TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Bairnsdale — 7 December 2017

Members

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Witness

Ms Bernadette Hammond, director of clinical operations/chief nurse and midwife, Bairnsdale Regional Health Service.
The CHAIR — Welcome, everyone, to this public hearing today of the Family and Community Development Committee’s inquiry into perinatal services in Victoria. This is the ninth public hearing held by the committee for this inquiry. I will just let everyone know from the start that there are no microphones for us up here; these microphones are to record for Hansard. We will try and raise our voices so everyone can hear, and we will request that the witnesses do that as well. The committee has had hearings in Melbourne and in regional Victoria and has also been conducting community forums to encourage participation from as many people as possible, and we will continue that today. We are delighted to be here in Bairnsdale.

These proceedings today are covered by parliamentary privilege and, as such, nothing that is said here today can be the subject of any action by any court. Please note that the broadcasting or recording of this hearing by anyone other than accredited media is not permitted. All mobile phones should now be turned to silent, please.

I now call our first witness, Ms Bernadette Hammond. I welcome you to these hearings, Ms Hammond, director of clinical operations, chief nurse and midwife from the Bairnsdale Regional Health Service. Thank you for attending here today. I just have to say a little spiel. 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 — nothing to be stressed about at all there. I now invite you to give us a 10 to 15-minute presentation, and we will follow up with some questions, if that is okay.

Ms HAMMOND — Sure. I have got way too many slides, and I know that I have only got 10 to 15 minutes, so I will try and do it within that time. Of course then there is the question time, so anything that I have not covered you could do then.

The CHAIR — No stress, Bernadette. We are here today to get as much information as possible about what is happening in Bairnsdale.

Visual presentation.

Ms HAMMOND — Sure. What I have prepared is just a little bit of an overview of our service from the perspective of what we offer, the way we involve consumers in our care and the service that we provide, and also the governance of that service, which I think will be important today. We are a level 3 maternity service and a level 1 nursery according to the Victorian maternity framework. Because we are a level 3 service we tend to provide a wellness model rather than a specialist medical model. We are woman centred, and one of our aims is to have care as close to home as possible. We know for families that is much more conducive to good outcomes if they are home and their families are less disrupted.

We now provide the antenatal and birth care for all of East Gippsland, with Orbost having ceased birthing in April. I understand they were not closed completely and they were looking to recruit another GP obstetrician, but that was going to be fraught with difficulty due to the geography, and so we are providing an outreach service to Orbost at the moment and women are coming here to birth. So we partner with other services for postnatal care across the region and then for high-level care if that is required down the line. We have about 360 births a year — it fluctuates a little bit, 350 to 380 — plus a lot of antenatal care and education. We are Baby Friendly Health Initiative accredited, and we have a full complement of medical staff who are GP obstetricians and midwives. We have a consultant obstetrician on our perinatal M and M committee as well. So we provide antenatal care.

Perhaps I should start with another slide, but we introduced a new model of care in June 2014 to really meet the changing needs of our community and to support staff — certainly support the GP obstetricians, who were under a lot of pressure, and midwives were under a lot of pressure. We tried to develop a model that would be more conducive to a better work-life balance but also be available when women need it. It is a feast or a famine in maternity, and we tried to have a model. Our midwives are on what we call annualised salaries; they get the same pay for a number of hours across a fortnight, and that means some fortnights they might work more and the next fortnight they might work less. It has taken some adjustment, and we are still working on that.

With the new model of care we wanted to improve access to antenatal care, so we opened a clinic down in the central business district that was very favourable with the women. They liked not having to go to the GP clinics
to wait amongst all the sick people. It also meant that there were times when they did not have to wait. Sometimes there were long waits — if the GP was called away, then there were long waits at the clinic. This model allowed them to have the antenatal care and not have to wait so long, so better access.

As I said, we provide outreach to Orbost. We have introduced a vaginal birth after caesarean section clinic to try to improve those rates. We have made improvements to childbirth education classes. We have recently introduced that and the Baby Makes 3 program. I think someone here is from Frankston?

**The CHAIR** — Yes.

**Ms HAMMOND** — That has been very successful. It assists parents to adapt to the demands and expectations of parenthood and promotes equal and respectful relationships. It is probably more of a social kind of model, which is proving to be popular. We run a breastfeeding clinic out of the CBD, and we have a vulnerable families committee that is multi-agency and meets monthly, more often if needed. It is good planning and support for those women identified as perhaps at risk or their babies.

The new model of care took eight months in the planning, and we had consumers, midwives, GP obstetricians, consultants and executive on the steering committee. The vision for the new model was that it would be collaborative, woman-centred care that provided more choice. We wanted safe care as close to home as possible and a flexible and sustainable workforce providing care when the women needed it.

To improve access to midwifery care we had a model where there was some shared care between GP obstetricians and midwives, but the research will show that a known midwife who then is available for labour and birth will improve birth outcomes. Also in the domiciliary — so the early postnatal period at home — having the known birth midwife visit is also beneficial to outcomes including breastfeeding and continuation of breastfeeding. That is a brief overview of our model.

I will just move on to clinical governance. I had a definition of that, but I think you all know what good clinical governance is. The way we govern is that we have a number of frameworks at Bairnsdale Regional Health Service. We have a good governance strategy and then an overarching clinical governance framework. We have a clinical governance in maternity care framework, a risk management framework, and incident management and consumer feedback systems that are well established. We have always had a clinical review committee, but we formalised it with the outcomes of the Duckett review and Targeting Zero, and we formalised our perinatal M and M committee and its terms of reference. A consultant obstetrician visits and sits on that committee. There is criteria for case review that is mandatory, and we are getting some good discussion and good feedback and improvements out of that.

I was not sure of the audience, so I have just included a little bit of the governance. The state responsibilities I think you know. There is the capability framework, which I have touched on, and we have to self-assess against the capability framework every year. For the last three or four years we have assessed as a level 3, and the department has confirmed that we are a level 3 out of the six levels, which makes us basically a low-risk service run by GP obstetricians and midwives.

We have shared responsibilities between the state and us in that we must report data on perinatal outcomes to the Victorian Consultative Council on Obstetric and Paediatric Mortality and Morbidity. Our performance is monitored by the department and reported to us quarterly looking at Apgar scores, birth weights, birth outcomes, induction of labour rates and timing of those, number of antenatal visits, in particular the first antenatal visit, percentage of women receiving domiciliary care and so on.

We also have internal monitoring monthly that the nurse unit manager does, and we report to the board’s clinical quality and performance committee quarterly; however, if there was another issue, we would report sooner than that. I think I have talked about local governance and our framework, and we have a number of clinical policies of course. We also have policies that — even though we are a level 3 service — we have to be prepared for the unexpected. That is the nature of the game. So we have a number of policies — for example, around emergency management of someone presenting with twins.

The safe governance framework also looks at and mandates safe staffing levels and our links to other services and transfer processes. We are also part of a regional committee that was established in the last 12 months. We are beginning to share a lot more policies and to work together on escalation of care to prevent any delays in
transfer of care or escalation of care if someone presents to us and things are starting to not head in the right direction. We are looking at ways that we can streamline transfer more promptly. We often sometimes are waiting for a bed somewhere, and that can delay people receiving the right care at the right time in the right place.

We have a regional BMI policy, so a high body mass index policy, which basically allows us to transfer women that present here with a high body mass index more promptly. So they might not be booked at our service for labour and birth care but they might present in labour, and so the regional policy allows us to transfer them more quickly. We have an MOU with Orbost around the care we provide for them and our relationship with them.

In 2014 and 2016 we commissioned external reviews of our service. One was in relation to a particular event; 2016 was just how are we doing — are we getting it right if we think we are getting it right? So all those recommendations that were made have been addressed. I did list them in the presentation, but it would take me too long to go through them.

Part of our clinical governance also includes the consumer voice, and that is very important to us. We were setting the model up, and since we have had the model established at six months and 12 months we have had consumer focus groups where we invited consumers in to give us feedback. We also survey them on a regular basis, and there is one out at the moment. The last two have been done by SurveyMonkey so that we make sure women can access the survey more easily. I think it is a method that they would normally use, so they are familiar with it.

I am just going to skip over the recommendations because it is too long.

The CHAIR — Just while you are doing that, Bernadette, you mentioned just before that there was an issue where you were waiting for beds. Could you tell us a little bit more about that?

Ms HAMMOND — Yes, sure. Sometimes if we have someone present who is outside our capability, we might ring two, three or four places before we can find a bed. We are working on pathways across the region, so then the escalation of care will be that the level 4 has to take them, then the level 5, which is Sale and LRH. There are no questions asked. If they do not have a bed, then they will have to sort something out at their end — transfer someone out or move someone, which generally can be done. So it is a more timely response, I suppose, from them. In the past we might have had delays of 4 hours sometimes. We might have been making multiple phone calls. The clinicians will be able to probably better explain the impact of that than I, but that is generally it. So the regional pathway is about developing or streamlining those transfers and making them more timely.

The CHAIR — Do you utilise PIPER?

Ms HAMMOND — We do utilise PIPER. We did have a time there when PIPER would not come and take the baby to Sale, for example, which is our level 2 nursery. They would take the baby back to Melbourne, which was not great for families, and the baby might not be that unwell and might not need a tertiary centre. Probably over the last four months we have been able to negotiate with PIPER, and they will now take the baby to Sale. We have also improved our own transport cot network, so we have a cot that sits at Bairnsdale that can be used by the road crews with a midwife.

The CHAIR — If you do not mind, can we have a copy of your presentation? It would be really handy for us if we could just have a chat and ask some questions.

Ms HAMMOND — Sure.

The CHAIR — Just going on there, along that line you said there was around an average of 360 births a year. I am just interested to know how far women travel to have their babies at Bairnsdale?

Ms HAMMOND — I suppose the furthest now would be east of Orbost, and some of the Mallacoota ones who would have gone to Orbost would now perhaps go to Bega because it is probably closer than Bairnsdale — probably anywhere between 1.5 hours and 2 hours, I think.
The CHAIR — And what percentage of pregnancies in this area would be put in the category of high risk that would need level 2 or level 1, anecdotally? We can ask someone else.

Ms HAMMOND — Yes, because Liz was going to come as the GP —

The CHAIR — We will get to Liz.

Ms HAMMOND — and would probably have more of an idea of that. Most of the women are well women having healthy babies, so our high-risk numbers are not huge, I would say just anecdotally.

The CHAIR — Okay. Good news. Thanks for that.

Ms McLEISH — Thanks for coming in. It is great to be down here in Bairnsdale, actually. On this screen you have a slide about outcomes. Is this the outcomes following the change to your model?

Ms HAMMOND — Yes.

Ms McLEISH — I would like to hear you talk about a couple of those outcomes with that. Perhaps you could put the context around what it was that led to the change in the model.

Ms HAMMOND — Yes, sure. I guess we were concerned about staffing and the ability to sustain a workforce that was ageing. Liz has since retired, but we wanted to build a workforce that was doing a lot more sharing of the care. As I said, predominantly they are well women. If we are to retain midwives, one way of retaining them is to allow them to work to their full scope of practice or have a model of care where they can work — to not so much allow them — to their full scope of practice. We also wanted to provide some better access for women. We wanted to provide them with other options for care so that it was not just one option and that was pretty much it.

Ms McLEISH — And this was internally driven?

Ms HAMMOND — Internally driven?

Ms McLEISH — There was not an external force that made you look at it? It was all internal?

Ms HAMMOND — At the time we had a My Midwife program, and it was very successful.

Ms McLEISH — The KIM program?

Ms HAMMOND — No. It was slightly different, but it was very similar. We wanted to provide that, but there were very few women. There were probably 80 of 360 births in that model. We wanted all women to have access to a known midwife for labour and birth because we know that outcomes will be better. So that was another driver, I guess, behind it.

On some of the outcomes, I suppose we wanted to provide more care in the community. We wanted to be a more community-based, less hospital-based model so we could provide domiciliary care and antenatal care in the community. So we have decreased our length of stay for uncomplicated births in the postnatal period. We have improved breastfeeding rates and, as I said, improved domiciliary care. We have improved the women presenting for their first visit with a midwife before 20 weeks. Midwives are working to their full scope of practice.

Whilst there was always a good relationship with the GP obstetricians, we would like to think that it has improved. And there is a well-established perinatal M and M committee. We have always worked side by side with GEGAC and the midwives there. I guess that is probably an area — there is only one midwife down there — where we can strengthen our relationship so that those women have access to a known midwife for labour and birth as well.

One of the outcomes is that our data is more timely and so we are more responsive to that. We have increased the continuity of known carer. Our caesar rate had decreased. It is just climbing up a little bit now, but it had decreased. There are certainly improved parenting education services and clinics at the CBD. I have mentioned our breastfeeding clinic, our VBAC clinic and our Baby Makes 3 program. I put down there that overall there was improved job satisfaction. We have had some staff deficits in the last six months due to unexpected illness
and things like that. I think they are able to work to their full scope of practice, but sometimes the demands can be overwhelming.

Ms McLEISH — And with the unexpecteds, because you mentioned that you have to prepare for the unexpecteds, how often do they pop up and is it easy to cope? And has this model had an impact on that at all?

Ms HAMMOND — With the model there is one more carer involved in the antenatal period, and so then people will pick up things that others might not have. There is more discussion — there is a team meeting each week — and I know Heather is going to speak about that. I think that it is easier to pick up things. I think when women present they are known to more than one person, and so when they present you can easily identify: ‘Well, I know that that woman has got this particular care need’, and so you can be more prepared, especially, it would be fair to say — I think the others would agree — around vulnerable families. Midwives will have more time than necessarily a GP, but then there are some things that will already be known to a GP because they might have been a family GP for years and years and years. But there will be things that if a midwife has got more time to build a relationship with a woman, then there will be disclosure of things that are bothering them. I think that provides that opportunity as well.

Ms COUZENS — Thanks for coming along today.

Ms HAMMOND — No worries.

Ms COUZENS — We appreciate it. I have got a couple of questions. One is around the services and programs tailored for Aboriginal women. Do you actually do that at your service?

Ms HAMMOND — No. That is the responsibility of GEGAC, but we do the labour and birth care. Most of the antenatal care is done at GEGAC by their midwife and their GP, whoever that is, and sometimes that is Liz or one of the other GP obstetricians. So that care is shared with them.

Ms COUZENS — So you have no involvement in that care?

Ms HAMMOND — We do in that we have to be part of the booking in and preparation for labour and birth as far as knowing who is coming in and their background. Their model does not support having a known midwife for labour and birth at the moment.

Ms COUZENS — Where staff are involved with Aboriginal women, are they culturally trained?

Ms HAMMOND — Yes. Probably two years ago we ran a day and a half program around cultural awareness that was scenario based in our maternity units so that midwives and doctors could get a sense of what it would be really like. That was very popular and very helpful. We have general cultural awareness training across the organisation. Over the last three to four years we have done a lot of work in engaging with the Aboriginal community and making them feel like it is a safe place for them to come, and the feedback from them is that there has been a great deal of improvement there. They feel that access is easier for them.

Ms COUZENS — Is one of the issues in Bairnsdale the fact that there are not enough midwives; is that an issue?

Ms HAMMOND — Yes, always probably an issue, and because of the unpredictable nature, we cannot book everyone to come in between 9.00 a.m. and 5.00 p.m. It is balancing a work-life balance for the midwives, and also being able to cover unexpectedly. We have always had an education model that allows us to train our own over two years, and they are well supported by us with additional study leave to get the qualification. Then we have almost like a three-month graduate period where they transition as a registered midwife, and then we support them going into the team reasonably early on. We have two teams: a hospital-based team and a community-based team.

Ms COUZENS — Do you offer incentives for people to take that path?

Ms HAMMOND — The midwifery path?

Ms COUZENS — Yes.
Ms HAMMOND — Yes, with additional study leave and scholarships. There are also some Australian College of Midwives and Australian College of Nursing scholarships and regional scholarships that are available to them. As well, we offer an internal scholarship. So there are a number of scholarships across the board, and then additional study leave and support. We have a midwifery educator who is six days a fortnight.

Ms COUZENS — Would you encourage Aboriginal women? Is there an incentive there for Aboriginal women?

Ms HAMMOND — Absolutely. There are some regional programs. We have just obtained funding to set up a collaborative model with GEGAC to offer a cadetship kind of program for undergraduate registered nurses. At the moment to my knowledge there is no-one locally that is doing their midwifery, but we would certainly look at setting up the same model. Also we have obtained some funding to provide more support for Aboriginal graduate registered nurses to support them.

Ms COUZENS — You mentioned earlier — and I am not quite sure if I have got this right — that the midwives accepted a change in regard to their wages being paid —

Ms McLEISH — Annualised salaries.

Ms COUZENS — Yes. Has that been successful? Are they happy with that?

Ms HAMMOND — The ANMF were very heavily involved. There were four options under the EBA for remunerating midwives in this model. So the midwives — actually all staff including non-midwives, registered nurses — on that ward voted for the model of remuneration. That is the model they voted for. I had a meeting with them about maybe four months ago and asked them if they wanted to continue with that remuneration model, and they did.

Ms BRITNELL — I would like you to tell me a bit more about the Baby Friendly accreditation process and what that has resulted in and what outcomes you have seen there.

Ms HAMMOND — It is a national program. Not everyone is accredited. It is not mandatory; it is something we choose to do. It really assesses you against criteria that determine, I guess, whether you are providing the best nutritional start for babies. It is not just nutritional, but obviously bonding and family dynamics and things like that. We get assessed against criteria. It is not just, I guess, about breastfeeding, because if women to choose to artificially feed, then we have to demonstrate that those women have been well informed, so they are making a very informed choice about doing that. But it is predominately about encouraging breastfeeding and making sure that babies in the newborn period get the best infant nutrition they can.

Ms BRITNELL — So you have been doing this since —

Ms HAMMOND — I think probably 2004, maybe even earlier. Some of the other midwives in the room would know. It was before my time that they started the program.

Ms BRITNELL — Have you seen increased success rates of babies being still fed at six months, nine months, 12 months?

Ms HAMMOND — I would say definitely on discharge; we see those figures. Then I would probably have to refer to someone else to give you the six month and nine month information. It would be the maternal and child health nurses perhaps that see that, but I know that some of our midwives that are involved in the program do monitor that as well. But I have not got that in front of me.

Ms BRITNELL — On perinatal mental health, what sorts of areas have you been challenged by or where you are seeing increased demand? Can you give us an understanding of how that looks for the region, particularly with your outreach to Orbost, and whether that is even more challenging? Can you help us to understand a bit more about that?

Ms HAMMOND — Sure. Again I am probably not the best person to ask. It would be more the clinical midwives and the midwives in the team who would have a better understanding. We do not get any specific data around that, but we have access to the regional program and we have access to other support programs should we need it. Other than the regional program there is no specific program, but we do not seem to have a
problem. It has not been brought to my attention that we have problems accessing that support for those women, but the clinical midwives would be better able to answer that.

Ms BRITNELL — Thank you very much for coming along today.

Ms HAMMOND — No worries.

Ms COUZENS — You talked about the caesars earlier, and that they were up and now they are starting to climb and go up again. Can you just talk a bit about why you think that is? We have heard in other regional centres of quite a high number of caesar births, so I am just curious what your experience is here?

Ms HAMMOND — I think sitting in my position and looking from where I am, there are probably more nervousness around better outcomes. As I said, we are a low-risk service and we have GP obstetricians. They do not have a specialist next door that would be perhaps more experienced and more inclined to say, ‘That’s okay, they could wait’ or ‘We could do this’ or ‘We could try that’. We probably opt for a caesar sooner rather than later to ensure a good birth outcome.

Ms COUZENS — Is that done in your hospital or are they transferred somewhere else?

Ms HAMMOND — No, caesers are done in our health service. So I think there is some nervousness around birth outcomes and certainly a tendency to move to a caesar sooner rather than later.

The CHAIR — Bernadette, just one last question from me. Not many hospitals are offering water births these days, and we are in a regional facility here. I just wonder if you can tell me a bit about the demand for water births these days and what are the perceived risks?

Ms HAMMOND — Sure, and again the clinicians might want to speak to this as well, but from where I sit, we have been doing water births for maybe 10 years or more. We have a very comprehensive policy. We identify the risks, and we have them on our risk register. We have staff who are well qualified and trained and who have been doing it for a long time.

The CHAIR — What is the uptake?

Ms HAMMOND — It has dropped off a little bit in recent years. Some midwives are very experienced at it and once they no longer work with us then there are less midwives that have been involved in it. It is very popular. I cannot tell you the exact numbers, but it is very popular with women. They love the idea of it. I do not know if it is still the case, but we used to have women that would come from a neighbouring town to have a water birth here. We have not had any adverse outcomes and do not expect any. We feel that it is a safe birthing option. Women are well informed and the risks are managed. For example, if anything is going wrong — there are strict criteria for being allowed to have a water birth, and if they do not meet the criteria, the women understand that then the water birth opportunity is no longer there for them. I think if you are working in partnership with a woman and they are well informed, then they make the right decision.

Ms McLEISH — I have just got a couple of quick questions. How many GP obstetricians do you have in the area?

Ms HAMMOND — Um.

Ms McLEISH — Six?

Ms HAMMOND — Oh, Antoinette’s here. Six? Seven. There you go. Thank you.

The CHAIR — Nice non-verbal there.

Ms HAMMOND — I was going to have to do a count. Sorry.

Ms McLEISH — And they are all located in the town?

Ms HAMMOND — Yes, pretty much.
Ms McLEISH — You mentioned you had a consultant obstetrician as well. Is that somebody local or is that somebody who comes in from — where?

Ms HAMMOND — They come in from Warragul. David Simon comes in from Warragul and does gynae surgery in our operating theatre two days a month, sometimes more. We coincide the meetings with him and he stays overnight and does the meeting.

Ms McLEISH — And does he assess anybody for —

Ms HAMMOND — For obstetrics?

Ms McLEISH — Yes.

Ms HAMMOND — I guess we can call on him if we needed.

Ms McLEISH — How many midwives do you have?

Ms HAMMOND — Maybe I will take a stab in the middle and say 14. We tend to have six in the team and that means we can manage our women’s load. Then we would have six on the ward roster and a bit more, and then we have a midwifery educator and the nurse general manager is a midwife.

Ms McLEISH — What is the biggest challenge, being a regional hospital in this area?

Ms HAMMOND — Getting women out when we need to get them out, I would say, is our biggest challenge.

Ms McLEISH — Meaning?

The CHAIR — Being discharged?

Ms HAMMOND — No, transferred out. So if they present or things are not going to plan and we have not been able to predict it, then getting women out would be our biggest challenge, I would say.

Ms McLEISH — You talked about the streamlining of that transfer process before. Is that getting better?

Ms HAMMOND — Yes. I know that they are probably shaking their heads behind me.

The CHAIR — You have a very supportive team back there, just so you know. They have got your back.

Ms HAMMOND — Good. Yes, I know.

Ms McLEISH — That remains your biggest challenge?

Ms HAMMOND — I would say that is our biggest challenge.

Ms BRITNELL — Is it a risk — the risk is why you are concerned?

Ms HAMMOND — Yes, sure, because if we cannot get them out in a timely manner, then we end up birthing women at our service that need high-level, outside of our capability. It does not mean we will not manage them as best we can, but it is not the best place for them.

Ms McLEISH — We have heard that at other hospitals as well. So how do you manage that? Has it gone okay if you have had to birth high-risk here?

Ms HAMMOND — Yes, I think so. We are lucky that we have a very skilled and experienced team, and I think that comes with having worked for many years in rural areas. All those midwives and doctors have probably faced something similar. They are all very well-trained in neonatal resuscitation and emergency scenarios. We run the Prompt program, which is the obstetric emergency program. It has been called something else, but we have done that for the last 10 years across this area alone. I think the fact that we have a 0.6 midwifery educator who organises and runs a lot of that training is very beneficial. So we feel like we have a very skilled team.
Ms McLEISH — Great. Thank you.

The CHAIR — When you said you had a skilled and knowledgeable team, there were people nodding their heads back there.

Ms HAMMOND — Good, I hope so. I cannot see what they are saying and thinking.

The CHAIR — Thanks so much for coming today, Bernadette.

Ms HAMMOND — No problem. You are welcome.

The CHAIR — Thank you for your submission. We very much appreciate your time, and know that what you have said today does reinforce a lot of what we have heard around Victoria and it will go towards the findings that will be presented to the government. Thank you so much.

Ms HAMMOND — Terrific. Thank you.

Witness withdrew.