

# TRANSCRIPT

## FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

### Inquiry into perinatal services

Geelong — 11 December 2017

#### Members

Mr Paul Edbrooke — Chair

Ms Cindy McLeish — Deputy Chair

Ms Roma Britnell

Dr Rachel Carling-Jenkins

Ms Chris Couzens

Ms Maree Edwards

Mr Bernie Finn

#### Witnesses

Ms Alyson Smith, Registered Nurse/Midwife, and

Ms Kylie Cole, Registered Nurse/Midwife.

**The CHAIR** — I would like to welcome our next witnesses, Ms Alyson Smith and Ms Kylie Cole, who are both registered nurses and midwives. Alyson, you're the Nurse Unit Manager at the Special Care Nursery and, Kylie, you're the Acting Midwife Unit Manager at the Birth Suite and Maternity Day Assessment Unit.

**Ms McLEISH** — So you're not representing Barwon Health, you're representing yourselves?

**Ms SMITH** — Yes.

**The CHAIR** — I welcome you to these public hearings and thank you for attending here today. All evidence at this hearing taken by the Committee is protected by parliamentary privilege as provided by the Constitution Act 1975 and is subject to the provisions of the Parliamentary Committees Act 2003 and other relevant legislation. Any comments you make outside the hearing will not be afforded such privilege. It is a contempt of Parliament to provide false evidence. These proceedings will be recorded and you will be sent a proof copy of the transcript.

Welcome and thank you for coming today to give us your time. My name is Paul Edbrooke and I'm the Chair of the Committee and Member for Frankston.

**Ms McLEISH** — Cindy McLeish, Deputy Chair and Member for Eildon.

**Ms COUZENS** — Chris Couzens, Member for Geelong.

**Ms EDWARDS** — Maree Edwards, Member for Bendigo West and Deputy Speaker.

**Ms BRITNELL** — Roma Britnell, Member for South-West Coast.

**THE CHAIR** — As you know, the inquiry is going forth, we are going to come up with a set of recommendations to give to the State Government and they've got six months to act on them. We would like to hear 10 to 15 minutes of your thoughts on the perinatal sector in this region and we might have a discussion about that and ask some questions, if that's okay.

**Ms COLE** — I think we decided that I would start. I would like to start by saying thank you for giving me this opportunity and also by saying that my opinions today that I provide are all mine and not the opinions of my employer.

I'm employed in maternity services at Barwon Health as a registered nurse and midwife. I have worked for many years in the midwifery group practice and for the last few years as an Associate Unit Manager, the midwife in charge of shifts in birth suite and postnatal ward, and acting in the Unit Manager role. I am also an eligible and endorsed midwife and am self-employed and to a very limited extent am practising privately providing support to Midwives Geelong Collective and very limited primary care to women choosing to birth outside of the hospital.

Firstly, I would like to discuss our birth suite. We are caring for almost 2,500 women per year birthing at our hospital. We have eight rooms available for birth, staffed by four midwives and now recently a fifth midwife, being the midwife in charge able to be supernumerary. Thankfully our employers have been able to recognise the need for supernumerary in charge in the birthing suite, something we have recognised as a safety risk and been asking for, for well over five years now. It is also pre-empting a change that is needed and we expect with the legislation review of the ratios. This still means that only six of these birth rooms are staffed. We are, however, in fairly constant use of all eight rooms.

Just two weeks ago I was in the birth suite when we needed to call a Code Grey because an anxious and distressed partner started to bang on furniture and yell offensive and threatening language because his partner was in established labour but we did not have a room available to her and she needed to wait in the waiting room and corridor while we organised one.

Whilst every effort is made to staff the birth suite according to need, this is not always possible due to the inability to get staff at short notice. We find ourselves often needing to delay and postpone inductions of labour that supposedly needed to be booked at the time of booking. This can be very distressing for a woman who has been advised that her baby needs to be born.

At the end of every weekday, the birth suite becomes a bottle-neck of activity. This, I feel, is due to the availability of medical staff as well as the maternity day assessment service being inadequate. At 5.30 pm the medical roster goes from six to ten staff and down from two to one registrar and one resident with a consultant on call. Often the women, who had their inductions commenced, are birthing with many needing assistance. Sometimes they are being transferred to theatre for caesarean sections for various reasons and urgency. This removes the medical staff from the birth suite for considerable amounts of time.

As well as the usual birthing activity the maternity day assessment unit is beginning to close and transfer women to birth suite who are still undergoing assessment and often waiting to be reviewed by the O&G team. Some of these women have been known to wait for many, many hours and even into the early hours of the next morning and are forced to wait in the very small waiting room.

On the weekends, the MDAU is closed and all of the essential fetal monitoring occurs in birth suite by birth suite staff. Extra staff for this is sometimes provided when available and the need is there, particularly on public holidays. I am not aware of any plans in the near or distant future that looks at redeveloping the space that is available for birth suite or maternity services as a whole unit.

We are also experiencing significant issues on the postnatal ward. Current ratios are one to four during the day and one to six at night. The ratios on their own are an issue as babies are not considered in these numbers. With increasing acuity and complications, women are now requiring more complex care on the postnatal ward. This also contributes to an increase in the numbers of babies at risk. With this there has been an introduction of a number of guidelines that require midwives to monitor and treat babies much more closely. In particular, any baby whose mother is diabetic, or who is small or large for gestational age requires frequent blood sugar monitoring and more regular feeding for the monitoring and management of blood sugar levels. A baby who is requiring this kind of monitoring can demand a large part of the shift in order to be managed appropriately. As well as monitoring for hypoglycemia, a baby might require increased observation for risk of sepsis and the treatment for jaundice using phototherapy and on some postnatal wards the administration of intravenous antibiotics. So, as well as mothers requiring more complex care, the babies who are currently not counted as patients are also requiring an increased amount of care.

Also, the amount of care that mothers and babies require at night is often no different to that of the day shifts. Babies usually feed more frequently overnight, and the monitoring of the babies at risk does not slow down at night either. There are also admissions to the ward all through the night as the time of birth cannot be scheduled and similar to an emergency department, the birth suite needs to be vacated as soon as possible in order to make room for the next labouring woman.

Add to these issues the short stay in hospital, up to two nights for a vaginal birth and three nights for Caesarean section, there is nearly no time for education and breastfeeding support. Then there is the barely adequate extended postnatal care service which provides one to two visits at home for what is thought to be ongoing support.

Our maternity service experiences significant staffing issues. We are the highest users of sick leave for various reasons, and our overtime usage puts us way over budget. One of the issues causing this is the daily workload and stress of the unit. With our staff working significant amounts of overtime and frequently short staffed, many of us are exhausted, prone to illness and traumatised with what we have had to deal with on an almost daily basis.

For example, someone who stays late into the next shift needs to be taken off their following rostered shift the next day and this leaves a gap to be filled. Staff are frequently shuffled around the different areas to fill gaps, often there are errors when this happens which causes yet another staffing problem. On and on it goes.

We are also a large cohort of childbearing women ourselves and therefore always have high numbers of staff on maternity leave. When returning from maternity leave most staff will choose to come back at reduced hours so we are largely a part-time group. And because of the amount of maternity leave, we have a large number of staff on temporary contracts so the recruitment and retention of staff is very difficult. Many of our temporary staff are wanting permanent work and seek other options or they look for options that doesn't allow shift work, particularly the night shift.

Becoming a midwife is a very difficult process, no matter the course; it involves lecturers, assignments, exams, student placements as well as the follow-through experience which involves following women through their pregnancy, birth and postnatal period. Added to this is the need to work in paid employment in order to simply survive. I recently learnt that the paid post graduate model of becoming a midwife is being stopped. I think this would be to the detriment of recruiting midwives. Ceasing this model of education would make the course unattainable for many, particularly those who may be disadvantaged such as single mothers and the Indigenous.

I would like to add that women's access to the caseload model of care is very limited. The MGP commenced in 2008, providing 25 per cent of women with midwife-led continuity of carer. Currently the numbers are at 20 to 22 per cent with no increase in numbers with the growth in numbers of women birthing at the hospital. We have a long waiting list for women requesting MGP and we know that the research has provided evidence that outcomes for women are improved and women are more satisfied with their care when they have a known carer.

I would also like to mention the difficulty in accessing appropriate resources for women who are struggling emotionally and mentally throughout the perinatal period. The loss of the Perinatal Emotional Health Program has left a large gap in the ability to care for women with these specific needs, an area that I think is vital with the struggles that women face today with raising children and I think that parents who are not coping will not be able to do this well.

Thank you for your time today.

**THE CHAIR** — Thanks, Kylie.

**Ms SMITH** — Thank you for having me here today. My comments are my representation and not that of Barwon Health. A brief overview of my background: I'm a registered nurse and midwife with post graduate qualifications in neonatal intensive care and maternal and child health. I have worked in the specialist field of neonatal nursing for 27 years and I have been the Nurse Manager of the special care nursery for 13 years. I have connections and links with neonatal nurses and other health services across Victoria. Currently I am a member of the following Department of Health and Human Services groups: Neonatal Advisory Group; Neonatal Handbook Subcommittee and Safer Care Victoria – Victorian Clinical Council.

Barwon Health Special Care Nursing is a level 5 neonatal unit and there are only three in Victoria and is the only regional level 5 service. Level 6 classification is the highest level of acuity and complexity and these services are all located in Melbourne. These classifications were implemented and described in the 2015 DHHS document, Defining Levels of Care for Victorian Newborns, that outlined the six levels of care rather than the previous three levels.

Level 5 neonatal capability means high risk, high acuity and emergency admissions at any time of day or night. Babies of 31 weeks gestation and/or 1200 grams are kept here for care and treatment. Emergency care, resuscitation and respiratory support are provided by skilled medical and nursing staff. Within a large medical and surgical hospital, the neonatal unit is often not considered an emergency area. We're almost the poor cousins. Intensive care is provided frequently; however, this is rarely mentioned as an intensive area despite the nursing and midwifery staff having post graduate qualifications required to provide this specialist care to neonates. When occupancy is down, staff are moved within the Women's and Children's service and if an emergency admission occurs during this downtime then staff are left to deal with that to the best of their ability.

Neonatal staff will attend other areas such as Emergency Department or Intensive Care to assist with unwell neonates in those areas when their specialist knowledge is required. Special care is required to attend all neonatal MET calls and Code Blues and in doing so leave their allocated babies to attend these emergency resuscitations. All this and more is achieved with the minimum of support and within base EFT.

Our service is growing steadily. In 2015, 20 per cent of births were admitted to our special care nursery. This rose in 2016 to 26 per cent and currently year to date it's sitting at around 29 per cent. 23 per cent are premature births, that means less than 36 weeks gestation; 12 per cent of admissions require respiratory support, which is CPAP or high flow or even intubation and ventilation and nine per cent of our babies are transferred to tertiary centres, i.e. Melbourne, for ongoing care.

Planning for the implementation of level 5 capability was inadequate in recognising the importance of safe and skilled nursing ratios for this level. Documents addressed the medical requirements with a brief mention of staffing in accordance with the EBA and having appropriate qualifications, but no mention of what these qualifications actually were. This was recognised by the neonatal nurse managers across Victoria as being a problem; however, it seems to have been up to each individual unit across Victoria to campaign for safe ratios. This took 12 months of reporting incidents of high acuity, high stress from staff, especially in-charge staff, who had the heavy burden of running the unit, coordinating all admissions, discharges and codes as well as having a full patient load.

Space and capacity. A privately funded redevelopment in 2015 increased our capacity up to 20 cot bays, including two resus areas, and improved the function and facilities greatly. However, currently the department only fund 13 cots so we have those extra bays unfunded. This huge project work was funded jointly by community donations from Cotton On, Run Geelong and various businesses and private donors, and then was matched by Barwon Health. Prior to this, work capacity was at a critical point, the old unit was very small with lack of facilities, virtually no space, and the parents didn't even have a bathroom so they were big winners in getting a bathroom, lounge and some rooming-in rooms.

Improvements to the resuscitation bays were long overdue and two rooms were completed with full emergency equipment, which was fantastic, but they were designed with minimum space. So even in an emergency situation it's very crowded and there are issues with occupational health and safety in that. Privacy was an issue then and is still an issue now, with many parents exposed during breast feeding in a public space and able to see and hear procedures and discussions still in certain areas of our unit with other babies being close by. Neonates may be small but they come as a family packaged deal and planning for space required for lower acuity cot bays was uncomfortably overlooked. They seem to think that a baby in a cot is the area that you require and forget that there could be mum, dad and two or three siblings. And that really needs to be a priority. Future planning for space and increased capacity were not acknowledged and not built in. Families who have been transferred to Barwon Health for further care or treatment have no accommodation support like they may have in Melbourne and assistance with accommodation is urgently required and should be a high priority on the list of services for families in this region.

Education support is also limited. Access to education is absolutely vital. The service as a whole would benefit from increased commitment to improve and maintain specialist knowledge for this region's level 5 neonatal unit. Presently there is minimal education hours allocated to someone to support the core staff and we also have first year graduate nurse rotations. We have two of them a year. Every six months they change over and we try and facilitate a training program for a graduate Certificate in Neonates which is in link with the Latrobe University.

**The CHAIR** — Alyson, can I just interrupt you there. Can we start asking some questions, because we've got a lot of things we need to drill down a bit on and focus on from what Kylie and yourself have been saying. I'd just like to start. We've heard that the levels of care across night and day are the same basically; you've admissions and people giving birth day or night. The ratio is 1 to 4 during the day and 1 to 6 during the night. I'm not familiar with the nurses' EBA to be able to say this but is there any clause in the EBA that would allow your employer to call extra staff in? I'm only talking from experience in my previous job with different levels of demand, and we were able to actually call extra staff in.

**Ms COLE** — We do have an agreement that if there is increased acuity on the ward, this isn't part of EBA, it's just local agreement, if we have I think it's more five day Caesars on the ward and other acuity, lots of babies needing sugars, then we are allowed to ask for an extra staff but basically it just comes down to numbers so one midwife for four during the day and one midwife for six women at night.

**The CHAIR** — What would be preferred by the majority of midwives, 1:4 across the board day and night, or is there a different figure?

**Ms COLE** — Definitely we would like the same day and night.

**The CHAIR** — And that doesn't count the baby, does it?

**Ms COLE** — Exactly.

**The CHAIR** — So 1:4 packages essentially?

**Ms COLE** — Yes.

**Ms SMITH** — The ratios in the neonatal unit are different and they are across the board every shift, so 1:3 in a specialist unit like a level 5.

**The CHAIR** — I might come back to some questions in a minute and I will hand over to Cindy.

**Ms McLEISH** — Thank you. Thanks for coming in today, it's always good to hear from people working at the coal face. Alyson, you've raised many, many issues. Are you actually happy in your role there?

**Ms SMITH** — I am happy in my role. I've got goals for that unit and they extend into the future.

**Ms McLEISH** — I'm glad to hear that. Kylie, I wanted to ask you too. You mentioned you were at Barwon Health and you're also self-employed. How much work do you do in your private capacity?

**Ms COLE** — Not a lot. There's a group of four or five midwives and mainly I do a bit of being the second midwife at births at home. I've done a little bit of annual leave relief this year so I've done some primary care this year while most of them have been on holidays but apart from that I'm really mainly second in.

**Ms McLEISH** — How often do you work at the hospital?

**Ms COLE** — I'm full time at the hospital.

**Ms McLEISH** — One of the comments — I think, Alyson, it was you that made it — was about the neonatal unit isn't considered intensive care.

**Ms SMITH** — No.

**Ms McLEISH** — By whom?

**Ms SMITH** — I think there's a general feeling that it's a baby unit and that people don't understand what we actually do, and we do a lot of intensive care.

**Ms McLEISH** — Who are the people?

**Ms SMITH** — Well, it could be the community, it could be the mothers. A lot of mothers don't even know that Geelong has a neonatal unit, so we've done a lot of work over that when we did our redevelopment. But, I think — it's the perception that intensive care happens in intensive care and that with babies that isn't the case and they all go off to Melbourne. And they don't. We actually have quite a strong and very capable level 5 service here in Geelong, it's fantastic.

**Ms McLEISH** — How can that change?

**Ms SMITH** — I think as the service is growing, people will understand that but also the commitment to education and support and getting staff, nurses and midwives, off to do specialist courses, postgraduate training.

**Ms McLEISH** — What is the average number of babies that you have at any one time?

**Ms SMITH** — It can vary and it fluctuates according to the women that come in, but our average number is 12 to 14 on most days.

**Ms McLEISH** — You've got capacity for 20; is that right?

**Ms SMITH** — Yes.

**Ms McLEISH** — Thank you.

**MS EDWARDS** — I have to leave at 12.00 and I do want to ask a couple of questions in relation to risk and the level of risk being obviously increased if that ratio is 6 to 1. Is that having an impact on outcomes?

**Ms COLE** — Absolutely. We're seeing more and more numbers of gestational diabetes, elevated BMIs, some preeclampsia, small babies. More and more reasons being found to induce.

**Ms EDWARDS** — Is that convenience?

**Ms COLE** — Sometimes yes but, no, not always. Once upon a time we use to monitor for women who complained about decreased foetal movements, now it seems that any woman who complains about decreased movements even once at term gets booked in for induction. So, the numbers of inductions are skyrocketing.

**Ms EDWARDS** — What would be the risks on the ward when that ratio is higher?

**Ms COLE** — It would depend on the outcome of that birth, or of each individual birth, so we're seeing lots of Caesars, our Caesar rate is sometimes up 38 percent, which is huge.

**Ms EDWARDS** — Why is that? Is that purely because of the risk for the mother?

**Ms COLE** — Yes.

**Ms EDWARDS** — So the mother is at risk?

**Ms COLE** — Yes.

**Ms EDWARDS** — Or is it because there's not enough midwives? Or choice.

**Ms COLE** — I think the more Caesars that you do, the more Caesars you are going to do so then we are encouraging women to try for Caesarean after they've had a Caesar and not all will want that.

**Ms BRITNELL** — Try for a Caesar after they've had a Caesar?

**Ms COLE** — Try for a vaginal birth, sorry. And that is a risk in itself.

**Ms EDWARDS** — Just the other question in relation to the number of neonatal nurses, trained midwives that we have in Victoria. Our understanding is that there is quite a shortage and how we alleviate that shortage means we need to get more and more people trained, obviously. Do you have a view on what that process might look like given that the level of education is required to get to where you are?

**Ms SMITH** — I think we need more commitment, and whether that's financial or scholarships, but we need commitment to ensure that our workforce into the future has specialist training so encouraging nurses and midwives that come out of their undergraduate with a huge debt can move forward and do some specialist training. Whether that's with the scholarships or linked special positions, I'm not sure.

**Ms EDWARDS** — How many neonatal midwives are there, nurses are there at Geelong?

**Ms SMITH** — We can have nurses and/or midwives in our unit. We're very lucky, we've probably got 75 per cent with a qualification in neonatal nursing and of that 75 per cent, 50 per cent have neonatal intensive care, so postgraduate.

**Ms EDWARDS** — That's quite high.

**Ms SMITH** — It's very high.

**Ms EDWARDS** — Thank you.

**Ms COUZENS** — Thank you for coming along today, we appreciate your time. The family violence and mental health, do you see much of that? Do you experience much of that within your work?

**Ms COLE** — Yes.

**Ms COUZENS** — How do you deal with that?

**Ms COLE** — Since the PEHP Program left us — we had a really well working PEHP Program where we had midwives employed to be in contact with women, antenatal and post-natal, referring them off to appropriate

people as needed. Since that's left it's simply down to referral to your GP and then they access the GP and not all women have good relationships with their GP so that can be very challenging and then accessing the bulk billing program, psychologists through the bulk billing program through that way. With acute situations, we contact the hospital psych triage, who can be very difficult to get in contact with, and are often very reluctant to come and see maternity women.

**Ms COUZENS** — Is there specific training offered by the employer for midwives and nurses, neonatal nurses?

**Ms SMITH** — There are training programs in how to deal with aggression and violence. It's quite a lengthy five day course and a lot of people aren't particularly encouraged to go because that's a lot of chunk out of their time but there are some shorter versions that are being worked on, but it is a gap in our service and I think the backup for a lot of the aggression and violence has some more work to do, we need more security, visible security for maternity services, and I'm hoping in 2018 that will start to improve because we do have a clientele, an at risk activity group in that child bearing age.

**Ms COUZENS** — In terms of the Aboriginal community, are you having cultural training within your areas?

**Ms COLE** — Yes.

**Ms SMITH** — Yes.

**Ms COUZENS** — Are you dealing with a lot of Aboriginal people in the community?

**Ms COLE** — Yes. The women that Mandy talked about are all the women that we care for as well. It's been made compulsory that we do the Aboriginal cultural awareness program that has been set out.

**Ms BRITNELL** — I just want to ask about the 38 percent of Caesarean sections. Where does that sit with the state average?

**Ms COLE** — I'm not sure what the state average is. I do know that the world health recommendation say that it should be 15 percent.

**Ms BRITNELL** — If you look back over the last 100 years where we've gone from maternity care, midwifery care. We've gone away from the holistic model to a medical model and now over the last 20 to 30 years we've gone back to short stay, two midnights, that sort of thing. We learnt at the last hearing about a very holistic approach to pregnancy and perinatal care rather than just medical checks and perinatal urines and blood pressures, etcetera. How do you feel given that you work in both sectors? Do we need to stay away from the medical model that we're sort of working back away from, or is the risk too great, because I'm hearing you talk about the pressures within the ward from an emergency potential perspective that you're not feeling confident about? How do we get that balance right?

**Ms COLE** — Good question. I feel like it's a real train wreck actually, the whole medical model and imposing its power over the whole service. Midwives are really at the forefront of caring for these women and women need that continuity, they need the continuity from the doctors as well as the midwives, so from both. I feel like there needs to be a blend of both, being mindful of the risk but not over balancing that risk and calling everybody at risk when it does not necessarily mean that.

**Ms BRITNELL** — You didn't make a submission to the inquiry, either of you. How did you hear about the inquiry, what brought you here today?

**Ms COLE** — I did actually see it in the paper and I heard about it through the ANMF as well.

**Ms BRITNELL** — Thank you.

**The CHAIR** — I don't want to keep you too much longer but I have got a couple of questions. Just in regards to what you've talked about, Alyson, with the redevelopment. Was there any consultation with the people working in that section?



**Ms SMITH** — Yes.

**The CHAIR** — I think we can all sit here and say we've got great admiration and respect for the work that you do but I find it really concerning the amount of sick leave you're talking about and obviously with that comes the amount of burn out and possibly PTSD. Could you give me an anecdotal suggestion of what percentage of your workforce are under stress?

**Ms COLE** — That's really hard because the employers really like to downplay what is called work stress.

**The CHAIR** — I guess what I'm getting at is we have heard time and time again we have got workforce shortages, but obviously we've got trouble retaining people because of the pressures that they are under. Allow me to ask that in a different way. Obviously, it's recognised by the hospital. What is being done by management to overcome this and to help people retain their jobs and get that work/life balance?

**Ms COLE** — I'm not sure that a lot that has done, actually.

**Ms SMITH** — From my perspective we've done a lot of work at the unit level to recognise the stress, encouraging staff to put in incident reports about busy shifts, if they're feeling that they're unsafe, their workload was too much, they're going home feeling very stressed, not wanting to come back to work or whatever. With 12 months of really intensive discussion with the staff, making sure they reported these things, my unit actually ended up with much better ratios, we were successful in Barwon Health supporting us to have a supernumerary in charge position and our EFT was increased for that reason. I think a lot of work is being done but it is up to the staff to say that they're stressed and they need that encouragement from the next levels up.

Just speaking from my perspective, I know in birth suite we also manage to get extra EFT for supernumerary in charge across all shifts. However, the postnatal ward did not get that for night shift and I can't explain why that is because in my perspective postnatal night shift is really bad. It's very difficult.

**The CHAIR** — Just one last question. I've asked this to a couple of people but I want to hear especially from you, considering the job you do is so important to the perinatal sector and without you we would be in real trouble. You've got four people in front of you now who are writing recommendations and doing an inquiry into perinatal services. What would be your advice to us on how we address those workforce constraints in the future?

**Ms SMITH** — My perspective is investing more in the staff and increasing the EFT and the ratios. Recognising, especially in maternity services, that babies do require care, they should be counted as a patient, and sometimes where you might have 20 women and 20 babies but on the board it says you've only got 20 patients.

**The CHAIR** — When does the baby become a patient?

**Ms SMITH** — When it comes to special care nursery and requires treatment. So they're unqualified admissions.

**The CHAIR** — From a lay person's perspective it seemed really weird. Roma, you're probably used to that working in the industry, but the fact that a newborn baby isn't classed as a patient for staffing ratios seems a bit odd. Thank you so much for your time today; it's been pretty interesting. We've had a very interesting day so far and thank you for your time.

**Ms COLE** — Thank you.

**Ms SMITH** — Thank you.

**Witness withdrew.**