T R A N S C R I P T

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Melbourne — 27 November 2017

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Witnesses

Dr Jennifer Weber, transition manager, pregnancy and support service, Caroline Chisholm Society.

The CHAIR — Welcome, Jennifer. I have just got to run through a little speech here. I welcome to these public hearings Dr Jennifer Weber, transition manager, pregnancy and support service, from the Caroline Chisholm Society. Again, welcome and thanks for coming today. All evidence at this hearing taken by the committee is protected by parliamentary privilege as provided that 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 also a contempt of Parliament to provide false evidence. These proceedings will be recorded, and you will be sent a proof copy of the transcript.

We are here today to listen to you. We want to drill down and find out lots and lots of information. We know you have been here for 12 days, and we will take full advantage of that fact. I would invite you to make a 10 to 15-minute contribution, and we will start from there.

Dr WEBER — Yes, thank you. I appreciate that. We do have video to show, and then I can speak to that.

The CHAIR — Awesome. Sounds good.

Video shown.

The CHAIR — Really inspiring.

Dr WEBER — Thank you. Every time I look at that it just makes me think back over the past 30 years. Even having been in the role for the past 12 days, I have known the Caroline Chisholm Society, as I say, for over 30 years. When I look at that, I think of my own experience in terms of when I was back at university. It was the Caroline Chisholm Society that I came into contact with as well as one of those parents in need. To be able to go on now after 30 years to say that that was a touchpoint there with the Caroline Chisholm Society as a university student and what it now means for my family in terms of my having four children and two grandchildren and recently graduating with a PhD. I think I am a good example of what it can mean if we can get to parents sooner rather than later. It is always in the back of my mind, but I was reminded of it as I was sitting there listening to those experiences.

As I was saying, the video does reflect a lot of our community-oriented work. With regard to that outreach we take about 500 appointments a year at the Essendon office. We begin to appreciate that connection, getting to parents sooner rather than later. Often it is a soft touchpoint, where parents are seeking out maybe material support, but it is actually through that that we are finding we are triaging into other areas and other needs are identified as a result of, say, welfare and material inquiries that we are receiving from the mothers and fathers coming in. We can offer the goods and the listening ear. We often find that there are greater and more complex issues families are facing in those settings. As I say, the stigma of being able to talk with somebody is diminished. You can sort of dilute it a bit because it is a very soft touch in terms of families that are approaching us for a need, and we are actually able to troubleshoot with them and have that discussion.

Most of the families coming to those appointments are from a country other than Australia. You would have seen in our report that was made that approximately 50 per cent of those receiving family support were born in a country other than Australia, with the majority of them being from Asia and Africa, so from Asia 24 per cent and Africa 11 per cent. In response to the concerns that they do raise with us, we also offer referral to our home visiting support or the supports provided by other community services — so really being able to undertake that triaged approach.

I am also here to present, as I mentioned to you prior to the proceedings starting, on behalf of Helen Cooney as our chief education officer, who fortunately for her and unfortunately for me is travelling at the moment. She is attending a family wedding in Germany, so lucky her. So I had the great pleasure and privilege to be here today. So you will have to excuse me, and any questions that I am not able to answer I will certainly take on notice, because I want to be able to give you the most accurate detail as well.

The CHAIR — Thanks Jennifer. We are quite relaxed, though. I hope you are too.

Dr WEBER — Okay. Thanks for that. Just in terms of this opportunity, when the society were presenting their submission, the society has a vision for a Victoria where families are stable and well connected to their communities, where support is delivered by primary or universal health and community services and where secondary-level services like homelessness and family violence supports are just touchpoints helping to prevent

and treat escalation, because an outstanding perinatal mental health system is ensuring good linkages. That is really what the vision is, what we hope to be able to see as a result of this inquiry. It is part of our vision that this is a Victoria where tertiary level services are a safety net and not the norm.

I think that is sort of where we are seeing that pressure on the tertiary and the secondary. We want to be able to go more upstream and connect sooner rather than later with parents. We are seeing that as an objective in terms of the research and other initiatives, in Australia, in Victoria and internationally. It really is a concern about how we build that continuum of supports and services so that we can connect sooner rather than later with parents, not putting that pressure around the services that we would typically go to as a last resort. But yet that seems to be the first touchpoint for so many families, and we are then having to try to bring them back into some of those other programs where our workforce needs may be put under pressure as well. I think that is really important. That is where children at most risk are in the most therapeutic environments, not the least where those in need of early intervention are helped quickly and effectively. To achieve this Victoria needs a strong, expert and growing universal service support system with integrated planning and service.

Again we often see that tension between health and community. How do we bring systems together to collaborate? Are they aligned, integrated, collaborated and cooperating? Where is the best fit to bring those efforts together? For the parent it should be a seamless entry point. It should be a seamless experience in that continuum. It is also not about a wrong door. So if it is at an event like a community activity, we have to have to have the staff on hand who can then make those connections. If it is a welfare visit, a home visitation through Child First, where is it that the parent needs to be connected into a system? So really it is mobilising our workforce to be out there and to connect with agencies to have that impact.

I am mindful too that these were just some elements that the society, in terms of its submission, were wanting to be able to present to you today. The society believes that the inquiry must be clear about the definition of perinatal services to effectively reform it in response to tragedies in the community. So we acknowledge that and see that as being very important, and this requires mapping of health and social services as well as the analysis of data. However perinatal services are defined, there is clear need for better linkages between health and community services, in part in order to address the social determinants of health. Of all the social services, including housing, needed during the perinatal period, the one in most dire need of investment and coordination is perinatal mental health and the disparity that we are seeing between rural and regional areas compared with metropolitan Melbourne needs. They need to be redressed. Victoria needs a perinatal service system that retains its distinctive cross-sectoral nature but is better coordinated.

We see perinatal services as being from the time a mother is identified as being pregnant and seeking out services right through until three years of age. In terms of children and families transitioning, there needs to be a greater focus to connect with the early years as well for the child and better coordination between maternal and infant health services. But you can establish that relationship at an earlier stage with regard to the mother. There is research to suggest supporting that. If you get to parents sooner, you can actually influence their parenting style. You can actually have an impact on postnatal depression. So it is how you actually connect with them sooner to build that capacity. We work on a strength-based model, believing in adult capacity for the practitioner who is working for the family as well as in the family.

Being able to get to parents in that perinatal phase is really connecting with them, because they are forming ideas and values around what it is to be a parent — what their plans are, what their goals and their dreams are in terms of that parenting — and when things start not to go to plan it is the way that you can connect with them, with health and community, breaking down some of those barriers and the stigma as well, and really build up that capacity around their parenting style to mitigate some of those impacts of neglect and abuse. That is why we define it up until about three years — because we can take into account then too the early years.

The CHAIR — Would you mind taking some questions from us?

Dr WEBER — Absolutely.

The CHAIR — Caroline Chisholm is a wraparound service, almost, up to three years; is that correct?

Dr WEBER — Yes.

The CHAIR — Can you just give me an idea of the breakdown of clients in regard to family violence and disadvantage?

Dr WEBER — That could be a tricky question — to give you an actual breakdown — but that is something that I could get for you.

The CHAIR — Even anecdotally from what you know.

Dr WEBER — I would say you would be looking at 80 per cent of families, but I could check that. Based on observation what I am seeing in terms of our case loads and the work that we are doing, predominantly families are finding that there is a need. At risk and vulnerable, that is an interesting discussion about what we consider at risk and vulnerable. We should not try to get into word games with it, but the at-risk vulnerabilities of social isolation as well we certainly know with poverty and homelessness. When a parent comes and makes a call to our society, or an organisation like Caroline Chisholm, there is a vulnerability there. Predominantly I would say it is pushing 90 per cent, based on that. Then breaking it down with the family violence: I would have to go back and have a look at the figures in terms of the family violence component.

The CHAIR — If you could take it on notice it would just be interesting to find out.

Dr WEBER — Yes, I will — absolutely.

The CHAIR — How are people referred to the Caroline Chisholm Society?

Dr WEBER — We have a number obviously, as I said, of welfare calls but also Child First, the alliances that we belong to. We receive calls through other agencies as well when they are starting to look at their own case loads and where the best fit is. Because of our specialisation, I think that is what puts us in a unique situation to be able to do perinatal up to six years of age, because that is our specialisation. For instance, if other agencies are working with families across the age spectrum and they are under pressure, and they can identify that — say, there is a family with children younger than six — they can actually come to us and we can work with the family and take them.

The CHAIR — And you recommend in the submission — and I understand that you are 12 days into the job, so I take that into account — a better integration of practice between health and social services for expectant and new families. Of course that touches on what you have already said about meeting people and their needs as early as possible. Can you explain to the committee what you mean exactly by better integration between health and social services, and expectant and new families, and how you would do that as an agency?

Dr WEBER — Absolutely. I think it is about where it is embedded in the community experience of families, so where those health services and community programs are. I reflect on my experience and time. I have just spent 10 years in Canada working with the provincial governments there exactly on this same issue of systems and where the touchpoints are — so is it a family who, say, goes to a playgroup, and who is in that, whether it is a hub setting or it is another way, such as drop-in programs that parents are accessing, that they can be triaged into the health and other programs that they need to be accessing? Can those programs be offered in a way that has universal access, but then you do your intervention to identify the family that is in need to be able to get them into the next level of services that they might need?

The CHAIR — So it is a soft entry.

Dr WEBER — Soft entry, often. For instance, with the announcement that we just attended last week about the paid kindergarten positions — pre-purchased — yes, I was very happy to see that, because that is a way, for families who are vulnerable and who are moving around quite a bit and may have moved into a community, that you can get them into a community context straight away. The professionals who are connected to that program are then able to better understand what the needs are of the families, because the team can work together. You might have a family liaison officer working across a couple of services who knows what is happening in the health context, because often kindergarten teachers or preschool teachers do not necessarily know what is actually going on in another system that may impact and could support their children. So it is how you coordinate without feeling the need to put everything into the one centre or one environment — how you can get professionals working across that continuum as well. So it could be hub models, hub-and-spoke models or professionals, as I said.

What we have found with that particular project, the ECMS, working with the ECMS model, is that our staff are better connected to the families even though we do not necessarily coordinate the position. Because we have a staff member who is connected to that work we are better able to actually meet the needs of the families faster than waiting, say, for a referral to be made and then waiting for a parent to have to make an appointment. We can be there on the ground ready to mobilise the services and be responsive.

Ms McLEISH — Thank you very much for coming in. I am not sure whether, Jennifer, the first question I am going to ask you you will be right across —

The CHAIR — She has told us she was all over it.

Ms McLEISH — What is the funding make-up of your organisation?

Dr WEBER — We have got DHHS with our piece funding —

Ms McLEISH — Sorry, which funding?

Dr WEBER — Through the department with regard to integrated family services, Child First — with homelessness as well — and Engaging Wyndham. So it is all through government, DHHS. I would say it is at the 90 per cent —

Ms McLEISH — Ninety per cent government funded?

Dr WEBER — Yes. But I can take that on notice.

Ms McLEISH — So are you independent or are you government? At what point does it stop being independent?

Dr WEBER — In what sense? The independence —

Ms McLEISH — Is Caroline Chisholm an independent organisation?

Dr WEBER — Yes, as a not-for-profit.

Ms McLEISH — As a not-for-profit 90 per cent, almost exclusively, funded by government? Ninety per cent?

Dr WEBER — Actually I would need to look at that. Can I take that one on notice just to make sure?

Ms McLEISH — That is okay. I was just trying to get a bit of a feel for the make-up, whether you have philanthropy or anything that brings money in for you.

Dr WEBER — Yes, it does. Absolutely, we do have that component with donations, from philanthropy, but I could get you a better breakdown of that.

Ms McLEISH — Sure. Do you have any services, for instance, like an op shop or something that brings money in to you?

Dr WEBER — Yes. Well, we have little services. Most of our goods that are coming in are donations that are actually given to the clients for free, so that is how we do that; we do not sell the items that are given to us.

Ms McLEISH — I understand that, but do you have any other revenue opportunities?

Dr WEBER — Not at this stage, no.

Ms McLEISH — One of the things you mentioned was about getting to parents sooner and that there are lots of reasons for it, and we hear this constantly. How do you do that?

Dr WEBER — In a general sense?

Ms McLEISH — Yes.

Dr WEBER — The experience I have had — and I can step outside the Caroline Chisholm experience at the moment, having established projects for the government of Alberta where a lot of my work was done in this area — is in going to communities to set up parent link centres as an initiative. It was a drop-in program for parents; parents stayed with the child. Immediately that was breaking down of barriers for parents so they could come in. It was around a parent and practitioner-led playgroup, parent education programs, and it offered screenings — the ASQ-SE — to give parents better information about children's development.

Ms McLEISH — So these people have already had children?

Dr WEBER — Yes, parents with children, and what we were doing —

Ms McLEISH — Sorry, I thought we were talking about getting to parents sooner before they had their babies.

Dr WEBER — Yes; sorry. One of these initiatives was that we were actually setting up a project called Welcome to Parenthood. We partnered with health and brought them into a community setting, so the parents who were expecting were coming into a community setting to receive a partnership between community health —

Ms McLEISH — How did you get those people to do that?

Dr WEBER — Putting the word out, going out and promoting it in their community groups, through schools, through church groups, through health services and parents who may have been connecting with other professional social workers through other agencies. Parents appreciated the opportunity to be able to connect in a different way. Rather than, say, having to go to a hospital, they felt more at ease meeting other parents, and that was part of it as well, breaking down that social isolation. For instance, the Caroline Chisholm Society found that for parents who are coming in because of the welfare appointments that they make, that has been their opportunity because there is a particular need. They may already have a child, but they are also expecting, so we can then put them into contact with appropriate services. Sometimes they may not have been to see a doctor or they are not too sure of their local community, so it is really being able to break down the barriers of where they may need to go in the community.

Ms McLEISH — So if they have never had a child, are you able to access them?

Dr WEBER — I think through setting up support services and making sure they get to the doctors, because we spend a bit of time listening to people saying that sometimes it is at 36 weeks or 40 weeks that they walk into the hospital.

Ms McLEISH — Yes, I know.

Dr WEBER — And there is a decline. We are seeing a decline in that access. We can look at all sorts of incentives. Another piece that we have added into the welcome to Alberta for pregnant parents was the Finland baby box. We looked at that. Again I will step outside because I do not want people to think that this is Caroline Chisholm Society that I am speaking about.

Ms McLEISH — I was asking a general question.

Dr WEBER — Okay, great. I have actually just established the Australian Baby Box Project as a not for profit, based on my experience in Canada, the US and the UK, having developed baby box initiatives, and based on the Finland experience. We actually just had our first board meeting last week, and we are working with Orora at the moment to actually prototype a baby box made here in Australia, in Victoria. It is really around two elements: being a tangible resource so a parent can actually sleep the baby in the box with the mattress that is internationally tested and all the rest, as well as engaging sooner rather than later so that when you engage with a parent by having, say, a baby shower, something in the community triggers for that parent that, 'I'm not being associated or identified with the system because I'm a family who is at risk or identified because my child might be taken from me', and you can engage with the parent differently.

For Finland, their experience of baby boxes has been significant not only in terms of the decline in infant mortality rates but because it connected the parents to their prenatal health programs sooner rather than later. The incentive was, 'You're going to receive this box full of all the goodies that you need for the first six months

of a baby's life, and you're going to go along to a prenatal health program and access that'. What we are seeing in terms of the work we would like to do is not to recreate another program but to be able to offer the boxes in the community so that we can engage differently with parents, our families, and provide them with the tangible resource. For instance, Caroline Chisholm already puts together layettes, so we would not need to do that again, but they can actually engage differently with volunteers who go out.

That is what we were doing in Canada with the Welcome to Parenthood project from the government of Alberta. The University of Calgary is actually doing a research project on this. I would have to get the figures for you; I do not have them, but the postnatal depression rates of the mothers in the project were lower than in the main population. Again that was because they were connecting sooner rather than later. We could impact their parenting style. We could build up their confidence. They were connected to a group of other families, mothers and fathers, because fathers are important in this as well, as well as a mentoring program so that they could really have somebody to talk to about the day to day.

So, for instance, rather than a health model for some of them where they were receiving information about good nutrition, we brought the health programs into a community setting where the parents actually did hands-on cooking classes in a community kitchen about making something to have, around good eating. They actually do a hands-on activity because we think underlining that is adult capacity. If we can get to parents sooner, we can build that skill set for them. That is an example of how you can break down some of those barriers.

The CHAIR — I have actually got a smaller, I guess, idea of that in practice at the Frankston North Community Centre. That is working fantastically. It is wonderful.

Dr WEBER — Yes. That is right. And it is not about recreating a service, because again, through the work that we have done, what we were doing with the Harvard Center on the Developing Child with Jack Shonkoff on this, it is not necessarily about more and more, but we know obviously with the rural-regional community we do have issues of disparity, and absolutely we do need to address that — but mobilising, pushing out into those communities to connect sooner rather than later with families.

The Caroline Chisholm Society actually has been running a baby box project in Shepparton and has been giving boxes to families sooner rather than later to be able to connect. Again it is that opportunity to be able to show and demonstrate to parents about a safe sleep practice, about the care of a baby and those sorts of activities through which you can actually engage differently with parents. They are then getting something that they see, as the Finland experience demonstrated. When social media erupted four years ago when for the first time Finland presented a baby box to the royal family, the overwhelming response was, 'What is it about Finland that values the role of being a mum and a dad that they would actually give a box like that?'. And that is the reaction we get from families. I have given boxes in First Nations, Métis — north of 50 projects in the north of Canada, where we could only get one shipment in a year to families. It is really around that valuing but also the tangible resource.

The CHAIR — Jennifer, you are answering these questions way too easily. I think it is time to step it up a little bit.

Dr WEBER — No. You have got me on the revenue and the funding one.

Ms EDWARDS — Only when I am in the chair are the questions difficult. Jennifer, thank you so much. It is really, really thrilling to see that the society has remained true to Caroline Chisholm's idea of being the emigrant's friend and supporting emigrant women. Carry on that wonderful legacy from hundreds of years ago. You mentioned that you do support women from culturally diverse backgrounds, and I just wondered, in terms of the support workers that you have, are they trained in cultural awareness?

Dr WEBER — Yes, absolutely.

Ms EDWARDS — Do you have interpreters, and, perhaps, what is the percentage of Aboriginal and Torres Strait Islanders as a component of those women?

Dr WEBER — Certainly in terms of our staff we have a diverse workforce ourselves. Even just on Friday morning when I was in the office we had a family of Arabic background and one of our staff were able to speak very freely and easily to translate for the family. So in those instances I think we have got quite a diverse skill

set there in our office, and for any gaps that we might have we will access interpreting services for families. But in the first instance I observe our staff engaging very well with that and also building then on their capacity with cultural diversity training — absolutely. With the Indigenous community, again, I would have to have a look at the figures because our Shepparton office does a lot of work with Rumbalara. I could check to see. It certainly is in Shepparton. We are very hands-on there and have a very good relationship, working closely, and have had discussions with them too about other projects and things like that as well.

Ms EDWARDS — In your Shepparton service do you have any workers who are Aboriginal or Torres Strait Islander?

Dr WEBER — Not at this stage because it is a very small operation at the moment. Again, in terms of that rural-regional disparity, that would be one area that we would certainly —

Ms EDWARDS — That is actually another thing I wanted to touch on. You keep mentioning disparities, and I know you gave an example of the boxes and why they were needed in Shepparton. Can you talk us through what the other disparities are between what you are seeing in your Shepparton office and what you are seeing in your metropolitan locations?

Dr WEBER — It is really around the postnatal care, the postnatal depression and mothers and the family violence. We are involved with a project —

Ms EDWARDS — So is there more family violence in the Shepparton area?

Dr WEBER — Yes, I am getting the impression that more families are coming forward with that; mothers are prepared to engage a bit more on that. It may be that it is not necessarily a greater increase but because parents are prepared to talk about it and come forward because they now know that there is a commitment there to do what we can; it is not just a case of talking about it but asking what other programs can we mobilise there. The Mothers in Mind project that we have going there at the moment has been able to assist with groups. But often again you are still working through some of the stigma. Sometimes it is more through a home visitation, that one-on-one. But the disparity occurs when you are dependent on where the funding is coming from to actually support the workers to be able to do it, and if other services are under pressure and have to try to manage case loads, then it tends to put pressure on the system there.

Ms EDWARDS — You mentioned the workforce capacity in your submission, particularly around perinatal mental health. I just wondered perhaps if you could elaborate on that as well, around how you think improving that workforce capacity could be achieved and what particular areas are involved that we need to actually consider focusing on.

Dr WEBER — Yes, I think it is not necessarily about a new workforce but what is there in our workforce at the moment. Often we are asking a lot of our social workers what it is about their roles understanding family violence and the training that they have to be able to mobilise their skill set to maybe have the specialisation so we are able to, say, do it through our programs at the moment but to build up that capacity around the training. For instance, with some of the programs that are there now, where are the opportunities in terms of doing more group work with parents as well as individual intervention? So what type of training and what types of programs can be run, which again are very contingent on how the programs are then funded to mobilise them in that way.

Ms EDWARDS — Would you say that there is an adequacy of mental health support for women during the perinatal period? Is there a difference between what is available in Melbourne and what is available in our regional cities?

Dr WEBER — Yes, I think there is because we are larger in terms of agencies' capacity in the city. Agencies do a terrific job I think in terms of that collaboration and coordinating through alliances. There are regular discussions with practitioners, management and the CEO level, so I think we have got that capacity there. Obviously there are still some gaps there. But I think there are two components to what you are saying because if you just look at the city area, I think we could even be better at the postnatal depression component during the perinatal phase to again focus on that, because it is all around the expectations and parenting styles that we are encountering during pregnancy. So at the point of screening when a baby is born and post, when that screening might occur within those six weeks, by the time they are getting to maternal and infant health care. So

I think in terms of if we can push back into the perinatal phase with some of the screens that are available and build the capacity of our workforce to administer that and to be aware of it and connect with the health system and our social workers, I think that would be one approach.

Then in the rural-regional communities we can see that, obviously, because where agencies are located and who can work with whom, they work very well obviously because of the nature of the communities, but again it is how do you use your resources to connect with the parents and the practitioners? For instance, are we making the most of technology with videoconferencing to be able to build up a workforce who can actually access services in Melbourne to connect and to support them in terms of their outreach, because even with the two staff that we have working in this area at the moment, often they are isolated. And that practitioner consulting is very important — that they have got the backup as well because the impact of clients with that family violence background can be quite significant too.

Ms EDWARDS — So, Jennifer, you would be aware that the commonwealth withdrew funding for the national perinatal depression initiative and I just wondered if you had any sense of what that has meant for some of the shortfalls that we know need to be addressed.

Dr WEBER — I think it has actually put, as I said, greater pressure on agencies because you find yourself in the situation of having to redirect, look at staff loads and things like that and say, 'Okay, now we've got a shortfall here. Where do we make up and maybe we can be creative over here with our case loads to actually pick it up'. It raises focus and people know there is a greater sense of care, but the agency still has to be able to absorb that and pick that up. That is where we find that you have to renegotiate all the time with case loads and things like that with staff. I am very mindful in our role that we want to be able to clear as many of those barriers for them to be able to get on and to do what they need to do in the community. So we are constantly negotiating that as well and, as I said, moving things around to see what we can do.

The CHAIR — Jennifer, we could keep you here all day I think and just keep learning, but we have got to stick to a time schedule. Thank you so much for giving us your time today, but I do have one last question. You have told us about your travels and work around the world in the provinces of Canada and whatnot. If you had just a couple of sentences of advice to a couple of people on an inquiry about perinatal services and how we can improve the regional community's access, what would they be?

Dr WEBER — It is embedding it in community, pushing it out. I think that is so important. It is the stigma, breaking down that barrier. Parents share aspirations. I have worked with First Nation Métis and talking to a group of parents from a First Nation community is like talking to a group of mums down in my community in Oakleigh here. They share the same aspirations and parenting style; they want to be good parents. So how do you break it down so that they do not feel that it is about the state coming in to take the children? They want to be like other parents.

So I think about community and building up social cohesion. If we want to be faithful to the determinants of health when we start to think about social isolation and the impact that that has, even on the fly in fly out parents that we were seeing in Canada, that social isolation I think is huge, regardless, for the families. So really building that stronger connection with health and community out in the community I think is really important.

The CHAIR — Thank you so much. There are a couple of questions outstanding that you took on notice. Could you just find out the answers to them, if possible, and email them to Greg so we can get them disseminated amongst the committee. Thank you so much for your time today. It was very much appreciated.

Dr WEBER — My pleasure. Thank you for the opportunity.

Witness withdrew.