

TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Melbourne — 27 November 2017

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Witnesses

Ms Anita Guyett, general manager, and

Ms Janelle Marshall, general manager, services, Sands Australia.

The CHAIR — I welcome to these public hearings Ms Anita Guyett, general manager from Sands Australia. Welcome, 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 this 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.

Ms GUYETT — This is Janelle Marshall.

The CHAIR — And your role, Janelle?

Ms MARSHALL — I am the general manager for services at Sands Australia.

The CHAIR — Anita and Janelle, we will give you 10 or 15 minutes just to give us a brief overview of Sands, and then we would like to ask some questions if that is okay with you.

Ms GUYETT — Thank you. By way of introduction, I am Anita Guyett and I am the general manager for improving bereavement care at Sands Australia. This is Janelle Marshall, and as we have explained before, Janelle is the general manager for services at Sands Australia. We just want to firstly say that it is really wonderful to hear from Safer Care Victoria and all the work that sounds like it is being done to reduce stillbirths in particular, but firstly we will give you an overview of who we are, our services and why we are so very needed.

At Sands we support bereaved parents who have experienced miscarriage, stillbirth or newborn death. Sands really is the voice for bereaved parents and their families across Australia, promoting healthy grieving and hope when a baby dies. We have been in existence for about 25 years, and in that time we have seen many changes and challenges in how we and other service providers deliver bereavement care to bereaved parents across Australia. Why are we here? Very sadly, despite many advancements in technology, research and medicine, approximately one in four pregnancies will end in miscarriage, impacting 103 000 families every year. As we have just seen, there has really been no change or significant downward trend in stillbirth, and it remains constant despite all these advancements in medical technology. One baby in every 120 births will be stillborn or die in the first 28 days.

So where does Sands Australia fit in and what do we do? Sands Australia's model of support is a peer-to-peer support model, and our position statement, including the evidence base to support this mode of delivery, will be provided today. I have got a copy here for the inquiry. In essence the peer-to-peer support model is evidence-based, it is backed and it is viewed as an unmatched, unlimited and, importantly, cost-effective mental health pathway for help and support in a safe environment. It is where people's lived experiences are heard, respected, honoured and understood.

To give an overview of Sands services, we provide a 24/7 support line that is staffed by trained and screened volunteers that are bereaved parents themselves — so they have experienced a loss through miscarriage, stillbirth or neonatal death. We also have a men's support line, again provided by a trained male bereaved parent supporter. We also offer a live chat service through our website, where supporters can be accessed and a chat conversation can be had with trained parent volunteers. We also offer email support for both parents and health professionals and local support groups that are face to face. We distribute approximately 70 000 brochures across Australia each year.

We recognise that perinatal loss not only affects the bereaved parents and their families but impacts significantly the health professionals that support the family throughout this time. We offer a low-cost e-learning course to help health professionals understand the importance of providing high-quality bereavement care. For bereaved families the care that they provide, and really importantly the select words that they decide to use in that time, that very short time that the parents have with their babies, have a lifetime of impact. These parents take those memories throughout their lifetime.

We have had many positive responses following our training. Healthcare professionals feel better equipped to deal with perinatal bereavement care following the death of a baby in their care. In fact many health professionals remarked that they not only have learned bereavement care techniques that are applicable to perinatal care but will carry bereavement care throughout their practice.

Sands also provides in-house information sessions for professionals upon request, and our website also has a breadth of information and e-brochures, which are available for free download. The aim for our services is to make our services as accessible as we can for every Australian, regardless of their location or their cultural or linguistic background.

I do have a very short 2-minute video on statistics I could play.

Video shown.

Ms GUYETT — As you can see, the statistics are large. It is not a small problem. One in four babies will die before they are born, 2850 will die of stillbirth or will die shortly after their birth, and stillbirth is approximately 10 times more common than SIDS. So we need to talk about it more.

We saw before with Safer Care Victoria that infant mortality rates have declined in Australia over the past two decades, but there has really been no significant reduction in the rate of stillbirth. I was not aware of the unpublished Indigenous rates there, but as you can see, for quite some time they were over twice that of non-Indigenous women. I guess the figures that we are quoting are Australian figures, so it is a collective of all states, whereas I believe Safer Care Victoria was talking about Victoria specifically.

There is a significant evidence base that bereaved parents experience the most effective grief group support for a response that includes receiving the best maternal services by informed health professionals, and it is really widely recognised that there is a unique nature of perinatal loss that makes grieving more complicated and difficult. It is frequently traumatic. It occurs suddenly, and it is without anticipation.

To address your terms of reference, access to Sands services is essential for bereaved parents; it is not a nice-to-have. Much literature suggests the benefit and the unique nature of peer support bereavement treatment care, in contrast to other forms of support. Just to be clear: we are very supportive of all different types of support and we really do feel that there is a place for both professional and peer-to-peer support models, but there is something unique that Sands can provide. I will provide you with a peer-to-peer support position statement on that.

Our community of bereaved parents who go through conversations on phone lines, our live chat and our support services have regularly commented how help for bereaved parents is really hard to find. We are often told that they wish they knew about us many years earlier, when they first lost their baby, and then they found us many years later. We are there for bereaved parents, no matter how long ago they experienced miscarriage, stillbirth or neonatal death. As mentioned earlier, there was a time not that long ago that seeing your baby after death was discouraged, and we tend to have a lot of women calling through to our line or making contact with us who experienced loss in that era and who then contact us many years later.

Although we support many bereaved parents around Australia and Victoria, we are acutely aware that our services are not being offered to every bereaved parent. Our aim would be to raise awareness and have frontline support and people on the ground so that each and every bereaved parent in Victoria and Australia is aware of our large range of support services. We really feel that no parent should ever feel like they are on this journey alone.

The availability of resources really is the main factor in not getting reach to each and every one of our bereaved parents, and we believe that it should be in best practice guidelines that each bereaved parent be informed not only of our services but of other support services that are available. We cannot possibly attend every time that a hopeful parent is informed that they now are a bereaved parent. But with extra resources and funding we can extend the education to nurses, midwives, doctors, obstetricians, counsellors, psychologists and even sonographers, who are really at the forefront of when bad news is delivered.

I put in our submission that Sands would like to take the lead on best practice guidelines in bereavement care for miscarriage, stillbirth and neonatal death, and we have actually started that. We have started that process, and we have an internal committee as well as an external expert panel in which we are developing standards and guidelines for improving bereavement care for miscarriage, stillbirth and neonatal death, because they do not exist.

Regarding the impact of the loss of commonwealth funding, it is no secret that Sands relies very heavily on funding, and continued and increased funding will be essential to implementing the services that we wish to maintain and improve upon in the future. The main service improvements that we see as essential are the development and implementation of the Sands bereavement care guidelines, not just implementing the guidelines but educating our healthcare professionals on the guidelines. This could include simple things like adding flowcharts to maternity wards so that nurses know how to deliver excellent and exceptional bereavement care.

As part of our best practice guidelines all bereaved parents are made aware of Sands' varied services by a health professional and, importantly, a care package is delivered to every bereaved parent who experiences a miscarriage, stillbirth or neonatal death. This care package is in current development with Sands Australia, and we are hopeful of pilot trials in mid-2018. But what we really seek is regional, rural and metro hospitals getting on board and really taking up not only the development of the contents in the care package but the guidelines as well. This element will be heavily relied upon for funding.

We expect that an appropriately delivered care package — and what I mean by that is not one size fits all but a care package for miscarriage and a care package for stillbirth and newborn death — may in fact have a significant flow-on effect to mental health costs. For example, Gold, Leon and Boggs in 2016 conducted longitudinal research. It was the largest epidemiologically based study to date to measure the psychological impact of perinatal loss. It involved 1400 bereavements. It was a multivariate analysis, and it showed that bereaved mothers —

Ms McLEISH — Is this Australian?

Ms GUYETT — This was actually in America. I think it was in Washington, but I will have to check that. I can get you a copy of the study.

Ms McLEISH — Thanks.

Ms GUYETT — I chose this study particularly because of the size and the closeness of the demographic to Australia. Bereaved mothers had fourfold higher odds of having a positive screen for depression and sevenfold higher odds of having a positive screen for post-traumatic stress disorder. So what we are talking about here is the most vulnerable of our community in our bereaved parents. So screening is not a nice-to-have, it is an essential. And again support is not a nice-to-have; it is an essential.

Whilst we have no direct link to term of reference 3, it is common for our community of bereaved parents to report, particularly in high-risk and premature births and subsequent deaths, that they were placed a long way from their home residence and support system. Sands understands that sometimes it is really in the best interests of both mothers and babies to be placed far away from the home, and we would always advocate safety and outcomes over location. However, there needs to be further understanding around the fact that location poses extra challenges when a baby dies — considerations of funeral arrangements and the fact that the bereaved parents usually do not have any family around them. Extra time needs to be taken by nurses to deliver exceptional bereavement care, with recognition from management that that needs to happen. Considerations need to be given to the psychological health of bereaved parents, and again there are extra support services that are needed. Where we really see our care packages fitting in is that we would like to ensure that the care packages and support service training are offered to every neonatal intensive care unit in Victoria and really Australia-wide and any special care units. Again, funding is imperative.

On term of reference 4, Sands is really not the appropriate organisation to comment on the current methods of safety and effectiveness, but again we would always welcome any recommendations to reduce any maternal and infant death so we can start to see some of these downward trends.

On term of reference 5, following on from previous comments, access to a qualified workforce that is skilled in perinatal loss bereavement care, not only from a clinical guideline perspective but from our proposed bereavement guideline perspective. Our community of bereaved parents, which runs into the tens of thousands — 20 000 alone on the Sands Australia Facebook page — report that although from a clinical point of view they feel generally well looked after, from a bereavement support point of view there is really a lot of inconsistency.

Some examples of inconsistency or lack of grief education are: it is not uncommon for bereaved parents to be placed in maternity wards with crying babies in the background, and we are so sure that every attempt is made for that not to happen but it still occurs and it is quite distressing for bereaved parents; differences in changes of shifts, so the mother having to re-explain that she has lost her baby to midwives, nurses and not necessarily just the clinical staff but the tea lady that comes in; nurses not knowing what support the patient might have already received or not received; and the really important one is the language used, which I touched on before.

There are examples of mothers reporting that a particular health professional would come in and say something along the lines of, 'The fetus is incompatible with life', and that is the choice of words. I am certainly not saying that every health professional acts in this manner, but the language used — and it is a big point for us in our training — is so important, because that particular phrase has travelled with that woman all the way through her life, and a few simple changes of wording in that sentence, although it delivers the same message, can be so impactful.

There is a lack of knowledge around funeral arrangements and other services required to be organised in a short period of time by parents. Memory-making in particular is very time sensitive, and that is again where our care packages come in but also the general training in bereavement care and what is available out there to memory-make. Ultimately Sands aims to address this via our education, our face-to-face and our online training to healthcare professionals, but importantly those best practice guidelines to unify the approach across all health professionals.

We believe that every bereaved parent should be offered the same supports, and that would be in our best practice guidelines. The delivery of an effective care package also takes pressure off resources within the hospital environment whilst providing appropriate support — so giving parents access to external support such as Sands and a lot of other external providers as well.

Looking at the disparity in outcomes between rural and regional, Sands is aware of disparity in outcomes particularly in rural areas of Australia and Victoria. However, we also see disparity in services offered in terms of bereavement care. We offer a 24/7 Australia-wide phone support service. However, we also see a lot of value in our face-to-face support groups and particularly the sometimes forgotten parent, the father. They can find a lot of comfort in peer-to-peer support groups and also our men's phone line. Sands Australia would like to offer a lot more face-to-face support meetings, particularly in our rural and regional areas, which again requires funding and awareness to create these opportunities. Really that comes through education. It is all tying back to educating the healthcare professional on what services are available out there and also educating the parents in a timely fashion so that they can access that when they need that.

Regarding identification of best practice, I think it has resonated quite strongly throughout our submission that we are advocating the need for these best practice guidelines in bereavement care, and I hope that has come through very strong. The benefits of having best practice guidelines are improved training, improved understandings between healthcare professionals and improved support provided to the bereaved parent at their most vulnerable time in need. We see this as the first essential component to improving perinatal loss support for all Victorians, and we really are excited to be part of this inquiry and presenting this to you. We welcome any improvement in support provided to bereaved parents, and we really hope that the inquiry sees the value in having the bereavement care guidelines for perinatal loss and potentially recommending, once they have completed, that they have a place in every hospital.

So what would best practice look like? This is really just a snapshot, but parents need to be able to have their questions answered to receive medical explanations to know whether this is going to happen again. Cultural norms, memory-making and down the bottom there, but it really should be up the top, is the training in language — this is not an exhaustive list.

We also recognise at Sands that this is so difficult for midwives and doctors and other maternity specialists. I myself have a sister who is a midwife, so I can recognise that they choose their profession with a view of bringing life into the world, and the death of a baby causes significant personal grief. The current state, I think it is fair to say and as health professionals have reported to Sands, is that they are poorly supported in terms of bereavement care and self-care. Providing extended support and access to services will enable professionals to provide better bereavement care confidently.

To bring this together, there are some more stats there that we have seen before, but effective bereavement care is important and can potentially reduce future healthcare costs. One thing it really highlighted to me was the risk factor and Safer Care Victoria's statistic of the mothers dying, half by suicide. That is not saying that it is all obviously caused by this, but that is something that needs to be worked on. Remembering that bereaved mothers have a fourfold increased risk of depression and a sevenfold increased risk of PTSD, it is vital that we continue to improve and build upon the support that we deliver to the most vulnerable Victorian mothers and bereaved parents.

We look after our mothers who go home with a live baby so well. They get a range of services offered and provided by the wonderful maternal and child health services that we have, but what about our mothers who do not get to take babies home? We rely on individual doctors and nurses to gather their knowledge, after they too have experienced the loss of that particular baby, to provide a fairly rushed bereavement care service, and is that really fair on them? Some hospitals have social workers. Many are not trained in the most effective bereavement care techniques specifically for the perinatal loss area, but again all are trying their best and do wonderful work. The fact is that we rely on many different people hopefully picking up what is needed for parents in the short term. More than 63 per cent of our bereaved parents were not provided details of continuing support services outside of the hospital.

Should we consider formalised welfare checks on our newly bereaved parents like we do for our maternal and child health nurse visiting our new babies or a funded program through Sands or another service provider that touches base through phone? Continuing support is such a large section of our recommendations. It needs to be there and it needs to happen because of those increased risks to that vulnerable bereaved parent. We do not really support our bereaved parents well. The lack of knowledge of what to say and the fear of saying the wrong things commonly mean the family support system falls away very quickly. This leaves bereaved parents exposed. They are in uncharted territory. They are unsupported, not knowing which way to go. They are grieving intensely with little places to turn. It is not a small problem; it is large. It is much larger than the national road toll. It is 10 times higher than the Victorian road toll. We at Sands cannot stop stillbirth, miscarriage or newborn death, but we can easily and effectively provide bereavement care training to healthcare professionals to greatly improve the service delivery and mental health outcomes for Victorian women. We can provide timely, cost-effective and proven support services to all bereaved parents no matter where they are located.

So we would ask you to seriously consider those three main points: the bereavement care training, the care packages and the guidelines. And on behalf of Sands Australia and our bereaved parents at Sands Australia, we would like to thank you so much for the opportunity to present to the inquiry our thoughts and recommendations to improve bereavement care to all Victorian bereaved parents and their families.

The CHAIR — Thank you, Anita, for a well thought out presentation. It is very obvious that there are a lot of people fighting battles that we do not know about every day. I just wanted to run through a couple of quick questions. You talked about a community of 20 000 to 30 000 people. What are your stats per annum for the live chats? I am really interested in hearing about how that works, because it seems like a really efficient way of giving peer support or counselling people. But just in regard to figures, how many people are you coming into contact with a year through Sands, and how many live chats — even if you have not got the stats, just an idea for us?

Ms MARSHALL — I can answer that. We do not offer live chat 24/7. It is a quite limited service at the moment that we are really recognising we need to build on. At the moment we average I think around probably 16 to 20 chats a month. So it is not a huge service, but it is certainly one of those services that we are looking at. With our online services we are presently undergoing a huge review and looking at how we can best provide those services to bereaved parents.

The CHAIR — How are people referred to your service?

Ms MARSHALL — Much of it is self-referral, or it could be that when they are within the hospitals they are either given a brochure from one of the maternal health specialists or they are told of us. Within hospitals and other health settings the maternal health specialist is able to refer to us. We are very savvy now as consumers going online and searching out. Sands will come up, and that is how they will access us. At the moment our most used service is still our phone lines. We are averaging about 250 or 260 calls a month into the

phone lines. As Anita was saying, each of the services that we have is 100 per cent delivered by peer-to-peer volunteers with that lived experience.

The CHAIR — What is your opinion — and I have no idea about this, so I am asking — of what the education and health sector workers get in regard to this, whether they are doing their midwifery course at uni or their doctors course or whatever? What is your understanding of how much or how little education they have in this space?

Ms GUYETT — There really is —

The CHAIR — Be as brutal as you want.

Ms GUYETT — My conversations that I have had with health professionals are varied, but my understanding is that doctors get very little. It has been quoted to me quite a few times that they get half an hour of bereavement training, and that is to cover all bereavement.

Ms BRITNELL — And a book.

Ms GUYETT — Yes. I think it might be fair to say that nurses and midwives do probably get a bit more, but that would most likely not be necessarily formalised training at the university but on-the-job training. There is a culture there, and I have heard this particular saying from many nurses, and it actually sticks with me in a negative way: ‘It’s not your grief, it’s their grief’. That is the disconnect. It is okay to say that, but it needs to be followed up with a few other sentences. So there is a culture of disconnection, and there is an element of self-protection and self-care within that. I completely understand that — I have a psychology background — but that needs to be extended, and that culture needs to be changed.

The CHAIR — So what would you say if I extended that line of questioning to: if we educated our health professionals, the allied workers and everyone in that space, they would be better able to deal with this situation themselves and we might have less burnout?

Ms MARSHALL — Absolutely.

Ms GUYETT — We specifically address that in our e-training module. So we have the bereavement care techniques, and importantly the language and memory-making and all of those aspects, but at the end we focus a lot on self-care and recognising that it is important to practice self-care, absolutely. The more confident that you feel in delivering those bereavement care guidelines or recommendations, the better you are going to be at self-care as well. It is not unusual that we hear that there is a particular nurse or a particular midwife that looks after all the bereavement in this ward, because they are fantastic. That is wonderful. It is great to have that beautiful resource. But what happens when Mary is not there that day or when we might have a student come in? That is when bereavement care might fall down the track. But it is also an opportunity. It is a learning opportunity for the others. So we should not have experts in bereavement care. My point of view is that we all should be experts in bereavement. That is the only way we are going to deliver good mental health outcomes for our mums.

The CHAIR — And workforce.

Ms GUYETT — Yes.

The CHAIR — Very interesting, thank you. I might pass over to our own expert, Roma.

Ms BRITNELL — I have a nursing background of many, many years. Tell me about the funding. I read that there is philanthropy and federal funding involved. Is there no state funding currently?

Ms MARSHALL — We work for Sands Australia, and Sands has been one of those organisations. Because of it starting at that grassroots level some 40 years ago we have had five separate state organisations. At the moment we have still got Sands Victoria. We are actually heading towards a unified model within the next 12 months, but Sands Victoria at the moment also does receive some funding as well as the federal funding that we receive.

Ms BRITNELL — So there is state funding.

Ms MARSHALL — Yes, there is. I am not sure whether that is ongoing.

Ms McLEISH — That is not the same in every state, though, is it? Is it different in every state?

Ms GUYETT — It is different in every state.

Ms BRITNELL — So you are not sure whether it is recurrent funding?

Ms GUYETT — My understanding would be a maximum of three years.

Ms MARSHALL — Two or three years, yes.

Ms GUYETT — And it is not as significantly large.

Ms BRITNELL — Tell me about the gaps in service. Where would the areas of growth be that you would like to see? We heard training, but you talked about the new technologies you are able to use. Are the gaps there? Is there a growth area that you are needing to fill those gaps with?

Ms MARSHALL — Within our service delivery?

Ms BRITNELL — Yes.

Ms MARSHALL — One of the things, and I think it aligns really well with others who have spoken this morning, is really about that continuity of support. In different areas across Australia there is very strong support and services there, but within the regional and remote areas there is not so much. That was a huge push for the 1300 phone line so that anybody anywhere could access that support and that consistent support. Certainly looking at our services going forward, we have got huge opportunities with our online and just how we will be delivering that. That is one of the things that we are looking at. We are doing that with some consultation and collaboration with some of the mental health players as well who have already done some of that and have got really good ideas around how we can do that.

Ms BRITNELL — And do you work closely with AHPRA on the training? Like the course, I imagine people would be looking at points per annum for their grading and their training. Is that something you work closely with them on to promote that opportunity?

Ms GUYETT — I actually visited AHPRA last week and also delivered training for them, because they deal in a really unique situation where they are dealing with the general public as well as the health professional. So to answer your question, yes, we do have accredited CPD points for our training as well as our in-person attendance, but we are also working with the regulatory authorities because they are having these conversations with bereaved parents and further recommendations for bereavement care training for healthcare professionals as well.

Ms BRITNELL — Good.

Ms McLEISH — Thank you, and thank you for coming in, because I think this is an issue that does get skirted around, and a couple of the health services that we have been to have mentioned this. Can you tell me are there one or two services that you think are doing this really well that perhaps others could look to to see how they do it?

Ms MARSHALL — Health services?

Ms McLEISH — I mean like the hospitals. Is somebody doing it well?

Ms MARSHALL — We are thinking of Australia-wide some examples —

The CHAIR — And the bad ones probably come to mind first, don't they?

Ms GUYETT — There are so many individual differences. I do not think I could pick out one particular hospital that does it well.

Ms McLEISH — What person, personally?

Ms GUYETT — It is the personal knowledge of that particular staff member on at that particular time. Unfortunately there is no particular standout hospital for me. There are certainly hospitals that are active and wanting to get education, but —

Ms MARSHALL — I think Deb is a really good one if you want to give Deb as an example in New South Wales.

Ms GUYETT — Deb de Wilde. What would her title be?

Ms MARSHALL — I am not sure.

Ms GUYETT — She is a bereavement care specialist. I do not know what her official title is, but she is just amazing when it comes to bereavement care. She is not with Sands Australia, but she was with Sands Australia some time ago.

Ms MARSHALL — She implemented Sands in New South Wales 20-some years ago, and then we disappeared within New South Wales.

Ms GUYETT — What Deb brings to the table is really educating midwives on the possibilities within bereavement care and the possibilities within memory-making and things like being able to take your baby home or to be able to have them in a cuddle cot. She provides quite a unique service, so I would probably have to give you a written overview of what she does, but she is exceptional in what she does and we just wish that we had more of her.

Ms MARSHALL — I think one of the great strengths with Deb and what we are seeing is anecdotally we are hearing some great feedback about some of the services that she is leading and involved with in New South Wales, and that is very much that collaborative approach — all of the services linking in together. She is really pushing for us to be working very closely with the midwives and other health professionals there within the hospitals and other frontline services so that we can all be in this together and doing quite a holistic approach.

Ms McLEISH — One of the comments you made that surprised me was the sonographer's delivery. Is that a common scenario?

Ms GUYETT — Yes.

Ms McLEISH — Baby not moving?

Ms GUYETT — I am a bereaved parent myself. I know from my personal experience that if the sonographers do not deliver the message, they are there when it happens. They are really in a very good position to provide that first-line level of support. My experience has been — and I am not sure what others' have been — that our community has spoken that the support that they receive from sonographers is usually pretty inadequate.

Ms McLEISH — And it is probably not something that people would normally think about — that they are one of the first ports of call.

Ms MARSHALL — No. A lot of the feedback that we have from people calling in to our 1300 line or the other support services would talk about that very initial response. The trauma for those parents is triggered from that moment onwards, because we are very clued into others' responses, particularly at a time like that, so you know it is the sonographer not saying anything and just walking away, walking out of the room or saying, 'I'll call someone in', and sometimes it being 20 minutes before someone comes back into the room. That is still not uncommon, but there really does seem to be a huge gap in service there around educating.

Ms GUYETT — When you think about miscarriage — this is particularly miscarriage; I am not discrediting stillbirth and neonatal death — it is one in four. They see a lot. They see a lot of miscarriage.

Ms McLEISH — Just thinking about stillbirth and neonatal death, would the largest hospitals do it better, would they see more of it than the smaller hospitals or is it something that you have not noticed?

Ms GUYETT — I have personally heard different stories. Some of our regional and rural hospitals can do it quite well, because it is a personalised touch and there are presumably less midwives who are better prepared. Some of them have their own beautiful little care packages. I know that Rockhampton Hospital in Queensland does some beautiful little care packages. I also know of midwives working in, for example, the Royal in Queensland who just by sheer volume of numbers do not have a bereavement care package. It is not that their staff do not know about it, but the coverage of our services is not as great as what it is in Rockhampton.

Ms McLEISH — Do you have one state that is stronger at delivering services than another, or is the phone line just national and it does not —

Ms MARSHALL — We collect some of that information, but it is more anecdotal than actually having evaluated that. From our understanding of it, I do not think you could really specify a state that does it better. One of the things that comes out is that there are such inconsistencies within states and then even inconsistencies within cities, and then public and private.

One of the things that I have seen in the four and half years I have been with Sands — and this is a personal observation, so again just my personal opinion — is that a lot of the time I think it is when one passionate person, like Deb de Wilde, takes it and they are really driving it and they take the responsibility for it. I think that is where we have really got to take that opportunity of the spreading of that, with upskilling and training more of our health professionals. Some of the comments that have come back to me over the time from midwives have been if they have been seen to grieve a baby with the parents, sometimes it has been seen to be very unprofessional and that they are not maintaining those boundaries that are expected within our profession, and then also if they openly grieve a baby — and it is hugely traumatic for them, we understand that — they are again seen as perhaps being lacking in some way. There are huge opportunities for us to address much around that.

The CHAIR — Thank you so much for coming in today and spending time with us. You have been very informative. You have given us a fair bit to go on with. I am still kind of reeling that the bedside manner of a doctor would be to say to someone that the fetus is incompatible with life, but I totally believe that someone would do that. It is quite amazing. Thank you so much for coming in today.

Ms GUYETT — Thank you so much for having us.

Ms MARSHALL — Thank you.

Witnesses withdrew.