] Submission No. 21, Australian Lawyers Alliance, pp. 21 – 22.
[457] Transcript of Evidence, 23 October 2024, Royal Australian College of Obstetricians and Gynaecologists, p. 52.
[458] Submission No. 83, Maternity Consumer Network, p. 18.
[459] Submission No. 56, Heather Sharpe, p. 1.

Obstetric violence

6.95. "Obstetric violence" was a term used in evidence given by a number of people presenting to the Committee. The understanding of the term is varied in individual, academic and legislative contexts. Often the terms birth trauma and obstetric violence are used interchangeably to define traumatic experiences. From the evidence received, the Committee considers it important to discuss obstetric violence as an element of birth trauma, which may not be present in all individual experiences of birth trauma.

6.96. Birth Trauma Australia discussed the lack of a legislated Australian context for obstetric violence, noting that research into the area has been increasing. The work of the BESt study team from Western Sydney University, led by Dr Hazel Keedle, has resulted in a publication specifically focusing on obstetric violence, which they define as the:

> *Dehumanized treatment or abuse by health professionals towards the body or reproductive process of women.*[460]

6.97. A publication from the Australian Nursing & Midwifery Federation (ANMF) defined obstetric violence as:

> *Acts in the context of labour and birth categorised as physically or psychologically violent due to unjustified use of medical intervention, dehumanising treatment and pathologization of natural processes.*[461] [462]

6.98. Human Rights in Childbirth said obstetric violence is a legal term that:

> *refers to the abuse and mistreatment of pregnant women and people in maternity health facilities as a systemic, normalised, everyday event embedded in institutional and obstetric culture and practice.*[463]

6.99. Their submission identified two categories of obstetric violence:

- *Interpersonal behaviours of individuals manifested through physical and verbal mistreatment, humiliation, lack of information and consent, the abuse of medicalization and the pathologizing of natural processes; and*
- *Dehumanising systemic actions, structures and policies*[464] *that lead to women's loss of freedom, autonomy, and the ability to freely make decisions concerning their body and sexuality.*

---

[460] Western Sydney University, 2022, ' Study Finds one-in-ten Australian women have experienced obstetric violence', https://www.westernsydney.edu.au/newscentre/news_centre/more_news_stories/study_finds_one-in-ten_australian_women_have_experienced_obstetric_violence.

[461] Footnote 1, Quattrocchi, P., Obstetric Violence Observatory: Contributions of Argentina to the International Debate. Medical Anthropology, 2019. 38(8): p. 762-776, from Australian Nursing & Midwifery Federation, 2023, ' Obstetric Violence and Birth Trauma', https://www.anmf.org.au/media/havkmrnj/anmf_information_sheet_obstetric_violence_and_birth_trauma.pdf, p. 1.

[462] Australian Nursing & Midwifery Federation, 2023, ' Obstetric Violence and Birth Trauma', https://www.anmf.org.au/media/havkmrnj/anmf_information_sheet_obstetric_violence_and_birth_trauma.pdf, p. 1.

[463] Submission No. 135, Human Rights in Childbirth, p. 3.

[464] Footnote 10, M Sadler et al, 'Moving beyond disrespect and abuse: addressing the structural dimensions of obstetric violence' (2016) 24(47) (2016/09/01) Reprod Health Matters 47-55. , from Submission No. 135, Human Rights in Childbirth, p. 8.

The two categories share a symbiotic relationship. The abusive interpersonal behaviours of care providers are structurally and systemically reinforced, in that they are enabled and sustained by a number of institutions, policies and guidelines, and medical liability laws and legislation.[465]

6.100. Consumer groups and peak bodies who use the term "obstetric violence" told the Committee they would like to see legislative reform to allow for legal recourse. They said current options for people who have experienced obstetric violence to access support, information, complaint processes or legal outcomes was limited in Tasmania.

6.101. Human Rights in Childbirth said medical leadership bodies are hesitant to engage with conversations regarding the use of the term obstetric violence:

There is currently an objection by institutional careproviders [sic] - led by medical and midwifery leaders respectively - to the use of the phrase "obstetric violence". Many seek to instead use the phrase "birth trauma". Birth trauma refers to the consequences of mistreatment and abuse[466]*... It shifts the focus away from the problem of obstetric violence and its causes.*

From a legal perspective, the objection is as odd as an objection to the phrase "domestic violence" and, unfortunately, reveals more about those objecting than about the legal phrase itself. The objection is a deflection from the serious problem of care providers openly engaging in abuse and mistreatment of women in Tasmania. It is a worrying signal of a refusal by providers to take responsibility for their violent behaviours.[467]

6.102. The organisation said medical liability played an important role in the hesitation from medical professionals and their representative bodies to engage with discussions about obstetric violence:

Medical liability and defensive medicine feature heavily in the practice of maternity care providers. Successful compensation claims turn into insurer's conditions for practice which turn into hospital policies and practice standards that are usually mandated, without any regard for the need for informed consent.[468]

Doctors commonly assert that liability mandates the overuse of interventions in maternity care, the overriding of informed consent and the focus on the fetus as a patient.[469] *The reality is somewhat more complex.*[470]

[465] Submission No. 135, Human Rights in Childbirth, pp. 7 - 8.
[466] Footnote 2, Maria TR Borges, "A Violent Birth: Reframing Coerced Procedures During Childbirth as Obstetric Violence" (2018) 67(4) Duke Law Journal 827-862., from Submission No. 135, Human Rights in Childbirth, p. 5.
[467] Submission No. 135, Human Rights in Childbirth, p. 5.
[468] Footnote 22, Tim Draycott, Rachel Sagar and Susannah Hogg, 'The role of insurers in maternity safety' (2015) 29(8) Best Practice & Research Clinical Obstetrics & Gynaecology 1126-1131., from Submission No. 135, Human Rights in Childbirth, p. 33.
[469] Footnote 23, CT Johnson et al, 'Malpractice and obstetric practice: the correlation of malpractice premiums to rates of vaginal and cesarean delivery' (2016) 214(4) (2016/01/16) Am J Obstet Gynecol 545- 546., from Submission No. 135, Human Rights in Childbirth, p. 33.
[470] Submission No. 135, Human Rights in Childbirth, pp. 32 - 33.

6.103. MCN founder Ms Staines explained reservations felt by medical practitioners in participating in training which may be advertised as regarding 'obstetric violence':

> ***Ms STAINES** - …*
>
> *Some of the pushback from obstetricians is the word 'obstetric violence', but it's internationally recognised now. We're pretty explicit that this isn't a shaming exercise, that this is actually to solve the problem. And if we're going to get caught up on words, it's actually not going to help women.*[471]

6.104. In an update to the Committee provided in October 2025 the AMA Tasmania noted their concern with the use of language in the area of birth trauma:

> *AMA Tasmania is concerned about the terminology used to describe birth trauma and adverse events in recent Australian publications, which appears to attribute responsibility for negative outcomes to medical professionals, such as OBGYNs and paediatricians. These specialists are often involved due to complications that arise antenatally or during labour, necessitating expert assessment or intervention to safeguard the health and welfare of both mother and infant. In urgent, time-sensitive situations, assessments, focused discussions, and consent processes must be conducted swiftly, with resources and lifesaving procedures deployed as required. It is essential that expectant mothers are informed about the possibility that their labour may not follow an uncomplicated vaginal delivery pathway and may require examinations or medically indicated interventions and support.*[472]

Complaints processes and legal pathways

6.105. The Committee heard evidence that the availability of complaint handling processes and legal pathways for people who experienced birth trauma were important. While not in themselves a cause of birth trauma, inadequate administrative complaint handling processes can compound a negative birth experience.

6.106. The DoH discussed how support is provided for people to access complaint handling processes:

> *It is common for services to be alerted to psychological trauma via a complaint after the birthing mother has been discharged from hospital. In this circumstance, issues are managed individually on a case-by-case basis, usually involving a meeting between the individual (and their family if desired) and the Clinical Director/Staff Specialist from the Obstetric and Gynaecology team, senior midwifery staff, the Director of Nursing and Midwifery and a representative of the Quality Patient Safety Service.*[473]

6.107. Throughout the Inquiry, the Committee received evidence from individual witnesses and representatives of the DoH regarding the management of birth trauma reported at the North West Private Hospital, prior to the transition of maternity services to the North West Regional Hospital. The experiences of fourteen women who birthed at the North West Private Hospital were reported

[471] Transcript of Evidence, 20 February 2025, Maternity Consumer Network, pp. 69 – 70.
[472] Updated Information, Australian Medical Association Tasmania, 10 October 2025, p. 2.
[473] Submission No. 129, Department of Health, p. 34.

to and managed by the THS. The Minister for Health, Mental Health and Wellbeing detailed the following regarding this matter:

> *The women were directly offered access to perinatal mental health services through the Gidget Foundation, funded by the Department. This support provided access to 10 perinatal mental health sessions, with access to additional sessions if deemed clinically required and approved. This offer of support was optional, provided free of charge, and maintained patient confidentiality; the THS did not have access to the personal details of those accessing this service. Five of the women accepted this support from the Gidget Foundation.*
>
> *To provide this support the Department had a 24-month contract with the Gidget Foundation between May 2023 and May 2025. The Department remains committed to providing ongoing and necessary support and care to women who have given birth in the North West. This includes access to supports such as social work or perinatal mental health services, and a pre or post discharge debrief.*[474]

6.108. Mrs Ramsey, a mother who experienced birth trauma at the North West Private Hospital, shared a number of concerns with the Committee regarding access to the services of the Gidget Foundation. Mrs Ramsey raised that access to the services appeared inequitable, was not easily accessible for some mothers, placed additional strain on the mothers and the details of the service lacked clarity.[475]

6.109. The Committee received evidence regarding existing complaint handling systems including with the DoH, the Health Complaints Commissioner, Tasmania Police and Australian Health Practitioner Regulation Agency (AHPRA). As each experience with the healthcare system is unique, so too is each experience with a complaint handling mechanism. Evidence received by the Committee reflects this, with both positive and negative experiences shared. These point to improvements that can be made to existing systems.

6.110. Ms Wingrove, Mr Streeflend and Mr Halliday shared their experience with the complaints process in the THS, which they said had been undertaken with a high degree of care. They accessed the complaint handling process because of their experience of an unplanned caesarean section. Their complaint led to an internal safety investigation by the THS into the actions of a medical practitioner.[476] In this case, the investigation found that there had been an error by the individual health practitioner, rather than with the system itself and they are now progressing their case with AHPRA.[477]

6.111. Mrs Ramsey, shared her experience with the complaint handling process after the birth of her first child at the North West Private (prior to its transition to the public system). Mrs Ramsey has had ongoing contact and complaints lodged with the former hospital, the DoH, THS, the Health Complaints Commissioner and AHPRA. In her appearance before a hearing of the Committee, Mrs Ramsey shared the

[474] Updated information, Attachment 1, Minister for Health, Mental Health and Wellbeing, 27 October 2025, p. 7.
[475] Transcript of Evidence, 18 February 2025, Amy Ramsey and Samuel Thomas, pp. 24 – 25.
[476] Transcript of Evidence, 20 February 2025, Chelsea Wingrove, Tristian Streefland and Corbin Halliday, p. 37.
[477] Transcript of Evidence, 20 February 2025, Chelsea Wingrove, Tristian Streefland and Corbin Halliday, p. 37.

following, including her concerns that practitioners may not be aware of the full extent of a patient's experience:

> ***Mrs RAMSEY*** *- Afterwards. In many meetings, the open disclosure and following meetings, everybody hid behind the excuse that they could not answer those questions because they had not been there on the day to make the decisions. They did not know why the junior midwife made up her own pain scale. They had no idea why my records were so far from what happened. Then when it came time to meet with them, they said it wouldn't be possible anymore. Then, later, I think it was* [redacted]*, in writing said that it wasn't possible because the contract had changed and they were no longer private hospital employees. Those people still exist. They still could have met with me.*
>
> *...*
>
> *Even at the very inappropriately late six-week debrief - debriefs need to be within 72 hours. That's what evidence tells us to avoid set-in PTSD [post-traumatic stress disorder]. There's another recommendation...*[478]

6.112. MCN made the following recommendation about reviewing complaints processes:

> *Review complaints procedures in all jurisdictions such that women receive fair investigations into allegations of mistreatment during childbirth. This should be independent of the hospital and women should provide feedback on this process.*[479]

6.113. The ALA recommended that adequate, independent and responsive complaints processes need to be available. They proposed opportunities for ensuring that medical professionals are able to report inappropriate conduct or structural issues in a personally safe manner, which would not impact their career:

> *a. Ensuring that whistleblower protections and mechanisms are available to medical professionals in Tasmania, so that concerned medical professionals can anonymously report incidents and systemic issues without fear of repercussions; and*
>
> *b. Where processes fail and women and/or their support networks experience birth trauma, there must be adequate, independent and responsive complaints processes in place.* [480]

6.114. Reflecting on the data collected in her study of birth experiences, Dr Ayton proposed that ongoing research is needed to better understand birth trauma in Tasmania. She explained her team at the University of Tasmania is working with the DoH to collect data and test it against best practice options:

> ***Dr AYTON*** *- ... We don't have enough research on this that's Tasmanian-specific. There's data from other states and territories and internationally, but for Tasmania, we really don't understand what that looks like. In our data, we can ... pull out the childbirth data and the birth trauma data, and have a look at that.*

[478] Transcript of Evidence, 18 February 2025, Amy Ramsey and Samuel Thomas, p. 30.
[479] Submission No. 83, Maternity Consumer Network, p. 18.
[480] Submission No. 21, Australian Lawyers Alliance, p. 24.

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

...

... *It's really problematic for all sorts of reasons. The birth trauma debriefing or support system that needs to be built around that - just like the support system that needs to be built around pregnancy loss, including miscarriage - needs to include all of the family, if the mother wants that. When that should happen and how often that should happen for the first 12 months ... we're doing the research right now to try to understand that.*[481]

6.115. The Committee received evidence from people who felt legal processes and current medical liability provisions may favour practitioners, with inadequate legal avenues of recourse for victims of birth trauma.

6.116. Human Rights in Childbirth described the nature of medical liability coverage in Tasmania:

Tort reforms were introduced in 2002 in Tasmania,[482] *which severely curtail consumer rights to redress for certain harms, such as by reintroducing a modified Bolam Principle, preventing certain claims for personal injury and death, imposing cost penalties on small claims, restricting claims for psychological harms, and placing caps on damages.*[483]

...

In addition, even if a claim contains both physical and psychological injury, the modified version of the Bolam Principle in relation to diagnosis and treatment, reinstated under section 22 of the Civil Liability Act 2002 (TAS) (CLA), prevents women from seeking justice (Bolam Defence). Under these provisions, a care provider is not negligent if the treatment provided was based on a peer accepted practice. This means that, provided an identifiable group of care providers all violate consent to prioritise an unborn infant over the mother, the woman may not have a claim.[484]

[481] Transcript of Evidence, 20 February 2025, Dr Jennifer Ayton, p. 64.
[482] Footnote 24, The Hon Justice Ipp, Review of the Law of Negligence (Final Report, Cth: Sept 2002)., from Submission No. 135, Human Rights in Childbirth, p. 33.
[483] Submission No. 135, Human Rights in Childbirth, p. 35.
[484] Submission No. 135, Human Rights in Childbirth, pp. 35 – 36.

6.117. The potential legal conflict between the rights of mothers and their unborn babies was also raised by Human Rights in Childbirth:

> *Medical liability laws and insurance policies also reinforce the myth of fetal rights over the human rights of women. Care providers are taught, through medical liability laws and insurance policies, to prioritise the infant over the mother, because infants are likely to fetch higher damages awards than mothers.*
>
> *…*
>
> *Even if a case makes it to court, precedent findings in medical malpractice cases tend to downgrade maternal injury and prioritise fetal injury. Winning is rare in maternal injury only claims and often justified only because of serious or permanent maternal injury. Consequently, this constitutes a barrier to access to justice that prevents a legal remedy even before courts have had a chance to examine what could be a meritorious claim. The failure to seek redress for such claims reduces incentives for deterring harms, as reflected in abusive facility based practice and culture today.*[485]

6.118. Representing the ALA, Ms Davies said the organisation believes there needs to be a deeper understanding amongst medical professionals, that complaint handling and litigation models should be seen as a mechanism to improve service delivery and patient experience, rather than as a thing to be feared by professionals:

> ***Ms DAVIES** - … From our perspective, we do consider that there is a level of fear around litigation in the medical profession. One of our recommendations is that as part of that education that we've advocated for, medical professionals would receive specific training around medical litigation and what it actually means for an injured person so that they might then understand it's not a punitive measure. It's not punishment of the doctor or the medical professional. It is about putting the person who's been injured back into a financial position that they would otherwise have been in but for their injury.*
>
> *…*
>
> *I think one of the other areas that we've made recommendations for is in the area of open disclosure. I know that in Victoria under their Human Rights Act, they actually have a legal obligation for public health services to discuss an adverse event. It's actually legislated and we make submissions that that should be explored in Tasmania. In Victoria, what then follows is there'll be an apology or an expression of regret, a factual explanation of what occurred, including the consequences. There will be an opportunity for the patient to relate their experience and then the steps taken to manage the event and prevent its recurrence. We know that if those things occur, the litigation often does not progress because the matter is resolved and not every error results in litigation.* [486]

[485] Submission No. 135, Human Rights in Childbirth, pp. 36 – 37.
[486] Transcript of Evidence, 23 October 2024, Australian Lawyers Alliance, p. 17.

6.119. Ms Davies said existing complaint handling processes could be improved to support a matter before it needs to reach litigation:

> ***Ms ROSOL*** *- … What is accessibility like for people who have less financial resources in terms of being able to get legal assistance in Tasmania for birth trauma issues?*
>
> ***Ms DAVIES -*** *Most law firms that would engage in this type of litigation would always accept an inquiry based on without charge or at a very low charge to at least provide some advice around whether there's the possibility of a claim... They're very expensive and very time-consuming and can be very re-traumatising, so litigation often will only suit very, very serious injuries. There is the health complaints process which can be utilised and it does not cost. I would say that certainly there are plenty of law firms that will take on no-win no-fee in the appropriate circumstances to provide that access, because… otherwise there's just simply none.*
>
> ***CHAIR*** *- You mentioned the Health Complaints Commissioner process. Have many of your clients who have gone on to formal litigation already been through the health complaints process, or through an Australian Health Practitioner Regulation Agency (AHPRA) process?*
>
> ***Ms DAVIES*** *- Look, yes. We would have both at different times, and often times they reach a barrier in that process which then would lead them on to further inquiries from us.*
>
> ***CHAIR*** *- … I wouldn't be alone in hearing people comment on the adequacy of AHPRA complaint processes, and we know there are long wait times and backlog of work in the office of the Health Complaints Commissioner. Do you have any insights into either of those that you care to share with the committee?*
>
> ***Ms DAVIES*** *- I would simply say that they are significantly important aspects of health care and they probably also need some staffing and funding increase so that they can properly provide what they've been given the power to do.*[487]

6.120. The ALA said a formal legislative recognition of birth trauma would be beneficial. In response to a question on notice taken by Ms Davies, the Committee heard about how this exists in New Zealand and Victoria.

6.121. The additional information provided by the ALA explained New Zealand's Accident Compensation (Maternal Birth Injury and Other Matters) Amendment Bill, which received Royal Assent in September 2022, which expanded the list of injuries covered by the Accident Compensation Corporation (ACC) to include maternal injuries:

> *This legislation updated the definition of 'accident' to include "a force or resistance internal to the human body at any time from the onset of labour to the completion of delivery" and extended the cover of the ACC to a proscribed list of maternal birth injuries that occur on or after 1 October 2022.*[488]

[487] Transcript of Evidence, 23 October 2024, Australian Lawyers Alliance, p. 22.
[488] Footnote 2, Ibid; 'Maternal Birth Injuries', ACC (Web page), from Response to Question on Notice dated 14 November 2024, Australian Lawyers Alliance, p. 2.

The list of injuries which are now eligible for cover are:[489]

- *Anterior wall prolapse, posterior wall prolapse, or uterine prolapse;*
- *Coccyx fracture or dislocation;*
- *Levator avulsion;*
- *Obstetric anal sphincter injury tears or tears to the perineum, labia, vagina, vulva, clitoris, cervix, rectum, anus, or urethra;*
- *Obstetric fistula (including vesicovaginal, colovaginal, and ureterovaginal)*
- *Obstetric haematoma of pelvis;*
- *Post-partum uterine inversion;*
- *Pubic ramus fracture;*
- *Pudendal neuropathy;*
- *Ruptured uterus during labour; and*
- *Symphysis pubis capsule or ligament tear.*

A caesarean section is not a maternal birth injury covered by this legislation. If the client has one of the listed birth injuries, then ACC is able to provide cover and entitlement aligning to that injury.

Those who have given birth from 1 October 2022 onwards and who have a covered injury can access the appropriate support, treatment, and care through the Accident Compensation Scheme to help their recovery and return to independence. Birthing parents can be considered for further cover if they suffer a mental injury or any other physical injury caused by a covered maternal birth injury.[490] *However, maternal birth injury cover does not include injuries to babies.*[491]

Once a claim is accepted, the relevant person can visit any local ACC-registered provider or practitioner to receive treatment and support – examples include a pelvic health physiotherapist, doctor, midwife, osteopath, chiropractor, rongoā Māori practitioner (traditional Māori healing system) or other specialised provider.[492] [493]

[489] Footnote 3, Ibid, from Response to Question on Notice dated 14 November 2024, Australian Lawyers Alliance, p. 2.
[490] Footnote 4, Ibid ('Maternal Birth Injuries', ACC (Web page), http://www.acc.co.nz/for-providers/provider-contracts-and-services/maternal-birth-injuries.), from Response to Question on Notice dated 14 November 2024, Australian Lawyers Alliance, p. 2.
[491] Footnote 5, Ibid; 'Maternal Birth Injuries', ACC (Web page), http://www.acc.co.nz/for-providers/provider-contracts-and-services/maternal-birth-injuries., from Response to Question on Notice dated 14 November 2024, Australian Lawyers Alliance, p. 2.
[492] Footnote 6, Ibid (Ibid; 'Maternal Birth Injuries', ACC (Web page), http://www.acc.co.nz/for-providers/provider-contracts-and-services/maternal-birth-injuries.), from Response to Question on Notice dated 14 November 2024, Australian Lawyers Alliance, p. 2.
[493] Response to Question on Notice dated 14 November 2024, Australian Lawyers Alliance, pp. 2 – 3.

6.122. The ALA also provided information about Victoria's open disclosure model, which prescribes legal obligations on public health services when an adverse event occurs. This is part of the *Victorian Charter of Human Rights and Responsibilities Act 2006*:[494]

> *Under this regime it is a legal obligation for public health services to discuss an adverse event with the affected patient/s. Open disclosure discussions usually involve:*[495]
>
> - *an apology or expression of regret;*
> - *a factual explanation of what occurred, including actual consequences;*
> - *an opportunity for the affected patient to relate their experience; and*
> - *the steps taken to manage the event and prevent its recurrence.*
>
> *We urge the Tasmanian Government to look at the Victorian open disclosure regime.* [496] [497]
>
> *Addressing errors and mistakes can significantly reduce the trauma experienced by women who give birth and their support network, and also allows those women and/or their child to receive the earliest possible care and treatment.* ***The ALA thus recommends that the following processes and services should be standard for women while giving birth and when post-partum in Tasmania, as well as for their immediate support network, as part of providing trauma-informed care*** *[original emphasis]:*
>
> > *a. Appropriate debriefing after the birth (including apologies, if relevant);*
> >
> > *b. Regular conversations and check-ins, especially with the woman who has given birth;*
> >
> > *c. Accessible counselling being offered;*
> >
> > *d. The provision of any physical treatments needed (such as pelvic floor physiotherapy and general physiotherapy); and*
> >
> > *e. the swift release of medical records upon request by the woman who gave birth and/or her support network.* [498]

The ALA submitted that a similar obligation could be implemented in Tasmanian legislation.

---

[494] Victorian Legislation, Charter of Human Rights and Responsibilities Act 2006, https://www.legislation.vic.gov.au/in-force/acts/charter-human-rights-and-responsibilities-act-2006/015.
[495] Footnote 9, Department of Health, Victorian Government, Open disclosure following adverse events in health services (Web Page, May 2022), from Response to Question on Notice dated 14 November 2024, Australian Lawyers Alliance, p. 4.
[496] Footnote 10, See: Ibid (Department of Health, Victorian Government, Open disclosure following adverse events in health services (Web Page, May 2022)), from Response to Question on Notice dated 14 November 2024, Australian Lawyers Alliance, p. 4.
[497] Response to Question on Notice dated 14 November 2024, Australian Lawyers Alliance, p. 4.
[498] Submission No. 21, Australian Lawyers Alliance, p. 22.

6.123. Human Rights in Childbirth provided a recommendation for legislative change, through the creation of a Health Care Consumer Bill of Rights:

> *Develop legislation containing a Health Care Consumer Bill of Rights (in consultation with women and human rights lawyers) which:*
>
> *• includes provision for protection from obstetric violence and recognises the right to informed consent and to choose or refuse treatment;*
>
> *• authorises consumer video and/or audio recordings in birthing suites;*
>
> *• provides consumers with an avenue to complain against care providers and/or facilities for breaches of the Act to Ahpra for investigation; and*
>
> *• gives consumers standing to commence proceedings against facilities and individual care providers for rights violations, including obstetric violence.*[499]

6.124. Representing Maternal Health Matters, Ms O'Keeffe discussed how the actions of medical professionals can be felt to be 'too much, too soon' and 'too little, too late':

> ***Mrs PETRUSMA***[500] *- …I am also very interested if you could share a bit more about where you talk about 'too much, too soon' and 'too little, too late', about the healthier and wealthier you are, the more likely you are to access expensive specialist care resulting in higher levels of intervention with resultant high levels of morbidity and trauma for both mother and baby. People would be really surprised about that.*
>
> ***Ms O'KEEFFE*** *- Yes, so 'too much, too soon, too little, too late' is a model identified by the Lancet in their midwifery series. That series was written by obstetricians, health professionals, health services, and midwives and it had some Australian experts on that literature. There is an identification that because of the fear in our society - and you have to be fearful if you're practising health professional because we've got an insurance system, a litigation system, a media system that thrives on what goes wrong and doesn't tell you what could be good. I use, again, homebirth as an example. Every time something goes wrong in a homebirth it is publicised in the media and it is considered negligent. Whereas, if something goes wrong with hospital it never hits the media and, more importantly, if it is in hospital it is considered inevitable, it could not have been prevented.*
>
> *That is not true. 'Too little, too late' [too much too soon] is where because of the fear in our society, the fear of litigation, the fear of things going wrong, the fear of loss of reputation, we do everything possible that is available from a technology, a surgical or a medical point of view and applying that to the whole population does harm. Whereas, if you only apply to the people who truly need it, it might ameliorate the problem they have and do good. It is 'too little, too late' [too much too soon] and it is best-evidenced in countries that have private health insurance, where lots of work is done in the private health insurance system in a private hospital.* [501]

[499] Submission No. 135, Human Rights in Childbirth, p. 71.
[500] At the time of this hearing in October 2024, the Hon. Jacquie Petrusma MP was a Member of the Committee.
[501] Transcript of Evidence, 21 October 2024, Maternal Health Matters, pp. 65 – 66.

Resources for change

6.125. The final part of this Chapter will discuss evidence the Committee heard about improvements for training and education for medical professionals.

6.126. The DoH submission highlighted available training for staff regarding the potential impact of psychological birth trauma on the development of strong familial relations:

> *CHaPS clinicians are able to screen and offer support to parents through promoting secure attachment, where this may be compromised by birth trauma, or providing appropriate referrals. CHaPS clinicians received My Early Relational Trauma Informed Learning (MERTIL) training during 2021, and a small number of clinicians were offered catch up training during 2022 and 2023. MERTIL training builds the capacity of clinicians to work confidently and sensitively with both parents and children where early relational trauma is identified. This includes a focus on undertaking difficult conversations, understanding the significant impacts of trauma, and commencing therapeutic early intervention strategies.*[502]

6.127. Ms Dawes, representing Birth Trauma Australia noted that while increased training for medical professionals does need to be developed, it needs to be undertaken with an awareness of the potential impact of previous trauma on both the individual giving birth and the medical professional:

> ***Ms DAWES** -… In an ideal scenario, everyone should be providing trauma-informed care. We recognise that there are barriers to doing that. We're effectively asking clinicians, potentially, to be exposed to trauma and taking into account that they may well have experienced it themselves. But, what I've seen is that if we think about the impact of trauma - and we're learning about the mind/body connection - to have a baby, physiologically, we've got to be relaxed and birth can be really impactful regardless of whether you have trauma or not. It's a huge experience to go through and we are just assuming that every woman can birth vaginally and pushing women to that mode of birth - assuming that that is the mode of birth best for them - without actually taking into account what she's carrying into the birth suite.*[503]

6.128. The ALA submitted that comprehensive changes need to be implemented to the training of medical professionals to initiate a shift in maternity and perinatal care offered in Tasmania:

> *In order to generally improve the safety and cultural safety of pregnant women and women giving birth in Tasmania, the ALA recommends that comprehensive training is provided to medical professionals about all aspects of birth trauma, medical litigation, and about how to engage with a diverse range of patients.*
>
> *a. This includes the provision of training in cultural safety and accessibility, such as in relation to the provision of healthcare to Aboriginal and Torres Strait Islander peoples and any related policies/protocols.*

[502] Submission No. 129, Department of Health, p. 34.
[503] Transcript of Evidence, 23 October 2024, Birth Trauma Australia, pp. 3 – 4.

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

c. *All of these new training initiatives must be included in the curricula of health and medical degrees and should be required as part of ongoing professional development for medical professionals.*[504]

6.129. They also suggested that this level of training be undertaken in regard to trauma informed and consent-based care:

> ***The ALA recommends that the Tasmanian Government requires and provides for comprehensive training on safe, trauma-informed [sic] to be undertaken by all medical professionals in Tasmania who interact with women and their support networks at any stage of a woman's pregnancy or delivery [original emphasis].***
>
> *a. This would encourage adherence by those medical professionals to any current or future regulations and policy guidelines for safe and trauma-informed deliveries. In turn, those medical professionals would also be better placed to communicate effectively with patients and educate them about risks and potential injuries before, during and after birth.* [505]

6.130. In their submission, MCN discussed the Respectful Maternity Care (RMC) Charter which was endorsed in Tasmania in 2019. The organisation delivers training in hospitals across Australia to assist workplaces implement the Charter:

> *Endorsed in 2019 by Tasmanian Health Minister within the Woman Centered Care National Strategy (Priority 2: Respect), the Respectful Maternity Care (RMC) Charter is grounded in the human rights of childbearing women and newborns based on internationally accepted human rights instruments. It provides a framework for high quality care that supports and upholds the dignity of birthing women and addresses the issues of disrespect and abuse among women seeking maternity care. Every staff member should be committing to and upholding the RMCC as per the Women Centered Care Strategy. Every maternity service should be benchmarking its maternity care against this Charter to drive respectful maternity care and improvements.*[506]

6.131. The training developed and provided by MCN is available as the Better Births with Consent workshop training program. At the time of their submission in August 2024, twenty maternity hospitals in Queensland had completed the training, with many booking additional training throughout the year to ensure that new staff

[504] Submission No. 21, Australian Lawyers Alliance, pp. 20 – 21.
[505] Submission No. 21, Australian Lawyers Alliance, p. 23.
[506] Submission No. 83, Maternity Consumer Network, pp. 15 - 16.

receive the training.[507] Ms Staines said the training has been mandated in Western Australian public hospitals with eleven recorded staff workshops having been held so far.[508] They provided some anecdotal responses to the training:

> *Survey results from the training, along with anecdotal evidence from hospital administration are that this workshop training is having a positive impact on improving the culture of disrespect against women in childbirth, are more enthusiastic about upholding a woman's right to informed consent and women are feeling safer.*[509]

6.132. The Committee heard multiple times that training in trauma-informed care was essential for change to the provision of care to be possible in Tasmania. Representing Birth Trauma Australia, Ms Dawes discussed how increased training in these areas can enhance understanding and investment for medical professionals:

> ***Ms DAWES** - Yes, I think the biggest elephant in the room, particularly for Tasmania, is the lack of workforce investment. We cannot have clinicians provide optimal care if they're suffering from burnout, compassion fatigue, vicarious trauma. And all those conditions, I think, are probably quite interplayed with one another. The outcome is all the same: women are on the receiving end of really poor care.*
>
> *When we're looking at big ticket items that can really help to prevent trauma, it's trauma-informed care, access to education - not just for women and birthing parents to have the information should they want to access it, but clinicians to understand those contributing factors to birth trauma and what they can do to help prevent it. The reason we say birth-related trauma is because it's events that can occur from conception through pregnancy, during the labour and birth, or that post-natal period. Typically, all those things are underpinned by how women, or people, are treated in the moment. So, what can we do to prevent poor treatment? And that is invest in workforce.* [510]

6.133. Birth Trauma Australia also discussed the need for the development of trauma-informed training:

> *Trauma-informed care requires an individualised approach to caring for mothers and birthing people. It requires acknowledging and understanding a person's prior birth experience or personal history and consideration of how past traumatic experiences can impact a present birth journey. A trauma-informed approach requires asking the woman or birthing person about what will help her/them feel safe (and unsafe) in their antenatal care, birth and delivery. It means women and birthing people have access to unbiased approaches to birth experiences and ensure that people feel in control during the process. It involves recognising triggers, avoiding re-traumatisation, and providing a supportive environment that promotes healing and empowerment.*[511]

[507] Submission No. 83, Maternity Consumer Network, p. 7.
[508] Transcript of Evidence, 20 February 2025, Maternity Consumer Network, p. 69.
[509] Submission No. 83, Maternity Consumer Network, p. 6.
[510] Transcript of Evidence, 23 October 2024, Birth Trauma Australia, p. 10.
[511] Submission No. 24, Birth Trauma Australia, pp. 58 – 59.

Findings

The Committee finds:

62. Some Tasmanians experience physical and psychological birth trauma.

63. There is no singular cause of birth trauma, with each birth experience affected by individual circumstances.

64. Birth trauma can be experienced by individuals giving birth, their support network and medical and health professionals.

65. An individual may not immediately understand or acknowledge that they have experienced birth trauma.

66. Birth trauma can have impacts beyond physical and psychological health, including financial costs and social impacts.

67. There are limited services available for family members who are impacted by birth trauma.

68. There is currently no dedicated public urogynaecology service provided in Tasmania.

69. There are instances in which Tasmanian women are not asked or able to give consent or informed consent during their labour.

70. Some women report a lack of opportunity during pregnancy to discuss birth options and potential interventions that could occur during labour. This can limit their ability to provide informed consent during labour.

71. Birth plans provide an opportunity for people to identify and discuss complications that may occur, and prepare for potential decisions they may need to make during labour.

72. Obstetric violence is not legally defined in Tasmania.

73. Actions which may be defined as obstetric violence can contribute to birth trauma.

74. Current complaint handling processes are not sufficiently person-centered and can lead to further trauma.

75. Other jurisdictions, including Victoria and New Zealand, have legislation that provides additional avenues for legal recourse and support services for those who have experienced birth trauma.

76. Trauma–informed training for medical and health professionals regarding consent, informed consent and birth trauma may assist in the provision of patient-centered care.

Recommendations

The Committee recommends:

33. **All pregnant people have the opportunity during pregnancy to develop a birth plan during pregnancy in consultation with health professionals. Birth plans should include consideration of unexpected birth events and potential interventions.**

34. **The Tasmanian Health Service provide a dedicated urogynaecology service in the state.**

35. **The Tasmanian Health Service develop and provide consent and informed consent education resources for use with patients during antenatal care.**

36. **The Tasmanian Health Service adopt the internationally recognised definition of obstetric violence and educate staff and patients about birth trauma and obstetric violence.**

37. **The Tasmanian Health Service provide the Better Birth with Consent Workshop, or a similar program, to all maternal health professionals.**

38. **A review of the Tasmanian Health Service complaints handling processes, with a view to providing a more trauma-informed process.**

39. **The Department of Health implement an open disclosure scheme similar to that operating under the *Victorian Charter of Human Rights and Responsibilities Act 2006*.[512]**

[512] Victorian Legislation, Charter of Human Rights and Responsibilities Act 2006, https://www.legislation.vic.gov.au/in-force/acts/charter-human-rights-and-responsibilities-act-2006/015.

7. ADEQUACY, ACCESSIBILITY AND SAFETY OF PERINATAL MENTAL HEALTH SERVICES

7.1. Chapter 7 will discuss access to perinatal mental health services, drawing on lived experience testimony and access to supports such as mother baby units, support for non-birthing parents and support networks.

7.2. In their submission, the Royal Australian College of General Practitioners (RACGP) Tasmania defined a number of aspects of perinatal mental health:

> *Perinatal mental health may encompass; response to birth trauma, maternal exhaustion, sleep and settling issues, feeding & growth issues, maternal depression and anxiety. Lack of or delayed intervention has a flow on effect for mental health of the whole family, childhood behaviour, and development while intervention has shown to be extremely effective.* [513]

7.3. They discussed the prevalence of perinatal related depression and anxiety:

> *In Tasmania there are approximately 6000 births per year. Perinatal depression and anxiety affect at least 1 in 5 mothers and around 1 in 10 fathers with approximately 1200 Tasmanian parents' experiencing mental health challenges each year. Families particularly at risk include Aboriginal and Torres Strait Islander families, culturally and linguistically diverse families and LGBTIQ+ parented families. Based on Productivity Commission modelling it is estimated that perinatal depression and anxiety costs Tasmania around $16.7 million per annum in health, economic, and wellbeing costs.*[514]

7.4. Karen Edwards, Clinical Director of Gidget Foundation Australia (Gidget Foundation), described the need for perinatal mental health support as well as the negative outcomes that can occur when adequate support isn't available:

> ***Ms EDWARDS** - … How parents adjust to pregnancy and the birth of their baby is an incredibly individual experience, which may take some time to process. But, for many expectant new parents, stereotypes and stigma around perinatal depression and anxiety can be a barrier to acknowledging their challenges. This can contribute to delays in accessing support and early intervention. However, routine assessment of mental health and wellbeing during antenatal and postnatal consultations can support improved recognition and response to perinatal mental health presentations.*
>
> *Without treatment, perinatal mental health issues can significantly impact parents, their infants, and the wider family. Affecting parent-infant attachment, family relationships, and feelings of self-worth as a parent and partner. Appropriate physical and psychological care is critical in reducing disruption to early attachment, and building parenting confidence and wellbeing.*[515]

7.5. The Committee received many submissions from lived experience witnesses who had navigated access to perinatal mental healthcare in Tasmania. Some of these submissions demonstrated, in real time, the changing landscape of access to care

[513] Submission No. 104, Royal Australian College of General Practitioners Tasmania, p. 3.
[514] Submission No. 104, Royal Australian College of General Practitioners Tasmania, p. 3.
[515] Transcript of Evidence, 30 October 2024, Gidget Foundation Australia, p. 31.

in the state, including the closure of St Helen's Mother Baby Unit (MBU). Since the closure of the Unit in 2023, the THS has provided a small number of dedicated MBU beds at the RHH and planning has commenced for a more permanent solution.

Lived experience

7.6. Playgroup Tasmania shared data, collated from a survey of families who use their service, which noted people's concerns around perinatal mental health and access to mental health services in Tasmania:

> *There are, however, many families who are struggling. In a recent survey more than 63% of new parents responded that they were concerned about their emotions or mental health and Playgroup Tasmania heard from many families that are finding it difficult to access information to support their perinatal mental health. They reported that existing online information is spread across numerous websites, is difficult to navigate, is not engaging or user friendly and is not always evidence based and up to date.*[516]

7.7. Playgroup Tasmania said respondents reported being confused about how to access information about care options, even before beginning to attempt to navigate the actual care:

> *The overwhelming message we received from families on this topic is that they are confused by existing information or are unable to access information about relevant services.*
>
> *Parents tell us they are confused about how to access programs and services and whether services are compulsory or optional. They do not know where to go to get help if they are struggling, and they do not know what will happen if they do ask for help. They reported feeling that they receive mixed messages from health care and support services, online parenting groups and their circle of family and friends.*
>
> *As one parent told us:*
>
> > *"I think the biggest barrier to not accessing appropriate support was that I wasn't able to identify that I needed it. I just thought what I was experiencing was part of becoming a Mum, but looking back now I definitely believe I suffered from post-natal anxiety and possibly even depression"*
> >
> > *Playgroup Tas Community Member, Postcode 7248*[517]

7.8. Private Witness 125 shared her experience that her mental health needs were not recognised postnatally. This included no opportunity for a post labour conversation, and ongoing comments from people involved in her care about how she 'should' feel after her birth. She felt the lack of support had an ongoing impact on her consideration of whether to seek future medical care:

> *I was discharged with no follow up appointments or referral for a birth debrief or*

[516] Submission No. 20, Playgroup Tasmania, p. 12.
[517] Submission No. 20, Playgroup Tasmania, p. 13.

mental health support. I now know, research shows that women who have undergone a complicated birth under a general anaesthetic are at a greater risk of developing postnatal mental health struggles and PTSD.

My baby came home a few days after I had been discharged. The CHaPS nurse came to visit. She made comment on our birth, and I could not talk about it, without getting emotional. Her next comment, "oh well, it doesn't matter what happened, at least you have a healthy baby is all that matters" ensured, that I would not be speaking up about the turmoil I was experiencing in the aftermath of the birth experience. Within a week, I was incredibly unwell. The thought of returning to the RHH made me anxious. I delayed seeking medical advice and attention due to the fears of having to have any further medical treatment or invasive procedures. My whole body felt like it had a lower pain threshold and I did not want to be touched by anyone, let alone a stranger.[518]

7.9. The same submitter shared another comment made by a healthcare professional regarding the 'presentation' of her mental health:

At the 4- or 6-month CHaPS appointment, the nurse asked me to complete one of the mental health screeners. I remember, sharing with her, the scores will likely reflect my inner turmoil, but it is okay because I have already accessed a private psychologist and have some supports now. She was shocked, commenting "You are so well presented, I never realised you would have been having mental health struggles."[519]

7.10. She also shared the emotional, psychological and financial impacts of her birth experience, including needing to seek private professional help of her own volition:

Emotionally- I experienced moments each day, that reminded me of my birth experience and left me in tears. I was less able to cope with the everyday tasks of being a Mum to 3. I experienced a lot of guilt for not being able to show up for my children in the way I used to.

Psychologically- I suffered an acute stress response within the first couple of months post-partum. I had panic attacks, lost my appetite, felt I couldn't get out of bed and had sleepless nights where I didn't know how I was going to get through to the morning. I couldn't go to the supermarket or be around groups of people. I withdrew from those closest to me. I had symptoms of postpartum depression & anxiety. Even at 17 months postpartum, there are still long nights, with ruminating and intrusive thoughts of the birth and occasional days where I am triggered. I have had to grieve, not being conscious for my baby's birth, missing out on the first hours and days of bonding time with him and having no photos from his birth to share with him or his siblings or to add to our family birth album.

Financially- there has been huge out of pocket costs to access pelvic floor physio, women's specialist GP, GP & Psychologist. I had to pay to get my birth notes released so I could work through these with a professional.[520]

[518] Submission No. 125, Private Witness, p. 3.
[519] Submission No. 125, Private Witness, pp. 4 – 5.
[520] Submission No. 125, Private Witness, p. 4.

7.11. Private Witness 62 discussed how she and her partner navigated support after a traumatic birth:

> *During that first 6 month we both struggled deeply with our own maternal and paternal dettachement from our son. It is difficult to explain just how profoundly our birth trauma impacted the early formation of bonding. For myself, as* [redacted] *mother, I struggled to understand how I had even become a mother, in some ways I could not comprehend it given the severe separation that we had experienced, yet here I was holding my often screaming highly distressed son trying to establish breastfeeding and heal his emotional wounds. I began to experience flashbacks from my birth, and nightmares that people were coming to take my son, or that we were separated again and I could not get to him. As if I needed any less sleep than I was already getting. I knew the risks of me developing PTSD, PND, or PNA were extremely elevated given our traumatic birth. Being the proactive woman that I am I sought out clinical psychology, counselling and a local supportive mother's group to help me through. I am grateful and proud of that fact that to this day I never spiraled into any post-partum mental illness.*[521]

7.12. Ms Marsden, shared the lack of support she received for her physical and mental health after an unexpected vaginal birth instead of her planned elective caesarean section:

> ***Ms JOHNSTON*** *- … Can you talk more about how you experienced that six-week gap until you finally got in touch with someone who could offer some support?*
>
> ***Ms MARSDEN*** *- I didn't really know where to look, to be honest, especially when I had that group that had been organised and then cancelled - that was the only thing that I had heard of. I really hung out for the CHaPS appointments, because she was so lovely. At the CHaPS appointments they do the mental health testing and all of that. It was at the review at the six week one and I mentioned that I still wasn't sleeping even though* [redacted] *was sleeping and then she suggested sending my details to Walker House.*
>
> *I don't know, during that time - I was really lucky I had my mum come and stay from Sydney and I had a friend come and stay. I didn't know what to do. I felt like a lot of people in our family circle are quite cagey about discussing birth stuff, and I mentioned that in the submission. If I would try to say this is how I'm feeling, it was very much like, 'Oh, don't say that, you might have something wrong with you'. That's why I was so relieved when the CHaPS nurse referred me to Walker House. I still meet with them monthly now. They've been the best support.*
>
> ***Ms JOHNSTON*** *- It really highlights for you how important it was for the hospital to have followed up with you immediately, given they knew what the situation was and how things hadn't gone to plan…*
>
> ***Ms MARSDEN*** *- Yes, even at the two and the six day midwife visits, no-one really checked in with me. I mentioned how much pain I was in and I was still obviously hunched over. I couldn't walk very well but it was very much 'weigh the baby, look at the baby, how's*

[521] Submission No. 62, Private Witness, pp. 5 – 6.

breastfeeding?' Lots and lots of advice on breastfeeding and what to do and what I shouldn't have been doing but that was about as far as it went.[522]

7.13. Ms Marsden provided recommendations to strengthen perinatal mental health supports in Tasmania:

> *Improving mental health support post birth, including increased resources to the services that already exist - I believe that this is especially important when a woman has already disclosed that she has a history of mental health concerns, it is a well known fact that this drastically increases a womans risk of developing PPD. I had a documented history of mental illness (I also flagged at my first midwife appointment that I was very early in the recovery phase of my eating disorder and had struggled to find support since coming to Launceston), a serious birth injury and even used the words 'traumatised' and 'in shock', several times when asking how I was going during my hospital stay post birth, surely I was raising all sorts of red flags that I wouldn't be okay? I was told that should my symptoms last longer than two weeks, I should see my GP to be referred to a psychologist - I don't believe that is providing mental health support, to say it met a minimum standard of care would be an understatement. What would have been appropriate would be for a midwife to tell me about the free services provided by Walker House and if I consented, they could send my information to the Walker House team who would contact me to make an appointment where I can bring my newborn and have a chat - if that was done, I would have had access to much needed support, far earlier than I did.*[523]

7.14. Dr Ayton's study, undertaken in her work for UTAS, includes the experience of 170 Tasmanian women and found the following in relation to perinatal mental healthcare:

> ***Perinatal and Mental health*** *support and care was absent. Some women described feeling unable to ask questions or seek help when needed, as one participant wrote about their postnatal care, 'it was awful I just shut down I was so raw and vulnerable'. Few women reported receiving any mental health care at any stage within their journey. Women commonly reported doing a 'survey' but felt this was a tick a box exercise and unhelpful.*[524]

Current access to perinatal mental health support

7.15. In their submission, the DoH discussed the nature of universal access to perinatal mental health services in Tasmania. These services are provided for low to mild perinatal mental health concerns:

> *Universal services are based on principles of primary health care to meet the needs of women, children and families at multiple contact points and can support families presenting with low-to-mild and perinatal mental health concerns. In addition to services and supports available via GPs, parents are proactively asked about their mental health as part of the services provided by CHaPS and offered strategies and parenting services to support perinatal wellbeing. CHaPS also offer parent support groups for new parents, which focus on prevention, early intervention, and some*

[522] Transcript of Evidence, 19 February 2025, Kate Marsden and Timothy Mohr, pp. 17 – 18.
[523] Submission No. 85, Kate Marsden, p. 13.
[524] Updated Submission No. 15, Dr Jennifer Ayton, p. 2.

targeted support including recognising and addressing the importance of child-caregiver attachment and infant/child mental health.[525]

7.16. Mental health services for more severe concerns are also available:

> *For families presenting with mild-to-moderate or moderate-to-severe mental health concerns in the perinatal period, CHaPS provide secondary and targeted services through three Parenting Centres in Tasmania, which are located in the South, North, and North West of the state. These Parenting Centres may prevent the onset of more serious mental health concerns by offering supports to families for a range of parenting needs including feeding and breastfeeding, sleep and settling, child and parent attachment and positive parenting behaviour management, social and emotional development, and perinatal mental health appointments and programs. …*
>
> *Families presenting with moderate-to-severe or severe mental health concerns during the perinatal period may benefit from specialist intensive care services. Services offered by DoH during the perinatal period include SMHS [Statewide Mental Health Services] for women in the antenatal period and postnatal period up to 12 months with both preexisting and new mental health illnesses or concerns of possible mental health illness; the Mental Health Inpatient Unit at the RHH for mothers with severe perinatal mental health concerns requiring individual acute psychiatric support; and the RHH MBU for parents and infants with moderate-to-severe mental health concerns who can be treated under joint admission … Once established, the four-bed Mother Baby Centre to be established at Launceston Health Hub will complement these services.*[526]

7.17. The DoH submission discussed ongoing work related to perinatal mental health, with a focus on expanding the Perinatal and Infant Mental Health Service (PIMHS):

> *In 2020, the Tasmanian Government received $4.5 million in Australian Government funding to expand PIMHS and support equitable access to services and resources for families living in the North and North West. This funding aims to support provision of sustainable PMH services that are responsive to the needs of communities in North and North West Tasmania; establish a SMHS [Statewide Mental Health Service] multidisciplinary specialist PMH team; and work towards a streamlined approach of providing perinatal mental health support across the care continuum.*
>
> *As part of this initiative, the project team is reviewing the workforce, model of service and care delivery within the PMH service. This includes investigating permanent funding sources to support service sustainability; the potential inclusion of a peer workforce to provide lived experience support; and the potential for clinical leadership support to provide the team and service with strategic direction, operational and clinical oversight, and reporting and consistency in practice.*
>
> *Following successful recruitment of staff to allocated positions, the North/North West PMH Service was able to increase service delivery during the 2022-23 financial year. The*

[525] Submission No. 129, Department of Health, p. 29.
[526] Submission No. 129, Department of Health, p. 29.

clinicians continue to build solid relationships and networks, creating a positive professional and community awareness of the level of service provided.[527]

7.18. In an update to the Committee in October 2025, the Minister for Health, Mental Health and Wellbeing, the Hon. Bridget *Archer* MP, provided some further context to available perinatal mental health supports in the North and North West of the state and proposed advancements in these locations:

> *The Department's Perinatal Mental Health Service in the North and North West offers free and confidential specialised mental health assessment and treatment. This is available for women within the perinatal period who experience or are at risk of developing moderate to severe mental health symptoms that are likely to impact their pregnancy and/or parenting.*
>
> *Additionally, work is underway to deliver a Perinatal Mental Health Service through mental health precinct redevelopment at the Launceston General Hospital and the North West Regional Hospital.*[528]

7.19. The DoH representatives spoke about triaging processes currently used for women and families throughout pregnancy, including in the perinatal period. It was noted that a thorough understanding of a patient's health and mental health history is essential for the provision of ongoing care:

> ***Ms FRENCH*** *- … Part of what we would do prior, when we received the referral, is a triaging process so you would begin to understand - that would include looking at any previous birth and obviously acknowledging there's an ability for the clinician to make some assumptions about a birth and if they'd engage with the service around what might be considered trauma or areas of concern but recognising birth trauma is a very individualised thing as well. Picking up on those cues in that immediate … booking in appointment, would be really part of those key factors in there.*
>
> *We also do perinatal screening so we do use other tools to sort of get a gauge of where someone might be sitting as far as their mental health. We do other screening - psychosocial screening, family violence screening and other things that are part of that whole suite of the process we do when anyone is booked into our service for maternity care. So it's kind of inclusive as far as our approach to the conversation and really being aware of cues with women, previously looking at their histories and just picking it up through that screening and booking-in process, acknowledging you might pick that up at every assessment or visit that comes through that space as things. As that relationship grows, things might come to light that they might not want to share in that initial visit.* [529]

7.20. The Committee received further information regarding perinatal mental screening undertaken in the THS:

> *Throughout pregnancy, all women are offered emotional and psychosocial health screening through the Edinburgh Postnatal Depression Screening tool. This is offered a minimum of two times in pregnancy, and referral to the Perinatal & Infant*

[527] Submission No. 129, Department of Health, p. 30.
[528] Updated information, Attachment 1, Minister for Health, Mental Health and Wellbeing, 27 October 2025, p. 7.
[529] Transcript of Evidence, 26 March 2025, Department of Health and Minister for Health, p. 23.

Mental Health Service or an alternative service is offered when the presentation meets referral criteria.[530]

7.21. Evidence provided by Women's Health Tasmania (WHT) suggested that a broader undertaking of such screening is required by all Tasmanian healthcare practitioners:

> *A concerning finding arising from the Talking about having a baby study was that Tasmanian women and birthing parents with pre-existing mental health conditions and/or psychosocial disability did not feel that their mental health support needs were adequately met by maternal health services during pregnancy and postnatally.*
>
> *Several participants in this cohort reported that critical information relating to their mental health histories and support requirements was either missing from their maternal healthcare records, ignored during antenatal check-ups, or led to a range of misunderstandings and mis-referrals.*[531]

7.22. Gidget Foundation's representative before the Committee Ms Edwards, also discussed how barriers to universal screening for perinatal mental ill health could be addressed to increase access to both screening and care:

> ***Ms ROSOL*** *- … We've heard in Tasmania that universal screening isn't being done particularly well, if it's happening. Are you able to share any insights of what's happening in other states, and whether there are systems or processes being used in places where it's working well?*
>
> ***Ms EDWARDS*** *- There are some states where it is working well and some of that depends on the policies and processes within the local health districts, or the health services that are providing public services. But, one of the things Gidget does is work towards also encouraging universal screening in private maternity hospitals and facilities.*
>
> *I guess the thing that really makes the difference between whether a program works significantly or not, is helping health professionals understand the importance and the value of universal screening, in creating opportunities and space to identify women who are at risk of or may have developed a perinatal mental health disorder - because without that clinician buy-in, you struggle to succeed to get the consistency with the screening.*
>
> *The other element of that is making sure that the training that clinicians need to have these conversations is available. Clinicians tend not to want to work in areas where they don't feel confident and comfortable to manage the presentations that might emerge. So, we want clinicians working at the top of their scope. To do that and to achieve that, they need the knowledge, skills, and understanding around how to screen, how to respond to what might come up in screening, and where to refer when that screening identifies issues.*[532]

[530] Updated information, Attachment 1, Minister for Health, Mental Health and Wellbeing, 27 October 2025, p. 5.
[531] Submission No. 31, Women's Health Tasmania, p. 26.
[532] Transcript of Evidence, 30 October 2024, Gidget Foundation Australia, p. 35.

7.23. Increased service provision in the perinatal mental health space was also discussed at the DoH's appearance before the Committee, including with then Minister for Health, the Hon. Jacquie *Petrusma* MP:

> ***Mrs PETRUSMA*** *– …*
>
> *The Tasmanian Health Service manages both physical and psychological birth trauma through various services including maternity and women's health services, perinatal and infant mental health services and the child health and parenting services. This multidisciplinary support team can support the mother through many different avenues, whether it is psychiatrists, psychologists, social workers or nurses. More intensive care and support is available for mothers experiencing mental health concerns such as post-natal depression and anxiety, whether it is at the mother and baby unit or also through Gidget House with the Peacock Centre in Hobart, because that is a new perinatal mental health centre open in Hobart in mid-2024 as part of the Federal Government commitment. That provides face-to-face and telehealth-based psychological support services for expectant and new parents.*
>
> *…*
>
> ***Mr WEBSTER*** *- … The Perinatal and Infant Mental Health Service is well established in the south of the state, as you probably know, Chair. Over the last three years, we have had funding from the Federal Government to expand that across the north and north west with a high degree of success. The important thing is the integration of that mental health service, particularly with our CHaPS service, but also with our maternal services, so that the referral pathways become seamless, identifying, at the hospital level, that someone is not coping and referring to perinatal before the birth or even a post-birth trauma. The Gidget House model is about that sort of continuity. It is part of a Federal Government initiative to have 12 perinatal infant mental health services rolled out across the country.*
>
> *One of those is based here in Hobart and as part of the relationship that we have with the Federal Government under our bilateral [agreement], Gidget House is actually co-located in our integration hub in North Hobart. They actually deliver their services out of the state Government facility there. There is that better integration with us, so if they do believe that the person, the consumer, has progressed beyond their model, there is referral into the more intensive model, which is PIMHS. This is similar to the parenting services that CHaPS runs, which again, are across the state. They are psychosocial, but also about breastfeeding, all of those things that young mothers might not be coping with, the parenting services are there. Again, it is the referral pathway out of CHaPS back into perinatal mental health. That is what we have strengthened, particularly in the north and north west with the model - including, the second Gidget House opening in Launceston alongside the new intensive residential parenting unit there, which will be run by Tresillian in the north.*
>
> *…*
> *What we are trying to do with our mental health services is have them integrated even though they sit as a separate element of the system. Again, it is also assuring we also are very aware that with acuity level with mental ill health, there is a need to actually balance the parenting element with the dealing with the mental ill health of*

the consumer as well. There will be occasions where clinicians will recommend separation of the [parent and child] - because of the acuity level as well and that's when adult mental health services kicks in alongside the perinatal mental health services.[533]

7.24. Further explanation on the functioning capacity of the Gidget House at the Peacock Centre was provided to the Committee:

> *Gidget House Hobart opened at the Peacock Centre in North Hobart in June 2024 providing face-to-face and virtual care-based individual psychological support services, group programs and early intervention screening for expectant and new parents with mild to moderate perinatal mental illness in Tasmania. Support is also offered for people and their partners who have experienced birth trauma, pregnancy -related loss, or are undergoing fertility treatment. Services are covered by Medicare via referral and a mental health care plan from a General Practitioner. While funding for primary care and early intervention services is a Commonwealth responsibility, the Department is actively engaged in discussions with the Commonwealth to develop long-term community-based solutions that focus on primary care and early intervention.*[534]

7.25. At the time of the hearing on 23 October 2024, it was noted that the final contract to engage Tresillian in the North of the state had not yet been signed.[535] The Committee requested information regarding the model of care proposed for the future Launceston hub:

> ***Ms DOW*** *- At the Launceston hub, will you have a multidisciplinary team?*
>
> *...*
>
> ***Dr DWYER*** *- ... We are actually in the middle of updating the service model... It's very much looking at that no wrong door approach... [The work] has been very much around how can we meet the needs of those who are currently missing out. That goes to the missing middle, it goes to those who have those complexities that need multidisciplinary care...* [536]

7.26. The provision of care outside of the Launceston hub was queried by Ms *Dow* MP:

> ***Ms DOW*** *- During the [2024] election campaign, the state government announced that there was going to be a commitment to mother-baby beds in the north of the state and there would be an outreach service. I'm trying to understand - you said that you don't have an agreement with them. Does your agreement include servicing via the buses, or is the money that's on the table for the service not going to stretch that far? I'm trying to understand exactly what services being committed to by the state government will*

[533] Transcript of Evidence, 26 March 2025, Department of Health and Hon. Jacquie Petrusma MP, pp. 16 - 17.
[534] Updated information, Attachment 1, Minister for Health, Mental Health and Wellbeing, 27 October 2025, p. 6.
[535] Transcript of Evidence, 23 October 2024, Tresillian, p. 29.
[536] Transcript of Evidence, 23 October 2024, Tresillian, pp. 31 – 32.

actually look like when it's delivered on the ground, particularly in rural and regional areas?

…

***Ms CRAWFORD** - A van has already been gifted for that area.*

***Associate Professor SMIT** - The work that's happening with Launceston hub now is for a face-to-face residential parenting, a virtual parenting residential program and a satellite to Burnie; I envisage that as phase one…*[537]

…

***Ms DOW - …** I want to understand when you think that you will have the contract finalised? You said that the beds should be available by mid next year [2025] but you know the contractual arrangements about what service delivery will look like. When do you expect that to be finalised?*

***Associate Professor SMIT** - I know it is a top priority with the various ministers at the moment. I have that assurance, so what can I say?*[538]

7.27. Ms *Johnston* MP requested further information on Tresillian's service delivery planned for Tasmania, including the likely immediate and ongoing demand for their services:

***Ms JOHNSTON** - …How do you triage the demand that the community is probably going to bombard you the minute you open your doors? How do you triage that?*

***Associate Professor SMIT** - We have our priorities already set out. We have well evidenced and established criteria for priority one, which is an admission within one week.*

***Ms JOHNSTON** - Who decides that? Do you decide or the referring doctor?*

***Associate Professor SMIT** - No, we decide based on history and the parents, given that they do not have to have a referral. That priority setting is made by a Tresillian nurse at the end of the phone because they will phone TAS BUB hopefully. That will then set that criteria. We have KPIs that we have set ourselves about how to manage it. There is a smoothing of demand through Day and Residential. Day is at a level two, where the throughput through that course is much higher. You can have three families through a day for a day service as opposed to four families a week through the residential. There is an ebb and flow through the residential and the day. It hasn't been our experience that we are absolutely inundated from day one because the pathways and acceptance by the community is still to be established. I'd be happy to be proven wrong.*

Let's remember also smoothing the demand through to the level 2 for the TAS BUB to hold them while they wait for a face-to-face.

[537] Transcript of Evidence, 23 October 2024, Tresillian, pp. 34 - 35.
[538] Transcript of Evidence, 23 October 2024, Tresillian, pp. 36 – 37.

Ms JOHNSTON *- With the services you'll be delivering in the north, and your triaging of that into priority 1 particularly for those residential beds, is there a requirement those people live in the north?*

Associate Professor SMIT *- No, it's statewide.*
…

Ms JOHNSTON *- …there will be significant amount of demand on you from day one - what's the mechanism for feedback to government about that demand?...*

Associate Professor SMIT *- We always have KPIs that we work to. Waiting times is an important one. Meeting our KPI for priority 1, 2 and 3 is another one. Presenting issues. In terms of flexible options, if our waiting time is blowing out, we can bring in a family, through day services. We can bring in families with a similar, so-called, simple presenting issue. All breastfeeding, or all sleep and settling. We can run clinics and for some that'll work before the more one-on-one intensive consultation starts. So, flexible options.*

Regarding our feedback, we're tightening up quite good reporting mechanisms on those KPIs...[539]

7.28. The Committee sought an update from Tresillian on the status of the organisation's provision of services in Tasmania, noting that the status update was received in October 2025. Danielle Levis, the current executive Director of Clinical Services at Tresillian, provided the following update regarding these services:

The site at the Launceston Health Hub is complete. Delivery of FFE commenced 25 September.

All documentation has been submitted to the Licensing Branch and is currently under review.

Tresillian will send an experience [sic] Nurse Unit Manager to Launceston to set up and open the Family Care Centre.

Recruitment to nursing positions has commenced. Recruited [sic] to all other positions will commence in the next few weeks.

The planned opening of the Launceston Family Care Centre is November 2025. The exact date is still to be confirmed.

The Tresillian 2 You van will be delivered to Launceston 27 October.[540]

7.29. The Minister for Health, Mental Health and Wellbeing also provided an update to the Committee on the status of services to be provided by Tresillian:

The Tasmanian Government committed $9 million over three years to 30 June 2028 to partner with Tresillian Family Care (Tresillian) to establish a four-bed Residential

[539] Transcript of Evidence, 23 October 2024, Tresillian, pp. 31 – 32.
[540] Updated information, Tresillian, 3 October 2025, p. 1.

Parenting Unit in the Launceston Health Hub. This includes a day service and a satellite service to the North West. The service is expected to be operational by the end of 2025.

The unit will offer a four-night/five-day program for families with children from newborn to three years of age experiencing significant parenting challenges that require intervention. It will provide strategies to promote family health and wellbeing, such as sleep and settling, breastfeeding support, toddler behaviour and parental wellbeing support. The service will include space to provide mental health support from the Gidget Foundation, an expert parental support provider, with a GP referral.

The satellite service will operate in the Burnie, Central Coast, Waratah-Wynyard and Circular Head Local Government Areas two days per week, providing services and advice on issues such as sleep, settling, feeding support, child behaviour, mental health support and referrals.[541]

In addition to the Tresillian services to be provided in the North and North West of the state, the Minister's update to the Committee noted that requests for funding to the Federal Government to facilitate further support had not currently been successful:

CHaPS applied to the Federal Government for a Commonwealth funded Gidget House, to be located at the Parenting Centre in Burnie. This submission was declined. Our government has advocated for this decision to be reconsidered.[542]

7.30. Consequentially to the receipt of the above updates in October 2025, the four bed unit, named the 'Tresillian North Intensive Parenting Unit' was officially opened on 28 November 2025 by the Health Minster and Rob Mills, the CEO of Tresillian.[543]

7.31. The Committee also requested information on the use of the Tresillian parenting line, TAS BUB, which was launched in mid-2024:

***Ms ROSOL** - … How is it going in terms of how many calls are you getting and what kind of requests are you getting? …*

***Associate Professor SMIT -** Thank you. It kicked off 1 July [2024], three months later, it is actually really slow. I have regular catch ups with Trudi Steedman as Director of Nursing and Midwifery for Child Health and Parenting Services, CHaPS. We are discussing options because the Healthdirect line for the Tassie parents is picking up maybe 100 calls a month. TAS BUB is really slow. We have peaked at three and this is on a helpline. Our other parents' helpline, we averaged between 1500 to 1800 calls a month.*

***CHAIR** - From mainland callers?*

***Associate Professor SMIT -** From all over Australia but primarily New South Wales. We would like that to pick up. Until the word is more out with the Tasmanian community,*

[541] Updated information, Attachment 1, Minister for Health, Mental Health and Wellbeing, p. 4.
[542] Updated information, Attachment 1, Minister for Health, Mental Health and Wellbeing, p. 5.
[543] Rhoades, Annika, 'New 'safe haven' opens to support Tasmanians struggling with parenthood', *The Examiner,* 28 November 2025, https://www.examiner.com.au/story/9122268/new-specialist-support-centre-opens-in-launceston-for-parents/.

we know that neither Trudi, nor I, want to terminate the Healthdirect line, but we are in a position to pick up that capacity overnight when it is ready. From there, the next level up is, if a caller wishes - if a caller takes on board the strategies that are advised on the first call and then calls again for additional support, we can make an appointment for them and they can have a virtual with us and we still have that one ready to go anytime. But until our calls increase, we are not going to be able to offer the level two services for that to happen.

We have all the services, the CHaPS services mapped so every caller is linked back into their CHaPS local service. Generally, they're already linked, but if they're not, we ensure that they have somewhere else to go once the call is over.

So, yes, we would love to be busier.

***Ms ROSOL** - ... You've alluded a little bit to that communication and mapping the service out, but if a parent calls you and you provide them with support, what are the reporting processes back to CHaPS?...*

***Associate Professor SMIT** - Right now we are collecting certain demographics, but, as I say, I think nine is a stretch goal of the number of calls, but it's demographics and it is the presenting issue so far has been breastfeeding. But, we would like all of that information to come back to Tasmania.*[544]

7.32. Ms Edwards, Clinical Director of Gidget Foundation, discussed the organisation's increasing presence in Tasmania, which commenced with a physical service in Hobart:

***Ms EDWARDS** - The Gidget centre in Hobart is going really well and we certainly have some really experienced clinicians working there who are quite well connected with some of the local community agencies as well, quite connected with some of the local health teams.*

We are looking at this stage at rolling out another Gidget House in Launceston and that will be co-located with the Tresillian facility that's coming to Launceston. So, we are looking to expand face-to-face service delivery in Tasmania, looking for opportunities to co-locate with other healthcare service providers so that we're able to provide that integrated care to people across that perinatal spectrum.[545]

7.33. Karitane is a non-government parental support organisation prioritising the first 2000 days of a child's life. The Committee received evidence from Karitane about the ForWhen national perinatal mental health navigation system, run through a phone line, which connects new and expecting parents to available supports. Karitane CEO Grainne O'Loughlin, provided Tasmanian statistics on the use of ForWhen:

***CHAIR** - ... Do you have any observations from the work that Karitane does in Tasmania about that service system and where the biggest gaps or, as you said, potential duplications, might be in a Tasmanian NGO context?*

[544] Transcript of Evidence, 23 October 2024, Tresillian, pp. 28 – 29.
[545] Transcript of Evidence, 30 October 2024, Gidget Foundation Australia, p. 37.

Ms O'LOUGHLIN *- I have, and I'm happy to share these afterwards if they're useful, a slide deck of some stats and data. I'll look at them but I'll read them out, if that's okay.*

Particularly for the ForWhen perinatal navigator service, we've been gathering data. We started that service in February 2022, funded by the Commonwealth Government. To date there have been 486 referrals. Those referrals are pretty constant. They're not really rapidly rising.

CHAIR *- Is that just in Tassie or is that nationally?*

Ms O'LOUGHLIN *- That's just Tassie, sorry. We have over 7000 nationally. I'll refer to Tasmania's context. You represent 7 per cent of the total national cases that have been referred. Seven per cent are from First Nations parents and families, and that is higher than the national average to the program, which is 4 per cent, and 5.5 per cent are male partners or non-birthing partners. We're getting quite good engagements with dads and male partners.*

Tasmania has a higher percentage of pregnant parents who referred in the second trimester, compared to other states. There is something there antenatally about engaging the families -

CHAIR *- Earlier.*

Ms O'LOUGHLIN *- Yes, so not focusing only on after the birth and the postnatal period, there are families who are being picked up who are developing anxiety and depression in the pre-birthing phase. We're definitely seeing a higher percentage of that coming through. You can't see it, but I have a location map of where the families are coming. It's not all clustered around Hobart, we have quite a cluster around Hobart and southern Tasmania, but there's a good cluster in central and north-eastern Tasmania, and then quite a few First Nations families, a lot up in the north and eastern corner, and in the centre as well...*[546]

7.34. Ms O'Loughlin further detailed the type of triaging being undertaken for Tasmanian callers:

Ms O'LOUGHLIN *- But in terms of moderate to severe cases - I'm just looking at our data - 86 per cent in March 2025 were screened and triaged as moderate to severe perinatal infant mental health families and 14 per cent [were mild cases] - the variation there seems to be anywhere from about 67 per cent up to 100 per cent - being moderate to severe...*

In Tasmania, 52 per cent of clients are entering a service with a K10 [Kessler Psychological Distress Scale] score of 30-plus, which is severe and that's above the national average which is 47 per cent through our program.

In terms of referrers to the service, there're more referrals, in fact, from your midwives in Tasmania to our navigator. So, as well as self-referrals, again we've got child and family health nurses, GPs, mental health professionals, midwives, other nurses and social workers...

[546] Transcript of Evidence, 26 March 2025, Karitane, p. 32.

From August 2023, where a service referral was needed, 88 per cent were able to be referred to the preferred service and 38 per cent were referred to telehealth services, including interstate private NGO psychology services, and the national average for that is 34 per cent.

So I guess it's making sure that Tasmania knows that they don't have to do all the heavy lifting. There are online resources, other pathways and so even if you're on a waiting list for somewhere, we can support that family whilst they're waiting for the preferred service of choice... [547]

Mother Baby Units

7.35. In June 2023, St Helen's Private Hospital (St Helen's), which then offered Tasmania's only dedicated mother baby unit, was permanently closed. In response to this closure, the Government and DoH announced the creation of an interim unit at the RHH. The DoH's submission detailed the closure and interim arrangements:

> *Previously, St Helen's Private Hospital (St Helen's) provided Tasmania's only maternal mental health and sleep inpatient unit. Due to the sudden permanent closure of St Helen's in June 2023, the MBU was opened at the RHH prior to St Helen's closure. The three-bed unit is designed to accommodate mothers experiencing mental ill-health, such as postnatal depression and anxiety. The MBU provides spacious and private rooms with ensuite bathrooms, shared living and dining areas, a kitchenette, and laundry facilities. The MBU is physically separate from the rest of the Women's and Children's Services ward, offering increased security and privacy and comfortable and home-like facilities for mothers and infants.*[548]

7.36. The DoH detailed the nature of the referral and admission process for access to the unit in its submission:

> *Clinicians can refer mothers to the MBU through Access Mental Health, the statewide mental health support, triage, and referral line. Admissions to the MBU are prioritised based on clinical need, regardless of financial status or location. Mothers experiencing other issues such as maternal exhaustion are accommodated in alternative settings such as the paediatric ward.*
>
> *Additional specific mental health supports for women experiencing perinatal mental health concerns or challenges with their baby's feeding and sleeping continue to be provided through a range of services, including PIMHS and CHaPS.*[549]

7.37. Information regarding the physical set up of the temporary unit was also provided to the Committee:

> *The current Mother and Baby Unit in the RHH has two dedicated beds to support mothers experiencing perinatal mental health concerns. The Unit at Ward K6 West*

[547] Transcript of Evidence, 26 March 2025, Karitane, p. 33.
[548] Submission No. 129, Department of Health, pp. 30 – 31.
[549] Submission No. 129, Department of Health, p. 31.

is in a space usually utilised to support the transition to home for families being discharged from Women's and Children's Services.

The Mother and Baby Unit is separate from the main part of the ward and has been optimised to cater to the unique needs of mothers and infants.[550]

7.38. The Committee heard evidence, including from WHT, the Australian Medical Association (AMA) Tasmania and the RACGP Tasmania, noting that while the interim unit is essential, its provision of care is inadequate. In their submission RACGP Tasmania said:

> *The interim unit is largely a mental health focussed service, the true scope of a mother baby unit needs to encompass infant wellbeing, physical and mental, sleep and setting [sic], as well as parental mental health. Focussing only on mental health services fails to address the variety of support new parents need in the first 1000 days of life.*[551]

7.39. While the interim arrangements allowed some level of care in the space left by the closure of St Helen's, key health stakeholders provided public criticism to the Government's solution. This was raised by several individuals and organisations including the Australian Nursing and Midwifery Federation (ANMF) Tasmania Branch:

> *In instances of care requirements for women who may be experiencing mental health illness or need support with their babies, the lack of service provision in Tasmania is nothing short of horrific. The ANMF staunchly advocated for the Tasmanian Government to take over the St Helens Private Hospital site in Macquarie Street, Hobart to ensure the continuity of care for women accessing the Mother Baby Unit and the ECT and EMS, however this was not supported due to alleged cost of renovations required. One might argue that this cost was likely to akin to the cost personally and to other health services for those women who now cannot access support for settling, feeding and sleeping challenges who have had to resort in many instances to leaving the state to seek support interstate, where they have had the means to do so. Those who don't, have had the option of seeking mental health support through services which are severely understaffed and with long wait times, or secured a bed at the RHH Mother Baby Unit, which is not a suitable environment for those needing mental health support whilst caring for a baby concurrently. The ANMF have welcomed the State Government funds for mother baby beds and implementation of the Tresillian model at the Launceston Medical Centre, yet no additional services have been supported in the South currently or in the forward estimates. Thankfully some private GPs, who are in high demand, have worked tirelessly to support these women as have the those nurses in the Child Health and Parenting Service, but this is not enough, nor is it good enough for the State Government not to immediately step in to address a dire gap for women and their babies who are in need of specialised support. The risk is that the women who are struggling with the care needs of their child is that, without the right support, they will too go on to develop mental health issues impacting, them, their babies, their*

[550] Updated information, Attachment 1, Minister for Health, Mental Health and Wellbeing, 27 October 2025, p. 3.
[551] Submission No. 104, Royal Australian College of General Practitioners Tasmania, p. 3.

families and broader communities. To ignore this critical health need is at best a serious oversight and bordering on negligent.[552]

7.40. Dr Tim Jones and Dr Marita Jones, practicing GPs representing RACGP Tasmania, discussed the discrepancy between the interim mother baby unit at the RHH and the former service provided by St Helen's:

> ***Dr M. JONES*** *- One problem is what the design of those beds were for. Initially, it was to cover the public psychiatry beds that were at the St Helen's Hospital, which could have been up to three beds. To use those beds, you need to be admitted underneath the Perinatal Infant Mental Health Service, which is a psychiatric service. That process requires seeing your GP, being referred to the service, and having two to three assessments, prior to having admission. There's a reasonable wait list of several weeks for that and telling your story over and over again to different people. Then we have a hospital-based system that's only in the south, so accessibility geographically is limited.*
>
> *Having treatment in a tertiary hospital which has stigma attached, it's not an easy place for people. Just the basics of parking and having your family come to visit you and access you in that hospital limits a family's comfort in being admitted there and staying there for the time they need. It also has limitations in terms of that the hospital is susceptible to infectious disease outbreaks, et cetera. For some families, their trauma began there and going back to have treatment there may not be helpful -*
>
> ***CHAIR*** *- Or impossible for some families.*
>
> ***Dr M. JONES*** *- or impossible, exactly. The nursing staff can only be commended for their skills in this area and there is no criticism over their focus from parenting support. However, the medical model that exists there is mostly mental health based, which is only a small number of the people who need help. Seeing as we no longer have other early interventions, potentially private patients, people with non-mental health-based struggles in parenting, may be taking the beds from people who need them. There are multiple problems with the structure as well as the limited number.*
>
> *…*
>
> ***Dr T. JONES*** *- By nature of the work I do, I have a fair number of patients who access the beds at the Royal and the biggest thing they tell me is they were there for the nursing care. They needed the support with hands on, knowing what their baby's signals were, how to feed their baby, how to settle their baby. They could take or leave the medical stuff. That wasn't the support they were really needing. The thing that they found really hard is that hands-on support, the moment they were discharged, they were just back out into the community where there wasn't any of that step-down care. There wasn't the ability to access a day program. There wasn't even the ability to follow up with anyone other than the medical team, who as we mentioned, the vast majority of my patients would say that's not the needed service. That's why we really look to the hub in the north as delivering more of that holistic wraparound approach. That's very much the feedback from the community I live and work in is that's what they need.*
>
> ***Dr M. JONES*** *- We do think we have always had a problem for our PIMHs team to have an appropriate place for parents who are really acutely psychiatric in need to have a*

[552] Correspondence from the Australian and Nursing Midwifery Federation Tasmanian Branch, dated 31 January 2025, p. 5.

place to go with their babies. There is an importance to separate that acute mental health need and the rest of parenting supports. They need to keep those beds, but they're not the same thing. It's a different service and it would be a shame for the psychiatric service to lose the ability to admit their tertiary patients if they need to.[553]

7.41. In October 2025 the AMA Tasmania raised their ongoing concern with the lack of matched mother baby unit services since the closure of St Helens:

> *AMA Tasmania has expressed concern that the services and beds previously offered at the mother-baby unit in St Helens Hospital have not yet been fully reinstated.*[554]

7.42. The Committee heard evidence from individuals with lived experience who were previous patients of the St Helen's Mother Baby Unit. These contributions highlight that while the former unit provided a much needed dedicated service, there could nevertheless also been improvements to the service. Clara White shared her experience in the former St Helen's MBU, including the complexity of seeking admission for her and her twins:

> ***Ms WHITE** - ... It was a bit unclear. I think there were a few different ways you could get admitted. Honestly, a lot of it now, probably - as it is with lots of things, there's a lot of like Facebook groups where mums are talking about, 'You need to do this, you need to do that,' which is sometimes helpful but sometimes not. Sometimes it's outdated information. Certainly, around insurance, it was a bit complicated because I knew that there was only one public bed and I didn't have the highest level of health insurance, but I was able to work out that I could access it, but I think even that would have put off a lot of people.*
>
> *It wasn't clear, exactly, what the reasons were. But I was in a good position in that one of my mum friends from my first pregnancy, from my mothers' group, she had gone in at one point, so I knew a little bit about how she'd gone in. And my mum is a retired paediatric nurse and she knew people who were working in the Mother Baby Unit. So, I think [if] it was difficult for me, I can't imagine what it would be like for other people.*
>
> *It also happened that I had randomly, in the middle of the night, when I couldn't get* [redacted] *to go to sleep, made a doctor's appointment and the doctors - that office - and then one of the doctors I ended up seeing was working at the Mother Baby Unit. So, I can't remember, is it - like my mum was like, 'I think this is where you should go,' and then it was just a bit difficult. I had to try a few different ways. It's hard to get a GP appointment. It wasn't really clear to me whether I [or the babies] should be admitted... And I was admitted because one of my twins was declared 'unsettled,' so I think that makes a difference in the care you receive. It was never really explained to me. I think if it's your babies that are the problem, they're kind of just like, 'Well, you're just here to like feed them and look after them during the day.' They didn't really talk to me about how I was going with things or anything like that.*
>
> *... I did call - I had to get a referral, had to talk to a doctor I'd never met before on the phone because it was just the easiest way to get an appointment. So, he did give me a referral, but, I don't know, he seemed to be grumpy about it. I don't know what he was doing. But anyway, he gave me a referral and then I called and I think I talked about in*

[553] Transcript of Evidence, 23 October 2025, Royal Australian College of General Practitioners Tasmania, pp. 64 – 65.
[554] Updated Information, Australian Medical Association Tasmania, 10 October 2025, p. 4.

my submission, that I had a bit of a difficult experience with the first person I spoke to was kind of like, 'Oh yeah, no worries, yes, you're definitely,' -

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

Ms WHITE *- So, that was a bit of a challenge. I think I ended up getting in over - like it was a different, I'm not sure - I saw - and then I did go and see that doctor, the doctor I'd met with previously, face to face, again. And he was like, 'I know you're on the list,' so Tasmanian isn't it? 'I'm trying to' - you know, 'You should get in soon,' but there's like this - and it was a very small facility as well. I think it was like 12 beds or something, so it's obviously very dependent on how those people are going and who else is on the list. So yes, it was just a challenging process. It's difficult because you feel like you needed to show why you needed it, but that would be quite emotional, like I am now, and so to have to do that with several different people.*[555]

7.43. Ms White also shared that prior to her admission to St Helen's she does not recall any other perinatal mental health support being offered to her or her family:

CHAIR *- … I wonder if you want to expand at all around the issue of mental health support: whether you were offered mental health support either prior to giving birth or after your stay at the Mother Baby Unit, or in between giving birth and the admission to the Mother Baby Unit. What kind of postpartum mental health support or care was provided or offered to you?*

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

CHAIR *- Insensitive.*

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

…

During that time, I wasn't offered anything.[556]

[555] Transcript of Evidence, 20 February 2025, Clara White, pp. 6 – 7.
[556] Transcript of Evidence, 20 February 2025, Clara White, p. 2.

7.44. The Committee also heard from Ms White how the institutional setting of the St Helen's MBU affected her experience, including the structure of formal processes and schedules:

> ***Ms JOHNSTON*** *- … Do you think that would have made a difference in your experience if it had just been you and your babies being admitted, not your babies being admitted and you're just here to provide care and support?*
>
> ***Ms WHITE*** *- Yes, I think so. I think some of the challenges are just around it was a hospital setting and so you have that classic thing you have in hospitals where there's shift changes and there's always about to be shift changes, so there's a lot of times when I got admitted, we went through some paperwork, and at that point I thought - they sketched out your whole family, and I really thought that was going to be more in-depth, but that had to be done relatively quickly. The whole thing is around sleep, obviously, so there's a lot of that, like, 'We need to do this before the next thing with the sleep'. So, yes, I think that would have been helpful. I think maybe also looking at the larger family system.*
>
> ***CHAIR*** *- The support around each person, yes.*[557]

7.45. Ms White told the Committee about follow up and transition support her family received once they finished the inpatient stay at St Helen's:

> ***Ms WHITE*** *- ... They were happy to chat about it, but one of the things I did that really helped was that I got - and I was lucky I could afford this - a babysitter to come a couple of mornings a week. … I asked, 'Do you know who would be a good place to start with that?', where I should go or anything like that. There wasn't anything around that, which was a bit of a lack in the system –*
>
> ***CHAIR*** *- A lack of knowledge.*
>
> ***Ms WHITE*** *- it feels like there should almost have been a case worker or someone like that who knew.*
>
> ***CHAIR*** *- Or someone specialising in multiple births.*
>
> ***Ms WHITE*** *- Yes. Also, who knew what some other facilities were when you left, that kind of thing. It was funny because I remember when we left, they said, 'You could always come back'. My husband was like, '…- they've been very clear. We definitely can't.' The experience was not that we could. It felt like it was a very specific intervention for a very - and it was, obviously, great in many ways, but it was just very specific and nothing was talked about as far as when you got home.*
>
> ***CHAIR*** *- What's next.*
>
> ***Ms WHITE*** *- Yes, exactly. And if you have older children, how do they fit into this? It's all very well to have this very strict sleep schedule. I was very like whatever works. I had no issues with that.*[558]

[557] Transcript of Evidence, 20 February 2025, Clara White, p. 9.
[558] Transcript of Evidence, 20 February 2025, Clara White, p. 9.

7.46. DoH representatives acknowledged that the current arrangement of the interim MBU at the RHH was not best practice. The DoH representatives recognised the need for a holistic mental healthcare service in the THS:

> ***CHAIR*** *- I know - and this might be useful for your answer, too - that that used to happen with the private service at St Helen's [Private Hospital]. They had a referral into the psychiatric ward if needed.*
>
> ***Mrs PETRUSMA*** *- Definitely. It still happens now.*
>
> ***CHAIR*** *- I know it was really rare, too. Midwives and nurses we've spoken to who maybe once in five years might've seen one of those referrals for really acute psychosis or someone referred into the psychiatric ward at the THS. By and large, most mental health concerns were dealt with in St Helen's. Is that kind of the model that's intended?*
>
> ***Mrs PETRUSMA*** *- That's the intention here because the whole point about having CHaPS there … is that they identify women who have anxiety or depression at a very early stage. It's those women who we intend on wrapping holistic supports around so they don't progress to having acute mental illness where they then tip over into needing to go into the Royal Hobart Hospital. It is only on very rare occasions that they do tip over to where we do, for the baby's sake or for the mother's sake, need to actually separate a mother and child. The intention is to keep the mother and baby together as long as we possibly can because we appreciate that dyad bond where they need to be together to get much better outcomes for both the child and for the mother as well.*
>
> ***Mr WEBSTER*** *- I'll just comment that it was probably a mistake on our point of view, that because the mother and baby unit sat in a mental health unit within Healthscope [at St Helen's Private Hospital], when it moved across to us, we parked it and put it on the mental health services. It was never a pure mental health services. The staff there are a mixture of CHaPS, mental health, midwives - because it needs all those inputs.*
>
> *The reason we've acknowledged it should sit under CHaPS comes from the CHaPS name. They're the parenting service part of the department. We think it's important that it is integrated rather than sitting out. Mental health don't usually do psychosocial. They're an acute service. They don't do midwifery. So, the skill sets don't generally sit within mental health, whereas they do within a CHaPS team.*[559]

7.47. The Committee was also provided with further information about the future staffing plans for the new unit proposed for development at St John's Park:

> ***CHAIR -*** *Correct me if I'm wrong, but my understanding of the staff mix at St Helen's, when it was being run there, was, yes, a mixture of midwifery trained staff, nursing staff, child health specialist nurses, et cetera, but they all had some mental health components to their qualifications and training either through a formal qualification, a diploma of mental health, perinatal or prenatal mental health, or through years of experience of working … - recognising that a mother-baby unit, while it's dealing with new parents, is more than a parenting service. It's usually where things - severe maternal exhaustion or a very disrupted baby - that means they need more support*

[559] Transcript of Evidence, 26 March 2025, Department of Health and Hon. Jacquie Petrusma MP, pp. 18 – 19.

than what the regular kind of parenting assistance can provide. Is that the intention for the mixture of staff at the St Johns Park facility?

***Mr WEBSTER** - Yes, and that's where the intensive work comes in. This is not just our day service or our regular parenting sessions for new mothers. It is the more intensive end. You have to have a mix of skills there. That's the intent. It was our experience with the unit at St Helen's, for instance, that we could very rarely get someone with acute mental ill health admitted to St Helen's, even though we had a contract with them for beds. That was because they didn't have the mental health staff to deal with acute ill health.*

...

It was the skill mix the other way, if you like; we're more confident because of our broader skill mix, that we can actually provide that service. A lot of perinatal, a lot of adult mental health, will be in-sourced, rather than sit there in the unit, on a regular basis. Because of our broader skill base across all of our units, we're probably more confident...
...

***Ms STEEDMAN** - Just a couple of notes - the majority of our CHaPS clinicians, approximately 80 per cent, do have a postgraduate certificate in child health and parenting services. In that comes quite extensive training around perinatal mental health - the assessment of, the prevention of, but also the management of that. It's a really good opportunity for the intensive parenting service to be in for that early support. We know that that early intervention can really help stop but also minimise the development of significant mental health concerns. We know that if we can get in there early, particularly for infant sleep and settling - really for CHaPS to be able to provide that wraparound, step down service in the community, going to the residential and then back to the community for more follow-up support - that hopefully that that progression into significant mental health will be minimised. We certainly see that in models across Australia, between the Karitane model and the Tresillian family care model, their percentage of families, or mothers or carers that need that extensive mental health support, is quite low, because it's that early intervention.*[560]

7.48. In October 2025 an update on the St John's Park facility, and an additional facility in Launceston, was provided to the Committee in writing:

> *Work to establish the new Intensive Residential Parenting Unit (IRPU) at St John's Park in New Town and the Residential Parenting Unit in Launceston at the Launceston Health Hub continues. These contemporary facilities will provide comprehensive parenting support for families by expert nurses, midwives and mental health professional, in a home-like environment outside of the hospital.*[561]

7.49. Specific operational information was provided regarding both the St John's Park and Launceston facilities. Regarding the St John's Park facility, the Minister for Health noted that a portion of $6 million of funding from the Federal Government

[560] Transcript of Evidence, 26 March 2025, Department of Health and Hon. Jacquie Petrusma MP, pp. 19 – 20.
[561] Updated information, Attachment 1, Minister for Health, Mental Health and Wellbeing, 27 October 2025, p. 2.

for the continuity of birthing services in southern Tasmania would be used for the service:

> *This will create a more holistic care setting through the establishment of an IRPU, which is intended to be a six-bed unit with two additional virtual beds.*
>
> *The Model of Care for the IRPU provides a holistic view of infant mental health, emphasising infants' social and emotional development and focusing on their ability to form secure relationships and regulate emotions. The IRPU will provide comprehensive parenting support for families, including assistance with sleep and settling, parent/infant attachment, parental anxiety, and early childhood behavioural concerns. This service will be delivered by Child Health and Parenting Services (CHaPS) nurses and a multi-disciplinary workforce, including specialist mental health supports.*
>
> *CHaPS will strengthen its links to Statewide Mental Health Service to support families experiencing moderate to severe perinatal mental health to step up into acute care levels when needed, and back down to community/residential parenting support once ready.*[562]

Similarly, context was provided regarding the Launceston care facility, supported by Tresillian as previously noted.

7.50. Prior to the announcement of the Government's plans for a new MBU at St John's Park, RACGP Tasmania emphasised that a different model of care will be needed, to that being provided at the interim unit at the RHH:

> *We propose community Early Parenting Hubs be in addition to beds within the Royal Hobart Hospital, which represent a separate and independently important service for mothers experiencing severe psychiatric illness. It is essential for the Perinatal and Infant Mental Health Service (PIMHS) to have access to beds, as their patients may not be suitable for community admission. In the past mothers who have required public psychiatric admission have been separated from their babies. The current interim beds at the RHH should be given permanently to PIMHS.* [563]

7.51. Dr Tim Jones, representing RACGP Tasmania, also provided his consideration of the scope of service and physical environment that should be provided at future mother baby units:

> ***CHAIR** - … perhaps be a bit more information for the committee about practically on the ground, the difference of model of care that can be provided in an acute setting versus a mother and baby unit in its true sense would be helpful for us to hear.*
>
> ***…***

[562] Updated information, Attachment 1, Minister for Health, Mental Health and Wellbeing, 27 October 2025, p. 4.
[563] Submission No. 104, Royal Australian College of General Practitioners, p. 4.

Dr T. JONES *- It begins with the structure of what a unit looks like. A hospital looks like a hospital. It feels like a hospital. There're ward rounds, emergency alarms going off, code blue's for arrests being called.*

What we're talking about in a parent-baby model is a residential space that feels like a quiet, private home-like environment where you feel comfortable to be yourself and where your baby is part of the design of the place. The difference is in not just that, but the communication. It's normalising the parental experience, not pathologising it. It's around getting to know parents and their babies and not delivering just a one-size-fits all strategy but really working with people on their own innate knowledge of their baby and supporting that. Rather than having people either in hospital or not, it's having the ability for people to access some day programs or a follow up phone or video call or even the ability to have someone video in at 2 a.m. and see how it's going. The ethos is very different.[564]

7.52. Representing RACGP Tasmania, Dr Tim Jones and Dr Marita Jones also discussed the importance of access to MBU and related care, including the need for step up and step-down opportunities:

Ms JOHNSTON *-… In terms of the triaging of who needs to access those services and the length of time of those services are offered for us, we've heard earlier this morning, I think I'm correct, five to seven days is the length of stay in the residential program. … Do you have a view about the length of service provision in some of those services, particularly those residential services? Perhaps you can elaborate on what those step-down services might look like…*

Dr T. JONES *- One of the key points to make in all of this is that we need both step-up and step-down services. Families often don't know what they need until the support is there working with them. It's quite okay for a family that's struggling in the community to be taken into one of these community-based services like the Tresillian model in the north will deliver, and potentially even there, integrate with the psychiatric beds provided at the Royal Hobart Hospital with the proviso that the teams talk to each other and that a family-centric handover of care that delivers the same goals and the same model of care is continued.*

Similarly, those patients needing those psychiatric beds may well be able to step-down into those community based residential services, if again those strong links of communication are happening, but service fragmentation at that point of care, mixed messages, changes of opinion in the mother/baby model... As GPs we were only allowed to admit for five to seven nights maximum. We frequently encountered that challenge where our only option was to hand over care to a paediatrician or a psychiatrist who may not necessarily always be aligned with the work that was already being done as we were ringing around to find them. Making sure that is baked into the design of a system, that pyramid approach, it could still use those services, but it would need to be absolutely enshrined to deliver the care … the community needs.

Dr M. JONES *- Some of the step-down models would involve being potentially discharged from the residential program but maybe being admitted to a virtual program so that you can then continue your work once you get home. In the ideal*

[564] Transcript of Evidence, 23 October 2024, The Royal College of General Practitioners, pp. 66 - 67.

picture in the Tresillian model the nurse can then visit you at home. That could help support an earlier discharge, which might be helpful for people who are either distant from the community setting, or people who have got other children and need to get home and that kind of thing. The other, hopefully, ideal factor is that the earlier we get in, sometimes a shorter admission will work, but sometimes it won't. That's why we do need to have a long-term option available as well as repeated admissions available too. Provided that the service is not inundated and then there's a six-week wait for you to get readmitted if the wheels fall off that weekend.[565]

Non–birthing partner and support networks

7.53. The Committee received evidence from a number of stakeholder organisations about the importance of perinatal mental health assessment and care for non-birthing parents and support people. Astrid Tiefholz, Branch Councillor at the ANMF, registered nurse, midwife and mental health nurse, representing the ANMF Tasmania Branch discussed this need:

> ***Ms TIEFHOLZ** - In particular, too, I think it's really important that when we're looking at infant and family mental health, it's not just the person who is biologically carrying and bearing the child. It is that person's partner, whether a male partner, female, or non-binary. It is about having regular check-ins with partners and families as well.*
>
> *In an ideal situation, women during the childbearing journey are being assessed for their mental health throughout - antenatally, to a much lesser extent, postnatally - but it is a standard part of the care planning protocol. But no-one ever checks in with fathers or non-birthing parents. If they do, it's usually in such a way as to just go, 'Are you alright there?', but without any formal way to follow up or to actually sit down with that person in an appropriate fashion to actually get a sense of how they're going and knowing what to do if that's required.*
>
> *That's a really important aspect. It shouldn't just be about being mother-baby centred care. It really needs to be family-infant centred care, parent-infant centred care, and recognising that there is a huge contribution of all members of the family towards the mental health and wellbeing of the mother and the baby and the family as a unit.*[566]

7.54. The DoH similarly noted the current risk of non–birthing parents 'falling through the gaps' for mental healthcare due to lack of available screenings:

> *It is also recognised that fathers and secondary carers are likely to experience perinatal depression and anxiety, with up to one in ten fathers experiencing depression between the first trimester and one year postpartum.*[567] *As Tasmanian fathers and secondary carers are very rarely screened or directly access PMH services, this places them at risk of not receiving the specialised PMH support they require, which can place extra stress on the family unit.*
>
> *Like other states and territories, Tasmania is working to standardise PMH [Perinatal Mental Health] screening and supports for the mother/primary carer and increase screening of fathers and secondary carers. To support this standardisation, DoH is*

[565] Transcript of Evidence, 23 October 2024, Royal Australian College of General Practitioners Tasmania, pp. 67 – 68.
[566] Transcript of Evidence, 20 February 2025, Australian Nursing and Midwifery Federation Tasmanian Branch, p. 20.
[567] Footnote 37, COPE 2023 Perinatal Mental Health Practice Guideline, from Submission No. 129, Department of Health, p. 32.

working with the Australian Government on implementing a PMH pilot to support the facilitation of routine digital PMH screening and reporting in line with the COPE, which is expected to commence in late 2024.[568]

7.55. Karitane provided recommendations to the Committee regarding access to mental healthcare for non-birthing parents in Tasmania:

- *Shift the focus of perinatal mental health to recognise the increased risk for perinatal mood and anxiety disorders also experienced by dads and partners.*
- *Provide routine mental health screening for partners (including fathers and non-birthing partners) during and after pregnancy, with the capacity for service provision for those at risk of perinatal mood and anxiety disorders.*
- *Provide community-based day programs for partners and families.* [569]

7.56. Tresillian also discussed models of care for family and support people, not only parents. They shared insights into how non-birthing parents are included in Tresillian models of care currently around Australia:

> ***CHAIR*** *- … Are there dads involved in those inpatient stays or in the outreach services that you provide or other non-birthing parents and same-sex couples?*
>
> ***Associate Professor SMIT -*** *Yes. Every time.*
>
> ***Ms CRAWFORD -*** *But there is only one admitted parent as such. So in the residential centres, one parent is identified as the admitted parent but the other parent can board and stay as well. In day services, as many people as they like can come to visit but one parent is the admitted parent. We are very father inclusive, we are very interested in fathers being involved and we present particularly some groups for dads to join. So like, Circle of Security Parenting groups for fathers.*
>
> ***…***
>
> ***…*** *we run our own Postnatal Depression and Anxiety group as well that is targeting mums but we have a dad's night so that they can come along and hear about how to support a partner with postnatal depression and hearing from them what it is like and we run some dads' groups in the residential units as well.*
>
> ***Associate Professor SMIT -*** *That one was quite informal, the dads' groups in the residence, whichever dad is present of an evening, and we make it evening, because it is it is more accessible for them.*[570]

Proposals and recommendations for perinatal mental health

7.57. The Committee received many recommendations relating to perinatal mental health. Some relate to developing and improving existing services, while others proposed new models of care for the Tasmanian context. These additional

[568] Submission No. 129, Department of Health, p. 32.
[569] Updated Submission No. 17, Karitane, p. 9.
[570] Transcript of Evidence, 23 October 2024, Tresillian, p. 28.

supports have been categorised into the areas of service provision and mental health support staff.

Service Provision

7.58. Dr Lumsden-Steel, representing the AMA Tasmania, discussed the need to provide support for mental health needs of patients and making a proactive decision about how services will be provided in each region of the state:

> ***Ms ROSOL -*** *I understand parents' mental health is one of the biggest factors in a child's development and their own mental health. If we were providing that service in CYMHS, and that focuses on the child, where do you see the parents' needs fitting in that? Where would that service be provided?*
>
> ***Dr LUMSDEN-STEEL*** *- … That is an excellent question, and I don't know if I have an actual answer for you to what the framework is, but it's a massive area of need. Clearly, obviously, we need to look at the journey, which can be antenatal depression and postnatal depression, it can be breastfeeding difficulties and trouble establishing a routine, and in that first 1000 days - even in the first 30 days - it's about how you support the parents who are having a rough time.*
>
> *At the moment, we don't have equitable, adequate access around the state. We lost the Mother Baby Unit in Hobart; the Royal is not fit for purpose. We need to get it out of where it is. It needs to have midwife support and mental health support, and it needs to be able to be accessed. I guess, how do you get access to that? That's one of the first things. At the moment, public patients pretty much never had clear access to the public Mother Baby Unit, because there weren't enough positions funded, so you only got access to that if you had money and you had private health insurance, which is appalling.*
>
> *How does a screening occur? I'm not sure we do that well. How do you identify those people who are at risk? Again, if you went back to the older models, where you had more GP practices and your nurses working with them, you had that shared care. After you had delivered, you'd have the obstetrician, but pretty much once you leave hospital you're on your own. How do you actually tap back into that? That's where your community health nurses come in. You'd go to them for your baby assessments and measures and all the questionnaires. We need to make sure that they're functioning well, and they're able to then escalate the concerns that they find.*
>
> *We need a combination of inpatient and outpatient care. When I say inpatient, it's purpose-built facilities. It's not in a mental health ward. That needs to be an overriding statewide umbrella, then, whether it's CYMHS or however the structure looks, it does need to be able to provide the appropriate service.*
>
> *Where should it sit operationally? We've suggested it's under the PIMHS service or under CYMHS, and that's for consistency, but, certainly we can discuss that. The important point is that we actually make a decision where we provide a service in each of the three regions that support it. It's got to transition from being support at home to escalating to support to an appropriate inpatient facility. At the moment, there's no real clear public access to that.*

We've obviously got, I think, Tresillian up the north-west, up at north sorry, which is providing a service which is being established. Again, we don't really have that down south at the moment, and to my knowledge, it is nothing like up the north-west. So, it's one of these situations where I think the Launceston area, the north, is leading the state recovering from this, but again, it needs to be funded, and there needs to be equity of access to that service, and we just don't have enough capacity.[571]

7.59. The AMA Tasmania discussed the benefits of reconsidering the structure of PIMHS including how it is accessed:

> *Commensurate with creating a Statewide PIMH [Perinatal and Infant Mental Health Services] service under CAMHS*[572]*, appropriate resourcing would allow those in the field to:*
>
> - *provide care to fathers as well as mothers, as there is a growing body of evidence that addressing paternal mental health in the perinatal period also yields positive outcomes for families (Dhillon et al, 2022) and almost 10% of fathers/partners also suffer perinatal depression (Cameron et al, 2016)*
> - *Provide therapeutic interventions to support infant neurodevelopment and wellbeing, which has profound long-lasting positive outcomes…*
> - *Provide longer term follow-up of vulnerable families.*
> - *Allow for secondary consultation to occur to the primary health sector and other stakeholders.*
> - *Provide home visiting services and increased outreach capacity.*
> - *Allow for primary preventative interventions and groups.*
> - *Potential to provide parenting capacity assessments and increased service collaboration between PIMH and Child Safety Services*
> - *Provide education and training opportunities for interested stakeholders and affiliated services.*
> - *Conduct research into this important area of practice.*
> - *Establish an appropriate Parent-Infant unit (formerly known as Mother-Baby Units) to support parents with severe mental illness and their infants to be admitted together, which is supported by evidence as best practice.* [573]

7.60. Representatives of Tresillian also discussed the interrelationship between perinatal mental health and infant mental health, noting how relationships

[571] Transcript of Evidence, 30 October 2024, Australian Medical Association Tasmania Branch, pp. 22 – 23.
[572] The Child and Youth Mental Health Services (CYMHS) was formally known as the Child and Adolescent Mental Health Service (CAMHS).
[573] Submission No. 25, Australian Medical Association Tasmania Branch, p. 8.

between parents and children in the early years are formative to a child's development:

> ***Associate Professor SMIT*** *- The focus on the infant, infant mental health is a new term. I don't even think 10 years ago people were using it as freely as they are now. But to think that a child is so vulnerable, so responsive to the risks that it's exposed to at the parental level. Finally we are really understanding that no child is safe in an unsafe environment. It's all about infant mental health. Even perinatal mental health is about infant mental health.*
>
> ***Ms CRAWFORD****- I think, and particularly in New South Wales, child and adolescent mental health services often fund the perinatal infant mental health arm of the work. That's where I came from before Tresillian. It's really an adolescent's mental health that starts in the perinatal period, it really does. We, in particular in the last 12 months, have invested a lot of training and supervision and expertise in our team in working in the infant mental health, which to some people sounds very strange. Like, what is an infant's mental health and how do you know when an infant's mental health isn't good? I suppose for some people you can say, well, it's when they're coming to a service like ours because they're not sleeping, they're not feeding, they're not settling, they've got what a parent might consider a difficult or challenging temperament. But it's very much a symbiotic relationship. The regulation of the child's emotion really comes from the parent and it's this co-regulating relationship.*
>
> *So, that infant mental health starts with the nurses doing that work that they're doing around the parenting support, and we're all working together so well, really, to support that infant and early childhood mental health to give them the best start.*[574]

7.61. Karitane, a provider of stepped models of care from universal, secondary and tertiary services, triage patients and connect them with mental health service facilities. Ms O'Loughlin, Karitane CEO, provided the Committee with an overview of the organisation's approach to the provision of care:

> ***CHAIR -…*** *could we have a little more information about the Karitane model? ... Could you tell us a little more about the model of how you triage and refer. ...*
>
> ***Ms O'LOUGHLIN -*** *… - a model of care that really describes the continuum of care from Karitane's care line where we just pick up the calls from parents seeking a little bit of help and support across a number of early intervention and prevention programs all the way up to what we would call intensive support.*
>
> *Intensive support in the child and family health lens being the inpatient residential unit or that tertiary level of care that we provide across the state in New South Wales, which is under a conversation obviously for Tasmania with inpatient residential beds. Karitane may be a little bit different to some of the child and family health services in Tasmania in that we do have what we call our PICMH service, which is perinatal, infant child and mental health services. We do employ perinatal mental health, infant mental health psychiatrists and clinical psychologists around early intervention, prevention for children with disruptive behaviours.*

[574] Transcript of Evidence, 23 October 2024, Tresillian, p. 33.

We have along our stepped model of care from careline and intake, because we've got so many programs that families could really fit that best meets their needs, it's quite important that at that front door we understand what the family's needs are - that we are not over-servicing people by funnelling into scarce, inpatient tertiary beds and that we help families every step of the way.[575]

7.62. Karitane told the Committee about a number of their online services in NSW, including child and family health nurse appointments and appointments for children with reactive behavioural conditions. Of great interest to the Committee was the development of virtual residential units, created as a response to the COVID–19 pandemic:

> ***Ms JOHNSTON*** *- You touched on a bit beforehand about virtual, digital and hybrid models of care. How important is that to a state like Tasmania where we're quite regionally diverse and to try to make sure we get access across the regions? Can you elaborate a bit more on how that works for our people coming in through your intake service in terms of the importance of digital and virtual access?*
>
> ***Ms O'LOUGHLIN*** *- …We thought, well, actually we've got some 20 staff trained and there are models of care and evidence, and we closed our doors during COVID to the residential units because of transmission and unvaccinated babies and safety for workforce and also babies and families. In that three weeks we shifted all our residential services to a virtual residential unit again in a pilot testing phase. We've done some publications, which are available, on the efficacy and impact.*
>
> *One, it was reactive, but the studies actually showed that for accessibility, we were increasing accessibility to rural and regional. We were overcoming some of the rural and regional workforce shortages because even with local secondary services trying to be established, we could see that we could extract and retain child and family health nurses in these remote locations. That left it up to probably mobile services or families travelling into metro areas for care.*
>
> *Again, we wrote after two years, a business case to the ministry and we were really delighted that the New South Wales Government funded 20 virtual residential parenting services on the basis of our virtual residential unit model. They allocated 10 of those virtual beds to Karitane and 10 to Tresillian. We've been running those for the last four years. There's an independent evaluation which is just about to fall due in April [2025]…*
>
> *The occupancy rates have been phenomenal; 95 to 100 per cent occupancy of those 10 beds. We do triage into those because not every family is clinically suitable, but there are a number of families who are and the impact and outcome for those families have been strong for any studies that we did. At six weeks post-follow up, families were actually more confident from the virtual cohort than from the inpatient cohort.*
>
> *We believe, and we'll do more studies, that it's because families are in situ. They're learning how to sleep and settle in their own home, in their own space not surrounded by child and family health nurses. When you're in an inpatient setting you feel like - families were nervous going home because 'it all sort of worked beautifully but -*

[575] Transcript of Evidence, 26 March 2025, Karitane, pp. 26 – 27.

...

What if it all falls apart when you get home?' Also, partner inclusion. If there's a parent working or whatever that situation or another carer in the family, people could tune in after hours at nights 24/7 on call. It's like having a nurse bell on call.[576]

7.63. Ms O'Loughlin further shared with the Committee Karitane's ongoing negotiations with the DoH in relation to launching similar services in Tasmania:

Ms O'LOUGHLIN *We are really hopeful that the virtual residential is here to stay. That's certainly one of the conversations we've been having with CHaPS. Out of all those services that are setting up, it's quite easy to set it up if you've got a good centralised intake and triage effected families, but you also don't need a local workforce to do it. They can lean in, partner, and collaborate.*

CHAIR *- So that's something you're talking to the THS and CHaPS about?*

Ms O'LOUGHLIN *- Yes, CHaPS and the THS. We put some proposal[s] for that and for the disruptive behaviours for the children waiting on paediatric waiting lists and the high demand for paediatricians. We think there's - I guess our conversation has been about, what do you have in your service system? Where can we help build a capacity or work with you to partner to build capacity across from Karitane or AAPCH colleagues; what will help CHaPS and the service system? Then where is there still a gap that might be useful to partner with someone as a service provider or to transition to getting CHaPS ready to be that service provider ultimately.*

What you also spoke about was the integrated and hybrid models of care. In the child and family hubs that we're setting up, they tend to be established in more regional centres with high levels of vulnerability and disadvantage.[577]

7.64. Dr Tim Jones and Dr Marita Jones representing RACGP Tasmania said new models of care needed to be considered, for the delivery of perinatal mental health services. This includes alternate forms of care than those currently and previously provided, such as day only services:

Dr T. JONES - *It's worth the attention of the committee that interstate we have seen models of care almost entirely relying on hubs that only provide day services for intensive support, coupled with virtual after-hours models of care, still deliver excellent outcome[s] and see less than 3 per cent of families accessing that level of care needing to progress to more formal residential mother-baby style models. Given our dispersed population, considering that from the beginning as to how we design these services is also very important.*

Ms JOHNSTON *- Whereabouts are those services?*

Dr T. JONES - *Mostly in rural New South Wales, which has the similar challenges with dispersed communities and large amounts of distance between them.*

[576] Transcript of Evidence, 26 March 2025, Karitane, pp. 34 – 35.
[577] Transcript of Evidence, 26 March 2025, Karitane, pp. 34 – 35.

Dr M. JONES - *Karitane, who I know has also made a submission to the committee, has quite a lot of research about virtual models of care that they put out and started, I believe, during COVID or just before COVID. There are some models out there that we could explore.*[578]

7.65. Gidget Foundation provided an overview of their service model:

> *At Gidget Foundation Australia we offer a stepped model of care to facilitate flexible access to a range of healthcare supports and resources, from low intensity self-help supports, through to high intensity clinician led interventions. This stepped-care model allows clients to engage in care which is person-centred, needs driven and evidence informed for at risk, and mild through to moderate clinical presentations.*
>
> *A blend of face-to face, telehealth and online resources allows Gidget Foundation Australia to support new and expectant parents across Australia, facilitating access by reducing both the individual and systemic barriers to care, including cost, availability and accessibility. It also allows clients to be stepped up or down in their care, based on changing clinical circumstances and support requirements.*[579]

7.66. Gidget Foundation's submission provided an assessment of current services in Tasmania and how these could be developed to be more responsive to the need in the community:

> *Unfortunately, access to perinatal mental health services based on geographical location is inconsistent across Tasmania, and not reflective of need. While some communities and populations have access to local primary, secondary and tertiary services, others have very limited options and face longer wait times for this care. They may also experience briefer interventions and shorter episodes of care to help ration limited resources. Increasing access to needs-based care through hub and spoke service provision should be a priority, particularly in poorly resourced communities. Priority should also be given to the establishment of new services in locations which are currently poorly resourced, with telehealth services used to provide both direct care and specialist consultation liaison for local services.*
>
> *Access to wrap around care that supports psychosocial wellbeing and addresses the social determinants of health can also improve equity, with early referral and upstream interventions critical to the delivery of genuine gains in health equity. Creating entry pathways and access to services for new and expectant parents with elevated risk and vulnerability factors should also be prioritised.*
>
> *Recommendation: Priority should be given to the establishment of free and low-cost perinatal mental health services in locations which are currently poorly resourced, with models of care and treatment duration matched to complexities in presentation.*
>
> *Recommendation: Models of care should provide sufficient scope to effectively treat and resolve perinatal mental health disorders. Ensuring all parents have access to*

[578] Transcript of Evidence, 23 October 2024, Royal Australian College of General Practitioners, p. 68.
[579] Submission No. 22, Gidget Foundation Australia, p. 2.

affordable treatment of sufficient intensity and duration to address complex perinatal presentations is critical to the wellbeing of families across Tasmania.[580]

7.67. Accessible care and information regarding care was discussed by COPE, the Centre of Perinatal Excellence, who noted that information collation could be used as a mechanism to increase community understanding of available supports:

> *COPE frequently receives requests for assistance around referral pathways in Tasmania for perinatal mental health treatment and community support – particularly in rural and regional areas as well as across the State broadly.*
>
> *We know from our work populating the eCOPE Directory of perinatal mental health services, that building the current workforce and ensuring clinicians have appropriate perinatal expertise is a key priority area in all areas of the state of Tasmania, with very few services currently identified and listed on the Directory.*
>
> *…*
>
> *We welcome the opportunity to work closely with Tasmanian representatives to scope the perinatal mental health workforce for inclusion on the Directory…*[581]

7.68. The Committee asked Ms O'Loughlin about Karitane's experience in providing online mental health supports, in the context of challenges with digital literacy:

> ***Ms JOHNSTON** - Regarding the virtual delivery of services, have you found challenges around digital literacy for many of the communities, some of the most disadvantaged you're trying to connect with? Because that's clearly an issue in Tasmania with digital literacy.*
>
> *How do you overcome those barriers?...*
>
> ***Ms O'LOUGHLIN** - There is a digital divide and affordability for people to have data and to run things, we actually as part of the outreach for the child mental health services provided dongles and other things to people. Again, we had to look at the whole solution.*
>
> *… We also kept hearing, our First Nations families don't want to connect through phones and what not. ForWhen has absolutely blasted that out of the water and because we got cultural leads, we got yarning leads, we've got Aboriginal family support workers. It's about that soft entry point. Where's your first touch point that builds enough trust to do that. There were some myths, I guess. We set up an NGO telepractice during COVID and there were a lot of - everybody said, 'it's relationship based and it can't be done virtually and nobody will trust it and nobody will do it' - and there are some families that don't. It's not a one-size-fits-all solution, but it actually increases access for a cohort of families that benefit.*[582]

[580] Submission No. 22, Gidget Foundation Australia, pp. 8 - 9.
[581] Submission No. 13, Centre of Perinatal Excellence, p. 4.
[582] Transcript of Evidence, 26 March 2025, Karitane, p. 36.

7.69. Ms O'Loughlin discussed the role of self-referral, the need for parents to be supported in service system navigation and highlighted Tasmania's Child and Family Learning Centres as a good example of multidisciplinary service delivery:

> ***Ms O'LOUGHLIN*** *- That created quite a shift in New South Wales. We spoke to our colleagues at Tresillian, to Rob [Mills, Tresillian CEO], who I know very well, and we said, 'Look, we are a secondary service, but we are going to have to create a self-referral pathway.' That doesn't mean a family can say, 'Hi, I want to come into your beds,' all it says is, 'I have a mechanism to make myself known to you that I need some support. I may not know what kind of level of support, but I need it.' Self-referrals come into intake, then we go through the process. The source is now, GPs, health professionals, and self-referrals.*
>
> ***CHAIR*** *- What kind of split is it between those three referral pathways?*
>
> ***Ms O'LOUGHLIN*** *- During COVID we were probably sitting around 80 per cent were self-referrals and it stayed quite high. Pre-COVID it was the reverse. About 75-80 per cent were all through health professionals. We went very high during COVID when there were a lot of service closures, obviously. We're probably just settling down, but still well over 50 per cent that are self-referral.*
>
> *Now, there are some risks with that, in that you get families who just have a universal [service] gap and they're referring to intake and the resources used to triage them, but they may never come to Karitane. In a broader service system, that navigation piece is critical for families. If we adopt the 'no wrong door' and help families to navigate to the right point of care, then that higher order vision is that families get to the service they need to get to. If it's our door or Tresillian's door or a phone call to whoever it is that there's a pathway to say, 'Okay, it's not us, but we're not just going to say it's not us, we're going to help you get to where you need to go.'*
>
> *…*
>
> *We're finding that intake and care navigation is becoming a stronger model. For Karitane, if I talk about the broader child and family ecosystem, we have lots of NGOs that are funded by Commonwealth programs for families in more vulnerable communities. We also have our health system, we have our early education, we have emerging foundational supports. In south west Sydney, where Karitane is, we have 52 NGOs that provide some form of child and family support. If we don't know how to navigate that system and what those NGOs do and what the health system does and what the early education does, then our families don't stand a hope.*
>
> *…*
>
> *… but that's the reason the centralised intake is super important because you'll have many service providers in your system that aren't just sitting in CHaPS and Health, but how do you make it seamless for families to get through to their points of care?*
>
> ***CHAIR*** *- It's that 'no wrong door' approach…*
>
> ***Ms O'LOUGHLIN*** *- It is. We're really excited. We don't know if Tasmania has been equally excited, but the Child and Family Learning Centres have been running for a very long*

time. Even though they're funded through Education - the whole of Australia is looking at child and family hubs as a model of care and I feel that there's a real golden egg opportunity.

***CHAIR** - There is. They're very well frequented in Tasmania where they exist. They're very important parts of our community.*

***Ms O'LOUGHLIN** - Yes, and in our submission there's a child and family hub for Fairfield that we're designing. It's like that. It has all the tentacles of NGOs, family violence, legal, social supports, wraparound supports that a family need. Our role is to bring those partners together. It's not just co-location where you just go in a door and you see them …, it is actually the family being navigated smoothly to all those providers. They won't know if it's Karitane or Barnardos or Uniting, …*

…

They don't need to know where the funding source is -

…

as long as they get their housing matters and their social supports and the domestic violence [supports]. It's just a seamless sort of come-in [continuum of care]… [583]

7.70. Gidget Foundation provided recommendations for access to mental health support for members of diverse communities, including Aboriginal and Torres Strait Islander families:

Recommendation: Development of culturally informed models of pre and postnatal physical and psychological care delivered within local communities is required to improve health outcomes for First Nations parents.[584]

7.71. The Committee heard about the structure of Tresillian's residential services in other states:

***Ms JOHNSTON** - … For those accessing the residential services, is there a timeframe in which they have to depart, or are they there until they're ready to walk out that door and have all the wrap around support?...*

***Associate Professor SMIT** - Generally, it's four nights, five days, but, if they need to return - and some do …- domestic violence - sometimes it takes a while to engineer a separation into safety for that parent and child. Tresillian services can be used for that, so, a repeat visit in between times and there's no limit on that.*

***Ms CRAWFORD** - They can ask for an extended length of stay. That does happen quite a bit for families where, perhaps, it takes a little while to get into the swing of it and the goals that they're trying to achieve. On that first admission, they talk about what they want to achieve at the stay, whether that's day service, virtual, or residential. If there's extra complexity or risk issues...*

[583] Transcript of Evidence, 26 March 2025, Karitane, pp. 30 – 31.
[584] Submission No. 22, Gidget Foundation Australia, pp. 11 – 12.

... There are people who we would identify to offer an extended length of stay, but that's usually still seven days, ... -

***Associate Professor SMIT** - That's a seven-day service where it is just continuous, whereas this initially will be a five-day service. I think that would be the other option to additionally fund. When you go from a five-day service to a seven-day service, you actually increase your throughput by up to 90 per cent...*[585]

7.72. Tresillian also discussed the services they use to screen and triage patients and the role this plays in the admissions process:

***Dr DWYER** - ... I'm very keen and Tresillian is very keen and committed to collecting adequate data so we really understand who we are supporting and who we might need to do more work with. So not only on who we're getting in the door, but how they go and how they travel.*

At Tresillian, we've committed to screening using the Centre of Perinatal Excellence guidelines, which is the national perinatal mental health guidelines that have been updated last year in 2023. They've trolled through all the literature and reviewed the ins and outs of how to screen, when to screen, what do we know works and what doesn't work.

The basic approach at the moment for perinatal mental health, and birth trauma comes into it, one of the instruments is to use the Edinburgh Post Natal Depression Scale and the Postnatal Risk Questionnaire. In the Postnatal Risk Questionnaire, there's a particular question that says, 'Did you find your birth experience disappointing or frightening?' We have obviously that data for every family or parent that comes in and is admitted to Tresillian. I recall it's about a third that endorsed that indeed they did find their birth experience frightening or disappointing. I quite like that question because it's wide. It's not asking, 'Did you find it traumatic' because, like you say, some people go, 'No, it was just hard'. But then as you start to ask them more questions and then they might say, 'Actually, I do have nightmares about it', or 'I never want to have a baby again, it was so awful'. Then you start to be able to develop that relationship with them and they can be more open.

That is a great first question... You obviously need to form that trusting relationship with someone to get a better picture. I think even asking a screening question like that gives you that opening to explore in more detail.[586]

The EPDS is more around depression, anxiety and doesn't ask about the birth at all. So, we use both of those. At Tresillian everyone who's admitted will be offered these screening tools and asked to fill them in, and that's in the admission process, which would happen within an hour or two of arriving.[587]

[585] Transcript of Evidence, 23 October 2024, Tresillian, pp. 37 – 38.
[586] Transcript of Evidence, 23 October 2024, Tresillian, p. 26.
[587] Transcript of Evidence, 23 October 2024, Tresillian, pp. 26 – 27.

7.73. Tresillian representatives further detailed the method of undertaking the questionnaires:

> ***CHAIR*** *- ... At what stage are you seeing people? Are people sometimes drawing on your services a long time after birth, or is it usually pretty soon after?*
>
> ***Dr DWYER*** *- It is zero to three for admission, and the Mental Health Service Model is looking at stretching us to zero to five. So, looking at those first 2000 days and really intervening as early as you can for that next generation, as well as for the parents.*
>
> ***Ms CRAWFORD*** *- They come back as many times as they like; there's no limit to that. Sometimes we have people come straight to us from the maternity ward, and they don't even go home yet, if they've got particular vulnerabilities, and it's been recognised in the hospital that they might benefit from a stay with us. They can come back again when the baby goes through different developmental stages, or they felt like they got part of the way there to reach their goals and they would benefit from another visit.*
>
> *So, the Edinburgh Postnatal Depression Scale, you can screen every seven days. It's asking about the last seven days. We wouldn't recommend that, but that's possible. Whereas the Postnatal Risk Questionnaire has a lot more historical information. It doesn't change as much. It does have some questions about your last 12 months. Of course, that can change a bit. But it asks things about your experience of your parent. Whether your mother was supportive? Whether you've experienced any abuse, physical abuse or sexual abuse, in your lifetime? All those sorts of things. It's designed to understand: do you have risk factors that could mean that you might experience a mental health concern post-birth?*
>
> ***...***
>
> ***Associate Professor SMIT*** *- The great thing about both these scales, that it doesn't have to be administered by a counsellor or anybody with counsellor experience. It's a nurse. So, it's on admission to a res or on registration to a day service as an ambulatory client. The nurses administer it. Long before the guidelines were updated, Tresillian took the decision to give nurses greater granularity in their clinical judgment… the marriage of the two of them, were in the EPDS and PNRQ, the Postnatal Risk Questionnaire, gave them the granularity to say, 'Okay, this is the threshold in which we include the multidisciplinary team'.*[588]

Mental health support staff

7.74. ANMF Tasmania Branch representative Ms Tiefholz, with significant experience in providing maternal and perinatal mental health services, discussed how staff shortages can lead to negative impacts on patients who cannot receive the care they need:

> ***Ms TIEFHOLZ*** *- …From the experience I've had in those sectors, but also the conversations I have daily with families, there are a lot of recurring themes that I'm noticing. One is that with the staffing shortages in the acute maternity service setting, we're finding that a lot of the time midwives are so run ragged that they're able to*

[588] Transcript of Evidence, 23 October 2024, Tresillian, pp. 27 – 28.

attend to the basic caregiving needs of helping babies get born, making sure no-one bleeds to death, making sure that there are no critical incidents. But what's really being eroded is the sense of midwife being able to provide that nurturing care, to help families become established, to help establish the breastfeeding journey and to take care for people in their mental health journey as well, both antenatally and postnatally.

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

We are seeing some positive steps forward. I don't want this to be all doom and gloom. Some of the great things that we've seen happen in Tasmania in the last few years are the opening of the Gidget House out at North Hobart as part of the Gidget Foundation [Australia], which has been terrific. But again, the word is out now and the waitlists are growing and growing. It's a terrific service but we need more of it and we need it more embedded.[589]

7.75. AMA Tasmania representatives strongly advocated for appropriate staffing levels for mental health services:

***Dr BARRATT** - Can I also add that if you're talking about the prenatal, what you need is access to psychiatrists - psychiatric nursing - quickly. At the moment, if the GP identifies a pregnant lady with a mental health issue, it can take a long time for that doctor to be able to make a referral. So, if you're talking about the first 1000 days being under CYMHS, you need to be able to have that early access to a psychiatrist with an interest in women's health in the public sector being easily accessible in all regions. At the moment, that is not something that GPs are able to do.*

***Dr LUMSDEN-STEEL** - … we know we don't have enough GPs. I mean, the entry points for a lot of this is going to be by a community nurse, or when your child's having that community assessment. If the patient doesn't actually have a GP - it's quite possible they won't have a GP - how will they then get referred back to the service, and how do they get their quick assessment done by an appropriate trained nurse, or midwife that could do that assessment and then escalate to CYMHS?*

It ranges from helping to settle the crying baby through to the mother having full-on postnatal depression or the other elephant in the room is sometimes the father, that might not be actually coping very well too, not being very supportive for the mother. There's a lot of dynamics, as we all know, that change when you have children, and not all of us biologically are actually set to do it well at the start, and sometimes the baby just isn't going to feed well, and we all know it can spiral from there.

[589] Transcript of Evidence, 20 February 2025, Australian Nursing and Midwifery Federation Tasmanian Branch, p. 92.

So, yes, thank you for identifying that this is a massive under met service and we need to look at the demand and then we need to fund a service that is structured and consistent across the state.[590]

7.76. RACGP Tasmania also noted that potential multidisciplinary approaches for perinatal care, including mental health support, rely on appropriate staffing:

Tasmania is the only jurisdiction that does not provide public inpatient and outpatient parenting support/inpatient or residential units. Either State-run or NGO-run (notable examples are Karitane and Tresillian) inpatient/outpatient services, with mixed funding are available in all other states. ACT has a similar birth rate to TAS and current [sic] provides 26 inpatient residential beds, virtual residential beds, and a day program with a multidisciplinary team (GP, child and family nurses, psychologists and social workers).

The most essential staff for these services are child and family nurses with experience in perinatal mental health or parent craft and primary care physicians (GPs), who are essential in that they can simultaneously treat parent and baby including mental health, sleep and settling, growth issues, and medical issues. A small number of patients will need psychiatric care or paediatric input.[591]

7.77. Gidget Foundation provided strong support for increased training for all primary healthcare professionals and mental health specialists to ensure Tasmania has a workforce that provides timely and appropriate care:

For many new parents, stereotypes and stigma around who gets PNDA and why, can create barriers to accessing timely appropriate care. Improving access to primary healthcare professionals who can provide culturally sensitive, routine assessment of mental well-being during antenatal and postnatal consultations is critical to improving the accessibility of entry points. All primary care perinatal clinicians across Tasmania should have foundational training in recognising and responding to perinatal mental health presentations in both birthing and non-birthing parents. Expectant parents should also have access to appropriate information and education around symptom recognition and support services to reduce stigma and normalise help-seeking.

Recommendation: Improved training for primary care providers in recognising and responding to perinatal mental health presentations should be prioritised to facilitate improved ease of access to existing care pathways. This training should be available to all public and private primary care providers across maternity and early childhood health services.

Recommendation: A statewide focus on community education and advocacy is required to increase understanding and awareness of perinatal mental health disorders and support appropriate self-referral.[592]

[590] Transcript of Evidence, 30 October 2025, Australian Medical Association Tasmania Branch, p. 24.
[591] Submission No. 104, Royal Australian College of General Practitioners Tasmania, p. 4.
[592] Submission No. 22, Gidget Foundation Australia, pp. 7 – 8.

7.78. This support for education was built upon by Ms Edwards throughout her evidence:

> ***CHAIR - ...*** *I wondered if you could share some insights about how that training can best be delivered to families and health professionals, also the importance of those referral pathways that you've referred to in that part of your written submission, recognising that the recognition of birth trauma might be some way down the track for some families.*
>
> ***Ms EDWARDS*** *- When we're talking about the education piece, there are a number of elements to that. The first thing is making sure that we embed that educational piece into the earliest level of training of healthcare providers. That needs to be in the tertiary education programs of our midwives, psychologists, doctors, et cetera. I think that's a really important piece, that the messaging starts really early in healthcare provider training. I also think it is something that needs to be continuous and ongoing. It needs to look at not only recognition of the signs and symptoms, but how to have the conversations that health professionals need to be having to help women understand their own experiences. We've just spoken about the delay for some women in recognising that perhaps they have been traumatised by their birth experience. The training for health professionals needs to help create the space and the appropriate conversations to elicit that information.*
>
> *It also needs to happen in a way that happens through the development of a trusted relationship. That education really needs to talk to the rapport building and the significant investment in the healthcare relationship. That is such an important part of understanding where women truly find themselves emotionally, psychologically and physically in their birth trauma experience.*[593]

7.79. The Committee heard that continuity–of–care and increased education for healthcare providers contributes to patients feeling safe to discuss their mental health:

> ***Mr FAIRS*** *- ...I wanted to get your experience and knowledge on this issue about patients having a better say on their own care. Do you find that in your experience patients are intimidated or scared to speak up about their own health and what's best for them, in their opinion, especially if there's greater risk?*
>
> ***Ms EDWARDS*** *- So, Rob, that's a really interesting and complex question in that there's probably not a single answer. Some people will feel very capable of speaking up and advocating for themselves and others not at all. What we do know from the research is that access to a primary care provider really increases the likelihood that people will communicate openly and honestly with their healthcare provider; that they will have conversations that involve mutual trust and that they are less likely to be distressed or traumatised by the decisions that are made because there is an understanding that they're having a conversation with someone that they trust, someone who knows and understands them, and someone who they feel confident and safe with.*
>
> *What's really important in improving the ability of, particularly, anyone from a marginalised community group, improving the ability of people in those circumstances to speak up, is to make sure that we're not changing their care providers constantly,*

[593] Transcript of Evidence, 30 October 2024, Gidget Foundation Australia, pp. 32 – 33.

we're not moving them from one person to the next so that every encounter with a health professional is a new and challenging experience.

We need to provide stability in that care, continuity in that care and we need to build meaningful and trusting relationships if people are going to feel confident to contribute to, and collaborate in, decision-making.[594]

7.80. Ms Edwards, representing Gidget Foundation, also raised concerns about wait times and a lack of available, qualified staff when accessing mental health care:

CHAIR *- ... One of the things that we know, not just in this area of health, but across the board in Tasmania, is long wait times. The referral pathway might exist, but the service that the patient needs to be referred into has an unacceptably long wait time. I wonder if you have any comments about your early experiences in Tasmania around wait times for programs that need to be resourced for people to be referred into or, equally, what your experience is in other jurisdictions that Gidget operates in?*

Ms EDWARDS *- Wait times are certainly one of the barriers that parents face in accessing onward referral and continuity of care. Wait times are not only about the length of time that ... might be associated with waiting periods to enter a service, but the entire referral process can add significantly to the wait time.*

I regularly speak with health providers, particularly hospital-based midwives, who talk about the challenges that they find in referring to not-for-profit providers and other service providers outside the state-based health system because, for many of the funding models, those referrals have to go back via a GP. So we're experiencing delays in getting that referral from the primary healthcare provider back to the GP, engaging with the GP, then getting the GP to make that onward referral. So, we've got a double wait happening there because we know, particularly in rural and regional areas, GPs are really, really time pressed and there can be significant waits to see a GP.

Streamlining some of those referral processes is an important part of the conversation and allowing - I guess facilitating - warm handovers. What we also get with warm handovers is a really, really critical transfer of information that helps the incoming service provider understand the urgency of care, the complexity of care and the support services required. Sometimes that enables them to put in place mechanisms that can begin immediate support even before they might be able to access the primary reason for referral. For example, they might be able to access some lower intensity interventions while they await their primary care intervention, or they may be provided with some wraparound support services that address some of their psychosocial stresses and improve their readiness to engage in care when they enter the service.

The other thing is that there are a number of issues that impact the waiting lists and one of them is around workforce generally. There is a very, very significant shortage of skilled perinatal mental health clinicians, and there is a skilled shortage of mental health clinicians in the workforce generally. That's something that some of our peak bodies have been talking to government about for an extended period of time. That shortage adds to waiting periods, particularly in more isolated regional and remote areas and

[594] Transcript of Evidence, 30 October 2024, Gidget Foundation Australia, pp. 37 - 38.

Tasmania has some of those more challenging workforce issues around isolation and the lack of large-city resources experiences that at a heightened level. [595]

Findings

The Committee finds:

77. Perinatal mental health services do not meet the needs of Tasmanian families.

78. Tasmania has less perinatal mental health services than some other Australian jurisdictions, including inpatient and outpatient services, online support, navigation services and community education.

79. There is inequity of access to perinatal mental health services in regional and rural areas of Tasmania.

80. The Department of Health and stakeholder organisations recognise the lack of perinatal mental health services and have indicated a willingness to work together to increase services.

81. Birthing parents do not routinely undergo perinatal mental health screening and non-birthing parents and support networks are almost never screened.

82. The closure of the St Helen's Private Hospital Mother Baby Unit has had a profoundly negative impact on access to perinatal mental health care in Tasmania.

83. The Department of Health acknowledges that the interim Mother Baby Unit at the Royal Hobart Hospital does not provide best practice in mother baby units. A more appropriate model of care is planned for the new St John's Park facility.

84. At the time the Committee heard evidence, the Tresillian TAS BUB Parent's Help Line had not received a significant number of calls and was not operating to its full capacity.

85. The underutilisation of the Tresillian TAS BUB Parent's Help Line is likely linked to a lack of community awareness of this new service and potential perceived duplication between it and other existing services including the Child Health and Parenting Service (CHaPS) Parent Line.

86. Increased education for health professionals would improve access to perinatal mental health support.

[595] Transcript of Evidence, 30 October 2024, Gidget Foundation Australia, p. 33.

Recommendations

The Committee recommends:

40. The Government ensure the adequate funding and provision of perinatal mental health support services in Tasmania.

41. The Government establish an expert working group, including not-for-profit organisations and peak bodies, to investigate and recommend a holistic model for the provision of perinatal mental health services.

42. The Tasmanian Health Service develop and implement clear perinatal mental health service navigation pathways.

43. The Tasmanian Health Service introduce universal perinatal mental health screening of both birthing parents and non-birthing parents, and where needed, support networks and families in both the antenatal and postnatal period.

44. The Government establish state run permanent inpatient mother baby units in each region of Tasmania.

45. The Government evaluate the public awareness and effectiveness of the Tresillian TAS BUB Parent's Help Line.

8 ADEQUACY, ACCESSIBILTITY AND SAFETY OF THE CHILD HEALTH AND PARENTING SERVICE (CHAPS) AND PAEDIATRIC HEALTH SERVICES

8.1. CHaPS and paediatric healthcare in Tasmania is vitally important to the growth and development of Tasmanian children. Chapter 8 will assess the adequacy, accessibility and safety of the Child Health and Parenting Service (CHaPs) and paediatric health services in Tasmania.

Child Health and Parenting Services (CHaPS)

8.2. The DoH provided the following description of CHaPS in their submission:

> *CHaPS is a statewide health and wellbeing service for families across Tasmania with children aged 0-5 years old, providing around 52 000 occasions of service each year. Services are delivered from clinical settings, home visits or via virtual care, from around 70 sites statewide.*
>
> *Each year across Tasmania, CHaPS sees approximately 5 500 babies, provides approximately 52 000 consultations, and conducts around 30 000 CHAs [Child Health Assessments].* [596]
>
> *…*
>
> *The CHaPS model of child health is unique within Australia, both in its scope of delivery of universal and targeted services, and its broad statewide cover. Family engagement with CHaPS remains high through until children are between 4.5 and 5 years of age, with services often including a combination of routine CHAs and support for a range of other parenting or developmental challenges.*[597]

8.3. The DoH further detailed the work undertaken by CHaPS, including required developmental checks and screenings:

> *CHaPS provides nationally recommended growth and developmental surveillance and screening through regular CHAs, along with support and anticipatory guidance to parents. CHaPS promotes the healthy development and wellbeing of children, providing health-focused early intervention, referrals, and connections with other early childhood service providers. The service also provides additional support for children and their families experiencing PMH [Perinatal Mental Health] challenges, sleep and settling issues, breastfeeding concerns, family violence, and identified risk factors that may impact the development and safety of an infant, child, or their caregivers. By providing access to information and services focussed on building relationships between children and parents, CHaPS works to enhance the confidence and capacity of Tasmanian parents.*[598]

[596] Submission No. 129, Department of Health, p. 43.
[597] Submission No. 129, Department of Health, p. 44.
[598] Submission No. 129, Department of Health, p. 44.

8.4. The map below shows the locations of CHaPS sites:

8.5. In its submission, the DoH stated that CHaPS employs approximately 150 – 155 staff, with close to 90 per cent of clinical staff being child and family health nurses (CFHNs).[599]

8.6. The Committee received evidence from a number of witnesses regarding CHaPS. Much of the evidence provided strong support for the work of CHaPS and its staff. However, it was also noted that extra staff, additional services and increased geographic access would significantly improve the service.

8.7. In her submission, Ms Cowen discussed the benefit of having CHaPS available in her local community, making access easy for her family:

> *Since being discharged we have had many visits to CHaPS, paediatric outpatient clinics, the ophthalmology clinic, ED and subsequently been admitted to the paediatric ward a handful of times. With the exception of the ophthalmology clinic, I have never questioned the care we have received. Our CHaPS nurses are wonderful and getting to see them locally in Sorell is so convenient for our community. The times we have been admitted to the paeds ward the care has been outstanding despite the challenges as*

[599] Submission No. 129, Department of Health, p. 77.

we are always needing to be in isolation due to viral induced wheeze. My son reacts badly to the nurses and doctors needing to be fully gowned up but they have always done such a great job managing it and helping us get home as soon as we safely can.[600]

8.8. Mrs Ramsey provided strong support for the CHaPS network, including the provision of social workers:

> ***Mrs RAMSEY*** *… CHaPS is the best service in the THS as far as anything to do with maternal and child health, across all CHaPS aspects, any role, nurses, social workers, speech pathologists, allied healthcare. Whoever is organising them and structuring that is killing it and give them more money to do more of that.* [601]

8.9. Ms White discussed her experiences with a local parenting centre, provided through CHaPS:

> ***Ms ROSOL*** *- … - you talked about the parenting centre being very helpful to you and coming to your house to help and give advice. Could you explain a little bit more about what that was?*
>
> ***Ms WHITE*** *- … That's part of the CHaPS (Child Health and Parenting Service) nursing program, and it's based in New Town. I'd come across it with my first, when I had some breastfeeding troubles. It's a really good service because you call and they triage you and they book you into the system. I think partly because I had twins, they came out to my house. I only really have positive things to say about it, apart from the fact that I feel like there's not enough information about it, and they are, obviously, limited.*
>
> *It's also quite difficult because you call and then it depends what day you call, because I think they triage on a Thursday. Then you have to wait to get triaged and they call you back. It's quite hard taking lots of phone calls when you're trying to sleep. There are just some challenges with that -*
>
> ***CHAIR -*** *Bureaucratic challenges?*
>
> ***Ms WHITE*** *- Yes, with that system. It's really helpful in some situations, but if you're in a real crisis situation, being told, 'We'll call you back in five days', or whatever, 'and we'll see if we can fit you in', is not always going to be the answer. But it is great that it has - I do think in the past they did have a residential offering, but they no longer do. I always mention it to people, and it is free as well, which I think is really good. There's a lot of things online now, sleeping courses, feeding courses, all these things that you can spend a lot of money on, and they might not be in Australia, they might not be specific to the situation, they might not be safe. I think it's really great that we do have these public systems which are staffed by professionals and that kind of thing. I just wonder if we could make people more aware of them and make it a bit more of a straightforward process. There's, like, a website. It's a very Tasmanian Government health website. It doesn't really explain things and you have to call a landline. I get it, but it doesn't feel accessible to everyone.*[602]

[600] Submission No. 121, Brigid Cowen, p. 2.
[601] Transcript of Evidence, 18 February 2025, Amy Ramsey and Samuel Thomas, p. 31.
[602] Transcript of Evidence, 20 February 2025, Clara White, pp. 10 – 11.

8.10. A Private Witness to the Inquiry discussed her experiences with CHaPS, noting that while support was given, additional assistance could not be easily provided:

> *The CHaPS service has been great. I was told repeatedly to call and seek support if I needed by [sic] the service. I eventually built up the courage to reach out and ask for help with sleep as the baby wouldn't be put down into a cot. I was sent off for a referral. The next day I was called and told they were so understaffed and wouldn't be able to see me for months. After, the careful support of staff in the community chaps [sic] nurses allowed me to be seen in a reasonable time frame. If that is an expected wait time normally, it is completely unreasonable and would have led me to further risk of poorer mental health outcomes. The experience can be summarised as being told repeatedly that support was available, then gathering the courage to ask for it and be told 'actually it's not'. Which is disheartening.*[603]

8.11. Private Witness 102 detailed examples of the support she felt was missing in her experience with CHaPS. She suggested that if these services had been provided, they would have enabled additional support for her family. She also acknowledged that her experience occurred during the COVID-19 pandemic which likely had an influence on the provision of care:

> *I have consistently seen the same CHaPS nurse in relation to both my children. While I cannot criticise her specifically, the service is lacking. I would like to see:*
>
> *a) The appointment schedule increased to include routine check-ins at 18 months; and*
>
> *b) A broader discussion of safe sleep that goes beyond SIDS recommendations and recognises that many families will find themselves co-sleeping at some stage (and that therefore includes advice about how to reduce risks while co-sleeping).*
>
> *Regrettably, I was not referred to a parent's group following the birth of my first child.*
>
> *I am unsure whether this was a consequence of COVID-19 restrictions that were in place at the time. I subsequently initiated my own parent's group and cannot express how meaningful it is to have peer support.*[604]

8.12. The Committee heard from lived experience witnesses and from organisations, about the need for parents to advocate for their children within the health system, including CHaPS. This evidence indicated poor communication channels between different healthcare providers, even if all within the one system. Private Witness 77 discussed the organisations lack of communication in relation to her child's weight:

[603] Submission No. 59, Private Witness, p. 5.
[604] Submission No. 102, Private Witness, p. 3.

From birth my breastfed son didn't seem to be putting on as much weight as what he should have been. We would attend our CHAPS appointments and then they would request that he come back in two weeks. At times due to the clinic nurse being sick or unavailable the weights could be drawn out to as long as three or four weeks. After my sons eight week check (which was done at 10 weeks) it was noted that he was sitting below the 3rd percentile. They then sent me away and asked for me to come back the next week which due to the nurse being unavailable this was drawn out to 12 weeks. At this appointment he was noted to be in the 1st percentile and she requested that I go to the Doctor to get a referral to a pediatrician ASAP. I saw a Dr the next day and he asked me what I had been supplementing with? I had told the Clinic nurse that I was happy to try and give my son formula but she didn't want me to risk losing my milk supply. I was that stressed about the possibility of him having CF [Cystic Fibrosis] that at this point I was willing to try anything to make my son classify as 'healthy'. The Doctor said that he would get me a referral to a pediatrician but that prior to this he would've thought that they would suggest a supplement. From the day of seeing the Doctor we introduced formula to trial mixed feeding and my son put on 460 grams in one week. My son is now on track and sitting close to the 25th percentile. I'm still yet to hear from a pediatrician in regards to the referral so it was lucky that the doctor could give me the advice that I really needed from my CHAPS nurse. I don't think that it is good enough that when your specific clinic nurse is sick or unavailable that your appointment just gets cancelled particularly in the case where weight is being monitored closely.[605]

Available services

8.13. The importance of services provided by CHaPS was repeatedly raised by individuals and organisations. This included specific services, the scope of care and access to services.

Assessments and checks

8.14. Trudi Steedman, Nursing Director-Child Health and Parenting Services, provided an update on service provision following COVID-19:

> ***Ms STEEDMAN*** *- … we have recovered very well from COVID. There was a period where the staff had to go and help with the COVID response. Since then, we actually have had really high engagements. In fact, in 2024, from the two-week check, we are at a 99 per cent engagement rate and at the eight-week check, we are at 95 per cent. Then, it progresses on. Even for our four-year healthy kids' check, we are currently at 53 per cent, which is quite high, considering there are other opportunities for the families to have those healthy kids' checks as well through school nursing and things like that. Yes, we have definitely overcome it and back to full capacity and back to full service delivery of all the child health assessments, but also, support and parental guidance that we give.*[606]

8.15. The Committee heard an update from the DoH regarding the implementation of a new health check for 18–month old babies. This check has been developed as a

[605] Submission No. 77, Private Witness, pp. 3 – 4.
[606] Transcript of Evidence, 26 March 2025, Department of Health and Hon. Jacquie Petrusma MP, p. 10.

result of the 'lifting literacy' funding provided by the Department of Premier and Cabinet (DPAC). CHaPS will operate the service:

> ***Ms STEEDMAN*** *- … CHaPS will be introducing a new 18-month check in July [2025]. At the start of July, it will start to be operational. That is through some of the funding that we have received from DPAC. It is around the lifting literacy funding. It is actually going to be called 18 Months Kids Love to Learn Check and it is around role modelling, behaviour around literacy, reading and it will also do some developmental checks as well. Then there will be referrals that could be made if the child health nurse picks up on any delays or development issues that they can see. A lot of it is really around role modelling and we have worked with Brand Tasmania, with Little Tasmanian. Initially for the first 12 months, every child will receive a book and the child health nurse will sit and role model some of that behaviour as well.*[607]

8.16. Private Witness 8, a CHaPS nurse, described the current provision of checks performed within the service and additional options which could be provided in the future:

> *CHAPS model of Care (currently under restructure after 2 external consultancy engagements) offers 7 Child Health Assessments (CHA)..at 2 weeks, 4 weeks, 8 weeks, 6 months 12 months, 2 yrs and 4 yrs. This is 3 less than considered best practice in Victorian MCH [Maternal and Child Health service] model. This model misses critical developmental periods of 4 months and 18 months and doesn't align with the SACS [Social Attention and Communication Surveillance] screening used for autism disorders which are 12m, 18m, and 2 years, making the screening we can do almost irrelevant as it doesn't align with the evidence around autism screening.*
>
> *The First 1000 days is recognised as the critical period in a child's development and missing opportunities for screening, referral, parenting anticipatory guidance in the Universal CHAPS leads to less optimal outcomes for Tasmanian children and parents. Providing early, more intensive universal services, hopefully in a continuity of care model, according to years of evidence, will result in better outcomes for Tasmanian families.*[608]

8.17. The Committee received evidence from the Australian Physiotherapy Association (APA) about physiotherapy throughout the antenatal, labour and perinatal periods, both for the birthing parent and children. Lizzie Barnes–Keoghan, a paediatric physiotherapist, discussed the role of physiotherapists in her area of practice, including their operational capacity within the THS:

> ***Ms BARNES-KEOGHAN*** *- Paediatric physiotherapists work with families to support their child's development, especially in the first five years of life. The most common state-funded pathway to paediatric physiotherapy in Tasmania is via referral from CHaPS [Child Health and Parenting Service] or GPs. Parents are also able to self-refer to access paediatric physiotherapy services and there are a growing number of private practice paediatric physios, although most of those are in Hobart, a few are in Launceston and there are very few in any of our rural or regional areas.*

[607] Transcript of Evidence, 26 March 2025, Department of Health and Hon. Jacquie Petrusma MP, pp. 10 – 11.
[608] Submission No. 8, Private Witness, p. 1.

As paediatric physiotherapists, we are often the first person to identify and discuss in detail a developmental delay with the family. There is simply not enough time or skills that our CHaPS nurses and our GPs have to have those conversations. This is a really challenging time for families, especially the birthing parent who … is processing the birth and likely physically and emotionally recovering.[609]

Access to and practice of paediatric physiotherapists will be further discussed later in this Chapter in relation to broader paediatric health services.

8.18. In correspondence received by the Committee, the Australian Nursing and Midwifery Federation (ANMF) Tasmania Branch provided the following comments on the ongoing work of CHaPS:

The CHAPS service is a critical lifeline for new babies, their mothers and families in the early days, 2 weeks post-partum, through to 4 years and beyond. This service provides critical support to women and their babies as they grow, learn and develop. The early checks of newborns to identify and take action on health issues from feeding challenges, weight gain, hearing, domestic violence matters, to hip dysplasia, is pivotal in setting children and their families up for a well and healthy lifestyle. These early interactions also offer a wonderful opportunity to support and guide health prevention discussions and actions from exercise to healthy eating options and encouraging smoke free environments. Unfortunately, the value of these early checks, supports and intervention and prevention is not valued adequately, with most Child and Health Services across the state struggling to fill vacancies and for many years, denying the opportunity for interstate Child Health and Parenting Nurses with Post Graduate qualifications to enter the services at as a Grade 4 Registered Nurse, or allowing those within the services to progress to a Grade [sic].

Fortunately, through years of advocacy, this matter has now been resolved, but it should never have been an issue in the first place with all other areas of the Tasmanian Health Service allowing this option and opportunity for many years.[610]

In addition, during COVID-19 the Child Health and Parenting Service was reduced with staff redirected to COVID-19 vaccination clinics. Whilst COVID vaccination clinics were essential and staffing challenges were dire, the effect that this had on a large cohort of women, babies and their families during this time was significant. Even when services resumed, only essential checks were carried out with many families missing out on healthy kids check at 4 years, the last check before children commence school and the last opportunity for heath [sic] issues to be detected and acted upon.

Similarly, like maternity services, the ANMF have sought a workload model to be implemented for Child Health and Parenting Services. This service has not had uplift in nursing staff for well over 5 years and has varying levels of administrative and business support, which generally have been inadequate to support the level of service provision. Again, this is a vital service not only to ensure the lifelong health of new babies and their families, but entire communities. If we are serious about changing our health outcomes and chronic disease burden, this is where we must start, early intervention, education and health prevention for the next generations.[611]

[609] Transcript of Evidence, 20 February 2025, Australian Physiotherapy Association, p. 101.
[610] Correspondence from the Australian Nursing and Midwifery Federation, dated 31 January 2025, p. 4.
[611] Correspondence from the Australian Nursing and Midwifery Federation, dated 31 January 2025, pp. 4 -5.

8.19. Witnesses from the Tasmanian Aboriginal Centre (TAC) also discussed the communication of information around the services CHaPS can provide. One concern repeatedly raised with TAC staff is potential misunderstandings between practitioners and patients about the checks recorded in the Personal Health Record or 'blue book', used from birth for children in Tasmania:

> ***Mrs PETRUSMA***[612] ***–*** *[the TAC submission says] 'Confusion exists around the role of CHaPS, with nurses often focused primarily on the blue book'. What do you mean by 'focused on the blue book'?*
>
> ***Ms FOSTER -*** *It is the check. I need to meet you to do your check.*
>
> ***Mrs PETRUSMA*** *- Are you saying that the community does not understand that nurses have to do the blue book or check...*
>
> ***Ms FOSTER -*** *I think it is the opposite to that - that that's all they're there for. I have always seen child health nurses as much more dynamic than that. Because those blue book checks have decreased over time, there is less interaction, so there is less time. We have been trying to work out how we get into supporting families more regularly, because that is all that is there. You've got to get the blue book check, that's the data - fixed, alright, that goes in the system. Now I can go to my next one [patient]…*
>
> ***Ms THOMPSON -*** *Then you don't pop up on recalls. So if you have had your two-week, four-week and six-week GP check, and your six-month and 12-month blue book, you are not coming up on recalls anywhere in between those checks. There can be big gaps, particularly if there is not enough staffing to do a four-month transition-to-solids discussion. Then you might not be seen from eight weeks until the baby is six months. In the life of a baby, that is a huge amount of time.*
>
> ***Ms HARRIS -*** *Even in the first two weeks, if mums are not seen and they cannot breastfeed properly, then their milk will dry out and that's their opportunity gone.*
>
> ***Ms THOMPSON -*** *By the time that first home visit at two weeks is being done, they have stopped breastfeeding.*
>
> ***Ms FOSTER -*** *Or they haven't slept for two weeks…*
>
> *…*
>
> ***Ms WOOLNOUGH -*** *If they have had a bad experience on that first one, they won't then do the rest. We have had families who haven't had checks in years. Because they had a bad experience that first time with one CHaPS nurse, then they are like, 'No, not doing it anymore; they just check this, this and this and tick the box'. They do not see the value in the conversation that comes with that and the opportunity to ask questions.*
>
> *…*

[612] At the time of this hearing in October 2024, the Hon. Jacquie Petrusma MP was a Member of the Committee.

Mrs PETRUSMA *- Is that a decline over time, you think? I know - and you can only reflect on your own personal experiences - that when I had my four children, the CHaPS nurses were brilliant.*

Ms FOSTER - *They were gods.*

...

Mrs PETRUSMA *- Is it time? Is it a quicker appointment or something?*

Ms THOMPSON - *There used to be what they called 'enhanced care', which was outside of the blue book checks. Definitely that, to my understanding, is far less of a thing. If your data is showing that blue book checks are being done, that's good, but that isn't the big picture.*

Ms FOSTER - *It is not holistic.*[613]

8.20. The Royal Australian College of General Practitioners (RACGP) Tasmania submission raised concerns about absence of four-year-old health checks by CHaPS, noting financial and equity issues related to accessing the checks through public and private health and education providers:

> *CHaPS services appear to be struggling with community demand as we often see patients in general practice with concerns that would previously have been managed in CHaPS but patents [sic] can't get appointments. Four year-old health checks used to be performed by both GPs and CHaPS, but the Medicare rebate for this in general practice was removed and CHaPS is no longer able to offer these appointments due to demand (worsened by COVID19). Importantly, hearing and vision were checked at these assessments to assess readiness for school. Four-year-olds are now missing this important screening. Children attending public school kindergarten can access a health check and hearing screening with the school nurse but children in private and Catholic schools do not receive this. Private hearing screening is $190 for a child through Hearing Australia. This lack of basic childhood assessment and screening compounds the concerns with development and behaviour seen later in the classroom*

8.21. Dr Tim Jones, representing RACGP Tasmania, discussed the absence of four-year old health checks on a child's development:

> ***Ms ROSOL*** *- Could you expand on the impact of four-year olds missing out on assessments, I noticed in your submission Medicare rebates have changed so they're not covered [by GPs], but Child Health and Parenting Services don't have the capacity to assess them. What I'm hearing is most four-year olds are missing out on that assessment. What's the impact of that?*
>
> ***Dr T. JONES*** *- What I'm hearing from my patients is that almost all four-year olds are missing out on those checks around our state. The impact of that is we're not identifying early those kids who are going to struggle in a school environment, it may be missed opportunities, for early support. We're also not picking up the kids with hearing impairment before they start school. As much as our education system is trying*

[613] Transcript of Evidence, 21 October 2024, Tasmanian Aboriginal Centre, pp. 13 – 14.

to do some things, they're trying to do some basic in-school screening with the school nurses now. That's not a system designed to do that, they've had to crib it to make it work.

The last factor that's really hurting, is we know a lot of our funded early intervention supports expire by age six. Given the lag times to access them, if we're not identifying kids at four, by the time they get through the system, they're already moving out of the window where supports can be available to them through early intervention. Which means they just miss out and there's nothing after that point really that we can access for them.

***Ms ROSOL** - Their whole life trajectory is impacted by that?*

***Dr T. JONES** - Yes.*

***Dr M. JONES** - For private and independent schools, it's variable as to whether or not they'll have a school nurse doing those kinder checks. The public schools at least have a kinder check opportunity, but again, it's not creating consistent and equal access to every child in the state.*[614]

Accompanying services

8.22. The Committee heard repeated evidence about the impact of poor communication between service providers, including GPs and CHaPS, creating barriers to timely assessment and intervention.

8.23. Representing RACGP Tasmania, Dr Tim Jones and Dr Marita Jones discussed the impact of the fragmentation of administrative services in healthcare systems and how this has a flow on effect on service delivery:

Dr T. JONES - *Fragmentation is a major challenge and individuals learn to get around it by having phone calls or sending little emails, but that's cribbed together, it's not built into our system*

***CHAIR** - And it relies on a high level of self advocacy-*

***Dr T. JONES -** It does.*

...

Related to that, we have the fact that our child health nurses, who are doing good community work, and our GPs don't share databases and don't share shared information about what's happening with a child and family situation, even though generally we're both trying to provide a very similar level of care in similar areas.

***Dr M. JONES** - In addition to that, sometimes, particularly patients who are vulnerable and high-need, if their instruction from a child health nurse is to follow-up with their GP, we don't know that they've been given that instruction. Whereas, we might know those patients very well and know if we get a note saying 'so-and-so is not growing well' or 'so-and-so has a problem with their hips' and we don't see them pop up on our books,*

[614] Transcript of Evidence, 23 October 2024, Royal Australian Council of General Practitioners Tasmania, pp. 63 – 64.

we call them and we chase them up. There's an opportunity to advocate for vulnerable patients, particularly non-English-speaking Aboriginal and Torres Strait Islander families. The lack of communication between those two services is really impacting patient care.

***CHAIR** - Are there other barriers to sharing that information digitally around private practice versus public health information, or is it deeper than that?*

***Dr M. JONES -** I believe it's probably because they don't have access to the same kind of software that the hospital does, but we still share information between private practices and the hospital quite freely.*

***Dr T. JONES -** This problem seems to be at an IT level.*

***Dr M. JONES -** You can hand write in the blue book and we communicate between the nurses and the GPs via comments written in the blue book, which is often left in the car, forgotten, left at school -*

...

But also we don't get that that flag of 'I know this person needs medical care and I know that they need a bit of extra help following it up'. It's only if they physically bring the blue book do we know if the child health nurse had a concern.[615]

8.24. The RACGP Tasmania submission discussed the merits of a GP with special interest in paediatrics working alongside CHaPS:

A GP with special interest in paediatrics, working within the CHaPS team, could assist in assessing infants that would otherwise be referred to tertiary paediatric services by community GPs or CHaPS nurses for a variety of simple problems of infancy - including growth problems, allergies, developmental screening, dermatological concerns, musculoskeletal problems and sleep and settling. CHaPS nurses provide an excellent screening service for infants through baby checks, but when a problem is identified, e.g. jaundice or hip problems, the next steps aren't clear. Families are usually referred to a GP for further assessment but access and affordability is an increasing concern. Without any correspondence from CHaPS it is hard for clinics to triage these concerns. There is also no formal communication from GPs back to the CHaPS nurses which compounds the problem.[616]

8.25. Dr Lumsden-Steel, President of the Australian Medical Association (AMA) Tasmania, discussed how the role of Child Health and Family Nurses could be increased to assist in managing the issues which arise across the health system, largely related to issues gaining access to care:

***Ms ROSOL** - ... There was some comment in your submission around the Child Health and Parenting Service (CHaPS). Potentially 'empowering nurses to take on a broader role' is how it was described in the submission. Can I ask for your thoughts on that? Are you talking about scope of practice for CHaPS nurses increasing, or are you talking*

[615] Transcript of Evidence, 23 October 2024, Royal Australian Council of General Practitioners Tasmania, p. 61.
[616] Submission No. 104, Royal Australian College of General Practitioners Tasmania, pp. 8 – 9.

about policies changing so that they can do more? Did you have specific suggestions around how we could be better utilising CHaPS?

***Dr LUMSDEN-STEEL** - …*

…We know that the key thing is assessing in the community and if we assess things in the community and we provide support for the community then there's a pathway to escalate concerns, be that the mental health pathway and your combined paediatric pathway for that assessment. It is really a sub-speciality area of providing that postnatal early care and assessment. I think they are a bridge to accessing care.

The question is, I don't believe there are enough nurses in that space. If there are not enough nurses how do you actually meet the demand, particularly if things have been flagged or families have been flagged as being high risk or needing support? How do you get in there to provide that support early and then how do you continue that support and guidance?

We know that early intervention can sometimes stop you from progressing down to things getting more complicated or mental health evolving. It's not a good term, but you can 'nip things in the bud' early. You can help turn away the unsettling baby. You can get on top of the situation much earlier with support.

Education support is really important to support young mothers who are struggling and provide them with the tools to cope. Reducing hospitalisation is always important. We don't want people to deteriorate to the point where they get to need hospitalisation. We're hoping that the CHaPS nurses can provide their early intervention but also be a conduit and support for that person getting access to medical care if they don't have a GP or into CYMHS. I think that's certainly an area we can focus on.[617]

Parenting groups

8.26. The Committee heard substantial support for parenting groups provided by CHaPS and a need to expand their scope and provide them in more locations:

> *When our CHaPS nurse asked if I would like to join a "parents" group, she was surprised when I said that my husband would like to join the group, either as well as or instead of me. He was our baby's primary carer, after all. While she agreed in principle that this shouldn't be a problem, she was very unsure about whether it would be possible, and had to check with her manager about whether a father could join a parent's group. It turned out that it was ok, but it was not a very welcoming start. A less determined father might have been put off by this experience, which would have been a shame. If we are serious about changing the idea that raising children is women's work, then it is important that we aren't putting barriers in the way of men to step up and take on the role of primary carer. My husband and I were surprised that it was an issue at all, given that they are called "parents' groups" not "mothers' groups".*[618]

[617] Transcript of Evidence, 30 October 2024, Australian Medical Association Tasmanian Branch, pp. 24 – 25.
[618] Submission No. 107, Private Witness, p. 1.

8.27. In data collected from their survey undertaken for their submission to the Inquiry, Playgroup Tasmania found that a number of families who use their services, found it difficult or impossible to access parenting groups:

> *Families report that support for new parents is available to a greater degree in some areas than others. More than 69% of families we spoke with did not attend a new baby/parent group and 34% of these families indicated that this service was not available in their area or that they did not know the service was available. Some families commented on the CHaPS model of new parent groups which limits availability to first time parents only:*
>
> > *"I would really like there to be second (or more) time parenting groups… no one does anything for parents on more than one, navigating sibling life as well as relearning the basics of a baby."*
> >
> > *Playgroup Tas Community Member, 7248*[619]

8.28. Witnesses from the TAC also discussed the positive impact of parenting groups:

> ***Ms THOMPSON** - I think, straight up, that parenting groups, or whatever you want to call those groups postnatally, are essential for everybody, not just a first time mum. You're put through that system and offered that first baby and never offered that again. That is something that every woman giving birth is welcome to come along to those groups.*[620]

8.29. The Committee discussed the performance of the CHaPS parenting groups after COVID-19 with Ms Steedman, Nursing Director of Child Health and Parenting Service. She noted that parenting group services were operational:

> ***CHAIR** - Are the parenting groups coming back as a regular part of CHaPS work as well [post COVID – 19]?*
>
> ***Ms STEEDMAN** - Yes. We have new parent groups that have been running for about the last 12 months, if not longer than that. Some of them are CHaPS stand-alone new parent groups; for some others, we are working collaboratively with the Department for Education, Children and Young People through the CFLCs, Child and Family Learning Centres, and working collaboratively to deliver them, particularly in the regional areas.*[621]

8.30. TAC representatives described parenting groups as an essential informal support network for parents, including peer-to-peer support, noting the success of their Ningi Pakata mums and babies group:

> ***Ms THOMPSON** - …Ningi Pakata are the mums and babies group that we have on Mondays, and in the other locations too, is a great example of that. The way in which some women - they're having their fourth or even their fifth - what they bring to the group and offer is extraordinary, and the things they're sharing.*

[619] Submission No. 20, Playgroup Tasmania, p. 18.
[620] Transcript of Evidence, 21 October 2024, Tasmanian Aboriginal Centre, pp. 11 – 12.
[621] Transcript of Evidence, 26 March 2025, Department of Health and Hon. Jacquie Petrusma MP, p. 10.

Also what you notice around birth debriefing, which a woman's never had, and you see that being an important space where women can actually be debriefing birth one and they're having their fourth baby, but they've still got a lot to - because perhaps someone else has had a very similar experience and they then say, 'Wow, that was exactly the same for my first birth and I never talked about it, but it had a big impact'. The way in which that support can be there and that sharing of knowledge like we saw with the breastfeeding, and the numbers of bags of clothes that have been swapped and given is just extraordinary. Again, it's building up and allowing community to have places to come and meet and to provide that support.

***Ms HARRIS** - The practicality of it also needs to be thought about. So, if they're second or third time mums, they need to think about if they're coming to these groups, they're going to have other children with them, and often that's the barrier, because they need to bring their other children and there's nowhere for those children to play or be supervised properly.*

***Ms FOSTER** - We run those in the child and family learning centres and those respective places, so that becomes a support mechanism for them to know that there's another place where they can bring their children to accommodate all of those needs.*

...

***Ms WOOLNOUGH** - It's also about the space where it's hosted, because it's great to say we'll run it for three or four weeks, but then it falls onto a new mother to try and hold it where we've seen - we 've got one mum who has four children and she comes along every week just for her cappuccino that's made and on the table ready for her. She's like, 'It's the one thing each week that's done for me, and I just get to come and enjoy it.'*

It's those little things that we're seeing, like having a morning tea, being able to create - and they've turned it into a bit of a craft group now where they're making something, because we acknowledge that it's awkward to walk into a room where you don't know anyone and then you're expected to talk.

...

***Ms WOOLNOUGH** - ... so having that opportunity to be making something whilst yarning has really opened up the door for connection.*

***Ms THOMPSON** - I would say, hands down, it's that connection and conversations between people, like you're saying, that is the most impactful. We'd been waiting for a physio who was going to be available and last week we did have a talk on pelvic floor. That was great; everyone had been asking for that. You can drip in some of that important information that's there and have those health messages coming in, and they're really valued. By far, the most valuable thing is the connections people are making.* [622]

[622] Transcript of Evidence, 21 October 2024, Tasmanian Aboriginal Centre, pp. 11 – 13.

8.31. TAC representatives shared feedback they have received from families and practitioners regarding Ningi Pakata and how it may be expanded into the future:

> ***CHAIR*** *- Raylene, you mentioned the child and family centres and that you run something out of them. Is that the Connected Beginnings program statewide?*
>
> ***Ms FOSTER -*** *That is the mums and bubs groups - Ningi Pakata.*
>
> ***CHAIR*** *- So that is in every child and family centre around the state?*
>
> ***Ms FOSTER -*** *It is in the three -*
>
> ***CHAIR*** *- Oh, in those three catchment sites. Okay, got it.*
>
> ***Ms FOSTER -*** *That is a model.*
>
> ***CHAIR*** *- That scope would be working well. I am interested in what you said about bringing in other knowledge, like vaccinations that you have gone and spoken about, and pelvic floor health.*
>
> ***Ms THOMPSON -*** *That was great. That was completely pro bono by the pelvic studio here in town. I contacted them and, eventually, there was a physio and she came out. She was great.*
>
> ***Ms HARRIS -*** *It was great that we learnt, too, that it is actually offered within the first six months for new mums from the hospital, but people don't get told about it unless it's a complex birth.*
>
> ***Ms THOMPSON -*** *The next day, we were on the phone, booking one of the mums in for her physio pelvic floor check, just from that information.*
>
> ***...***
>
> ***Ms FOSTER -*** *It is even worse when you get older and you realise now what you should have done, but I think that notion of child and family centres is an amazing model.*
>
> ***...***
>
> *I think it's to be nurtured. It's shown with the kids' care clinics across Tasmania being rolled out in the majority of those child and family learning centres. It really shows the importance of bringing education and health together, and how that works together well for families regardless of where they live or what their demographic is - that those things, like your allied health services, can be aligned. Now we've got community health centres around the state, but they don't have that interaction of, 'I'm coming in next - I feel really well, safe, and it's a nice place. The kids feel like it doesn't matter if they're a bit noisy because people understand all that'. Child and family learning centres are set up for those things.*
>
> ***Ms THOMPSON -*** *And they're non-clinical. They're social.*
>
> ***CHAIR*** *- Is that Federally funded for those three catchments, or is that state Department of Health funding?*

Ms FOSTER - *Connected Beginnings is Commonwealth funded.*

CHAIR *- Okay. But the mums and bubs groups?*

Ms THOMPSON - *It's through Connected Beginnings funding.*

CHAIR *- With the right funding, do you think that could be expanded to other child and family centres around the state?*

Ms FOSTER - *Yes. I always think that you don't need more money. It's actually how you realign what you're doing to provide the service. Because from one end, you're going to fill a gap. In economics, you're going to balance the books somehow, because you're going to have more people accessing a part of a service provision, and they're not going to have to have that acute end of whatever it might be for them, or more of something. That's where I think co-design is really throwing up everything in the air and saying, 'Let's see where it all lands'.*

CHAIR *- Like you said, it might not be about more money. It might just be about realigning existing resources to deliver services differently.*

Ms FOSTER - *The kids' care clinics are a really good example of that. Although there was more money to bring in provisions of service delivery, the bricks and mortar weren't recreated. They were used in relation to what was already there, building the capacity of the paediatric registrars to come out into community and actually learn their skills, place based, doing really good place-based work. It eliminates a whole lot of other stuff for families who are taking their kids along, because it's accessible and they're able to deliver the service for that child, whether they've got ADHD or autism, or just speech, or OT.*[623]

8.32. While different to parenting groups, the Committee also heard support for the provision of Circle of Security groups which are provided by CHaPS, in association with other community providers.[624] The classes educate parents to understand the emotions of their children and how to support them over the course of their childhood as these develop and change**.**

Access to CHaPS

8.33. Hannah Fielder, representing Health Consumers Tasmania (HCT), provided the Committee an assessment of service access for women and children in Tasmania, including to CHaPS:

> *First off, the access to services. Obviously, people have described across the different types of services that you would expect, reproductive, maternity, antenatal and child health - Tasmania has a big service access issue in terms of primary care and in terms of specialists as well. Some of the other services are especially hard to access in rural areas. For example, we've heard from people on the East Coast and also Tasman Peninsula, the CHaPS service is quite difficult to access on the East Coast, especially the Coles Bay area. People were saying, 'They used to come here but they don't anymore'. I know*

[623] Transcript of Evidence, 21 October 2024, Tasmanian Aboriginal Centre, pp. 15 - 17.
[624] Transcript of Evidence, 18 February 2025, Amy Ramsey and Samuel Thomas, p. 32.

from my own personal experience, they come once a fortnight for about five hours in the middle of the day on a Tuesday. If you work on a Tuesday then that's it, too bad.

You can access some of that through a GP, and we're lucky to have a great GP there, but if you didn't then - there's a few gaps in terms of all the different types of services that you might need ranging from antenatal through birthing...[625]

8.34. Limited access to CHaPS in rural and regional locations was also raised by the TAC, with specific reference to the impact of understaffing on the availability of parenting groups in the North West.[626]

8.35. Playgroup Tasmania shared further findings from their client survey, indicating that increasing access to CHaPS would improve attendance, service provision and community engagement. Increasing resourcing and access to CHaPS would likely lead to ongoing positive connections into the future:

Families report differing experiences engaging with CHaPS. These experiences range from extremely positive with continued engagement through to complete dissatisfaction and disengagement. This may go some way to explaining why not all families continue to engage with the service through to the four-year check-up.

CHaPS already works in place-based settings through its co-location in CFLCs; this could be extended to geographic locations where CFLCs do not exist by working in community settings alongside playgroups and other appropriate groups. This would support the building of trusting relationships between services and families in familiar, informal settings.[627]

8.36. Private Witness 8 discussed the effect of the current limitations on the CHaPS service:

Currently the CHAPs service is an inflexible, 9-3.30 service of principally centre-based booked appointments. There is such scope for more innovation: before hours, after hours, weekend appointments; fathers participation, liaising with child care centres to capture the older children in Child Care, Playgroups, Launch into Learning, a presence in Women's Shelters, prison system etc.[628]

Paediatric Health Services

8.37. The submission from the DoH provided an introduction to the scope of paediatric health services available in the THS:

Tasmania's paediatric healthcare services follow a child and family-centred approach, working in partnership with children, young people, and their family or care giver. It is important that the child and young person feels valued, respected, and involved in decisions about their health.[629]

[625] Transcript of Evidence, 21 October 2024, Heath Consumers Tasmania, p. 48.
[626] Transcript of Evidence, 21 October 2024, Tasmanian Aboriginal Centre, pp. 11 – 12.
[627] Submission No. 20, Playgroup Tasmania, p. 18.
[628] Submission No. 8, Private Witness, p. 1.
[629] Submission No. 129, Department of Health, p. 35.

Paediatric services in Tasmania are made up of multiple service providers and funding streams. This results in different eligibility criteria and standards across services, which can present challenges for families navigating services for their children and result in unequal access to services for children and young people across Tasmania.[630]

8.38. Paediatric health services within the THS include the following:

- Paediatric surgery;
- Paediatric oncology;
- Paediatric neurology;
- Newborn Services and Children's Critical Care (SCN/NICU/PICU);
- Neonatal and Paediatric Emergency Transport Service;
- Tasmanian Community Paediatric Service;
- Tasmanian Paediatric Rehabilitation Service; and
- Tasmanian Gender Service.[631]

8.39. Themes arose in the evidence received, regarding paediatric health services including lived experiences, issues accessing specialised and outpatient care and administrative complexities. Within these areas, waiting lists and broader access issues were repeatedly raised as matters of concern by patients and service providers.

8.40. The Committee heard that access to paediatricians is worryingly limited in Tasmania. This has a flow on effect to the type of care received on an ongoing basis, as well as the pathways families traverse to find care in emergencies:

> ***Ms ARMSTRONG -*** *At the moment books are closed. You cannot access a paediatrician. The changes to the NDIS are going to create even more challenges for families, in being able to access the services they need. Again, we understand there's workforce shortages in paediatric services, particularly in and around allied health as well. So if you have a child who you may be concerned that there is development delay or any other kind of disability you're observing, there's no pathway that's open for you.*
>
> *The information around paediatric services is also really inconsistent. Families don't know how they can access, their books are closed anyway, but private services and the cost of private services is out of reach of most families. There's an argument or a discussion on ensuring - we included it in our submission - that 18 month check. I do believe through the lifting literacy recommendations that 18 months actually has been implemented, so that there's a screening…*
>
> ***…***

[630] Submission No. 129, Department of Health, p. 35.
[631] Submission No. 129, Department of Health, p. 36.

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

…

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

***CHAIR** - There's no availability.*

***Ms ARMSTRONG -** No.*

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

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

…

Yes, they are [going without]. What we're seeing is kids are hitting kindergarten and they haven't had any early intervention. They haven't had their assessments. Schools haven't had the opportunity then to make reasonable adjustments. It's just getting pushed into the schooling [system].[632]

8.41. AMA Tasmania provided a written update to the Committee which also included an assessment of lack of private paediatric health services in Tasmania, most notably felt in the North and North West:

Private paediatric services remain limited in the North and Northwest regions, with paediatric MBS item numbers offering insufficient indexation and resulting in low patient rebates relative to the doctors' fees. This situation continues to place significant pressure on paediatric outpatient clinics. Paediatricians observe that follow-up referrals are frequently not scheduled or completed within the recommended timeframe, or do not receive adequate appointment duration due to the necessity of accommodating new referrals. Furthermore, it is unlikely that paediatric FTE has increased to meet rising demand, and current budget constraints appear to be impacting both strategic planning for demand and workforce modelling.

[632] Transcript of Evidence, 18 February 2025, Playgroup Tasmania, pp. 37 – 38.

The RHH has also struggled to maintain a full complement of Paediatric intensivists.[633]

8.42. The Committee was informed through a written update from the Hon. Bridget *Archer* MP, Minister for Health, Mental Health and Wellbeing, that work is being undertaken to address workforce and access issues facing Tasmanian paediatric services:

> *The Department is developing a state-wide strategy for hospital-based paediatric services, which will identify a range of actions for reform. This strategy will outline approaches to expand the specialist workforce, streamline referral pathways, and implement patient-centered models of care to improve health outcomes and service sustainability. The Department is undertaking service planning for release in mid-2026 to improve access to hospital-focused services for children under 18.*[634]

Specialised outpatient paediatric care

8.43. A majority of the evidence received by the Committee about paediatric health services related to access to outpatient services, in both the public and private sectors. The Committee received evidence regarding access to specialised care for particular healthcare needs, including developmental conditions, Attention – Deficit Hyperactivity Disorder (ADHD), Autism Spectrum Disorder (ASD), early intervention services and physiotherapy. Central to these concerns were wait lists and confusing referral pathways, which all impact care.

8.44. RACGP Tasmania discussed access to specialised care for developmental conditions:

> *Developmental conditions*
>
> *• There is an immense, early intervention service gap for kids 0-5 in Tasmania, disproportionate even when compared to the challenges in other states. The majority of early childhood concerns currently seen in the community (via child health nurses and/or GPs) are relatively common and normal (sleep, meltdowns, communication between parent and child, speech delay, continence issues) but awareness of evidence-based strategies and supports amongst GPs is generally low.*
>
> *• This results in a large number of referrals to tertiary paediatric services, who do not have the resources to provide the required level of care to such a high percentage of the paediatric population. The shortage is compounded by no private paediatric access across the state (generally) for developmental or behavioural concerns.*
>
> *• For children noted to have developmental concerns (e.g. motor skills, speech delay), the Early Childhood Intervention Service (ECIS) was an ideal [sic] for a single point GP referral. Children could receive timely allied health assessment and treatment without paediatrician input, if further concerns (e.g. autism spectrum disorder) were identified then things could be escalated for diagnosis and supports through paediatrics and NDIS. This service is largely unavailable now. When a child*

[633] Updated information, Australian Medical Association Tasmania, 10 October 2025, pp. 3-4
[634] Updated information, Attachment 1, Minister for Health, Mental Health and Wellbeing, 27 October 2025, p. 1.

presents in general practice with a concern regarding specific developmental delays or an autism diagnosis there is nowhere for the GP to refer them except a multi-year wait through tertiary paediatrics.

• In particular, there is a special service gap in children with autism traits. Our statewide assessment service (TADS) has 12-18 month wait times and there is limited professional/public education and guidance as to supports available for children with these concerns. Prior to being referred to TADS a family must first wait for a paediatric appointment (years through the Royal Hobart Hospital).

• Most school supports are tied to diagnoses (eg ADHD and autism) when we know that early labelling of developmental concerns is frequently inaccurate and doesn't necessarily lead to better outcomes[635]*. Due to the significant delay in diagnosis through paediatric services families and schools are left languishing without help for months and years, while the challenges for the individual child grow.*

• Providing increased school supports to children who required classroom assistance, that is used at the discretion of the school and is not tied to diagnoses, will improve the function of the school, the family and most importantly the experience of the child who needs help.[636]

8.45. The AMA Tasmania also discussed access to specialised paediatric care and care pathways in Tasmania:

Currently, children are referred to the Paediatric team via GP's. Long wait lists are causing challenges and ever changing referral criteria to NGO's (St Giles) for autism diagnostic in this early age are making it almost impossible for parents to navigate the services. Consequently, children are not diagnosed in a timely manner, and are not therefore receiving support when they need it, which can lead to secondary mental health issues and inadequate education supports being put in place leading to significant disadvantage later in life. Even if children are diagnosed early, the NDIS pathway takes over and yet again it is dependent on the parent's knowledge and education of how well they can navigate the system to access the appropriate health and allied health professionals.

Sadly, waiting times for children to access speech pathology, OT, Physio or a Psychologist are many months to years, especially in the North West. There are several non-urgent cases who have been on the waitlist for "behaviour assessment" for over 700 days! This is a disaster for a child that potentially has a neurodevelopmental disorder. Delayed access, diagnosis and treatment can lead to severe mental health concerns later in life, particularly throughout puberty including depression, anxiety, eating disorders and suicidality.[637]

[635] Link from submission, removed from text for ease of readability: https://www1.racgp.org.au/newsgp/clinical/early-asd-diagnosis-may-fade-by-school-age-study.
[636] Submission No. 104, Royal Australian College of General Practitioners Tasmania, p. 6.
[637] Submission No. 25, Australian Medical Association Tasmanian Branch, p. 9.

8.46. The Hon. Bridget *Archer* MP, the Minister for Health, Mental Health and Wellbeing provided an update in October 2025, outlining current plans to increase specialised out-patient paediatric care in the state:

> *As part of our First 100 Day Plan, the Government will announce a new strategy to decrease sub-speciality paediatric waiting lists.*
>
> *Since April 2025, there has been an increase in medical staff employed across paediatric gastroenterology, endocrinology and cardiology to support improved access to these paediatric outpatient services. Clinics in these specialists are currently being planned and rolled out to support the flow of paediatric patients through the Tasmanian Health Service (THS).*
>
> *Work is also underway to increase access to neurodevelopmental and behavioural services for paediatric patients at the RHH through a pilot model of care, with the intention of extending services state-wide. The model includes a collaborative ADHD assessment service through the Child and Youth Mental Health Service and Paediatric Medicine.*[638]

Attention Deficit Hyperactivity Disorder

8.47. Ms Cowen discussed issues she is currently facing in accessing a paediatrician and support for ADHD for her twins:

> ***Ms COWEN** - There are a few things since I did the submission, one in particular, that is really highlighted for me and my twins is the lack of paediatricians. They have just started kindergarten and they probably both have ADHD [attention-deficit/ hyperactivity disorder], but I can't get into a paediatrician. Accessing other help is also very, very hard, like an occupational therapist, the practical support. Right now it feels like I'm never going to get in to see a paediatrician. Everyone's books are closed. Am I going to have to go to Melbourne? I don't understand. There has to be something to get more paediatricians here, and I know so many other parents in the same boat.*
>
> ***...***
>
> *I just want them to have the best journey through school and I know that means getting help as early as I can.*
>
> *...*
>
> *Well, I was, and then in December I got a letter from Hobart Paediatric Group ... to say they wouldn't be seeing any of their new referrals that they were sent last year, which were over 500.*
>
> ***CHAIR** - Because there's just no capacity?*
>
> ***Ms COWEN** - And their paediatricians are retiring.*
>
> ***CHAIR** - It's scary.*

[638] Updated information, Attachment 1, Minister for Health, Mental Health and Wellbeing, 27 October 2025, pp. 1-2.

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

…

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

***Ms COWEN** - No.*

…

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

***CHAIR** - But that's the next step … That's the access block.*

***Ms COWEN** - Yes, because there's another clinic in Hobart called the ADHD Clinic - I've looked it up - but they don't have a paediatrician, and a paediatrician is the only one who could prescribe medication for a child.*[639]

8.48. When queried regarding access to ADHD support in the state, representatives of the DoH discussed metrics for assessing the management of specialised conditions moving forward, including retraining the workforce:

***CHAIR** - … The early intervention message is really strong, and I think everyone in the community really understands and appreciates the need for early intervention. … Students are already school age, even though they might have been picked up early by a psychologist or a paediatrician as having neurodiversity, they're well into their school journey by the time they can get into TADS specifically…*

***Mr WEBSTER** - Again, TADS is overwhelmed with numbers. We are growing that service but, importantly at the moment, if there are high-risk children, we have a program in place where we are actually referring out to the private sector to make sure we can get through the higher-risk patients.*

… What we're trying to do is re-educate our entire Health [work]force to say there are some situations - and ADHD is an example - where you do a treatment plan and then the prescriptions can follow that treatment plan for a period of time. It doesn't follow the usual pathways that we're used to in Health.

… we're moving towards these longer-term treatment pathways, so that you're not coming back constantly for the purpose of just getting a script, and those sorts of things. It's not just in this space, it is more broadly, but particularly in this space we do need to do it. This is one where there is a shortage of paediatricians and psychiatrists who are specialising in ADHD. That means that when you get one and you get a

[639] Transcript of Evidence, 20 February 2025, Brigid Cowen, pp. 26 – 27.

treatment plan, you don't want to waste that opportunity by someone in the chain saying, 'It's been nine months since you last saw your specialist. I won't be able to do anything until you've gone back to the specialist.' We need that knowledge of how treatment plans work being across the whole workforce. That's what that program is about, is educating health professionals in this new way, or relatively new way… [of] understanding treatment plans. [640]

8.49. The then Minister for Health, the Hon. Jacquie *Petrusma* MP, also provided the Committee with additional information regarding increased funding for ADHD supports from the Government:

> ***Mrs PETRUSMA*** *- … in the 2024-25 state Budget, we allocated $2.5 million to establish a new service that will give families across Tasmania faster access to GPs with special interests who can diagnose and manage children with ADHD. Staff in this service will have the appropriate training to be authorised to prescribe medications for up to three years, an increase from the previous two-year period. The new GP specialised service for children will help ensure that Tasmanian children with behavioural or neurodevelopmental concerns are able to get the care they need in a timely and accessible manner. As part of the planning for the new GP specialist service for children, the Department of Health is preparing to pilot a dedicated multidisciplinary ADHD model in southern Tasmania to address the significant service demand and waitlists for specialist assessment in this region. This model will combine the resources of the paediatric neurodevelopmental clinic in the THS with staffing from both the women's and children's services, paediatric services and Child and Youth Mental Health services.*
>
> *Planning for this model is based on the GP with a Special Interest (GPwSI) model and it is anticipated that once piloted it will be considered and reviewed by the Women's and Children's Clinical Network with potential for statewide rollout across Women's Adolescents and Children's Service (WACS) and the Child and Youth Mental Health Service areas. Planning includes liaison with Primary Health Tasmania, GPs, and the Department for Education, Children and Young People to ensure cross-sectoral and cross-agency collaboration and efficiency of utilisation of resources.*[641]

The Committee noted the ADHD pilot will commence in the 2025 - 2026 financial year and be evaluated in the 2026 - 2027 financial year.[642]

8.50. This information addressed some of the concerns raised by the AMA Tasmania regarding support for ADHD in Tasmania:

> *The problem is access block - no private paediatricians are regularly accepting routine new referrals and there are around 3,300 children on public waiting lists (according to the Mercury recently). The most significant reason for this is the single prescriber laws in Tasmania for prescribing stimulant medication for ADHD plus annual review by a specialist. Given ADHD is the most common disorder in children with 8.2% of children and 11% of boys (probably reflecting under diagnosis in girls)*[643] *for which stimulant medication is first line treatment, every paediatrician in Tasmania is spending most of*

[640] Transcript of Evidence, 26 March 2025, Department of Health and Hon. Jacquie Petrusma MP, pp. 9 – 10.
[641] Transcript of Evidence, 26 March 2025, Department of Health and Hon. Jacquie Petrusma MP, p. 11.
[642] Transcript of Evidence, 26 March 2025, Department of Health and Hon. Jacquie Petrusma MP, p. 12.
[643] Link from submission, removed from text for ease of readability: https://www.aihw.gov.au/reports/children-youth/australias-children/contents/health/children-mental-illness.

their time simply servicing the repeat prescription requirements of children who have been diagnosed and are on continuing treatment and simply getting bigger. If they all did nothing else ever, they would not keep up with demand. In other jurisdictions, there are other models of care that allow for GPs to participate in diagnosis and in continuing provision of treatment along with allied health support, with 'review by specialist' timeframes both longer and with greater flexibility. Nurse led clinics focusing on specific developmental disorders, supported by Paediatricians, may also be appropriate to establish where there are demand and workforce shortages.

There are multiple costly implications of this ruling - firstly for the roughly 12,000 Tasmanian children likely to have the diagnosis, which is associated with large increases in injuries including head injuries, in substance abuse, interactions with the justice system including incarceration, suicide, insomnia, educational and workforce underperformance, anxiety and depression, domestic violence exposure and so on. The failure to assess, diagnose and treat these children quickly leads to educational trajectory loss that will never be recovered and adverse impacts on their teachers and fellow students. Many of these children will have comorbid diagnoses that also need assessment and management.[644]

The Committee notes that since this evidence was received, GPs in Tasmania are now authorised to diagnosis and co-manage ADHD alongside specialists, however co-prescribing is still not possible in Tasmania.

Autism Spectrum Disorder

8.51. The Committee received evidence from individual witnesses regarding supports for patients and families managing ASD, including seeking a diagnosis. Angela and Shannon Allen discussed their difficulties in accessing diagnosis for suspected ASD for their daughter:

***Mrs ALLEN**- .... We had concerns about our daughter from as young as 18 months as she was different from our first born. However, the first external person to share these sentiments was her family daycare provider due to [her] obvious lack of speech and lack of social engagement. This occurred in July 2023, about 19 months ago.*

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

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

[644] Submission No. 25, Australian Medical Association Tasmanian Branch, p. 11.

Dr [redacted] finally referred … to TADS in July 2024 and we are now on a 20-month wait list for a formal diagnosis. At this rate we will be seen by TADS in March 2026 after [redacted] enters the schooling system.[645]

8.52. Mrs Allen also discussed the difficulties she experienced in accessing the Tasmanian Autism Diagnostic Service (TADS), the major provider of public ASD assessments in Tasmania:

> **Mrs ALLEN** - *… TADS is quite inaccessible as a department. When trying to speak to an actual person on the phone to find out further information regarding their processes, you were told via automated message to send an e-mail and to expect a 20-month wait from when your child is referred. The information sheets are not detailed as to what an assessment actually includes, noting that it involves a psychologist and an occupational therapist. The website also notes consultations with the child take 45 minutes to one hour and then there's a separate parent interview. Why there's a 20-month wait for a process that has profoundly less time taken than birthing a child is hard to contemplate. …*
>
> *To summarise, because I've thrown a lot of information out there, the lengthy delays of 16 months to see a Tasmanian paediatrician either within the public or private system from the date of the GP referral and after that another 20 months to be assessed by TADS from the date of the paediatrician referral have been detrimental, in our view [to our daughter accessing appropriate care].*[646]

8.53. Mrs Allen expanded upon her family's experience awaiting service after their referral to TADS:

> ***Mrs ALLEN***- *…on the TADS website it says a referral can be made by either a paediatrician or a clinical psychologist. However, when you scroll down further into the FAQ section it then elaborates that it has to be made by a paediatrician, not a psychologist. … you can access a child psychologist if you're persistent. It's hard to find one for a young child particularly for one that doesn't talk because what are they going to do, just watch? But when it is literally such a narrow criteria to get in, that is very hard for parents to be able to navigate because, immediately, it just amplifies the wait time.*[647]
>
> *…*
>
> ***Mr STREET*** *- What is the benefit of TADS' assessment being confirmed?...*
>
> ***Mrs ALLEN***- *… This is why I noted that it's hard to get in touch with TADS. I've tried to call them. I tried to call them yesterday at 12.30 p.m. to get a bit of an understanding of what they do in their assessment process. …No one picked up the phone. It went straight to an automated message saying, 'Send an email or leave a message', which no one returned.*

[645] Transcript of Evidence, 20 February 2025, Angela Allen and Shannon Allen, p. 13.
[646] Transcript of Evidence, 20 February 2025, Angela Allen and Shannon Allen, pp. 13 - 14.
[647] Transcript of Evidence, 20 February 2025, Angela Allen and Shannon Allen, pp. 14 – 15.

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

Then they also have a parent interview, which - we've had numerous parent interviews with many providers. What exactly they do is a bit of a mystery to me. Why there's such a long wait again is a bit of a mystery to me. From an initial thorough read of their website, the services they offer are OT and psychology… They're more abundant than paediatricians. Why aren't there more there pushing everyone through?[648]

8.54. The Committee asked Ms Armstrong, CEO of Playgroup Tasmania, if assessments and early service intervention were more accessible in the past and what may have contributed to current delays:

> ***Ms ARMSTRONG*** *- I think it's a wicked problem. I think it has had times when it has worked okay, but there's always people who are excluded from that. I do find it interesting that the Tasmanian Autism Diagnostic Service (TADS) will only accept referrals … from a paediatrician, psychologists and psychiatrists. A GP can't even refer into, or CHaPS [Child Health and Parenting Services], can't even refer into that service.* [649]

8.55. Mr and Mrs Allen provided ideas about what would have improved their experience within the healthcare system:

> ***Mr ALLEN -*** *I suppose I kick started the initial process. As a normal bloke, I guess, you come to this stuff and you know nothing, … you just go to the childhood nurse and you're like, 'There's something wrong, what do I do?'.*
>
> *…*
>
> ***…****You have all these abbreviated departments, but the childhood nurses also don't really know the process, but you're splintered off into multiple different departments and ultimately it all goes through TADS, but as a parent you're very lost…*
>
> ***…*** *you almost have to learn a new role just to push this through.*
>
> ***…***
>
> ***Mrs ALLEN****- …Instead of being like the only gateway to this service is a paediatrician, why not broaden it out a bit, upskill various people in the health industry to be able to*

[648] Transcript of Evidence, 20 February 2025, Angela Allen and Shannon Allen, p. 15.
[649] Transcript of Evidence, 18 February 2025, Playgroup Tasmania, p. 40.

identify, certainly have the checks and balances [regarding] over diagnosing and giving out services that might not be required...[650]

Early intervention

8.56. The Committee heard detailed evidence from Dr Tim Jones and Dr Marita Jones, on behalf of RACGP Tasmania, regarding early intervention services in Tasmania:

> ***Dr T. JONES*** *- I really wanted to speak to the Early Childhood Intervention Service [ECIS] which, for the purposes of the record, is the state government's funded early supports for families of kids experiencing developmental differences through the Department of Education. This service covers zero to age 5 under the current system.*
>
> *What we have seen progressively over my time as a GP, which is seven years now is with the rise of NDIS, there's been a progressive defunding of that service. Now it does still exist, but in a very limited capacity. As a GP I speak on behalf of our profession. We are not getting good results out of early intervention like we used to because the difference I believe, again, was that this service was localised. It was aware of everything that was in the community and it had direct links through the Department of Education to all the school systems. A child who is deviating from normal development - maybe they had a visual or hearing loss, or maybe they had autism, all sorts of things could access this service receive both therapeutic supports but also, really importantly, a navigator role in making sure that child's journey through accessing care was much smoother and their transitioning to the school system was well supported.*
>
> *What we've seen now is that early intervention supports are largely being promoted through NDIS which has an extended wait time, which is a national model that has very limited local links and none of that continuity or navigator stuff is happening for our families anymore and the abrupt handover into education systems is very, very jarring as a point for those families.*
>
> ***CHAIR*** *- I imagine there'd also be a lot of young people with developmental issues who wouldn't necessarily be eligible for an NDIS package.*
>
> ***Dr T. JONES*** *- Yes.*
>
> ***CHAIR*** *- They could very much be falling through the cracks.*
>
> ***Dr T. JONES*** *- You read my mind. A lot of the kids I'm seeing have very mild challenges. They may be mildly delayed in their development in one or more areas. They may have some significant speech concerns. They don't need enormous five figure NDIS support packages that will take two years to get access to.*
>
> ***CHAIR*** *- No, they probably wouldn't be approved for one, realistically.*
>
> ***Dr T. JONES*** *- No, but, again, having that very timely, very focused individual circumstance, okay, well, these services can all support you and we're going to keep popping up through your journey until you're well established in school-based systems.*

[650] Transcript of Evidence, 20 February 2025, Angela Allen and Shannon Allen, pp. 20 – 21.

I think it's very much within the scope of our submission that we need to re-examine the role of state level early childhood intervention, because it was delivering better outcomes at far reduced cost compared to what NDIS is delivering as a nationwide strategy.

***Dr M. JONES** - It is worth highlighting that we call it ECIS or the Early Childhood Intervention Service. It didn't need to be a diagnosis to access help and it could be allied health driven. We absolutely know that a speech pathologist is very well placed, qualified to assess and make a management plan without any intervention from a medical person. That's being limited and the same going for physiotherapy for a child with a gross motor delay...*

These interventions were put in place, therapy was started and then the allied health professional would refer to us and say, we've started these things and we're concerned this child has this condition or that condition and can you start the medical process, so things were happening in a dual way, whereas now you can't necessarily access [allied health].[651]

8.57. Dr Tim Jones further expanded upon his clinical observations of the impact of changes in early intervention on patients and the Tasmanian healthcare system:

***CHAIR** - And that has changed over time, that availability of the ECIS supports? ... Over what period of time have you seen that reduction in funding and availability?*

***Dr T. JONES -** To me, that is the last five years that we have really seen that progress. The other thing really good about ECIS is we get letters back from them, saying we have seen the family, we have met with the concern, we have seen the child, we are activating these programs of support. Now, more than likely, we may get a letter back from ECIS saying they can no longer meet our eligibility criteria. We are having to prioritise the services.*

The best example of where this model works is our premature babies, who we know are high-risk for all sorts of developmental concerns. They automatically enter what is called Premature Baby Playgroup at ECIS where, on a regular basis, the families are all meeting, they are playing together and they are being observed by trained allied health professionals, OTs, speech pathologists. Concerns, they do not even have to wait for the family to start advocating, there is a collaborative environment right to the start to say hey, they are not walking quite early enough, their speech is not coming along, they are not seeming as brave with the other kids. Again, there is not necessarily any labelling or diagnosis happening, it is just 'we will get some supports running and see how we go.'[652]

8.58. Dr Tim Jones also provided a case study of a patient's experiences which he managed in the absence of appropriate early intervention processes:

***Dr T. JONES** - I want to follow through into how early intervention for children in Tasmania is currently working and to share an example of where some of the gaps in our services are. There's a child I'm familiar with who, unfortunately, several years ago was the victim in a road rage MVA where the vehicle they were travelling in was*

[651] Transcript of Evidence, 23 October 2025, Royal Australian College of General Practitioners Tasmania, pp. 69 – 70.
[652] Transcript of Evidence, 23 October 2025, Royal Australian College of General Practitioners Tasmania, pp. 70 – 71.

repeatedly rammed. From that point on, that child started to experience high levels of stress, worry - they weren't sleeping very well. The concern that was raised was that, in the early school environment, they weren't concentrating and they weren't applying themselves. Now, this family was really trying with any resources they could cobble together to support their child, but there were no private child psychologists available in that area who could take them on. The only thing that their GP knew to do was to refer them into public paediatrics. Because the concern was around behaviour and learning in school, it went to our ADHD assessment clinic, which had a two-year wait time. It was two years of that child struggling before receiving a service that really wasn't targeted at what they needed anyway.

So, trying to ascertain that, when we talk about early intervention, we're talking about a whole spectrum. We do have, through NDIS and other services, very high level supports available to kids with significant disability. What we really lack are some of those focused early intervention supports to kids with milder spectrum presentations, where ideally you want something family focused and community-based, again just to make all the difference in the world and not let those problems snowball as well.[653]

8.59. The RACGP Tasmania representatives also discussed potential long-lasting impacts that children can experience as a result of decreased access to early intervention services:

***Ms JOHNSTON** - … Can you give some evidence and speak to what the impact of a waitlist is on very young people? …*

***Dr M. JONES** - The impact is significant. We can describe it differently depending on what they're referred for. For example, if you're referred for early parenting support for a tiny baby where every day and every week is critical, what happens is that the mental health of the parents deteriorates. If the baby is not feeding well, is not growing well, they tend to start seeking alternative solutions. Maybe they're going to alternative health practitioners for solutions to why their baby won't sleep, or they're paying money for non-evidence-based treatments because they're desperate and really simple, safe, and supportive interventions aren't available to them. The other problem is that sometimes what might start out as a lack of a parenting skill, turns into a child who has a growth problem and it turns into a disease.*

It's different with older children having to wait, say, for a behavioural clinic. It's impacted on by waiting in other clinics. For example, if the reason they have a behavioural problem is that they're not hearing very well, they're waiting a long time for an ear, nose, and throat appointment, they then need to be seen in the developmental behavioural clinic because their behaviour and development is hampered. You miss those windows of opportunity to develop and that child might be behind for the rest of their life.

***Dr T. JONES** - Another pertinent example around what happens is a child I came to as beyond a tertiary level of care and it was a good example of how the wheels can really fall off. This was a single parent doing a really good job for a very big personality toddler, but the sleep just wasn't working. The parent was spending four hours a night trying to help their toddler settle. They had managed to get into paediatric services and they'd received generic advice, but it wasn't tailored to their individual circumstance. It*

[653] Transcript of Evidence, 23 October 2025, Royal Australian College of General Practitioners Tasmania, p. 60.

was impossible for that one parent to implement and that crushed the parent even more because they just felt like, 'well, if even the highest level supports aren't helping us, it's not going to work'. Whereas, fortunately, because of my areas of love as a general practitioner, I was able to put strategies in place that were family focused to that family and the situation resolved itself within two visits. It wasn't big interventions.

***CHAIR** - It was the right intervention.*

***Dr T. JONES** - Yes, and tailored to an individual circumstance, which, when you have that relationship - and it's why we keep talking about community-based services - it is so important. Also, because it removes the stigma. You know, this parent was talking about their child needing to be assessed for NDIS-level supports and possible autism, when really the problem was that the child wasn't sleeping.*

***Ms JOHNSTON** - I'm hearing clearly … there's potentially two patients that are impacted by waitlists, the caregiver and the patient itself, the child. So, the impact of waitlists can have adverse health outcomes on multiple parties…*

***Dr T. JONES** - … The thing that we lose in all of this is parental confidence, that ability to feel like they actually can be an effective parent to their child. If that isn't supported early that relationship is very vulnerable from that point on and when that child moves through their next set of challenges, it's almost like a re-traumatisation, in a way, for that parent. Whereas, if they learn very early on that they've got this and that the system supports them, we see long-term thriving and the impact that has on our communities is tremendous.*[654]

8.60. Playgroup Tasmania's submission detailed experiences of their clients seeking access to early intervention services around the state:

Service providers, parents and carers told us that children in Tasmania are missing out on early diagnosis and interventions because of:

- *The National Disability Insurance Scheme (NDIS)*
- *Problematic implementation and assessment processes impacting on service demand and access for families.*
- *Some challenges families are facing around participating in and accessing early intervention services or programs include:*
    - *Services aren't available where and when families need them. Transport, distance, and isolation, particularly for those residing in rural and regional locations.*
    - *Economic circumstances. For example, capacity to pay, constantly living in poverty given the needs of the child, private therapy is expensive, travel costs and migrant families and ineligible non-residents.*
    - *Family circumstances or capacity to participate such as parent/carer health issues, health literacy, parent/carer mental health, including family*

[654] Transcript of Evidence, 23 October 2025, Royal Australian College of General Practitioners Tasmania, pp. 62 – 63.

trauma due to child circumstances, lack of childcare/support for siblings, family breakdown, separation, and divorce, first time mums and dads and English as a Second Language (ESL).

o Advocacy. For example, families lack information on how to access paediatric services in Tasmania including how to get a diagnosis and how to access and navigate NDIS to ensure that their children get the right level of support.[655]

8.61. Ms Armstrong, CEO of Playgroup Tasmania, expanded on the connection between early intervention services and the need for Commonwealth foundational supports:

> ***Ms ARMSTRONG*** *- ... There are some children where early intervention will mean they may not need further intervention down the line, but we're not set up. Our workforce isn't set up, the services aren't accessible and so that opportunity is being missed. I do have concerns about how the changes to the NDIS [National Disability Insurance Scheme] will impact that.*
>
> *We've also concerns with foundational supports. We are a provider of foundational supports and we are concerned if families aren't being able to access therapeutic supports once they've received diagnosis, then we will be seeing them coming back into our programs, which of course we do not say no, but often we will see families with children who have higher complexities than what our staff are trained to work with. So, it is challenging.*
>
> *It is probably one of the biggest issues that we see in the birth to five [years of age] space at the moment. I cannot underestimate just how important and how challenging this period is for families.* [656]

8.62. Ms Armstrong also discussed the transition away from Early Childhood Inclusion Service (also known as the Early Childhood Intervention Service) (ECIS) and the potential impact on Tasmanian families:

> ***Ms DOW*** *- … how has that changed [from] when ECIS was provided by the state in the early intervention centre for families, particularly across regional areas to what exists now, with a lot of that being pared back and transferred to the NDIS? … is there a role still for the state to play in providing those services?*
>
> ***Ms ARMSTRONG*** *- Yes. Tasmania is one of the only states that kept their contribution to ECIS. It went out to the sector in most of the other states. We are probably one of the only states that actually has that service as a state service. It is a very valuable support for families. The changes that have happened have meant that it is being taken out of the community settings and put into education settings. Not every child will go to a public school and the families have found that it is increasingly difficult for them to access or feel like it is the environment that they want to engage with ECIS in. In a Launching into Learning program that can be quite confronting for a family who has a child with additional and complex needs. When it is taken out of that specific*

[655] Submission No. 20, Playgroup Tasmania, pp. 15 – 16.
[656] Transcript of Evidence, 18 February 2025, Playgroup Tasmania, p. 38.

community setting that ECIS was working in previously, I think it has created some barriers for engagement.[657]

The Committee requested information from DECYP regarding the provision and location of ECIS services in Tasmania. While the information confirmed that ECIS is a statewide service providing place based and outreach services, the response did not clearly explain where services are provided or address the access and equity issues raised in evidence to the Committee.[658]

Paediatric physiotherapy

8.63. As discussed previously in this Chapter, paediatric physiotherapy is available via CHaPS referral to outpatient services at St Giles or North West Regional Hospital. Ms Barnes–Keoghan, a paediatric physiotherapist, explained the nature of this relationship:

> ***Ms BARNES-KEOGHAN*** *- … It is critical that fully state-funded physiotherapy services for early childhood screening and interventions are easily accessible to Tasmanian families. St Giles currently holds funding for state-funded paediatric physiotherapy in Hobart and Launceston, and North West Regional Hospital holds it in that region. There is a huge demand on the state-funded service with wait times currently upwards of four months for paediatric physiotherapy. For example, a colleague in private practice recently recounted her experience with clients seeking private input due to being quoted excessive wait times, upwards of six months. In this instance, it was for a nine-month-old, despite not having the means to then pay for adequate intervention.*
>
> *Paediatric services should be well integrated into the new Commonwealth foundational supports model, which is under development. There is significant wait time for Commonwealth-funded services such as the early childhood approach of the NDIS [National Disability Insurance Scheme], with families waiting at least six months and often more from referral.*[659]

8.64. The accessibility of paediatric allied health services was also discussed in detail:

> ***Ms ROSOL*** *- … I was thinking about the Child and Family Learning Centres (CFLCs), … From what you're saying, physio is not available in those spaces yet. Have there ever been conversations about that and could you comment on that?*
>
> ***Ms BARNES-KEOGHAN*** *- …the way that the paediatric physio works here, it's contracted to St Giles. St Giles runs outreach in some, and some of them are Child and Family Learning Centres, some are the national ones as well. There are a couple across the state. We have New Norfolk, Sorell, Huon Valley, I think are the three main ones where St Giles provides services. That's not really that many in comparison to all the people in Tasmania - providing services there. St Giles is always just trying to stretch its FTE that it's allocated as far as it can. It has to try to fill all those gaps and meet the NDIS where it's at … I think there is scope to use the CFLCs much more than is currently being used for physio paediatric, but potentially also women's. We know that the midwives*

[657] Transcript of Evidence, 18 February 2025, Playgroup Tasmania, p. 39.
[658] Correspondence from the Department for Education, Children and Young People, dated 17 December 2024, p. 1, https://www.parliament.tas.gov.au/__data/assets/pdf_file/0021/91272/Additional-Information-Department-for-Education,-Children-and-Young-People-dated-17-December-2024.pdf.
[659] Transcript of Evidence, 20 February 2025, Australian Physiotherapy Association, p. 102.

and CHaPS, they practise out of there and it's a beautiful space, and you start that journey of motherhood before you've given birth and you can continue it through, which I think could be potentially very powerful.[660]

Findings

The Committee finds:

87. The Child Health and Parenting Service (CHaPS) is a key healthcare service for Tasmanians which is highly valued and trusted by the community and healthcare practitioners.

88. There are some limitations on service provision by the Child Health and Parenting Service (CHaPS) including:

    a. Geographical access, particularly in rural and regional Tasmania;

    b. Timeliness of access; and

    c. Consistency and flexibility in service provision.

89. The ability of the Child Health and Parenting Service (CHaPS) to provide four-year-old health checks in Tasmania is inadequate due to under resourcing. This results in many children missing this check, preventing the early identification of developmental delays and the opportunity for early intervention prior to the commencement of school.

90. Outside of the Child Health and Parenting Service (CHaPS), there is further inequitable access to four-year-old health checks as some, but not all, schools have access to a school nurse who can provide these checks and only some families can afford to pay for these checks with a private practitioner.

91. The number of Child Health Family Nurses (CHFNs) employed by the Child Health and Parenting Service (CHaPS) is inadequate to meet the needs of Tasmanian families.

92. Parenting groups provided by the Child Health and Parenting Service (CHaPS) are highly valued by the Tasmanian community, however accessing the groups, or information about them, can at times be difficult.

93. There is a significant shortage of paediatricians in Tasmania. There is also a shortage of General Practitioners and other medical and allied health specialists. This places a burden on the healthcare system more broadly and leads to Tasmanian children missing out on timely healthcare.

94. Tasmanian families experience significant wait times in accessing specialised support for the assessment, diagnosis, intervention and treatment of Attention – Deficit and Hyperactivity Disorder (ADHD) and Autism Spectrum Disorder (ASD).

[660] Transcript of Evidence, 20 February 2025, Australian Physiotherapy Association, pp. 106 – 107.

95. Accessing the Tasmanian Autism Diagnostic Service (TADS) is complicated and difficult to navigate. There are limited referral pathways and the capacity of the service is inadequate, delaying diagnosis and intervention.

96. The capacity of the Early Childhood Inclusion Service (ECIS) has been reduced, making it harder to access services. A lack of early intervention can have lifelong impacts on children and their families.

97. Early intervention services such as Early Childhood Inclusion Service (ECIS) can reduce the need for the National Disability Insurance Scheme (NDIS) services.

98. The estimated wait time for paediatric physiotherapy through the Tasmanian Health Service is four to six months.

99. There is potential to expand the range of allied health services provided through Child and Family Learning Centres (CFLCs).

100. The Committee note the current Government Administration Committee B, *Inquiry into the Assessment and Treatment of attention deficit hyperactivity disorder (ADHD) and Support Services*, and expect its recommendations will be relevant to matters raised in this Committee regarding paediatric attention deficit hyperactivity disorder (ADHD) diagnosis and treatment.

Recommendations

The Committee recommends:

46. As a matter of urgency the Government recruit additional Child and Family Health Nurses (CFHNs), paediatricians and General Practitioners with Special Interests (GPwSIs) to meet the level of need.

47. The Government fund and deliver as a priority, four-year-old health checks to all Tasmanian children.

48. The Tasmanian Health Service provide additional Child and Parenting Health Service (CHaPS) parenting groups for all parents or caregivers.

49. The Government increase funding to the Early Childhood Inclusion Service (ECIS) to enable a return to the delivery of more community place-based services.

50. The Government review referral processes for Autism Spectrum Disorder (ASD) assessment, including exploring the expansion of Tasmanian Autism Diagnostic Service (TADS) referral pathways to include General Practitioners, Child and Family Health Nurse (CFHNs) and psychologists.

51. The Government expand the provision of allied health services in Child and Family Learning Centres (CFLCs).

9. EDUCATION AND WORKFORCE

9.1. Access to education for healthcare professionals as well as workforce pressures impacts on the healthcare experience of Tasmanians. The Committee heard many examples of the effect of staff shortages and retention challenges, and the adequacy of tertiary education and ongoing professional development for health professionals on patient experience.

9.2. The Committee heard a strong theme of workforce shortages throughout the hearings and submissions. In her submission detailing the findings of her study titled the 'Giving Voice to Women Project,' Dr Ayton noted that of the over 170 Tasmanian women participants:

- *Almost half the sample talked of being aware of workforce shortages, describing the health professionals as 'clearly under strain'. In the hospital environment women rarely saw the same person twice...*[661]

9.3. Private Witness 99 shared the impact workforce shortages had on her experience during the birth of her child:

> *I was scheduled for an induction to begin on Sunday* [redacted] *at the Royal Hobart Hospital. Balloon induction was commenced with the aim to continue into labour the next morning. The next morning I was informed that my induction would be delayed until the afternoon or night shift as there were not enough midwives on shift. I soon learned that being short staffed was a common theme for midwives on the maternity ward.*
>
> *Unfortunately as the afternoon and night shifts rolled around there were still not enough midwives so my labour was delayed until the next morning. I felt scared for myself and my baby when I knew that the induction process had been started but was not able to be continued at the planned time.*[662]

9.4. Private Witness 99 noted that the care provided by midwives was excellent, but the impact of shortages on their work was evident:

> *Whilst the midwives were kind and amazing there were simply not enough of them on shift at any one time. I could sense the midwives on shift were very stressed and struggling to keep up with their workload. There were certain things that seemed to be missed or not completed on time such as my blood sugars and routine observations post birth.*[663]

9.5. A similar experience with understaffing was discussed by Private Witness 115:

> *However, I want it noted that on both occasions I attended the maternity ward at the RHH (for a scan and then the birth) there was chronic understaffing. The midwives on shift were un [sic] off their feet and advised us this was a common experience. On the day I gave birth the maternity ward was shockingly understaffed and I was aware of several midwives doing double shifts.*

[661] Updated Submission No. 15, Dr Jennifer Ayton, p. 3.
[662] Submission No. 99, Private Witness, p. 1.
[663] Submission No. 99, Private Witness, p. 2.

I have also lived with a midwife who worked at the RHH hospital and heard first hand of the chronic short staffing issues. This is a long-term and ongoing problem.

This is unacceptable and we must do better. The staffing levels are unsafe for all involved - the birthing mothers, their babies and the midwives who work tirelessly to provide care to people during an incredibly vulnerable time. [664]

9.6. Dr Khot, representing the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), provided an assessment of the competing factors at play which impact the healthcare workforce and patients:

> ***Dr KHOT - ...*** *something that is a challenge for everyone, not just Tasmania, across the country and across the world. But there are some real challenges to having accredited training sites in Tasmania. Currently, the North West Regional Hospital doesn't have accreditation for training, which means that we are not able to have as many trainees in Tasmania. People who train usually tend to stay and provide a service in that same place. If you don't have the number of trainees, then you don't have the number of doctors who will stay on and provide the service. That has implications for workforce as well.*
>
> *We understand that there are wage disparities which may be contributing to these workforce shortages. Depending on how much people get paid may be a reason to make a choice to live and work in a particular state or a particular place versus another.*[665]

9.7. Updated information provided by the Australian Medical Association (AMA) Tasmania in October 2025 also provided context to access to specifically maternal healthcare at the North West Regional Hospital, especially Obstetrician-Gynaecologist (OBGYN) services. This context includes ongoing effects of the 2023 transition of private maternity services to the public hospital:

> *Northwest specialist OBGYN services are currently operating at reduced FTE and are being supplemented by Locum support, without onsite 24/7 OBGYN or anaesthetic coverage. The private OBGYN service has been suspended for the past 12 months, following the withdrawal of a private OBGYN practitioner, due to ongoing indemnity concerns arising from the continued delivery of NWRH maternity services within the northwest private hospital under the purchased model arrangement. The result is patients preferring private deliveries are travelling to Hobart, or under care of OBGYN in Launceston, delivered at the LGH.*[666]

9.8. Dr Khot also discussed the potential broader impact of workforce shortages in a particular area, such as maternal healthcare, on the systemwide care provision including the willingness of staff to work in understaffed environments:

> ***Dr KHOT*** *- ... When we lose a rural maternity unit, we actually lose a whole lot more than just the doctors and midwives and the babies being born because a maternity unit*

[664] Submission No. 115, Private Witness, p. 1.
[665] Transcript of Evidence, 23 October 2024, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, pp. 48 – 49.
[666] Updated Information, Australian Medical Association Tasmania, 10 October 2025, p. 2.

is kind of like a litmus test. If there's a maternity unit, that usually means that that's a community where babies are being born and it's not just the doctors who are providing pregnancy care and midwives. It also means that there will be an anaesthetist there, so surgical procedures can carry on. Most people are obstetricians and gynaecologists, which means that they not only birth babies, they also provide other women's healthcare, gynaecological care, treat heavy periods, provide contraception, provide abortion services. So, when you lose a maternity unit, you actually lose a whole lot more than just the maternity unit and, of course, it has implications not just for birth trauma, but for women's healthcare in general.[667]

Midwifery

9.9. Current workforce conditions and midwifery education in Tasmania were repeated themes in evidence received regarding midwifery care. Taken together this evidence suggests that there has been a lack of appropriate education pathways in the state and that existing midwives in Tasmania are overworked.

Current workforce conditions

9.10. The Australian College of Midwives (ACM) provided an overview of a number of factors currently facing the Tasmanian midwifery workforce:

> *Midwifery and maternity workforce shortages are evident across Tasmania, with high reliance on agency and locum staff, and poor retention in some areas. While formal reports of FTE deficits are not available, these are known to have been alarmingly high in some areas over the past two years, and last year resulted in one service being on bypass, thereby forcing women to travel long distances to access maternity care.*[668]

9.11. Ms Shakes, representing the ACM, also highlighted potential Tasmanian actions within the national context:

> ***Ms SHAKES** - … ACM acknowledges that there are midwifery workforce shortages across Australia and indeed internationally, and that strategies to address these shortages needs to reflect both the unique local needs within Tasmania and broader national commitment by all stakeholders to valuing [and] sustaining the midwifery profession, through dedicated midwifery workforce supply and demand models, recruitment and retention strategies, career pathways, support for midwives and leadership.*[669]

9.12. Representing the AMA Tasmania, Dr Lumsden–Steel commented on the impact of midwife shortages on Tasmanian patients:

> ***Dr LUMSDEN-STEEL** - … We've seen in the media recently that we have had extreme concerns raised by midwives around potential delays to labour through inadequate midwife resources. It literally is a case of trying to pick who is the most urgent delivery to start from induction time. That means we are starting inductions on patients at unsafe hours because that is when the next shift of midwives comes on. So a higher risk delivery, which would normally be started first thing in the morning, the induction process is started when the next midwife shift starts, which might be in the afternoon,*

[667] Transcript of Evidence, 23 October 2024, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, p. 55.
[668] Submission No. 32, Australian College of Midwives, p. 9.
[669] Transcript of Evidence, 23 October 2024, Australian College of Midwives, p. 74.

which means that when it all goes to, unfortunately, needing a caesarean section or an urgent surgical intervention, that is happening after hours.[670]

9.13. In information received by the Committee from the Australian Nursing and Midwifery Federation (ANMF) Tasmania Branch, Emily Shepherd, Branch Secretary, raised possible solutions to workforce shortages and how addressing it would benefit the overall care provided by midwives:

> *The ANMF believe that improving staffing with filling all midwifery positions (with agency staff as required) is critical to achieve the other required improvements. This includes the implementation of more lactation consultant positions to assist those women who need breastfeeding support. The benefits of supporting breastfeeding for women who are able and choose to breastfeed their baby is enormous, proven in evidence-based research and simply put has lifelong health benefits for both the baby and mother.*[671]

9.14. During the Inquiry, several changes occurred in Tasmania's maternal, reproductive and paediatric healthcare system. This included the announcement by Healthscope of the closure of the Hobart Private maternity services from 20 August 2025. Healthscope cited workforce shortages as a key factor in the decision. In their announcement of the closure, Healthscope stated:

> *Hobart Private Hospital will be accepting its last maternity admissions on 13 August 2025, with the service proposed to close on 20 August 2025. Expectant parents due to give birth prior to 13 August will not be impacted by this decision and will still receive the high-quality care Hobart Private Hospital prides itself on.*
>
> *For families due after this date, Hobart Private will work in partnership with their treating obstetrician to ensure a safe transfer of their maternity care to other providers.*
>
> *Healthscope has been in ongoing discussions with the Tasmanian Government and the Department of Health about the challenges we have been facing to secure the workforce needed to maintain our maternity service.*
>
> *No other services are impacted at Hobart Private Hospital as a result of this decision. Other clinical specialities, including gynaecological services, will continue as usual for patients.*[672]

9.15. Following the announcement, the Committee invited Healthscope including Hobart Private executives, to attend a hearing. Mr La Spina, Healthscope CEO, provided further context regarding the decision:

> ***Mr La SPINA** - … The decision to cease maternity services at Hobart Private Hospital was not made lightly. It follows a long and thorough review of the service's operational viability, particularly in the face of critical workforce shortages. Despite extensive local, national, and international recruitment efforts, including the appointment of a talent acquisition manager, we've been unable to secure the midwifery workforce required to*

[670] Transcript of Evidence, 30 October 2024, Australian Medical Association Tasmanian Branch, p. 17.
[671] Correspondence from the Australian Nursing and Midwifery Federation, dated 31 January 2025, p. 3.
[672] Healthscope, 20 February 2025, ' Healthscope announces intention to close maternity services at Hobart Private Hospital,' https://healthscope.com.au/news-media/Healthscope-announces-intention-to-close-maternity-services-at-Hobart-Private-Hospital.

sustain a safe, high-quality maternity service. At times, up to half of our midwifery workforce has been reliant on agency staff flown in from the mainland, which is unsustainable both financially and in terms of continuity of care. We also note that this is a challenge around the country, with recent public reporting citing figures provided by the National Association of Specialist Obstetricians and Gynaecologists showing that by the end of 2025, 18 private maternity units across Australia will have closed in the past seven years.[673]

9.16. Ms Banks, General Manager of the Hobart Private Hospital, discussed their attempts to address midwifery workforce shortages prior to the closure decision:

> ***CHAIR*** *- … You touched on workforce shortages… What would you nominate as some of the solutions do you think to those workforce challenges for Tasmania and elsewhere? Is it specifically around midwifery care or is it broader than that from your experience?*
>
> ***Ms BANKS*** *- Great question, in terms of midwifery specifically, obviously, some of the challenges we've faced have been securing any workforces. … just as a comparison, we've been able to successfully recruit over 20 staff, or 20 FTEs, into other domains within our workforce, but for maternity we've just not been able to secure - we managed to secure one special care nursery registered nurse, but no midwives into our portfolio despite all of those different campaigns. Unfortunately, the lack of tertiary education within Hobart has, I think, contributed to it. Sourcing midwives locally to then be able to on-train has been an ongoing challenge for Hobart.*[674]

9.17. Ms *Dow* MP further questioned Ms Banks as to the exact measures undertaken to fill midwifery roles:

> ***Ms DOW*** *- … I wondered, when you speak about the challenges that you had with recruiting midwives, did you offer any incentives or any sort of recruitment packages or anything around trying to get midwives to come and work at your hospital?*
>
> ***Ms BANKS -*** *… We certainly did. What we have seen over the time - and obviously I can only talk to Hobart more specifically in recent times - we've seen our workforce become highly casualised. If we look back on the data we can see that really over the last two to five years, we have an older workforce. Many of our midwives have been there a very long time with us, which is amazing... There are lots of people who have been there 30 plus years. I think that it is a lifestyle choice as they start to become more casualised.*
>
> *In terms of offering them - obviously, we're offering extra shifts, offering penalties for additional shifts, when we got to a point of 45 per cent of the workforce being casual, they'd really made their decision to have lifestyle over working set rosters. What we can say is that many of those decisions were made around penalty shifts, afternoons and night duties. Not so much weekends, we usually have no concern with that, but it was the decision not to take on those particular shifts and hence going casual.*
>
> *In terms of part of the recruitment packages, we certainly had relocation allowances, we had accommodation provided, sponsorship of visas. They were some of the*

[673] Transcript of Evidence, 26 March 2025, Hobart Private by Healthscope, p. 80.
[674] Transcript of Evidence, 26 March 2025, Hobart Private by Healthscope, p. 81.

methods that we looked at to try and employ people, certainly in the timeframe that I have been there.

Mr La SPINA - *Even the ones that did come to work, they were at penalty rates. They are not what you would call at ordinary time rate.*[675]

9.18. Following the Healthscope announcement, the Committee also invited representatives from Calvary to discuss the anticipated transition of all Southern based private maternity services to Calvary. The transition itself was discussed previously in Chapter 4, but the representatives of Calvary were asked about their experiences with midwife shortages and the impact on care:

CHAIR *- … Do you want to share with us any more detail around the challenges that you are finding, particularly in recruiting and retaining midwives - which I understand is a problem for everyone, everywhere - or other health professionals adding to maternity services or having a role to play in maternity services?*

Ms SALISBURY - *…it's not just a Tasmanian problem either, we are certainly experiencing it nationally.*

Ms MAGLIANO - *We have had challenges in recruiting and retaining. We had a period of time where we didn't train students. We have actively trained students over the last two years and we have had issues in retaining them, because students want the bright lights of the tertiary organisation.*

We have a very committed body of midwives that have worked very hard at keeping the unit viable and safe for the patients of Hobart. We have a permanent workforce, but we also have a very good casualised workforce. We've had to complement that workforce over the years with agency contracts, to ensure that we have enough midwives to manage the births that we have booked in at Calvary Hobart.

Ms EVANS - *We have also introduced some incentive programs as well, to attract midwives to stay with us and to increase their positions from being casual to permanent. That was successful, for a while.*

CHAIR *- What kind of incentives were they?*

Ms MAGLIANO - *It was monetary incentive, so bonus sort of structures for them to join the permanent workforce or to work more shifts.*

Ms EVANS - *A scholarship to do education as well.*

CHAIR *- Masters in maternal health, that kind of thing?*

Ms EVANS *- No, the postgrad in midwifery.*[676]

9.19. ANMF Tasmania Branch representatives were also invited to discuss the then pending closure of the Hobart Private's maternity ward. For further context, the

[675] Transcript of Evidence, 26 March 2025, Hobart Private by Healthscope, pp. 83 - 84.
[676] Transcript of Evidence, 26 March 2025, Calvary Lenah Valley Hospital, p. 91.

ANMF Tasmania Branch appeared before the Committee on 20 February 2025, the same day on which the closure of the ward was announced:

> ***Ms TIEFHOLZ*** *- I think it's also really important that we learn from the closure of St Helen's. We lost a lot of psychiatrists at that time. We had psychiatrists who left the state, who retired, who are just no longer practising psychiatry with the local community. That was a huge loss to the mental health services community, both public and private. It also meant that there was this need to be able to absorb the consumers of those services in other services that were themselves already quite overstretched.*
>
> *I'm very concerned that following on from this closure of Hobart Private, we might also see an exodus of obstetricians and gynaecologists as a result of that. That would just further exacerbate the skills shortage ....*[677]
>
> ***Ms JOHNSTON*** *- ... Calvary [Lenah Valley Hospital] has a limited capacity. Can you perhaps elaborate on the way forward in terms of the announcement today?...*
>
> ***Ms SHEPHERD*** *- Absolutely. Aside from the personal toll, as I mentioned before, some of the midwives at Hobart Private have gone through the exact process at St Helen's. They're now facing it again at Hobart Private. It takes an enormous toll. Many midwives have become a midwife and worked at the Hobart Private for many, many years. That is where they want to work. They want to work in the private sector, but it is true that Calvary won't be able to pick up the entirety of that cohort of birthing.*[678]

Since this point in time, the Committee received an update from Calvary regarding the transition of some of the maternity demand in the South of the state to their Lenah Valley campus, including staffing levels. This information is available in full on the Committee webpage.[679]

9.20. The Committee also heard evidence about staff retention. ANMF Tasmania Branch representatives discussed the workplace environment for midwives and the impact of these experiences on retention:

> ***Ms WERNER*** *- I think when it comes to staffing, we've got to make nursing and midwifery attractive again. At the moment, it's not. We're burning out our new grads. We've got new grads crying and saying, 'I hate my job,' and they're leaving. While we're being told that there's active recruitment, we're not keeping up with the exodus.*
>
> ***...*** *We get contracted staff from outside of Tasmania. They come in because they're told it's a beautiful state and it is, but when they hit the floor and start working –*
>
> ***...*** *where our conditions are inferior to anywhere else in the country and they're getting flogged and -*
>
> *... they're burnt out. We're not retaining our grads. We're probably not even recruiting into UTAS for registered nurses. We're not even conducting a midwifery course here within the state to keep our own at home.*

[677] Transcript of Evidence, 20 February 2025, Australia Nursing and Midwifery Federation Tasmania Branch, p. 97.
[678] Transcript of Evidence, 20 February 2025, Australia Nursing and Midwifery Federation Tasmania Branch, p. 95.
[679] Updated Information, Calvary Health Care, 3 October 2025, p. 1.

...

***Ms SHEPHERD** - Just on the training aspect, I don't want to sound critical with the University of Tasmania withdrawing the course because I certainly understand with the changes in curriculum and the enormous amount of work that does need to go into developing a course like that. For a very small cohort and small numbers, it is a lot of cost and expense. But, we need to think more broadly about how do we make that viable for the University of Tasmania -*

***CHAIR** - And what it means for the future of the workforce.*

***Ms SHEPHERD** - Exactly. As well as thinking about our child health qualifications for child health and parenting, other opportunities that might be part of a suite of courses that could be offered as an adjunct to that. Because, certainly, curriculum changing regularly and having to rewrite courses for a small cohort would be very difficult. I think, again, that comes down to that vision and strategy and planning about how we make the education and training, the service delivery, sustainable.*[680]

The matters raised regarding the provision of midwifery education will be further discussed below.

9.21. Ms Shepherd further explored the need to retain existing staff in the Tasmanian healthcare system, including midwives:

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

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

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

Our advice is that - and we have met, obviously, with the department and the minister about this - we actually need to focus on supporting existing staff. It was great that there was an allocation in this year's state Budget in relation to peer support programs. For many public sector nurses and midwives, there is currently no peer support program. There's an employee assistance program, which, when you're talking about maternal health care in a birthing setting, child health and parenting, these are really traumatic - they can be really traumatic episodes of care, and care of those in accessing

[680] Transcript of Evidence, 20 February 2025, Australian Nursing and Midwifery Federation Tasmania Branch, pp. 97 – 98.

those services. There's not appropriate mental health support for those individuals who might need specialised care from a mental health perspective.

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

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

...

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

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

***Ms SHEPHERD** - 'We're going to take it on despite the fact we haven't adequately resourced the services that we're trying to provide from the outset.' I think there's a lot of work to be done in that space around how we support existing workforce. I do believe if we can support staff in these settings that people who have reduced hours will increase their hours again. People want to come back and work, but we need to work on the culture. We need to work on trust.* [681]

9.22. The ACM provided recommendations to recruit and retain staff:

Ms SHAKES - *… Implementation of strategies to sustain and retain midwives across all stages, from students to late career. This requires incentives, developing innovative approaches to meeting staff needs, and exploring barriers to midwives remaining in the industry.*

Addressing workforce shortages and investigating barriers to midwives working in continuity of care models, and implementation of count the babies in midwifery ratios, to ensure safe staffing levels for midwives and families.[682]

[681] Transcript of Evidence, 20 February 2025, Australian Nursing and Midwifery Federation Tasmania Branch, pp. 94 – 95.
[682] Transcript of Evidence, 23 October 2024, Australian College of Midwives, p. 74.

9.23. Ms Dawes, representing Birth Trauma Australia, also discussed how midwives and other healthcare providers should be supported through potential vicarious trauma:

> ***Ms DAWES*** *- … We need to invest in midwives, but we also need to provide support for them. If they're witnessing trauma, what is the impact on that? And I think we see it for midwives and doctors. We expect our care providers to be superhuman, but we know the effect of witnessing trauma and what that has on the brain, yet there's no opportunity for reflective practice in there.* [683]

9.24. The Committee received lived experience evidence from practicing PPM, Ms Smith, regarding the interrelationship between training, retention and workplace experiences of midwives in Tasmania:

> ***Ms DOW*** *- … You've obviously had the experience to work in both private practice and in a public health setting. What are your thoughts on what it is that are barriers to people wanting to take on midwifery? Is it the structure of the course? Is it the fact we don't have a course provided by the University of Tasmania? …*
>
> ***Ms SMITH -*** *Yes, I was one of the last groups to go through UTAS for midwifery. That reminds me, I was going to say when I was speaking to you, our training is very woman-centred. Universities are really good at teaching midwives to be woman-centred and then we get out and practice and its system-centred. There is a culture that we have to fit into or we get bullied, or policies that actually aren't woman-centred and are outdated. We know it takes about 17 years for research to end up in hospital policy, so there's a massive lag there between best practice, evidence-based practice and the outworking of that in reality and so, I've actually started another business called the Midwives' Midwife.*
>
> *Midwife means 'with woman' and midwives are burning out and leaving at a rate of knots, we're a million midwives short worldwide at the moment. I can't remember what the Australian number is, but we say it's the best job in the world. If you're a midwife, every midwife is like, 'I've got the best job in the world.' Yet, why aren't we keeping midwives? I think it's because of that mismatch between we do this as a profession because we want to be with women, we want to support women's autonomy and positive birth and pregnancy experiences and then, we're forced to work in a system that, like, 97 per cent of women in Australia birth in hospitals.*
>
> *Most of us are birthing in hospitals and most midwives work in hospitals, but it doesn't support woman-centred, personalised, individualised care. The system has to run as a system. It's en masse. It's get you in, get you out, keep you alive. But that should be the bottom rung of the ladder. There's a lot more to what we offer them than just keeping mums and babies alive. I believe that's the problem. We have this cognitive dissonance where how we want to work and function doesn't align with our employer and the system we're working in. After a while that burns midwives out and makes them feel like they're being forced to work at odds to their own conscience. They're traumatised by what they're seeing and having to participate in, and decide to leave.* [684]

[683] Transcript of Evidence, 23 October 2024, Birth Trauma Australia, pp. 10 – 11.
[684] Transcript of Evidence, 19 February 2025, Jaimee Smith, p. 11.

Education opportunities

9.25. A key issue raised with the Committee relating to midwifery workforce shortages is the tertiary path to midwifery registration in Tasmania. Since 2016, there has been no midwifery training at the UTAS. Pathways provided by interstate universities are available to Tasmanians, including graduate certificate and undergraduate courses. The Committee received information regarding this matter from multiple witnesses, including a synopsis of the midwifery pathways available in Tasmania, provided by the DoH:

> *To manage midwifery pathways after the University of Tasmania suspended midwifery course offerings in late 2016, DoH partnered with the University of Southern Queensland (UniSQ) to deliver a Bachelor of Midwifery course for registered nurses in Tasmania. The first cohort commenced in February 2017 and, since this time, other universities have successfully secured placements for students in Tasmania.*
>
> *The Registered Nurse (RN)/Bmid course offered in Tasmania by UniSQ is an accelerated pathway for the RN seeking to become a midwife, reduced from three years to two years. Students participate in clinical placement time across the two years. Charles Sturt University also offers an accelerated pathway (12 months) for RNs seeking to become a midwife. Charles Darwin University has established placement with RHH for students of its Bachelor of Midwifery undergraduate program which is a three year full time program.*
>
> *Since late 2022, all three public sector maternity services in Tasmania have moved to offering part time employment to all RN Midwifery Students for the entire duration of their course. Tasmania is one of only a few jurisdictions to offer fully paid student placements.*
>
> *Arrangements are in place to ensure that students in placement work to their professional scope as they progress through the course. In recognition of the skill level of RN Student Midwives in the second year, students can work additional paid shifts as an RN/Student Midwife.*[685]

9.26. The Committee also received a written response to questions addressed to the School of Nursing, UTAS in February 2025 regarding the current structure of midwifery programs and any proposed changes in the future:

> 1. ***Could you please provide the Committee with an overview of the current pathways to midwifery qualifications in Tasmania.***
>
> *The University of Tasmania offers postgraduate qualifications for those with an existing midwifery qualification to further their professional development. The University of Tasmania paused its intake for the Graduate Diploma of Midwifery in 2016 due to low enrolments. Midwifery qualifications are available to Tasmanians through attending an interstate university whilst undertaking their clinical practicum in a Tasmanian hospital. Bachelor offerings and postgraduate programs (for Registered Nurses) can be provided this way, and for the postgraduate pathway*

[685] Submission No. 129, Department of Health, p. 27.

this usually requires employment with a midwifery service prior to enrolment in the course (these places are limited). Students attend a 'block of study' at the home university, usually twice per year. Exact course structures are dependent on the relevant offering university.

2. ***Does the University of Tasmania have any current plans to establish an undergraduate degree in midwifery?***

   The University of Tasmania is exploring options for providing Tasmanians the opportunity to study midwifery. We recognise that midwives are an essential part of our health workforce, and discussions are continuing with the Department of Health through our strategic partnership on how our university can best support midwifery education in the State. These discussions are of high priority and we are actively engaging in conversations and acutely aware of the needs to find a viable solution. Midwifery offerings have specific practicum requirements for students which creates complexity around ensuring the offerings are long term financially sustainable and appropriate to future workforce development.[686]

9.27. Dr Lumsden-Steel further expanded upon the connection between education in Tasmania and the transition of workers into the Tasmanian health system:

> ***Ms DOW*** *- … one of the recommendations that's been made to this committee is recommencing an undergraduate Bachelor of Midwifery or establishing an undergraduate Bachelor of Midwifery course in Tasmania, whether that's in partnership with the mainland university. I wanted to get the AMA's comments on that and whether you think there's merit in that.*
>
> ***Dr LUMSDEN-STEEL*** *- Yes, we would support the capacity for Tasmania to provide end-to-end training for our healthcare workers. We can't provide everything in Tasmania, but we think we should be able to provide midwife training. Be that in collaboration with another university, but we need to provide a pathway that removes barriers so that people that want to become midwives, can do, in Tasmania and easily.*
>
> *There's another subtle point and it's not necessarily my comment to necessary say how our nurses should be trained, but overwhelmingly I get the impression that we need to get back to training nurses in our hospitals. Sorry to speak frankly about this, but I think there's increasingly observations that, and a bit like medicine, we spend a lot of our time actually in the hospital with our training, but producing nurses who are actually having their training aligned to the role, which is not always what you get from a university-based process. I think we need to maybe look at how we're doing that within Tasmania.*
>
> *Midwife training is a classic example, and you would all be aware that the midwives now don't have to do nursing before they become a midwife. The subtle little point about that is that occasionally, from time to time, particularly in a challenging situation, you need to make sure you've got enough midwives who also have a nursing background because patients, when they deteriorate, can have other medical conditions and things that you need to treat. It's not just always about a safe, straightforward delivery. Increasingly, it's about managing patients with other comorbidities who are also having*

[686] Response to request for additional information from University of Tasmania, dated 26 February 2025, p. 1.

babies as well. You have to manage the patient with other medical conditions, which is important.[687]

9.28. The ANMF Tasmania Branch also provided comment on this:

> ***Ms SHEPHERD*** *- … Since 2016, we have seen what the ANMF would describe as a degradation of health services and reproductive services, as well as maternity services. We have also seen significant challenges in the child health and parenting space, inclusive of mental health services in that, and also challenges in actually seeing school nurses implemented across the state as well.*
>
> *Those concerns relate to the loss of training and education for midwives in Tasmania with UTAS ceasing to offer the postgraduate diploma of midwifery in Tasmania. We believe that has contributed to perhaps less uptake of midwifery in Tasmania with those wanting to train as midwives having to access that course through interstate universities.*[688]

9.29. At her appearance before the Committee in March 2025 as then Minister for Health, Hon. Jacquie *Petrusma* MP provided an update on the DoH's collaboration with UTAS to develop Tasmanian midwifery pathways:

> ***Mrs PETRUSMA - ...*** *The Department of Health has been working very hard with the University of Tasmania to reintroduce the Diploma of Midwifery in 2026, including a residential program enabling nurses who wish to become midwives to undertake this course here again in Tasmania.*[689]

9.30. Then Minister *Petrusma* and Secretary of the DoH, Mr Webster, discussed this further:

> ***Mr WEBSTER*** *- …There is a shortage again Australia-wide, worldwide of nurses and midwives, so it is actually attracting and keeping that workforce in Tasmania as much as we can. On that track, we already have agreements in place with Charles Darwin University and Charles Sturt University - I think that's the right names - where the people do their intensive on-campus, you know, as residential blocks through the year, but do their placements with us and that then flows through to a graduate program with us. Now we're entering into an agreement with UTAS to try to onshore some of that activity. We will try to balance, to keep three agreements going because we think it's important that universities do offer midwifery. We don't want to see a situation where our cohort pulling out of Charles Sturt means that their program becomes unviable. We need to balance that as well.*
>
> ***CHAIR*** *- Do you know how many Tasmanian students are studying through those two interstate universities?*
>
> ***Mr WEBSTER*** *- There're six through Charles Sturt University. I'll have to check Charles Darwin University because it's not in my head at the moment. Probably about the same number. As I said, if we can get an onshore cohort, the second part of that is making*

[687] Transcript of Evidence, 30 October 2024, Australian Medical Association Tasmanian Branch, pp. 27 – 28.
[688] Transcript of Evidence, 20 February 2025, Australian Nursing and Midwifery Federation Tasmanian Branch, p. 88.
[689] Transcript of Evidence, 26 March 2025, Department of Health and Hon. Jacquie Petrusma MP, p. 3.

sure that we offer that through Calvary [Lenah Valley Hospital] as the other provider. It's not just for our staff; it's actually broadly across -

***...** midwifery. In fact, any RN [registered nurse], it wouldn't necessarily be Calvary. There might be RNs in Healthscope or in general practice who wish to do midwifery. We want to pick them up as well. The best way to do, we think, is to have an onshore element.*[690]

9.31. The timeline for the provision of the UTAS midwifery courses was also discussed in detail with the Committee:

***CHAIR** - ... I just want to explore the negotiations you're having with UTAS because I'm really glad to hear that those are going on. ... Could you tell us a bit more about the timelines with UTAS, if they're known at this time, whether there will be an option for direct-entry midwifery, or if it will be through that nursing pathway, and what you'd like the Committee to know about those negotiations?*

***Mrs PETRUSMA** - For the diploma, we're looking at early 2026. That's probably -working with UTAS in regards to direct-entry of midwives - that won't be - that will still continue through the other pathways at this stage because we need to get the diploma up and running first of all and make sure that that's viable. That's part of the reason why we need to ensure that there are other options as well.*

The other options do allow nurses to do online, too, which may suit them. We also offer, where you can be a student midwife and still work for us - you can work part-time for us while being a student midwife. We also offer different scholarships to encourage people to become midwives. That all sort of feeds into the package. If people want to do a direct midwifery course that is online, they can get a scholarship towards doing that. We do pay for placements in different universities to enable that.

***Mr WEBSTER** - Just to add to that, our discussions with UTAS about a direct-entry course are much earlier stage than a graduate diploma. We prioritise[d] the graduate diploma. We're on a timeline of discussion with them. They know that we're looking for 2027 to be our first year [for the direct-entry course]. Obviously, that's a five-year solution rather than a one-year solution that comes with a graduate diploma. That's why we've prioritised one over the other, but it is early stages and, obviously, they have to go through an accreditation process and things like that, plus their internal processes, but we've asked them to work with us on a 2027 entry.*

***CHAIR** - If students are doing direct-entry midwifery interstate, can they do their practical placements in Tasmania?*

***WITNESSES** - Yes.*[691]

[690] Transcript of Evidence, 26 March 2025, Department of Health and Hon. Jacquie Petrusma MP, p. 6.
[691] Transcript of Evidence, 26 March 2025, Department of Health and Hon. Jacquie Petrusma MP, pp. 6 – 7.

9.32. In a written update to the Committee in October 2025 the Hon. Bridget *Archer* MP, the Minister for Health, Mental Health and Wellbeing provided an update on midwifery shortages and the Government's plans in this area:

> *To strengthen and expand the midwifery workforce and midwifery-led services, the Department published a new strategy and action plan for consultation in September 2025, titled Midwifery Matters – Tasmanian Midwifery Workforce Strategy 2025 – 2030. In addition to written submissions, consultation sessions have been held with key stakeholders such as midwives, professional bodies and colleges and consumers. Submissions close on 5 October 2025.*
>
> *The Midwifery Workforce Strategy will include actions to grow 'direct entry' midwifery education pathways and graduate workforce opportunities in areas like Child Health and Parenting. This will be complemented by expanded postgraduate education courses for direct entry midwives and broader carer options. This is the foundation for strong professional pathways for midwives in Tasmania and is fundamental to the retention of the midwifery workforce.*[692]

9.33. The ACM representatives discussed that students may wish to pursue midwifery training in Tasmania:

> ***Ms WEATHERSTONE** - … Growing a midwifery workforce with a pipeline, as we spoke about in the opening statement, is having access to undergraduate then postgraduate study, and having that local, is demonstrated to support [retention].*
>
> *Also, there's a number of students who don't wish to hold a dual qualification, so having a double degree is a barrier for some students. In other states the Bachelor of Midwifery is often oversubscribed, and then we are losing those future workforce because they're not re-enrolling the next year if they're not successful.*
>
> ***...***
>
> ***Ms SHAKES** - We have heard from quite a lot of women who would like to study midwifery and delaying it and delaying it because there aren't local opportunities for them. So, that is a key area to make a difference, to grow them here, because then they have a commitment to stay here.*
>
> ***Ms WILKINSON** - To speak from my own experience, I grew up in Hobart but travelled to Melbourne to do a Bachelor of Midwifery. I was young, I wasn't really sure what I wanted to do - I had midwifery or linguistics as my top two. I definitely wasn't going to do nursing. If Melbourne hadn't been an opportunity for me, I would have done something entirely different. I saw them as completely different professions, which they are.*[693]

[692] Updated Information, Attachment 1, Minister for Health, Mental Health and Wellbeing, 27 October 2025, p. 2.
[693] Transcript of Evidence, 23 October 2024, Australian College of Midwives, pp. 75 – 76.

9.34. Ms Weatherstone and Ms Shakes continued their discussions of these matters:

> ***Ms WEATHERSTONE*** *- …There is also the Postgraduate Diploma of Midwifery once you've got your nursing qualification. You can go back and do 12 to 18 months of midwifery, so it does vary across states and territories. There are different contributing factors to that as in the entry requirements for each of those courses and there are slight nuances in each state and territory. What we do see is that the majority of people wanting to study midwifery want to do midwifery alone because they also have the consolidation side of that and the continued professional development. If you have two degrees, you need to maintain your recency of practice in both.*
>
> ***…***
>
> ***Ms SHAKES*** *- In one of my other roles, I work with student midwives in Tasmania and I polled them. There were probably 15 in total and they were all nurses, already doing midwifery. I asked them all what their preference was. All but one wanted to be midwives and they had done nursing first. For some of them it has taken 18 years to get to where they want to be, doing midwifery, and some of them have just got their nursing qualification and straight into midwifery.*
>
> *What that tells us, and what we know from our own clinical practice, is that for midwives in Tasmania to have to do nursing first if they're doing it within the state, we're effectively poaching from the nursing workforce, which has its own shortages. The opportunity for student midwives to really specialise in the field as well is enhanced when you're doing a Bachelor of Midwifery so that's three years of specialising within all the nuances of midwifery, which is a very diverse field, doing one year or 18 months on top of it is absolutely right for some people, but for others, being immersed in it will be more helpful to them.*
>
> *One other thing that we also know from the research is that a higher percentage of midwives who choose to work in continuity of care models have done a Bachelor of Midwifery, so that's quite telling. It's a national objective to have more continuity of care models. We know that it's the gold standard. We know there are issues to attracting people to these models of care, but midwives, as we have done, BMid, we are very well placed to prioritise that. It's our preferred model of care.*[694]

9.35. The Committee received evidence from many individuals on improvements that could be made to other tertiary qualifications and continuing professional development. Representatives from the Tasmanian Aboriginal Centre (TAC) explained that cultural awareness training is also vital. The extract from their appearance at a hearing below discusses this specifically in relation to their understanding of training provided in undergraduate nursing degrees at UTAS:

> ***Mrs PETRUSMA***[695] *- I know the current nursing students who are at UTAS do a whole semester on cultural awareness and everything. That's why I was interested in how that is translating in practice.*

[694] Transcript of Evidence, 23 October 2024, Australian College of Midwives, pp. 76 – 77.
[695] At the time of this hearing in October 2024, the Hon. Jacquie Petrusma MP was a Member of the Committee.

***Ms FOSTER** - It's so systemic. It's really difficult. We do a lot of training for GPs as well - GP registrars. You'll get a cohort who are just - there are 10 out of the 12 who are fully immersed and you only need the two that are not, because that could be the two people that you see. It is so difficult to get it right. But if we are acknowledging that, that's a really important part of the service system that needs developing better, then we're a long way along the track compared to where we were 10 years ago, for example.*

***Ms HARRIS** - After going through UTAS doing my nursing, I did that component and I feel like it's still at such a deficit lens. When you work with families, if they tick the box to say, 'Yes, I'm Aboriginal', it shouldn't be, 'Right, they're going to need this, this and this'. It should be to have a discussion with them. What are their circumstances? What things are on offer for them? Is that something that they want? Let them make the decisions for themselves, not just assume that they will need these things.*

***Mrs PETRUSMA** - Which is what they should be doing for every patient who comes in the door. They should not allow any unconscious bias. You need to be doing that proper assessment.*

***CHAIR** - Is the TAC involved in delivering that in the nursing degree? Who delivers that teaching?*

***Ms HARRIS** - It is through Riawunna. They don't have Aboriginal people delivering that.*[696]

9.36. Gidget Foundation Australia (Gidget Foundation) also emphasised the need for healthcare professionals to have increased cultural awareness of Aboriginal and Torres Strait Islander communities and recommended extra training around the needs of culturally and linguistically diverse (CALD) patients:

> *Recommendation: Improved training for healthcare workers around delivery of culturally safe care, along with increased access to appropriately trained interpreters is needed to improve service accessibility among CALD parents.*[697]

General Practitioners (GPs)

9.37. Access to GP services in Tasmania was raised by numerous participants in the Inquiry. Women's Health Tasmania (WHT) noted the impact on GP shortages as well as access to reproductive health services:

> *Tasmania's chronic GP shortage has produced an ongoing scarcity of GP appointments and appointments with female GPs particularly, which many women prefer for reproductive health-related matters. Even in Tasmania's metropolitan centres it is not uncommon to wait more than six weeks for an appointment with a woman GP.*[698]

[696] Transcript of Evidence, 21 October 2024, Tasmanian Aboriginal Centre, p. 11.
[697] Submission No. 22, Gidget Foundation Australia, p. 12.
[698] Submission No. 31, Women's Health Tasmania, p. 12.

9.38. MSI Australia discussed Tasmanian specific statistics relating to GP access:

> *The Tasmanian Population Health Survey 2022 sheds light on the accessibility of General Practitioners in the state.*[699] *It revealed that while a majority (83%) of Tasmanians accessed a GP in the past year, a significant portion (32%) who needed GP services were unable to access them. This issue is particularly acute among women and Aboriginal and Torres Strait Islander communities.*
>
> *The main barriers to accessing GP services include the unavailability of services when needed, which accounted for 40% of the cases, followed by long waiting times and cost-related issues. Women faced more challenges due to service unavailability, and cost was a notably higher barrier for the younger population aged 18-24 years.*
>
> *…*
>
> *For one person in the North-West, the GP shortage made it hard to find a doctor who would provide a termination referral, particularly as she wanted to avoid GPs she knew in a professional capacity.*[700]
>
> *Women's Health Tasmania also found that culturally and linguistically diverse people, LGBTQIA+ people and people with a disability, said the existing barriers to termination access in Tasmania are compounded by a lack of inclusive healthcare systems and practices.*[701]

9.39. The Royal Australian College of General Practitioners (RACGP) Tasmania provided insight into their members' experiences with GP shortages:

> *The GP workforce shortage in Tasmania is evidently impacting the ability of primary care teams to sufficiently deliver reproductive, maternal, and paediatric health services. These health service areas are the domain of generalists and the current shortage of GPs in Tasmania and the forecast increasing shortage will negatively impact the ability of these areas to be cared for appropriately.*[702]

Physiotherapists

9.40. Dimi Papavassiliou shared her experiences in accessing pelvic floor physiotherapy after the birth of her child:

> *There is a significant shortage of resources in pelvic floor care. Having a clearer understanding of how the pelvic floor functions before and during pregnancy, along with support in accessing a physiotherapist for proper care, would have been immensely beneficial. Barriers to care, including financial constraints, hindered my ability to receive immediate and ongoing assistance.* [703]

[699] Footnote 3, Cox J, Dyke H, Martino R, & Edwards L (2023). Report on the Tasmanian Population Health Survey 2022. Department of Health, Tasmania: Hobart., from Submission No. 26, MSI Australia, p. 6.
[700] Footnote 5, Women's Health Tasmania (2022), Submission to the inquiry into universal access to reproductive healthcare, https://www.womenshealthtas.org.au/sites/default/files/resources/inquiry-universal-accessreproductive-healthcare/sub07womens-health-tasmaina.pdf, from Submission No. 26, MSI Australia, p. 6.
[701] Submission No. 26, MSI Australia, p. 6.
[702] Submission No. 104, Royal Australian College of General Practitioners Tasmania, p. 5.
[703] Submission No. 7, Dimi Papavassiliou, pp. 1 -2.

9.41. The Committee heard direct evidence from representatives of the Australian Physiotherapy Association (APA) regarding the lack of positions for qualified physiotherapist in Tasmania:

> ***Ms ROSOL*** *- .... We have heard a lot about staff vacancies being a significant issue that's putting pressure on the system and meaning that services aren't available. What's it like with physiotherapists in terms of availability of physios?*
>
> ***Ms GREEN*** *- For us, it's more that our positions are filled but we just don't have enough capacity to service what we would like to. It's not that there are positions vacant. We have the skill mix here in Hobart to fill the positions if there were more positions offered. Women's, Men's Pelvic Health is the fastest growing national group in the Australian Physio Association. There's huge interest from physios out there to take part in this area of physio, but we just don't have the FTE.*
>
> ***...***
>
> ***Ms BARNES-KEOGHAN*** *- The same to be said for paediatric physiotherapists. Particularly in the past three to four years we've really been able to consistently fill spots and we just don't have the FTE. That's why we're seeing more private practices open, which comes with its own issues in terms of making sure staff is appropriately supervised and things like that. ...*[704]

Findings

The Committee finds:

101. There is a local, national and international shortage of midwives.

102. Workforce shortages, including of midwives, is a major factor in the cessation of maternal services at the Hobart Private Hospital.

103. Workforce shortages negatively impact patient experience of maternal healthcare and limit choice.

104. Conditions for healthcare professionals, including staff shortages and workplace culture, impact recruitment, job satisfaction and staff retention.

105. Implementing the 'Count the Babies' policy to include both mothers and babies in midwifery workloads would ensure appropriate and safe staffing levels and better outcomes on obstetric wards in the Tasmanian Health Service.

106. When Tasmanians have to study midwifery qualifications interstate, it results in many choosing to work interstate. This contributes to midwife shortages in Tasmania.

107. The Government and University of Tasmania have announced the establishment of a graduate Diploma of Midwifery by 2026 and a direct-entry undergraduate course potentially by 2027.

[704] Transcript of Evidence, 20 February 2025, Australian Physiotherapy Association, pp. 104 – 105.

108. General Practitioner shortages in Tasmania lead to additional pressure on the public health system.

109. Tertiary education and continuing professional development for health professionals require a greater focus on the needs of Aboriginal and Torres Strait Islanders, culturally and linguistically diverse people and members of the LGBTIQA+ community.

110. There are not enough women's and paediatric physiotherapy FTE positions in the Tasmanian Health Service.

Recommendations

The Committee recommends:

52. The Government continue to provide workforce incentives to increase the midwife, nurse and General Practitioner workforce in Tasmania.

53. The Government prioritise as a matter of urgency the ongoing development of graduate and undergraduate midwifery degrees with the University of Tasmania.

54. The Tasmanian Health Service implement the 'Count the Babies' policy.

55. The Government work with providers of tertiary and continuing professional development education in Tasmania to ensure cultural awareness training is implemented into all degrees and programs for health professionals.

56. The Government create more FTE positions in women's and paediatric physiotherapy in the Tasmanian Health Service.

APPENDIX A: LIST OF SUBMISSIONS

Full submissions can be found on the following Committee webpages: 50th Parliament and 51st Parliament.

1. Breastfeeding Coalition Tasmania;
2. Angela Allen;
3. Private Witness;
4. Private Witness;
5. Tresillian;
6. Emma Deane;
7. Dimi Papavassiliou;
8. Private Witness;
9. Private Witness;
10. Clara White;
11. Australian College of Rural and Remote Medicine;
12. Health Consumers Tasmania;
13. Centre of Perinatal Excellence (COPE);
14. Dr Natasha Vavrek;
15. Dr Jennifer Ayton;
16. Australian Breastfeeding Association – Tasmania Branch;
17. Karitane;
18. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists;
19. Triple P;
20. Playgroup Tasmania;
21. Australian Lawyers Alliance;
22. Gidget Foundation Australia;
23. Private Witness;
24. Birth Trauma Australia[705];
25. Australian Medical Association Tasmania Branch;
26. MSI Australia;
27. Equality Tasmania;
28. Family Planning Tasmania;
29. Selina Park;
30. TasCOSS;
31. Women's Health Tasmania;
32. Australian College of Midwives;
33. Q – Bital;
34. Working It Out;
35. Western Sydney University School of Nursing and Midwifery;
36. Private Witness;
37. Holly Bennett;
38. Cas;
39. Private Witness;
40. Kali Heald;
41. Private Witness;
42. Jackie Joseph;
43. Private Witness;
44. Private Witness;

[705] Published as Australasian Birth Trauma Association

45. Private Witness;
46. Private Witness;
47. Chelsea Wingrove;
48. Private Witness;
49. Private Witness;
50. Private Witness;
51. Private Witness;
52. Private Witness;
53. Private Witness;
54. Private Witness;
55. Private Witness;
56. Heather Sharpe;
57. Missy Obezuk;
58. Georgia Lilley;
59. Private Witness;
60. Mothers & Midwives Australia (MAMA);
61. Hannah Butcher;
62. Private Witness;
63. Private Witness;
64. Camila Bosaans;
65. Private Witness;
66. Karen Schlage;
67. Private Witness;
68. Private Witness;
69. Private Witness;
70. Crystal – Leigh Eiszele;
71. Ashleigh Loubser;
72. Private Witness;
73. Hygieia Health Ltd;
74. Private Witness;
75. Private Witness;
76. Claire Holloway;
77. Private Witness;
78. Kirsten Chilcott;
79. Anneika Chatwin;
80. Private Witness;
81. Private Witness;
82. Private Witness;
83. Maternity Consumer Network;
84. Private Witness;
85. Kate Marsden;
86. Private Witness;
87. Private Witness;
88. Private Witness;
89. Private Witness;
90. Homebirth Australia;
91. Tasmanian Aboriginal Centre;
92. Private Witness;
93. Private Witness;
94. Private Witness;
95. Ash Barwick;
96. Private Witness;
97. Birth in Tasmania;
98. Kaylia Marshall;
99. Private Witness;
100. Private Witness;
101. Private Witness;
102. Private Witness;
103. Miracle Babies Foundation;

104. The Royal Australian College of General Practitioners Tasmania;
105. Private Witness;
106. Rashelle Szoke;
107. Private Witness;
108. Private Witness;
109. Jaimee Smith;
110. Catherine Bell;
111. Private Witness;
112. Private Witness;
113. Private Witness;
114. Private Witness;
115. Private Witness;
116. Private Witness;
117. Private Witness;
118. Private Witness;
119. Private Witness;
120. Better Births Illawarra;
121. Brigid Cowen;
122. Private Witness;
123. Private Witness;
124. Private Witness;
125. Private Witness;
126. Private Witness;
127. Private Witness;
128. Blossom Motherhood;
129. Department of Health;
130. Hannah Boyd;
131. Early Pregnancy Loss Coalition;
132. Maternal Health Matters;
133. Australian Physiotherapy Association;
134. Private Witness; and
135. Human Rights in Childbirth.

APPENDIX B: LIST OF HEARING WITNESSES

Transcripts of Evidence and Broadcast recordings from public hearings can be found on the following Committee webpage: 51st Parliament.

Monday 21 October 2024, Parliament House, Hobart		
Witness Number	**Witness**	**Organisation** (if applicable)
1.	Chloe Woolnough, Manager of Connected Beginnings	Tasmanian Aboriginal Centre
2.	Raylene Foster, CEO	Tasmanian Aboriginal Centre
3.	Dannielle Harris, Registered Nurse	Tasmanian Aboriginal Centre
4.	Anissa Thompson, Child Health Nurse	Tasmanian Aboriginal Centre
5.	Charlottee Fielding, Assistant Branch President	Australian Breastfeeding Association, Tasmania Branch
6.	Anna Folkerts, retired endorsed midwife	Homebirth Australia
7.	Kristyn Begnell, Coordinator	Homebirth Australia
8.	Ellen MacDonald, CEO	Health Consumers Tasmania
9.	Hannah Fielder, Advocacy and Impact Lead	Health Consumers Tasmania
10.	Ellen O'Keeffe, President	Maternal Health Matters

Wednesday 23 October 2024, Parliament House, Hobart		
Witness Number	**Witness**	**Organisation** (if applicable)
11.	Amy Dawes. Co-founder, CEO and Director	Birth Trauma Australia, then Australasian Birth Trauma Association
12.	Bernadette Davies, Member	Australian Lawyers Alliance
13.	Tanya Crawford, Clinical Director – Parent, Infant and Childhood Mental Health Services	Tresillian
14.	Associate Professor Jenny Smit, Executive Director of Clinical Services	Tresillian

15.	Dr Alice Dwyer, Medical Director of Parent, Infant and Early Childhood Mental Health	Tresillian
16.	Kelly Langford, endorsed midwife and founding midwifery leader of MAMA	Mothers and Midwives Australia (MAMA)
17.	Dr Nisha Khot, Vice – President	The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
18.	Dr Martia Jones, GP	Royal Australian College of General Practitioners (RACGP) Tasmania
19.	Dr Tim Jones, GP and Chair of Child and Young Persons Health for RACGP	Royal Australian College of General Practitioners (RACGP) Tasmania
20.	Rowena Shakes, endorsed Midwife, Secretary of ACM Tasmania Branch	Australian College of Midwives (ACM)
21.	Maya Wilkinson, ACM member	Australian College of Midwives (ACM)
22.	Alison Weatherstone, Chief Midwife	Australian College of Midwives (ACM)

Wednesday 30 October 2024, Parliament House, Hobart

Witness Number	**Witness**	**Organisation (if applicable)**
23.	Isabelle Oderberg, Co-Founder and Chair	Early Pregnancy Loss Coalition
24.	Dr Sarah Simons, Policy Advisor	Early Pregnancy Loss Coalition
25.	Dr Michael Lumsden – Steel, President	Australian Medical Association (AMA) Tasmania Branch
26.	Dr Annette Branch	Australian Medical Association (AMA) Tasmania Branch
27.	Karen Edwards, Clinical Director	Gidget Foundation Australia

Tuesday 18 February 2025, Cradle Coast Authority, Burnie

Witness Number	Witness	Organisation (if applicable)
28.	Kaylia Marshall, Lived experience witness	
29.	Kimberley Harding, Lived experience witness	
30.	Amy Ramsey, Lived experience witness	
31.	Samuel Thomas, Lived experience witness	
32.	Jacinda Armstrong, CEO	Playgroup Tasmania

Wednesday 19 February 2025, Hotel Grand Chancellor, Launceston

Witness Number	Witness	Organisation (if applicable)
33.	Jaimee Smith, Endorsed, Privately Practicing Midwife (PPM)	
34.	Kate Marsden, Lived experience witness	
35.	Timothy Mohr, Lived experience witness	
36.	Georgia Lilley, Lived experience witness	

Thursday 20 February 2025, Parliament House, Hobart

Witness Number	Witness	Organisation (if applicable)
37.	Clare White, Lived experience witness	
38.	Angela Allen, Lived experience witness	
39.	Shannon Allen, Lived experience witness	
40.	Brigid Cowen, Lived experience witness	

41.	Chelsea Wingrove, Lived experience witness	
42.	Tristian Streefland, Lived experience witness	
43.	Corbin Halliday, Lived experience witness	
44.	Heather Sharpe, Lived experience witness	
45.	Dr Jennifer Ayton, Researcher and Senior Lecturer	University of Tasmania
46.	Emma Goyne, Lived experience witness	Maternity Consumer Network
47.	Alecia Staines, Founder	Maternity Consumer Network
48.	Catherine Bell, researcher	
49.	Emily Shepherd, ANMF Tasmanian Branch Secretary	Australian Nursing and Midwifery Federation
50.	Astrid Tiefholz, ANMF Tasmanian Branch Councillor	Australian Nursing and Midwifery Federation
51.	Monica Werner, ANMF Tasmania Branch Councillor	Australian Nursing and Midwifery Federation
52.	Emma Green, Chair of the APA Women's, Men's Pelvic Health Tasmania Branch	Australian Physiotherapy Association (APA)
53.	Lizzy Barnes – Keoghan, Chair of the APA Paediatric Tasmanian Committee	Australian Physiotherapy Association (APA)

Wednesday 26 March 2025, Parliament House, Hobart

Witness Number	**Witness**	**Organisation (if applicable)**
54.	The Honourable Jacquie Petrusma MP, Minister for Health	
55.	Dale Webster, Secretary	Department of Health
56.	Trudi Steedman, Nursing Director of Child Health and Parenting Service	Department of Health
57.	Sally Badcock, Associate Secretary	Department of Health
58.	Becky French, Nursing Midwifery Director for Women's and Children's Services at the Royal Hobart Hospital	Department of Health
59.	Grainne O'Loughlin	Karitane
60.	Jo Flanagan, CEO	Women's Health Tasmania

61.	Lucinda Shannon, Deputy CEO	Women's Health Tasmania
62.	Elinor Heard, Policy Officer	Women's Health Tasmania
63.	Dr Natasha Vavrek	The Bubble Tasmania
64.	Cate Grant, Birth and postpartum doula	Birth in Tasmania
65.	Ayla Judd, Postpartum doula and remedial massage therapist	Birth in Tasmania
66.	Georgia Banks, General Manager	Hobart Private Hospital
67.	Tino La Spina, CEO	Healthscope
68.	Chris Hewison, State Manager for Tasmania and Victoria	Healthscope
69.	Kris Salisbury, National Direcgtor of Clinical Governance and Chief Nurse	Calvary Health Care
70.	Leah Magliano, Director of Clinical Services	Calvary Health Care Hobart
71.	Melissa Evans, Regional CEO for Tasmania	Calvary Health Care

APPENDIX C: GLOSSARY OF TERMS

Term	Definition
ABA Tasmania Branch	Australian Breastfeeding Association – Tasmania Branch
ACM	Australian College of Midwives
ACRRM	Australian College of Rural and Remote Medicine
ADHD	Attention Deficit Hyperactivtiy Disorder
AIHW	Australian Institute of Health and Welfare
ALA	Australian Lawyers Alliance
AMA Tasmania Branch	Australian Medical Association Tasmania
APA	Australian Physiotherapy Association
ASD	Autism Spectrum Disorder
BESt study	The Birth Experience Study, Western Sydney University
Calvary	Calvary Lenah Valley
CFHN	Child and Family Health Nurse
CFLCs	Child and Family Learning Centres
CHaPS	Child Health and Parenting Service
COPE	Centre of Perinatal Excellence
C – section or Caesar	Caesarean section

DoH or Department	Department of Health
FPT	Family Planning Tasmania
GPwSI	General Practitioners with Special Interests
HCT	Health Consumers Tasmania
Hobart Private	Hobart Private Hospital by Healthscope
IVF	In Vitro Fertilisation
LARCs	Long-acting reversible contraception
LGH	Launceston General Hospital
MTOP	Medical Termination of Pregnancy
NICU	Neonatal Intensive Care Unit
OBGYN	Obstetrician Gynaecologist
PICU	Paediatric Intensive Care Unit
PII	Private Indemnity Insurance
PIMHS	Perinatal and Infant Mental Health Service
PMH	Perinatal Mental Health
PND	Post – Natal Depression
PPM	Privately Practicing Midwife
RACGP Tasmania	Royal Australian College of General Practitioners Tasmania

RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RHH	Royal Hobart Hospital
SSU	Special Support Units
STOP	Surgical Termination of Pregnancy
St Helen's	St Helen's Private Hospital
TAC	Tasmanian Aboriginal Centre
TADS	Tasmanian Autism Diagnostic Service
THS	Tasmanian Health Service
VBAC	Vaginal birth after caesarean
WHT	Women's Health Tasmania

APPENDIX D: MINUTES

THURSDAY, 9 November 2023

As *Ordered*, the Committee met in Committee Room 1, Parliament House, Hobart at 11:36 a.m.

Members Present:

Mr *Behrakis*
Ms *Dow* (via WebEx)
Ms *Johnston* (via WebEx)
Ms *O'Byrne* (via WebEx)
Mr *Wood* (via WebEx)
Dr *Woodruff*

APOLOGIES

There were no apologies.

ORDER OF THE HOUSE READ

The Secretary took the Chair and read the Order of the House of Assembly appointing the Committee.

ELECTION OF THE CHAIR

The Secretary called for nominations, Dr *Woodruff* nominated Ms *Dow*, who consented to the nomination, Ms *O'Byrne* seconded the motion.

There being no other nominations, the Secretary declared Ms *Dow* elected as Chair.

Ms *Dow* took the Chair.

ELECTION OF THE DEPUTY CHAIR

The Chair called for nominations, Dr *Woodruff* nominated Ms *O'Byrne*, who consented to the nomination, Ms *Dow* seconded the motion.

There being no other candidates nominated, the Chair declared Ms *O'Byrne* elected as Deputy Chair.

NOMENCLATURE

The Chair asked for the Committees consideration regarding its name.

Dr *Woodruff* proposed to remove: - 'and perinatal mental health'.

Resolved, the Committee name be Select Committee on reproductive, maternal and paediatric health services in Tasmania (Ms *Johnston*)

TENTATIVE PROGRAM

The draft tentative program was discussed.

Resolved, That the Tentative Program for the taking of evidence and the preparation, consideration, production and tabling of the Committee's report be agreed to, noting that a reporting extension may be required and that dates for future meetings be circulated out of session (Ms *Dow*).

ADVERTISEMENT

Amendment to the draft advertisement, as previously circulated by the Secretary proposed (Dr *Woodruff*): -

Amend the introduction to read as follows:

The House of Assembly has appointed a Select Committee on reproductive, maternal and paediatric health services in Tasmania. The Committee is calling for submissions regarding the Terms of Reference:-

Reorder the paragraphs regarding dates to read as follows:

The Committee invites interested persons or organisations to make written submissions to the Committee by the closing date of **Thursday, 25 January 2024**.

The Committee has been ordered to report by 9 April 2024.

Resolved, that the amendments be accepted (Ms Johnston).

Resolved, that the Chair approve the amended advertisement out of session, to be placed in the three

major Tasmanian newspapers on Saturday 18th November 2023 (Ms *Dow*)

ADDITIONAL RESEARCH SUPPORT

Resolved, That unless otherwise ordered Officers of the Parliamentary Research Service be admitted to the proceedings of the Committee whether in public or private session (Mr *Behrakis*).

Resolved, that the Parliamentary Research Service be asked to prepare a briefing paper in relation to ambulance ramping and the Inquiry's terms of reference (Ms *O'Byrne*).

WITNESSES AND SUBMISSIONS TO THE COMMITTEE

Resolved, That a letter be sent to the individuals and organisations featured on the list as previously circulated by the Secretary, seeking a submission to the Inquiry, and that the deadline for submissions be Thursday, 25 January 2024:-

Resolved, that the following additional individuals and or organisations be added to the list of letter recipients:

Royal Australian College of General Practitioners (Ms *Dow*);
Minister for Mental Health and Wellbeing (Ms *Dow*);
Minister for Women (Ms *Dow*);
Australian Breastfeeding Association (Ms *Dow*);
Karitane (Ms *Dow*);
Tresillian (Ms *Dow*);
Marie Stopes Australia (Ms *O'Byrne)*;
Hampton Park Women's Health Clinic (Ms *O'Byrne)*;
Fertility Control Clinic (Ms *O'Byrne)*;
Addition of head of gynaecology and obstetrics from each major hospital (Ms *O'Byrne)*.

CHAIR TO BE THE SPOKESPERSON

Resolved, That the Chair be the spokesperson in relation to the operations of the Committee (Dr *Woodruff).*

PRESS STATEMENTS

Resolved, That unless otherwise ordered, press statements on behalf of the Committee be made only by the Chair after approval in principle by the Committee or after consultation with Committee Members (Mr *Wood*).

NEXT MEETING

Resolved, that dates for the next meeting of the Committee and confirmation of dates for Public Hearings be circulated out of session (Ms *Johnston*).

At 11:54 a.m. the Committee adjourned until a later date.

Confirmed,

FRIDAY, 1 December 2023

The Committee met in Committee Room 1, Parliament House, Hobart at 9:05 a.m.

Members Present:

Mr *Behrakis*
Ms *Dow* (via WebEx)
Ms *Johnston* (via WebEx)
Mr *Wood* (via WebEx)

APOLOGIES

Ms *O'Byrne* and Dr *Woodruff* were apologies.

MINUTES

The minutes of the meeting held on 9 November 2023 were read and agreed to. (Mr *Behrakis*)

CORRESPONDENCE

Department of Health dated 27 November 2023:

- *Resolved*, to accept the Departments request for an extension, providing a due date of 13 February 2024. (Ms *Johnston*)

CONDUCT OF INQUIRY

REPORTING DATE

The Committee discussed the reporting date of the Inquiry, noting that discussions will be held upon the receival of submissions to determine if an extension is required. (Ms *Dow*).

JANUARY MEETING DATE

Resolved, to meet to accept submissions, agree on publication and select witnesses to appear before hearings at 9am on 1 March 2024. (Ms *Dow*).

HEARING DATES AND LOCATIONS

Hearing dates were discussed, and the following hearing dates were *Resolved*:-

February 19 – 23 2024;
February 26, 27 and 29 2024; and
March 1 2024. (Ms *Johnston*)

Resolved, to hold hearings in the following locations, as to be allocated upon receipt of submissions:-

Burnie;
Launceston; and
Hobart. (Mr *Behrakis)*

DELIBERATIVE MEETINGS

Resolved, to tentatively create placeholders for the following dates for deliberations of the Committee regarding the Report:-

March 25 – 28 2024; and
April 3 – 5 2024. (Ms *Johnston*)

MEDIA ADVISORY

Resolved, that a press release be drafted and sent to regional newspapers (Mr *Wood*)

Resolved, that a post be published on the Parliament Facebook page for Committee members to share (Ms *Dow*).

OTHER MATTERS

None.

NEXT MEETING

At 9:14 a.m. the Committee adjourned until *Thursday, 1 February 2024*.

THURSDAY, 1 FEBURARY 2023

The Committee met in Committee Room 1 and via WebEx, at 9:03 a.m.

Members Present:

Mr *Behrakis*
Ms *Johnston* (via WebEx)
Ms *Dow* (via WebEx)
Ms *O'Byrne* (via WebEx)
Dr *Woodruff*
Mr *Wood* (via WebEx)

APOLOGIES

No apologies.

MINUTES

The minutes of the meeting held on 1 December 2023 were read and agreed to (Dr *Woodruff*).

CORRESPONDENCE

BACKGROUND PAPER

The Committee noted as received the background paper from PRS, dated 23 January 2023 (Ms *Dow*).

REQUEST FOR EXTENSION

The Committee considered the request for extension to submissions from Equality Tasmania until Monday, 5 February next.

Resolved, that Equality Tasmania be granted an extension for its submission until 5 February 2024 (Ms *Johnston*).

The Committee considered the request for extension to submissions from the following until Tuesday, 13 February next:

Women's Health Tasmania;

Australian College of Midwives (ACM);

TasCOSS;

Royal Australian College of General Practitioners;

Selina Park; and

Rachel Andrew.

Resolved, that the aforementioned groups and individuals be granted an extension for submission until 13 February 2024 (Dr *Woodruff*).

The Committee considered the request for extension to submissions from the Tasmanian Sexual and Reproductive Collaboration Group until Wednesday, 28 February next.

Resolved, that the Tasmanian Sexual and Reproductive Collaboration Group be granted an extension for its submission until 28 February 2024 and for the Secretary to write to the group informing them of the option to appear before a public hearing of the Committee if a submission cannot be drafted. (Dr *Woodruff*).

SUBMISSIONS

Ordered, That the following submissions be received and published in full, with the personal contact details of individuals being removed (Ms *Johnston*):

Submission No. 1: Breastfeeding Coalition Tasmania

Submission No. 2: Angela Allen

Submission No. 5: Tresillian

Submission No. 6: Emma Deane

Submission No. 7: Dimi Papavassiliou

Submission No. 10: Clara White

Submission No. 11: Australian College of Rural and Remote Medicine

Submission No. 12: Health Consumers Tasmania

Submission No. 13: Centre of Perinatal Excellence (COPE)

Submission No. 14: Dr Natasha Vavrek

Submission No. 15: Dr Jennifer Ayton – Tasmanian School of Medicine

Submission No. 16: Australian Breastfeeding Association

Submission No. 18: Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Submission No. 19: Triple P

Submission No. 20: Playgroup Tasmania

Submission No. 21: Australian Lawyers Alliance

Submission No. 22: Gidget Foundation

Submission No. 24: Australasian Birth Trauma Association

Submission No. 25: Australian Medical Association – Tasmania Branch

Submission No. 26: MSI Australia

SUBMISSIONS

Ordered, That the following submissions be received and published with details redacted as requested by the submission authors (Ms *Dow*):

Submission No. 3: Name withheld.

Submission No. 8: Name withheld.

Submission No. 17: Karitane.

Ordered, that the following submission be received and kept confidential (Dr *Woodruff*):

Submission No. 4: Private witness

Ordered, that the following submission be received and published upon receipt of the

individual's formal confidentiality request (Dr *Woodruff*):

Submission No. 9: Name withheld

SUBMISSION REQUEST

Resolved, that the Secretary write to the Australian Nursing and Midwifery Association inviting them to submit or to attend a public hearing of the Committee (Ms *Dow*).

PUBLIC HEARINGS

Witnesses to be invited to appear before the Committee were discussed.

Resolved, that the following individuals and organisations be invited to attend public hearings:

Submission No. 1: Breastfeeding Coalition Tasmania

Submission No. 2: Angela Allen

Submission No. 3: Name withheld

Submission No. 4: Private witness

Submission No. 5: Tresillian

Submission No. 6: Emma Deane

Submission No. 7: Dimi Papavassiliou

Submission No. 8: Name withheld

Submission No. 10: Clara White

Submission No. 11: Australian College of Rural and Remote Medicine

Submission No. 12: Health Consumers Tasmania

Submission No. 13: Centre of Perinatal Excellence (COPE)

Submission No. 14: Dr Natasha Vavrek

Submission No. 16: Australian Breastfeeding Association

Submission No. 17: Karitane

Submission No. 18: Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Submission No. 19: Triple P

Submission No. 20: Playgroup Tasmania

Submission No. 21: Australian Lawyers Alliance

Submission No. 22: Gidget Foundation

Submission No. 24: Australasian Birth Trauma Association

Submission No. 25: Australian Medical Association – Tasmania Branch

Submission No. 26: MSI Australia

Resolved, that the Secretary contact the following individual regarding the potential to appear before a public hearing:

Submission No. 9: Name withheld.

Resolved, That the Committee hold public hearings in Devonport 21 February and Hobart on 29 February and 1 March (Ms *Dow*).

MEDIA RELEASE

Resolved, that the Secretary can circulate meeting schedules to media outlets prior to each public hearing.

CONSIDERATION OF INQUIRY TIMELINE EXTENSION

Committee discussed the potential for an extension for the Committee reporting date given the extensions given to submitters and the necessity to hold additional public hearings at a later date.

Resolved, to extend the Committee reporting date beyond the current date of 9 April 2024. Agreed for the Secretary to circulate a potential extension date. (Ms *Dow*).

FUTURE MEETINGS

The Committee discussed the necessity of holding an additional meeting on February 14 or 15 next to accept outstanding submissions.

Resolved, for the Secretary to circulate potential dates to Committee members (Mr *Behrakis*).

FUTURE PUBLIC HEARINGS

The Committee further discussed the necessity of holding additional public hearings to enable all potential witnesses to attend.

Resolved, for the Secretary to circulate potential dates to Committee members (Mr *Wood*).

OTHER MATTERS

No outstanding matters.

At 09:23 a.m. the Committee adjourned until a later date.

Confirmed,

FRIDAY, 23 August 2024

The Committee met at Parliament House Hobart, via Webex, at 1.02 p.m.

Members Present via WebEx:

Ms *Johnston*
Ms *Haddad*
Mr *Fairs*
Mrs *Petrusma*
Ms *Rosol*

APOLOGIES

Ms *Dow*

ELECTION OF CHAIR

The Secretary took the Chair, noted the Resolution as circulated, and called for nominations for Chair.

Mrs *Petrusma* nominated Ms *Haddad,* who consented to the nomination.

This nomination was seconded by Mr *Fairs.*

There being no other candidates nominated, the Secretary declared Ms *Haddad* elected as Chair.

Ms *Haddad* took the Chair.

ELECTION OF DEPUTY CHAIR

The Chair called for nominations for Deputy Chair

Ms *Haddad* nominated Mrs *Petrusma,* who consented to the nomination.

This nomination was seconded by Ms *Rosol.*

There being no other candidates nominated, the Chair declared Mrs *Petrusma* elected as Deputy Chair.

ADDITIONAL RESEARCH SUPPORT

Resolved, that unless otherwise ordered Officers of the Parliamentary Research Service be admitted to the proceedings of the Committee whether in public or private session (Mrs *Petrusma*).

CHAIR TO BE THE SPOKESPERSON

Resolved, That the Chair be the spokesperson in relation to the operations of the Committee (*Mr Fairs*).

PRESS STATEMENTS

Resolved, that unless otherwise ordered, press statements on behalf of the Committee be made only by the Chair after approval in principle by the Committee or after consultation with Committee Members (*Ms Rosol*).

EVIDENCE OF PREVIOUS COMMITTEE

Resolved that the submissions, papers and any other evidence of the Select Committee on Reproductive, Maternal and Paediatric Health Services in Tasmania of the 50th Parliament be received by this Committees for its consideration (Ms *Haddad*).

PROGRESS OF COMMITTEE OF THE 50TH PARLIAMENT

The Committee discussed the briefing paper regarding the work of the previous Committee of the 50th Parliament, noting that considerable work had been undertaken.

SUBMISSIONS

The Committee discussed the status of submissions, with 26 formally received by the prior Committee, 7 received by the Secretary and a number of outstanding extensions. The Committee considered options for its work plan going forward.

Resolved, to reopen submissions for a period of 4 weeks from Monday 26 August 2024 - Monday 16 September 2024 (Ms *Haddad*)

Resolved, to write to all of those who had previously submitted to the Committee and those with outstanding extensions, regarding the new submission period and inviting interested parties to provide an updated submission if they so wish (Mrs *Petrusma*)

A number of submissions had been received by the Secretary prior to the Dissolution of the 50th Parliament, but had not been formally received by the Committee, as follows:

Submission No. 27: Equality Tasmania

Submission No. 28: Family Planning Tasmania

Submission No. 29: Selina Parks

Submission No. 30: TasCOSS

Submission No. 32: ACM Tasmania Branch

Submission No. 33: Q- Bital

Submission No. 34: Working It Out

Resolved, to write to these individuals and organisations detailing the status of their submissions and inviting them to provide an updated submission if they wish, or confirm the use of the current copy in the Committee's possession (Mrs *Petrusma*)

The Committee noted that Women's Health Tasmania had provided Submission No. 31 to the Secretary prior to the Dissolution and have since requested the opportunity to provide an updated or redacted submission

Resolved, to write to Women's Health Tasmania notifying them of the reopening of submissions and that they are invited to update their submission accordingly. (Ms *Haddad*).

WEBSITE WAVIER

The Committee discussed the process for the management of new and old submissions, including the current publication of some submissions from the former Committee.

Resolved, that the Secretary insert a disclaimer on both versions of the Committee webpage, noting that the submissions as currently uploaded are from the former Committee and that stakeholders have been invited to provide updates if they so wish. (Mrs *Petrusma)*

ADVERTISEMENT

Resolved, to advertise via the short form advertisement in the three major Tasmanian papers on Saturday, 31 August 2024. (Mrs *Petrusma*)

MEDIA RELEASE

Resolved, that the drafted media release be circulated on Monday, 26 August 2024. (Ms *Haddad)*

REPORTING DATE

The Committee discussed the current reporting date of 28 November 2024.

Resolved, that the Committee extend its reporting date to 25 March 2025, with the option to further extend if required. (Ms *Haddad*)

Secretary to prepare Motion to be moved by the Chair in the House.

TENTATIVE PROGRAM

The Committee considered the tentative program as circulated by the Secretary.

Resolved, that the Committee proceed with the proposed inquiry timeline, opening and closing dates of submissions deliberative meetings and public hearings, as circulated and as follows:

Submissions open: Monay 26 August 2024

Submissions close: Monday 16 September 2024

Meeting to consider submissions: Friday 27 September 2024 – 11:15am – 12:15pm

Hearing 1 (Hobart): Monday 21 October 2024

Hearing 2 (Hobart): Wednesday 23 October 2024

Hearing 3: (Devonport tbc): Tuesday 29 October 2024

Hearing 4: (Launceston tbc): Wednesday 30 October 2024

Meeting to consider report: tbc, late – January and February 2025 (Ms *Johnston*)

The Committee noted regarding the above that on Friday 27 September 2024 Ms *Johnston* is unable to attend and on Monday 21 October 2024 Ms *Rosol* is unable to attend in the morning.

The Committee discussed potential allocation of witnesses before public hearing, noting that all submissions will be considered for potential attendance, outside of the scope of the decisions of the former Committee.

ANY OTHER MATTERS

Noted that the Secretary will contact Members regarding best contact details for the period of the Inquiry.

Noted that the Secretary will, once submissions have been received, contact Members to determine if they wish to receive hardcopies of the submissions.

At 1:41pm the Committee adjourned until 11:15am on Friday 27 September 2024.

MONDAY, 30 September 2024

The Committee met at Parliament House Hobart and via Webex, at 12.01 p.m.

Members Present:

Ms *Johnston*
Ms *Haddad*
Mr *Fairs* (via WebEx)
Mrs *Petrusma* (via WebEx)
Ms *Rosol* (via WebEx)

APOLOGIES

Ms *Dow*

MINUTES

The minutes of the meeting held 23 August 2024 were adopted as an accurate record (Ms *Johnston*)

CORRESPONDENCE

The Committee noted the correspondence received from Ms Magdalena Cameron, dated 11 September 2024. The Committee was carbon copied into Ms Cameron's correspondence to the Department of Health (Ms *Haddad*)

The Committee noted the receipt of correspondence from Dr Katharine Basset, Director of Health Policy, Catholic Health Australia, requesting information regarding the manner in which the organisation may be able to participate in the Inquiry.

Resolved, that the Secretary invite a written submission from Catholic Health Australia, due on Monday 28 October 2024 (Ms *Haddad*)

Mrs *Petrusma* joined the meeting at 12:05 p.m.

SUBMISSIONS

The Committee discussed its approach to the consideration and publication of submissions. It was noted that 132 submissions have currently been received. Given the large quantity of submissions, it was agreed that submissions will be accepted in two tranches, first organisations

and later individual submissions. Organisations were henceforth considered during the meeting.

RECEIPT AND PUBLICATION OF SUBMISSIONS FROM ORGANISATIONS

Ordered, that the following submissions be received and published in full, with the personal contact details of individuals being removed (Ms *Haddad*):

Submission No. 1: UPDATED Breastfeeding Coalition Tasmania

Submission No. 11: UPDATED ACRRM

Submission No. 17: UPDATED Karitane

Submission No. 18: UPDATED RANCOZG

Submission No. 21: UPDATED ALA

Submission No. 27: Equality Tasmania

Submission No. 28: Family Planning Tasmania

Submission No. 30: TasCOSS

Submission No. 31: Women's Health Tasmania

Submission No. 32 ACM

Submission No. 33: Q – Bital

Submission No. 34: Working It Out

Submission No. 35: The Birth Experience

Submission No. 60: Mothers & Midwives Australia (MAMA)

Submission No. 73: Hygieia Health Ltd

Submission No. 91: Tasmanian Aboriginal Centre

Submission No. 97: Birth in Tasmania

Submission No. 104: RACGP Tasmania

Submission No. 120: Better Births Illawarra

Submission No. 129: Department of Health

Submission No. 131: Early Pregnancy Loss Coalition

Submission No. 132: Maternal Health Matters

CONTENT REDACTIONS AND CONSIDERATIONS

The Committee discussed the future publication of submissions from individuals in relation to potential content redactions. The protection of the personal information of submitters was considered, as well as third parties, institutions and children.

Resolved that, when individual submissions are considered for publication, the following standard redactions be implemented:

Dates of birth of children, the names of children and partners and the names of medical practitioners be redacted for publication (Ms *Haddad*).

Hospital, medical clinics, organisations and ward or programs names remain in full for publication (Ms *Johnston*).

The Committee further discussed the publication of the names of individual submitters. It was noted that all submitters have been contacted with a general disclaimer detailing their rights regarding the publication of their submission. The protection of sensitive witnesses, including the longevity of the publication of the Committees submission was noted alongside the express interest of some submitters for their submissions to be published in full under their name.

Agreed that the publication of individual names will be considered in detail when the submissions are individually assessed and further, that the reference to submitters in the Committee's final report will be drafted in an aware and conscious manner (Mrs *Petrusma*).

Noted that the Secretary will endeavour to re-contact all individual submitters to determine if they have a publication request regarding their submission.

Agreed, and noted by the Committee that some individual submissions contain strong and or explicit language which can be published (Ms *Johnston*).

CONDUCT OF INQUIRY

WEBSITE WAIVERS

Resolved, that the following waivers be uploaded to the Committee webpage:

Individual experiences

Members of the Committee thank those who have provided a submission to the Inquiry. Submissions which detail personal individual experiences will inform the Committee understanding of access and experiences with reproductive, maternal and paediatric health services in Tasmania. However, the Committee cannot conduct investigations into specific matters. Such matters of this nature can be referred to the Health Complaints Commissioner at 1800 001 170 or health.complaints@ombudsman.tas.gov.au.

Sensitive content

Committee Members recognise that the evidence received in submissions and in public hearings may discuss highly sensitive matters and themes that have deeply impacted the lives of Tasmanians and may be distressing for some people.

Seeking support

If you feel distressed as a result of the sensitive content of the Inquiry please contact one of the following resources:

Lifeline Tasmania on1800 98 44 34 for mental health support.

Lifeline's helpline on 13 11 14 or via text at 0477 13 11 14 for 24/7 mental health support.

Tresillian Tasmania's Parents helpline on 1300 827 282.

PANDA National helpline on 1300 726 306. PANDA's Helpline provides support Monday – Friday from 9am – 7:30pm and from 9am – 4pm on Saturdays and public holidays.

PRE – HEARING BRIEFING

The Committee discussed the potential to conduct a pre-hearing briefing with an expert specialist to provide additional support to Members in their preparations for the hearings. *Resolved* that, in lieu of a formal briefing, organisations will be invited to attend the first round of public hearings. This will provide a supportive basis for the Committees conduct (Ms *Haddad*).

ADDITIONAL TIME BEFORE HEARINGS

Resolved, that an additional 5 – 10 minute period be included in each scheduled appearance of individual witnesses. This will allow the witness to be introduced to Members and Committee staff prior to the commencement of the formal proceedings of the session (Ms *Haddad*).

The Committee further noted that all individuals will be invited to bring a support person and/ or their partner with them to their session.

GIDGET FOUNDATION SUPPORT

Resolved, that the services of Gidget Foundation be sought for the provision of clinical support at the public hearings of individual witnesses. The Secretary to write to the Clerk to request additional funds for the use of this services (Ms *Haddad*).

HEARING DISCLAIMER

Resolved, that the following disclaimer be included in the Chair's introductory remarks at public hearings:

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

I'd encourage anyone impacted by the content matter during this hearing to contact services and supports such as:

Lifeline's helpline on 13 11 14 or via text at 0477 13 11 14 for 24/7 mental health support.

Tresillian Tasmania's Parents helpline on 1300 827 282.

PANDA National helpline on 1300 726 306. PANDA's Helpline provides support Monday – Friday from 9am – 7:30pm and from 9am – 4pm on Saturdays and public holidays."

PUBLIC HEARING SCHEDULES

Agreed, that the following tentatively booked public hearings be kept as follows for organisations:

Monday 21 October 2024 - Hobart;

Wednesday 23 October 2024 – Hobart;

Tuesday 29 October 2024 – Hobart (if needed); and

Wednesday 30 October 2024 – Hobart (if needed) (Mrs *Petrusma)*

Agreed, that the following dates be tentatively booked for additional hearings, to which individual witnesses will be invited and the support of Gidet Foundation requested:

Tuesday 12 November 2024 – North; and Wednesday 13 November 2024 – Hobart (Ms *Rosol*).

Noted that the Committee is open to further extending the reporting date if necessary to ensure its work can be completed effectively.

PUBLIC HEARING WITNESSES

Resolved, to invite the following to appear as witnesses before the Committee (Ms *Haddad*):

Submission No. 1: Breastfeeding Coalition Tasmania

Submission No. 5: Tresillian

Submission No 12: Health Consumers Tasmania

Submission No 16: Australian Breastfeeding Association – Tasmania Branch

Submission No. 17: Karitane

Submission No. 18: RANZOCG

Submission No. 21: Australian Lawyers Alliance

Submission No. 22: Gidget Foundation
Submission No. 24: Australasian Birth Trauma Association

Submission No. 25: AMA Tasmania

Submission No. 32: Australian College of Midwives

Submission No. 60: Mothers & Midwives Australia (MAMA)

Submission No. 90: Homebirth Australia

Submission No. 91: Tasmanian Aboriginal Centre

Submission No. 104: RACGP Tasmania

Submission No. 129: Department of Health

Submission No. 131: Early Pregnancy Loss Coalition

Submission No. 131: Maternal Health Matters

Resolved, that the following organisations be invited to attend a joint hearing (Ms *Johnston*):

Submission No. 27: Equality Tasmania

Submission NO. 28: Family Planning Tasmania

Submission No. 30: TasCOSS

Submission No. 31: Women's Health Tasmania

Submission No. 34: Working It Out

Noted that, once Submission 83 from Maternity Consumer Network has been formally received, the organisation may be invited to attend a joint hearing with Birth In Tasmania who provided Submission 97.

MEDIA RELEASES

Resolved, that the draft media release be updated and circulated with public hearing schedules before the public hearings, inclusive of the disclaimer content regarding support services (Ms *Johnston*).

ANY OTHER MATTERS

No other matters.

At 1:04 pm the Committee adjourned until 9:00 am on Monday 21 October 2024.

MONDAY, 21 October 2024

The Committee met at Parliament House Hobart and via Webex, at 9.58 a.m.

Members Present:

Ms *Johnston*
Ms *Haddad*
Mrs *Petrusma*
Ms *Rosol* (via WebEx)

APOLOGIES
Mr *Fairs*

PUBLIC HEARINGS

WITNESSES

At 9.59 a.m., Ms Raylene Foster COO of the Tasmanian Aboriginal Centre and Director of Connected Beginnings Program, Ms Chloe Woolnough Manager, Connected Beginnings Program, Ms Anissa Thompson Child Health Nurse, Connected Beginnings Program and Ms Dannielle Harris Registered Nurse, Connected Beginnings Program were called, made the Statutory Declaration and were examined by the Committee in public

At 10.47a.m. the witnesses withdrew.

Suspension of sitting 10.47 a.m. to 10.55 a.m.

WITNESS

At 10.55 a.m., Ms Charlotte Fielding, Breastfeeding Counsellor and Educator and Assistant Branch President of the Australian Breastfeeding Association Tasmania Branch was called, made the Statutory Declaration and was examined by the Committee in public.

At 10.39 a.m. the witness withdrew.

Suspension of sitting 11.39 a.m. to 11.58 a.m.

Ms *Dow* joined the table at 11.44 a.m.

WITNESSES

At 11.58 a.m., Ms Anna Folkerts, a retired Endorsed Midwife appearing on behalf of Homebirth Australia was called, made the Statutory Declaration and was examined by the Committee in public.

Ms Kristyn Begnell, Homebirth Australia Coordinator, was called (WebEx) and was examined by the Committee in public.

Mrs *Petrusma* withdrew from the table at 12.52pm.

At 12.51 p.m. the witnesses withdrew.

Suspension of sitting 12. 52 p.m. to 2.00 p.m.

WITNESSES

At 2.01 p.m., Ms Ellen MacDonald, CEO and Ms Hannah Fielder, Advocacy and Impact Lead, of Health Consumers Tasmania were called, made the Statutory Declaration and were examined by the Committee in public.

Ms *Dow* joined the table at 2.27 p.m.

At 2.44 p.m. the witnesses withdrew.

Suspension of sitting 2. 44 p.m. to 2.48 p.m.

DELIBERATIVE MEETING

WORKPLAN OF THE COMMITTEE

The Committee discussed its workplan, including the receipt and publication of

submissions and the second tranche of public hearings.

Resolved, that the currently scheduled hearings for Tuesday 12 November 2024 and Wednesday 13 November 2024 be postponed allowing additional time for the consideration of submissions and hearing witnesses (Ms *Dow*).

Resolved, that the following amendment be made to the workplan of the Committee:

Monday 25 November 2024: Deliberative meeting 11.30 a.m. – 12.30 p.m.

Wednesday 19 February 2025: Public hearing – North; and

Thursday 20 February 2025: Public hearing – Hobart (Ms *Haddad*)

Resolved, that the Secretary investigate options to conduct site visits at the following facilities:

- The Launceston General Hospital;
- The North West Regional Hospital;
- The Launceston Birth Centre; and
- The Royal Hobart Hospital. (Ms *Dow*)

Resolved, that the following date be included for potential site visits:

- Tuesday 18 February 2025: North and North West.

PUBLICATION OF HANSARD

Resolved, that Hansard uncorrected proofs be shared with witnesses for corrections of mistranscriptions for a 2 day period. Secretary to manage corrections and publish. *(Ms Johnston)*

MINUTES

The minutes of the meeting held 30 September 2024 were adopted as an accurate record (Ms *Johnston*)

Mrs *Petrusma* returned to the table at 3.00 p.m.

PUBLIC HEARING ARRANGEMENTS

Resolved, that the incoming Minister for Health and the Department for Health be contacted after the swearing in of Cabinet on Wednesday 23 October 2024 to cancel the scheduled appearance on Wednesday 30 October. A future date for the hearing is to be discussed for February 2025. (Ms *Haddad*)

CORRESPONDENCE

Noted correspondence from TasCoss and Working It Out regarding participation in a joint public hearing. Agreed that the joint hearing be reassessed in 2025. (Ms *Haddad*).

COMMITTEE UPDATE

Resolved that, due to the ongoing projection of the Committee's workplan, a letter be circulated to all submitters providing a status update on the work of the Committee. This letter is to include details regarding the future work of the Committee, the consideration of submissions and note who has appeared before the Committee. The Secretary to liaise with the Chair to finalise the letter (Ms *Haddad*).

Noted that the Committee's reporting date will need to be extended again to ensure adequate time for the assessment of the Report.

The deliberative meeting concluded at 3.14 p.m.

PUBLIC HEARINGS

WITNESS

At 3.17 p.m., Ms Ellen O'Keeffe, President of Maternal Health Matters was called (WebEx) and was examined by the Committee in public.

At 4.02 p.m. the witness withdrew.

ANY OTHER MATTERS

No other matters.

At 4:04 pm the Committee adjourned until 9:00 am on Wednesday 23 October 2024.

WEDNESDAY, 23 October 2024

The Committee met at Parliament House Hobart and via Webex, at 9.03 a.m.

Members Present:

Ms *Dow* (via WebEx)
Ms *Johnston*
Ms *Haddad*
Ms *Rosol* (via WebEx)

APOLOGIES
Mr *Fairs* and Mrs *Petrusma*

PUBLIC HEARINGS

WITNESS

At 9.04 a.m., Ms Amy Dawes OAM, Founder, CEO and Director of Australasian Birth Trauma Association was called, made the Statutory Declaration and was examined by the Committee in public.

At 9. 52 a.m. the witness withdrew.

Suspension of sitting 9.52 a.m. to 10.00 a.m.

WITNESS

At 10.01 a.m., Ms Bernadette Davies, Solicitor, representative from the Australian Lawyers Alliance, was called, made the Statutory Declaration and was examined by the Committee in public.

At 10. 41 a.m. the witness withdrew.

Suspension of sitting 10.43 a.m. to 11.03 a.m.

WITNESSES

At 11. 04 a.m., Associate Professor Jenny Smit, Executive Director of Clinical Services, Dr Alice Dwyer Medical Director Parent Infant Early Childhood Mental Health (PIEC – MH) Services and Ms Tanya Crawford Clinical Director PIEC-MH Services, representatives from Tresillian were called, made the Statutory Declaration and were examined by the Committee in public.

At 12.03 p.m. the witnesses withdrew.

Suspension of sitting 12.05 p.m. to 12.06 p.m.

WITNESS

At 12. 07 p.m., Ms Kelly Langford, Founder and Midwifery leader, representative from Mothers & Midwives Australia (MAMA), was called (WebEx) and was examined by the Committee in public.

At 12. 38 p.m. the witness withdrew.

Suspension of sitting 12. 41 p.m. to 2.21 p.m.

WITNESS

At 2.24 p.m., Dr Nisha Khot, Vice – President of The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZOCG) was called (WebEx) and was examined by the Committee in public.

At 3. 05 p.m. the witness withdrew.

Suspension of sitting 3. 06 p.m. to 3.15 p.m.

WITNESSES

At 3. 17 p.m., Dr Martia Jones and Dr Tim Jones, representatives of The Royal Australian College of General Practitioners (RACGP) Tasmania, were called, made the Statutory Declaration and were examined by the Committee in public.

At 4. 04 p.m. the witness withdrew.

Suspension of sitting 4.04 p.m. to 4.11 p.m.

WITNESSES

At 4.14 p.m., Ms Rowena Shakes, ACM Tasmania Branch Secretary and Endorsed Midwife and Ms Maya Wilkinson Branch Committee Member, representatives from the Australian College of Midwives were called, made the Statutory Declaration and were examined by the Committee in public.

Ms Alison Weatherstone, Chief Midwife of the Australian College of Midwives, was called (WebEx) and was examined by the Committee in public.

At 4. 59 p.m. the witnesses withdrew.

HANSARD TRANSCRIPTS

Resolved, that Hansard uncorrected proofs be shared with witnesses for corrections of mistranscriptions for a 2 day period. Secretary to manage corrections and publish. *(Ms Haddad)*

MINUTES

The minutes of the meeting held 30 September 2024 were adopted as an accurate record. (Ms *Rosol*)

PUBLIC HEARING ARRANGEMENT – OTHER MEMBER TO FACILITATE HEARING

Resolved, that Ms *Johnston* administer the call during the 30 October public hearing while the Chair participates via Webex videoconference, and act as the Deputy Chair if required in the absence of a formal Deputy Chair.

Moved by Ms *Haddad*, Seconded by Ms *Dow*.

ANY OTHER MATTERS

ADDITIONAL INFORMATION

The Committee discussed the evidence received thus far, noting that additional queries have arisen.

Resolved, that the following organisations be written to and invited to attend public hearings in February:

The Australian Nursing and Midwifery Federation Tasmanian Branch; and

The Health and Community Services Union Tasmania. (Ms *Dow*).

Resolved, that the following be written to in regards to questions which have arisen from evidence received by the Committee. They are to be invited to, in the first instance, attend a public hearing or, if not appropriate, provide responses to written questions:

The University of Tasmania (in relation to undergraduate midwifery degrees); and The Department for Education, Children and Young People (in relation to the Early Childhood Inclusion Services (ECIS), Child and Family Learning Centres and the role of school nurses in providing health assessments). (Ms *Rosol*).

TABLING OF REPORT

Noted discussions regarding the tabling of the Committee's final report, including the potential to invite some submitters to attend the Parliament.

Ms *Dow* proposed that a Parliamentary Friends Group centred on reproductive, maternal and paediatric services and supports could be created and launched with the Report.

Noted that an extension to the reporting date will be required and that, prior to the motion being moved in the Committee and consequently in the House, the Secretary will receive the updated proforma motion from the Clerk of the House regarding the communication of the motion with the Leader of the House.

At 5:16 pm the Committee adjourned until 9:00 am on Wednesday 30 October 2024.

WEDNESDAY, 30 October 2024

The Committee met at Parliament House Hobart and via Webex, at 9.08 a.m.

Members present

Ms *Dow* (via WebEx)
Mr *Fairs* (via WebEx)
Ms *Haddad* (via WebEx)
Ms *Johnston*
Ms *Rosol* (via WebEx)

APOLOGIES
Mrs *Petrusma*

PUBLIC HEARINGS

WITNESSES

At 9.11 a.m., Ms Isabelle Oderberg, Co – Founder and Chair and Dr Sarah Simons, representatives of Early Pregnancy Loss Coalition, were called (WebEx) and were examined by the Committee in public.

At 9. 55 a.m. the witnesses withdrew.

Mr *Fairs* withdrew from the meeting from 9.55 a.m. until 9.59 a.m.

WITNESSES

At 10.02 a.m., Dr Michael Lumsden Steel, President of the Australian Medical Association Tasmania Branch, was called (WebEx), made the Statutory Declaration and was examined by the Committee in public.

Dr Annette Barratt, former Vice President of the Australian Medical Association Tasmania Branch, was called (WebEx) and was examined by the Committee in public.

At 10. 58 a.m. the witnesses withdrew.

Suspension of sitting 11.13 a.m. to 11.32 a.m.

WITNESS

At 11. 36 a.m., Ms Karen Edwards, Clinical Director of Gidget Foundation Australia, was called (WebEx) and was examined by the Committee in public.

At 12.13 p.m. the witness withdrew.

HANSARD TRANSCRIPTS

Resolved, that Hansard uncorrected proofs be shared with witnesses for corrections of mistranscriptions for a 2 day period. Secretary to manage corrections and publish. *(Ms Haddad)*

MINUTES

The minutes of the meeting held 23 October 2024 were adopted as an accurate record. (Ms *Dow*)

CORRESPONDENCE

The Committee noted correspondence from Amy Ramsey, dated 24 October 2024. It was agreed that Ms Ramsey be contacted by the Chair after the Committee's deliberative meeting. (Ms *Haddad*)

ANY OTHER MATTERS

No issues arising.

At 12:23 pm the Committee adjourned until 11:30 am on Monday 25 November 2024.

MONDAY, 25 November 2024

The Committee met at Parliament House Hobart and via Webex, at 11.41a.m.

Members present

Ms *Dow* (via WebEx)
Ms *Haddad*
Ms *Johnston* (via WebEx)
Ms *Rosol* (via WebEx)

APOLOGIES
Mr *Fairs* and Mrs *Petrusma*

MINUTES

The minutes of the meeting held 30 October 2024 were adopted as an accurate record. (Ms *Johnston*)

CORRESPONDENCE
The Committee noted the following outgoing correspondence (Ms *Johnston*):

- Letter to submitters;
- Question on Notice - Australian Breastfeeding Association – Tasmania Branch;
- Question on Notice - Homebirth Australia;
- Question on Notice - Australian Lawyers Alliance;

- Question on Notice - Australian College of Midwives;
- Question on Notice - Australian Medical Association – Tasmania Branch;
- Additional information request - Department for Education, Children and Young People;
- Additional information request - University of Tasmania, School of Nursing;
- Invitation to participate - Australian Nursing and Midwifery Federation; and
- Invitation to participate - Health and Community Services Union.

The Committee noted the following incoming correspondence (Ms *Johnston*):

- Reply from Minister for Health, Hon Jacquie Petrusma MP to letter from Secretary.

The Committee noted the following incoming replies to Question on Notice and *Resolved* to publish them (Ms *Haddad*):

- Response to Question on Notice - Homebirth Australia; and
- Response to Question on Notice - Australian Lawyers Alliance.

RECEIPT AND PUBLICATION OF SUBMISSIONS FROM OUTSTANDING ORGANISATIONS AND INDIVIDUALS

Ordered, that the following submissions be received and published in full, with the personal contact details of individuals being removed and the Committees previously agreed to redactions implemented (Ms *Haddad*):

Submission No. 15: UPDATED Dr Jennifer Ayton

Submission No. 29: Selina Park

Submission No. 37: Holly Bennett Submission

No. 38: Cas (published as 'Cas')

Submission No. 40: Kali Head

Submission No. 42: Jackie Joseph

Submission No. 47: Chelsea Wingrove

Submission No. 57: Missy Obezuk

Submission No. 58: Georgia Lilley

Submission No. 61: Hannah Butcher

Submission No. 64: Camilla Bosaans

Submission No. 66: Karen Schlage

Submission No. 70: Crystal – Leigh Eiszele

Submission No. 71: Ashleigh Loubser

Submission No. 76: Claire Holloway

Submission No. 78: Kirsten Chilcott

Submission No. 79: Anneika Chatwin

Submission No. 85: Kate Marsden

Submission No. 95: Ash Barwick

Submission No. 106: Rashelle Szoke

Submission No. 109: Jaimee Smith

Submission No. 121: Brigid Cowen

Submission No. 130: Hannah Boyd

Submission No. 133: Australian Physiotherapy Association

Ordered, that the following submissions be received and kept confidential (Ms *Haddad*):

Submission No. 44: *Name withheld*

Submission No. 65: *Name withheld*

Submission No. 68: *Name withheld*

Submission No. 74: *Name withheld*

Submission No. 80: *Name withheld*

Submission No. 82: *Name withheld*

Submission No. 110: *Name withheld*

Submission No. 124: *Name withheld*

Submission No. 134: *Name withheld*

Resolved, to send correspondence to submitter 74 and 124 regarding the status of their submissions.

Ordered, that the following submissions be received and published as an anonymous submission, with the personal contact details of individuals being removed and the Committees previously agreed to redactions implemented (Ms *Johnston*):

Submission No. 36: *Name withheld*

Submission No. 39: *Name withheld*

Submission No. 43: *Name withheld*

Submission No. 45: *Name withheld*

Submission No. 46: *Name withheld*

Submission No. 48: *Name withheld* (including updated content)

Submission No. 49: *Name withheld*

Submission No. 50: *Name withheld*

Submission No. 51: *Name withheld*

Submission No. 52: *Name withheld*

Submission No. 53: *Name withheld*

Submission No. 54: *Name withheld*

Submission No. 55: *Name withheld*

Submission No. 56: *Name withheld*

Submission No. 59: *Name withheld*

Submission No. 62: *Name withheld*

Submission No. 63: *Name withheld*

Submission No. 67: *Name withheld*

Submission No. 69: *Name withheld*

Submission No. 72: *Name withheld*

Submission No. 75: *Name withheld*

Submission No. 81: *Name withheld*

Submission No. 84: *Name withheld*

Submission No. 86: *Name withheld*

Submission No. 87: *Name withheld*

Submission No. 88: *Name withheld*

Submission No. 89: *Name withheld*

Submission No. 92: *Name withheld*

Submission No. 93: *Name withheld*

Submission No. 94: *Name withheld*

Submission No. 96: *Name withheld*

Submission No. 98: *Name withheld*

Submission No. 99: *Name withheld*

Submission No. 100: *Name withheld*

Submission No. 101: *Name withheld*

Submission No. 102: *Name withheld*

Submission No. 105: *Name withheld*

Submission No. 107: *Name withheld*

Submission No. 108: *Name withheld*

Submission No. 111: *Name withheld*

Submission No. 113: *Name withheld*

Submission No. 114: *Name withheld*

Submission No. 115: *Name withheld*

Submission No. 116: *Name withheld*

Submission No. 117: *Name withheld*

Submission No. 118: *Name withheld*

Submission No. 119: *Name withheld*

Submission No. 122: *Name withheld*

Submission No. 125: *Name withheld*

Submission No. 126: *Name withheld*

Submission No. 127: *Name withheld*

Ordered, that the following submissions be received and published as an anonymous submission, with the personal contact details of individuals being removed, the Committees previously agreed to redactions

implemented and the requested redactions implemented (Ms *Haddad*):

Submission No. 41: *Name withheld* (only publish bold text)

Submission No. 77: *Name withheld* (redact location and initials)

Ordered, that the following submission be received and published, with the personal contact details of individuals being removed, the Committees previously agreed to redactions implemented, last names removed and consistent requested redactions and anonymity from individual submissions carried over (Ms *Haddad*):

Submission No. 83: Maternity Consumer Network

Submission No. 103: Miracle Babies Foundation

Ordered, that the following submissions be received and published in part without attachements published, with the personal contact details of individuals being removed and the Committees previously agreed to redactions implemented (Ms *Haddad*):

Submission No. 90: Homebirth Australia
Submission No. 128: Ayla Judd

Ordered, that the following submissions be received and published anonymously in part without attachements published, with the personal contact details of individuals being removed and the Committees previously agreed to redactions implemented (Ms *Haddad*):

Submission No. 112: *Name withheld*
Submission No. 123: *Name withheld*

Ordered, that the following submission be received and published in part with the personal contact details of individuals being removed, the Committees previously agreed to redactions implemented and an additional redaction of the name of a third party (Ms *Haddad*):

Submission No. 9: Amy Ramsey

Ordered, that the following submissions received by the former Committee be updated to reflect the Committee's agreed upon content redactions (Ms *Haddad*):

Submission No. 2: Angela Allen

Submission No. 6: Emma Deane

Submission No. 10: Clara White

Submission No. 23: *Name withheld*

ADVERSE COMMENT DISCLAIMER

Resolved, that the following adverse comment disclaimer be included on the Committee webpage:

Adverse comment:

Some submissions to the Inquiry may reflect adversely on third party persons, organisations or businesses. Through the Secretariat, the Committee will endeavour to contact those mentioned, where possible, to provide a reply. If you feel that an adverse comment has been made about you, please contact the Committee Secretariat on (03) 6212 2139.

REPORTING DATE

The Committee discussed the current reporting date of 25 March 2025.

Resolved, that the Committee extend its reporting date to 19 August 2025. (Ms *Haddad*)

Resolved, that the Committee authorises the Chair, Ms Ella Haddad, to provide other Members of the House of Assembly with advance notice of the agreed upon motion to extend the reporting date of the Committee. (Ms *Johnston*)

Secretary to prepare Motion to be moved by the Chair in the House.

PUBLIC HEARING SCHEDULES

Noted Committee's current scheduled hearings for 19 and 20 February 2025, with potential to add an additional date in March for the Department of Health and further outstanding organisations.

PUBLIC HEARING WITNESSES

Noted the Committee's outstanding resolution to invite the following organisations to hearings, including potentially to the hearings in February if schedules permit:

Submission No. 17: Karitane

Submission No. 28: Family Planning Tasmania

Submission No. 31: Women's Health Tasmania

Australian Nursing and Midwifery Federation Tasmania Branch

Health and Community Services Union Tasmania

Noted an additional date for a hearing will be sought to host the following organisation:

Submission No. 129: Department of Health

Resolved, to invite the following to appear as witnesses before the Committee (Ms *Haddad*):

Submission No. 97: Birth in Tasmania

Submission No. 109: Jaimee Smith

Submission No. 133: Australian Physiotherapy Association

OTHER MATTERS

Resolved, to meet on Friday 29 November 2024 to invite individual hearing attendees.

At 12:43 pm the Committee adjourned until 10:30 am on Friday 29 November 2024.

FRIDAY, 29 November 2024

The Committee met at Parliament House Hobart and via Webex, at 10.41a.m.

Members present

Ms *Haddad*
Ms *Johnston*
Ms *Rosol*
Mr *Street*

APOLOGIES
Ms *Dow* and Mr *Fairs*

MINUTES

The minutes of the meeting held 25 November October 2024 were adopted as an accurate record. (Ms *Johnston*)

ELECTION OF DEPUTY CHAIR
Election of Deputy Chair deferred to next meeting. (Ms *Haddad*)

CORRESPONDENCE

Nil to receive or note.

SITE VISITS

Proposed North and North West site visits on Tuesday 18 February 2025 were discussed. Noted that Members will be available to participate in site visits from Tuesday morning, with the schedule to tentatively commence at 10 a.m., beginning in the North West and concluding in the North.

PUBLIC HEARINGS WITNESS SELECTION

Resolved, to invite the following to appear as witnesses before the Committee (Ms *Haddad*):

Submission No. 2: Angela Allen

Submission No.6: Emma Deane

Submission No. 9: Amy Ramsey

Submission No. 10: Clara White

Submission No. 14: Dr Natasha Vavrek

Submission No. 15: Dr Jennifer Ayton

Submission No. 43: *Name withheld*

Submission No. 47: Chelsea Wingrove

Submission No. 56: *Name withheld*

Submission No. 58: Georgia Lilley

Submission No. 67: *Name withheld*

Submission No. 78: Kirsten Chilcott

Submission No. 79: Anneika Chatwin

Submission No. 85: Kate Marsden

Submission No. 95: Ash Barwick

Submission No. 110: *Name withheld*

Submission No. 121: Brigid Cowen

PUBLIC HEARING INVITATIONS

Resolved, that the invitation for witnesses to attend public hearings be updated to include an explanation regarding the Committees role and provisions, noting that it is not a complaints mechanism or handling process. (Ms *Johnston*)

MEDIA RELEASE

Resolved, that the Secretary circulate a media release with public hearing schedules before the public hearings, inclusive of the disclaimer content regarding support services (Ms *Rosol*).

OTHER MATTERS

No other matters raised.

At 11.23 a.m. the Committee adjourned until Tuesday 18 February 2025.

TUESDAY, 18 February 2025

The Committee met at the Cradle Coast Authority, Burnie at 9.47 a.m.

Members present

Ms *Haddad (Chair)*
Ms *Dow*
Mr *Fairs*
Ms *Johnston*
Ms *Rosol*

PUBLIC HEARINGS

WITNESS

At 9. 48 a.m., Kaylia Marshall was called, made the Statutory Declaration and was examined by the Committee in public.

At 9.50 a.m. Mr *Fairs* joined the table.

At 10.21 a.m. the witness withdrew.

Suspension of sitting 10.21 a.m. to 10.25 a.m.

WITNESS

At 10.25 a.m. Kimberly Harding was called, made the Statutory Declaration and was examined by the Committee in public.

At 10.55 a.m. the witness withdrew.

Suspension of sitting 10.55 a.m. to 11.07 a.m.

WITNESSES

At 11.07 a.m. Amy Ramsey and Samuel Thomas were called, made the Statutory Declaration and were examined by the Committee in public.

At 12.01 p.m. the witnesses withdrew.

Suspension of sitting 12.01 p.m. to 12.07 p.m.

WITNESS

At 12. 07 p.m. Jacinda Armstrong, CEO of Playgroup Tasmania was called, made the Statutory Declaration and was examined by the Committee in public.

At 12.43 p.m. the witness withdrew.

DELIBERATIVE MEETING

ADDITIONAL HEARING ATTENDEES

Noted, the out of session agreement of the Committee via email on Friday 7 February 2025, to invite the following additional attendees to appear at the Burnie hearing to manage scheduling changes (Ms *Haddad*):

- Submission 20: Playgroup Tasmania; and
- Submission 98: Private Witness.

ELECTION OF DEPUTY CHAIR

The Chair called for nominations for Deputy Chair

Ms *Haddad* nominated Ms *Dow,* who consented to the nomination.

This nomination was seconded by Ms *Rosol.*

There being no other candidates nominated, the Chair declared Ms *Dow* elected as Deputy Chair.

HANSARD TRANSCRIPTS

Resolved, that Hansard uncorrected proofs be shared with witnesses for corrections of mistranscriptions for a 2-day period. Secretary to manage corrections and publish. *(Ms Johnston)*

MINUTES

The minutes of the meeting held 29 November 2024 were adopted as an accurate record. (Ms *Dow*)

SUBMISSIONS

Resolved, to update publication status of Submission 56 and Submission 98 to include the submitters name, as per their consent to the Secretary. (Ms *Haddad*)

Deferred discussion of Submission 135 to a later meeting. (Ms *Haddad*)

CORRESPONDENCE

RECEIVED

Resolved, to receive and publish the following replies to Questions on Notice as additional information, with relevant redactions of personal information as required (Ms *Dow*):

- Australian Breastfeeding Association TAS Branch, received 28 November 2024;
- Secretary for Education, Children and Young People, received 18 December 2024; and
- Australian College of Midwives, received 20 December 2024.

OTHER MATTERS

CONTENT OF HANSARD TRANSCRIPTS

The Committee discussed matters raised in contributions from witnesses at the morning's hearings. Discussed how the use of name's should be managed, including if a Right of Reply should be offered to those adversely mentioned, as well as the gaining of consent for other third parties mentioned. Noted that the matter will be further raised once the transcripts can be assessed.

Resolved, that the adverse comment disclaimer currently available on the submissions section of the Committee's webpage be replicated on the Committee's homepage. (Ms *Rosol*)

SITE VISIT

Noted the Committee's site visit to the North West Regional Hospital from 2 p.m.

At 12.58 p.m. the Committee adjourned until Wednesday 19 February 2025.

WEDNESDAY, 19 February 2025

The Committee met at the Hotel Grand Chancellor Launceston at 9.00 a.m.

Members present

Ms *Haddad (Chair)*
Ms *Dow*
Ms *Johnston*
Ms *Rosol*

APOLOGIES

Mr *Fairs* and Mr *Street* were apologises.

PUBLIC HEARINGS

WITNESS

At 9. 01 a.m., Jaimee Smith was called made the Statutory Declaration and was examined by the Committee in public.

At 9.38 a.m. the witness withdrew.

Suspension of sitting 9.38 a.m. to 9.42 a.m.

WITNESSES

At 9. 44 a.m. Kate Marsden and Tim Mohr were called, made the Statutory Declaration and were examined by the Committee in public.

At 10.20 a.m. the witnesses withdrew.

Suspension of sitting 10.21 a.m. to 11.07 a.m.

WITNESS

At 11. 09 a.m. Georgia Lilley was called, made the Statutory Declaration and was examined by the Committee in public.

At 11.42 a.m. the witness withdrew.

Suspension of sitting 11. 42 a.m. to 11. 44 a.m.

DELIBERATIVE MEETING

SUBMISSIONS

Resolved, that the following submission be published in full, with the personal contact details of individuals being removed (Ms *Haddad*):

Submission 110: Catherine Bell

CORRESPONDENCE

Resolved, to publish the letter from the ANMF, dated 31 January 2025 (Ms *Haddad*)

SITE VISIT

Noted the Committee's pending site visits as follows:

- Launceston Birth Centre from 1 p.m.; and
- Launceston General Hospital from 2 p.m.

OTHER MATTERS

No other matters raised.

At 11.47 a.m. the Committee adjourned until Thursday 20 February 2025.

THURSDAY, 20 February 2025

The Committee met in Committee Room 1 and via Webex, at 9.01 a.m.

Members present

Ms *Haddad (Chair)*
Ms *Dow* (Webex)
Mr *Fairs* (Webex)
Ms *Johnston*
Ms *Rosol*
Mr *Street*

APOLOGIES
Nil.

PUBLIC HEARINGS

WITNESS

At 9. 04 a.m., Clara White was called, made the Statutory Declaration and was examined by the Committee in public.

At 9.07 a.m. Ms *Dow* joined the meeting via Webex.

Suspension of sitting 9.13 a.m. to 9.16 a.m.

At 9.37 a.m. Ms *Dow* withdrew from the table.

At 9. 39 a.m. Ms *Dow* resumed attendance at the meeting via Webex.

At 9.40 a.m. the witness withdrew.

Suspension of sitting 9.40 a.m. to 9.43 a.m.

WITNESSES

At 9. 45 a.m. Angela Allen and Shannon Allen were called, made the Statutory Declaration and were examined by the Committee in public.

At 10.28 a.m. the witnesses withdrew.

Suspension of sitting 10.28 a.m. to 10.31 a.m.

WITNESS

At 10. 34 a.m. Brigid Cowen was called, made the Statutory Declaration and was examined by the Committee in public.

At 10.59 a.m. the witness withdrew.

Suspension of sitting 10.59 a.m. to 11.15 a.m.

DELIBERATIVE MEETING

ADDITIONAL PUBLIC HEARING WITNESSES

Resolved, that the following organisations be invited to attend the hearing of the Committee on 26 March 2025 (Ms *Haddad*):

Healthscope; and

Calvary Lenah Valley Hospital.

Suspension of sitting 11.16 a.m. to 11.20 a.m.

PUBLIC HEARINGS

WITNESSES

At 11.23 a.m. Chelesea Wingrove, Tristian Streefland and Corbin Halliday were called, made the Statutory Declaration and were examined by the Committee in public.

At 12.01 p.m. the witnesses withdrew.

Suspension of sitting 12.01 p.m. to 12.06 p.m.

WITNESS

At 12.07 p.m. Heather Sharpe was called, made the Statutory Declaration and was examined by the Committee in public.

At 12.31 p.m. the witness withdrew.

Suspension of sitting 12.31 p.m. to 1.36 p.m.

WITNESS

At 1.38 p.m. Dr Jennifer Ayton was called, made the Statutory Declaration and was examined by the Committee in public.

At 2.22 p.m. the witness withdrew.

Suspension of sitting 2.22 p.m. to 2.25 p.m.

WITNESSES

At 2. 28 p.m., Alecia Staines, representing Maternity Consumer Network was called (WebEx) and was examined by the Committee in public.

Emma Goyne, also representing Maternity Consumer Network was called, made the Statutory Declaration and was examined by the Committee in public.

At 3.00 p.m. Alecia Staines withdrew.

At 3.09 p.m. Emma Goyne withdrew.

Suspension of sitting 3.09 p.m. to 3.17 p.m.

WITNESS

At 3. 18 p.m., Catherine Bell was called (WebEx) and was examined by the Committee in public.

At 3.51 p.m. the witness withdrew.

Suspension of sitting 3.53 p.m. to 3. 06 p.m.

WITNESSES

At 4.16 p.m. Emily Shepherd, Astrid Tiefholz and Monica Werner, representatives of the Australian Nursing and Midwifery Federation Tasmania were called, made the Statutory Declaration and were examined by the Committee in public.

At 4.58 p.m. the witnesses withdrew.

Suspension of sitting 4.58 p.m. to 5.02 p.m.

WITNESSES

At 5.04 p.m. Emma Green and Elizabeth (Lizzy) Barnes - Keoghan, representatives of the Australian Physiotherapy Association were called, made the Statutory Declaration and were examined by the Committee in public.

At 5.32 p.m. the witnesses withdrew.

Suspension of sitting 5.32 p.m. to 5.35 p.m.

OTHER MATTERS

No other matters raised.

At 5.35 p.m. the Committee adjourned until Tuesday 25 March 2025.

TUESDAY, 25 March 2025

The Committee met at Committee Room 1, Parliament House and via Webex, 12.00 p.m.

Members present

Ms *Haddad (Chair)*
Ms *Dow (Webex)*
Ms *Johnston*
Mr *Street (Webex)*

APOLOGIES
Mr *Fairs* and Ms *Rosol* were apologises.

MINUTES

The minutes of the meetings held on 18, 19 and 20 February 2025 were adopted as accurate records. (Ms *Johnston*).

CORRESPONDENCE
Resolved, to receive and publish the following correspondence received by the Committee (Ms *Haddad*):

- Additional information received from Ms Catherine Bell on 20 February 2025;
- Additional information in response to questions from the Committee received from Christine Stirling, Head of School of Nursing, Utas, on 27 February 2025.

Resolved, to receive and publish correspondence from Minister for Health, the Honourable Jacquie Petrusma MP, on 21 February 2025 (Ms *Johnston*).

Noted, options to receive evidence from Minister for Mental Health and Wellbeing, the Honourable Roger Jaensch MP, including at a hearing or through written questions. The Committee will further discuss this matter after the appearance of the Minister for Health to consider what further information may be required (Ms *Haddad*).

Noted, receipt of additional information from Amy Ramsey received on 24 February 2025 regarding the former LuyeCare website (Ms *Dow*).

SUBMISSIONS

Ordered, that Submission 135 – Human Rights in Childbirth, be received and published in part, with the personal contact details of individuals being removed, and with the following redactions (Ms *Haddad*):

- As per the Committees previous resolution, the removal of names and birth dates of children and names of medical practitioners;
- Replication of any redactions made to the original sources of 30 quotes received in other submissions to the Inquiry;
- Redactions of three quotes which appear in a confidential submission to the Inquiry; and
- Four redactions as per the request of the submitter.

HANSARD TRANSCRIPTS

The Committee discussed the use of the names of third parties in the Hansard Transcripts from hearings held on 18 – 20 February 2025, for consideration of publication.

RIGHT OF REPLY

Resolved, that Dr Janine Stevens be contacted in reference to the use of her name on pages 35 and 39 of the transcript for February 20 2025 and offered a Right of Reply (Ms *Dow*).

REDACTION OF NAME

Resolved, that the first name of the person referred to as [redacted] mentioned five times during Ms Heather Sharpe's appearance before the Committee on Thursday 20 February 2025, be expunged from the *Hansard* transcript and the broadcast footage for that same day. Ms Sharpe is to

be contacted regarding this resolution. (Ms *Haddad*).

REPORT DELIBERATIVE MEETINGS

The Committee discussed the future workplan. *Resolved*, that the following timeline be that of the Committee (Ms *Johnston*):

- Week of 2 June 2025 –Chair's draft Report to Chair;
- Week of 16 June 2025 – copy of Chair's draft Report to all Members;
- Week of 4 – 8 August 2025 – x4 Report deliberative meetings.

The Committee discussed the consideration of the Chair's draft Report, noting the expectation that Members will attend the deliberative meetings having read the draft.

SITE VISIT

Noted, that the site visit to the Royal Hobart Hospital scheduled for 2pm has been cancelled due to a lack of a quorum.

ANY OTHER MATTERS

Nil.

At 12.27 p.m. the Committee adjourned until Wednesday 26 March 2025.

WEDNESDAY, 26 March 2025
The Committee met at Committee Room 1, Hobart at 9.00 a.m.

Members present

Ms *Haddad (Chair)*
Ms *Dow (from 10.38 a.m. via Webex)*
Ms *Johnston*
Mr *Street*

APOLOGIES
Mr *Fairs* and Ms *Rosol*

PUBLIC HEARINGS

WITNESSES

At 9. 00 a.m., the Honourable Jacquie Petrusma MP, Minister for Health, was called and was examined by the Committee in public.

The following representatives of the Department of Health were called, made the Statutory Declaration and were examined by the Committee in public.

- Dale Webster – Secretary;
- Sally Badcock – Associate Secretary;
- Trudi Steedman – Child Health and Parenting Service (CHaPS); and
- Becky French - Nursing and Midwifery Director - Women's, Adolescent and Children's Services.

At 9:07 a.m. the Minister tabled a paper titled 'Meeting the needs of Tasmanian parents, families and children.'

At 9.15 a.m. the Minister tabled a paper titled 'Review Implementation Committee – Themed Recommendation Table.'

At 10.30 a.m. the witnesses withdrew.

Suspension of sitting 10.32 a.m. to 10.44 a.m.

Ms *Dow* joined the table during the suspension of the sitting.

WITNESS

At 10.46 a.m., Grainne O'Loughlin, CEO of Karitane was called, made the Statutory Declaration and was examined by the Committee in public.

At 11.36 a.m. the witness withdrew.

Suspension of sitting 10.36 a.m. to 11.40 a.m.

Ms *Johnston* withdrew from the table during the suspension of sitting.

WITNESSES

At 11.41 a.m., Jo Flanagan, Lucinda Shannon and Elinor Heard, representing Women's Health Tasmania, were called, made the

Statutory Declaration and were examined by the Committee in public.

At 12.09 p.m. Lucinda Shannon tabled a paper titled 'Talking to people about terminations of pregnancy in Tasmania.'

At 12.52 p.m. the witnesses withdrew.

Suspension of sitting 12.54 p.m. to 12.56 p.m.

WITNESS

At 12. 57 p.m., Dr Natasha Vavrek was called via Webex, made the Statutory Declaration and was examined by the Committee in public.

At 1.32 p.m. the witness withdrew.

Suspension of sitting 1.33 p.m. to 2.33 p.m.

WITNESSES

At 2.34 p.m., Ayla Judd and Cate Grant, representing Birth in Tasmania, were called via Webex, made the Statutory Declaration and were examined by the Committee in public.

At 3.11 p.m. the witnesses withdrew.

Suspension of sitting 3.12 p.m. to 3.17 p.m.

WITNESSES

At 3.18 p.m., Tino LaSpina, Chris Hewison and Georgia Banks representing Hobart Private Hospital by Healthscope, were called, made the Statutory Declaration and were examined by the Committee in public.

At 3.55 p.m. the witnesses withdrew.

Suspension of sitting 3.56 p.m. to 4.10 p.m.

WITNESSES

At 4.11 p.m., Kris Salisbury, Leah Magliano and Melissa Evans, representing Calvary Lenah Valley Hospital, were called, made the Statutory Declaration and were examined by the Committee in public.

At 4.37 p.m. the witnesses withdrew.

OTHER MATTERS

Nil.

At 4.44 p.m. the Committee adjourned until Monday 4 August 2025.

TUESDAY, 8 April 2025

The Committee met at Committee Room 1, Hobart at 2.00 p.m.

Members present

Ms *Haddad (Chair)*
Ms *Dow*
Mr *Fairs*
Ms *Johnston*
Mr *Street*

APOLOGIES
Nil.

MINUTES

The minutes of the meetings held on 25 and 26 March 2025 were adopted as accurate records. (Ms *Street*).

CORRESPONDENCE RECEIVED
Noted, correspondence from Ms Amy Ramsey, received on 25 March 2025 (Ms *Dow*).

Noted, confidential correspondence from [redacted], received on 26 March 2025 (Ms *Haddad*).

CORRESPONDENCE OUTGOING
Noted, circulation of Question on Notice to Healthscope (Ms *Haddad*).

ADDITIONAL INFORMATION
The Committee discussed the potential for any further requests for information from the Minister for Health and the Minister for Mental Health and Wellbeing.

Resolved, that Members provide the Secretary with any questions for the Ministers within 2 weeks, noting that further requests may be made of the Minister's up to the reporting date of the Committee.

Noted Ms Dow's proposed questions to the Minister's (Ms *Haddad*).

CHAIR'S DRAFT REPORT

Committee discussed the structure and content of the Chair's Draft Report.

OTHER MATTERS

Nil.

At 2.13 p.m. the Committee adjourned until Monday, 4 August 2025.

TUESDAY, 16 September 2025

The Committee met at Parliament House Hobart and via Webex, at 11.32 a.m.

In Committee Room 1

Ms *Johnston*

Via WebEx:

Ms *Dow*
Ms *Haddad*
Mr *Fairs*
Ms *Rosol*

ELECTION OF CHAIR

The Secretary took the Chair, read the Resolution as circulated, and called for nominations for Chair.

Ms *Dow* nominated Ms *Haddad,* who consented to the nomination.

This nomination was seconded by Mr *Fairs.*

There being no other candidates nominated, the Secretary declared Ms *Haddad* elected as Chair.

Ms *Haddad* took the Chair.

ELECTION OF DEPUTY CHAIR

The Chair called for nominations for Deputy Chair

Ms *Johnston* nominated Ms *Rosol,* who consented to the nomination.

This nomination was seconded by Ms *Dow.*

There being no other candidates nominated, the Chair declared Ms *Rosol* elected as Deputy Chair.

APOLOGIES

No apologises.

CONDUCT OF THE INQUIRY

ADDITIONAL RESEARCH SUPPORT

Resolved, that unless otherwise ordered Officers of the Parliamentary Research Service be admitted to the proceedings of the Committee whether in public or private session (Ms *Haddad*).

CHAIR TO BE THE SPOKESPERSON

Resolved, That the Chair be the spokesperson in relation to the operations of the Committee

(Ms *Dow*).

PRESS STATEMENTS

Resolved, that unless otherwise ordered, press statements on behalf of the Committee be made only by the Chair after approval in principle by the Committee or after consultation with Committee Members (Ms *Rosol*).

HANSARD TRANSCRIPTS OF EVIDENCE

Resolved, that the transcripts of any public hearings be published after being provided to witnesses for two days for mis-transcription corrections (Ms *Haddad*).

PUBLICATION OF BROADCAST PROCEEDINGS

Resolved, that the broadcast of any public proceedings be published on the parliamentary website (Ms *Haddad*).

EVIDENCE OF PREVIOUS COMMITTEE

Resolved that all evidence and papers received by the Select Committee on Reproductive, Maternal and Paediatric Health Services in Tasmania of the 51st Parliament be received by this Committee for

its consideration *(Ms Haddad)*

MINUTES

The minutes of the last meeting of the Committee of the 51st Parliament held on 8 April 2025 were adopted as an accurate record (Ms *Haddad*).

PROGRESS OF COMMITTEE OF THE 51ST PARLIAMENT

The Committee discussed the briefing paper regarding the work of the previous Committee of the 51st Parliament, noting that considerable work had been undertaken.

PROPOSED INQUIRY TIMELINE

The Committee noted the proposed draft workplan timeline, including the reporting date of 19 March 2026.

Resolved, to hold the following deliberative meetings to consider the Chair's Draft Report (Ms *Haddad*):

- Wednesday 15 October 2025 from 9am – 12.45pm;
- Thursday 16 October 2025 from 9am – 4.30pm;
- Monday 20 October 2025 from 9am – 2pm;
- Tuesday 21 October 2025 from 9am – 4.30pm; and

Monday 27 October 2025 from 9am – 2pm.

DRAFT CHAIR'S REPORT

Noted the status of the Chair's Draft Report, to be circulated to the Chair and then to Member's.

WEBSITE WAVIER

Resolved, that the Secretary insert the same disclaimers as agreed to by the committee of the 51st Parliament, on the new webpage (Ms *Haddad)*.

EVIDENCE COLLECTION

Resolved, to circulate draft correspondence to Committee Members for consideration of requests for written updates from the following individuals and organisations regarding the Committee's Terms of Reference, or specific topic areas (Ms *Dow*):

- The Minister for Health, Mental Health and Wellbeing;
- The Department of Health;
- Tresillian;
- Calvary Health Care and Calvary Lenah Valley Hospital;
- Healthscope and Hobart Private Hospital;
- The AMA Tasmania Branch; and
- The ANMF Tasmania.

UPDATE TO PARTICPANTS

Resolved, that the Committee endorses the Chair to draft an update to Committee particpants with the Secertary for circulation to all particpants of the 51st Parliament (Ms *Johnston*).

ANY OTHER MATTERS

No other matters raised.

At 12:06 pm the Committee adjourned until 9:00am on Wednesday 15 October 2025.

Confirmed,

WEDNESDAY, 15 October 2025

The Committee met at Parliament House Hobart and via Microsoft Teams, at 9.04 a.m.

In Committee Room 1

Ms *Haddad*
Ms *Johnston*

Via Microsoft Teams:

Ms *Dow*
Mr *Fairs*
Ms *Rosol*

APOLOGISES

No apologies.

MINUTES

The minutes of the last meeting of the Committee held on 16 September 2025 were adopted as an accurate record (Ms *Johnston*).

CORRESPONDENCE

The Committee received and resolved to publish the following correspondence:

- Updated information from Tresillian, dated 3 October 2025;
- Updated information from Calvary Health Care, dated 3 October 2025; and
- Updated information from AMA Tasmania, dated 10 October 2025 (Ms *Haddad*).

PROPOSED MEETING DATE

The Committee considered a new meeting date.

Resolved, that the Committee meet on Friday 31 October 2025 from 9am – 12pm (Ms *Haddad*).

CONSIDERATION OF CHAIR'S DRAFT REPORT

The Committee considered the Chair's draft Report.

<u>Chapter 1: Background, Appointment, Terms of Reference and Conduct of Inquiry</u>

Paragraphs 1.1 and 1.2 agreed to.

Paragraph 1.3 agreed to as amended.

Paragraph 1.4 agreed to as amended.

Paragraphs 1.5 – 1.17 agreed to.

Paragraph 1.18 agreed to as amended.

Paragraph 1.19 agreed to.

Paragraph 1.20 agreed to as amended.

Paragraphs 1.21 and 1.22 agreed to.

Paragraph 1.23 agreed to as amended.

Paragraph 1.24 deferred.

Paragraph 1.25 agreed to as amended.

Paragraph 1.26 agreed to as amended.

Paragraph 1.27 agreed to.

Paragraph 1.28 agreed to as amended.

Paragraph 1.29 agreed to.

Paragraph 1.30 agreed to as amended.

Paragraph 1.31 agreed to.

Paragraph 1.32 agreed to as amended.

Paragraph 1.33 agreed to.

Paragraph 1.34 agreed to as amended.

Paragraph 1.35 agreed to.

Paragraph 1.36 agreed to, with placement to be moved to the location of the first reference to evidence from Birth Trauma Australia.

New Paragraphs 1.37 – 1.40 agreed to.

New Paragraph 1.41 to be added detailing the decisions made by the Committee regarding redactions in submissions. To be assessed at next meeting.

New Paragraphs 1.42 -1.47 agreed to.

Noted that for Appendices containing the list of submissions and list of hearing witnesses, an introductory line be included on the appendices to refer the reader to the Committee's webpage to access full submissions and the broadcasts of hearings or transcripts of evidence.

<u>Chapter 2: Context of the Inquiry in Tasmania</u>

Paragraphs 2.1 and 2.2 agreed to.

Paragraph 2.3 agreed to as amended.

Paragraph 2.4 agreed to.

Paragraph 2.5 deferred, accuracy to be checked.

Former Paragraph's 2.6 and 2.7 to be moved to Chapter 4 and reconsidered in their new proposed position.

Former Paragraph 2.8 deferred, with additional content to be added regarding AMA Tasmania discussion on the North West Private Hospital.

Former Paragraph 2.9 to be moved to discussion of North West maternity services.

New Paragraph 2.10 deferred.

Former Paragraphs 2.11 – 2.15 to be moved to relevant sections of the Report.

Chapter 3: Adequacy, Accessibility and Safety of Reproductive Health Services

Paragraph 3.1 agreed to as amended.

Paragraph 3.2 agreed to as amended.

Paragraph 3.3 agreed to as amended.

Paragraphs 3.4 - 3.11 agreed to.

Paragraph 3.12 agreed to as amended.

Paragraphs 3.13 and 3.14 agreed to.

Paragraph 3.15 agreed to as amended.

Paragraph 3.16 agreed to as amended.

Former Paragraphs 3.17 - 3.19 to be moved to Chapter 4.

New subsection heading included before new Paragraph 3.19: 'Surrogacy.'

New Paragraph 3.19 agreed to as amended.

New Paragraph 3.20 agreed to as amended.

New Paragraph 3.21 agreed to as amended.

Former Paragraphs 3.23 and 3.24 moved to be new Paragraphs 3.17 and 3.18.

Suspension of sitting from 10.49 a.m. – 11.02 a.m.

All Members present.

New Paragraphs 3.22 and 3.23 agreed to.

New Paragraph 3.25 agreed to as amended.

New Paragraph 3.26 agreed to as amended.

New Paragraph 3.27 agreed to as amended.

New Paragraph 3.28 agreed to as amended.

New Paragraph 3.29 agreed to as amended.

New Paragraphs 3.30 and 3.31 agreed to.

New Paragraph 3.33 agreed to.

New Paragraph 3.35 agreed to as amended.

New Paragraphs 3.36 and 3.37 agreed to.

Agreed to rearrange subsections so 'Objectors and Coercion' appears before 'Community understanding of Terminations.' The new paragraph numbers below reflect this change.

New Paragraphs 3.38 - 3.40 agreed to.

New Paragraph 3.41 agreed to as amended.

New Paragraph 3.42 agreed to as amended.

New Paragraph 3.43 agreed to as amended.

New Paragraph 3.44 agreed to as amended.

New Paragraph 3.45 agreed to as amended.

New Paragraph 3.46 agreed to as amended.

New Paragraph 3.47 agreed to as amended.

Former Paragraph 3.44 agreed to as amended and moved to be new Paragraph 3.32.

Former Paragraph 3.45 agreed to and moved to be new Paragraph 3.24.

New Paragraph 3.48 agreed to as amended.

Former Paragraph 3.52 split. All words from 'The other thing' to 'pregnancy loss at any point' to form New Paragraph 3.49. All other words from 'I recently had' to 'is very poor,' to be moved to Chapter 4.

New Paragraph 3.49 agreed to as amended.

New Paragraph 3.50 agreed to.

Findings

The findings were considered and amendments made.

Recommendations

The recommendations were considered and amendments made.

ANY OTHER MATTERS

No other matters raised.

At 12:31 p.m. the Committee adjourned until 9:00 a.m. on Thursday 16 October 2025.

Confirmed,

THURSDAY, 16 October 2025

The Committee met at Parliament House Hobart and via Microsoft Teams, at 9.02 a.m.

In Committee Room 3

Ms *Haddad*
Ms *Johnston*
Ms *Rosol*

Via Microsoft Teams:

Ms *Dow*
Mr *Fairs*

APOLOGIES

There were no apologies.

CONSIDERATION OF CHAIR'S DRAFT REPORT

The Committee considered the Chair's draft Report.

The Committee reconsidered the following Paragraphs:

Paragraph 1.24 reconsidered and agreed to as amended.

New Paragraph 1.40 inserted and agreed to as amended.

Paragraph 2.5 reconsidered and agreed to as amended.

New Paragraph 2.7 inserted and agreed to.

New Paragraph 2.8 reconsidered and agreed to as amended.

Paragraph 3.24 reconsidered and deferred for further consideration, including a potential data subsection in the Report.

New Paragraph 3.32 inserted and agreed to.

New placement of Finding 13 agreed to.

Chapter 3: Adequacy, Accessibility and Safety of Reproductive Health Services

Recommendations

At 10.08 a.m. Ms *Dow* joined the meeting via Microsoft Teams.

The recommendations were considered and amendments made.

Suspension of sitting from 10.12 a.m. to 10.18 a.m.

Members present – Ms *Dow*, Mr *Fairs,* Ms *Haddad* and Ms *Rosol*.

Chapter 4: Adequacy, Accessibility and Safety of Reproductive Maternal Health Services

Paragraphs 4.1 – 4.3 agreed to.

Paragraph 4.4 agreed to as amended.

Paragraph 4.5 agreed to as amended.

Paragraph 4.6 agreed to as amended.

Paragraph 4.7 agreed to as amended.

Paragraph 4.8 agreed to as amended.

Paragraph 4.9 agreed to.

Paragraph 4.10 agreed to.

Paragraph 4.11 agreed to as amended.

Paragraph 4.12 agreed to as amended.

Paragraph 4.13 agreed to.

Paragraph 4.14 agreed to as amended.

Paragraph 4.15 agreed to as amended.

Paragraph 4.16 agreed to as amended.

Paragraph 4.17 agreed to as amended.

Paragraph 4.18 agreed to as amended.

Paragraph 4.19 agreed to as amended.

Former Paragraph 4.20 removed as a stand alone Paragraph, moved instead to appear as second last section of Paragraph 4.19.

New Paragraphs 4.20 and 4.21 agreed to.

New Paragraph 4.22 agreed to as amended.

New Paragraph 4.23 agreed to.

Former Paragraph's 4.25 – 4.27 removed to be included in a later chapter of the Report.

New Paragraph 4.24 agreed to as amended.

New Paragraph 4.25 agreed to.

New Paragraph 4.26 agreed to as amended.

New Paragraph 4.27 agreed to as amended.

New Paragraph 4.28 agreed to as amended.

New Paragraph 4.29 agreed to.

New Paragraph 4.30 agreed to as amended.

New Paragraph 4.31 agreed to.

New Paragraph 4.32 agreed to as amended.

New Paragraph 4.33 agreed to as amended.

New Paragraph 4.34 deferred for further consideration.

New Paragraphs 4.35 and 4.36 agreed to.

New Paragraph 4.37 agreed to as amended.

New Paragraph 4.38 agreed to as amended.

New Paragraph 4.39 agreed to as amended.

New Paragraph 4.40 deferred for further consideration.

New Paragraph 4.41 agreed to as amended.

New Paragraph 4.42 agreed to as amended.

New Paragraph 4.43 agreed to as amended.

New Paragraphs 4.44 and 4.45 agreed to.

New Paragraph 4.46 agreed to as amended.

New Paragraph 4.47 agreed to.

New Paragraph 4.48 agreed to as amended.

Former Paragraph 4.53 removed.

Suspension of sitting from 1p.m. to 2:08 p.m.

Members present – Ms *Haddad*, Ms *Johnston*, Ms *Rosol*.

New Paragraph 4.49 agreed to as amended.

New Paragraph 4.50 agreed to as amended.

New Paragraph 4.51 agreed to, being former Paragraph 4.60.

New Paragraph 4.52 agreed to as amended.

New Paragraph 4.53 agreed to as amended.

New Paragraph 4.54 agreed to as amended.

New Paragraph 4.55 agreed to as amended.

New Paragraph 4.56 agreed to as amended.

At 2.29 p.m. Mr *Fairs* joined the meeting via Microsoft Teams.

New Paragraph 4.57 agreed to.

New Paragraph 4.58 agreed to as amended.

New Paragraph 4.59 agreed to as amended.

New Paragraph 4.60 agreed to as amended.

New Paragraph 4.61 agreed to as amended.

New Paragraph 4.62 agreed to as amended.

Subheading amended from 'Access to maternal health services for different identity groups' to 'Minority group access to maternal health services.'

New Paragraph 4.63 agreed to as amended.

New Paragraph 4.64 agreed to.

New Paragraph 4.65 agreed to as amended.

New Paragraph 4.66 agreed to as amended.

New Paragraph 4.67 agreed to as amended.

New Paragraph 4.68 agreed to as amended.

New Paragraph 4.69 agreed to as amended.

New Paragraph 4.70 agreed to as amended.

New Paragraph 4.71 agreed to as amended.

At 3.02 p.m. Ms *Dow* returned to the meeting via Microsoft Teams.

New Paragraph 4.72 agreed to as amended.

New Paragraph 4.73 agreed to as amended.

New Paragraph 4.74 agreed to.

New Paragraph 4.75 agreed to as amended.

At 3.26 p.m. Mr *Fairs* withdrew.

New Paragraph 4.76 agreed to as amended.

New Paragraph 4.77 agreed to.

New Paragraph 4.78 agreed to as amended.

Suspension of sitting from 3.47 p.m. to 3.52 p.m.

Members present: Ms *Dow*, Ms *Haddad*, Ms *Johnston* and Ms *Rosol.*

New Paragraph 4.79 agreed to as amended.

New Paragraph 4.80 agreed to as amended.

New Paragraphs 4.81 – 4.83 agreed to.

New Paragraph 4.84 agreed to as amended.

New Paragraph 4.85 agreed to as amended.

New Paragraphs 4.86 – 4.88 agreed to.

New Paragraph 4.89 agreed to as amended.

New Paragraph 4.90 agreed to as amended.

New Paragraph 4.91 agreed to as amended.

New Paragraph 4.92 agreed to as amended.

New Paragraphs 4.93 – 4.96 agreed to.

New Paragraph 4.97 agreed to as amended.

New Paragraphs 4.98 – 4.102 agreed to.

ANY OTHER MATTERS

No other matters raised.

At 4.30 p.m. the Committee adjourned until 9:00 a.m. on Monday 20 October 2025.

Confirmed,

MONDAY, 20 October 2025

The Committee met at Parliament House Hobart and via Microsoft Teams, at 9.26 a.m.

In Committee Room 3

Ms *Haddad*
Ms *Johnston*
Ms *Rosol*

Via Microsoft Teams:

Ms *Dow*
Mr *Fairs*

APOLOGISES

No apologies.

CONSIDERATION OF CHAIR'S DRAFT REPORT

The Committee considered the Chair's draft Report.

<u>Chapter 4: Adequacy, Accessibility and Safety of Reproductive Maternal Health Services</u>

Paragraph 4.103 agreed to.

Paragraph 4.104 agreed to as amended.

Paragraph 4.105 agreed to.

Paragraph 4.106 agreed to as amended.

Paragraph 4.107 agreed to as amended.

Paragraphs 4.108 – 4.111 agreed to.

Paragraph 4.112 agreed to as amended.

Paragraph 4.113 deferred.

Paragraphs 4.114 and 4.115 agreed to.

Paragraph 4.116 agreed to as amended,

Paragraphs 4.117 and 4.118 agreed to.

Paragraph 4.119 agreed to as amended.

Paragraph 4.120 agreed to.

Paragraph 4.121 agreed to as amended.

Paragraph 4.122 agreed to as amended.

Paragraph 4.123 agreed to as amended.

Paragraph 4.124 agreed to as amended.

Paragraph 4.125 agreed to as amended.

Paragraph 4.126 agreed to as amended, splitting former paragraph into two.

New Paragraph 4.127 agreed to as amended.

New Paragraph 4.128 agreed to as amended.

Agreed to rearrange 'Birth plans' and 'Doulas' sections, with 'Birth plans' appearing first.

New Paragraph 4.129 agreed to as amended.

New Paragraph 4.130 agreed to as amended.

New Paragraph 4.131 agreed to as amended.

New Paragraph 4.132 agreed to as amended.

New Paragraph 4.133 agreed to.

New Paragraph 4.134 agreed to as amended.

New Paragraph 4.135 agreed to as amended.

New Paragraph 4.136 agreed to as amended.

Suspension of sitting from 11a.m. – 11:12a.m.

All Members present.

New Paragraph 4.137 agreed to as amended.

New Paragraph 4.138 agreed to as amended.

New Paragraph 4.139 agreed to as amended.

New Paragraph 4.140 agreed to as amended.

New Paragraph 4.141 deferred.

New Paragraph 4.142 agreed to as amended.

New Paragraph 4.143 agreed to as amended.

Former Paragraph 4.130 removed.

Subheading amended from 'Education and resources regarding maternal healthcare' to 'Education and resources.'

New Paragraph 4.144 agreed to as amended.

New Paragraph 4.145 agreed to as amended.

New Paragraph 4.146 agreed to as amended.

New Paragraph 4.147 agreed to as amended.

New Paragraph 4.148 agreed to as amended.

New Paragraph 4.149 agreed to as amended.

New Paragraph 4.150 agreed to as amended.

New Paragraph 4.151 agreed to.

New Paragraph 4.152 agreed to as amended.

New Paragraph 4.153 agreed to as amended.

New Paragraph 4.154 agreed to as amended.

New Paragraph 4.155 agreed to as amended.

New Paragraph 4.156 agreed to as amended.

New Paragraph 4.157 agreed to as amended.

New Paragraph 4.158 agreed to as amended.

New Paragraph 4.159 agreed to as amended.

New Paragraph 4.160 agreed to as amended.

New Paragraph 4.161 agreed to as amended.

New Paragraph 4.162 agreed to as amended.

New Paragraph 4.163 agreed to as amended.

New Paragraph 4.164 agreed to as amended.

New Paragraph 4.165 agreed to.

New Paragraph 4.166 agreed to as amended.

New Paragraph 4.167 agreed to as amended.

New Paragraph 4.168 agreed to as amended.

New Paragraphs 4.169 and 4.170 agreed to.

New Paragraph 4.171 agreed to.

Remove subheading reading 'Resources for parents' and replace with 'Navigating maternal health services.'

At 1.04 p.m. Ms *Dow* withdrew.

Findings and Recommendations deferred.

Chapter 5: Homebirth and Professional Indemnity Insurance

Paragraph 5.1 agreed to as amended.

Paragraph 5.2 agreed to.

Paragraph 5.3 agreed to as amended.

New Paragraph 5.4 agreed to as amended.

New Paragraph 5.5 agreed to as amended.

New Paragraph 5.6 agreed to as amended.

New Paragraph 5.7 agreed to as amended.

Remove subheading 'Homebirth context.'

New Paragraph 5.8 agreed to as amended.

New Paragraph 5.9 agreed to as amended.

New Paragraph 5.10 agreed to as amended.

New Paragraph 5.11 agreed to as amended.

New Paragraph 5.12 agreed to as amended.

New Paragraph 5.13 agreed to as amended.

New Paragraph 5.14 agreed to as amended.

New Paragraph 5.15 agreed to as amended.

New Paragraph 5.16 agreed to as amended.

New Paragraph 5.17 agreed to as amended.

Remove subheading 'Access to homebirth in Tasmania.'

New Paragraph 5.18 agreed to as amended.

ANY OTHER MATTERS

No other matters raised.

At 2:00 p.m. the Committee adjourned until 9:00 a.m. on Tuesday 21 October 2025.

Confirmed,

TUESDAY, 21 October 2025

The Committee met at Parliament House Hobart and via Microsoft Teams, at 9.05 a.m.

In Committee Room 3

Ms *Haddad*
Ms *Johnston*

Via Microsoft Teams:

Ms *Dow*
Mr *Fairs*
Ms *Rosol*

APOLOGISES

No apologises.

CORRESPONDENCE

The Committee discussed the outstanding update from the Hon. Bridget *Archer* MP, Minister for Health, Mental Health and Wellbeing and the Department of Health. Noted email correspondence from Minister *Archer's* office confirming that the update will be ready for the Committee this week.

CONSIDERATION OF CHAIR'S DRAFT REPORT

The Committee considered the Chair's draft Report.

Noted the Committee's following preferences for consistency throughout the Report:

- The pronouns of Private Witnesses can be used;
- All witnesses or submitters are to be introduced in full for their first appearance in the report and then via prefix, last name and title for each subsequent use; and
- Organisations be reintroduced in full in each chapter of the Report.

At 9.10 a.m. Ms *Dow* joined the meeting via Microsoft Teams.

Chapter 4: Adequacy, Accessibility and Safety of Reproductive Maternal Health Services

Findings

The findings were considered and amendments made.

Suspension of sitting from 11.05 a.m. to 11.21 a.m.

Members present – Ms *Dow*, Ms *Haddad*, Ms *Johnston* and Ms *Rosol*.

Recommendations

The recommendations were considered and amendments made.

At 11.39 a.m. Mr *Fairs* joined the meeting via Microsoft Teams.

Chapter 5: Homebirth and Professional Indemnity Insurance

Paragraph 5.18 agreed to as amended.

Paragraph 5.19 agreed to.

Former Paragraph 5.20 agreed to as amended and moved to be new Paragraph 5.24.

New Paragraphs 5.20 and 5.21 agreed to.

New Paragraph 5.22 agreed to as amended.

New Paragraph 5.23 agreed to as amended.

New Paragraphs 5.25 and 5.26 agreed to.

New Paragraph 5.27 agreed to as amended.

New Paragraph 5.28 agreed to as amended.

New Paragraph 5.29 agreed to as amended.

New Paragraph 5.30 agreed to as amended.

New Paragraph 5.31 agreed to as amended, with all words from 'Homebirth is' to 'reducing birth trauma,' removed to be added as a new paragraph in Chapter 6.

Suspension of sitting from 12.28 p.m. to 1.35 p.m.

All Members present.

New Paragraph 5.32 agreed to as amended.

New Paragraph 5.33 agreed to as amended.

New Paragraph 5.34 agreed to as amended.

New Paragraph 5.35 agreed to as amended.

New Paragraph 5.36 agreed to as amended.

New Paragraph 5.37 agreed to as amended.

New Paragraph 5.38 agreed to.

New Paragraph 5.39 agreed to as amended.

New Paragraph 5.40 agreed to.

New Paragraph 5.41 agreed to as amended.

New Paragraph 5.42 agreed to as amended.

New Paragraph 5.43 agreed to as amended.

New Paragraph 5.44 agreed to as amended.

New Paragraph 5.45 agreed to as amended.

New Paragraph 5.46 agreed to as amended.

New Paragraph 5.47 agreed to.

New Paragraph 5.48 inserted and agreed to.

New Paragraph 5.49 agreed to as amended.

New Paragraph 5.50 agreed to as amended.

New Paragraph 5.51 agreed to as amended.

New Paragraph 5.52 agreed to as amended.

At 2.27 p.m. Ms *Johnston* withdrew.

Former Paragraph 5.52 split into 2 new Paragraphs, 5.53 and 5.54.

New Paragraph 5.53 agreed to as amended.

New Paragraph 5.54 agreed to as amended.

New Paragraph 5.55 agreed to as amended.

New Paragraph 5.56 agreed to as amended.

New Paragraph 5.57 agreed to as amended.

New Paragraph 5.58 agreed to as amended.

Suspension of sitting from 3.04 p.m. to 3.26 p.m.

Members present – Ms *Dow*, Mr *Fairs*, Ms *Haddad* and Ms *Rosol*.

New Paragraph 5.59 agreed to as amended.

New Paragraph 5.60 agreed to.

New Paragraph 5.61 agreed to as amended.

New Paragraph 5.62 agreed to as amended.

New Paragraph 5.63 agreed to.

Former Paragraph's 5.62 and 5.63 merged as new Paragraph 5.64, with introduction of former Paragraph 5.63 removed.

New Paragraph 5.65 agreed to.

At 3.49 p.m. Ms *Johnston* resumed her seat at the table.

Former Paragraph's 5.65 and 5.66 summarised and merged as new Paragraph 5.66.

New Paragraph 5.66 agreed to as amended.

New Paragraph 5.67 agreed to as amended.

Former Paragraph 5.68 removed.

Findings

Findings 49 – 56 considered and amended.

ANY OTHER MATTERS

No other matters raised.

At 4:34 p.m. the Committee adjourned until 9:00 a.m. on Friday 31 October 2025.

Confirmed,

FRIDAY, 31 October 2025

In Committee Room 1

Ms *Dow*
Ms *Haddad*
Ms *Johnston*

Via Microsoft Teams:

Ms *Rosol*

APOLOGISES

Mr *Fairs* was an apology.

CORRESPONDENCE

The Committee received and resolved to publish the following correspondence:

- Updated information from the Hon. Bridget *Archer* MP, Minister for Health, Mental Health and Wellbeing, dated 27 October 2025 (Ms *Johnston*).

CONSIDERATION OF CHAIR'S DRAFT REPORT

The Committee considered the Chair's draft Report.

Chapter 5: Homebirth and Professional Indemnity Insurance

Findings

The findings were considered and amendments made.

Recommendations

The recommendations were considered and amendments made.

Chapter 6: Experiences with Birth Trauma

Paragraph 6.1 agreed to as amended.

Paragraph 6.2 agreed to as amended.

Paragraph 6.3 agreed to as amended.

Paragraph 6.4 agreed to as amended.

Paragraph 6.5 agreed to as amended.

Noted potential consideration to be given to the title of the Chapter. 'Experiences with Birth Related Trauma' proposed as a potential alternate title.

The Committee discussed the structure of Chapter 6. Agreed to reorder the beginning of the Chapter so that paragraphs which formally appeared in the 'Defining birth trauma in the Tasmanian context,' subsection which detail data on the prevalence of birth trauma be moved to the next subsection 'Experiences of birth trauma in Tasmania.'

Paragraphs relating to the physical, psychological and joint definitions of birth trauma which were formally found in the latter mentioned subsection moved up to

the ‘Defining birth trauma in the Tasmanian context’ section.

New Paragraph 6.6 agreed to.

New Paragraph 6.7 agreed to as amended.

New Paragraph 6.8 agreed to as amended.

New Paragraph 6.9 agreed to as amended.

New Paragraph 6.10 agreed to as amended.

New Paragraph 6.11 agreed to as amended.

New Paragraph 6.12 agreed to as amended.

New Paragraph 6.13 agreed to as amended.

New Paragraph 6.14 agreed to as amended.

New Paragraph 6.15 agreed to as amended.

New Paragraph 6.16 agreed to as amended.

New Paragraph 6.17 agreed to as amended.

New Paragraph 6.18 agreed to as amended.

New Paragraph 6.19 agreed to as amended.

New Paragraph 6.20 agreed to as amended.

New Paragraph 6.21 agreed to as amended.

New Paragraph 6.22 agreed to as amended.

New Paragraph 6.23 agreed to as amended.

Suspension of sitting from 10.41a.m. to 10.54 a.m.

Members Present: Ms *Dow*, Ms *Haddad* and Ms *Johnston.*

New Paragraph 6.24 agreed to as amended.

New Paragraph 6.25 agreed to as amended.

New Paragraph 6.26 agreed to as amended.

New Paragraph 6.27 agreed to as amended.

New Paragraph 6.28 agreed to as amended.

New Paragraph 6.29 agreed to as amended.

New Paragraph 6.30 agreed to as amended.

New Paragraph 6.31 agreed to as amended.

New Paragraph 6.32 agreed to as amended.

New Paragraphs 6.33 and 6.34 agreed to.

New Paragraph 6.35 agreed to as amended.

New Paragraph 6.36 agreed to.

New Paragraph 6.37 agreed to as amended.

New Paragraph 6.38 agreed to as amended.

New Paragraphs 6.39 and 6.40 agreed to.

New Paragraph 6.41 agreed to as amended.

New paragraph 6.42 agreed to as amended.

New Paragraph 6.43 agreed to.

New Paragraph 6.44 agreed to as amended.

New Paragraph 6.45 agreed to as amended.

New Paragraph 6.46 agreed to as amended.

New Paragraph 6.47 agreed to as amended.

New Paragraph 6.48 agreed to.

New Paragraph 6.49 agreed to as amended.

New Paragraph 6.50 agreed to.

New Paragraph 6.51 agreed to as amended.

New Paragraph 6.52 partially considered and deferred.

New Paragraph 6.21 agreed to.

New Paragraph 6.22 agreed to as amended.

New Paragraph 6.23 agreed to as amended.

ANY OTHER MATTERS

No other matters raised.

At 12:00 p.m. the Committee adjourned until a later date and time.

Confirmed,

TUESDAY, 27 Janaury 2026

The Committee met at Parliament House, Hobart, and via Microsoft Teams, at 9.05 a.m.

In Committee Room 3

Ms *Haddad*
Ms *Johnston*

Via Microsoft Teams:

Ms *Dow*
Mr *Fairs*
Ms *Rosol*

APOLOGISES

There were no apologises.

MINUTES

The minutes of the meetings of the Committee held on 15 October 2025, 16 October 2025, 20 October 2025, 21 October 2025 and 31 October 2025 were adopted as an accurate record (Ms *Johnston*).

CORRESPONDENCE

The Committee received and noted the following correspondence (Ms *Haddad*):

a. Correspondence from the Australian College of Rural and Remote Medicine Limited dated 30 October 2025;
b. Forwarded correspondence from the AMA Tasmania dated 4 November 2025.

Resolved, to publish the correspondence from the Australian College of Rural and Remote Medicine (Ms *Haddad*)

CONSIDERATION OF CHAIR'S DRAFT REPORT

The Committee considered the Chair's draft Report.

Chapter 6: Experiences with Birth Trauma

Paragraph 6.53 agreed to as amended.

Paragraph 6.54 agreed to as amended.

At 9.16 a.m. Ms *Dow* joined the meeting via Microsoft Teams.

Paragraphs 6.55 – 6.57 agreed to.

Paragraph 6.58 agreed to as amended.

Paragraph 6.59 agreed to as amended.

Paragraph 6.60 agreed to as amended.

Paragraph 6.61 agreed to as amended.

Paragraph 6.62 agreed to as amended.

Paragraph 6.63 agreed to as amended.

Paragraph 6.64 agreed to as amended.

Paragraph 6.65 agreed to as amended.

Paragraph 6.66 agreed to as amended.

Paragraph 6.67 agreed to as amended.

Paragraph 6.68 agreed to as amended.

Paragraph 6.69 agreed to as amended.

Paragraph 6.70 agreed to as amended.

Paragraph 6.71 agreed to as amended.

Paragraph 6.72 agreed to as amended.

Paragraph 6.73 agreed to as amended.

At 10.21 a.m. Ms *Rosol* withdrew from the Table and returned at 10.23 a.m.

Paragraph 6.74 agreed to as amended.

Paragraph 6.75 agreed to as amended.

Paragraph 6.76 agreed to as amended.

Former Paragraph 6.77 agreed to as amended and moved to be new Paragraph 6.73.

New Paragraph 6.78 agreed to as amended.

New Paragraph 6.79 agreed to as amended.

New Paragraph 6.80 agreed to as amended.

New Paragraph 6.81 agreed to.

New Paragraph 6.82 agreed to as amended.

New Paragraph 6.83 agreed to as amended.

New Paragraph 6.84 agreed to.

New Paragraph 6.85 agreed to as amended.

New Paragraph 6.86 agreed to as amended.

New Paragraph 6.87 agreed to as amended.

New Paragraph 6.88 agreed to as amended.

New Paragraph 6.89 agreed to as amended.

Suspension of sitting from 11.25 a.m. to 11.37 a.m.

New Former Paragraph 6.90 agreed to as amended and relocated to be new Paragraph 6.74.

New Paragraph 6.91 agreed to as amended.

New Paragraph 6.92 agreed to as amended.

New Paragraph 6.93 agreed to as amended.

New Former Paragraph 6.94 agreed to as amended and moved to be New Paragraph 6.84.

Subsection 'Intervention and Risk' moved to appear above Subsection 'Consent and Informed Consent,' leading to consequential changes in the numbering of Paragraph's.

New Paragraph 6.95 agreed to as amended.

New Paragraph 6.96 agreed to.

New Paragraph 6.97 agreed to as amended.

New Paragraph 6.98 agreed to as amended.

New Paragraph 6.99 agreed to as amended.

New Paragraph 6.100 agreed to as amended.

New Paragraph 6.101 agreed to as amended.

New Paragraph 6.102 agreed to as amended.

New Paragraph 6.103 agreed to as amended.

New Paragraph 6.104 agreed to as amended.

Former New Paragraph 6.105 removed.

New Paragraph 6.105 agreed to as amended.

New Paragraph 6.106 agreed to as amended.

New Paragraph 6.107 agreed to as amended.

New Paragraph 6.108 agreed to as amended.

New Paragraph 6.109 agreed to as amended.

New Paragraph 6.110 agreed to as amended.

New Paragraph 6.111 agreed to as amended.

Former New Paragraphs 6.112 – 6.113 removed.

New Paragraph 6.112 agreed to as amended.

New Paragraph 6.113 agreed to as amended.

New Paragraph 6.114 agreed to as amended.

New Paragraph 6.115 agreed to.

New Paragraph 6.116 agreed to as amended.

Former New Paragraph 6.117 merged with New Paragraph 6.116.

New Paragraph 6.117 agreed to as amended.

New Paragraph 6.118 agreed to as amended.

New Paragraph 6.119 agreed to as amended.

ANY OTHER MATTERS

No other matters raised.

At 1:02 p.m. the Committee adjourned until 9 a.m., Tuesday 17 February 2026.

Confirmed,

TUESDAY, 17 February 2026

The Committee met at Parliament House, Hobart, and via Microsoft Teams, at 9.09 a.m.

In Committee Room 3

Ms *Dow*
Ms *Haddad*
Ms *Johnston*

Via Microsoft Teams:

Ms *Rosol*

APOLOGISES

Mr *Fairs* was an apology.

MINUTES

The minutes of the last meeting of the Committee held on 27 January 2026 were adopted as an accurate record (Ms *Johnston*).

CONSIDERATION OF CHAIR'S DRAFT REPORT

The Committee considered the Chair's draft Report.

Chapter 6: Experiences with Birth Trauma

Paragraph 6.119 agreed to as amended.

Paragraph 6.120 agreed to.

Paragraph 6.121 agreed to as amended.

Paragraphs 6.122 and 6.123 agreed to.

Paragraph 6.124 agreed to as amended.

Paragraphs 6.125 and 6.126 agreed to.

Paragraph 6.127 agreed to as amended.

Paragraph 6.128 agreed to as amended.

Paragraph 6.129 agreed to.

Paragraph 6.130 agreed to as amended.

Paragraph 6.131 agreed to.

Paragraph 6.132 agreed to as amended.

Paragraph 6.133 agreed to.

Findings

The findings were considered and amendments made.

Recommendations

The recommendations were considered and amendments made.

At 10.21 a.m. Ms *Haddad* withdrew from the Table and returned at 10.25 a.m.

At 10.26 a.m. Ms *Dow* withdrew from the Table.

Suspension of sitting from 10.27 a.m. to 10.36 a.m.

All Members present.

Chapter 7: Adequacy, Accessibility and Safety of Perinatal Mental Health Services

Paragraphs 7.1 – 7.9 agreed to.

Paragraph 7.10 agreed to as amended.

Paragraph 7.11 agreed to as amended.

Paragraph 7.12 agreed to as amended.

Paragraph 7.13 agreed to as amended.

Paragraph 7.14 agreed to as amended.

Paragraph 7.15 agreed to.

Paragraph 7.16 agreed to as amended.

Paragraphs 7.17 and 7.18 agreed to.

Paragraph 7.19 agreed to as amended.

Paragraphs 7.20 – 7.22 agreed to.

Paragraph 7.23 agreed to as amended.

Paragraph 7.24 agreed to.

Former Paragraph 7.25 removed.

Former Paragraph 7.26 removed.

New Paragraph 7.25 agreed to, including content merged from former Paragraphs 7.25 and 7.26.

New Paragraph 7.26 agreed to as amended.

New Paragraph 7.27 agreed to as amended.

New Paragraph 7.28 agreed to as amended.

New Paragraph 7.29 agreed to as amended.

New Paragraph 7.30 agreed to as amended.

New Paragraph 7.31 agreed to as amended.

ANY OTHER MATTERS

No other matters raised.

At 12:03 p.m. the Committee adjourned until 9 a.m., Tuesday 18 February 2026.

Confirmed,

WEDNESDAY, 18 February 2026

The Committee met at Parliament House, Hobart, and via Microsoft Teams, at 9.06 a.m.

In Committee Room 3

Ms *Haddad*

Ms *Johnston*

Via Microsoft Teams:

Ms *Dow*
Mr *Fairs*
Ms *Rosol*

APOLOGISES

There were no apologises.

CONSIDERATION OF CHAIR'S DRAFT REPORT

The Committee considered the Chair's draft Report.

Chapter 7: Adequacy, Accessibility and Safety of Perinatal Mental Health Services

Paragraph 7.32 agreed to as amended.

Paragraph 7.33 agreed to as amended.

Paragraph 7.34 agreed to as amended.

Paragraph 7.35 agreed to as amended.

Paragraph 7.36 agreed to.

Paragraph 7.37 agreed to as amended.

Paragraph 7.38 agreed to.

At 9.27 a.m. Ms *Haddad* withdrew from the Table and returned at 9.34 a.m.

Paragraph 7.39 agreed to.

Paragraph 7.40 agreed to.

Paragraph 7.41 agreed to.

Paragraph 7.42 agreed to as amended.

Paragraph 7.43 agreed to.

Paragraph 7.44 agreed to.

Paragraph 7.45 agreed to as amended.

Paragraph 7.46 agreed to as amended.

Paragraph 7.47 agreed to as amended.

Paragraph 7.48 agreed to as amended.

Paragraph 7.49 agreed to as amended.

Paragraphs 7.50 and 7.51 agreed to.

Paragraph 7.52 agreed to as amended.

Paragraphs 7.53 - 7.55 agreed to.

Paragraph 7.56 agreed to as amended.

Paragraph 7.57 agreed to as amended.

Paragraph 7.58 agreed to as amended.

Paragraph 7.59 agreed to as amended.

Paragraph 7.60 agreed to as amended.

Paragraph 7.61 agreed to as amended.

Paragraph 7.62 agreed to.

Suspension of sitting from 10.31 a.m. to 10.46 a.m.

Members present: Ms *Dow*, Ms *Haddad*, Ms *Johnston* and Ms *Rosol*.

Paragraph 7.67 agreed to as amended.

Paragraph 7.68 agreed to as amended.

Former Paragraph 6.70 removed, with content moved to Paragraph 7.69.

Paragraph 7.69 agreed to as amended.

New Paragraph 7.70 agreed to as amended, CALD recommendation removed for insertion into Chapter 9.

Former New Paragraph 7.71 removed.

New Paragraph 7.71 agreed to as amended.

New Paragraph 7.72 agreed to as amended.

New Paragraph 7.73 agreed to as amended.

New Paragraph 7.74 agreed to.

New Paragraph 7.75 agreed to as amended.

New Paragraph 7.76 agreed to.

New Paragraph 7.77 agreed to as amended.

New Paragraph 7.78 agreed to as amended.

New Paragraph 7.79 agreed to as amended.

New Paragraph 7.80 agreed to as amended.

Findings

The findings were considered and amendments made.

Suspension of sitting from 12.30 p.m. to 1.36 p.m.

All Members present.

Recommendations

The recommendations were considered and amendments made.

Chapter 8: Adequacy, Accessibility and Safety of Perinatal Mental Health Services

Paragraphs 8.1 - 8.4 agreed to.

At 2.24 p.m. Mr *Fairs* withdrew.

Paragraph 8.4 agreed to as amended.

Paragraphs 8.5 – 8.12 agreed to.

Paragraph 8.13 agreed to as amended.

Paragraph 8.14 agreed to as amended.

Paragraph 8.15 agreed to as amended.

Paragraph 8.16 agreed to.

Paragraph 8.17 agreed to as amended.

Paragraph 8.18 agreed to.

Suspension of sitting from 2.53 p.m. to 2.59 p.m.

Members present: Ms *Dow*, Ms *Haddad*, Ms *Johnston* and Ms *Rosol.*

Paragraph 8.19 agreed to as amended.

Resolved, that in each instance within which Mrs *Petrusma* appears in the Hansard as a Member of the Committee, a footnote is provided to confirm her capacity as a Member at that time.

Former Paragraph 8.20 agreed to as amended.

Former Paragraph 8.21 agreed to as amended.

Former Paragraph 8.22 agreed to as amended.

Former Paragraph 8.23 agreed to as amended, with second Paragraph moved to be New Paragraph 8.20.

Former New Paragraph 8.25 removed.

Former New Paragraphs 8.26 – 8.27 removed.

New Paragraph 8.25 agreed to as amended.

ANY OTHER MATTERS

No other matters raised.

At 3.53 p.m. the Committee adjourned until 9 a.m., Monday 23 February 2026.

Confirmed,

MONDAY, 23 February 2026

The Committee met at Parliament House, Hobart, and via Microsoft Teams, at 9.07 a.m.

In Committee Room 3

Ms *Haddad*
Ms *Johnston*

Via Microsoft Teams:

Ms *Dow* (from 10.13 a.m.)
Ms *Rosol*

APOLOGISES

Mr *Fairs* was an apology.

MINUTES

The minutes of the meetings of the Committee held on 17 February 2026 and 18 February 2026 were adopted as an accurate record (Ms *Johnston*).

CONSIDERATION OF CHAIR'S DRAFT REPORT

The Committee considered the Chair's draft Report.

Chapter 8: Adequacy, Accessibility and Safety of Perinatal Mental Health Services

Paragraph 8.26 agreed to as amended.

Paragraph 8.27 agreed to.

Paragraph 8.28 agreed to as amended.

Paragraph 8.29 agreed to as amended.

Paragraph 8.30 agreed to as amended.

Paragraph 8.31 agreed to as amended.

Paragraph 8.32 agreed to.

Paragraph 8.33 agreed to as amended.

Inserted New Paragraph 8.34 agreed to.

New Paragraph 8.35 agreed to as amended.

New Paragraph 8.36 agreed to as amended.

New Paragraph 8.37 agreed to as amended.

New Paragraphs 8.38 and 8.39 agreed to.

New Paragraph 8.40 agreed to as amended.

New Paragraphs 8.41 and 8.42 agreed to.

New Paragraph 8.43 agreed to as amended.

New Paragraph 8.44 agreed to as amended.

New Paragraph 8.45 agreed to.

New Paragraph 8.46 agreed to as amended.

New Paragraph 8.47 agreed to as amended.

New Paragraph 8.48 agreed to as amended.

New Paragraph 8.49 agreed to as amended.

At 10.13 a.m. Ms *Dow* joined the Table via Microsoft Teams.

New Paragraph 8.50 agreed to as amended.

Sitting suspended from 10.32 a.m. – 10.44 a.m.

All Members present.

New Paragraph 8.51 agreed to.

New Paragraph 8.52 agreed to as amended.

New Paragraph 8.53 agreed to as amended.

New Paragraph 8.54 agreed to as amended.

New Paragraph 8.55 agreed to as amended.

New Paragraph 8.56 agreed to as amended.

New Paragraph 8.57 agreed to as amended.

New Paragraph 8.58 agreed to as amended.

New Paragraph 8.59 agreed to as amended.

New Paragraph 8.60 agreed to.

New Paragraph 8.61 agreed to as amended.

New Paragraph 8.62 agreed to as amended.

Inserted New Paragraph 8.63 agreed to.

New Paragraph 8.64 agreed to as amended.

New Paragraph 8.65 agreed to as amended.

New Paragraph 8.66 agreed to as amended.

Sitting suspended from 12 p.m. – 12.53 p.m.

All Members present.

Findings

The findings were considered and amendments made.

Recommendations

The recommendations were considered and amendments made.

<u>Chapter 9: Education and Workforce</u>

Paragraph 9.1 agreed to as amended.

Paragraph 9.2 agreed to as amended.

Paragraph 9.3 agreed to as amended.

Paragraph 9.4 agreed to.

Paragraph 9.5 agreed to as amended.

Paragraphs 9.6 – 9.8 agreed to.

Paragraph 9.9 agreed to as amended.

Paragraph 9.10 agreed to.

Paragraph 9.11 agreed to as amended.

Paragraphs 9.12 and 9.13 agreed to.

Paragraph 9.14 agreed to as amended.

Paragraph 9.15 agreed to as amended.

Paragraph 9.16 agreed to as amended.

At 2.48 p.m. Ms *Rosol* left the table.

Sitting suspended from 2.48 p.m. – 3.21 p.m.

Members Present: Ms *Dow*, Ms *Haddad* and Ms *Johnston*.

Paragraph 9.17 agreed to as amended.

Paragraph 9.18 agreed to as amended.

Paragraph 9.19 agreed to as amended.

Paragraph 9.20 agreed to as amended.

Paragraph 9.21 agreed to as amended.

Paragraph 9.22 agreed to as amended.

Paragraph 9.23 agreed to as amended.

Paragraphs 9.24 – 9.26 agreed to.

Former Paragraph 9.27 removed.

New Paragraph 9.27 agreed to as amended.

New Paragraph 9.28 agreed to as amended.

New Paragraph 9.29 agreed to as amended.

New Paragraph 9.30 agreed to as amended.

New Paragraph 9.31 agreed to as amended.

New Paragraph 9.32 agreed to as amended.

New Paragraph 9.33 agreed to as amended.

ANY OTHER MATTERS

No other matters raised.

At 4:02 p.m. the Committee adjourned until 9 a.m., Tuesday 24 February 2026.

Unconfirmed,

TUESDAY, 24 February 2026

The Committee met at Parliament House, Hobart, and via Microsoft Teams, at 9.03 a.m.

In Committee Room 3

Ms *Haddad*

Ms *Johnston*

Via Microsoft Teams:

Ms *Dow*
Mr *Fairs*
Ms *Rosol*

APOLOGISES

There were no apologises.

CONSIDERATION OF CHAIR'S DRAFT REPORT

The Committee considered the Chair's draft Report.

Chapter 9: Education and Workforce

Paragraph 9.33 agreed to as amended.

Paragraph 9.34 agreed to as amended.

Paragraph 9.35 agreed to as amended.

Paragraph 9.36 agreed to as amended.

Paragraphs 9.37 – 9.39 agreed to.

Paragraph 9.40 agreed to as amended.

Paragraph 9.41 agreed to as amended.

Findings

The findings were considered and amendments made.

Recommendations

The recommendations were considered and amendments made.

The Committee reconsidered the following paragraphs in the Report:

Paragraph 3.19 agreed to as amended.

Paragraph 3.24 agreed to as amended.

Paragraph 4.8 agreed to as amended.

Paragraphs 4.21 and 4.22 agreed to.

Paragraph 4.139 agreed to as amended.

Paragraph 4.140 agreed to as amended.

Paragraph 6.3 agreed to.

Sitting suspended from 10. 24 a.m. – 10.46 a.m.

All Members present.

Chapter 3 – Adequacy, Accessibility and Safety of Reproductive Health Services

Findings

The findings were further considered and amendments made.

At 11.24 a.m. Ms *Dow* withdrew from the Table.

Recommendations

The recommendations were further considered and amendments made.

Chapter 5 – Homebirth and Professional Indemnity Insurance

Findings

The findings were further considered and amendments made.

At 12.02 p.m. Ms *Johnston* withdrew from the Table.

Sitting suspended from 12.10 p.m. – 1. 13 p.m.

Members Present: Ms *Dow*, Ms *Haddad* and Ms *Rosol*.

Chapter 5 – Homebirth and Professional Indemnity Insurance

Recommendations

The recommendations were further considered and amendments made.

Chapter 4 – Adequacy, Accessibility and Safety of Maternal Health Services

Findings

The findings were further considered and amendments made.

Recommendations

The recommendations were further considered and amendments made.

At 2.04 p.m. Ms *Johnston* and Mr *Fairs* returned to the Table.

Chapter 6: Experiences with Birth Trauma

Findings

The findings were further considered and amendments made.

Recommendations

The recommendations were further considered and amendments made.

At 2.34 p.m. Ms *Dow* withdrew from the Table and returned at 2.39 p.m.

Chapter 7: Adequacy, Accessibility and Safety of Perinatal Mental Health Services

Findings

The findings were further considered and amendments made.

Recommendations

The recommendations were further considered and amendments made.

At 2.47 p.m. Ms *Haddad* withdrew from the Table and returned at 2.50 p.m.

Chapter 8: Adequacy, Accessibility and Safety of Perinatal Mental Health Services

Findings

The findings were further considered and amendments made.

Recommendations

The recommendations were further considered and amendments made.

Chapter 9: Education and Workforce

Findings

The findings were further considered and amendments made.

Recommendations

The recommendations were further considered and amendments made.

The Chairs Foreword agreed to as amended.

Chapter 1, as read, agreed to.

Chapter 2, as read, agreed to.

Chapter 3, including Findings 1 – 18 and Recommendations 1 – 10, as read, agreed to.

Chapter 4, including Findings 19 – 47 and Recommendations 11 – 26, as read, agreed to.

Chapter 5, including Findings 48 - 61 and Recommendations 27 – 32, as read, agreed to.

Chapter 6, including Findings 62 – 76 and Recommendations 33 – 39, as read, agreed to.

Chapter 7, including Findings 77 – 86 and Recommendations 40 – 45, as read, agreed to.

Chapter 8, including Finding 87 – 100 and Recommendations 46 – 51, as read, agreed to.

Chapter 9, including Findings 101 – 110 and Recommendations 52 – 56, as read, agreed to.

Appendices, as read, agreed to.

Resolved, that the final two minutes of the Committee, being 23 February 2026 and 24 February 2026 be included in the Report, as unconfirmed (Ms *Haddad*)

Resolved, that the Draft Report be the Report of the Committee (Ms *Dow*).

Report to be tabled on Tuesday 3 March 2026.

ANY OTHER MATTERS

No other matters raised.

At 4:01 p.m. the Committee adjourned *sine die*

Unconfirmed,

APPENDIX E: TRANSCRIPTS OF EVIDENCE