NATIONAL RECOMMENDATIONS FOR INDEPENDENT EXTERNAL REVIEW OF SEVERE OBSTETRIC PERINEAL INJURY (OBSTETRIC ANAL SPHINCTER INJURY)

14 AUGUST 2026

Consensus Recommendations of Peak Specialist Societies:
National Association of Specialist Obstetricians and Gynaecologists (NASOG)
Urological Society of Australia and New Zealand (USANZ)
Colorectal Surgical Society of Australia and New Zealand (CSSANZ)

Introduction

The prevention of severe obstetric perineal injury is first and foremost a patient safety issue.

Third- and fourth-degree perineal tears, collectively referred to as obstetric anal sphincter injuries (OASI), represent one of the most significant maternal birth injuries associated with vaginal birth. For many women, these injuries result in lifelong anal and urinary incontinence, chronic pelvic floor dysfunction, persistent pain, sexual dysfunction and profound psychological trauma. They frequently occur in the setting of a physically and emotionally traumatic birth.

Women have the right to expect that evidence-based strategies to minimise preventable birth injury are consistently applied regardless of where they give birth in Australia.

Variation in severe perineal injury rates exists between Australian maternity services. While recognised maternal and fetal risk factors explain some variation, they do not account for all differences in outcomes. Variation may also reflect differences in casemix, the clinicians and professional groups attending births, clinical practice, models of care and hospital or health-service factors. Where maternity services become statistical outliers for serious maternal injury, independent review is an essential component of contemporary clinical governance.

Third- and fourth-degree perineal laceration during delivery is already recognised within Australia's Hospital-Acquired Complications (HACs) framework and can be identified within routinely collected hospital data using ICD-10-AM diagnosis codes O70.2 and O70.3. Under the National Health Reform Agreement 2026-2031, Hospital-Acquired Complications continue to form part of Australia's national safety and quality framework.

These recommendations outline a national framework for the independent review of maternity services demonstrating unusually high rates of severe obstetric perineal injury, with the objective of improving maternal and neonatal outcomes through evidence-based quality improvement.

NASOG National Association of Specialist Obstetricians and Gynaecologists

CSSANZ COLORECTAL SURGICAL SOCIETY OF AUSTRALIA AND NEW ZEALAND

UROLOGICAL SOCIETY OF AUSTRALIA AND NEW ZEALAND

Recommendation 1

Establish a National External Review Framework

The Australian Commission on Safety and Quality in Health Care should establish a nationally consistent framework for the independent external review of maternity services identified as outliers for severe obstetric perineal injury.

In undertaking its role in hospital safety and quality, the Commission should ensure that rates of third- and fourth-degree perineal injury are examined at hospital and health-service level and that significant outlier rates are appropriately investigated.

The purpose of external review is quality improvement, transparency and patient safety. It is not intended to attribute blame to individual clinicians or health services.

Recommendation 2

Automatic Trigger for External Review

An agreed national threshold should automatically trigger independent external review.

The signatory organisations recommend that a third- and fourth-degree perineal tear (OASI) rate exceeding 5% of vaginal births be adopted as the initial threshold for review, subject to future refinement as national evidence, reporting systems and risk adjustment evolve.

Hospitals demonstrating substantially elevated rates of serious maternal birth injury should not rely solely on internal review processes. Independent assessment is a fundamental principle of good clinical governance and strengthens public confidence in healthcare quality.

Recommendation 3

Independent Multidisciplinary Review Panels

External review should be undertaken by an independent multidisciplinary panel comprising expertise in:

- Specialist Obstetrics and Gynaecology
- Urogynaecology
- Colorectal Surgery
- Urology
- Midwifery
- Clinical Governance and Patient Safety

Panel members should be entirely independent of the health service under review.

Recommendation 4

Comprehensive Clinical Review

Every woman sustaining a third- or fourth-degree perineal tear should undergo structured review to determine whether recognised maternal and obstetric risk factors were identified and appropriately managed.

This review should include, but not be limited to:

- Maternal height
- Maternal body mass index
- Previous obstetric anal sphincter injury
- Ethnicity
- Birthweight
- Parity
- Duration of labour
- Instrumental vaginal birth
- Shoulder dystocia
- Fetal position
- Episiotomy, including indication, timing and technique

The review should determine whether recognised evidence-based preventative strategies were appropriately applied and whether any potentially preventable clinical or system factors contributed to the injury.

At maternity-service level, analysis should also appropriately consider casemix so that differences in patient populations are accounted for when interpreting variation in OASI rates.

Recommendation 5

Review of Clinical Management and Models of Care

External review must extend beyond patient risk factors.

The review should determine whether women with recognised risk factors received appropriate specialist obstetric assessment during pregnancy and labour, whether evidence-based intrapartum management was consistently applied, and whether recognised techniques for reducing obstetric anal sphincter injury were utilised.

This should include consideration of:

- Specialist obstetric involvement during pregnancy and labour.
- Whether women at increased risk were appropriately identified and managed.
- Use of recognised perineal protection techniques, including manual ("hands-on") perineal support where clinically appropriate.
- Technique used for delivery of the fetal shoulders.
- Decision-making regarding instrumental vaginal birth.
- Appropriate use and technique of episiotomy.
- The clinician and professional group attending the birth.

External review should also examine whether broader organisational factors—including staffing, workforce capability, supervision, escalation pathways, clinical governance arrangements and the local model of maternity care—may have influenced patient outcomes.

The review should therefore consider patient and casemix factors, clinician factors and hospital or health-service factors when determining possible explanations for an elevated OASI rate. The identification of an association should not, of itself, be taken to establish causation.

Recommendation 6

Broader Maternal and Neonatal Safety Review

Major obstetric perineal injury frequently occurs during a complex or traumatic birth.

External review should therefore extend beyond the injury itself and examine other important indicators of maternal and neonatal safety, including:

- Major postpartum haemorrhage.
- Severe maternal morbidity.
- Five-minute Apgar scores.
- Admission to Special Care Nursery.
- Admission to Neonatal Intensive Care.
- Hypoxic-ischaemic encephalopathy.
- Therapeutic hypothermia.
- Neonatal seizures.
- Perinatal mortality.

The inclusion of these outcomes does not imply that one causes another. Rather, they should be considered collectively as indicators of the quality and safety of intrapartum care. Where multiple adverse outcomes occur at rates exceeding expected levels, broader system issues should be investigated.

Recommendation 7

Governance, Accountability and Continuous Improvement

Every external review should produce a formal report identifying opportunities for improvement.

Health services should develop implementation plans addressing each recommendation, with follow-up review to ensure meaningful and sustained improvement in patient outcomes.

Recommendation 8

National Learning

De-identified findings from external reviews should contribute to a national learning system coordinated by the Australian Commission on Safety and Quality in Health Care.

Lessons arising from reviews should inform:

- National clinical guidance.
- Education and training.
- Workforce development.
- Models of maternity care.
- Clinical governance.
- Future quality improvement initiatives.

The objective should be continual reduction in preventable maternal birth injury and improvement in outcomes for women and babies throughout Australia.

Recommendation 9

Clinical Leadership, Consumer Partnership and Patient Safety

The prevention of severe obstetric perineal injury is fundamentally a patient safety issue.

The medical specialist organisations represented by this statement comprise Australia's recognised experts in the prevention, diagnosis and management of obstetric anal sphincter injury and its lifelong consequences. As such, specialist clinicians have a responsibility to establish the evidence-based clinical standards and governance frameworks that provide the guardrails for safe maternity care.

These clinical guardrails must be founded on the best available scientific evidence, contemporary multidisciplinary practice and continuous quality improvement.

Within those guardrails, the lived experience of women is indispensable.

Women who have experienced severe obstetric perineal injury should be genuine partners in the development, implementation and evaluation of external review processes. Their experiences provide essential insight into communication, informed consent, shared decision-making, continuity of care, respectful maternity care and the broader impact of childbirth injury on women and their families.

Patient safety and evidence-based clinical practice must remain the primary objective of every maternity service. Meaningful consumer partnership strengthens—not replaces—the expert clinical leadership required to achieve that objective.

Conclusion

Independent external review is a cornerstone of modern clinical governance.

Where serious maternal birth injury occurs at rates substantially exceeding those expected, independent multidisciplinary review should become the national standard. Such review provides transparency, strengthens public confidence and ensures that opportunities to improve care are identified objectively and consistently.

The signatory organisations therefore call upon the Australian Commission on Safety and Quality in Health Care, together with Australian governments and state and territory health departments, to establish a nationally consistent framework for independent external review of maternity services identified as outliers for severe obstetric perineal injury, using existing Hospital-Acquired Complications data and appropriate consideration of patient casemix, clinician and hospital or health-service factors.

Every Australian woman deserves confidence that serious childbirth injury will be independently scrutinised, that lessons will be learned wherever unwarranted variation exists, and that maternity care throughout Australia is continuously improving through evidence, transparency and clinical excellence.

Dr Elizabeth Jackson
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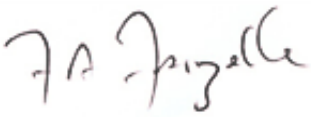

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