ABORTION LEGISLATION REFORM BILL 2023

Committee

Resumed from 14 September. The Deputy Chair of Committees (Hon Stephen Pratt) in the chair; Hon Sue Ellery (Leader of the House) in charge of the bill.

Clause 8: Part 12C Divisions 1 to 5 inserted —

Progress was reported on the following amendment moved by Hon Kate Doust —

Page 10, after line 12 — To insert —

202MEC. Obligations of medical practitioners and prescribing practitioners to provide information about counselling

(1) Before a medical practitioner or prescribing practitioner, under section 202MC, 202MD(2) or 202ME(1), performs an abortion on a person, the practitioner must provide all necessary information to the person about access to counselling, including publicly-funded counselling.

(2) A medical practitioner or prescribing practitioner may, in an emergency, perform an abortion on a person without complying with subsection (1).

Hon KATE DOUST: We are picking up from where we were last time we sat. I had just moved the amendment standing in my name to insert into this bill a provision to ensure that information is still provided to women seeking an abortion at any stage of the pregnancy, even though the government is seeking to remove mandated counselling. We began the discussion about what is currently available. Minister, I will say that, albeit there was a series of documents tabled last week, one in particular from North Metropolitan Health Service was an information booklet for consumers. It is quite a detailed document and I think a very good document in terms of the breadth of information that is provided. My first question is: in anticipation of the changes that are going to happen with mandated counselling being removed, does the government have any plans in place to ensure that that type of document is provided through both doctors' surgeries and other health providers, be they public or private, in the first instance when a woman has her first visit to start the discussion about seeking an abortion? Rather than having it isolated to King Edward Memorial Hospital for Women, or a possible variation to Broome, will the government give consideration to ensuring that that type of booklet is automatically provided to every woman throughout the state?

Hon SUE ELLERY: We have planned a bit of that already. The document that the honourable member referred to is available now. It will be updated and available when the laws change. As to directly providing it to individual consumers, no, there are no plans to do that, but that information will be available, as it is now, to any GPs looking for it.

Hon NICK GOIRAN: I think the Leader of the House has a copy of the document, *Abortion: An information booklet for consumers*, available at the table. On page 5, a question is asked on behalf of the consumer: "How do I access an abortion?" It says —

You will need to make an appointment with your health care provider who will:

It then lists a number of dot points, the first of which is to confirm the pregnancy. The second point is to "discuss the medical risks of abortion and pregnancy". Is that discussion mandatory?

Hon SUE ELLERY: It meets the provisions as set out under the current legal framework. It meets the definition of that.

Hon NICK GOIRAN: Is it intended that that particular provision in the document will change moving forward?

Hon SUE ELLERY: The question is: is it our intention to include that particular sentence? The material will be updated. I do not have information about what it will include. I am advised, and we have had that discussion before, that in the process of ascertaining consent, discussions will occur about making sure people understand the procedure, including abortion care, that they are discussing with their medical practitioner. It is intended that the material will be updated to reflect whatever comes out of the chamber. I cannot give the member a guarantee that those specific words will be in the document in the future.

The DEPUTY CHAIR (Hon Stephen Pratt): Member, before I give you the call, I will point out again that the clocks are not working so the clerks are keeping track of time limits from here.

Hon NICK GOIRAN: Thank you, deputy chair. At the moment, that document that can be provided to consumers includes an indication that consumers will discuss the medical risks of abortion and pregnancy with their healthcare provider. The Leader of the House has indicated that then meets the current statutory regime. The statutory regime

is changing as a result of the bill. Will that make it no longer necessary for a healthcare provider to discuss the medical risks of abortion and pregnancy with the consumer?

Hon SUE ELLERY: As I indicated, informed consent, honourable member, will always include the practitioner explaining the benefits and medical risks associated with the procedure. Consent will include the medical outcomes and risks of the abortion versus the alternative, which would be the medical outcomes and risks of the ongoing pregnancy.

Hon NICK GOIRAN: If the assessment and informed consent will always include that, will a discussion on medical risks of abortion and pregnancy continue to be mandatory?

Hon SUE ELLERY: Can we use a different language, honourable member? We are talking about informed consent, as opposed to a form of words in the legislation, "which requires counselling". Informed consent will be taken to include a discussion, as I have outlined, and it is proposed in the legislation that that is what will apply going forward. The government is not accepting this amendment or that we put into the bill before us words referencing mandatory counselling.

Hon NICK GOIRAN: Can the Leader of the House indicate where the words "mandatory counselling" appear in the amendment?

Hon SUE ELLERY: I will put it another way. I am not trying to be tricky, honourable member. We are deleting the provisions in the Health (Miscellaneous Provisions) Act 1911—the honourable member will remember that we have talked about this bespoke definition of "informed consent" before, which refers to counselling. We will take that out of the legislation. We are not agreeing to the amendment before the chamber. If I got my language mixed up, I am sure the honourable member will forgive me for that, but I think the intention is clear.

Hon NICK GOIRAN: Moving forward with the new statutory regime, will it still be the case that informed consent, under the new common-law definition, will need to be obtained by the healthcare provider from the consumer? I am happy to take that by interjection.

Hon Sue Ellery: Yes, honourable member.

Hon NICK GOIRAN: In order to meet the test under the new statutory regime, it will be mandated under the law for the healthcare provider to obtain informed consent of the common-law standard. Will that include discussing the medical risks of abortion and pregnancy?

Hon SUE ELLERY: The ordinary understanding of testing informed consent or not will include a discussion about risks and alternatives.

Hon NICK GOIRAN: Moving forward, whether the government chooses to include that dot point in an updated brochure, it will still need to happen as a matter of law. Obviously, it will be up to the government what it wants to have in its documents and information moving forward, but the important point for members is that there will be no change to the mandatory obligation of health practitioners to discuss the medical risks of abortion and pregnancy. Moving specifically to the amendment put forward by Hon Kate Doust, which refers to information about counselling, I note that in the document that is presently available for consumers, the third dot point says that the healthcare provider will —

> Offer an option of referral to free counselling to assist with decision making, information and support

Is that offer mandatory at the present time under the current statutory regime, and will it continue to be an obligation on the part of the healthcare provider to offer the option of a referral for free counselling to assist with decision-making information and support?

Hon SUE ELLERY: It is a requirement now under the regulatory framework, but, assuming the house passes the bill in its current form, it will not be a requirement going forward.

Hon KATE DOUST: The government is saying that it will not support providing an information statement. Essentially, that is what South Australia has done. It is quite a generic information statement that goes through a range of matters. It also picks up on some issues that are not factored into Western Australia's current booklet. It picks up on interpreters and refers to child care. It is a relatively brief but substantial document. I do not understand why the government does not want to provide some basic information at the first point of contact that would enable women to make a decision about what they want to do or where to go to get information. The data that is provided in the current Western Australian document on where to go to get further information is about abortion providers essentially, not necessarily standalone counselling services. I do not understand why the government would delete that option for someone who might have pause for thought and seek further advice. I do not understand why the government does not want to provide information in that way to any woman in this state, no matter where

they are located or what their circumstances. Why would the government not enable them to avail themselves of that service?

Hon SUE ELLERY: I canvassed some of the reasons for that in the debate we had earlier about other aspects of the bill. I will go back to the first principles that we have tried to put into this legislation. The first is to treat abortion care like any other form of medical care, which is to recognise that a discussion occurs between the consumer and the GP in the first instance to ascertain whether or not the woman wants counselling. They might make that decision together at that first consultation. Second, it recognises the rights of the consumer to make their own decisions about what information they receive or are offered. There is nothing preventing a woman from seeking that information and there is nothing preventing the GP from providing additional information if the GP believes that would be helpful to the patient. Nothing will prevent them from providing that. At its heart, this legislation presumes that we treat the consumers of this particular form of health care in the same way that we treat consumers of other forms of health care; that is, we do not prescribe what particular information they must be provided with or offered. It is expected that in the normal course of consultation between the consumer and the GP, it may be determined that the consumer wants further information about what counselling services are available, and the GP will be able to provide that.

Hon MARTIN PRITCHARD: I will not support this amendment, mainly because I think it focuses too much on the counselling provision. I accept that there are many occasions when a woman has already made up her mind and should not be in any way coerced into receiving something that she does not want at that time. However, I agree with Hon Kate Doust in that if a person had any other medical condition and a leaflet or pamphlet was available that gave them general information about that condition, it would be preferable if they were provided it. I think it is the same with this. The information provided by the North Metropolitan Health Service and the information provided in South Australia seem like good, general advice on much more than just counselling. I do not know whether or not it needs to be mandated, but if I was asked whether I thought it was a good idea that someone with a condition, whether it be pregnancy or any other condition, was provided a leaflet, I would support that sort of amendment in a heartbeat.

Hon SUE ELLERY: The first point I will make is to go a little way back in this discussion to, I think, the first question asked when we resumed today. The intention is to update and make available the information that has been prepared by the North Metropolitan Health Service for consumers, which members have in front of them now. The member would know from his own personal experience, and I know from personal experience with my GP, that if my GP wants me to understand a particular issue, she has available online a bunch of stuff and she will print that for me in the practice. That is the way GPs use that information now and that is the way they will be able to use that information going forward, except that the information will be updated to take into account the changes we will make to the regulatory framework.

Hon SANDRA CARR: I do not support this amendment and I think that the minister has made it very clear why this is not the most sensible of suggestions. I think probably the most compelling reason is that it is somewhat of a nonsense argument to suggest that someone needs counselling before a procedure. If I were to have a medical procedure, I cannot think of any other circumstance for which counselling is mandated. That treats this procedure as though it is not a medical process, but it is a medical process. Additionally, we heard during the second reading debate the suggestion that a person making this decision does not know their own mind and has not given thought or consideration to their decision. Frankly—I will echo the words of Minister Jarvis—that is insulting. It is insulting to suggest to women that perhaps they had better have a look at this little counselling pamphlet. It is a ridiculous suggestion, I have to say, that women have not given due thought and done their own research, weighed up their own considerations and looked inward and contemplated their own values on what they think is appropriate for their own bodies. I feel that this has been adequately explained and that the minister has made good points about treating this for what it is, which is a medical procedure and one that the woman has made a decision on after going to a doctor. Adding the extra obstacle or burden of requiring the provision of this information for women making that decision and levelling the accusation at a medical practitioner that they did not hand the patient a pamphlet seem to be delving into the absurd somewhat. I think we should treat this and women's decisions with the respect that they are entitled to. We should respect their decision and understand that they have made a medical decision about their own bodies and their own lives. Burdening them with all these voluminous requirements around information does not make a great deal of sense.

Hon NICK GOIRAN: The minister indicated in response to Hon Kate Doust that we do not prescribe what information the consumer will receive, yet earlier we established that we do that because the healthcare provider is obliged to provide information on the medical risks of abortion. I think the minister also added the phrase "and alternatives". I think the minister said that they have to provide information about the medical risks of abortion and alternatives. At the moment and moving forward, we will indeed prescribe information that must be provided

to the consumer as a matter of law. In terms of the alternatives that the Leader of the House referred to, might those include counselling in part?

Hon SUE ELLERY: Again, I think we have to go back to the point that I have tried to make a few times about treating the provision of abortion care in the same way as the provision of care anywhere else. The honourable member is right about the medical practitioner needing to satisfy themselves that they have informed consent. I do not mean to trivialise the debate at all, but I had to have some dental work done. I cannot remember what dental surgeons are called; they have a long name. In order for the dental surgeon to satisfy himself about informed consent, he decided that I needed to see a bunch of pictures that would show me the procedure he was going to do in my mouth. I tried to stop him to say that it was not helping me to make my decision at all. Again, I do not mean to trivialise this debate, but he said that he wanted me to understand exactly what he was going to do.

I then had to have another procedure and I went to a different person who explained it to me in an entirely different way. In both instances, the practitioners met the requirement to satisfy themselves that they had informed consent. They made a choice about how they did that. In the provisions in front us now, we are saying that there should be no difference between the information that is provided to the consumer in order to obtain informed consent for an abortion and that provided to undertake any other medical procedure. We do not accept that we should put an additional layer of information on top of what the clinician decides that they need to personally satisfy themselves that they have informed consent. That is not to say that they might not take advantage of the updated information that will be provided in the material produced by north metro that we have discussed. They may decide that that is a helpful way for them to satisfy themselves. We are saying that it is about what the consumer wants and what the GP needs to satisfy themselves that they have informed consent. However, we should not treat this form of care differently from the way we treat any other form of care. We should not add an additional layer that says that when somebody goes to get this particular form of medical care, we will require and prescribe that they be given additional information. That is the difference between what we are doing now and what we want to do going forward.

Hon NICK GOIRAN: I think that we have hit the point of difference here. I would like to think that many Western Australians consider the life of an unborn baby to be very different from a tooth. I acknowledge that the Leader of the House said that she was not trying to trivialise the debate and I know that she is not. It was actually a very helpful illustration. Members are entitled to hold the view that we should treat this in exactly the same way as any other medical process. However, I encourage them to also reflect on the fact that this is very different from any other medical procedure that might take place, because a tooth is not an unborn child. When a family has an ultrasound and sees the unborn child moving its legs and arms, they see that it is a human being, not a tooth. We absolutely see this as a very different type of medical procedure from anything else.

We had extensive debates last week about the decisions some families might make regarding the sex selection of the baby and a diagnosis of Down syndrome. Last week, the Leader of the House herself indicated that late-term abortions are always awful decisions—something that I agree with her on. Why is it that we call these things awful decisions and are at pains to say that it is very difficult for everybody involved? It is because it is not a tooth; it is an unborn child. In fact, at present, the legislation in Western Australia refers to the unborn child—something that we are now trying to desensitise ourselves to by referring to them as a fetus. I certainly have no great expectation that there is going to be overwhelming sudden support for Hon Kate Doust's amendment, but I ask that honourable members understand that from our perspective, this is not any old medical procedure taking place; this is a decision about whether or not the life of an unborn child is going to be taken.

Hon SUE ELLERY: I will just respond by saying that I think that, to a certain extent, the honourable member has correctly characterised the views of people in the chamber who have moved amendments. That is right; the difference between us is that we see this as a form of medical care that should be treated in the same way as other medical care. I entirely understand the argument from the member's point of view that he does not. There should be no illusion that we are under any misapprehension about the member's views. I understand them completely. However, the proposition is that this decision ought to be made by the consumer, with clinical assistance from her medical practitioner. In that sense, the arrangements that we put in place around that should be no different from those for any other form of medical care.

Hon Dr BRIAN WALKER: I would like to echo the comments just made by the Leader of the House and by my colleague Hon Sandra Carr. To take up what my colleague Hon Nick Goiran has said, he has very clearly pointed out that it is a procedure unlike any other. It is a major decision in which life is involved. However, it is not the only example. For example, if I were to recommend a patient to approach cardiac surgery, I would have to explain to them that there is a substantial risk that it may end negatively and they may not actually wake up from the anaesthetic. I would have to ask them if they wished to proceed. If the child of a family had a major accident and procedures had to be done, I would have to explain to the family that there would be a significant chance that it would end badly. These are major life-threatening conditions and there are many of them that we could look at. It is not just the question here of an abortion in which a fetus, albeit with great defects, is not compatible with life but is still living,

as the member said. This is not just a simple decision. That is why it is very sensible that a provision for counselling be available.

However, to echo the idea that it be mandated that people are not able to make up their mind is actually quite insulting—and I quite agree with my colleagues on that. From our point of view, the option of consulting with psychologists and taking further advice is certainly an excellent idea for those who choose to go down that path. However, forcing that on people who have already made the decision is not actually something that we in the medical profession say has to happen. Otherwise, it would happen with every decision. For example, even an injection for influenza has a statistically present chance of causing Guillain-Barré syndrome and might affect the person's life or even kill them—although very rarely. Are we going to mandate consultation for people who may be stressed about the concept of having an injection that might cause severe harm? I appreciate the argument behind the question, but it is actually flawed.

Hon PETER COLLIER: I have something to say. Again, it will have minimal impact on this debate, but I just want some clarification on what the previous member said. Perhaps the minister can respond, too. According to my understanding, the amendment will not force anyone to get advice. The amendment says that the information will be available and that it will be up to the individual woman involved to make a determination on whether she accesses that information. Is that correct?

Hon KATE DOUST: I might just respond, given that it is my amendment. That is correct. It is not saying that the woman—or that very impolite term, the "consumer"—in the circumstance is compelled to do anything with the information. All the amendment is saying is that the doctor who is involved in this exercise must provide to that individual information about counselling. It is then up to the individual. They might just leave it on the table, they might take it away with them, they might read it, they might do something about it or they might not. At the end of the day, it will be up to the woman to choose whether she uses that information. All we are saying in this amendment is that the doctor should provide them with information about where counselling could be accessed. It will then be up to the woman to choose whether or not to use it. It will not compel the woman to participate in counselling in any way, shape or form if she does not want to do it; it is about opening that door to the woman if she wants it, or saying that it is available. I agree that there will be some women who have already made up their mind, and that is their call, but there might be others who are uncertain or in a position in which they are being coerced. For some women who have language or cultural issues, a straight-up conversation with the GP might not convey all the information or all the nuances about what is going to happen. I think that saying the doctor should still provide information about where counselling can be accessed should the person choose to access it is a very sensible thing to do. It means that all the information will be laid out on the table, and if people want to use it, they can. It is better to put a safeguard into this legislation to enable access to information if people want to use it. I worry that once mandated counselling is totally removed, this information may not be provided at all; it may simply be a discussion about what the procedure will be, rather than any psychological or health impacts or any other matters pertaining to the procedure. I think it is better to err on the side of caution so that if people choose to avail themselves of that service, it is entirely up to them. This amendment was successful in South Australia; members of the South Australian Parliament felt entirely comfortable about putting it in place. All we are saying with this amendment is that the doctor should provide that information. There will be no guarantees that it will be taken up, but why would we deny them that option?

Hon SUE ELLERY: I will take the opportunity to respond to that as well. The amendment states, in part —

> … the practitioner must provide all necessary information to the person about access to counselling, including publicly-funded counselling.

Honourable member, the difference between us is that during the consultation, to which there were 17 000 respondents, respondents were overwhelmingly in favour of removing the current mandated counselling. But it is also the case—Hon Kate Doust just referred to this—that the amendment, by insisting that information be provided about how to access counselling, is working on the assumption that the woman—the consumer—is not clear in her own mind. We say that it should become clear in the course of the conversation between the woman and the GP—the woman may ask for the information straight up—whether or not information would be helpful . Let us leave it to the two people in the room who are discussing the woman's body and her right to make decisions about what happens with it. That is the difference between the two. The amendment would require all GPs to provide that information regardless of whether a woman walks in and says, "I think I'm this many weeks pregnant. I want to arrange a termination." If we accept this amendment, despite a woman saying that, the GP will be compelled to provide the woman with information. In that situation I would say, "I can make that decision myself, thanks very much."

Those who are not able to make that decision can, in the first instance, have a conversation with the GP, and in the same way that GPs make determinations when providing all sorts of other care for what patients might need, they will be able to provide information, including the updated information we have already referred to in the North Metro Health Service report, and any other information.

Hon NICK GOIRAN: The minister in her response referred to the *Abortion legislation reform: Community consultation summary report*. She indicated that as a result of the consultation that was undertaken, there was overwhelming—I think she used the word "overwhelming", but certainly significant—support for the removal of mandatory counselling. That prompted me to look at what the report says. On page 3, under the heading "Informed consent and mandatory counselling", it states —

> Under current legislation, abortion care can only be accessed if the pregnant person has been provided counselling about the medical risk of termination of pregnancy and of carrying the pregnancy to term, by a medical practitioner other than the one performing the procedure.

We established earlier that it will continue to be the case that medical practitioners will be obliged to discuss the medical risks of abortion and pregnancy, and alternatives. None of that was put to the survey respondents; they were simply told that this was the situation. The report states —

> The survey asked respondents to choose one the following:
>
> - **Option 1:** no change. Retain the existing provisions requiring mandatory counselling in order to obtain informed consent for abortion.

There was 32.5 per cent support for that option. The report continues —

> - **Option 2:** remove existing legislated provisions requiring mandatory counselling in order to obtain informed consent.

There was 63.1 per cent support for that option. The report continues —

> - **Option 3:** no preference or unsure.

There was 4.3 per cent support for that option. None of that answers the question posed by Hon Kate Doust, which is: should information about counselling be provided—not necessarily mandatorily taken up? People could be provided with this document that the government has prepared and that, I note in passing, is now a year old. I also note in passing that certain groups that are happy to support and walk with women who want to keep their child, as one of the alternatives, have been removed from the publication; Pregnancy Assistance and Pregnancy Problem House are two that immediately come to mind. These organisations were in the previous iteration of this document but are no longer present in the information that is being provided. The point is that the survey is of no value to us in the chamber at this time for this question because no-one in Western Australia was asked the question: should information about counselling be provided? They were asked: should mandatory counselling be removed?

Division

Amendment put and a division taken, the Deputy Chair (Hon Stephen Pratt) casting his vote with the noes.

Bells rung and the committee divided.

The DEPUTY CHAIR (Hon Stephen Pratt): I advise members in the public gallery to be seated at this time. Thank you very much.

The division resulted as follows —

Ayes (6)

Hon Peter Collier	Hon Donna Faragher	Hon Neil Thomson
Hon Ben Dawkins	Hon Nick Goiran	Hon Kate Doust *(Teller)*

Noes (25)

Hon Martin Aldridge	Hon Lorna Harper	Hon Stephen Pratt	Hon Dr Brian Walker
Hon Klara Andric	Hon Jackie Jarvis	Hon Martin Pritchard	Hon Darren West
Hon Dan Caddy	Hon Ayor Makur Chuot	Hon Samantha Rowe	Hon Pierre Yang
Hon Sandra Carr	Hon Kyle McGinn	Hon Rosie Sahanna	Hon Peter Foster *(Teller)*
Hon Stephen Dawson	Hon Sophia Moermond	Hon Matthew Swinbourn	
Hon Colin de Grussa	Hon Shelley Payne	Hon Dr Sally Talbot	
Hon Sue Ellery	Hon Dr Brad Pettitt	Hon Wilson Tucker	

Amendment thus negatived.

Hon NICK GOIRAN: We are still on clause 8 and I note that the next amendment standing on the supplementary notice paper is in the name of Hon Kate Doust and deals with what might happen in the event that a baby is born alive after an abortion procedure. Does this occur?

Hon SUE ELLERY: The honourable member would be aware that we have canvassed this in earlier parts of the debate. Late-term abortions are carefully planned clinical arrangements. I am advised that the general or usual practice

is around feticide, but sometimes a decision is made by the parent for a range of reasons. They know that the child will not live for more than a few minutes, perhaps more than an hour, but they make the decision for their own reasons that, in some of the examples given, they want skin-on-skin contact and they want to hold the baby to say goodbye to the baby. We know that is what has happened in some cases, and we have canvassed that in earlier parts of the debate.

Hon NICK GOIRAN: When the minister says that that can happen, is it that a baby can be born alive after an abortion procedure?

Hon SUE ELLERY: That is what I just said and have said on more than one occasion in the debate to date.

Hon NICK GOIRAN: I am grateful that the minister has said it on more than one occasion, particularly because the Minister for Health, Hon Amber-Jade Sanderson, is reported as saying that there is no such thing as a baby born alive after an abortion. Being the case that it can happen, given information readily available to the minister, on how many occasions has it happened in Western Australia?

Hon SUE ELLERY: Between 20 May 1998 to date, the State Coroner has confirmed there have been 28 cases whereby a fetus was born alive following a termination of pregnancy. Of these, 25 were induced abortions at 20 weeks' gestation and later. Data is not available for post–23 weeks. That number of live births following a termination has significantly decreased over the years. In 2019, 2020 and 2022 there were zero, and in 2018 and 2021, there were under five.

Hon NICK GOIRAN: Did the minister say that the coroner confirmed that this was the case, or is that meant to be the department?

Hon Sue Ellery: The coroner.

Hon NICK GOIRAN: The coroner has confirmed that there are 28 cases. That is interesting, because the information that is publicly available is that the coroner has not yet proceeded with investigations into the 28 cases, so I respectfully query the accuracy of that information—I should hasten to add, though, not the overall information. I am in complete agreement that there are 28; I am just not presently confident that it is the coroner who confirmed that rather than the Department of Health. Maybe that could be checked and clarified at a later stage. It matters not too much who has provided the information. I think that we can agree that there are 28 cases. That said, earlier, in fact last year on 24 March 2022, the minister responded to a question from me in her capacity as Leader of the House at the time representing the Minister for Health. I asked —

> I refer to the cases of babies who show signs of life after an abortion procedure, and I ask:
>
> (a) what is the total number of these cases between 20 May 1998 and 31 December 2021;

The minister indicated that 31 was the answer. On 24 March 2022, the minister indicated that the number was 31. Today, the indication is that it is 28. Is there an explanation for the difference of three?

Hon SUE ELLERY: A total of 31 deaths have been reported to the coroner by WA Health. Only 28 of those were found to be reportable deaths for the purposes of the Coroners Act. On 19 September 2018, Hon Nick Goiran reported to the State Coroner that 27 cases of abortion procedures resulted in a live birth between July 1999 and December 2016. On 26 April 2019, 26 cases were reported to the State Coroner by the Department of Health. The Department of Health advised the coroner that a twenty-seventh case occurred at a private hospital and 28 medical records were enclosed; however, it was ascertained that in two of those cases, the baby was not born alive and therefore both of those cases were closed for no jurisdiction, leaving 26 open. On 18 December 2019, two additional cases were reported to the State Coroner, but on review of the medical records it was ascertained that they related to only one death. This left 27 open cases. On 26 May 2021, one additional case was reported, leaving a total of 28 cases.

Hon NICK GOIRAN: The minister has helpfully taken us through the chronology of events in 2018, 2019 and 2021, but on 24 March 2022, the following calendar year, the minister indicated to the house that the number was 31. Question 491, asked on Thursday, 24 March 2022, was —

> … what is the total number of these cases between 20 May 1998 and 31 December 2021;

The answer was 31. I just want to be absolutely crystal clear here. Is the answer 31 or is it 28?

Hon SUE ELLERY: I am at a slight disadvantage as the member has the question and answer in front of him and I do not. I am advised that the Department of Health reported that the number of babies who showed signs of life after an abortion procedure was 31. The coroner's advice is that of those 31 babies, for the reasons that I read out earlier, the actual number reported is 28.

Hon NICK GOIRAN: The quick observation that I make is if the Department of Health has inaccurately provided information to the minister, which has then been reported to Parliament, at some point that needs to be corrected because the record currently says that it is 31. I am concerned about these three cases because the question that was put to the government was —

… the cases of babies who show signs of life after an abortion procedure …

The information that came back is that it was 31. In fact, the information is so strong, if you like—my phrase—that the Department of Health thought it necessary to put paperwork before the coroner. Why would it put information before the coroner about a baby who showed signs of life if the baby did not show signs of life? That is unclear to me at the present. I am concerned about these three, what I would describe as "mystery cases". It is not clear that there has been genuine transparency. On the public record at the moment we have a significant inconsistency between what the Leader of the House representing the Minister for Health told Parliament last year on 24 March, which is that there were 31 cases—that was consistent with what the Department of Health then sent to the coroner—but now we are told that the number of cases was 28. I am concerned, having been a person who has been pursuing this matter since it was first exposed by Hon Ed Dermer in 2011, that this is an issue in Western Australia. That said, like the minister, I am also at a disadvantage at this time because I do not have the material on those three cases, so it remains unclear why there would suddenly be 28 cases and not 31. I hear what the minister is saying and that it apparently became clear, at least in one of the cases, that there were no signs of life. Why then was Parliament told that there were signs of life? Why then did the Department of Health, if it knew there were no signs of life, still provide material to the Coroner's Court? Those are questions that remain unresolved. That said, whether the number was 28 or 31, what was helpful was when the minister indicated that there were 25 cases in which babies showed signs of life after an abortion procedure. These were in the cases of induced abortions at 20 weeks' gestation or later. In other words, 25 late-term abortions have resulted in the live birth of a child and that remains the case irrespective of whether the dataset is 31 or 28.

My question is about the other three, possibly six, cases, but for the purposes of this exercise, let us say that it is three. Evidently, those are the three cases that must have been what I described earlier as phase 1 abortions—that is, an abortion that took place prior to 20 weeks' gestation. How is it possible that those three phase 1 abortions resulted in a live child? We were told last week that feticide will be introduced from 22 weeks' gestation and later because it is not possible—we were told—for a child to survive the birth canal prior to 22 weeks. How then is it possible that there are at least three cases in Western Australia of babies who showed signs of life after an abortion procedure when they were less than 20 weeks' gestation?

Hon SUE ELLERY: I do not know where the honourable member gets the view from that they must have been pre–20 weeks abortions. I understand the point member is making and that he wants clarification, and he is entitled to it. I do not have any further information here. I can take on board what the member is asking and ask the minister to provide the member with that information, but I do not have any other information that I can see, with the exception of one. On 18 December 2019, two additional cases were reported to the coroner, but on review of the medical records, it was ascertained that they related to only one death. The records of both the baby and the mother had been provided, so maybe that was counted as the two. I do not have any further information than that.

Hon NICK GOIRAN: I will just explain where the number three comes from. In the minister's earlier response, she indicated that the coroner had identified that there were 28 cases.

Hon Sue Ellery: From 28 to 31—is that the three that you were talking about?

Hon NICK GOIRAN: No. In the minister's response, she indicated that 28 cases of babies who showed signs of life after an abortion procedure had been identified by the coroner. I have quibbled about whether that number is 28 or 31, but we are going to park that for the moment.

Hon Sue Ellery: Is it the 25 to 28?

Hon NICK GOIRAN: It is 28; that is right. Of that number, the minister said that 25 were post–20 weeks' gestation. Therefore, that means there are three that must have been pre–20 weeks' gestation. How is that possible?

Hon SUE ELLERY: As I said, I do not have any other information available to me now. I can give the member an undertaking to provide that, but I do not know when I might get the answer to that.

Hon NICK GOIRAN: The issue that arises, though, is the committee was informed last week that the reason that feticide is being introduced at 22 weeks' gestation is that it is not necessary before 22 weeks. This was very important when we were considering the amendment on whether the late-term threshold should be 20 weeks or 23 weeks. We were told that it is not necessary for there to be feticide prior to 22 weeks because it is not possible for the child to survive the birth canal. Is it possible for the child to survive the birth canal prior to 20 weeks?

Hon MARTIN PRITCHARD: Chair, can I please make a clarification. I think the bill will introduce feticide at 18 weeks.

Hon Nick Goiran: We were told last week that it was 22 weeks.

Hon MARTIN PRITCHARD: Okay. I thought it was 18 weeks.

Hon SUE ELLERY: Based on the information available to me at the table, I cannot say to the member that his assumption that we must be talking about pre–20 weeks' gestation is correct; I do not know whether it is correct. I have no other information available to me, so I do not know whether I can take this line of questioning any further. I have noted what the honourable member's query is. There are people listening to this debate. I am just not so sure, given when this occurred and when that information was collated, that there is someone sitting there with this information at their fingertips. I cannot guarantee the member an answer, not because I am trying to hide anything from him; I am just not sure that I will be able to dig into the level of detail that he wants or is asking for in a reasonable time while we are having this debate.

Hon KATE DOUST: I will ask a couple of questions before we get to deal with the actual amendment. When a baby is born alive, post-abortion in the circumstances that we have talked about—predominantly, a late-term abortion—what are the actual arrangements for managing that situation?

Hon Sue Ellery: What do you mean?

Hon KATE DOUST: What do the doctors or the staff do in that circumstance?

Hon SUE ELLERY: While the advisers are looking for more information, I will say that it depends on the circumstances. The honourable member will recall that we have debated and discussed this issue. Some mothers and families go through this knowing that the baby may be born, take a few breaths and live for minutes or even up to an hour or so. They know that because they want to have skin-on-skin contact and they want to hold the baby when the baby passes. What occurs will depend entirely on the circumstances. If the member is asking what clinical steps are taken, I will see if I can get that information for her.

Hon KATE DOUST: Minister, I would be interested to know whether there are any formal guidelines or instructions for staff on how they should manage those procedures. I note that Queensland has a document titled *Queensland clinical guidelines: Translating evidence into best clinical practice—Termination of pregnancy*. If a baby is born alive post-abortion, the guidelines make it clear that there is to be no provision of medical care, either palliative or life-saving treatment, to a baby who survives an abortion. The Queensland guidelines state —

- If a live birth occurs:
    - Support the woman's wishes and preferences
    - Handle baby gently and carefully and wrap to provide warmth
    - Offer opportunities to engage in care provision (e.g. cuddling/holding) as desired
    - Do not provide life sustaining treatment (e.g. gastric tubes, IV lines, oxygen therapy)
    - Provide sensitive emotional support and reassurance to parents throughout the process and afterwards
    - Document date and time end of life occurs

Does Western Australia have a similar set of guidelines for staff or practitioners when this circumstance occurs?

Hon SUE ELLERY: I am not aware of any guidelines for clinicians similar to those described by the member in the Queensland jurisdiction. I can advise that a clinician or health service provider is not obliged to provide futile medical care. We should bear in mind that we are talking about carefully planned procedures. In such cases, mindful and considerate palliative care is provided to the fetus and support is given to the patient and their family. A perinatal loss team is available to provide comprehensive, continuing and coordinated care and support for families that have experienced that loss. That includes mothers who have experienced a live birth following an abortion. A range of grief support services are available.

Hon MARTIN PRITCHARD: I wish to return to the point made about feticide. I thought King Edward Memorial Hospital for Women introduced a policy to introduce feticide at 18 weeks and that prior to the birth, it was determined that the fetus had passed. With regard to feticide, I believe clinicians follow a process to ensure the fetus has passed before it is delivered through the birth canal.

Hon Sue Ellery: Say that again.

Hon MARTIN PRITCHARD: I understand that with feticide, the clinicians confirm that the fetus has passed prior to delivery of the fetus being expelled. With regard to the babies born post–20 weeks—say, at 25 weeks—at the moment because feticide did not occur, if a late-term fetus or baby is delivered or if it is delivered alive, what would it pass of in the main? There are a range of reasons for an abortion being approved. One of those is social and such with regard to the mother. Could a late-term abortion be delivered alive? That is viable because it is past 23 weeks; it may be 25 or 30 weeks, or whatever. How would the baby pass away if there was no intervention?

Hon SUE ELLERY: There are a couple of things in there. It is definitely 22 weeks, not 18 weeks. When feticide is being used, the clinicians will check that it has worked and that the fetus has died. I think the member is asking what the baby could die of if feticide does not work.

Hon Martin Pritchard: If, for cultural reasons, feticide was not utilised, so a late-stage baby is born.

Hon SUE ELLERY: The baby will not be viable. That is why a decision has been made that a termination is required. Whatever condition the baby has, it is not going to survive. It may survive a matter of minutes or about an hour, so the baby will die of whatever caused the problem in the first place.

Hon NICK GOIRAN: What the minister just told the house is manifestly incorrect. I ask her to take further advice on this point. The justification for me saying that is as follows. This matter was looked into by the Standing Committee on Environment and Public Affairs in the last Parliament. The chair of the committee at that time was Hon Matthew Swinbourn. The Minister for Health at the time was Hon Roger Cook. He provided information to that standing committee on this exact point.

With regard to viability, it is, in part, true what the minister said—there are circumstances when the unborn baby has been diagnosed with what was referred to in that inquiry as a lethal condition. We might interpret "lethal condition" to be a condition incompatible with life. Last week we spent some time talking about anencephaly and the like. Equally, during that committee inquiry, it was clear that not all conditions lack viability. We know that to be true because late-term abortions have taken place in Western Australia. Without us going into a pre-gestational period such as 18 or 19 weeks and the like, we know that late-term abortions have been carried out in Western Australia for conditions such as trisomy 21. We spent some time talking about that last week. In 2012, there was a trisomy 21 case at 21 weeks; in 2002, there was one at 34 weeks; and in 2010, there was a case at 27 weeks for fetal alcohol syndrome.

The reason I spent a little time identifying those cases is because it is manifestly untrue to simply say, in response to the honourable member asking what the babies die of, that they die of the particular condition they have. A baby with Down syndrome, or trisomy 21, does not die one or two hours after delivery because of Down syndrome. They die if no-one provides any care to them, just like every Western Australian who is born alive would die if no-one provided care to them. The only reason that there are members sitting in the chamber today is that once we drew breath when we were born, care was provided to us. It is the same for any other baby born alive in Western Australia. They are not going to survive if nobody provides any care for them. Hence, that is why Hon Ed Dermer asked these questions in 2011.

Is there any new information available to the minister at the table, particularly on the question about these cases? We know that there are at least 28. There is an argument about whether there are 28 or 31, but let us not get bogged down in that for the purpose of today's debate. The debate is hard enough as it is, so let us work on 28. Did all 28 babies who showed signs of life after an abortion procedure have a condition incompatible with life?

Hon SUE ELLERY: I have asked the advisers whether there is anything I can add to the answer that I gave Hon Martin Pritchard to make it clearer. I guess I can add this: it might be that as a function of their prematurity, if you like, their lungs are not properly formed or there may be heart conditions.

On the question asked by Hon Nick Goiran, I do not have the clinical details of the 28. I do not have them and I am not going to be able to get them, so I cannot provide further information on that. I can say that the practice at King Edward Memorial Hospital for Women is that if the clinical expectation is that the reason for the termination is not that it is a lethal—that is my word—condition, feticide will be used and that decision will be made. I am advised that although the parent might say that they want to hold the baby, or whatever it is, in those circumstances, that will be a clinical decision about feticide.

Hon NICK GOIRAN: The minister indicated that she does not have the clinical details of the 28 cases. Does that mean that, because she does not have the information before her, it may be the case that one or more of the 28 babies who were born alive after an abortion procedure died because no care was provided to them?

Hon SUE ELLERY: I cannot possibly answer that question—I cannot possibly—not because I do not want to, but because I do not have the medical records. I think it is entirely unreasonable to ask a question that I could answer only if I had the medical records. I do not have them.

Hon NICK GOIRAN: I accept that the minister does not have that information available to her at present. This is not a criticism of her. This is a criticism of the process. This is a matter that Hon Ed Dermer identified in 2011. My office told me in a message earlier today that I have spoken on this matter in Parliament at least 18 times. I am informed by my staff that I have delivered 18 speeches on this matter—that is, purely speeches, not including questions. There would be little doubt that those preparing for this debate, knowing that Hon Kate Doust has on the supplementary notice paper the amendment that is before us, would be aware that this is an issue. There is no doubt that the government would be aware that this is an issue because it was a matter before the coroner and the

coroner has made a recommendation. The government would be in no doubt because petitioners have asked the government to release that particular recommendation of the coroner. The government would be in no doubt because it responded to the Standing Committee on Environment and Public Affairs on the release of the coroner's recommendation. The government would be in no doubt because I have asked question after question on this matter.

It seems that these debates happen once every 25 years in Western Australia, yet here we are on 19 September 2023, more than 12 years after Hon Ed Dermer first uncovered that 14 Western Australian babies had been born alive and left to die, and we do not have the clinical details of the 28 cases—not the names. No-one has ever been interested in the names of the people involved. As a chamber, we do not currently know what the situation was in those 28 cases. We do know what Hon Roger Cook said to the Standing Committee on Environment and Public Affairs when he was the Minister for Health. I note that the response provided by Hon Roger Cook to a question from the standing committee about how many live births since 2013 involved babies with a lethal abnormality was —

> To identify this number would allow the calculation of the answer to the next dot point due to the answer at question 3. In the circumstances, it is not appropriate to identify the number.

The answer that had been provided in response to question 3, which was about how many late-term abortions had resulted in a live birth since 2013, was —

> From 2013 to 2017 (inclusive) there were 8 abortions at 20 weeks gestation or greater that resulted in a live birth.

We know that Hon Roger Cook told a parliamentary committee that from 2013 to 2017 there were eight such cases. We know that some were babies with a lethal abnormality. This goes to the point raised by Hon Martin Pritchard. What happens? How do they die? As the minister has indicated, some die because they have a lethal abnormality. That is true. However, what about the ones who do not have a lethal abnormality? The same standing committee asked Hon Roger Cook how many live births since 2013 involved babies with a nonlethal abnormality. The answer was fewer than five. We will not be told the answer to how many had a lethal abnormality because to do so would allow people to calculate the next number. The total number is eight. That means that the number of babies with a nonlethal abnormality must have been either one, two or three. It has to be one of those three numbers. It cannot possibly be any other number because the number of babies with a lethal abnormality was at least five, and the total number was eight. No-one needs to be a mathematical genius to work that out.

It simply is the case—it is a statement of fact—that we are to trust the word of Hon Roger Cook to a standing committee, because there are penalties for misleading a parliamentary committee. That is why I am going to give this great weight. I am going to give no weight to the responses provided from time to time by the current health minister, who has repeatedly been exposed during this debate to have provided inaccurate information. I am going to give great weight to Hon Roger Cook's response to the Standing Committee on Environment and Public Affairs on this. It was a written response, not a flippant response provided to a media outlet. It was a written response to a parliamentary committee, not a flippant response provided in the other house during consideration in detail. It was a written response from the current Premier of Western Australia when he was the Minister for Health. It identified that there had been cases in Western Australia of babies with a nonlethal abnormality being born alive after an abortion procedure. The question is: what happened to them? As Hon Martin Pritchard implied, how did they die? We do not know. In fairness to the Leader of the House, she does not know because she does not have the 28 cases before her.

My question for members is whether or not they will support Hon Kate Doust's amendment when it is moved in due course. Nobody can be under any doubt that this is a real thing. We debated the issue of sex selection last week—a big discussion about whether somebody would do that, and whether we could enter the mind of the person asking the question, and so on. This is a real issue. It was identified by Hon Ed Dermer in 2011. I have pursued it year after year. The former Commonwealth Parliamentarian of the Year will move an amendment asking us to support that care be provided. Whatever the response, it cannot be that this does not happen. Some people may still not want to support it and they will have their reasons. I do not look forward to hearing the justification for not supporting it, but people are entitled to have their view and vote accordingly. After all this time, I will not remain silent on any suggestion that this practice does not happen. When the health minister said there is no such thing as a baby born alive after an abortion, that was wrong. It clearly does happen; we know that. There can be no member in this place who does not know that that happens. There can be no member in this place who does not know that it sometimes involves a baby with a nonlethal abnormality. Make no mistake: I am not making the case for babies to be left to die if they have a lethal abnormality. However, for those who place greater weight on whether a baby has a lethal or nonlethal abnormality, be under no illusion that this happens in Western Australia and it is the reason I will support Hon Kate Doust's amendment.

Hon LORNA HARPER: I was not intending to rise and speak about this, but I oppose this amendment. As members can tell, I am quite agitated and upset by what I felt was sermonising during the last point. What members have to

remember is that women go in for an abortion because they wish to terminate a pregnancy. The reason for that is none of our business. When a woman makes a decision to abort a late-term pregnancy, she has to make a decision about whether to undertake feticide of the fetus—I hate the term—in the womb or whether she will give birth and the child will die after. That is what we are talking about with live births. We need to remember that a fetus born at 20, 21 or 22 weeks is not viable and will not live. Providing extra lifesaving, breathing or whatever procedures to the fetus of a woman who has made a decision to terminate her pregnancy is not viable for anybody.

We are here to discuss changes to legislation around abortion, which is legal. We are discussing whether or not women make decisions with their doctors about what they are going to do. We are not here to listen to a sermon about live births. Whether people do that or not, that is their business. We are here to talk about the legislation. To be sermonised again and again, I find highly offensive. This is hard enough as it is, because we now know more about abortion than most people ever want to know. The details are discomforting for everybody, but the member has then highlighted the most discomforting pieces to try to make us feel guilty: shame, shame, shame! We are here to discuss legislation. We are not here to discuss theories or people's beliefs. I support the bill as it has been put forward. I think it is time we move forward with this.

Hon NICK GOIRAN: With all due respect to the honourable member, Hon Roger Cook told the parliamentary committee —

Hon Lorna Harper: I don't care what Roger Cook said in 2011. Let's deal with 2023 and move on.

Hon NICK GOIRAN: The record reflects what the member has just said.

Hon Lorna Harper: Yes, please. I said it loudly enough. Move on!

The DEPUTY PRESIDENT: Order, members. Hon Nick Goiran has the call.

Hon NICK GOIRAN: I invite members to familiarise themselves with what Hon Roger Cook told the parliamentary committee on this issue of viability. At the same time, he told the committee that there were indeed babies born beyond the clinical limit of viability. The suggestion that this does not happen with regard to viability is false and inaccurate, and I once again invite members to make a decision based on the facts rather than how they might feel about this matter.

Hon KATE DOUST: I will respond to comments made earlier before I ask a couple of questions. The amendment I propose to move will move beyond the question of whether an abortion has happened. It is not about targeting the woman at all. Keeping in mind that we are shifting the goalpost from 20 to 23 weeks, when viability is a different question from 20 or 22 weeks, this motion is about how we treat a baby born alive post-abortion. In those circumstances, if by chance a child is born alive, how do we treat them? Do we cast them to one side and allow them to pass away without any care or due attention, or do we treat their lives at that point with the appropriate amount of dignity that they should be afforded as though they were born in normal circumstances, such as prematurely and unexpectedly? This is not about casting blame on individuals or seeking to cause them distress. The reality is that a child born alive in that situation will more than likely pass away of their own volition at some point. As the minister referred to, this could be perhaps a matter of minutes or an hour, or in some cases that we are aware of, several hours. This is about how we propose to treat a baby in that situation to afford them dignity and respect at that point. I will talk about that more when I finally get to dealing with the formal amendment.

I note that the member has already referred to the questions that have been circulating in this chamber since our good friend Hon Ed Dermer first canvassed them in the early to mid-2000s. The questions continue. I appreciate that it has been difficult information to extract and I am not too sure why that is the case. Queensland and Victoria provided evidence to a recent Senate committee inquiry into a bill around these situations and it was found that from 2010 to 2020, in each of those states, the number of babies born alive had been steadily increasing. I do not know whether that is because those states have a different period of time for a late-stage abortion, similar to what this bill is moving towards, when a higher preponderance of live births occur, or if there are other situations. I also note the fact that they appear to have put significant effort into maintaining the data. The current legislation has been in place in Western Australia since 1998 and these questions have been arising.

It always seems to be quite—I am not sure if intriguing is the right word—challenging. It seems to be a real struggle at a local level to extract that type of information about the circumstances when a child is born alive and how long life is sustained and the nature of the circumstances around their death. I fully accept that a substantial number of babies that are born alive will die very quickly because of the nature of their health issues prior to the termination. My concern is with how those babies are managed and what care they are given. I think the Leader of the House might have used the word "futile" before. I take on board that the cold, hard reality is that they will not have a long life, but it is about how, in that instance, we engage with and treat that situation. I will say more in a minute.

Hon SUE ELLERY: Thanks for the question, honourable member. I did answer it before but I am happy to answer it again. I want to make this comment: I noted the language used by Hon Kate Doust in responding to, perhaps, the exchange with Hon Lorna Harper. The language that the honourable member used was that the choice around her amendment, when we get to it, is between whether a baby is, to use her expression, "passed aside" —

Hon Kate Doust interjected.

Hon SUE ELLERY: I wrote it down, but *Hansard* will be the ultimate judge, I guess.

She used the expression "without dignity". I think we have to be careful about our language because, now, no baby born in those circumstances is "passed aside". Dignity is applied in the care of the fetus or the baby and the mother in those circumstances. That happens now. There will be no lack of dignity applied post the changes to the laws we are dealing with now. The honourable member went on to say that she found the difficulty in finding the data and information "intriguing" or "challenging". I think we have to be careful that we are not suggesting that something untoward is happening with the way the data is provided or not provided. We are talking about what I referred to earlier; it is consistent with how all patients are handled. A clinician or a health service provider is not obliged to provide futile medical care. In such circumstances, mindful and considerate palliative care is provided to the fetus and support is given to the patient and their family. I went on to talk about the perinatal loss team, for example, and the services it offers.

Hon Dr BRIAN WALKER: I want to reinforce what the Leader of the House has said, but also that the language used earlier by my esteemed colleague Hon Nick Goiran may have given a wrong impression. Let me give an example of a child born, for example, at 26 weeks. Let us assume that the pregnancy suddenly ended at 26 weeks for whatever reason. That much-wanted healthy child, who was not intended to be aborted, is now in this world. Heaven and earth are moved by very experienced neonatal intensive care unit staff to do everything possible to keep that life going. They very often fail. At 26 weeks, that is not a viable birth; should everything be left as it is? The amount of effort that goes into maintaining that life at 26 weeks, which is probably the earliest you can imagine, is enormous. The results, even for a deeply wanted, loved, cherished baby, may well be long-term, permanent damage and a life led as an invalid. There may be good results, but we cannot guarantee that.

Let us take this one step further to 23 weeks, which we are limiting it to now. We may well get a live birth, but not a viable birth. The difference is that we could, theoretically, take the same approach with all the intensive care from the NICU to try to sustain that life for a little while longer. That would be futile. That would harm all. What we are looking for, and I can quite support the words of Hon Kate Doust, is that every effort be made to give dignity to preserve humanity, which is probably going to be in terms of the child being given to the arms of the mother and father to care for the child for its short time of life on earth—to name it, to hold it, to cherish it and then, with dignity, to bury it.

There is a vast difference between that and the idea of doing everything possible to save the life of a child born alive although it was intended to be aborted. We never want to abort a child because of minor mishaps. Especially with a late-term pregnancy, abortion is always going to be for something serious. I think the language used is understandable for those of a particular persuasion, but it is simply not applicable to those early births.

I would like to speak out on behalf of my colleagues. I find myself doing that quite a lot. The concept that healthcare professionals would simply let a human life expire in horrible conditions is an insult to all healthcare practitioners. It is not what we do. I echo the words of the Leader of the House that care and love can be given in the short time that that life will be on earth, but I absolutely do not support the idea of giving intensive care fruitlessly to try to prolong a life that is destined to end shortly.

Hon KATE DOUST: I think at this point, deputy chair, I will move the amendment standing in my name. I move —

Page 12, after line 28 — To insert —

202MGA. Care of person born after performance of abortion

(1) This section applies if the performance of an abortion results in a person being born alive.

(2) Nothing in this Division prevents the registered health practitioner who performed the abortion, or any other registered health practitioner present at the time the person is born alive, from exercising any duty to provide the person with medical care and treatment that is —

(a) clinically safe, and

(b) appropriate to the person's medical condition.

(3) To avoid doubt, the duty owed by a registered health practitioner to provide medical care and treatment to a person born alive as a result of the performance of an abortion is no different than the duty owed to provide medical care and treatment to a person born alive other than as a result of the performance of an abortion.

Hon SUE ELLERY: I indicated during the course of the discussion across the chamber that the government will not be supporting the amendment. It is not necessary. It is the case now, in the circumstances we are talking about, that appropriate palliative care is provided and fits the circumstances as they present. We do not think it is necessary for that to be prescribed within the bill.

Hon KATE DOUST: I want to be very clear with members about aspects of this amendment. In the very unusual circumstance that it would be agreed to—I can certainly read the numbers in the house—this proposed section would apply only in circumstances in which a baby is born alive—in this case it refers to a person.

Nothing in this provision would prevent the health practitioner performing the abortion or any other present health practitioner—a nurse or somebody else—from doing anything they possibly could to provide medical care and treatment that is both clinically safe and appropriate to the person's medical condition. That picks up the matter that was canvassed about futile care. The amendment basically says that if that is the case, they will not proceed down that pathway. I think most people would accept that. That was certainly applied in the voluntary assisted dying debates as well. It is not saying that health practitioners must go all-out to preserve the life if it is not viable. I think it clears the way for that situation.

As I referred to earlier, the amendment is really about saying what will happen in, hopefully, the absolute rarest of circumstances. From our earlier discussions, we know that it is, indeed, one of the toughest calls to make. Hon Dr Brian Walker talked about when it is found that the life of a much-wanted child is not going to be viable for whatever reason. Whether that child was born alive post-abortion at 22 to 23 weeks or beyond, they should be treated with the same dignity, care and respect—however it is phrased, people use different words—as any other child born at that point as the result of a premature birth. It is not about attacking anyone. It is about asking how we will care for the baby in that circumstance. When they have drawn breath, how do we make their last minutes or their last hours comfortable and make them feel embraced? How do we care for them in an appropriate manner?

We have read stories about circumstances in which babies have been put to one side or in Petri dishes. We have read about medical staff who have been suspended because of how they managed that situation. It is a dreadful situation. This amendment is about saying that when that situation does happen, appropriate measures should be taken to ensure that the person born is treated with the upmost dignity and respect that they can be afforded.

Hon NICK GOIRAN: I have a couple of points to make. I want to draw to Hon Dr Brian Walker's attention some information from the Child and Adolescent Health Service of Western Australia. It says that the survival rate for babies admitted to the neonatal intensive care unit is approximately 60 per cent at 23 weeks and rises to 80 per cent at 24 to 25 weeks. I want to put that on the record because the honourable member suggested that it is difficult to survive at 23 weeks—I forget the exact term he used. I am sure that that is true and that it is probably impossible to survive without the assistance of the neonatal intensive care unit. However, the point is that we know that the survival rate at 23 weeks is 60 per cent and rises to 80 per cent at 24 to 25 weeks.

The Leader of the House indicated that the government is not supporting the amendment and that it has said it is not necessary because palliative care is provided. Why would we provide palliative care to a Western Australian baby who does not have a lethal condition? How can the Leader of the House say that the government says this is not necessary when there is no information on the 28 cases presently before us? The limited information that we have was provided to the parliamentary committee during the prior inquiry. I respectfully ask members why the government is suggesting that it is not necessary to enshrine into statute what is already the right of a Western Australian baby—that is, to receive medical care under the provisions of the Criminal Code. We know that there have been circumstances in which there have been problems associated with this and the government does not presently have access to the clinical files. We know that this has also been a problem in other jurisdictions.

I heard Hon Dr Brian Walker again defending the medical profession earlier, as it is his right to do. I quite rightly could hear his heart horrified at the suggestion that a medical or health practitioner might leave a baby to die. I can understand that horror, and yet there was the case of Jessica Jane in the Northern Territory. The Northern Territory coroner found that that was exactly what took place. We know that the New South Wales coroner found that this has happened at Westmead. It is the case that some health and medical practitioners in Australia have literally left babies born alive after an abortion to die.

I really plead with members and ask why, in these circumstances, would we not enshrine a provision to simply guarantee that a medical practitioner provide the quality of care that we would all expect? If it is the case that this is already occurring and it is apparently not necessary, there would certainly be no harm whatsoever in including this provision. If the bill before us goes to the extent of enshrining the term "person" for clarity and safety purposes, why would we not enshrine the care of a person born after the performance of an abortion in all the circumstances?

Division

Amendment put and a division taken, the Deputy Chair of Committees (Hon Dr Sally Talbot) casting her vote with the noes, with the following result —

Ayes (9)

Hon Martin Aldridge	Hon Nick Goiran	Hon Dr Steve Thomas
Hon Peter Collier	Hon Martin Pritchard	Hon Neil Thomson
Hon Donna Faragher	Hon Tjorn Sibma	Hon Kate Doust *(Teller)*

Noes (23)

Hon Klara Andric	Hon Lorna Harper	Hon Dr Brad Pettitt	Hon Wilson Tucker
Hon Dan Caddy	Hon Jackie Jarvis	Hon Stephen Pratt	Hon Dr Brian Walker
Hon Sandra Carr	Hon Ayor Makur Chuot	Hon Samantha Rowe	Hon Darren West
Hon Stephen Dawson	Hon Kyle McGinn	Hon Rosie Sahanna	Hon Pierre Yang
Hon Colin de Grussa	Hon Sophia Moermond	Hon Matthew Swinbourn	Hon Peter Foster *(Teller)*
Hon Sue Ellery	Hon Shelley Payne	Hon Dr Sally Talbot	

Amendment thus negatived.

Hon NICK GOIRAN: We are continuing to consider clause 8. The series of amendments we have been considering would have been inserted, on the advice of Parliamentary Counsel, at page 10, just prior to proposed section 202MF. I note that the next amendment —

Hon Sue Ellery: Which one, honourable member?

Hon NICK GOIRAN: Proposed section 202MF, on page 10. The series of amendments we have been considering were proposed to be inserted at that particular portion of the Abortion Legislation Reform Bill 2023, but I would like to briefly ask some questions about the provisions that follow. Proposed section 202MF deals with the performance of medical abortions by certain registered health practitioners on the direction of a medical practitioner or prescribing practitioner. Proposed subsection (3) refers to —

> A registered health practitioner in a relevant health profession (other than pharmacy) …

Who is intended to be captured by this?

Hon SUE ELLERY: Proposed subsection (3) captures the broad range of practitioners. The member will be aware that the heading of the proposed section is —

> **Performance of medical abortion by certain registered health practitioners on direction of medical practitioner or prescribing practitioner**

In a hospital setting, that may well be a registered nurse who is part of a multidisciplinary team and is directed by a medical practitioner to supply or administer a particular drug. Outside of that setting, it may well be a nurse practitioner—we have talked about that role before—or an endorsed midwife.

Hon NICK GOIRAN: A nurse practitioner or an endorsed midwife, who are captured by proposed section 202MD, which deals with the performance of medical abortion by certain other registered health practitioners at not more than 23 weeks. We earlier discussed the concept of a prescribing practitioner, but other than the nurse practitioner and the endorsed midwife, who are already captured by proposed section 202MD, is there another class of registered health practitioner that is intended to be captured by proposed section 202MF?

Hon SUE ELLERY: The first one I mentioned, honourable member: a registered nurse, working in a hospital, who is part of a team directed by the medical practitioner to supply and administer the drug.

Hon NICK GOIRAN: Moving to proposed section 202MG(4), the legislation now introduces the situation of a student being involved in the performance of an abortion by a medical practitioner or a prescribing practitioner. Why is it necessary to have an assistant supervising the student if someone else is actually performing the abortion?

Hon SUE ELLERY: I just want to make sure we are getting our language right here. Under proposed subsection (3), the student is assisting; but maybe we misheard what the honourable member said.

Hon NICK GOIRAN: In a scenario in which a student is involved, it will only be the student and the same practitioners who we have described earlier—either a medical practitioner or a prescribing practitioner?

Hon SUE ELLERY: Who provide supervision to the student—is that the member's question?

Hon Nick Goiran: Yes.

Hon SUE ELLERY: In addition to the two we referred to earlier, it could be that there is a prescribing practitioner. Proposed section 202MG(4)(b)(i) captures the medical practitioner or the prescribing practitioner; proposed subparagraph (ii) captures a registered health practitioner in a relevant health profession who is assisting in the

performance of the abortion, and that could be another nurse; and proposed subparagraph (iii) captures the student's primary clinical supervisor, who may be a nurse or a medical practitioner, depending upon what the student is.

Hon NICK GOIRAN: This goes to my original question. Why would there be another person introduced at this point in time? Would it not be the case that there will always be present with the student either a medical practitioner, a prescribing practitioner or, as the minister says, a registered health practitioner who has received direction under the provision we discussed earlier? Those are the three types of people who can, if you like, be involved. We are now introducing the concept of a student being involved. They are going to be supervised, presumably, by one of the other practitioners, yet this provision opens up the door for the student's primary clinical supervisor.

Hon SUE ELLERY: It is for the purpose of a student demonstrating the student learning, if you like. It might be appropriate that the student's primary clinical supervisor is in the area where that student is assisting for the purpose of observing how the student conducts themselves in that setting and, separate from the clinical procedure that is going on, assessing their performance.

Hon NICK GOIRAN: It is not a limiting clause, as I see it, minister. The student's primary clinical supervisor, in fact any other person, could be present. However, proposed section 202MG(4)(b) uses the word "or", and so the supervision will need to be undertaken by a person from one of the three categories set out there. The point I am trying to make is that, as I understand it, there would always be a medical practitioner, prescribing practitioner or registered health practitioner present. If one of them is always present, would they not be doing the supervision of the student and therefore it will not be necessary to include the student's primary clinical supervisor? I am just not sure what is added to the bill by the insertion of lines 20 and 21 at page 12.

Hon SUE ELLERY: I took a little minute to walk through in my head an example of when that might occur. In the normal course of the procedure, we would expect that that student would be supervised by the medical practitioner, the prescribing practitioner or a registered health practitioner in the relevant profession who is assisting in the performance of the abortion. But it may well be that in, for example, the supply and administration of a drug, they might be doing a medicine round and the student's primary clinical supervisor might be the one supervising the student for the purpose of assessing the student's skill, technique or whatever practice in supplying and administering that drug. In terms of what might happen in a theatre, we would expect that the medical practitioner or another registered health practitioner will be the one doing the supervision. But there might be various points in the assessment of the student that they might be supervised by only their clinical supervisor. The most common example would be in respect of drugs.

Hon NICK GOIRAN: Will the student's primary clinical supervisor always be a medical practitioner?

Hon SUE ELLERY: If it is a nurse, for example, it may well be a nurse as opposed to a medical practitioner.

Hon NICK GOIRAN: In that case, if it were a nurse, would that nurse not be captured by being either the prescribing practitioner or registered health practitioner under proposed subsection (4)(b)(ii)?

Hon SUE ELLERY: Not necessarily, honourable member. It has been a long time since I worked for the Australian Nursing Federation, but the clinical supervision of nursing students and the assessment thereof is carried out by somebody who is separate from the ongoing delivery of care. They are not part of the multidisciplinary team that is providing the abortion care. Their job in that hospital setting is the supervision and clinical assessment of nursing students.

Hon NICK GOIRAN: In this scenario, are we opening the door for a scenario whereby the abortion will be performed by a student with a supervisor who is neither a medical practitioner nor a prescribing practitioner?

Hon SUE ELLERY: No. It would always be, as this clause goes to, assistance by certain registered health practitioners or students. They will not be performing; they will be assisting.

Hon NICK GOIRAN: They will be assisting in the performance of an abortion without the medical practitioner or the prescribing practitioner being present?

Hon SUE ELLERY: I have tried to describe the various stages. It might be that the patient is in their bed in the ward receiving a drug. The student might be assisting to do that and demonstrating their clinical capacity to their assessor. That is part of the provision of abortion care, but it is not the person in the theatre, for example, if we are talking about a surgical intervention. It depends entirely on the nature of the student as to what role they can play in it, and it will be done under supervision.

Hon NICK GOIRAN: Is proposed section 202MG consistent with existing law?

Hon SUE ELLERY: I am advised that in the national laws that go to accreditation and registration of the various professions, that is where the provisions in law, to use the language in the member's question, set out the arrangements that apply, be it student doctors, student nurses et cetera. I am seeing whether I can get the member

a reference for that. For example, under the Health Practitioner Regulation National Law (WA) Act 2010, it goes to arrangements for student registration, persons undertaking approved programs of study or limited registration for various arrangements et cetera.

Hon NICK GOIRAN: Perhaps, then, a better way to phrase the question is: under current Western Australian law, is it the case that students are assisting in the performance of an abortion?

Hon SUE ELLERY: Yes.

Hon NICK GOIRAN: I might indicate for the benefit of the deputy chair, as she manages this particular substantial clause 8, that I have concluded my questions on proposed sections 202MF and 202MG. I note that the next proposed section deals with conscientious objection for medical and health practitioners.

Hon KATE DOUST: I indicate that at this point, I have some amendments that deal with proposed section 202MI. This amendment is at 9/8 on the supplementary notice paper. I move —

> Page 14, lines 20 to 24 — To delete the lines and insert —
>
> (b) the medical practitioner or prescribing practitioner (the ***unwilling practitioner***) is unwilling to comply with the request, whether for the reason that the unwilling practitioner has a conscientious objection to abortion or for some other reason.

Before I start talking about that amendment, I have a couple of questions that relate to the language used throughout this clause whereby the word "refusing" is inserted into this bill and regards someone who has a conscientious objection to participating in the abortion process, even with the first contact with a woman who is seeking an abortion. My first question is: in what other states are the words "refuses" or "refusing" used in this capacity?

Hon SUE ELLERY: I do not have any information at the table that suggests that those words are in use in any other jurisdiction. It might be the case, but we do not have that information here. I can tell the member, though, that the legislation was designed to capture conscientious objection or "for some other reason", which would leave the practitioner to make the decision that they cannot provide the abortion care.

The DEPUTY CHAIR: Just to be clear, the question before the committee is: that the words to be deleted be deleted.

Hon KATE DOUST: I understand that Victoria and the ACT use the word "refuse" but they do not use the words "refusing doctor". Therefore, my next question is: when we are dealing with the issue of conscientious objection in this circumstance, why was that particular word selected as opposed to any other word?

Hon SUE ELLERY: I am advised it was a drafting issue that was raised by Parliamentary Counsel. I will put on the record that we will not support the amendment. I think there is a difference between refusal and being unwilling, because one can be unwilling but still actually do something. One can do it unwillingly. Refusal makes it clear that one is not going to do it; for reasons that one is entitled to hold, one is not going to do it, whereas I do not think that being unwilling is clear because one can be unwilling to do something but still do it.

I have not made this point yet, so forgive me if I am making an assumption, but I do not think there is anything pejorative, if you like, about the use of that term. In my current finance portfolio, I deal with contractual matters, and there is a standard right of refusal. It does not mean anything good or bad; it is just first right of refusal. It is a term used to make clear that a person has made a decision that they are unable to perform that particular kind of care. I think if we were to use the word that the honourable member seeks in her amendments to use, it would not provide any additional clarity because one can still do something although unwillingly.

Hon KATE DOUST: When a medical practitioner, based on their conscientious objection, does not want to engage in an abortion, will they be required to provide a reason to their patient?

Hon SUE ELLERY: If we go back to page 13 of the bill, proposed section 202MH(2) states —

> If a registered health practitioner who has a conscientious objection … is requested … to do a thing referred to in subsection (1), the registered health practitioner must disclose the practitioner's conscientious objection to the … person immediately after the … person makes the request.

Hon KATE DOUST: One of the reasons we are seeking to change the language used in not just this part of the bill, but also a number of other subclauses is that, based on feedback, some medical practitioners find the language unusual and quite strident. It is a much stronger term than "unwilling". People might be unwilling to perform an abortion for a whole range of reasons other than just a conscientious objection. They might not have time available. They might have other things happening. There could be any range of reasons, and so I think the term "unwilling" is a softer term, if you like, and perhaps does not draw as much attention in this set of arrangements. Conscientious objection has certainly been a very contentious issue in the matters pertaining to end of life—be it the beginning or the end—and sometimes doctors who do not want to engage in this practice are targeted. Part of the concern is that the nature of the language used in this bill may lead to doctors being targeted because of their personal, religious

or cultural views or other reasons. Therefore, there is a view that the nature of the language could have been different. I do not understand why there could not have been a reference such as if a doctor has a conscientious objection, they will do X, Y and Z, as it flows in the rest of the bill. Why does this specific word have to apply to that medical practitioner in that situation?

Hon SUE ELLERY: I guess we will just have to agree to disagree. I think the word "refusal" is clearer; I do not think it is any more strident or there is anything pejorative added to it. It makes it clear, whereas I think the word "unwilling" does not make it clear at all. The member has put her argument, but there is no value attached to the term. As I said, in contractual terms, "first right of refusal" is a common expression and it means nothing more or less than that.

Division

Amendment put and a division taken with the following result, the Deputy Chair (Hon Dr Sally Talbot) casting her vote with the noes, with the following result —

Ayes (3)

Hon Nick Goiran	Hon Neil Thomson	Hon Kate Doust *(Teller)*

Noes (27)

Hon Martin Aldridge	Hon Sue Ellery	Hon Shelley Payne	Hon Dr Sally Talbot
Hon Klara Andric	Hon Donna Faragher	Hon Dr Brad Pettitt	Hon Wilson Tucker
Hon Dan Caddy	Hon Lorna Harper	Hon Stephen Pratt	Hon Dr Brian Walker
Hon Sandra Carr	Hon Jackie Jarvis	Hon Martin Pritchard	Hon Darren West
Hon Ben Dawkins	Hon Ayor Makur Chuot	Hon Samantha Rowe	Hon Pierre Yang
Hon Stephen Dawson	Hon Kyle McGinn	Hon Rosie Sahanna	Hon Peter Foster *(Teller)*
Hon Colin de Grussa	Hon Sophia Moermond	Hon Matthew Swinbourn	

Amendment thus negatived.

Hon NICK GOIRAN: I refer to proposed section 202MI, "Obligation of medical practitioners and prescribing practitioners who refuse to participate in abortion". The house has dealt with the use of the words "refuse" and "unwilling". Proposed subsection (2) on page 14, line 25, states —

> The refusing practitioner must —
>
> (a) without delay transfer the patient's care —

How is "without delay" intended to be interpreted?

Hon SUE ELLERY: Although we are not being prescriptive, it is anticipated that the patient's care will be transferred "as soon as practicable", so most likely in the consult when the person raises the issue, whether that is to make a phone call or write out a referral, but as soon as practicable.

Hon NICK GOIRAN: If the refusing practitioner does not readily have information at their disposal about a place that might be able to provide this service to the consumer, is there intended to be a period of time or a code of practice or something whereby the health practitioner knows that they might be in jeopardy of breaching this proposed section?

Hon SUE ELLERY: No. As I said, we will not prescribe a specific period of time. The expectation is that the practitioner will do it as soon as practicable. For example, if the internet is down, in the general reasonableness test, that would be considered a reasonable reason the practitioner may need to wait or find some other way to get that information. That is why the expectation is that it is done as soon as practicable. We will not be prescriptive, but the expectation is that the practitioner has told the person that they are a conscientious objector. They have the obligation to provide a referral and they will take steps to do that.

Hon NICK GOIRAN: Apparently, one of the other options available to the refusing practitioner is to give the patient information approved by the Chief Health Officer. What is that information?

Hon SUE ELLERY: Standardised information regarding the process will be developed during the implementation stage. That will help the person access the relevant resources and supports they need.

Hon NICK GOIRAN: Is no such information of this kind presently available?

Hon SUE ELLERY: Not over and above what has already been tabled in those two documents—the "north metropolitan documents", one for consumers and one for clinicians.

Hon NICK GOIRAN: I know the minister indicated that this information would be updated. Would material of this kind, if provided, satisfy compliance with proposed section 202ME(2)(b)?

Hon SUE ELLERY: In respect of proposed section 202MI(2)(b), the information approved by the Chief Health Officer may or may not look like the information that we have been referring to in the North Metropolitan Health Service document. It will most likely include information about how to locate somebody who can provide the service. For practical purposes, one would think that it would be written in such a format that it would be easy to read where the closest service is—for example, we were talking about somebody seeking that care outside metropolitan Perth—and how they could get access to that service.

Hon NICK GOIRAN: I have some questions about proposed section 202MJ, "Student with conscientious objection to abortion", which starts at page 16, but before I start, can I get some guidance from you, deputy chair, on which amendment on the supplementary notice paper is intended to be moved next?

The DEPUTY CHAIR (Hon Dr Sally Talbot): I might need an indication from Hon Kate Doust about whether she is going to move amendment 14/8.

Hon KATE DOUST: I will, on the basis that I assume you are about to tell me that the other amendments in my name, amendments 10/8 to 13/8, now disappear as a result of the last division.

The DEPUTY CHAIR: That would be the assumption.

Hon KATE DOUST: If that is the case, yes, I do intend to move amendment 14/8.

Hon NICK GOIRAN: This might be a good time.

Hon KATE DOUST: I think so. Nothing is uncomplicated in this debate, as I have discovered. I move —

> Page 15, after line 29 — To insert —
>
> (5) To avoid doubt, this section does not apply to a medical practitioner or prescribing practitioner who would be willing to comply with a request referred to in subsection (1)(a) but is unable to comply with the request because of unavailability or some other reason.

This provision is not about having a go at anyone; it is about trying to be helpful. Sometimes there are reasons why a practitioner may not be able to provide the service that is being requested. It may not be because of a conscientious objection. It could be for an entirely different reason. In light of the other amendments that have been dealt with, this amendment was proposed as a bit of a catch-all, or a protector or safeguard if you like, for the medical practitioner. It might be a conscientious objection; it might not be. It might be that they are going to be away, they might not have the staff available or they might have a full book of patients. There could be a range of reasons. It is about ensuring that they have protection and are not seen to be, in the words of this bill, refusing. It was added with the thought of trying to provide some assistance to those doctors who may want to be involved but, for some reason outside of their control, may not be able to.

Hon SUE ELLERY: The government will not be supporting this amendment. Proposed section 202MI(1) refers to the refusing practitioner refusing, whether for the reason that the refusing practitioner has a conscientious objection or for some other reason. It also goes to the issue that I was just discussing with Hon Nick Goiran about why we did not put a prescription of timing into the provision. There may well be reasons why it is not possible, such as the practitioner going on holiday, an issue with staffing or whatever. It will capture that. The test of reasonableness is that the referral is to be done as soon as practicable. If that is the practice we intend to adopt, the amendment before us now is unnecessary.

Hon MARTIN ALDRIDGE: Can I get some clarity on this provision? I think what Hon Kate Doust is trying to say through the insertion of proposed subsection (5) is that effectively proposed section 202MI will not apply to practitioners who may, for some other reason, be unavailable to perform an abortion, whereas the minister has said that that is anticipated in proposed subsection (1)(b), which states "whether for the reason that the refusing practitioner has a conscientious objection to abortion or for some other reason". The other reason could be a physical reason, a health reason or a range of other things that could be anticipated in running a medical practice. In those circumstances, the same obligation to refer the patient will exist whether they are a conscientious objector or whether they object for another reason; is that correct?

Hon SUE ELLERY: That is correct.

Amendment put and negatived.

Hon KATE DOUST: I have another amendment at 15/8. I am just clarifying that that falls away given that the earlier amendments were also knocked out.

The DEPUTY CHAIR: Honourable member, yes, it has.

Hon NICK GOIRAN: I note that the next amendment on the supplementary notice paper is in the name of Hon Wilson Tucker, who is away from the chamber on urgent parliamentary business, but it applies only to page 22

of the bill. Although page 22 is still within clause 8, it is still some period away. I have some questions about the matters that precede it, particularly at page 16 of the bill, which deals with a student with a conscientious objection to abortion. What mechanisms will a student have if taking part in an abortion procedure goes against their conscience?

Hon SUE ELLERY: I am not sure exactly what the honourable member means by "mechanism", but proposed section 202MJ(3) provides that if a student has a conscientious objection and they have been requested to assist, they must disclose their objection to the supervising person immediately after the supervising person makes that request. They will have the right to refuse.

Hon NICK GOIRAN: What mechanisms will be in place to ensure that a student is informed of the right to refuse?

Hon SUE ELLERY: It could be in a number of ways. I think we talked before about, for example, a nursing student. A nursing student might do their prac in various parts of the hospital and their clinical supervisor will be different from perhaps the nursing supervisor on a particular ward or in a particular theatre. Issues about the kind of care that they will cover will be discussed between the student and the student supervisor. In addition to that, there may well be material in the updated version of the North Metropolitan Health Service document that we referred to. It may well be in the material that is going to be put together by the Chief Health Officer in the six-month period between when the bill passes and when it is implemented. At a number of points along the journey, it would be made clear to the student, "This is the type of care we're about to go into and these are your options."

Hon NICK GOIRAN: Those options include the right to refuse.

Hon Sue Ellery: Correct.

Hon NICK GOIRAN: I want to be clear whether there is a mandatory obligation on the part of whoever is supervising the student at that time to let them know what they are about to do and, secondly, that in that instance they have a right to refuse.

Hon SUE ELLERY: I am not sure that it could be considered mandatory but in the course of their training, including their training now, they would be advised of a whole range of matters, including voluntary assisted dying, for example. In the same way that they would be informed "This is what we're about to learn and these are the sorts of things you're likely to deal with", that information will be provided to them. Whether it is in the updated version of the north metro document, other material prepared by the Chief Health Officer or by the nursing schools or medical schools, that information will be provided.

Hon NICK GOIRAN: Is it "will be provided" or "may be provided"? Does the new, updated statutory scheme the chamber is going to pass cater for a situation in which a student has not been told that they have a right to refuse?

Hon SUE ELLERY: There is nothing, unless someone at the table points me to something. This is not the only bit of medical care that people have different values about. End-of-life care is another example, and not just end-of-life care that is captured by the voluntary assisted dying legislation but all sorts of clinical decisions can be made that some people might take a particular value position on. I am advised that it is standard practice now to provide information to students about what they can do if they have a view about a particular form of care. It is not mandated in the legislation in front of us. It is not mandated now about all manner of things, yet the practice is that students are given the right to express their point of view if it is a procedure they cannot be involved in. If the question is whether it is mandatory now or whether it will be mandatory in the future, it is not mandatory now and it will not be mandatory under the provisions of the bill in front of us, but I am advised it is the practice now and it is intended to be the practice going forward. The material to be prepared will include reference to that.

Hon NICK GOIRAN: I am comforted by the fact that the existing practice is that a student is told and it is the intention for that to continue. I think the bill could be improved by mandating that requirement for the sake of the protection of the student. Proposed subsection 202MJ(2) makes it clear that the student has a statutory right to conscientiously object. That is a provision I support but the provision is of little value to a person who does not know that it exists. That is why I think it would be an improvement if the supervising person had a mandatory obligation to draw to the student's attention that they have a right to conscientiously object.

In an earlier part of our consideration of the bill, the minister indicated that one of the methods that is used for an abortion is a dilation and curettage but not every D&C is for an abortion. When the student is told that, as part of their education and training, they are going to be involved in a D&C, if it is for the performance of an abortion, is that expressly brought to their attention?

Hon SUE ELLERY: The experience of the doctor at the table is that the surgical list would not list "D&C" if it was to be a termination. It would list "termination of pregnancy" so it would be clear. The experience of the doctor at the table is also that it is normal practice for a surgeon to check with everyone on the team that they know what they are doing, why they are doing it, and that they are comfortable with participating in the procedure.

Hon NICK GOIRAN: Hon Wilson Tucker has returned to the chamber from urgent parliamentary business. Really for his benefit, I indicate that we are currently making our way through clause 8. In particular, we have just dealt with section 202MK. He has an amendment standing in his name on the supplementary notice paper for page 22. For the present purposes, we are currently making our way at page 17. Of course, that does not stop the honourable member from moving his amendment at an earlier stage should he wish to do so. In systematically making our way through this very substantial clause 8, my question to the minister is on proposed section 202ML, which goes out of its way to indicate that section 177 of the Criminal Code will not apply. Why has that been thought necessary?

Hon SUE ELLERY: By excluding the application of section 177 of the Criminal Code, the performance of an abortion by a registered health practitioner will be excluded from penalties under the code. That is consistent with the intent of proposed section 202MK for practitioners to be subject to the same professional and legal consequences, which are set out in proposed subsection 202MK(2), as those that apply to other medical procedures pursuant to the Health Practitioner Regulation National Law and the Health and Disability Services (Complaints) Act 1995.

Hon NICK GOIRAN: Is it then the case that, moving forward, the only section of the Criminal Code that will not apply to abortions is section 177?

Hon SUE ELLERY: Yes, that is what I am advised.

Hon NICK GOIRAN: For example, section 262 of the Criminal Code refers to a duty to provide the necessaries of life. It states —

> It is the duty of every person having charge of another who is unable by reason of age, sickness, mental impairment, detention, or any other cause, to withdraw himself from such charge, and who is unable to provide himself with the necessaries of life, whether the charge is undertaken under a contract, or is imposed by law, or arises by reason of any act, whether lawful or unlawful, of the person who has such charge, to provide for that other person the necessaries of life; and he is held to have caused any consequences which result to the life or health of the other person by reason of any omission to perform that duty.

Will that provision in the Criminal Code continue to apply?

Hon SUE ELLERY: Yes, it will.

Hon NICK GOIRAN: If a baby is born alive after an abortion, will the necessaries of life continue to be provided in each and every case?

Hon SUE ELLERY: The honourable member will recall that in an earlier part of the debate I made reference to the fact that, as with all patients, there is no obligation on a practitioner or health service provider to provide futile medical care.

Hon NICK GOIRAN: I accept that there is no need to provide futile medical care, but there is a duty to provide the necessaries of life.

Hon SUE ELLERY: It is intended for that element of the Criminal Code to be read in connection with the regulatory framework set out in the bill before us, which goes to planned, clinically supervised abortions. That element of the Criminal Code is to be read with: there is no obligation to provide futile medical care. If it were the case that the Criminal Code provision referred to by the member existed to override everything else, a whole range of medical care and services would have to fall away. However, that is not how that provision of the Criminal Code is interpreted or applied. It is interpreted and applied with the other existing laws that regulate how we provide medical care in all manner of circumstances and clinical presentations.

Hon NICK GOIRAN: I am spending some time here because I want to make sure that by inserting proposed section 202ML, under which we are expressly saying that a particular provision of the Criminal Code does not apply, that in no way is it to be interpreted that section 262 of the Criminal Code will not apply and it will apply in full force. This is particularly important because, as the minister might recall, earlier we talked about the inquiry undertaken by the Standing Committee on Environment and Public Affairs into babies born alive after abortion. One of the questions put to Hon Roger Cook at the time was, "What are the legal implications for health workers when intensive care is not provided to a baby born alive with a nonlethal condition following an abortion, and has the health department sought legal advice on this issue?" The response at the time was that legal advice had not been sought on the question. Has it been sought since?

Hon SUE ELLERY: No. I am advised by the advisers at the table, not to the best of their knowledge.

Hon NICK GOIRAN: Recognising that we are still on clause 8—the performance of abortions in Western Australia generally—moving forward, will the necessaries of life need to be provided to a baby with a nonlethal condition born alive following an abortion?

Hon SUE ELLERY: We have been over this point before, and I get that the honourable member is drawing it to my attention by aligning it with the Criminal Code. I understand the point the member is making, but nothing in my answer has changed. Palliative care is provided to the baby, and perinatal loss services are provided to the mother and the family, if that is required. Nothing the member has drawn my attention to in the Criminal Code changes the answer I have given on this previously.

Hon NICK GOIRAN: I acknowledge that the minister has indicated that palliative care is provided and that she does not have the 28 cases and the clinical information. I am not sure how it is that we can say that palliative care is provided when we do not actually have the information. I am not sure what the source of the information is that assures us that palliative care is provided. However, I will park that because I am not talking about lethal cases. I am talking about nonlethal cases. We do not provide palliative care to nonlethal cases. I know the minister has had one of Western Australia's leading palliative care providers at her disposal throughout this debate. I am pretty confident when I say that we do not provide palliative care to nonlethal conditions. I press this point a little bit further to be sure that nothing in clause 8 will change the state of the law at the moment. The health department may not have received advice on this back whenever this inquiry took place or at present. Is there anything in clause 8 that will change the state of the law—that is, if a baby with a nonlethal condition is born alive after an abortion, they are entitled to the necessaries of life as a person.

Hon SUE ELLERY: I cannot think of another way to put it to the honourable member. I understand the point he is making about that section of the Criminal Code. There is nothing in the bill before us other than proposed section 202ML, which refers to section 177 of the Criminal Code. I am advised nothing else in the bill before us will counteract or interact with the provisions of section 262 of the Criminal Code. It might the case that the member's next public mission in life is to pursue that argument—maybe it is. However, that section of the Criminal Code operates now and it has not been called into conflict with existing laws around this or any other kind of health care. I do not have anything at the table that I can add to the debate to satisfy the member, other than to say that current practices are not deemed and have not been found to be in contravention of that provision of the Criminal Code. It is not anticipated that they will be found to be in contravention of the Criminal Code.

Hon NICK GOIRAN: I am going to move to proposed section 202MM. I am comforted that the minister indicates that nothing in the bill takes away from section 262 of the Criminal Code and, as the minister has foreshadowed, this can be taken up at another time and place. Proposed section 202MM is headed "Consent to performance of abortion on children who are not mature minors". Has the Commissioner for Children and Young People been consulted in respect of this provision?

Hon SUE ELLERY: I am advised no.

Hon NICK GOIRAN: Is this going to change the state of the law with regard to the performance of abortion on children?

Hon SUE ELLERY: The member would be aware that currently in the Health (Miscellaneous Provisions) Act and the Children's Court of Western Australia Act there is a requirement for parental involvement when a dependant minor seeks an abortion—that is, a patient aged under 16 years who is supported by a parent or guardian. Western Australia is the only jurisdiction in which minors, regardless of their maturity, are required to meet a higher standard of informed consent for abortions compared with other medical care. We canvassed the new provisions—I am sure the member is probably going to ask me about them—including the notion of a mature minor and Gillick competence and the like.

Hon NICK GOIRAN: I note in passing that despite the fact that the title of proposed section 202MM refers to the notion of "mature minors", there is nothing in the section itself that uses that phrase or defines that phrase. Under those circumstances, how will those who seek to comply with the legislation define "mature minors"?

Hon SUE ELLERY: The honourable member is right. The expression "mature minors" does not appear in the text of that proposed section. It is found in the heading that is a descriptor of what is covered. If the member recalls what we are doing here, we are taking everything out of the Health (Miscellaneous Provisions) Act 1911 and relying on common law, and then in the bill before us putting anything we want to put in on top of common law. Proposed section 202MM applies if, under proposed subsection (2), a health practitioner proposes to perform an abortion for someone who is under 18 years of age and they consider that the patient does not have the capacity to consent on their own behalf because they have not achieved a sufficient understanding and intelligence to enable them to understand fully what is proposed, or it is not possible to ascertain whether the patient has the capacity to consent, and the patient agrees to a parent or guardian being involved, and the provision goes on.

Back to the member's original point, he is right. That is the descriptor in the heading and the words do not appear in the text, but this about taking it out of one provision, relying on common law and then putting a bit on top of that to make it particularly pertinent to the circumstances.

Hon NICK GOIRAN: This provision makes it clear that if the person—that is the child—under the age of 18 is deemed to not have the capacity to consent, and if they agree that a parent or guardian can participate in the decision-making process, the practitioner can rely on the views of the parent or guardian, if you like, in substitution.

Hon Sue Ellery: By interjection, yes. Remember, we canvassed this before. I think it was in the clause 1 debate, honourable member.

Hon NICK GOIRAN: Yes, but this section does not necessarily deal with what happens in the event that the parent or guardian refuses to provide the consent. Proposed subsection (3) states —

> If this section applies —
>
> (a) the parent or guardian referred to in subsection (2)(c) may consent or refuse consent to the performance of the abortion on the patient by the registered health practitioner; …

If that consent is not provided or specifically is refused, does that end the matter?

Hon SUE ELLERY: Flowing on from proposed subsection (3)(a), to which the member just referred, if a parent refuses consent, and the registered health practitioner thinks it is in the best interests of the child—the patient—to still proceed, then the practitioner will need to take that matter to the Family Court of Western Australia or the Supreme Court, which is set out in the next proposed subsection. We did canvass this during the course of the clause 1 debate.

Hon WILSON TUCKER: I have an amendment that I believe is the last amendment on the supplementary notice paper. We are jumping ahead in the bill, but perhaps we can deal with it now for the sake of simplicity.

Hon Sue Ellery: Fine by me.

Hon WILSON TUCKER: The amendment in my name inserts section 202MPA, "Relevant persons must notify Chief Health Officer about performance of abortion for particular reason of sex selection". This amendment seeks to take a softer approach to a previous amendment that we dealt with put forward by Hon Kate Doust. The amendment will not outlaw an abortion of the basis of gender selection, but rather the CHO will be notified by a clinician if somebody seeks an abortion on the basis of gender selection. My take here is that if we cannot measure it, we will not know it is an issue. The evidence suggests that it is an issue in other jurisdictions. Other jurisdictions in Australia are concerned about this and have taken appropriate steps. We are not doing that in WA. We have not agreed to the amendment raised by Hon Kate Doust. The idea here is to measure if this is becoming an issue and put some provisions in place.

I have had some behind-the-scenes discussions with the Minister for Health and we have come to the agreement that I will not move this amendment on the floor on the basis of the agreements that we had behind the chair. Perhaps I will reserve my comments until the Leader of the House has made a statement on that point.

Hon SUE ELLERY: Yes, I have been advised of the conversations and discussions that the member had with the Minister for Health. The government would not support the amendment, however the Minister for Health has authorised me to advise that she has committed to working with the Chief Health Officer to prepare a survey for practitioners involved in the delivery of abortion care that will include a question on the topic of abortion on the basis of sex selection. The survey will commence 12 months after the bill has become operational. The Chief Health Officer already has the capacity to undertake that work. It would not require an amendment or regulatory change. There is nothing in the act limiting the Chief Health Officer from doing a survey of this nature.

I think the member referred in his comments to what has been done in other jurisdictions. There was a review in New South Wales that found that, between 1 October 2019 and 30 September 2020, the number of abortions that could be attributed to sex selection was negligible, at just 0.02 per cent. I think I made that point in the earlier debate. That reflects the advice that I have been given about the commitment that the Minister for Health gave the member. I reiterate that the government would not support the amendment.

The DEPUTY CHAIR (Hon Stephen Pratt): Before I give the call to Hon Wilson Tucker, for the clarity of members and the clerks, can he please indicate the amendment and whether he is going to move it?

Hon WILSON TUCKER: Thank you, deputy chair. No, I will not be moving the amendment. I would just like to put on the record my thanks to the health minister for the way she has openly engaged with the debate and in collaborating with myself on this matter. I have a few questions regarding the survey that I would like to tease out. Firstly, will the survey be made publicly available?

Hon SUE ELLERY: I have the Deputy Chief Health Officer sitting next to me at the table. I think it is reasonable to expect that at least a summary of the findings of the survey will be made public. The reason that I am a little bit hesitant in my language is because I have not had a discussion with the minister about what exactly would be published. However, I think it would be reasonable to expect at least a summary to be made public. Given that we

will be breaking for the taking of questions in a minute, I might be able to get something that will make it much clearer for the honourable member.

Hon WILSON TUCKER: Thank you, Leader of the House. I have a final question on the subject of the survey. Given that it will be a one-off after 12 months, if the evidence suggests that people seeking abortions on the basis of sex selection is becoming an issue in WA, will the CHO undertake to conduct the survey on an ongoing periodic basis?

Hon SUE ELLERY: Again, I have not had a conversation with the Minister for Health about that. Given the time, I will see what undertakings I am able to get whilst we are taking questions.

Hon MARTIN ALDRIDGE: The arrangement of this survey has been quite an interesting revelation in the Legislative Council today. I think that the Leader of the House mentioned that the Chief Health Officer does not require statutory authorisation to conduct a survey and that it is effectively a mechanism in which he will go out to the medical fraternity and ask them to respond on a voluntary basis. Does the Chief Health Officer do this from time to time on other issues?

Hon SUE ELLERY: I am not sure if a survey has been used. Maybe we can find that out in question time. I am advised that he will seek the views of the profession on a range of matters from time to time. That might be through holding an in-person clinical roundtable or a teams meeting. It is not unusual for him to seek the views of the profession on a range of public health matters. I do not have an answer to whether the format of a survey has been used at the table now.

Hon MARTIN ALDRIDGE: If there is an opportunity during the interruption shortly to seek some further information, I would also be interested to understand what sort of response rate the Chief Health Officer enjoys. As somebody subject to survey fatigue, my diary is not segmented into five-minute blocks like many medical practitioners. I am interested to see or understand their appetite to participate in voluntary surveys by the Chief Health Officer.

Hon NICK GOIRAN: We will wait to see what further response comes back from the Leader of the House in respect of that matter. I note, of course, that just because Hon Wilson Tucker indicated to the Leader of the House that he will not be moving the amendment standing in his name, that does not prevent any other member from moving the exact same amendment. I will be keenly looking forward to hearing the response provided by the Leader of the House, particularly regarding the notion that this survey will be a one-off. I do not really understand the point of that. What are we going to do with a one-off survey? I could perhaps understand if there was a commitment that it was going to be a rolling survey done on an annual basis because, as I understood from the debate last week, everybody is in agreement that, at least as a matter of principle, abortions should not be happening for sex-selection purposes. That was certainly my understanding from last week. We might have had a disagreement about whether it was necessary to put it in the legislation to make it clear that this ought not to happen. However, I can see little merit in doing a one-off survey one time only. I could concede a little bit of weight to it if it was going to be done on an ongoing basis.

Noting that the time for taking questions without notice is rapidly approaching, I will go back to the point about mature minors. The Leader of the House referred us to a WA Health consent to treatment policy last week. It states that under the Commonwealth Family Law Act 1975, responsibility for any children under 18 years of age rests with the parents. How does WA Health's consent to treatment policy and the commonwealth's Family Law Act interact and intersect with this particular provision on mature minors?

Committee interrupted, pursuant to standing orders.

[Continued on page 4736.]